

**The impact of religion/spirituality on people living with HIV and
AIDS: A sample from KwaZulu-Natal**

**by
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AIDS: A sample from KwaZulu-Natal**

by

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DECLARATION ON COPYRIGHT

I, the undersigned, J. Moodley hereby declare that the thesis is my own original work and that it has not been submitted, and will not be presented, to any other University for similar or any other degree award.

Signature

Date: 15 February 2017

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ABSTRACT

In South Africa, one of the most distressing concerns of many people living with HIV/AIDS is the stigma attached to this diagnosis. This intense stigma is psychologically traumatic, even leading to levels of depression. Religion or spirituality has come to be one of the most essential and effective coping strategies to live with the pandemic and depression as its consequence. This study sought to establish the impact of religion/spirituality on people living with HIV/AIDS using a convenient sample in South Africa. Using quantitative research methods, the study used the Beck Depression Inventory (BDI-II) to assess the severity of depression on HIV/AIDS victims. The BDI-II is presently one of the most commonly used scales for rating depression to indicate the level of distress the respondent is experiencing. To assess spirituality among people living with HIV, the Religious Coping (RCOPE) was used to measure the coping measures used by people living with HIV and AIDS. The results of the study established that, in both samples, respondents having a HIV positive status with depression levels within the spiritual/religious cohort, are different from those of the nonspiritual/religious cohort. Expressed differently, spirituality or religion seems to have a calming effect on the respondents to the extent that it lessens their level of depression. Furthermore, it was established that there is a considerably strong inverse relationship between religion/spirituality and depression. In fact, the correlation coefficient is -0.89 suggesting a near perfect negative relationship between the variables. In other words, as one's spirituality/religious quotient increases, one's depression levels decreases. The study concludes that, spirituality and religiousness plays an important role in the lives of patients with depression and HIV, and is the corner stone of coping strategies and longevity. Moreover, the study recommends that physicians should consider fusing in spirituality coping strategies in treating depressed HIV positive patients.

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ABBREVIATIONS

ABC	Abstain, Be faithful, Use condoms
AHWCA	Australian Health and Welfare Chaplaincy Association
AIDS	Acquired Immune Deficiency Syndrome
ARC	AIDS Related Complex
ART	Antiretroviral Therapy
ARV	Antiretroviral
BDI	Beck Depression Inventory
CBOs	Community-based organisations
CBT	Cognitive-behavioural Therapy
CDCP	Centres for Disease Control and Prevention
CNS	Central Nervous System
DNA	Deoxynucleic Acid
EAA	Ecumenical Advocacy Alliance
FBOs	Faith-Based Organizations
EST	Ecological Systems Theory
FDG	Focus Group Discussion
HAART	Highly Active Antiretroviral Therapy
HAD	HIV-Associated Dementia
HDRS	Hamilton Depression Rating Scale
HIV	Human Immunodeficiency Virus
HIVnp	HIV-negative patient
HIVpp	HIV-positive patient
HPT	Hypothalamus–pituitary–thyroid
IEC	Information Education and Communication
KZN	KwaZulu-Natal
LAMIC	Low-and-Middle-Income Country
MD	Major Depression
NACOSA	National AIDS Coordinating Committee of South Africa
NGO	Non-Governmental Organisations
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
NRC	Negative Religious Coping
NSP	National Strategic Plan
PLWHAs	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PTSD	Post Traumatic Stress Disorder
RCOPE	Religious Cope
RNA	Ribonucleic Acid
SACBC	Southern African Catholic Bishops' Conference
SANAC	South African AIDS Council
SCA	Spiritual Care Australia

SD	Standard Deviation
SMMEs	Small, medium and micro enterprise sector
SSVI	South African AIDS Vaccine Initiative
STD	Sexually Transmitted Diseases
USA	United States of America
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

In one study Klukow (2012), religiosity or spirituality had a significant inverse relationship with depression. This suggests the complexity of the study in question since there are a number of intervening variables that can be involved. For example, Christians who face crisis situations without a solution, may feel neglected by God, thus experience more depression. Recent literature by Tabei, Zare and Joulaei (2016), argue that religious beliefs together with other spiritual approaches, if adhered to, have a positive impact in reducing acute and chronic diseases. Cole (2005) and Lothane (2004) posited that spiritual experiences need to be taken seriously as an appropriate field of study in psychology. Jung (1933) articulated this postmodern principle, suggesting that psychology should interpret the spiritual experience of people as valid expressions of their psyche.

Spirituality plays an important role in South African conceptualization and understanding of illnesses such as HIV/AIDS (van Dyk, 2001). Findings from research conducted in the United States are mixed with respect to the spirituality-functioning relationship. More specifically, researchers examining spirituality found that it was inversely related to depression (Simoni & Ortiz, 2003). Klukow (2012) specifically looked at depression and Evangelical Christian spirituality. In contrast, Wachholtz (2013) found that prayer played a major role in reducing depression. In the same breath Bernstein, D'Angelo and Lyon (2013) discovered that religion/spirituality may play a positive role among adolescents living with HIV. This study further revealed mixed results particularly if religion is taken as a punishment. This suggests that there is no linear causal effect relationship between religion/spirituality and coping with HIV/AIDS and depression if participants are not carefully selected.

Spirituality is regarded as one of the resources that are used in reducing distress for a number of people across the globe. It was therefore important to examine this construct using the South African sample in order to share the scientific knowledge which brings the different worlds together. Numerous research studies conducted in the United States of America lend support to this hypothesis. First, many researchers have established that HIV-infected persons are more likely to report a number of different types of stressful factors when compared to similar non-infected persons, including sexual assault, partner abuse, and separation/divorce (Jones, Beach & Forehand, 2003). However, other research studies did not find significant differences between HIV-infected and non-infected individuals in terms of coping with challenging factors (Catalan et al., 1996). A recent study with African-American mothers found that a high level of family stressful events was associated with depressive symptoms, and subsequently with physical health status (Jones, Beach, Forehand & Foster, 2003). Researchers have also established a relationship between physical assaults and depressive symptoms (Murphy, Koranyi, Crim & Whited, 1999; Simoni & Ng, 2000), as well as between general negative life events and psychological distress (Catalan et al., 1996; Kimerling et al., 1999; Mellins, Ehrhardt, Rapkin & Havens, 2000; Silver, Bauman, Camacho & Hudis, 2003; Streib & Hood, 2016). Additional research studies have further shown that more cumulative stressful life events are also associated with faster progression of HIV to full blown AIDS (Leserman, 2003), and with poorer antiretroviral treatment adherence (Mellins, Kang, Leu, Havens & Chesney, 2003). It is clear that data from the United States with regard to HIV/Aids infected individuals revealed a strong association between stressful life events and malfunctioning; thus, warranting an investigation into these relationships in the South African context. Authors such as van Belzen (2010) emphasize cultural sensitivity when dealing with religious phenomena. This study ensured that the respondents' culture was taken into consideration during interviews.

There are only a few empirical studies in South Africa that have examined the rates of stressful life events among HIV-infected people, and even fewer that have assessed the relationship between the psychological functioning and spirituality. One study examined

the rates of gender-based violence among HIV-infected women in Soweto (Dunkle et al., 2004). These researchers found that the only type of trauma that was predicted by HIV status was intimate partner violence. For example, 38% of women experienced intimate partner physical abuse, 27% experienced intimate partner sexual abuse, and 40% experienced both physical and sexual abuse by an intimate partner. In addition, 35% of these women reported a history of child sexual abuse, 38% reported a history of forced first sexual intercourse, and 32% reported a history of an adult sexual assault by a non-partner. This study did not assess for the relationship between these stressors and psychological functioning; however, one study did find a relationship between negative life events and depression in individuals with HIV-infection (Olley, Seedat, Nei & Stein, 2004). Other studies, with HIV negative samples, have found a relationship between stressful life events and psychological distress (Pretorius, 1998; Spangenberg & Pieterse, 1995).

As such, existing data by Vyavaharkar et al. (2010) which is available from the United States highlights that the established relationship between HIV/AIDS and psychological distress in the United States may also hold true for South Africa. However, additional empirical research is necessary to further explicate this relationship.

1.2 Statement of problem

In South Africa, one of the most distressing concerns of many people living with HIV/AIDS is the stigma attached to this diagnosis (Simbayi et al., 2007). This intense stigma is psychologically traumatic, even leading to levels of depression. A significant amount of research has been conducted in the United States assessing the relationship between HIV/AIDS and psychological functioning. The majority of these studies have specifically examined the relationship between HIV/AIDS and depression. Recent meta-analysis indicated that the rate of major depression among individuals who are HIV-positive is twice as high as the rate among individuals who are HIV-negative (Ciesla & Roberts, 2001).

In the South African context, psychological stress is not an uncommon disorder in patients with HIV/AIDS (Olley, Seedat, Gxamza, Reuter & Stein, 2005). There are numerous personal factors that may act as moderators in reducing psychological distress from persons who are faced with the HIV/AIDS pandemic, but spirituality appears to feature strongly. In a study of assessing religion in victims of the post-apartheid era in South Africa, Moodley (2005) pointed out that 100% of the respondents pointed to Christianity and ancestors (amadlozi) as their religion and coping mechanism and as a way to alleviate stress. In fact, South Africa is a country where spirituality is very important. According to De Cruchy (2004), 75% percent of South Africans claim to be Christians and about 20% of the population claim to have alliance with other religions. Kourie and Kretzchmar (2000) pointed out that South Africa has a renewed interest in spirituality since the advent of democracy in 1994. Moodley (2005) pointed out that the apartheid era in South Africa resulted in a set of social phenomena that resulted in numbers of traumatised victims. The study explored the long-term impact of victims who lost their loved ones and consequently experienced post-traumatic stress disorder (PTSD). This group represents a large segment of the traumatised population in South Africa whose psychological needs remain valid. For these victims, especially after democracy, they see hope to spirituality. This study aims to investigate the correlation between spirituality and the stress situations in HIV positive individuals in South Africa.

1.3 Significance of the study

The present study is more likely to demonstrate the role played by religion/spirituality in addressing and possibly reducing the catastrophic impact of HIV/AIDS and depression in the South African context. The following sections will discuss its global and national effects, specialised South African policy around HIV/AIDS and its effect on the local socio-economic context.

1.3.1 HIV/AIDS a world pandemic

In an attempt to find proper treatment for HIV/AIDS patients, it was necessary to assess the impact of HIV/AIDS globally by examining the prevalence rates. The effect and treatment of HIV/AIDS is undoubtedly a major global concern. Over the past two decades, the implementation of prevention and care programs for those suffering from HIV/AIDS has greatly increased. Despite the development of new treatments and prevention programs, the destructive epidemic of HIV/AIDS continues to impact individuals and families worldwide. Since the first HIV/AIDS diagnosis in 1981, over 20 million people have died from HIV/AIDS around the world (UNAIDS, 2004). The Joint United Nations Programme (UNAIDS, 2004) estimated that five million people worldwide contracted HIV/AIDS in 2003, which is the highest number since the beginning of the epidemic. Most recent studies reveal that 33.2 million people are currently living with HIV/AIDS globally (UNAIDS, 2008). Although global statistics indicate a reduction of 16% as compared with the published estimate in 2006 (39.5 million), global statistics draw attention to HIV/AIDS as a serious epidemic that requires more urgent attention than it has received in the past.

It can thus be asserted that the HIV/AIDS pandemic has been recognized to have aggravated impacts on the general well-being, thereby acknowledged as a significant barrier to development (UNAIDS, 2013). The pandemic has caused significant economic harm. The HIV/AIDS pandemic has profoundly affected the economy, the work force, individual workers and their families, health care expenditures, the cost of labour, and savings and investments. AIDS also has pricey dire consequences, more so affecting the poor. The pandemic affects the people mostly during their most productive years, thus it has negative consequences for worker productivity, family income and national revenues (UNAIDS, 2013). It is the second highest cause of death and it mostly takes away the most productive personnel in developing countries, with a projection that 40% of the deaths will be accounted for by HIV/AIDS by 2020 (UNAIDS, 2013). In some middle-income countries, the cost of HIV/AIDS care is affected by the growing availability and use of antiretroviral medications for HIV-related illnesses. The use of antiretroviral drugs

has gone a long way into decreasing the number new cases of HIV/AIDS. However, the effect of antiretroviral medications on the cost of HIV/AIDS care in most developing countries is limited because of high cost and the lack of a medical infrastructure to manage the distribution and use of these therapies (UNAIDS, 2013). Generally, world-wide HIV/AIDS expenditure will intensely affect care in the future. The gap in new HIV infection rates and AIDS deaths between rich and poor countries, especially between Africa and the rest of the world, is likely to grow even larger in the next century.

1.3.2 HIV/AIDS an African plague

The devastatingly high statistics on the impact of HIV/AIDS world-wide are alarming. Estimates of the United Nations Agency for AIDS (UNAIDS) indicate that over 35 million people were living with HIV/AIDS in 2013, that nearly 40 million people have died of AIDS since the disease was first discovered in the early 1980's, and that new HIV infections among children have increased by 58% since 2001 (UNAIDS, 2013), progress being attributed to advancement in technology. Africa is one of the deadliest regions that the grip of HIV and AIDS has been with twenty-seven million people in Africa that are living with HIV/AIDS. Southern Africa has the highest HIV adult prevalence in the world. The infection rates in individual countries, such as South Africa, Botswana, Malawi and Swaziland are much higher. According to Parag (2009), the high infection rate suggests the magnitude, burden and impact of HIV/AIDS.

Statistics in 2004 indicated that Sub-Saharan Africa (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) was the most affected by the HIV/AIDS epidemic with 26.6 million of the people infected with HIV/AIDS and accounting for 2.3 million of the deaths in 2003. South Africa accounts for only 2% of the world's population, yet accounts for nearly one-third (32%) of all new HIV/AIDS infections and AIDS-related deaths globally (UNAIDS/WHO, 2004). In addition, national adult HIV/AIDS prevalence in Sub-Saharan Africa exceeded 15% in eight countries in 2005 such as, Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and

Zimbabwe (UNAIDS, 2013). Meanwhile in other regions of the African continent, empirical literature pointed out that Africa is greatly affected by the HIV/AIDS pandemic, and this is most likely to affect also the demand and supply of quality in all sectors of the African economy, especially South Africa. Literature also pointed out that HIV/AIDS is an epidemic that could become the leading cause of adult morbidity and mortality and this impact would put a severe depression in the nation's progress. One factor that compounds the impact of HIV/AIDS and destroys mitigation efforts is the stigma around the disease. Negative and unfair attitudes toward persons living with HIV/AIDS (PLWAs) impose enormous pain to the people infected and their loved ones, and could also lead to fear of seeking help or assistance among PLWAs (Githinji & Chang'ach, 2011).

1.3.3. HIV/AIDS pandemic in South African

HIV/AIDS remains one of the many challenges affecting South Africa to date (Steyn & Mfusi, 2013). In South Africa, it is estimated that 6.5 million people are living with HIV/AIDS and the magnitude of this problem can be outlined in that two in every five people are HIV positive. At a human level, the financial burden of HIV/AIDS is greater than deaths from other causes, because it affects the most productive age group that is the 15-49 years old, and because of the cost of medication and caring for the sick, family members are more likely to face financial problems. HIV/AIDS leads to financial, resource and income impoverishment (Barnett & Gotlib, 1988), and puts severe strain on individuals and households. The psychological stress that is a direct consequence of the impact of HIV/AIDS on individuals and families can compromise school and work performance, family relationships, and the capacity to take care of children. People may also end up partaking in risky behaviour such as alcohol, drug abuse and in unsafe sexual behaviour (Barnett & Gotlib, 1988; Booysen & Summerton, 2002, Zhou, 2010).

Research by UNAIDS (2008) addressed the impact and prevalence of HIV/AIDS in the Sub-Saharan countries. They indicate that South Africa has the highest prevalence of HIV/AIDS in Sub-Saharan Africa, and are significantly impacted by the HIV/AIDS

epidemic. An estimated 6.5 million people live with HIV/AIDS in South Africa (Department of Health South Africa, 2007). The Department of Health (2003) recorded the prevalence rates range significantly by the regions. Dorrington, Bourne, Bradshaw, Laubscher and Timaeus (2006) provided statistics of the prevalence range in different provinces. The authors' estimates ranged from 11.2% (Western Cape) to 36.5% (KwaZulu-Natal); Gauteng is the smallest province in South Africa, yet it has the second highest estimated HIV/AIDS prevalence rate (32%). In addition, research indicated that KwaZulu-Natal has the first highest prevalence rate in South Africa (Dorrington et al., 2006). Belzen and Lewis (2010) are of the view that cultural psychology has a strong relationship with religion and that it may make a remarkable contribution to mental health issues. Also, in an attempt to finding proper treatment for HIV/AIDS patients, it will be necessary to assess the impact of HIV/AIDS by examining the birth rates and changes in life expectancies. Dorrington et al. (2001) provided data regarding the impact of HIV/AIDS by examining the death rates and alterations in life expectancy of South Africans. The impact of HIV/AIDS on mortality in South Africa is significant, accounting for 25% of all deaths in 2000. An estimated 1.8 million South Africans have died from AIDS-related disease since the epidemic began. Total annual deaths (from all causes) increased by 87% from 1997 to 2005 (Statistics South Africa, 2005, 2006 & 2007; Bradshaw, Laubscher, Dorrington, Bourne & Timaeus, 2004; Dorrington et al., 2001; Anderson & Phillips, 2006).

In addition to the significant high death rates, scientists predict that life expectancy for HIV/AIDS infected people will fall from the current 54 years to 41 years by 2010 (Dorrington et al., 2001). In 2006, life expectancy at birth for males was 49 years and 52.5 years for females. This decline in life expectancy contributed to the decline in the country's population growth rate from 1.25% in 2001-2002 to slightly more than 1% in 2005-2006 (Statistics South Africa, 2007). Further reports by the U. S. Bureau of Census (1999) indicated that HIV/AIDS related death rates are higher globally. There are no improvements in death rates for children and general population growth has declined.

In addition to finding proper treatment for HIV/AIDS patients, it will be necessary to assess the impact of HIV/AIDS on women. Studies conducted by UNAIDS/WHO (2002) showed that South African women are impacted more severely than men and comprise 57% of all the new HIV/AIDS infections. Young women in South Africa face greater risks of becoming infected than men. Indeed, young women between the ages of 15-24 account for 90% of new HIV/AIDS infections (Rehle et al., 2007). HIV/AIDS incidence among women aged between 20 and 29 in 2005 was approximately 5.6%, which is more than six times higher than for men of the same ages 0.9% (Rehle et al., 2007).

The Department of Health (2003) indicated 26.5% of pregnant women were HIV positive, aged 25 to 34. The current death rate among young women is 3.5 times higher than the death rate when HIV/AIDS was first diagnosed. Furthermore, the current death rate is higher among younger women (20 years old) than among older women (late 50s and 60s). The epidemic varies significantly between provinces for HIV/AIDS prevalence among pregnant women. The highest is in KwaZulu-Natal province (39%), and lowest in the Northern Cape (15%), Western Cape (16%) and Limpopo (19%) provinces. In the five other provinces (Eastern Cape, Free State, Gauteng, Mpumalanga and North West) at least 25% of women attending antenatal clinics in 2006 tested HIV-positive.

Rehle et al. (2007) pointed out that the prevalence rates range significantly within the provinces and populations. In the Northern Cape, average prevalence among pregnant women ranged from 5% at clinics in one district to almost 23% in another, while in the province of Limpopo it varied from 14% to 28%, depending on the district. Although only 9% of South Africa's population, ages 2 years and over, live in urban informal settlements, 29% of people living with HIV/AIDS are found in these areas. Dorrington et al. (2001) noted that the impact of AIDS-related deaths on women of childbearing age is persistently high.

Most recent data by the Department of Health South Africa (2007) notes that HIV/AIDS infection levels might be levelling off, with prevalence in pregnant women at 30% in 2005

and 29% in 2006. The decrease in the percentage of young pregnant women (15-24 years) found to be infected with HIV/AIDS also suggests a possible decline in the annual number of new infections.

Douglas (2000) suggested that HIV/AIDS is most prevalent among Black South African women living in rural areas. Barbarin, Richter and DeWet (2001) indicated that Black South African women are the poorest, least educated, and most economically marginalized group in South Africa. The authors also suggested that the poverty, low education and economics make South Africans particularly vulnerable to HIV/AIDS.

In an attempt to minimize the pandemic, South Africa has launched many prevention campaigns, such as Lovelife (2000), aimed at reducing the spread of HIV/AIDS. The previously stated statistics clearly indicate that the HIV/AIDS epidemic continues to be a major problem among South African men and children, but even more significantly among women. Based on the prevalence and death rates of persons with HIV/AIDS in South Africa, one can conclude that there are limited studies in addressing many aspects that will be examined in this research. Research pertaining to the alleviation of the impact on HIV/AIDS infected people is clearly limited. The development of methods of interventions aimed at improving the quality of life among all HIV/AIDS infected people in South Africa presents a significant, yet beneficial challenge because of its unique political background.

However, literature has come to document the impact of HIV/AIDS on the infected and affected. It has been asserted that older people have been shown to have a higher burden of HIV than previously expected (Mutevedzi & Newell, 2011; Negin & Cumming, 2010; Wallrauch, Barnighausen & Newell, 2010, Olowu, 2012). Richter and Desmond (2008), stated that the burden of HIV is also frequently found in caregivers of children and young adults. Little is however known of the prevalence and correlates of depression in older people by HIV status or how this may impact on their health perceptions. This highlights the notion that diseases such as HIV/AIDS brings about unrelenting pain and burden, more so on those who are affected by the pandemic. Sub-Saharan Africa faces a triple

burden of HIV, TB and chronic disease epidemics. In South Africa, communicable and non-communicable disease burden is high (Coovadia, 2009; Karim, Churchyard, Karim et al., 2009; Mayosi et al., 2009) as is the burden of depression (Tomlinson et al., 2009). Psychological distress has been associated with HIV as well as hypertension and diabetes (Kagee, 2010). However, the relationship between depression and HIV is complex (Gupta et al., 2010; Szaflarski et al., 2012). Some studies report an HIV diagnosis to be associated with becoming depressed (Hand, Phillips & Dudgeon, 2006; Boarts et al., 2009). On the other hand, others report that depression is associated with rapid HIV disease progression (Ickovics et al., 2001) either directly, or through inconsistent use or poor adherence to antiretroviral treatment (Carrico et al., 2011; Gonzalez, Batchelder, Psaros & Safren, 2011). There is even evidence of an increased risk of onset of HIV-related dementia among depression patients (Farinpour et al., 2003), but less information on the impact of antiretroviral therapy (ART) on this relationship.

1.3.4 HIV/AIDS policy in South Africa

South Africa has responded to the HIV/AIDS challenge by introducing policies and programs which were implemented through various Ministries led by the Ministry of Health. These policies were meant to provide the South African population, which includes medical practitioners and patients, with the knowledge and skill to protect themselves from infection and to assist others who are infected. This was done under the supervision of adequately trained facilitators. These policies were implemented via the life skills approach which is the adaptive and positive behaviour that enable individuals to deal effectively with demands and challenges of everyday life (Bialobrzaska, 2007).

Pre-independence in 1992, the National AIDS Coordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV and AIDS. Cabinet endorsed this strategy in 1994. This in turn led to the National AIDS Plan in 1994. Since then, the government's policy evolved to formulating the HIV/AIDS and Sexually Transmitted Disease Program in 1996, and the establishment of the South African

National Aids Council in 2000 (Joachim & Sinclair, 2013). The NACOSA policy was reviewed in 1997 to streamline it in accordance to its strengths and overcomes its own weaknesses and that of the health sector in general. This translated to the focus on disease-specific approach to HIV and AIDS. The results of the extensive review were recommendations related to capacity building for implementing agencies, increasing political commitment, increase involvement of People Living with HIV/AIDS (PLWH) and strengthening integration (HIV/AIDS & STI Strategic Plan for South Africa, 2011).

To supplement the success of this national policy, additional policies were also implemented. Development of other national policies, including the Syndromic management of STDs, the establishment of the South African AIDS Vaccine Initiative (SAAVI) in 1998, the establishment of South African AIDS Council (SANAC), the establishment of the national Interdepartmental committee on HIV and AIDS, as well as the development of a Strategic Framework for a South African AIDS Youth Programme took place (HIV/AIDS & STI Strategic Plan, 2007). To further strengthen the implementation of the NACOSA policy, as well as to enhance the national response to HIV/AIDS & STIs, the National Strategic Plan (NSP) (2000-2005) was developed and has been the cornerstone of South Africa's response in mitigating against HIV and AIDS. The NSP seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the past decade. It is informed by the nature, dynamics and character of the epidemic, as well as developments in medical and scientific knowledge.

The aim of NSP was to particularly reduce the number of new infections among people in the 15-24 age group (Pettifor et al., 2005). The interventions that were identified as essential and needed to reach the NSP's goals are structured under four key priority areas:

- Prevention;
- Treatment, care and support;

- Human and legal rights; and
- Monitoring, research and surveillance (NSP, 2000-2005).

An assessment of the implementation of the NSP 2000-2005 has been useful in defining the capacities of the implementing agencies. The outcome of reviewing of the NSP 2000-2005 established that in as much as the NSP was widely adopted by all stakeholders, leading to the establishment and expansion of key programmes such as health education, Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), and Antiretroviral Therapy (ART), it was also established that, stigma and discrimination remain unacceptably high and this has been a deterrent to the utilization of some of the services. Furthermore, implementation of programmes tended to be vertical, with some serious capacity deficits especially in the previously disadvantaged rural communities. Moreover, the two major weaknesses of the NSP 2000-2005 were poor coordination at the level of the South African AIDS Council (SANAC), as well as lack of clear targets and a monitoring framework (HIV/AIDS & STI Strategic Plan for South Africa, 2007-2011). This led to the recommendations that assert:

- A need for a revision of the behaviour change approaches;
- Strengthening government implementation;
- Consolidating and build existing partnerships;
- Strengthening coordination, monitoring and evaluation at the level of SANAC;
- Increasing the contribution of the business sector, especially with regard to the (small, medium and micro enterprise sector) SMMEs;
- Making all interventions accessible to people with disabilities

Review of the NSP led to the development of the HIV/AIDS & STI Strategic Plan for South Africa 2007-2011, which emanates from the National Strategic Plan of 2000-2005, as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment. It represents the country's multi-sectorial response to the challenge of HIV infection and the wide-ranging impacts of AIDS. The constraints faced under the NSP has

led to the calls for a more concerted effort of the intensification of the multi-sectorial national response to HIV and AIDS through much improved coordination and monitoring. Furthermore, this called for a special focus and recognition of people with disabilities. In other words, the challenge of HIV and AIDS in South Africa requires an intensified comprehensive, multi-sectorial national response.

This response should:

- “Address the social and economic realities that make certain segments of society most vulnerable;
- Provide tools for prevention of infection; and
- Provide services designed to mitigate the wide-ranging impacts of the epidemic” (HIV/AIDS & STI Strategic Plan for South Africa, 2007-2011).

The national multi-sectorial response to HIV and AIDS is managed by various structures at all levels. Provinces, local authorities, the private sector and a range of Community-based organisations (CBOs) are the main implementing agencies. Each government structure has an individual, designated task-team responsible for planning, budgeting, implementation and monitoring HIV/AIDS interventions. In this plan, communities are targeted to take more responsibility and to play a more meaningful role (HIV/AIDS and STI Strategic Plan 2007-2011).

More policies and guidelines were promulgated and these include workplace policies in all government departments, the Integrated Nutrition Programme, Maternal, Child and Women’s Health, Development of the District Health System, Patients’ Right Charter, the White Paper on Transformation of the Health System in South Africa, the Health Charter, as well as many other relevant policy guidelines. The South African HIV/AIDS policy is not without controversy. The country’s response to the epidemic for a period of about eight years from 1999-2008, was hampered by misguided political leadership questioning the causality of HIV/AIDS and the effectiveness of ART. Owing to this political stand-off,

South Africa had an adult HIV/AIDS prevalence rate of 17.3% in 2011 (Joachim & Sinclair, 2013). Furthermore, there were 310,000 AIDS related deaths that year and 1.9 million orphans due to the AIDS deaths, coupled with a dire situation of high mother-to-child transmission rate because of restricted use of freely donated nevirapine, which prevents mother-to-child transmission.

However, after the introduction and implementation of HIV/AIDS counselling and a Testing Campaign in 2010, there was a significant improvement. The new strategy led by the Minister of Health, Aaron Motsoaledi is accounted for the improvement made. In a three-year period, 20 million South Africans were tested for HIV/AIDS; mother-to-child HIV transmission decreased; life expectancy had risen; over 600,000 men had voluntarily been circumcised. The number of facilities providing antiretroviral (ARV) treatment increased significantly. The number of patients receiving ARV treatment; and expenditure on combating HIV/AIDS in South Africa is now the highest of any middle-income or low-income country. This is owed to the strategy, which called for regular HIV testing and counselling, promoting behaviour change and regular condom use, providing voluntary medical male medical circumcision, scaling up syndromic management of STI and intensified PMTCT programs. It is suggested that more professionals are needed to implemented task shifting and able to test for HIV, prescribe ARVs and administer ARV treatment (Joachim & Sinclair, 2013). The current government's willingness for transformation of the HIV/AIDS policy is also demonstrated through a new National Strategic Plan on HIV/AIDS and TB for the period 2012–2016. This Strategic Plan will integrate HIV and AIDS and TB in the same strategic plan and will outline a 20-year vision of the country in the fight against the double scourges of HIV/AIDS and TB. The transformation of the South African HIV/AIDS policy South Africa has become a model for comprehensive HIV/AIDS management. There is therefore a need to align the treatment and prevention strategies so as to deal with the stigma and failure to adhere to prescribed medicines and therapeutic interventions (Morgan, Green & Boesten, 2013).

1.3.5 HIV/AIDS in the South African socio-economic context

Ramerini (2006) shed light on the spread of the epidemic by providing a historical context for the full understanding of the spread of HIV/AIDS. The author also provided an analysis and discussion of the historical and social context of South Africa. In 1652, the Dutch settled in the Cape of Good Hope. The people of South Africa have been the victims of continuous colonialization by the Dutch, French and British settlers. The battles between the Xhosa and the Boers, such as the Battle of Blood River, and Anglo/Boer War between the Boers and the British left emotional scars to a number of people. The war created a context of hatred, violence and political unrest until 1994. The wars resulted in policies of racial segregation, discrimination, and restriction of rights among Black, Indian and Coloured South Africans.

Ramerini (2006) pointed out that in the early 1900s the Union of South Africa was created, federating the British colonies and the old Boer republics, thus denying Blacks the right to vote. In 1913, the Native Land Act was passed, which restricted Black ownership to 7% of the country's land. The South African Native National Congress of 1912 was a result of restrictions put against Black South Africans (Encyclopaedia Britannica, 2008). In 1948, after World War II, the National Party was elected and made responsible for establishing the Apartheid system, under which racial segregation was strictly enforced (laws against interracial sex or marriage, separate and inadequate education systems for Black children).

Thompson (2001) pointed out that in 1994, under the leadership of Nelson Mandela and F. W. de Klerk, segregation was dissolved. Further, the new leadership resulted in a new constitution giving all South Africans the right to vote for the first time in South African history. Democracy resulted in the election of President Nelson Mandela, the example of forgiveness and reconciliation for all South Africans.

After one decade of democracy and the dismantling of the apartheid system, South Africa continues to face socio-economic problems that stem from the economic legacy of the apartheid system. Researchers such as Campbell and Mzaidume (2001), and Baldwin-Ragawen, London, and DeGruchy (2000) pointed out that under the apartheid system, non-whites were disenfranchised politically, socially, and economically, and were often the victims of human rights violations.

In post-apartheid South Africa, the majority of Blacks still continue to suffer the impact of the apartheid system of abuse. The past South African regime dominated the land with abuse, violence, hatred, and poverty. Recent statistics by the World Bank (2016) indicated that approximately 13% of the nation's population lives in 'first world' conditions, whereas 53% live in 'third world' conditions, and 35% of the population lives on less than two U.S. dollars a day. Rey (2002) pointed out that South Africa's wealth distribution is still skewed after two decades of democracy, given that 10% of the people, mostly whites, control 80% of South African riches. The ills of the past left many South Africans continue to experience homelessness, live in degraded neighbourhoods and suffer due to unemployment. The above statistics reveal the significant income disparity between the rich white and the poor Blacks in South Africa. Also, black women are more prone to unemployment due to a lack of skill and low education (Campbell & Mzaidume, 2001).

Delius and Glaser (2002) suggested that the South African history of colonialism and apartheid largely impacted issues related to sexuality. The authors pointed out ways that South Africans' view of sexuality and sexual communications have changed as a result of these political systems. According to Delius and Glaser (2002), before colonialism, Black South Africans had a more liberal and open view of sexuality, where sex was discussed often and comfortably. In Black communities, adolescent peer influence often helped monitor and manage adolescent sexuality. With the influence of Western society, sexuality became a taboo topic, and the positive influence of adolescent peer groups diminished.

Jones, Beach and Forehand (2001) suggested that in understanding the context of HIV/AIDS, it is very important to highlight the current political context, as it relates to HIV/AIDS in South Africa. The author highlighted the considerable amount of international attention received in response to comments made by President Thabo Mbeki and his spokesperson Mr. Mankahlana, on HIV/AIDS. In 2000, President Mbeki discussed his scepticism that HIV/AIDS may be caused by poverty. Consequently, the South African government spent two million rand on research re-examining the etymology of HIV/AIDS (Jones et al., 2001). President Mbeki's administration was criticized worldwide and by many HIV/AIDS activists in South Africa who believed that his comments were contrary to current scientific knowledge regarding HIV/AIDS.

Jones et al. (2001) suggested that President Mbeki's response and comments must be understood within the context of the apartheid South Africa. Many Black South Africans experienced widespread exclusion and marginalization from scientific and medical information. Certainly, President Mbeki's comments did not settle well with Western scientific and medical research (Jones et al., 2001). For the purposes of this literature review, it is important to note that these types of comments have a larger impact on HIV/AIDS in South Africa, and will certainly increase confusion about HIV/AIDS prevention and interventions.

After ten years of democracy, South Africa continues to struggle with making major transitions in the area of prevention and intervention of HIV/AIDS, while also dealing with the pollution of the apartheid poverty. The National Unity and Reconciliation Act of 1995 expressed that South Africans are slowly moving from the legacy of apartheid toward pure reconciliation between all people of their society. This reconciliation process will take many decades.

Masoga (1999) indicated that Black South Africans are trying to keep a balance in their commitment to their African roots. Masoga (1999) also pointed out that rituals performed by South Africans are a description of a deep pain in people's heart and a hole in people's

soul. These rituals indicate avoidance patterns, intrusive thoughts and histories of post-traumatic depression, suicide ideation, substance abuse and abusive relationships.

Moodley's (2005) statistics point out that people who experience or witness traumatic disasters make comments such as, "Not one day has passed when I have not thought about her/him" or "Not one day has passed when I have not ached to hold her/him in my arms once more" (Moodley, 2005:114). Considering the traumatic experiences Black South Africans have been exposed to in the past, the South African society can be viewed as having a distinct history and challenging current socio-political issues. This creates an interesting context for the exploration of the relationship between HIV/AIDS status, levels of depression, and the impact of spirituality on depression levels, and access to resources within this unique context. Furthermore, when exploring the impact and devastation of HIV/AIDS on an individual's functioning, it is important to consider the contextual basis of the present study.

1.4 Purpose and aims of the study

This aim of the study was to explore the relationship between religion/spirituality and depression in HIV/AIDS persons in South Africa. The study determined the forms of religion or spirituality that are frequently used in the South African context. The present study attempted to address the impact of religion/spirituality and depression on people living with from HIV and AIDS.

1.5 Hypotheses

This research puts forth the following hypotheses:

- 1.5.1 People living with HIV who have high levels of religious conviction or spirituality will exhibit lesser levels of psychological symptoms.

1.5.2 People living with HIV who have low levels of religious conviction or spirituality will exhibit more levels of psychological symptoms.

1.6 Conceptual framework

When examining the impact of HIV/AIDS in South Africa from a conceptual standpoint, the biopsychosocial model is utilized. Winiarski and Winiarski (1997) provide a guideline of what should be considered when using the biopsychosocial aspect.

- The biological aspect of a person is important to consider the impact of flesh, blood, bone, organism and viral problems.
- The psychological aspects are important in considering the intrapsychic processes of the person, including factors such as emotions, self-judgments, motivations and coping styles.
- The social aspects of a patient are important as it is necessary to consider family involvement, social support, community influences and societal pressures and influences (Winiarski & Winiarski, 1997).

The biopsychosocial model will be used as a guide in examining how HIV/AIDS affects the functioning of South Africans. Several researchers in the United States found the biopsychosocial model to be helpful in understanding and guiding research and practice around HIV/AIDS and psychological functioning (Cohen, 1990; Cohen & Weisman, 1986; Marcus, Kerns, Rosenfeld & Breitbart, 2000; Schlebusch & Cassidy, 1995; Thomason, Jones, McClure & Brantley, 1996; Wolfe et al., 1991).

When trying to identify resources in the relationship between HIV/AIDS and psychological functioning, the biopsychosocial-spiritual model theorises the importance of examining

both individual and socially shared practices. This research is concerned mainly with examining the influence or impact of spirituality through the following specific questions:

- Do you have religious/spiritual beliefs?
- Think about other people in your community. Compared to them, how religious/spiritual are you?
- Think about other people in your community. Compared to them, how much does religion/spirituality help you in your life?
- How often do you participate in religious activities by yourself (e.g. prayer, meditation, talking to ancestors)?
- How often do you participate in religious activities with other people (e.g. prayer group, Church, bible study, religious ceremonies)?
- In what ways does religion/spirituality help in your life?

When examining coping styles, this study will draw on Folkman and Lazarus' (1980) coping model in which two styles of coping are identified: problem-focused coping and emotion-focused coping. Problem-focused coping is defined as taking goal directed, action-oriented steps aimed at altering the cause of stress. Emotion-focused coping strategies are aimed at managing the emotions aroused by stressors. Research examining these coping styles with HIV/AIDS infected persons in the United States indicates that both coping styles may be useful. Problem-focused coping has been associated with better psychological functioning in HIV-infected individuals (Friedland, Renwick and McColl, (1996); Pakenham, Dadds and Terry, (1994) and certain forms of emotion-focused coping (i.e., seeking support and optimism) have been associated with improved psychological functioning (Moneyham et al., 1998). Moreover, both of these coping styles have specifically been found to be associated with fewer depressive symptoms (Ball, Tannenbaum, Armistead, Maguen & Research, 2002; Grassi; Righi, Sighinolfi, Makoui & Ghinelli 1998; Moneyham et al., 1998). In the United States, it appears that an important determinant of psychological adaptation to HIV/AIDS infection

is how well one is able to cope with the diagnosis and the disease (Turner-Cobb et al., 2002).

1.7 Methodology

This section expounds on the research design used in this study. It also discusses the data collection methods utilised. The study targeted respondents from KwaZulu-Natal Province community clinics where the patients, in this case, the participants receive their medication. Respondents were also targeted from Non-Government Organizations (NGO's) in KwaZulu-Natal, where participants are tested, supported and counselled.

1.7.1 Research design

A quantitative research method was used to analyse the impact of religion or spirituality on depression among HIV and AIDS victims.

In view of the sensitivity of the topic, the researcher used convenience sampling. The sample size was 240 participants; for according to Cooper, Schindler and Sun (2006:550) "when sample size approaches 120, the sample Standard Deviation becomes a very good estimate of the population standard deviation; beyond 120 (the normal distribution with more tail area than in a z normal distribution) and z (the normal distribution of measurements assumed for comparison) distributions are virtually identical".

1.7.2 Data collection methods

Data was collected using a questionnaire; a fluent African language speaker was employed to administer the questionnaire to respondents in their African language. In the questionnaire, the Beck Depression Inventory (BDI-II) was chosen to assess the severity of depression on HIV/AIDS victims. The BDI-II is presently one of the most commonly used scales for rating depression and to indicate the level of distress the respondent is

experiencing. To assess spirituality among people living with HIV, the researcher designed a new scale in selecting items from the Religious Coping (RCOPE), which did not have a coping character. The information was used in conjunction with professional judgment, taking into account the context of the instrument's administration and any other pertinent information concerning the individual. The rationale was that concentration tends to be on symptom reduction. If the intervention, that is religion/spirituality, can have an effect on symptom/s, then the researcher has demonstrated the impact of the intervention. In addition, the scales found in the questionnaire have been used before, validity and reliability issues were addressed.

1.8 Limitations

There is no currently available research that examines the coping-functioning relationship in a sample of people living with HIV/AIDS in South Africa. Given its relationship to functioning among United States infected, it is critical that this relationship be explored within the South African context. Due to the diversified forms of religion in the South African context, the present study may not be able to provide an accurate representation of spirituality and its influence on HIV/AIDS persons. The translation of the instrument used in the Western contexts undoubtedly posed some validity and reliability of the results.

1.9 Layout of the thesis

Chapter One outlines the introduction and background of the study. Chapter Two provides literature reviewed pertaining issues of religion, depression, HIV/AIDS and spiritualism, as well as the theoretical framework guiding this study. Chapter Three provides the methods used in collecting data and data analysis. Chapter Four therefore provides discussion about the study findings. Lastly, Chapter Five gives a conclusion and recommendations for the study, as well as areas of further research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Theoretical and empirical literature points out that Africa and the rest of the world in general is greatly affected by the HIV/AIDS pandemic, which is most likely to affect the socio-economic fabric of society. This study explores the extent and effect of spirituality/religiousness and how it influences people living with depression and HIV/AIDS. Further literature is engaged and deliberated on, providing a thorough overview of HIV/AIDS, its different stages, challenges and treatment of the disease. Literature review will also cover the theoretical and conceptual aspects of the study, potential disparities for further interrogation and a chapter synopsis.

2.2 Spirituality

Spirituality, broadly defined as the concept that gives meaning and purpose to life, is often a central issue for patients at the end of life or those dealing with a chronic illness such as HIV/AIDS (Cotton, Zebracki, Rosenthal, Tsevat & Drotar, 2006). Religion/spirituality is a complex construct that can incorporate as internal, personal and emotional expressions. It can be assessed by spiritual well-being, peace and comfort derived from faith, or spiritual coping. Also, it can be a formal, institutional, and outward expression of religion. In addition, it can be assessed by the importance of religion, belief in God, and frequency of attendance at religious services or prayer (Skokan & Bader, 2000). Spirituality encompasses all aspects of being human and is a means of experiencing life. Spirituality has also been defined as an integral dimension of the health and well-being of every individual (Skokan & Bader, 2000). In descriptions of spirituality, the following nine words appeared most frequently: personal, life, principle, animator, being, God, quality, relationship and transcendent (Emblem, 1992).

Looking into its conceptualization, it can thus be asserted that several authors have attempted to define it, but only to come out with quite vague definitions. There are ongoing debates about the need to distinguish spirituality from religion or religiosity. Furthermore, it has been established that the common points of any definition of spirituality are that it is a subjective religious experience, and that it may or may not include institutionalized religion (Larson, Swyers & McCullough, 1998). The most common attributes used to describe spirituality are: 1) it is a transcendent or spiritual state accompanied by a sense of existential meaning or purpose [which will be described here in slightly different terms than those used in chapter one]; 2) it provides a deep sense of hope; 3) it includes the ability to establish deep interpersonal connections and 4) it is somehow involved with religious practices.

Spirituality has thus become an essential tool to deal with the heavy burden of living and coping with a pandemic, by enabling people living with chronic diseases like HIV/AIDS to cope with disease to positively frame their mind and regain purpose of living in the face of an often-devastating situation. Belief and constant spiritual/religious strengthening often is believed to lead to improved health, health-related quality of life and overall well-being of a human being. Spirituality is an essential link between religiosity and depression, and may mediate this relationship. Furthermore, spirituality has been identified as a potential mediator of psychological distress among patients with advanced cancer and AIDS (Cotton et al., 2006).

Hence the motivation to undertake this study promotes the undertaking of research relating to spirituality/religiousness and how it affects people living with HIV/AIDS, by the furthering of existing literature, which asserts that “despite the body of empirical evidence supporting a mostly salutary effect of various aspects of spirituality/ religion on mental and physical health outcomes in people with chronic health conditions, relatively little attention has been paid to the role of religion/spirituality in the lives of people living with HIV/AIDS” (Cotton et al., 2006:6). Spirituality is of great significance for those diagnosed with chronic illnesses such as HIV/AIDS or Cancer. This may be that these diagnoses

often force patients to think about their mortality, while the unpredictable nature of the diseases may limit the usefulness of previously used coping strategies. Spirituality provides one with the inherent ability and power to properly align their mental strength, through which they may interpret events to help gain an understanding of him or herself, and be able to cope with unpleasant or unavoidable circumstances without becoming depressed.

The subsequent sections further explore spirituality in terms of its dimensions, its essential elements and various perspectives on spirituality, its expression of the unconscious, spiritual development and an acknowledgement of spirituality in psychotherapy.

2.2.1 Dimensions of spirituality

In the holistic perspective of health care, the body, spirit and mind are interconnected and interact in a dynamic way in a 'whole person,' making it difficult and artificial to try to separate these three dimensions. However, health care providers find it useful to distinguish between them for purposes of assessment and treatment. One way to differentiate between them is the following (Mansen, 1993; Taylor & Ferszt, 1990):

- The physical dimension (body) is world-conscious. It is that aspect of individuals that allows them to taste, feel, see, hear, smell and be experienced by others.
- The psychological dimension (mind) involves self-consciousness and self-identity. It is that aspect of an individual that deals with issues related to human interactions (and associated emotions such as grief, loss and guilt) on an intimate level.

- The spiritual dimension (spirit) is described as a unifying force within individuals, integrating and transcending all other dimensions. This dimension is also described as God-consciousness, or related to a deity or supreme values. It is concerned with the meaning of life, individual perceptions of faith and an individual's relationship to the ultimate being (Puchalski, 2001).

2.2.2 Essential elements of spirituality

It is of paramount importance for health care practitioners to understand the key elements of spirituality and how different individuals express them, so as they can be able to appropriately identify their clients' spiritual needs and provide spiritual care. Literature has revealed that the self, others and 'God' provide the key elements within a definition of spirituality and that other emerging themes, namely meaning and purpose, hope, relatedness/connectedness, beliefs/belief systems and expressions of spirituality can be articulated in the context of those three key elements (Dyson, Cobb & Forman, 1997). The essential elements of spirituality are further expounded hereunder as follows: Self, Others and supreme being (God).

The centrality of the relationships between self, others and a higher power of God is a major focus of spirituality and a prominent emerging theme in the spiritual literature.

- Self: The individual's inner self and inner resources are fundamental in the exploration of spirituality (Puchalski, 2001).
- Others: The individual's relationships with others are equally important. The need for affiliation and interdependence has long been recognized as part of the human experience (Puchalski, 2001).

- God: The concept of God and a person's relationship with God has traditionally been understood within a religious framework. Today however, a broader and less restrictive framework is emerging. God is experienced as a unifying force, life principle or essence of being. The nature of God may take many forms and have different meanings for different individuals. Individuals experience God in many ways, such as in relationships, nature, music, art and pets. For example, nurturing children or caring for plants and animals can provide a sense of self-satisfaction and joy (Carrol & Walton, 1999).

Effective health care providers and spiritual care providers integrate these expressions of spirituality in their care of clients (Puchalski, 2001). Spiritual relationships with self, others and a higher power can be a tremendous source of comfort, providing healing energy and strength to an individual. This energy can be reciprocal, insightful and meaningful for both health care providers and clients (Dyson et al., 1997; Carrol & Walton, 1999).

Other pivotal elements also feature strongly under Spirituality. These (discussed hereunder) are, meaning and purpose, hope, transcendence, relatedness/connectedness, beliefs and beliefs system.

a) Meaning and purpose

The quest to find meaning in life emerges as a dominant theme in spirituality, with the relationship to self, others and God contributing to its discovery (Dyson et al., 1997). Meanings in life: "may be heavily weighted by personal and unique values and histories; for others, meanings may stem largely from the community and culture in which we live. It is well established that from a life span perspective sources of meaning in people's lives may be thought of as a continuum or as a developmental trajectory that unfolds throughout life journey" (Hasselkus, 2002: 3). The need for purpose and meaning in life is a universal trait and may be essential to life itself. If an individual is unable to find meaning and purpose, all aspects of his or her life may be affected and a sense of

emptiness and unworthiness can result. Spiritual distress may then be experienced, which can contribute to emotional distress and can ultimately lead to physical problems (Nagai-Jacobson, Gail & Burkhardt, 1989). Frankl's (1984) description of life in the Nazi Concentration camps exemplifies how humans can find purpose and meaning even in the most degrading and inexplicable circumstances. Frankl sought meaning and purpose by adopting an almost Buddhist attitude of acceptance when faced by seemingly intolerable circumstances. According to Frankl (1984), by accepting your situation, life can never cease to have meaning and purpose even when one is deprived of everything or facing death. It has thus also been asserted that spiritual persons are more likely to experience meaningful life as compared to non-spiritual persons.

b) Hope

Ross (1981) suggests that hope is a positive and potent spiritual practice with the power to pull us through difficult times. It is a ray, a beam, a glimmer; the break in the clouds; the light at the end of the dark tunnel, and it can make a profound difference in whether one lives or succumbs to death. Frankl (1984) asserts that, hope is how we view our lives, it is often discovered in unexpected places. Hope can be learned through practicing patience, the ability to tolerate delays and a willingness to let events unfold in their own time. It is a mixture of courage, confidence, persistence and the determination to keep going no matter what happens. According to Carson, Soeken, Shanty and Terry (1990) and Rajakumar (1995), hope increases our self-esteem and well-being. We have hope when we can say that all will be well, and mean it.

Hope is perceived as emanating from mutual affiliation and concern for others as well as the self, and it encompasses a sense of relatedness to possibilities and powers beyond the self and the present (Hinds, 1988; Owen, 1989). It is worth mentioning at this stage that spiritual individuals tend to be more hopeful than their non-spiritual peers (Mahoney & Graci, 1999). It is often said that where there is life, there is hope, but Kleindienst (1999)

also believes that there is just as much truth to the opposite sentiment: Where there is hope, there is life.

c) Transcendence

Transcendence is another one of the major emerging themes of spirituality. It refers to an ongoing process that makes an individual's life a quest to be in a relationship with this mastery (Chiu, 2000), that is, having the urge and need to make a significant connection with a higher power, like God or a divine being. It involves an appreciation of a dimension beyond the self and continually expanding self-boundaries (Reed, 1991). According to Narayanasamy (1991) in striving for self-transcendence, one will encounter a relationship with the other in some form. It is the striving for meaning, purpose and knowledge of the transcendent that has personal, communal, and public aspects. All of these serve as indicators of spirituality (Reed, 1991). This hence helps in coming up with a conclusion that there indeed exists a higher power which has comprehensive powers beyond, or exceeds the limits of human existence. This brings forth the notion that there is more to us than we actually can comprehend.

d) Relatedness/Connectedness:

According to Nagai-Jacobson et al. (1989), the sense of relatedness and connectedness can be described in terms of harmony with the self and others, and a sense of relatedness to God. Dossey (1997) offers the following examples of this interconnectedness:

- Loving, painful, supportive and difficult relationships with family, friends and others;
- Caring for others and being cared for by others;
- Recognizing relationships as a source of growth and change.

Spirituality is also expressed and experienced through an interconnectedness with nature, the earth, the environment and the cosmos. All life exists in an interconnected web; what happens to the earth affects everyone, and everyone's behaviour affects the earth. Therefore, it is essential to be aware of and to appreciate the interconnected web of all life. Spirituality contributes to this awareness and appreciation (Dossey, 1997; Spaniol, 2002). The consequences of disconnectedness (from self, others and a larger meaning or God), can include self-alienation, loneliness and a lack of meaning or purpose (Bellingham, Cohen, Jones & Spaniol, 1989).

e) Beliefs and belief system

The cognitive factors involved in beliefs have less to do with facts and more with feelings; they represent a personal confidence or faith in the validity of some person, object or idea (Dossey, 1997). For fulfilment of beliefs, 'faith' plays an important role in an individual's beliefs and decisions in life. Health care practitioners who actively explore the content of the belief systems of their clients in a respectful manner can better appreciate the benefits clients might experience from their belief and value systems (Coyle, 2002). Health care providers should also be aware of and know the importance of their own belief systems as well as those of others (Dossey, 1997). Negash and Ehlers (2013) point out the importance of the internal make up of a person to risk taking behaviours and the influence of associating with individuals whose beliefs deviate from the "norms" of the society which upholds the moral fibre.

According to the Christian perspective, religion and spirituality is seen as the potential for wellbeing in patients (Koenig, 2005; Sorajjakool, 2006; Underwood, 2006) - most recent research in religion been the highlight of the century (Spohn, 2001; Worthington, 1989; Chant, 2010). Infrequently, the accompanying words are utilized reciprocally - religious, spiritual and spirituality (Benner, 1989). The term 'spiritual' will be utilized much of the time as a part of this study. It will likewise be utilized to pass on the significance and intuition behind this exploration.

Areas other than counselling are making progress in the arena of deep sense of being and spirituality. For instance, in February 2010, there was the introduction of a national top body for chaplaincy, pastoral and spiritual care called the 'Spiritual Care Australia', already known as the Australian Health and Welfare Chaplaincy Association, Inc. Its findings may be beneficial in providing valuable material to specialists in disciplines linked to chaplaincy. Most research in the past has concentrated on religion. According to Poroch et al. (2009), spirituality is currently a more prominent term and is gaining standing in being used in healthcare. Underwood and Teresi (2002) recognized that spirituality can be an expansive and even undefined term, yet less debilitating or confronting than religion. A few scholars are doubtful of the present prevalence of the word in the most profound sense of being (Spohn, 2001). One of the troubles in the use of 'spirituality' is that for a few Christians it has an implication of a New Age rationality (Herrick, 2003).

Customarily, spirituality and religiousness were seen as one thing (Kirkpatrick, 1990; Koenig, 2005). As indicated by Kirkpatrick (1990), there was a movement of accentuation in the 1980s where spirituality was separated from religiousness. This is a generally new marvel and mirrors an ascent in secularism. It additionally mirrors a social change in the move from a more efficient ceremonial way to deal with individualistic methods of thinking (Bowers, 2006; Koenig, 2005). This is clear in the disregard that religion and religious issues have encountered in the psychology texts, and have expansive ramifications for training issues.

Spirituality can be communicated through numerous regions, for example, innovativeness in artistry, music and reluctant reflection. Spirituality can likewise be identified with the capacity for self-transcendence and a lived reality, as noted in a contemporary content for medicinal services discipline, Spirituality points to key capacity levels in people. It is communicated within human experience before individuals distinguish that involvement with a specific religious or spiritual set of convictions, customs or morals. Spirituality, as an intrinsic human trademark, includes the capacity for self-transcendence: being genuinely required in, and by focusing on the world past an individual's personal

boundaries. This important inclusion and responsibility shapes the way individuals live and permits them to incorporate their lives. Spirituality can be plainly distinguished and examined in human occasions and composed writings, or different types of expression, for example, workmanship art and music, desires and inspirations. Spirituality is likewise a scholarly discipline. Utilizing interdisciplinary techniques, the elements of the profound measurement of life can be examined (McSherry, 2006). The different meanings of spirituality open up the horizon for its utilization and grasp the idea of God. Benner (1989) hypothesises that spirituality is the human reaction to God's charitable call to an association with himself and he considers spirituality to be a quest for God – the Hallowed. Pargament (1999) points out that spirituality has to do with how people think, feel, act or interrelate in their endeavours to discover, moderate, and if important, change the sacred in their lives.

Thoresen (1998) considers spirituality to be having faith in, esteeming, or being dedicated to some force higher than what exists in the physical world. In this way, spirituality is essentially the condition of being spiritual, that is of having a mindfulness and valuation for the domain of the spirit, as well as centring one's life on that appreciation.

Regardless of the determination to locate a valuable meaning of Christian spirituality, it turned out to be especially testing. Underwood (2006) found more than two hundred unique definitions just of the word spirituality. The researcher distinguishes the difficulty that rises when religion is taken out of the social and authentic setting. She contends that spirituality then turns out to be so unclear as to end up good for nothing.

One trouble in inquiring about spirituality is the qualification amongst religiousness and spirituality. Some would say it is difficult to describe (Hart, 1994). Notwithstanding, Aponte (1998) has a reasonable meaning of spirituality with which he endeavours to elucidate the issue.

Spirituality is used comprehensively Chant (2010), alluding to the significance, reason and values in individuals' lives. Spirituality is the manner by which they comprehend life, where they need to run with it, and the benchmarks by which they quantify and judge life (Aponte, 1998).

Worthington's (1989) meaning of religion is likewise clear and to the point. Individuals exceptionally dedicated to religion often assess their reality on no less than three essential worth measurements: the part of power of human pioneers, sacred text or regulation, and religious gathering standards.

The separation amongst spirituality and religion is seen by some to grow. Religion is routinely being depicted as institutional and formalized, and spirituality as being individualistic and liquid. One (religion) is characterized as being negative and the other (spirituality) as being sure. Consequently, a most profound sense of being turns out to be progressively separated from religion; Pargament (1999) composes that spirituality is presently cool; religion is uncool. Religion is uncool because we have appointed lower scores on religious development records. Wellbeing experts are a great deal more worried about the motivational, full of feeling, behavioural, experiential and subjective sides of religion than with the institutional.

Meystedt's (1984) call for examination into religion and spirituality was reverberated by Zinnbauer et al. (2001). The assorted qualities of the different meanings of spirituality and religion and the numerous implications are recognized and talked about in their noteworthy and helpful paper. Late understandings of most profound sense of being as discrete from religion are recognized and talked about with the acknowledgment of the social issues supporting these creating bits of knowledge. The creators' endeavour was to put these issues into viewpoint with an indication of the life span of religion as against the originality and conceivable temporariness of individual spiritual existence.

According to Stander, Piercy, MacKinnon and Helmeke (1994), spirituality is an individual and observational experience, which gives a feeling of importance. Religion then again, is largely about institutional convictions about God. Martin and Carlson (1988) portray an otherworldly individual as somebody who has a solid duty to a profound or religious perspective. They additionally name a few attributes of an otherworldly individual: firstly, having a centre faith in God as maker, furthermore engagement in certain profound exercises, for example, supplication, contemplation and love of God; thirdly, thinking and conducting in accordance with educating upheld by sacred writings, lastly, their convictions, musings, perspective and practices would be affected by their confidence. It will be promptly seen that the greater part of these ascribes could likewise apply to a religious individual. According to Chant (2010) spirituality and religion are offspring of the same family.

One of the undertakings of a researcher in the wake of resourcing the various points of view of spirituality is to gage and survey what the importance is for the individual members. Since spirituality, for a large portion of them, is identified with an individual measurement of their Christian confidence communicated through their everyday lives, and associated with their Christianity, as showed by the reactions to the surveys, it is important to clear up a comprehension of 'Christian spirituality'.

McGrath (1999) defines 'Christian spirituality' as a term which, "alludes to the path in which the Christian life is comprehended, and the expressly reverential practices which have been created to cultivate and manage that association with Christ. Christian spirituality might be along these lines comprehended as the route in which Christian people or gatherings expect to develop their experience of God or to practice the nearness of God..." (p. 2).

Holt's (1993), portrayal of 'Christian spirituality' is likewise useful to comprehend the numerous aspects included. He looks more distant than an internal individual comprehension to a more extensive Biblical centre of Christian group. Holt states that,

“Christian spiritual existence; this is a word which has come much into vogue to depict those states of mind, convictions, hopes which enliven individuals' lives and help them to connect towards super-sensible substances. This implies spirituality is not just for the inside life or the internal individual, yet as much for the body with respect to the spirit, and is coordinated to the usage of both the rules of Christ, to love God and our neighbour. Without a doubt, our adoration, as God's, ought to reach out to the entire of creation. Christian spirituality being at its most bona fide, incorporates into its extension both humankind and nature” (p. 18).

According to Chant (2010), the Christian Sacred texts proposes that to be spiritual, is to have confidence in Christ, to be loaded with and guided by God's Blessed Soul and to subject one's reasoning to God. In other words, to live in a Soul coordinated manner. Christian spirituality, then, is to carry on with a Soul centred life, in which there is an individual trust in Jesus Christ and having other worldly issues given as much, if not more consideration, than others. In addition, a Christian life is a guide to assisting the poor and mistreated people (Chant, 2010).

Lartey (1997) posits that scripture is the most profound sense which incorporates caring for poor people and destitute. The scripture is steady for Christian advisors and/or a peaceful consideration on an individual's part. Lartey, as a theologian scholar, underlines the freeing and enabling (both independently and publicly) parts of peaceful consideration, even to the degree of proposing support and working with individuals in these ways that can have the effect between individual prosperity and psychiatric illnesses (Lartley, 1997).

Pattison's review of the recent history of pastoral consideration takes note of a socio-political scrutinize of a United States. He inspired a pastoral counselling model that would centre on pathology, independence and narcissism to look for rather something more extensive, more all-encompassing, more political and more theological (Pattison, 2008).

Christian counsellors are active representatives of God. They should convey his healing message in the restorative experience and search for his managing hand in each directing circumstance. Having a hypothetical comprehension of the profound measurement empowers a more extensive comprehension of its significance to encourage help to the entire individual. It likewise encourages into the counsellor's capacity to make spiritual evaluations and intercessions and gives a structure to looking at the patient's backgrounds. Farran, Fitchett, Quiring-Emblen and Burck (1989) thought about both, a coordinated methodology and a unified way to deal with the profound measurement. Their integrated approach is the profound measurement as one framework among many.

The unifying approach indicates the profound measurement as affecting the totality of a man's life, and this empowers a more extensive comprehension of the effect of a profound measurement in patient's lives (Chant, 2010). Therefore, there are possibilities to review the spiritual measurement. One is to consider spirituality as only one methodology among numerous, an incorporated methodology. Another better alternative is the 'bringing together approach', in which the profound measurement speaks to the totality of one's being, not only a different compartment (Farran et al., 1989).

2.2.3 Perspectives of spirituality

The postmodern ontological structure recommends that the importance of individual's credit by giving importance to their experiences is critical. It additionally proposes that there is no infallible truth, yet numerous truths, contingent upon various perspectives. Connected to spirituality, this approach would recommend that the significance of spirituality from alternate points of view should be talked about - viz. the Christian, African, Eastern, Islamic perspectives. In addition, the stances of Frankl, Jung, Peck, Hillman as well as some other perspectives will be expounded upon in this section.

2.2.3.1 Christian points of view

For a considerable length of time, spirituality, in Christian circles, was connected with a plain way of life of withdrawal communicated in the wonders of hermits and monastic groups (Kourie & Kretzchmar, 2000). The second half of the twentieth century, be that as it may, saw a decrease in this elucidation, and endeavours being made to decipher spirituality in a more contemporary setting (Grenz, 2003).

From that point forward, Christian spiritual existence has turned into an unlimited field, hard to outline in a few passages. A portion of the overwhelming ascriptions of meaning however, is as follows:

- An extremely wide definition: Swinton (2001) provides maybe the broadest definition, securing his thought in postmodern thinking. He recommends that Christian spirituality is only one of the numerous ways individuals attempt to express the profound, internal desires of the human soul, and will vary from individual to individual. He concedes that, for most Christians, this would include a kind of connectedness to an otherworldly being.
- Accentuation on the spiritual: some Christian scholars trust that Christian spiritual existence essentially includes an association with the extraordinary (Berkhof, 1979). More recently, Hughes and Lowis (1995) in an article on music and spirituality, recommend that spiritual existence includes an association with a higher force, as does Hudson (2005) in his examination of the principles of alcoholic anonymous.
- Others are more particular, relating deep spirituality to God or Christ (Foster, 1992; Grenz, 2003; Hudson, 1995, 2001; Kelsey, 1980). Hudson (1995:15) for instance, states: "Spirituality is being intentional about the development of

those convictions, attitudes and actions through which the Christ-following life is shaped and given personal expression within our everyday lives”.

2.2.3.2 African points of view

Any South African study on spirituality necessitates the consideration of African points of view, essentially because the context is African, and, furthermore, in light of the fact that Africans have a tendency to have a world view that is more profound than western points of view. The African perspective of the individual, for occasion, is a comprehensive and human-centric worldview, inferring solidarity with God, others and nature (Pato, 2000; Viljoen, 2003c).

In African spirituality, the universe is partitioned into three areas. The division in which God is experienced is the macro cosmos, which becomes clear in the religious presence that is a vital part of the normal existence of the customary African (Viljoen, 2003c).

In this circle, God is extraordinary, with the ancestors going about as mediators between individuals and God (Viljoen, 2003c). The ancestors are more noticeable than God is in the ordinary life of customary Africans. The spirits of the ancestors stay close to their graves, exercising an amiable impact on their relatives, if they are not overlooked. At general interims, along these lines, animals are customarily slaughtered in ceremonies in which ancestors are called upon to favour their descendants (Knappert, 1990). The ancestors are a kind of collective unconsciousness, including mythical beings like 'river spirits', to whom the living are in charge of responsible behaviour (Beuster, 1997).

God is separated from the universe, not concerning himself straightforwardly with the undertakings of humankind. That is seen in some present day Christian writer's thoughts on spirituality (Merton, 1976). In African spirituality there is no division between the sacred and the secular all of life is religious (Pato, 2000).

African spirituality is additionally worried with community: humanness is formed from cooperation in the convictions, functions, ceremonies, and celebrations of the community (Beuster, 1997; Viljoen, 2003c). The meso cosmos is a sort of middle ground where fortuitous events, ancestors, evil spirits, and sorcerers are predominant. This dimension is set in a universe of individual and aggregate imagination, including ancestors, animals, people, forests, brambles, trees, and rivers. All conflictions, and in addition ailment, both physical, and mental, as well as events such as, passing away and tragedy, are set in the context of this dimension (Beuster, 1997; Viljoen, 2003c).

The meso cosmos is reminiscent of the idea of the universe as a front line amongst good and evil in spite of the fact that there more unpredictable features with rationalistic features. This world perspective, as indicated by Viljoen (2003c) may add to an outside locus of control among conventional Africans, in light of the fact that the micro cosmos stress that the individual in the context of a collective existence is influenced by the macro cosmos and the meso cosmos. African spirituality stresses emphatically the significance of right connections. Individual desire and the interests of the individual are optional to the welfare of the family and the community. Connected to this is the significance given to sharing and generosity; rivalry or competition is not a piece of African spirituality, neither is spirit of hoarding or acquisitiveness (Pato, 2000).

Rites by comparison is a part of African spirituality, particularly circumcision, marriage, and internment. Respect for the elderly and for others, is a basic piece of African spirituality. So solid is the common part of African spirituality that the very existence of a private confidence or spirituality is questionable (Oosthuizen, 1995; Pato, 2000).

Confounding the significance of African spirituality in an African connection is that numerous Africans live with two sorts of spirituality, one western and one conventional, in a period of transition (Oosthuizen, 1995; Pato, 2000; Viljoen, 2003c). For instance, most Africans have two wedding functions, one in a Christian church, and one in a conventional setting.

2.2.3.3 Eastern points of view

As of late, western psychology has been progressively open to thoughts from the East including the spiritual thoughts from these fields. Some western therapists have been so open to these thoughts, that they form a bridge between west and east. Western therapists fused thoughts furthermore from eastern. African spirituality is a heartfelt life, or genuine humanness, gets from cooperation with one's kindred individuals (Hillman, 1972; Viljoen, 2003b).

Viljoen (2003b), utilizes the word 'spirituality', which he accepted was the worry of scholars. He considers Hillman's perspectives that can be overall seen to characterize spirituality in light of his accentuation on spirituality concepts, such as, soul, knowledge, idyllic considering, finding meaning and purpose, love, death, the interconnectedness of humankind and our ultimate destination (Viljoen, 2003b).

Fundamental to Hillman's hypothesis is his idea of soul, which embraces in its significance the mysteries of human life, in this manner connecting psychology to subjects, such as, spirituality. As Hillman saw, any psychological study dealing with soul and spirituality necessitates the need to consider eastern points of view, in light of the fact that eastern psychology research originates from a foundation of religion and power, and accentuates profound spiritual themes such as the knowledge and liberation of the soul (Viljoen, 2003b).

The field of eastern spirituality is an unfathomable and complex one; nevertheless, put basically, eastern spirituality stresses the potential greatness of the individual self, through identification with extreme reality, which is normally the element, unendingly moving cosmos (Attwood & Maltin, 1991; Viljoen, 2003b).

Moreover, eastern spirituality is worried with the connectedness of persons to kindred fellow human beings, society, nature and the universe (Bankart, 2003), rather than

western psychology, where the idea of the individual self dominates. Eastern psychology, drawing from its spiritual roots, places a contextualized self, a familial self, (focusing on individual connections) and a spiritual self, exhibiting itself in an association with the spiritual (Roland, 1988). According to Paranipe (1984) bliss can be identified as when your genuine self is accomplished in a trans-cognitive state. The Vedanta shows that the identity has two measurements; the genuine self (or Atman), and the temporary, evolving self (Jiva). The genuine self must be come to by Vedantic strategies for self-realisation, for example, meditation.

Another vital part of Vedantic Hinduism is the guideline of karma, which shows that all things energize and are animate, and are liable to the ethical rule of just rewards for activities (Misra, Suvasini & Srivastava, 2000). In such manner, it is like the Christian rule of "reaping what you sow". Karma is connected likewise to the doctrine of incarnation, and, unfortunately, is utilized to legitimize the oppressing position framework in India (Viljoen, 2003b).

Buddhism has its inceptions in the philosophical, religious, and psychological insights of knowledge of Gautama the Buddha (563-483 B.C.) The main reason for Buddhism is to discover an answer to the secret of human suffering, which can be found in a condition of aggregate self-denial, a condition of nirvana where the being is 'vacant', i.e., free from all impacts of the self of the ego (Khong, 2003; Viljoen, 2003b). It is hard to compress contemporary Buddhism, as there are numerous assortments such as Theravada Buddhism, Mahayana Buddhism, Vajrayana Buddhism, Lamaism and Zen Buddhism (Metz, 1984).

Comprehensively, in any case, the accompanying components are common to Buddhist spirituality (Drummond, 1984):

- Karma: The law of karma is important in both good and physical measurements of life. It is the same guideline of reward for activities found in Hinduism, which advises that Buddhism came out of Hinduism.
- Reincarnation: Through rebirth, all individual encounter rewards or punishment for their activities.
- Liberation from the human condition: By endeavouring to comply with this rule, it is conceivable to start another process in life, and to develop 'great karma'.
- This liberation bases on confidence in the four respectable truths of Buddhism (the universal experience of torment, the requirement for less material values, the likelihood of change and duty to the eightfold way of compliance).
- The objective of life is nirvana, which is not a destruction of self, but rather a changed method of human consciousness. Dhama is the best approach to nirvana, a dynamic standard that gives inward power and quality to life.

2.2.3.4 Islamic points of view

It is vital to consider Islamic points of view. Aside from the way that Islam is presently a noteworthy player in world governmental/political issues (Armstrong, 2000), it is the second quickest developing religion in South Africa, second to the African Free Holy places. Islamic spirituality is maybe best summed up in the significance of the word 'Islam' the willing and dynamic acknowledgment of and submission to the order of the one Allah (Altareb, 1996; Waines, 2001).

Kerr (1984) brings up that there is no real word in Islam for spirituality, which is as well 'internal' a term; Islam shows that external acts of worship and internal intentions should be held in tension. As indicated by Altares (1996), Muslims take direction towards God-

awareness in all circles of life: behaviour, worship, and business. Waines (2001) and Jaoudi (1993) stress that Islamic spirituality revolves around the five mainstays of Islam:

- A promise to obey God and take after the prophet Mohammed.
- A promise to observe salat, the ritualistic type of prayer that all Muslims must observe at fixed hours.
- The recognition of the zakat, i.e., providing for those less fortunate than oneself. The internal state of mind of the provider is immensely critical. The zakat is the mercy to the provider as much as the beneficiary is.
- The fourth mainstay of Islam is fasting (saum), recommended amid the month of Ramadaan, the ninth month of the Islamic schedule. Amid the hours from dawn to nightfall, those grown-ups whose wellbeing permits are required to go without food, drink and sexual relations (Waines, 2001).
- The fifth of the central obligations of Islamic spirituality is the Hajj, or journey to Mecca and its region, to be satisfied once in a lifetime if possible.

2.2.3.5 Frankl's perspective

Inside Western psychology, according to Shantall (2003), Viktor Frankl can be viewed as the father of spirituality. He was the first to coin the particular term 'spirituality' as a basic measurement of human functioning (Shantall, 2003). Frankl characterized spirituality in the connection of the improvement of his theory of logotherapy, in which he recognized three levels of function: the physical, the psychological, and the spiritual (Frankl, 1969).

On the physical dimension, individuals resemble complex machines (Frankl, 1969). On the psychological measurement, individuals resemble creatures, with needs and drives

(Frankl, 1969). In any case, Frankl contends that individuals are more than the sum of their parts, and when seen comprehensively, they have a spiritual dimension (Frankl, 1969). In "Doctor and the Soul", for instance, Frankl characterizes logotherapy as a psychotherapy which not just perceives man's spirit, in any case begins from it. In this association, logos is proposed to imply "the spiritual" and, beyond that, "meaning" (Frankl, 1965: xi). Eastern spirituality can in this way maybe best be characterized as an individual discovering importance, or agreement, through the transcendence of the self, as in Hinduism, or through the denial of the self, as in Buddhism, furthermore finding importance in perceiving the self's connectedness to others (Bankart, 2003; Misra et al., 2000; Viljoen, 2003b).

The similitudes with Frankl, who proposes that importance can be found by transcendence of the self through an undertaking, an objective, or a cherishing activity Frankl (1959) and with ecosystemic thinking, which views the universe as interconnected, can plainly be observed. The likeness to the basic commandments of Christianity to love God and neighbour appears to be moreover evident. To give this meaning of spirituality more depth, a brief synopsis of Vedanta (representing Hinduism) and Buddhism take after. In Vedanta, Brahman is the likeness God in western religious philosophy (Viljoen, 2003b).

Brahman can be known in two ways. The primary comprises of a trans-cognitive condition of consciousness in which the transcendent, shapeless and featureless Brahman is experienced. The second is through the ordinary senses and awareness through which we experience the world. Also, Brahman, similar to the Christian God, has certain traits, including Being, Awareness and Bliss. The latter is the joyful state to which the spiritual must endeavour, in spite of the fact that the considerations of this world keep the vast majority from achieving Rapture/Bliss (Viljoen, 2003b).

Bliss can be found when the genuine self is accomplished in a trans cognitive state (Paranjpe, 1984; Viljoen, 2003b). This spiritual dimension, for Frankl, is identified with the

"will to mean", which is the essential main impetus in the life of a person (Frankl, 1959:121). Frankl differentiated this will to meaning from Freud's idea of a will to pleasure and Adler's will to power (Shantall, 2003). By a "will to meaning", Frankl implied that individuals have an existential longing for life that is as important as could be allowed. When this longing is upset, existential dissatisfaction emerges, prompting what Frankl called noogenic anxieties, emerging from a profound void (Frankl, 1959).

It can be seen that Frankl's perspective of spirituality is solidly established in his philosophical structure of existentialism. He asserts that, for instance, individuals have lost the security of instinctual decision making (which was a component of our animal past) and in addition the security of our tried and trusted customs, hence losing the sense of meaning in life, therefore, human beings are thrown back on the spirituality (Frankl, 1959; Graber, 2005).

Keeping in mind the end goal to discover meaning in life, along these lines, individuals are thrown back on the spirituality which Frankl depicts as our moral obligation, and the consequent freedom to choose (Frankl, 1959; Giovinco, 2005; Hutchinson & Chapman, 2005).

Without the determination of this existential crisis, neuroses emerge, showing themselves in the mental illnesses of the twentieth century: fatigue, the will to power (making money) or the will to pleasure (sexual hedonism) (Frankl, 1959). For Frankl, spirituality compares to the will to meaning, which thus suggests that individual's freedom to choose is meaningful and alternative as possible.

Frankl (1959) suggests that an individual is a limited thing, and his freedom is restricted. It is not freedom from conditions, but rather it is flexibility to stand firm against the conditions. In the light of the meaning of Christian spirituality laid out before, Frankl (1965) also advocates that a spiritual/religious individual has an association with a transcendence God. In addition, the religious man contrasts from the sceptical man just

by experiencing his presence not just as a task, but rather as a mission. This implies he is likewise mindful of a taskmaster, the source of his main goal. For thousands of years that source has been called God (Frankl 1965).

Frankl (1959) trusted that spirituality is feasible for each individual, even for those individuals who, incomprehensibly, precluded the presence from the existence of God. Along these lines, his meaning spirituality is exceptionally adaptable. He trusted that individuals must be given the opportunity to choose for themselves how to discover meaning, "whether along the lines of religious or rationalist feelings" (p. 132).

In Frankl (1959) he suggests that the meaning of spirituality is also extremely expansive; spirituality manifests itself in countless unique ways, contrasting from individual to individual. He stated that, "the importance of life varies from man to man, from day to day, and from hour to hour. What makes a difference in this manner, is not the importance of life all in all, yet rather the particular importance of a man's given life at a given minute" (p.131). In this multi viewpoint approach, Frankl can likewise be seen as a pioneer of postmodernism. Spirituality, for him, was what brought meaning to a man's life, furthermore, that unmistakably contrasted from individual to individual.

2.2.3.6 Jung's perspective

Jung, with regards to western psychology research, besides Frankl, was the most influential specialist with respect to spirituality psychology. Whereas Freud viewed the instincts as the source of human problems, Jung found that his patients came to him more frequently with spiritual issues (Jung, 1933c).

Like Frankl, Jung in this way gave much regard for spirituality as a psychological phenomenon. Jung found the Freudian paradigm of repressed material in the unconscious supportive in the early phases of treatment, yet when these presenting problems had been transcended, existential inquiries concerning guilt, new life and

salvation came to prominence (Bertine, 1967). Jung additionally came to reject Freud's mechanic perspectives and what he saw as a pre-occupation with human sexuality, and criticised Freud for not sufficiently giving consideration to religion, and particularly to the collective unconsciousness (Smith, 1990; Viljoen, 2003a).

Jung's definition of spirituality is so complex to the point that it should be put within the context of his theory as a whole. Key to Jung's perspective of the mind is that it is basically argumentative, in a dynamic procedure, struggling to evolve from the unconscious to a higher state through the creative resolution of opposing tendencies, a resolution which in turn sets up another dialectical process, in a constant and lifelong quest for wholeness (Clarke, 1992; Smith, 1990; Viljoen, 2003a). The psyche, which alludes to the totality of all unconscious psychic processes, has the 'self' as a fundamental component (Jung, 1971; Viljoen, 2003a). The 'self' functions as a prime example, which is a typical image transmitted by the unconscious through hundreds of years of human development (Jung, 1953).

Within this worldview, Jung speculated that spirituality was an essential, natural part of the human psyche (Bertine, 1967; Jung, 1955). It is situated in the unconscious, and uncovers itself in a man's dreams (Jung, 1955). One of its functions is to induce the self towards psychic development and to keep up psychic balance (Jung, 1933a; Viljoen, 2003a).

Jung couldn't help but contradict and disagree with Freud and science on this issue, contending that the religious images of the mind were not gibberish, but rather critical typical messages from the unconscious and in this manner, to be treated with utmost seriousness (Bertine, 1967; Jung, 1933b). Along these lines, he paved the way for spirituality to be acknowledged as a proper subject for psychological examination. Be that as it may, Jung's meaning of spirituality is a long way from conventional. Not at all like Christian scholars, and Frankl (in specific circumstances), he did not propose a transcendent God at all in his perspective on spirituality (Jung, 1933b).

He trusted that the presence of a supernatural entity "out there" did not fall inside the parameters of psychological research. Nonetheless, he accepted that the self is capable spirituality, and could be depicted as the "God within us" (Jung, 1953:236; Viljoen, 2003a). This inner spirituality contains a rationalization principle: a great penchant for spiritual growth and in addition has potential for evil. For Jung, customary Christianity had anticipated these values of the unconscious onto an all-powerful charitable God and an abhorrent evil.

Jung (1933c) trusted that genuine spirituality was communicated when these two were claimed and were integrated into the person's unconscious. This procedure, which Jung called the individuation of the self is what might be called the 'ideal human being' or 'finding God' (Smith, 1990:78). Inquisitively, despite the fact that Jung does not talk about the likelihood of a transcendent God, he does appear to acknowledge the presence of a life following death, with the perished surrounding us in the scriptural thought of a cloud of witnesses, and contributing to the collective consciousness, which represents to the gathered psychic wish of the ages (Jung, 1933c).

Jung's theory of spirituality considers important the issue of mankind's feeling of existential insignificance, which he believes is first and foremost a psychic problem. This hidden reason for cause of meaninglessness is psychic fragmentation, which happens when the individual is cut off from the unconscious and its archetypal (Jung, 1933b). Since the issue is a psychic one, the cure is additionally a psychic one: through the enlivening of the unconscious, a renewal of life can resume, and meaning and purpose can be established (Jung, 1933b; Smith, 1990). In summary, individuation of the self, in Jung's theory, is the beginning of spirituality, which in turn, is a definitive objective of human life, and the source of ultimate meaning.

2.2.3.7 Peck's perspective

In this exchange of the importance of spirituality in western psychology, notice must be made of Scott Peck. One of the philosophers of the twentieth century occurred when Scott Peck, a psychiatrist, wrote a book about psychotherapy that took spirituality of individuals seriously. He was considered as a scholarly giant like Frankl and Jung. (Robertson, 2006).

Peck (1978) maintains that everybody has a spirituality of sorts (frequently mistaken for religion). This spirituality is connected to the thoughts and convictions, either understood or expressed, that individuals hold about the way of nature. This arrangement of convictions, or world perspective, is regularly at the foundation of individuals' psychological problems. For the most part, spirituality utilizes synonymously with world perspective as unconscious, or not entirely conscious, is passed on to us by our parents. Peck (1978) suggests that our first thought of God's nature is a basic extrapolation of our parent's nature. Furthermore, if an individual has one has adoring and forgiving parents, they are likely to believe in a cherishing and pardoning God. On the other hand, if an individual has brutal, harsh and punitive parents, they are likely to develop with an idea of a cruel, monster-like God.

What is more, in the event that they neglected and failed to look after us, we will probably imagine the universe as comparably uncaring. Peck trusts that this spirituality should be changed. Such a procedure is accomplished by psychotherapy, in which the client's understanding is always augmented to incorporate new information of the more extensive world (Peck, 1978). Genuine spirituality is a trip out of the microcosm into a universe. In its earlier stage, it is a journey "of knowledge, not of faith" (p. 207). In a memorable phrase, Peck asserts that, "the path to holiness lies through questioning everything" (p. 207). It can be seen that Peck, in his meaning of spirituality, has rather skilfully incorporated parts of Frankl (a value system), Jung (the unconscious), and Christian spirituality (God as an

external other). Peck (1978) includes his concept of spirituality as a questioning attitude which develops in new knowledge and understanding.

2.2.3.8 Hillman's perspective

Jung's influence can also be found in the work of Hillman, who uses Jung's views on the unconscious as the basis for his own views, but then transcended them by viewing human behaviour not only in the light of archetypes, but also in the light of myths and gods (Hillman, 1996). People should get in touch with their unconscious by opening themselves to fantasy and imagination. In this way, a soulful existence is possible (Hillman, 1972).

2.2.3.9 Other perspectives

The unconscious is not an important element in Eastern spirituality. According to the Vedantic approach, the individual may be in one of four states of consciousness: wakefulness, dreaming, deep sleep or a trance state (Viljoen, 2003b). Truly spiritual people attain the trance-like state only by rigorous meditation. This fourth state is described as a conscious state, but it is in fact beyond consciousness, where the ego is swallowed up in the blissful contemplation of Brahman. Yet one cannot really describe this state as unconscious, in the Jungian sense. It is rather a form of ecstasy, or intense mysticism (Flood, 1996).

Similarly, in Buddhism and Islam, the unconscious does not play a major role. Buddhism envisages a constant stream of states of consciousness that are constantly in motion, and which change continuously (Khong, 2003). Islam focusses very much on outward observance of religion, with an inward component, but which cannot be said to be related to unconscious (Waines, 2001). The unconscious may be an avenue of study in African spirituality, where dreams and visions are seen as messages from the spiritual world, especially in the Africa Initiated Churches (Tshelane, 2000).

2.2.4 Spirituality as an expression of the unconscious

Spirituality as an expression of the unconscious psyche is also a prominent theme in the literature. It is “important to discuss it firstly because it is becoming more and more prominent in Christian spirituality. Hudson (1995, 2001) recommends that a pursuit of true spirituality will bring the ‘shadow selves’ of the unconscious to God for transformation, and also that the recording and analysis of dreams should be practised, since God may be speaking to the individual via this method. Moreover, one of the recent suggestions on psychology and spirituality has been that the study of spirituality should move from attempts to define the ‘constructs’ of spirituality to a view that equates the unconsciousness as an expression of spirituality (Fahlberg & Fahlberg, 1991). The following section will refer briefly to the main perspectives.

2.2.4.1 Jung’s viewpoint

According to Jung, the modern era was characterized by the loss of the metaphysical certainty which had sustained past generations, a loss that was replaced by a search for a new spirituality that showed itself in a fresh interest in the unconscious (Jung, 1933b). Such spirituality is discovered by acknowledging the darkness of the unconscious, bringing its reality into the light, and striving to integrate the contradictions into our conscious living (Jung, 1933b). The archetypes in the unconscious serve as spiritual guides for the personality. The religious minded would call this guidance from God (Jung, 1933c).

2.2.4.2 Frankl’s viewpoint

Frankl (1978) also relates spirituality to the unconscious. In a sense, Frankl replaces Freud’s concept of the id with unconscious spirituality. Unconscious religiousness, or spirituality, is defined as humankind’s inherent and potential relationship to transcendence: “Man has always stood in an intentional relation to transcendence, even

if only on an unconscious level” (p. 60-61). Frankl (1978) coins the phrase “the unconscious God” in order to describe this phenomenon (p. 62). This notion of the unconscious God must not be misinterpreted. It is not pantheistic, it is not occultic, nor omniscient, neither is it impersonal (Frankl, 1978). Instead, humankind’s unconscious relation to God is profoundly personal (Frankl, 1978).

In this way, Frankl differentiates his view of man’s religiousness from that of Jung. For Jung, religiousness was something instinctual; for Frankl, religiousness is something spiritual and existential, stemming from the personal core of the individual rather than from an impersonal collection of images shared by people (Frankl, 1978). Frankl’s genius is to replace Freud’s therapeutic concept of uncovering the unconscious id with that of logotherapy: uncovering the patient’s unconscious spirituality. What is repressed, in Frankl’s thinking, is humankind’s capacity for spirituality and it is the task of the logotherapist to unlock this dimension of the person. This repressed transcendence is at the heart of neurosis, because although concealed in the transcendent unconscious, repressed transcendence makes itself apparent as “an unrest of the heart” (Frankl, 1978:66).

2.2.4.3 Peck’s viewpoint

Jung’s views of spirituality and the unconscious have been popularised by Scott Peck (1978). Peck describes Jung’s view of the collective unconsciousness, equates this to God, contrasts it to personal consciousness, and then argues that the personal unconsciousness is the struggle between these two realms, i.e., collective unconsciousness versus personal consciousness. Mental illness occurs when this conscious will of the individual deviates substantially from the will of God, which is the individual’s own unconscious will (Peck, 1978). The aim of the journey to spirituality is to develop a conscious ego that is more in tune with the unconscious, which for Peck, is finding the will of God. The similarities to Jung are obvious.

2.2.5 Spiritual development

2.2.5.1 Spiritual development as transcendence

Much of the material on spirituality in the literature has suggestions for spiritual growth. Many researchers on spirituality from Eastern and African perspectives emphasize spiritual growth as a form of self-transcendence. Frankl (1959) believes that there is a reality other than oneself. His definition of this “other” is wider than God, although it could include belief and relationship with a transcendent God. He states, “ ...being human always points, and is directed to, something, or someone, other than oneself - be it a meaning to fulfil or another human being to encounter” (p. 133).

This self-transcendence can be discovered in three possible ways: firstly, by creating a work or doing a deed, secondly, by experiencing something or encountering someone, and thirdly, by the attitude we take to unavoidable suffering (Frankl, 1978). In these three points Frankl is close to modern writers on Christian spirituality who suggest that spiritual growth should issue outwardly in good works, that at the heart of spirituality is an encounter with God, and that suffering takes on new meaning in Christ (Foster, 1992; Hudson, 1995).

Eastern perspectives also resemble Frankl’s emphasis on growth through suffering. Vedantic Hinduism, for example, welcomes suffering as an aid to spiritual growth (Flood, 1996; Viljoen, 2003b), and Buddhism stresses the importance of finding meaning in and through suffering (Bankart, 2003; Ikeda, 1976; Ross, 1981). African perspectives like Frankl, see spiritual growth as a link to increasing connectedness to others” (Pato, 1997, 2000; Viljoen, 2003c).

2.2.5.2 Spiritual development toward a long-term goal

Finding meaning can result in an inner tension between one's present context and the meaning that lies in the future. According to Frankl, such goal directedness gives meaning to life (Frankl, 1959). It can be safely assumed that Frankl believed goal directedness to be part of true spirituality. Striving to be like Christ and becoming aware of the motivating power of Heaven are likewise part of modern Christian spirituality (Berkhof, 1979; Grenz, 2003; Hudson, 1998; Robertson, 1986).

Hinduism is also goal directed, in that it teaches development towards a blissful state, although its doctrine of reincarnation imparts a gentle, cyclical nuance to its doctrine of growth (Flood, 1996; Viljoen, 2003b). In Buddhism, a long-term goal is the attainment of the ideal state of Arafat, through many experiences of Nirvana (Bankart, 2003; Viljoen, 2003b). Buddhism, however, is also process orientated, with a cyclical pattern (Ikeda, 1976). Birth and death, phenomena occurring everywhere, are only varying modes of universal life, which is eternal and coexistent with the whole universe. The individual cannot be said to exist in any specific place after death. It is, however, part of universal, essential life and is awaiting re-manifestation in the world of actuality. African spirituality, likewise, cannot be said to be goal directed, believing in a lengthy past, a present, and virtually no future (Pato, 2000; Viljoen, 2003c).

For Jung, spirituality also has a future goal dimension. He believed, for example, that the symbols of the unconscious possessed teleological significance, representing an inner striving towards a goal. If the symbols were interpreted correctly, the message would impact meaning and purpose to a person's life (Bertine, 1967; Jung, 1933b). Spiritual growth, for Jung (1933b), was to allow the archetypal symbols to launch one on a unique journey of integrated wholeness rather than towards moral perfection, as in Christian and Eastern perspectives. Moreover, for Jung, psychotherapy is the catalyst for this journey of spiritual growth. According to Jung, spiritual maturity is to become as conscious as possible, with the minimum of unconsciousness (Jung, 1933b; Smith, 1990).

Peck (1978) equates spirituality to a journey, with a destination. Peck contends that by commitment to knowledge, it is possible to find a spiritual journey that leads first out of superstition towards agnosticism and then transcends agnosticism to discover an accurate knowledge of God. Such a journey is a difficult process, and faces the impediment of laziness, which for Peck is original sin. He interprets the Adam and Eve myth as humankind's attempt to avoid the hard work of getting God's side of the story, the hard work of listening to conscience, the God within us (Peck, 1978). Instead humankind takes short cuts and attempts to find knowledge not worked for (Peck, 1978). For Peck, the "process of psychotherapy is to assist the person to overcome this lazy part of human nature, and to co-operate with the 'healthy' side of human nature that prompts us toward growth" (p. 295).

All people are capable of commencing this journey of spiritual growth, which Peck also calls a response to 'grace'. Why some do and some do not is a mystery. For Peck, psychotherapy is an indispensable ingredient of spiritual growth. Some of the theorists on spirituality refer to stages of spiritual growth; others imply that spirituality is a kind of evolutionary process. Peck states that there are four stages to spiritual growth (Peck, 1993). The first stage comprises a chaotic/antisocial phase, a stage of absent spirituality, characterized by unprincipled and self-serving behaviour (Peck, 1993). At times, "people connect with this "chaotic" facet of their existence. If so, three possibilities are latent: suicide, or stoic endurance, or progression to stage two, the formal/institutional phase of spiritual growth, characterized by dependence on institutionalized religion to govern thinking and behaviour, and an attachment to the outward forms of worship. People in this phase conceive God as an "external' being" (Peck, 1993:123). They have little understanding of the immanence of God, that is, that part of God which lives inside them (Peck, 1993). They generally have a picture of God as masculine, and while they believe in God's love, they also believe in God's propensity to punish those who step out of line. In Peck's delightful phrase: "...it is a vision of God as a giant, benevolent cop in the sky" (Peck, 1993:123).

Peck adapts Kohlberg's moral development model to spirituality. For instance, Peck's first stage, comprising a chaotic/antisocial phase, devoid of spirituality and characterised by unprincipled and self-serving behaviour, has affinities with Kohlberg's pre-conventional moral level, in particular "naïve instrument orientation", in which the individual's needs are paramount (Murray-Thomas, 1996).

The second stage, as outlined above, seems to be similar to Kohlberg's conventional moral level, in which a person does the right thing either to earn the approval of others, or to observe 'law and order' for its own sake (Murray-Thomas, 1996). Peck's third stage of spiritual growth is described as a sceptical phase (Peck, 1993). People become disillusioned with institutional and outward forms of religion. They tend, as a result, to drop out of church, and may even call themselves atheists or agnostics. Nevertheless, according to Peck (1993), they are further along the road to true spirituality than those in phase two. These individuals, for example, are not antisocial. On the contrary, they are often deeply involved in society, are often loving parents, and are usually open-minded seekers after truth (Peck, 1993).

Often those in stage three, in their search for spiritual reality, move on to stage four, which Peck calls the mystical/communal phase (Peck, 1993), and which corresponds with Kohlberg's post-conventional level, especially stage six, the universal ethical principle orientation, in which a person's moral decisions are based on the universal principle of justice and on respect for the dignity of persons (Murray-Thomas, 1996; Muuss, 1996). In this stage of spirituality, people sense the interconnectedness of all things (including connectedness to the afterlife), become committed to unity and community in a common humanity, and are characterised by an awareness of paradox and mystery. They are comfortable with the complexity of existence, uneasy with cut and dried, simplistic solutions and are not afraid of saying: "I just don't know" (Peck, 1993:69-70). Peck (1993) stresses that his four stages are not cast in stone and that people can get stuck in a certain stage. They can manifest all four stages in their personality at the same time. They

can regress to previous stages, and having reached stage four, they need humility: stage four is just the beginning of the spiritual journey (Peck, 1993).

Christian writers on spirituality do not distinguish stages specifically, but rather a gradual growth into Christ-likeness, using certain spiritual disciplines (Foster, 1978, 1992; Hudson, 1995, 2001). Perhaps this trend is best epitomised by what is now considered a classic in Christian spirituality. Foster (1978) maintains that affluence and materialism have strangled true spirituality, especially in the Western world. The thirst of people for spiritual reality has not been met by the institutional church, with the result that many are turning to cults, eastern mysticism and the occult to satisfy this hunger. The real need today is for “deep people”, who acknowledge their spirituality and have the courage to explore it. One of the reasons for this is that people lack the skills. For while the “inner transformation” Foster speaks of is unattainable by self-effort, a judicious implementation of the classical spiritual disciplines opens the door to God’s transforming “inward grace” (Foster, 1978:5).

Foster outlines the following spiritual disciplines which he believes will enhance spirituality (Foster, 1978):

- Meditation: For Foster (1978), Christian meditation is similar to Eastern meditation in that it should include detachment from the world. However, it should go on to incorporate attachment to God and other people. Of interest is that meditation is now a technique used in wellness in the workplace programs, evidence of the growing importance of spirituality in different contexts (Bensley, 1991; Seaward, 1995).
- Prayer: For Foster, prayer is the means by which we change and become more Christ-like. Real prayer is something that involves life-long learning. It is best learnt by beginning and persevering (Foster, 1978). Prayer is a discipline common to all the religions in this study: Christianity, Hinduism, Islam and

African spirituality. The commonalities in the practice may be an avenue of further research.

- Fasting is likewise a discipline that transcends religious barriers and might repay further study. For Foster, fasting refers to the abstention from food (and sometimes water) for spiritual purposes. According to Foster (1978:53), “Fasting can bring breakthroughs in the spiritual realm that could never be had in any other way”.
- The discipline of study is a means of transformation that begins cognitively, that is, what we think influences our feelings, attitudes and behaviour. In this regard, he sounds remarkably similar to cognitive behavioural theorists (Corey, 1996; Hawton, Salkovskis, Kirk & Clark, 1989).
- The fifth spiritual discipline is that of simplicity, which must begin in the inward recesses of the personality, and then work itself out in a simple lifestyle (Foster, 1978).
- Solitude is distinguished from loneliness, but instead focuses on an inner solitude and silence that leads to a healthy balance between being with people and being alone (Foster, 1978).
- Submission is the seventh guideline for spiritual growth. It involves the ability not to always get your own way, surrendering our rights where appropriate. Aware of possible criticism from feminists and human rights groups, Foster stresses that submission, if it is destructive, is not true to the ideal (Foster, 1978).

- Linked to submission is the discipline of “service” (Foster, 1978:110). People need to freely choose to be servants, which begins in an inward attitude of servanthood, often expressed in small acts of kindness.
- Confession: by this Foster (1978) means confession to God, confession to others, and the ability to forgive, which is a quality emphasized by other writers on spirituality such as Peck (1978) and Frankl (1959). Forgiveness, in recent years, has been suggested as an important factor in a healthy lifestyle, which forms another focal point where spirituality can contribute to other disciplines (Worthington, Berry & Parrott, 2001).
- Worship is a uniquely religious and communal avenue to spirituality, and a way in which spirituality can be channelled into the renewal of institutional structures (Foster, 1978).
- Celebration, which Foster links with an inward joy in the midst of suffering, which is enriched by corporate and familial expression, and which is linked to a sense of humour (Foster, 1978).

Foster (1978) indicated that the inner spirituality can be grown by the observance of outward disciplines, is echoed in many of the other perspectives mentioned in this study.

In Hinduism, the Vedantic method of spiritual growth requires a preparation phase in which two disciplines must be mastered; a recognition of the difference between the permanent spiritual values and transient values, as well as the ability to cultivate inner peace and tranquillity. After this, a journey to self-realisation needs to be embarked upon, utilising the following four disciplines (Bankart, 2003; McGee, 1996; Viljoen, 2003b):

- A careful reciting of and listening to the Vedantic texts, especially the Baghavad Gita.

- Constant reflection upon and implementation of these texts.
- Complete absorption in the contemplation of Brahman.
- Enlisting the help of a guru, which is reminiscent of Jung's and Peck's stress on a therapist as vital for growth, although a guru is far more autocratic in approach than any Western therapist (Hammer, 1984; Viljoen, 2003b).

There seems to be no stages in Buddhism, but rather a journey towards psychological growth that is rather similar to the views of Rogers (1961) and Maslow (Viljoen, 2003b). Humankind has the nature of Buddha within, as a seed, or spark, which needs to be realized in practicality. Mankind innately partakes of the Buddha nature. Man does not become a Buddha by being enlightened to the meaning of the Law, because in the depths of life, force itself is the power to become a Buddha if the human being will but recall and realize it (Ikeda, 1976).

Such optimal development is attained by the experience of nirvana on many occasions, through meditation (Bankart, 2003; Ikeda, 1976; Viljoen, 2003b). The presence of stages in African spirituality is difficult to assess, because as Pato (1997, 2000) emphasizes, African spirituality is still in the process of disengaging itself from the influence of western missionary Christianity, and forming a separate identity and ethos. In the same vein, it can be safely said that, African spirituality would stress evolutionary growth into connectedness with others rather than stages of growth (Pato, 1997, 2000).

2.2.6 Acknowledging spirituality in psychotherapy

Spirituality and psychotherapy is another major theme in the literature. Karasu (1999), Miller (2002) and Swinton (2001) have called for human spirituality to be taken into account in psychotherapy and counselling. Moreover, since South Africa has numerous spiritualities embraced by the majority of its people, it seems necessary to discuss the

possibility of incorporating spirituality into the psychotherapeutic process in a South African context. The following sections will provide an interpretation on spirituality, will discuss the idea of personal spiritual growth, will describe a 'soulful and spiritual' existence and will view patients as human beings with potential for spiritual growth.

2.2.6.1 Interpretation of spirituality

Spirituality needs to be interpreted in its widest sense. Frankl defines spirituality as that which gives meaning to our existence, i.e., the ultimate values and commitments upon which we base our lives (Frankl, 1959; Kourie & Kretzchmar, 2000). In this sense, one can be quite irreligious, or even an atheist, but still possess spirituality. If the therapist adopts this broad view, he or she will be less likely to impose his/her own discourses of spirituality upon the therapeutic process.

2.2.6.2 Personal spiritual growth

In order to incorporate spirituality into the therapeutic process, the therapist's task is to give attention to his/her own spiritual growth. It is the author's contention that underlying the therapeutic process are principles of existence: it is not so much what the therapist does, but who he/she is, in interaction with another person, that matters. The spiritual state of the therapist in action is partly expressed in Chopra's law of least effort, an attitude characterised by few words and little action (Karasu, 1999). The similarities to client-centred therapy are obvious, underlying the need to rediscover the works of Carl Rogers in a postmodern context. Walker (2001), for example, has suggested that postmodern and Rogerian perspectives are supportive of each other. Snyder (2002) has argued that unconditional positive regard enhances the co-creation of meaning in therapy, and advocates that the Rogerian concept of empathy be expanded to include a mutuality of empathy, in which empathy becomes a two-way process. Bott (2002) adds to the debate by postulating that the postmodern turn in family therapy is in essence a return to humanistic-existentialism in a new guise, incorporating needful aspects relating to the

centrality of language. Bott (2002) rightly adds that the Rogerian concept of respect for the person can add an ethicality that is sometimes lacking in postmodern approaches.

2.2.6.3 A soulful and spiritual existence

Karasu (1999:146), drawing from eastern perspectives, suggests helpfully that a therapist open to spirituality (what Karasu terms “the spiritual psychotherapist”) needs to develop a soulful and spiritual existence. By soul it is meant that part of the self that is involved in the world and that is moved by human suffering, and by “spirit”, he refers to a relationship between the person and the universe. Karasu believes that the soul and the spirit are separate entities from the material and physical world, and that together these form a unity (Karasu, 1999). The task of the spiritual psychotherapist is to awaken his/her own soulfulness and spirituality, in a way that is meaningful for him/her, and then to allow this into the therapeutic process, in the hope that in this reflexive interaction, the client’s own soulfulness and spirituality will develop.

Karasu’s spiritual psychotherapy is basically suggesting that therapists grow in love and faith (common to all religions), and allow these into the therapeutic journey. He states, “The way to soulfulness is achieved by transformation of the extraordinary to the ordinary - and its only required ingredient is love. Comparably, the way to spirituality is achieved by the transformation of the ordinary to the extraordinary and its only required ingredient is belief” (Karasu, 1999: 146-147).

Having established the importance of the therapist’s own soulful and spiritual growth, the question needs to be asked: how can the therapist begin this journey, in practical ways? The answer is that growth in soulfulness and spirituality will mean different things to different people: for a Christian, it will mean an inner spirituality that is fed by the disciplines outlined by Foster; for the Hindu, it will mean a journey towards union with Brahman; for the Buddhist, growth into spiritual and psychological maturity through Nirvana; for the African, an incorporation of Western and traditional values in a unique

African spirituality; for the non-religious, an attempt to grow in sensitivity to self, to others, to creation and the universe Eck, (2002); King, Speck and Thomas, (1994) and for others, a combination of the foregoing.

Such spiritual growth will begin to be felt in the therapeutic process. Carl Rogers (quoted in Moore, 2003) puts it with inimitable insight, and in a manner, which, by suggesting a mutual transcendence of the relationship, anticipates postmodern thinking: "I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing ... At those moments, it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself, and has become a part of something larger. Profound growth and healing are present" ... I am compelled to believe that I, like many others, have underestimated the importance of this mystical, spiritual dimension" (p. 387).

2.2.6.4 Viewing patients as human beings with potential for spiritual growth

A therapist attempting to incorporate spirituality into his/her therapy will not see the person as a client, but rather as a human being with potential for spiritual growth (Karasu, 1999, as cited in Robertson, 2006). In this, the therapist's attitude would resonate with postmodern principles that the patient is the expert. Dualistic categories need to be rejected in favour of the interconnectedness of all things. In a sense, Rogerianism needs to be rediscovered in a spiritual context. There is no sane-insane, no normal-abnormal – these categories are transcended by a journey of spiritual growth (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995 as cited in Robertson, 2006).

2.3 Religiosity/Religion

While religion refers to an organized system of beliefs, practices and ways of worship, it can serve as a way to channel or direct the expression of spirituality. Some researchers

have defined it as, the formal, institutional, and outward expression of the sacred, assessed by measuring importance of religion, belief in God, and frequency of religious attendance, prayer or meditation (Koenig & Cohen 2001; Miller & Thoresen 2003; Szaflarski et al., 2012). Emblem (1992), established that the following six words appeared most frequently when describing religion: system, beliefs, organized, person, worship and practices.

The following sections will explicate how theology and gender have a religious effect on the HIV endemic.

2.3.1 Religion, theology and the HIV epidemic

Internationally, theologians and physicians have worked together to develop theological responses to the HIV epidemic. One important dialogue among religious leaders was initiated by UNAIDS in Namibia in 2003, focusing especially on stigma. The international dialogue among theologians has continued, exemplified in the ecumenical conferences at the international AIDS conferences in Bangkok (2004), Toronto (2006), Mexico City (2008) and Vienna (2010). Scholars in theology have addressed a range of topics related to the HIV epidemic, such as gender and violence (Ackerman, 2009), treatment, sexuality and condom use, sickness and suffering, sermon guidelines and liturgy (Dube, Benton, Cruess and Evans (2005), and theological education (Akerman, 2007). The Ecumenical Advocacy Alliance (EAA), an international network of churches and Christian organizations, has initiated a global theological dialogue on HIV prevention, which has resulted in a publication presenting some theological difficulties regarding HIV prevention. One of the fundamental differences among theologians is between those who read the Bible as literal truth, and those who take a more historical or contextualized view. The different interpretations have differing views about how the scriptures should be applied to contemporary issues (Eriksson, Lindmark, Haddad & Axemo, 2011).

Another difference lies in the understanding of the HIV epidemic. For some Christians, HIV prevention is understood as a moral issue, while for others, it is a public health problem, a gender issue or a social justice problem. Perhaps the main problem for the theological discussion on HIV prevention is that topics which have been taboo within the Christian tradition must be addressed. These include sex and sexuality, gender inequality, violence, drugs, homosexuality and promiscuous lifestyles. The examples mentioned above illustrate that theologians have responded to the HIV epidemic, and the ongoing conversation and publications are crucial to the educational institutions in the training of new religious leaders. Although theology is developing in relation to HIV, religious leaders in KwaZulu-Natal struggle when relating theology to their daily work in their local churches. This has limited open discussions on HIV by religious leaders and contributed to stigma towards people living with the disease.

2.3.2 Religion, gender and the HIV epidemic

Religion is one factor influencing the construction of gender roles, and perhaps it is especially important in countries where the majority of the population identify themselves as religious. Religion is often described as a factor that legitimizes gender inequalities and therefore, as outlined above, especially increases women's vulnerability to HIV infection. However, within Christianity the extent of gender inequalities varies between denominations. In Mozambique, Agadjanian (2005) established that gender differences were less pronounced among members in mainline churches (churches established through Western missionaries) than in Pentecostal churches. For instance, women in the Pentecostal churches had less knowledge about HIV preventive measures than women in the Roman Catholic and other Protestant churches.

Within Christianity, gender inequalities are often mentioned in relation to patriarchal structures in the churches, and the dominance of men in leadership positions. Patriarchy within Christianity has a long tradition and can be traced back to the background culture that informs the Bible, which was patriarchal (Chitando, 2010). Through history, theology

has taken patriarchy to be the ordered structure of humans, and in that way, legitimized patriarchy (Dayam, 2010). The overall patriarchal context has also shaped attitudes towards human sexuality, and men have been socialized to be dominant in sexual relationships (Chitando, 2010). In Africa, women theologians have raised their voices against the oppression of patriarchy that women experience in the wider society, as well as within the faith communities (Phiri, 2008).

In 1989, the Circle of Concerned African Women Theologians (also “the Circle”) was launched as a community of African women theologians who came together to encourage research on women’s experiences of religion, culture, politics and socio-economic structures in Africa. Members of the Circle have promoted the teaching of gender issues in theological curriculums, encouraged research on HIV and AIDS in relation to religion, and invited African male theologians to address ideals of masculinity that can be harmful in relation to HIV (Phiri, 2009).

2.4 Spirituality and religiousness/religiosity differentiated

In discussing spirituality, it is essential that it is distinguished from religiousness/religiosity. These two constructs have been regarded as synonymous and generally been operationalized as religious involvement or conviction. Religion/spirituality is sometimes used as an umbrella term to denote the various dimensions of spirituality and religion/religiousness (Miller & Thoresen, 2003). Empirical literature has established that there is significant support around the existing distinction between spirituality and religion as distinct, yet overlapping ideas. This has led to patients living with HIV/AIDS to deem spirituality and religion to be equal, yet others still hold the view that the terms are distinct (Belcher, Dettmore & Holzemeret, 1989).

However, Social science researchers have begun to unravel these two constructs. Spirituality is defined as helping one to understand and find purpose and meaning in life. Other authors have also defined spirituality as that which gives a transcendent meaning

to life and may include the internal, personal, and emotional expression of the sacred (Szaflarski et al., 2012). It is measured by assessing spiritual well-being, peace and comfort derived from faith, and spiritual coping.

Spirituality is an extensive and more universal construct than religiosity, framing spirituality as a subjective experience that can exist both inside and outside a religious framework. Henceforth, spirituality can exist in people who consider themselves very religious, slightly religious, or not at all religious. Religiosity is a related, but distinct construct that refers to organized behaviours intended to put spirituality into practice (Szaflarski et al., 2012).

It is important to note that within the context of the research, 'spirituality' and 'religion' are used interchangeable (although strictly speaking there are slight differences between the two terms). With regards to the definition and characterising of depression, the clinical framework as espoused by Belcher et al. (1989) is used. Empirical literature, has established that, there is significant support about the existing distinction between spirituality and religion as distinct, yet remain overlapping with each other. This has led to patients living with HIV/AIDS to deem spirituality and religion to be equal, yet others still hold the view that the terms are distinct (Belcher et al., 1989).

2.5 HIV/AIDS

Human Immunodeficiency Virus (HIV) causes a progressive failure of the immune system, which can lead to subsequent increased vulnerability to infections and other immunological disorders, and increased risk for different types of cancer (Arseniou, Arvaniti & Samakouri, 2014). HIV infection progresses in four stages: primary infection; clinically asymptomatic stage; symptomatic HIV infection; and progression from HIV to AIDS when CD4 cell count falls below 200. It is also associated with a progressive decrease of the CD4 T-cell count. Each of its stages has a different duration and severity of symptoms (WHO/HIV, 2005; Kelly et al., 1993). The T helper cell is sometimes referred

to as a CD4+ lymphocyte because it has the protein CD4 on its surface which HIV uses to attach itself to the cell before gaining entry (Chan & Kim, 1998). As the HIV viral load and CD4 counts increase, it indicates a progression of the HIV/AIDS virus. In other words, the drop in the CD4 count causes profound changes and deficiencies in a person's immune system.

The course of progression of the HIV/AIDS virus varies from time to time, and is dependent on whether proper treatment has been administered. If not properly treated, as much as 90 % of people infected by the virus progress to full blown AIDS in about 10 to 15 years (Buchbinder, Katz, Hessel, O'Malley & Holmberg, 1994). It also depends on whether the one infected is typically a progressor or a non-progressor in relative terms of the progression of the disease. For instance, rapid progressors (about 10 %) develop AIDS within 2 to 3 years following HIV infection, whereas long-term, non-progressors (about 5%) remain asymptomatic even after 12 or more years (Kremer & Ironson, 2007). The introduction of Anti-retroviral drugs has come to be a short in the arm, in the measures of managing HIV/AIDS. Infected people who use ARVs are now able to increase their life expectancy by a significant number of years. For instance, the average survival time is estimated to be more than five years even after the diagnosis of AIDS (Schneider et al., 2005), whereas those who do not receive the anti-retroviral drugs, the median time from AIDS diagnosis to death is estimated at 10 months, with a range from 3 to 51 months (Morgan et al., 2002).

The following sections will expand on the progression stages of HIV/ AIDS, the challenges brought about by the disease, treatment for the illness and some impediments to HIV/AIDS prevention, care and support.

2.5.1 HIV/AIDS progression stages

The HIV/AIDS progression stages include the; primary infection, asymptomatic stage, symptomatic HIV/AIDS infection; progression from HIV to AIDS.

a) Primary infection

On initial infection, an initial burst of viremia occurs leading to a subsequent drop in CD4+ cell counts (Piatak et al., 1993). Viral-like symptoms of fatigue, rash, fevers, night sweats, and weight loss (known as constitutional symptoms) can be experienced by the infected person (Guss, 1994). The immune system begins to fight the virus and the HIV/AIDS virus hides in the lymph nodes. As such, the symptoms disappear and the CD4 count increases. However, the person infected remains infected and highly contagious, as HIV is highly concentrated in blood, tissue and semen of the patient. The infected person can infect any other person within 24 hours after initial infection (Daar, 2002). The infected person may feel very healthy and strong for many more years unless the CD4 count drops below 500.

b) Asymptomatic stage

During this stage, the virus replicates and symptoms begin to show once more. To fully determine the level of HIV viral load and CD4 count during this stage requires laboratory tests. The length of this stage is two weeks to 20 years, with an average of 10 years. During this stage, HIV inflicts most of the damage to the body by continuing to reproduce itself 10 billion times a day, every day (Burton, Keele, Estes, Thacker & Gartner, 2002).

c) Early symptomatic stage

This is the AIDS Related Complex (ARC) in the early phase of HIV/AIDS discovery. Patients experience constitutional symptoms such as night sweats, weight loss, diarrhoea, wasting syndrome, severe fatigue lasting several weeks and prolonged fevers (Guss, 1994). Patients are attacked by opportunistic infections that the body's immune system usually fights and defeats. At this stage, the body becomes vulnerable to systematic HIV infection. This stage is characterised as the multi-system disease

(Holmes, Losina, Walensky, Yazdanpanah & Freedberg, 2003). The opportunistic diseases can be treated; however, HIV/AIDS continues to weaken the system.

d) The last stage

The 'AIDS' stage is the last stage of the progression of the HIV. At this stage, weakening of the immune system occurs to a degree where the body becomes defenceless against infections. At this stage, the CD4 count is well below 200 (Holmes et al., 2003). Furthermore, at this stage, the fungus affects the respiratory system which is evident by a dry cough, fever, night sweats, and increasing shortness of breath (Guss, 1994). Additionally, more diseases overwhelm the immune system resulting in neurological deficits or seizures, severe headache, diarrhoea and abdominal pain, tuberculosis and cancer, coupled with psychiatric symptoms of depression, hallucinations, delusions and paranoia (Wood & Dietrich, 1990). The Centres for Disease Control and Prevention (CDC) classified HIV as categories A, B and C. "Category A refers to HIV infection without symptoms. Category B is to classify symptomatic conditions attributable to HIV infection that do not meet clinical category C definitions. Category C represents clinical conditions attributable to HIV infection or CD4 count less than 200, which is equivalent to a diagnosis of AIDS. Once a patient has reached category C, the patient remains in that category even if their clinical condition improves" (Lee, 2012:6).

2.5.2 The Challenges brought by HIV/AIDS

Medical and religious organizations are trying to find solutions to the same problem; HIV/AIDS is a devastating disease, affecting millions of lives without a viable solution present. Both are trying to help people with the same problems, using different methods and understandings as to what is most valuable when trying to find an answer. For medicine, the most obvious answer to this problem is the discovery of a cure. Religious organizations also want a cure to be found, but they are unable to conduct the research themselves, and are typically not trained in medicine to provide proper medical care. Not

only does the inability to cure HIV present difficulties to organizations trying to respond, but also the devastation it causes in the lives of those that have contracted HIV/AIDS. For these patients, it is long and painful, and often accompanied by loneliness due to stigmatization. Also, there is fear of contracting HIV many times more powerful than compassion and love (Ballard & Sarah, 2014).

Religious organizations at times can perpetuate this challenge of AIDS by focusing on what they consider to be the root of the problem: moral misconduct and sin. Instead of focusing on the cure as the main solution, these religious organizations hold behaviour modification as their top priority, which they believe will lead to a decrease in the transmission of HIV, therefore slowing the effects it has on the world. Regardless of if we are examining science or religion, the main challenge presented by HIV/AIDS is that it spreads so quickly, there is no way to cure those that are infected, and it has terrible distressing effects on the lives of those infected by the disease. In contrast to this strict binary, Churches United Against HIV and AIDS, (CUAHA) attempts to bridge medicine and religion in response to these challenges, by acknowledging the utility medicine has to offer, rather than denying it. This is what makes the model revolutionary in terms of the HIV/AIDS epidemic and I will be discussing the methods they use to bridge this gap, and to offer a solution not only to the physical ramifications from HIV, but also the emotional (Ballard & Sarah, 2014).

2.5.2.1 Depression

Depression is a significant contributor to the global burden of disease and affects people in all communities across the world, with substantial morbidity and mortality (Schwenk et al., 2014). It has been defined as a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite and poor concentration. Depression can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his

or her everyday responsibilities. At times, it can become unbearable leading to suicide or suicidal tendencies (WHO, 2012).

In the African context, epidemiological studies and data on prevalence rates of major depressive disorders are limited. However, in South Africa, small rural-based studies have found a prevalence rate of depressive symptomatology of 18.5% and a rate of depression of 27% (Rumble, Swartz, Parry & Zwarenstein, 1996). Other results include a prevalence of depression of 25.2% in an urban setting, while Cooper et al. (1999), established a 34.7% prevalence of postpartum depression in a peri-urban settlement in Cape Town. Furthermore, empirical research established among low income, African–American women with antenatal depression, has shown that depression during pregnancy was strongly associated with a global reduction in functional status and perceived wellbeing (Mckee, Cunningham, Jankowski & Zayas, 2001). For instance, women living in low and middle-income countries have a much higher risk of antenatal depression than their high-income counterparts. In comparison, research has established that, pregnancy in high income countries does not hold specific elevated risk for depression. Nonetheless, there is growing evidence that a previous history of depression significantly elevates risks for depression during pregnancy (Gavin et al., 2005; Lusskin, Pundiak & Habib, 2007).

Early detection of early symptoms of depression may prevent antenatal depression and may protect against the onset of depression in the postnatal period. Furthermore, resources need to be mobilized to facilitate routine screening (Patel et al., 2010). However, in conducting these screening processes, it is essential to maintain cultural sensitivity and validity, in the assessment of depression, for two reasons., Firstly, contextual factors may influence how individuals in different cultures perceive psychological and social stressors and, secondly, culture and language may influence how antenatal depression is reported experienced, or responded to (Bernazzani et al., 2004; Bina, 2008). Thus, “training, awareness and resources are necessary to ensure that primary health care providers are able to detect and respond to severe cases of

depression during pregnancy. This may improve opportunities to prevent postnatal depression which has a significant impact on child outcomes in poorly resourced settings” (Rochat, Tomlinson, Barnighausen, Newell & Stein, 2011:371).

Despite this empirical evidence to date, there have not been enough nationally representative data on the prevalence of major depressive disorder in South Africa. In a resource-constrained setting such as South Africa, nationally representative data that include age of onset and role impairment comparisons are of crucial importance both in terms of highlighting the country's burden of disease, and to enable targeting of limited intervention funding (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). The scantiness of data on mental disorders in low- and middle-income countries (LAMICs) significantly hampers the development of new and innovative interventions. Furthermore, the use of a standard instrument to detect depression renders research to be vulnerable to the criticism that we are potentially ignoring relevant culturally specific idioms of distress.

Moreover, there has been rigorous data on the proportion of the health budget spent on mental health services in the South African setting. However, the data is not yet readily available. Thus, there has been a consensus that a gross lack of parity exists, with significant under-funding of mental health services and research (Seedat Emsley & Stein, 2004). In addition, there is the additional and overwhelming challenge, which is that, there is lack of research related to developing mental health interventions that can be scaled up and that do not need to be delivered by mental health professionals. This is a critical intervention in low-and middle-income countries, given the existing human resource crisis. Thus, there is need for extensive research data with regard to mental disorders in South Africa, so as to sufficiently inform South African mental health policy with an appropriate increase in funding for mental health services (Tomlinson et al., 2009).

In comparison with data from other countries, South Africa has lower rates of depression than the USA, but higher rates than Nigeria, and higher than in most of other countries that have participated in the first wave of the WHO WMH initiative. The findings are

broadly consistent with previous empirical literature in South Africa. Such findings are the first step in documenting a level of need for care in a context of significant under-funding of mental health services and research in South Africa. Literature also established an association between gender and depression mood disorders, which is consistent with other lower income countries statistics (Schwenk et al., 2014).

In the next few sections, the following will be developed: causes and forms of depression, its signs and symptoms, some factors related to depression, in particular, the psychosocial factors related to depression, and psychopathology as a form of depression. Specific focus will be devoted to spirituality and depression.

2.5.2.1.1 Causes and forms

There are various forms of depression that people can suffer from. These are depressive mode, bipolar affective disorder, major depression, dysthymic disorder or dysthymia, and minor depression.

a) Depressive mode

This involves symptoms such as depressed mood, loss of interest and enjoyment, and increased fatigability. Depending on the number and severity of symptoms, a depressive episode can be categorized as mild, moderate or severe. An individual with a mild depressive episode will have some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely. During a severe depressive episode, on the other hand, it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent (WHO, 2012).

b) Bipolar affective disorder

This typically consists “of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated mood and increased energy, resulting in

over activity, pressure of speech and decreased need for sleep” (Marcus Taghi Yasamy, van Ommeren, Chisholm & Saxena, 2012: 6).

c) Major depression

Severe symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy most aspects of life. An episode of major depression may occur only once in a person’s lifetime. But more often, a person can have several episodes.

d) Dysthymic disorder, or dysthymia

Depressive symptoms that last a long time (two years or longer) but are less severe than those of major depression.

e) Minor depression

Similar to major depression and dysthymia, but symptoms are less severe and may not last as long.

There are several factors that may contribute to depression amongst people – these are linked to genes, brain chemistry and hormones, and stress.

f) Genes

People who are born in a family with a history of depression may be more likely to develop depression as compared to those who than those whose family members do not have the illness.

g) Brain chemistry and hormones

The brains of people with depression look different on scans than those of people without the illness. Also, the hormones that control emotions and mood can affect brain chemistry.

h) Stress

Loss of a loved one, a difficult relationship or any stressful situation may trigger depression episodes in some men. Most of the time, it is likely a combination of many factors.

Major depression (MD) is highly prevalent in HIV infected patients and presents significant diagnostic challenges because of the biological, psychological, and social components associated with the infection. Depressive symptoms in HIV-positive patients (HIVpp) have generally the same clinical characteristics as those in HIV-negative patients (HIVnp) with depression: low mood; anhedonia; insomnia; anorexia/polyphagia and subsequent changes in bodyweight; irritability; difficulty concentrating; impairment; and psychomotor change (Colibazzi, Hsu & Gilmer, 2006). Literature has established that depression is likely to negatively affect the course of HIV infection and may also affect the immune response of the organism against the infection (Leserman, 2003). The cells that play a key role in the response of the organism against HIV infection are the most affected and thus can easily be influenced by depressive symptoms. The cells affected are the CD4 T lymphocytes, CD8 T lymphocytes and natural killer cells (NK) (Arseniou et al., 2014).

The differential diagnosis between (i) depression that occurs as a complication of the disease; and (ii) depression that occurs due to HIV infection itself (secondary) can be very difficult to identify. There are some instances whereby patients with medical depression attributed their illness with HIV, hence, did not necessarily have prior history of mood disorders. This is referred to depression due to HIV-infection, hence secondary infection. The medical depression may be a primary consequence of the involvement of HIV in the

central nervous system (CNS). The depression could be triggered by the stigmatization and emotional consequences resulting from the diagnosis (Owe-Larsson, Sall, Salamon & Allqulander, 2009). The estimation of depression prevalence is particularly difficult because it is necessary to take into account of:

- Demographic data (gender, age);
- Whether the depressive disorder is caused by the infection itself or is a complication (primary or secondary); and
- Whether there is an overlap between HIV symptoms and depression (Arseniou et al., 2014).

Psychiatric disorders amongst those who are HIV negative as compared to those who are HIV-positive vary extensively. Psychiatric disorders affect mentally both the HIV-positive and HIV-negative as both sets of people suffer a decrease in quality of life and health. HIV/AIDS patients are more likely to be diagnosed with medical depression. However, prevalence may be attributed to differences in methodology and subject characteristics. Thus, it can be asserted that medical depression can alter immune function and may affect HIV disease progression, in the case that it goes unrecognized and untreated. Literature asserts that medical depression rates are low in patients whose disease has not evolved to AIDS, or who have received (HAART) compared with those who did not receive it (Starace et al., 2002; Atkinson et al., 2008).

Depression significantly affects an HIV/AIDS person's differently. Literature asserts that HIV-positive women are more likely to experience depressive symptoms compared with seronegative women of the same age (19.4% vs. 4.8%); (Morrison et al., 2002). Furthermore 19-35% of seropositive hospitalized women present with depression symptoms (Dube et al., 2005), and additionally, 30-60% of seropositive women not hospitalized suffer from the depression ailment (Moore et al., 1999). Ickovics et al. (2001)

observed that HIVpp women with depressive symptoms were nearly twice as likely to die as those without depressive symptoms. Furthermore, Antakly de Mel and Malgebier (2006) conducted a study with a sample of 60 HIVpp women with AIDS symptoms, and 60 HIVpp without AIDS symptoms. The prevalence of medical depression was higher in the symptomatic group (38.3%) than in the asymptomatic group (13.3%). Depression is also highly prevalent in HIVp men, and varies along racial groups or nationality. For instance, in a study by De Santis, Gonzalez-Guarda and Vasquez (2012) established that 65% in a cross-sectional study of HIVpp were Hispanic men.

Furthermore, in another study by Sivasubramanian et al. (2011), it was found that 31.4% in Botswana, and 15.29% in India were affected by depression owing to their infection with HIV/AIDS. Lopes et al. (2011) reported that when compared with their HIV negative counterparts, HIVpp men were more likely to have depression (odds ratio, 3.77). Authors such as Ciesla and Roberts (2001), view that depression can affect homosexual and bisexual men in much the same way as the general population. Literature has also established that the infection of the CNS by the HIV virus significantly affects and alters the functional neural networks, including areas in the bilateral frontal cortex, parietal cortex, caudate head and thalamus, as these are the most vulnerable to HIV infection. It may be that HIV infection is involved in the etymology of secondary depression. However, it is still to be ascertained whether the involvement of HIV in the CNS is entirely responsible for the vulnerability of HIVpp to depression (Arseniou et al., 2014).

Langford, Baron, Joy, Del Valle and Shack (2011) re-counted that HIV infection of the CNS may contribute to changes in the hypothalamus-thyroid hormone signalling, thereby resulting in abnormal Hypothalamus-pituitary-thyroid (HPT) axis feedback, and concluded that HIV may play a role in the pathogenesis of depression in HIVpp through this mechanism. Furthermore, empirical literature, for instance, by Dantzer, O'Connor, Freund, Johnson and Kelly (2008), established that increasing pro-inflammatory cytokines that act on the brain can cause depressive-like behaviour. It has also been found out in a study by Lawson, Kelle and Dantzer (2011) who investigated the role of the HIV trans-activator of transcription (Tat protein) in activation of brain cytokine

signalling and subsequent induction of depression like behaviour in a murine model; established that a single exposure to Tat protein in brain tissue is sufficient to induce brain cytokine signalling that culminates in depression.

These results indicate a possible role of Tat protein in the development of depression in HIV positive people (Lawson et al., 2011; Arseniou et al., 2014). Depression usually affects HIV positive patients mostly during the symptomatic HIV stage, which is characterised as the multi-system disease (Holmes et al., 2003), but not the HIV infection by itself that increases the risk of medical depression (Atkinson et al., 2008). Such is exacerbated by a significant number of factors, such as HIV stigma, occupational disability, body image changes, isolation, and debilitation, which worsen depression in HIV positive patients (Olatunji, Mimiaga, O’Cleirigh & Safren, 2006). The aforementioned factors are the primary contributors to depression.

It is fundamental to state that in both the early and late period of HIV infection there are several factors or depressive symptoms which are indicative of depression as well as several neurodegenerative processes, such as dementia of AIDS (HIV-associated dementia, HAD) and HIV-associated mild neurocognitive disorder (MND); (Lyketsos & Treisman, 2001). Depression can be an early manifestation of HAD and can negatively be related to the cognitive decline of the patient (Wojna & Nath, 2006). According to Ironson et al. (2005), when the CD4count and HIV viral load increase, one’s depression increases, hence there is a greater risk of mortality.

Depression is unfortunately usually underdiagnosed, mainly due to the lack of willingness from clinicians, due to the misconception that it is actually normal for an HIV-positive patient to experience depressive symptoms. It can thus be asserted that it is important for the clinicians attending HIVpp to be able to evaluate possible signs of depression and refer symptomatic patients for psychiatric assessment whenever necessary. Contrarily, underdiagnosing depression amongst HIV/AIDS patients can also be attributed to the reluctance of patients to come forward, owing to the stigma associated with HIV (Arseniou

et al., 2014). Subsequently, when such a dire situation is not addressed, depression can increase risky sex behaviours, which in turn increases the probability of contracting additional diseases that compromise the immune system (Schuster, Bornovalova & Hunt, 2011).

This thus creates the need for a concerted effort for the better management of the HIV pandemic and the consequences of depression. Spiritual and social support coupled with the use of anti-retroviral medication and anti-depressant drugs can play a significant role in minimizing the effect and consequences of HIV infection. Additional measures inclusive of cognitive behavioural stress management therapy have proven to be particularly effective in decreasing the depressive symptoms. In other words, its efficacy and usefulness in HIVpp has been confirmed by literature (Arseniou et al., 2014). The successful management of depression in HIVpp can lead to better prognosis and can have multiple positive outcomes including an improved quality of life, improved adherence to medication, reduction of high-risk behaviours and suicidality. Identification and management of depression amongst HIV/AIDS patients ought to be integral elements of HIV care.

Numerous research studies conducted in the United States lend support to this hypothesis. First, many researchers have established that HIV-infected persons are more likely to report a number of different types of stressful factors when compared to similar non-infected persons, including sexual assault, partner abuse and separation/divorce (Jones et al., 2003; Zierler et al., 1996). However, other research studies did not find significant differences between HIV-infected and non-infected individuals in terms of coping with challenging factors (Catalan et al., 1996). In a recent study with African-American mothers, it was found that a high level of family stressful events was associated with depressive symptoms, and subsequently with physical health status (Jones et al., 2003).

Researchers have also established a relationship between physical assaults and depressive symptoms (Murphy et al., 1999; Simoni & Ng, 2000). Researchers also found a relationship between general negative life events and psychological distress (Catalan et al., 1996; Kimerling et al., 1999; Mellins et al., 2000; Silver et al., 2003).

Additional research studies have further shown that more cumulative stressful life events are also associated with faster progression of HIV positive individuals to full blown AIDS (Leserman et al., 1999; Leserman, 2003) and with poorer antiretroviral treatment adherence (Mellins et al., 2003). It is clear that data from the United States with regard to HIV/Aids infected individuals, has revealed a strong association between stressful life events and malfunctioning; thus, warranting an investigation into these relationships in the South African context.

There are only a few empirical studies in South Africa that have examined the rates of stressful life events among the HIV-infected and even fewer that have assessed the relationship between the psychological functioning and spirituality. One study examined the rates of gender-based violence among HIV-infected women in Soweto (Dunkle et al., 2004). These researchers found that the only type of trauma that was predicted by HIV status was intimate partner violence. For example, 38% of women experienced intimate partner physical abuse, 27% experienced intimate partner sexual abuse, and 40% experienced both physical and sexual abuse by an intimate partner. In addition, 35% of these women reported a history of child sexual abuse, 38% reported a history of forced first sexual intercourse, and 32% reported a history of an adult sexual assault by a non-partner. This study did not assess for the relationship between these stressors and psychological functioning; however, one study did find a relationship between negative life events and depression in individuals with HIV-infection (Olley et al., 2004).

Other studies, with non-HIV infected samples, have found a relationship between stressful life events and psychological distress (Pretorius, 1998; Spangenberg & Pieterse, 1995). As such, existing data available from the United States highlights that the

established relationship between HIV/AIDS and psychological distress in the United States may also hold true for South Africa. However, additional empirical research is necessary to further explicate this relationship.

2.5.2.1.2 Signs and symptoms

Different people have different symptoms, as they vary from every individual. Some symptoms of depression include:

- Feeling sad or 'empty'
- Feeling hopeless
- Being irritable
- Feeling anxious, or angry
- Loss of interest in work, family, or once-pleasurable activities, including sex
- Feeling very tired, not being able to concentrate or remember details
- Not being able to sleep, or sleeping too much
- Overeating, or not wanting to eat at all
- Thoughts of suicide, suicide attempts
- Aches or pains, headaches, cramps, or digestive problems
- Inability to meet the responsibilities of work, caring for family, or other important activities.

2.5.2.1.3 Factors related to depression

Some factors related to depression are hereditary factors, biochemical factors and gender-related factors.

a) Hereditary factors

The incidence of depression is significantly higher among blood relatives than the general population (Carson & Butcher, 1992). The adoption method of genetic research has confirmed this hypothesis: unipolar depression was eight times more likely to occur among the biological relatives of those who were depressed than in the case of adopted relatives (Wender, Kety, Rosenthal, Schulsinger & Ortmann, 1986). More recently, Collins, Katona and Orrell (1996) and Fitzpatrick and Sharry (2004) have indicated that what is inherited is not a single gene, but a genetic vulnerability that may be activated by environmental factors.

b) Biochemical factors

A growing body of evidence since the 1960's strongly suggests that biochemical factors are a factor in depression (Mulder, Porter & Joyce, 2003). Neurotransmitters which mediate the transfer of nerve impulses between neurons seem to figure prominently (Stimmel & Aiso, 2005). The research in this area was sparked by the observation that certain medical interventions, such as electroconvulsive therapy, antidepressant drugs and lithium carbonate seemed to ameliorate depression by influencing the concentrations of neurotransmitter chemicals at the synapse (Carson & Butcher, 1992). It was also noted that depression possessed, in many cases, a biological component, such as insomnia, loss of appetite, fatigue, which lent credence to this hypothesis (Kaplan & Sadock, 1998). Although the field is highly complex, and the etymology of depression is multi-faceted, it is generally accepted in psychiatry today that biochemistry plays a significant role in major depressive disorder (Mulder et al., 2003). De Winter et al. (2003) for example, have suggested that there are various sub-types of depression, such as melancholic and anxious retarded, which need specific chemical treatments. Bullock (1996) and Stimmel and Aiso (2005) confirm the psychiatric view that biochemical factors, particularly the influence of neurotransmitters, are central to depression, with recent research focusing

on the action of serotonin and dopamine, as well as norepinephrine, neurophysiological and neuroendocrinal factors.

Thase, Frank and Kupfer (1985) contended that depression may be related to neurophysiological factors, such as disturbance in sleep rhythms. Rosenthal et al. (1984) argue that neurophysiological factors play a significant role in seasonal affective disorder, a depression related to the amount of light in the environment. The evidence for neurophysiological elements as a factor in the etymology of some depressions is compelling, and reminds us again of the holistic nature of people, which in turn determines that depression has physical, emotional and spiritual correlates (Carson & Butcher, 1992). With regard to neuroendocrinal factors, research has focused on the role of the hormone cortisol, because of the high levels of this substance in the blood plasma of people suffering from major depression (Carson & Butcher, 1992).

Arana, Baldessarini and Ornstein (1985) suggested that non-suppression of plasma cortisol may be related to depression. However, Thase et al. (1985) discovered that people with other disorders also presented with non-suppression of cortisol, which has left research in this area in a state of flux. More recent studies have suggested that increased cortisol levels, probably caused by stressful life events, may themselves lead to a lowering of neurotransmitter levels, such as serotonin, which then leads to depression (Cowen, 2002; Garland, 2002; Gold, Drevets & Charney, 2002). Cowen (2002:100) emphasizes a need in the research on cortisol which is pertinent. He stated, "we need a model integrating biological, personal and social factors". Moore warns against viewing raised cortisol levels as a causative factor in depression, because there are exceptions, and on this basis, encourages further research in the field (Moore, 2002).

c) Factors related to gender

Women are considered to be at greater risk for depression than men (Jack, 1991; Walters, 1993). The gender differences in prevalence have stimulated much theorizing and

research, including the suggestion that biological factors such as hormones play a role (Ussher, 2002). Other hypotheses and research centre virtually around social labelling, social inequalities and lack of social support as factors in women's depression (Nolen-Hoeksema, 1987). It has also been suggested that women tend to ruminate about their depressed condition and its causes, which only exacerbates their condition. Men, on the other hand, perhaps because of socialization, tend to respond actively to a depressed mood by escapist behaviours (like playing sport) that tend to alleviate their depression (Nolen-Hoeksema, 1987). Du Plessis (2002) suggests that, in the South African context, men are socialized to believe that experiencing depression is unmanly, and are therefore more reluctant than women to seek help, and that this may have skewed the statistics. Mothers of young children seem a particularly vulnerable group with regard to depression.

Rapmund and Moore (2000) draw attention to the no-win situation women find themselves in when they are pulled in many directions: by divided loyalties, failure to meet expectations, tension between external control and internal control, competence eclipsed by incompetence, a background containing mixed messages concerning love and rejection, a feeling of alienation from the world, ambivalence between confrontation and avoidance, and confusion with regard to sources of support. The overall feeling of being stuck perpetuated the depression. Webster (1990) suggested that depression needs to be reframed as a coping mechanism for women in a society that expects both self-sacrifice and self-actualization from women. Depression sublimates the ensuing rage.

Walters (1993), in a stratified random sample of 365 Canadian women, found the following all to be pertinent in women's depression: socio-economic status, ethnicity, family structure, the quality of family relationships, heavy workloads, society's gender roles, issues of female identity and the nature of women's participation in the labour market. In a phenomenological study, Hedelin and Strandmark (2001) found the following to be characteristic of depression in elderly women: re-experiencing a painful personal insult, a perception of greater vulnerability than previously felt, alienation, fear, meaninglessness and emptiness, self-searching and guilt, diminished vitality and physical

pain, and a feeling of tension between various opposing demands. Srinivasan, Cohen, and Parikh (2003) found that women were more likely to attribute their depression to biological factors.

Women are also more likely to suffer relapse after recovering from an episode of major depression. This feature was among a number of factors uncovered in research by Lewinsohn, Zeiss and Duncan (1989). The other factors related to relapse were the number of previous episodes and the depression level at the time of the interview. Women who relapsed were also more likely than men to have more severe episodes (Lewinsohn et al., 1989). Booij, Van Der Does, Hoffmans, Spenhoven and McNally (2005) suggest that relapse in women is related to greater tryptophan depletion in women than men. The high number of women who suffer from depression led to the postulation that the genes located in the X chromosome might be responsible for depression. Since males can only inherit the X-chromosome from the mother, it was reasoned that, if depression was in fact located in this chromosome, there would be no incidence of depression passed on from father to son. Unfortunately, subsequent research found apparent transmission of depression from father to son which has brought this hypothesis with regard to unipolar depression into question (Carson & Butcher, 1992; Sadock & Sadock, 2003).

Du Plessis (2002) has suggested that depression manifests differently in men than in women, namely by men isolating themselves and behaving aggressively. It could be also that traditional views about masculinity, such as independence, self-sufficiency and inexpressiveness, contribute to depression and suicide in men (Moller-Leimkuhler, 2003; Sadock & Sadock, 2003; Sinclair & Taylor, 2004).

2.5.2.1.4 Psychosocial factors

Various psychosocial factors may also cause depression. Amongst them are: stress; cognitive and personality vulnerability; feelings of helplessness and hopelessness; interpersonal and systemic factors; and cultural factors.

a) Stress

A large body of research has indicated that stress may lead to biochemical changes in the brain, which in turn induces depression (Akiskal, 1979; Barchas, Akil, Elliott, Hollman & Watson, 1978; Thase et al., 1985; Van Praag, De Kloet & Van Os, 2004). This phenomenon is particularly applicable to major depression (Carson & Butcher, 1992). Beck (1967), in his pioneering research, contended that stress of various kinds was related to all types of depression. The most frequent kinds of stress seemed to be: (a) situations that lower self-esteem (b) situations where a person is frustrated in the reaching of a certain goal (c) a physical disease or disability (d) any single stressor of overwhelming magnitude (e) multiple stressors (f) insidious stressors of which a person seems unaware, such as a member of the police who has grown hardened to traumatic situations (Beck, 1967; Paykel, 1982; Steger, 2003). In recent years, stress in the form of sexual abuse (past or present) and stress resulting from HIV/AIDS has been associated with depression (Coleman, 2004; Lewis, 2004; Simoni & Cooperman, 2000). In a similar vein, stress from partner abuse has been associated with depression (Fowler & Hill, 2004). Stress in the form of strokes and rheumatoid-arthritis is also related to depression (Bartlett, Piedmont, Bilderback, Matsumoto & Bathon, 2003; Robinson-Smith, 2004).

Stress is also a factor in the over fifty-five age group, particularly in the form of loss of spouse or job, health problems and lack of social support (Phifer & Murrell, 1986; Wink, Dillon & Larsen, 2005; Wynchank, 2004). Ellermann and Reed (2001) noted that the inability to transcend self is related to stress and depression in middle-age adults. These findings point to the subjectivity of stress: stress is different things to different people and

can be related to factors such as values, needs, personality characteristics and life developmental stages. In addition, certain cognitive schemas predispose people to depression when encountering stress relevant to their self-schemas. For example, people with dependency self-schemas were prone to depression when encountering stressful interpersonal life events, such as loss, whereas people with self-critical self-schemas were vulnerable to stressful life events related to achievement issues (Hammen, Marks, Maylol & DeMayo, 1985; Kaplan & Sadock, 1998).

Multiple stressors that feature most prominently in breakdowns are as follows: failure to meet male or female role demands, changes in marital relationships, relocation (often involving a change of job), facing a denied reality, physical illness, failure in job performance, failure of children to meet goals set by parents, increased responsibility, damage to social status and bereavement (Carson & Butcher, 1992). Recent research by Rost and Smith (2001) and Shapiro and Schwartz (2000) confirmed the important relationship of stress to depression. In the South African context, Du Plessis (2002) suggests that up to 80% of all depression is stress related. Moller-Leimkuhler (2003) argues that depression is linked to changes in gender roles, postmodern individualism and stressfully rapid social change. In the light of this evidence, it seems that the definition of depression without a precipitating factor of some kind needs to be questioned. Even where there seems to be no preceding stress, it may be that the stressor was overlooked by the person and professional alike, although care must be taken not to deny the experience of the person, and the role of hereditary, biological, chemical and neurological factors as indicated previously. More recently, Kramer (2005) have confirmed the stress model of depression, but emphasize that underlying anxiety and aggression have vital roles in stress-related depression. In addition, they highlight the complexity of depression, and suggest that much evidence is lost through the use of psychometric tests and interviews (Kramer, 2005). Another recent development is the proliferation of stress management programs and the possibility that these reduce stress and anxiety (Shapiro et al., 2000).

b) Cognitive and personality vulnerability

Beck (1967), the pioneer of cognitive-behavioural therapy, maintained that stress produces depression only in people with negative views about self, the world and the future. People with this kind of cognitive disposition have often suffered parental loss through death or permanent separation (Beck, 1967). Studies by Barnes and Prosen (1985) and Roy (1985), and more recently, Kendler, Hettema, Berters, Gardner and Prescott (2003) provide support for this hypothesis. Attempts to describe a certain personality type that is vulnerable to depression are made difficult by the complexity surrounding the whole idea of human personality. People who display the personality dimensions of dependency and self-criticism seem particularly vulnerable to depression, and people who are both dependent and self-critical seem to experience very intense depressions (Blatt, Quinlan, Chevron, McDonald & Zuroff, 1982; Hammen et al., 1985). There seems to be a link between people with a tendency to feel anxiety and depression (Kaplan & Sadock, 1998; Priest & Montgomery, 1988). People who tend to see problems as frustrations and not as challenges may also be candidates for depression (Hirschfeld et al., 1989). Blatt (1995) argued convincingly that intense perfectionism is a personality characteristic associated with depression and that more extensive therapy may be necessary for intensely perfectionist people. Van Praaget (2004) suggests that anxiety and aggression are related to depression. Burr (2003), from the social constructionist perspective, argues that depression cannot be linked to personality at all, but needs to be re-interpreted from a societal level.

c) Feelings of helplessness and hopelessness

These feelings have been postulated by many theoretical paradigms as features of depression. Perhaps the best known comes from the behaviourist Seligman (1973), who experimented with dogs and electric shocks. Seligman (1973) found that when the dogs were not permitted to escape the shock, they became helpless and hopeless, even when it became possible to escape the shocks. Seligman reasoned that people who see no

way out of their difficulties will subside into similar helplessness and hopelessness. Seligman (1973) suggested that, since this condition is a learned one, it can also be unlearned. In more recent studies, Hedelin and Strandmark (2001) found hopelessness to be a feature of the depression of elderly women, and Marcus, Kerns, Rosenfeld and Breitbart (2000) suggest that hopelessness is related to depression and desire for death in terminally ill cancer patients.

The psychoanalytic school held that depression is a result of the ego's awareness of its helplessness (Carson & Butcher, 1992; Lothane, 2004). The narrative therapeutic approach has suggested that depression may be related to a future story that is without hope (Robertson, Venter & Botha, 2005). The evidence from such divergent theoretical schools provides a strong case in favour of helplessness and hopelessness being an important feature of depression.

d) Interpersonal and systemic factors

For the reason that an individual is part of a system, whether that system is the family or work situation or both, the individual with depression will impact upon the system and vice versa (Haley, 1963; Jones, 2003). Systems theory suggests that depression is a part of the system in a recursory pattern, with 'feedback loops' causing reciprocal influence. Depression often elicits a negative response from the system (Gurtman, 1986; Howes & Hokanson, 1979), which in turn exacerbates the depression (Meyer, Moore & Viljoen, 2003; Strack & Coyne, 1983). Simply being around someone who is depressed can stimulate depression in others (Howes, Hokanson & Loewenstein, 1985; Kaplan & Sadock, 1998). Conversely, family and friends have been indicated as crucial factors in recovery from depression (Nasser & Overholser, 2005).

Systemic factors as diverse as place and surrounding community has been suggested as possible factors in the depression of some people (Knox, Virginia & Lombardo, 2002). Depression can be a factor in the games of power and control that people play (Carson

& Butcher, 1992). In terms of narrative therapy, the life stories of significant others can have a negative or positive influence on the life stories of individuals. In terms of this paradigm, dominating socio-political narratives (for example, that heterosexuality is a societal norm) also seem to be related to depression (Robertson, 2002). Depression may at times, be seen as a result of a desperate way of trying to communicate in difficult situations such as intimate relationships (Carson & Butcher, 1992; Haley, 1963).

Barnett and Gotlib (1988) suggested that marital distress may be involved in the etymology of depression. For example, marital distress may be the 'last straw' which triggers depression (Barnett & Gotlib, 1988). Interestingly enough, Paykel (1979) found that marital conflict was the most frequently reported life event among a group of female patients six months before the onset of depression, which supports Barnett and Gotlib's hypothesis. Marital difficulties may also impact adversely upon the other sources of social support possessed by the person, thus increasing their sense of social isolation (Coyne & De Longis, 1986; Santrock, 1995). Moreover, Nasser and Overholser (2005) found that support from spouse and family were significant factors in recovery from depression.

e) Cultural factors

The incidence of depression, just like other traumatic experiences, varies from culture to culture. In China for instance, depression is not a frequent phenomenon (compared to the West), and when it does occur, it often manifests psychosomatically (Kleinman, 1986). In parts of Africa that are relatively free of Western influence, depression is likewise an infrequent occurrence. The reason for this may be a sense of connectedness that frees the people in this culture from inordinate self-blame and individual responsibility (Carson & Butcher, 1992; Pato, 2000). However, the more western these cultures become, the more depression as described by the DSM-IV begins to appear (Hussain & Cochrane, 2002; Meyer et al., 2003).

It is true that in some non-Western countries depression is a common phenomenon, but the form it takes differs from the West. Feelings of guilt and self-blame, sad feelings and suicidal ideation are replaced by sleep irregularities, diminished appetite, weight loss and loss of libido (Carson & Butcher, 1992). A recent study among Turkish university students revealed six factors related to their depression, namely: trauma, job-related problems, loss, disposition, intimacy, and isolation (Cirakoglu, Kokdemir & Demirutku, 2003). Research conducted among Black African-Caribbean people found that the majority of the participants did not consider depression, in the Western sense, as an illness at all (Marwaha & Livingstone, 2002).

A study among Asian women found that conflicting cultural expectations, psychosocial, spiritual, physical health problems and communication problems were pivotal in these women's experience (Hussain & Cochrane, 2002). In Western cultures, the following features seem pertinent. Firstly, certain sectors of society seem more at risk for depression, such as unemployed women with young children (Brooks, 1996; Carson & Butcher, 1992). Secondly, in western culture, depression is more common among people of high educational and occupational status (White, 1982). It has recently been suggested that the cultural picture in the west is far from homogeneous. In the United States, for example, Latinos conceive depression differently than Anglo Saxon Americans (Koss-Chioino, 2004).

The last two decades have seen the growth of Transcultural Psychiatry, which aims to bring cultural factors into the clinical process. The Transcultural psychiatrists are critical of the medical model, but do not go as far as the relativism of the antipsychiatry movement. One of their aims is to develop a cultural axis for the DSM IV's multiaxial model (Moldavsky, 2003). In the South African context, Ellis (2003) suggests that depression presents differently in people from African cultural backgrounds, namely in the form of psychosomatic symptoms, fatigue, dizziness and irritability. He adds that problematic relationships are almost always a factor in these cultures because of the importance of community. Traditional Africans tend also to describe their depression in

picture language, and cultural factors, such as women feeling uncomfortable with a male doctor, often complicate depression and its diagnosis (Ellis, 2003).

2.5.2.1.5 Psychopathology

Research has shown that mental health problems are common among people which are HIV-positive. These common mental problems often arise shortly after diagnoses or during the course of the disease (Olley et al., 2005). Bing et al. (2001) found almost half of the sample screened positive for one or more psychiatric disorders, including major depression, dysthymia, generalized anxiety disorder and panic attacks. Another study found more than half of the sample screened positive for a psychiatric disorder, with one-third of the sample meeting criteria for two or more disorders (Israelski et al., 2007).

2.5.2.1.6 Spirituality and depression

Spirituality plays an important role in South African conceptualization and understanding of illnesses such as HIV/AIDS (van Dyk, 2001). However, no empirical study examining this relationship in the South African population is available. Findings from research conducted in the United States are mixed with respect to the spirituality-functioning relationship. More specifically, researchers examining spirituality found that it was inversely related to depression Simoni and Ortiz, (2003) and directly related to survival (Ironson et al., 2002) in HIV-infected individuals. This thus infers the relationship between depression and being HIV Positive, substantiated by literature that asserts that depression has been linked to immune function and mortality in patients with chronic illnesses, reflected by poor spiritual well-being and other mood disorders in patients with HIV/AIDS (Michael et al., 2006).

In contrast, although Biggar et al. (1999) found higher reports of prayer for HIV/AIDS infected versus non-infected women, they did not find a relationship between spirituality and functioning for the women in their study. Unlike in the United States of America,

spirituality is more likely to serve as a resource to reduce distress for people in South Africa and it is important to examine this construct.

Established researchers have explored the association between spirituality (as a distinct construct from religiosity) and depression. The results of these initial studies indicated that, higher levels of spirituality are correlated with lower levels of depression. There is consistent literature that supports the relationship between religion/spirituality and depression, for instance, this notion is evident in a sample of 162 terminally ill cancer and AIDS patients. Nelson and Brescia (2000) established that a negative relationship ($r = -0.40$) between FACIT spiritual well-being scores, and scores on the Hamilton Depression Rating Scale (HDRS; Using a multi-variate model, this relationship remained significant ($\beta = -0.30$) after controlling for religiosity, number of physical symptoms, social support, and physical functioning. In a succeeding analysis, after substituting total FACIT scores with the two subscales of the FACIT (i.e., meaning/peace and faith) in the multivariate model, it was apparent that the meaning/peace subscale ($\beta = -0.34$), as opposed to the faith subscale (non-significant), accounted for the association between spirituality and depression (Nelson & Brescia, 2000).

In a sample of terminally ill cancer patients, McClain, Rosenfeld, and Breitbart (2003) also found a relationship between FACIT scores and scores on the Hamilton Depression Rating Scale (HDRS) ($r = -0.51$). In the study by Nelson, Rosenfeld, Breitbart and Galiotta (2002) it was established that, both the meaning/peace subscale ($r = -0.52$) and the faith subscale ($r = -0.39$) produced a negative correlation with depression. However, these relationships were not tested in a multivariate model as in the study conducted by Nelson and Brescia (2000). Furthermore, in an examination of religiosity, Nelson et al. (2002) established that among men with prostate cancer, spirituality, specifically meaning/peace, was the salient variable that accounts for the relationship between religiosity and depression. The results indicated that was a lesser significant association between intrinsic religiosity and depression scores ($r = -0.23$ $p < .01$), while there was no association between extrinsic religiosity and depression scores. Furthermore, of the

subscales of the spiritual well-being scale, the meaning/peace subscale produced a large association with depression scores ($r = -0.64$ $p < .01$); the faith subscale demonstrated a medium correlation with depression ($r = -0.35$ $p < .01$). In other words, Nelson's et al. (2002), study deduced that, spirituality appeared as the construct that was strongly negatively correlated to depression. More expansively, the results of the study implicated that meaning/peace mediates the relationship between religion and depression.

Spirituality and religiosity can thus be ascertained that, they are two specific resources that are associated with lower rates of depression, and may help men with prostate cancer, more effectively manage their distress. Spirituality may be a useful coping mechanism as men with prostate cancer deal with the existential issues that accompany this disease (Nelson et al., 2002; McClain et al., 2003). In a study conducted, it was established that, spirituality/religiousness among HIV-infected individuals was associated with larger social networks, better mood, higher self-reported health, and fewer medical problems, thus may facilitate successful aging with HIV (Cuevas, Vance, Viamonte, Lee & South, 2010).

This then implies that those who find solace in the religious or spiritual environment and beliefs create a buffer zone to reduce the impact of depression, thus use religion and spirituality as a coping source. In other words, spirituality is hypothesized to buffer or exacerbate the effects of decreased social support, stigma (age and HIV-related), and mental illness experienced by people living with HIV/AIDS. Furthermore, clinical implications are that those who find meaning in their lives are strengthened by the level and spiritual/religious development. However, even those who do not rely on spiritual or religious beliefs can also benefit from finding meaningfulness of their lives.

2.5.3 HIV/AIDS treatment

When treated early and properly, depression can be well managed, thus can help affected people cope well with the disorder. Since the inception of anti-retroviral drugs which

suppresses HIV, thus controlling the viral for decades and boosting the immune system, HIV infection has shifted from a death sentence to a life with a chronic disease. Thus, the prognosis of the disease has dramatically improved shown by longer life expectancy, reduction of disease progression and fewer complications (Cotton et al., 2006). It has been estimated that, for the individuals who take antiretroviral medication, the mean age of death is estimated to be above 60 years, with 41% dying of illness not directly associated with HIV (Braithwaite et al., 2005). However, this treatment is not without side effects, which are detrimental to treatment. For instance, nausea, headaches, diarrhoea, joint pain, neuropathy (numbness in limbs) and large amounts of fat deposits are common unpleasant side effects of antiretroviral drugs that may further complicate treatment (Lee, 2012). Anti-retroviral drugs are recommended for patients with CD4 counts between 350 and 500. Furthermore, it is recommended for asymptomatic HIV infected persons, based on many factors including the individual's readiness to start drug treatment, likelihood of adherence to the treatment regimen, and the risks and benefits of antiretroviral therapy for that person in addition to CD4+ cell counts and viral load (Lee, 2012).

Standard antiretroviral therapy (ART) consists of the combination of at least three antiretroviral drugs to maximally suppress the HIV virus and stop the progression of HIV disease (Webb, 1997). Huge reductions have been seen in rates of death and suffering when use is made of a potent antiretroviral regimen, particularly in early stages of the disease (World Health Organization). Again, it is crucial to note that antiretroviral therapy is not a cure for HIV or AIDS, but rather a way to avoid the illness associated with AIDS for a longer period. ART is only a temporary solution, and after participating with a certain antiretroviral treatment for an extended period, it has been observed that HIV reacts to the drug in the person's body and evolves so that it is no longer affected by the drug (Ballard & Sarah, 2014).

In other words, HIV builds up a resistance to the drug, or the combination of drugs, rendering the therapy no longer effective. This is why this treatment plan is not a cure, but instead it prolongs the life of a person infected with HIV. Before explaining the different

types of drugs available, terms that will be used must first be defined and described, as it is essential to comprehending how the antiretroviral therapies work. Transcription is the process of copying DNA in order to form new RNA, which will later be used to form new proteins. In contrast, HIV has a reverse transcriptase enzyme that does the reverse of normal transcriptase enzymes, and synthesizes DNA using RNA as a template. Many of the drugs used in ART focus on this enzyme, and I will provide two cocktails as an example. Another key piece in the replication of HIV is the protease, which is an enzyme that breaks the peptide bonds between amino acids, therefore breaking down a protein (Ballard & Sarah, 2014). This action performed by HIV protease is also affected. There are four dominant groups of antiretroviral drugs, which include nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors, and fusion or entry inhibitors. Nucleoside reverse transcriptase inhibitors were the first available drug in combating HIV. It works by inhibiting HIV's reverse transcriptase, which hinders the ability of the enzyme to convert its genome to double stranded DNA, which is essential to infect the cell (Ballard & Sarah, 2014).

Non-nucleoside reverse transcriptase inhibitors, or NNRTIs, also stop HIV from infecting cells by intervening with the transcriptase of the virus. The non-nucleoside drugs work slightly differently from the nucleoside analogues in that they bind in a different way to the reverse transcriptase. NNRTIs bind to a hydrophobic pocket in the reverse transcriptase of HIV-1; HIV-2 is resistant to most NNRTIs. Protease inhibitors hinder protease, which in HIV attacks the long health chains of enzymes and proteins in the cells and cuts them into smaller pieces. These infected smaller pieces of proteins and enzymes continue to infect new cells. The protease inhibitors work by not allowing HIV protease to break down these proteins and enzymes, and therefore stop HIV from replicating. Finally, fusion inhibitors are the most recent drug that has been found, and the one that has been approved is Fuzeon. The surface of HIV carries proteins called gp41 and gp120. These are proteins which allow HIV to attach itself to and enter into cells. By blocking one of these proteins, fusion inhibitors slow down the reproduction of the virus. Literature suggests that while these are the current categories of drugs involved in ART, new

research and new discoveries are leading to additional drugs, and giving more options for antiretroviral therapies (FoundCare, 2014).

The next few sections will illustrate other HIV/AIDS treatment interventions aside from drugs. These are: decreasing the risk of the disease; decreasing vulnerability to the disease; reducing the impact of HIV/AIDS; the role of religious faith-based organisations; psychological interventions; and spiritual interventions.

2.5.3.1 Decreasing the risk of infection

HIV infection is associated with specific risks, including: Behaviours where there is a risk of HIV infection, most commonly unprotected sexual intercourse, and, in some parts of the world, the use of infected injecting equipment; Situations where there is a risk of HIV infection, such as needing a blood transfusion in a setting where blood safety precautions are not implemented, or being forced to have sex. Risk reduction interventions have been the mainstay of HIV/AIDS prevention programmes to date. They include the provision of information, the development of relevant skills and the promotion of supportive values and attitudes. Many specific prevention methods are focusing on changing risk-taking behaviours and decreasing the occurrence of risk situations (Department of Health 2010, 2009; Department of Social Development; UNAIDS, 2001,2010, 2011).

UNAIDS (2001) listed many strategies to reduce risks, such as “postponing first sexual intercourse; safer sexual practices such as consistent condom use; reducing the number of sexual partners; preventing and treating sexually transmitted infections; the avoidance of traumatic sexual intercourse ; preventing transmission from HIV infected mothers to their infants ; reducing the harm associated with drug use, especially among the young people ; the avoidance of unsafe injections and preventing HIV transmission within the health care setting” (UNAIDS, 2001:7).

2.5.3.2 Decreasing vulnerability

Vulnerability is the result of dynamic social processes. To counter vulnerability, individuals and communities can be supported to take greater control over their own lives and the risks they face. Social exclusion undermines this sense of control. Vulnerability reduction strategies seek to replace social exclusion with inclusion. Programme and policy interventions can reduce vulnerability at individual, community and societal levels. Protecting and supporting individuals promotes social inclusion, particularly for young people. Access to essential community services enables individuals to act on decisions to reduce their risk to HIV and to access care and support. Supportive legal and social norms decrease vulnerability by enhancing realization of human rights – civil, political, economic, social and cultural. Social inclusion strategies help to reduce both the risk of infection and its negative consequences. The same things that cause HIV vulnerability also lie behind many other diseases and social problems, including discrimination, gender inequality, violence, substance use, unwanted pregnancies and many communicable and non-communicable diseases (UNAIDS, 2001). Consequently, vulnerability reduction strategies have positive benefits on health and development far beyond HIV/AIDS.

UNAIDS (2001) further posits strategies to decrease the vulnerability of HIV. These strategies are as follows: “sexual health information, education and services including information and access to male and female condoms; schools and other organized education programmes at secondary level; life-skills based HIV/AIDS education to develop the knowledge, attitudes and values needed to respond to the epidemic; voluntary counselling and testing; antenatal care that includes treatment to reduce mother to child transmission; rehabilitation and legal services; and essential protection, prevention and care services for populations in complex emergencies, especially women and girls at risk” (UNAIDS, 2001:9).

In addition, they suggest strategies of reducing vulnerability: “a special focus on youth is a positive relation with trusted adults; peer relations that model safer behaviours;

participation in family, religious and community activities; positive orientation to education and health; the development of schools as more inclusive, protective and gender sensitive community-based organisations” (UNAIDS, 2001:7).

Furthermore, they recommend supportive legal and social norms: “the reduction of gender and economic disparities that fuel the epidemic; Greater equity in educational and vocational training, and employment opportunities; Increased participation in community, religious and political activity; the reduction of stigma associated with sex, sexuality, sex work and drug use; attention to policies or programmes which have the effect of perpetuating HIV within particular communities; the promotion and protection of human rights” (UNAIDS,2001:9).

2.5.3.3 Decreasing impact of HIV/AIDS

The AIDS epidemic has a negative impact on the physical, mental and social well-being of individuals, and on the social, economic, cultural and political life of communities. The “greater the impact of the epidemic on individuals, families and communities, the less they are able to respond effectively. Impact mitigation strategies help those who are most affected by the epidemic to become stronger. Prolonging the productive lives of individuals infected with HIV increases their ability to contribute to the well-being of their families, also helping to decrease the discrimination and pauperization which can make surviving family members more vulnerable to HIV. Similarly, increasing investments in education, care, social support and general development efforts within affected communities strengthens their capacity to respond to the epidemic” (UNAIDS, 2001:11).

These strategies contribute to creating an environment where human rights are realized, stigma is reduced, and the open discussions required to address AIDS can take place. A more supportive and open environment helps to reduce the vulnerability of community members to HIV infection.

The UNAIDS (2001) suggest the following are possible strategies for decreasing the impact of HIV/AIDS on individuals and families:

- Direct support to reduce the catastrophic financial impact of HIV/AIDS on families;
- Early support to children, especially those orphaned by AIDS, focusing on their health, nutrition and education;
- Vocational training opportunities for young people;
- Improving access to quality care for people living with HIV/AIDS, including peer group support, voluntary counselling and testing, essential drugs and commodities, access to antiretroviral and social support services, including appropriate supportive roles for traditional practitioners;
- Improved access to legal services and human rights protection (UNAIDS, 2001:11).

2.5.3.4 The role of religious faith based organizations

Faith-based organizations have been established and play a significant role serving the purpose of facilitating, caring and preventing of HIV. However, they face serious challenges, and thus have been the recipients of many accusations of being a 'sleeping giant'; of promoting stigmatizing and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgments on those infected; of obstructing the efforts of the secular world in the area of prevention; and of reducing the issues of AIDS to simplistic moral pronouncements, that have not made Churches or Mosques places of refuge and solace, but places of exclusion to all those 'out there' who are, but suffering the consequences of their own moral debauchery and sin (Parry, 2001; Olarinmoye, 2012).

While it cannot be denied that in some instances these accusations may tragically and regrettably be justified, it has not been always and everywhere. Whilst the churches morally debate the issues of condom issue, it has raged in many circles, stalemating action, and in many eyes discrediting the Churches' commitment to tackling AIDS and saving lives. Congregations and parishes have themselves been in the forefront of care and support right across Africa. A great number of these initiatives did not wait for funding in order to begin, they just responded. Their courage and determination in the face of so many obstacles are a humbling lesson to many, and a reflection of deep compassion in the real world of suffering.

Religious faith based organisation's efforts have been questioned due to their stand on some of the preventive mechanisms, particularly condom use. As long as they are calling it ABC (Abstinence, Be faithful, Use condoms) and not bashing condoms, that would be no problem. What would be an area of problem is to deny support for condoms. There is no common ground between contraception educators and authentic abstinence educators. That is because, like oil and water, abstinence and condoms never mix (Unruh, President & Clearinghouse, 2005).

In Uganda, the correct and consistent condom use shall be widely and openly promoted to all sexually active individuals as an effective means of preventing HIV/STI transmission and as a family planning method. The Ugandan Government has supported organizations that spread false information about the effectiveness of condoms against HIV.

Public health organisations and NGOs working on the prevention of the spread of HIV recommend the use of condoms. The Church's teachings have not supported these practices, arguing that they send the wrong message about sex and drugs, and may ultimately lead to the increased spread of HIV. The statements recommend education and treatment aimed at changing behaviour. One exception to this teaching was a statement by the Social Commission of the French Bishops' Conference in 1996. In a

very limited and nuanced way, the statement acknowledges that the use of condoms to prevent the spread of HIV may be necessary (Karanja, 2005).

Furthermore, “political factors” are threatening the FBO’s fight against the disease. In Zimbabwe, President Robert Mugabe cracked down on NGOs, which he said, in August 2005, were being used as “conduits of foreign interference” in his country. The government then introduced a law that would give it more control over these bodies (Karanja, 2005). Collaboration between FBOs and other public health agencies seems to be a big challenge. According to an important study by the World Health Organization (WHO) in Zambia and Lesotho, efforts are needed to encourage greater collaboration between public health agencies and FBOs, if progress is to be made towards the goal of universal access towards HIV prevention, treatment, care and support by 2010 (WHO, 2007).

The report estimates that between 30% and 70% of the health infrastructure in Africa is currently owned by faith-based organizations (FBOs), yet there is often little cooperation between these organizations and mainstream public health programmes (WHO, 2007). The study focused on Lesotho and Zambia, which had HIV prevalence rates of 23.2% and 17% respectively in 2005. It found that Christian hospitals and health centres are providing about 40% of HIV care and treatment services in Lesotho and almost a third of the HIV/AIDS treatment facilities in Zambia are run by FBOs. According to the report, FBOs play much a greater role in HIV/AIDS care and treatment in sub-Saharan Africa than previously recognized. The report concludes that greater coordination and better communication are urgently needed between organizations of different faiths, and the private and public health sectors.

Health, religion and cultural norms and values define the health-seeking strategies of many Africans. The failure of health policy makers to understand the overarching influence of religion, and the important role of FBOs in HIV treatment and care, could seriously undermine efforts to scale up health services. WHO has done a great service in

quantifying the role of the faith community in providing HIV/AIDS care and treatment in sub-Saharan Africa, as it reports that Pastors, religious workers, and volunteers who minister to those who are suffering from deadly diseases, are fully aware of their constituents' needs, and have responded with care on the front lines (WHO, 2007).

Religious leaders are sometimes accused of stigmatizing people with AIDS. This is attributed to their stand for good morals in society and someone who will have contracted the disease will be looked as having not taken the advice of the church, but the reverse. The religious community's sober approach to the AIDS threat helped to reduce stigma attached to the disease while challenging people to adapt safer sexual behaviours (UNAIDS, 2003).

In March 2004, Sibambene, an AIDS and orphan organization run by the Catholics of Bulawayo, became a casualty of the new law. The region's District Administrator ordered it to close its operations until it registers. The organization offers home-based care to over 200 orphans and AIDS sufferers. Another organization, Souls' Comfort, was ordered to stop taking photographs of people living with AIDS (Karanja, 2005). The law needs a concerted response from Church leaders and other human rights groups. Our health and education institutes could be under threat, says Alouis Chaumba, National Coordinator of the Catholic Commission for Justice and Peace (Karanja, 2005).

It is documented that religious leaders have a unique authority that plays a central role in providing moral and ethical guidance within their communities (UNAIDS, 2009). However, religious leaders have faced difficulties in talking about HIV prevention in their congregations (INERELA, 2008). In the early years of the epidemic, many religious leaders thought that AIDS did not affect them or the members of their churches. When people living with HIV were found to be members of their own churches, many religious leaders reacted with denial. As a result, many people living with HIV experienced stigma in various forms from their churches (Paterson, 2009).

Religious leaders can play both a facilitating and a hindering role in the creation of supportive social spaces to challenge stigma. Religious leaders who have contributed to addressing stigma within their own communities are those who personally live with HIV. Before 2003, very few religious leaders in Africa lived openly with HIV, fearing stigma and discrimination. In 2003, African religious leaders who were positively living with HIV founded a network and sought to address these issues. Partners to the network outside Africa proposed a global expansion, and in 2008, the International Network of Religious Leaders living with or Personally Affected by HIV was launched at the International AIDS Conference in Mexico City (INERELA, 2008). The network aims to empower its members to use their positions within their faith communities to challenge stigma and provide 18 deliveries of evidenced-based prevention, care and treatment services. In spite of the initial denial of AIDS, African religious leaders have been involved in HIV education in Trinidad, Senegal, Malawi, Mozambique and South Africa (Eriksson et al., 2011).

2.5.3.5 Psychological interventions

Evans et al. (1997) pointed out that individuals diagnosed with HIV/AIDS are likely to experience severe stress related to the prospect of physical, social and sexual threats associated with their new health status. In the United States, researchers have focused a significant amount of research on assessing the relationship between HIV/AIDS status and psychological functioning. The majority of these studies specifically examine the relation between HIV/AIDS and depression. Recent studies indicated that the rate of major depression among individuals who are HIV positive is twice as high as the rate among individuals who are HIV negative (Ciesla & Roberts, 2001). Caribbean HIV and AIDS Alliance (2012) emphasize the point of prevention to those who are not yet infected by the epidemic of HIV/AIDS.

The research conducted with HIV/AIDS infected women suggests that women exhibit rates of depression ranging from 30-60% (Kaplan, Marks & Mertens, 1997; Moore et al., 1999). The rate of depression in HIV/AIDS infected males, as compared to females, was

found to be 20% or lower (Perkins et al., 1994; Schonnesson, 2002). Studies testing sex differences found that women with HIV/AIDS report significantly more symptoms of depression than men with HIV/AIDS (Lipsitz, Williams & Rabkin, 1994; Zorilla, McKay, Luborsky & Schmidt, 1996).

Jones et al. (2001) studied the correlations between depression and HIV/AIDS in African-American women. This large-scale longitudinal study found that single African-American women who are HIV/AIDS infected display significantly more depression than a group of non-infected single, African-American women. The study measured the cognitive and affective symptoms, but both the self-report and clinician-rated measure indicated depression.

Data in the United States strongly suggests that individuals with HIV/AIDS experience an increased risk for depression. Research in the United States discovered a link between anxiety and one's HIV/AIDS-status. Research by Schonnesson (2002) indicated that individuals with HIV/AIDS reported mood distress characterized as anxiety, including anguish, worry, and powerlessness. Furthermore, research among women has shown higher rates of anxiety among individuals who are HIV/AIDS infected, as compared to non-infected women (Kaplan et al., 1997; Moneyham et al., 1998).

Research by Morrison et al. (2002) found that although HIV/AIDS-infected and non-infected women exhibit no difference in terms of rate of anxiety disorder diagnoses, the HIV/AIDS infected women displayed 55% more anxiety symptoms than their HIV/AIDS negative counterparts. Therefore, the existing data on the link between HIV/AIDS infection and anxiety seems to suggest that women with HIV/AIDS may not be more susceptible to specific anxiety disorders, but that they may have an overall elevated level of anxious symptoms or features (e.g., worry, stress, difficulty sleeping). Studies examining the link between anxiety and HIV/AIDS are limited; more research is necessary to draw comparisons in the relationship.

Although research data from the United States provide strong support for a relationship between HIV/AIDS and psychological functioning, data exploring these relationships in the unique socio-political context of South Africa is limited. Studies from other areas of Africa that compare HIV/AIDS-infected to non-infected individuals, revealed a significant relationship between HIV/AIDS and depressive symptoms (Malanda, Meadows & Catalan, 2001; Wilk & Bolton, 2002). A recent study in South Africa found a 35% rate of depression and a 15% rate of post-traumatic stress disorder among men and women with HIV/AIDS infection (Olley et al., 2003). The study found no significant gender differences in terms of the prevalence of mood disorder. HIV/AIDS patients in South Africa, according to research by Mfusi and Mahabeer (2000), experienced significantly higher rates of depression and anxiety (33%) than non-infected individuals (24%). Another study by Mfusi and Mahabeer (2000) found higher levels of anxiety among an HIV/AIDS infected group in South Africa, relative to a non-HIV/AIDS infected group. However, no difference existed in the level of depression between HIV/AIDS infected and non-infected individuals. Although research from South Africa suggested that a relationship may exist between HIV/AIDS infection and psychological functioning, the literature is limited. As such, additional research is needed to investigate this question within the context of South Africa with a specific focus on women, as they may be particularly vulnerable to depression and anxiety.

However, it is clear that HIV/AIDS impacts the psychological functioning of an individual. Ickovics et al. (2001) suggested that the psychological functioning of an HIV/AIDS infected individual is associated with health-related outcome variables. For example, a prospective, longitudinal research study with HIV/AIDS-infected women showed that depressive symptoms are associated with HIV/AIDS disease progression (Ickovics et al., 2001).

Antoni (2003) examined the health impact of a cognitive behavioural stress management intervention. Those who had stress management training experienced an improvement in mood, neuroendocrine functioning and immunologic status. Research submits that

interventions aimed at improving psychological functioning may directly impact physical health. The above research in the United States, therefore, indicated a strong link between psychological functioning and physical health.

South African researchers need to identify factors that influence the psychological outcome in individuals infected with HIV/AIDS and design more effective interventions to reduce psychological symptoms. Research in the United States suggests that one can positively influence HIV/AIDS infected psychological functioning through interventions, thereby creating a positive influence in the overall wellbeing of persons infected by HIV/AIDS. Therefore, the identification of crucial factors that influence the psychological functioning of HIV/AIDS is necessary for the development of proper interventions.

Amongst the many psychological interventions, the following therapies are usually administered: pharmacotherapy; cognitive-behavioural therapy; psychoanalytical therapy; interpersonal psychotherapy; systematic therapy; person-centred therapy; and combined psychotherapy and pharmacotherapy.

2.5.3.5.1 Pharmacotherapy

Antidepressant medication influences the concentration of neurotransmitters at the nerve synapses, and is available in a number of varieties (Kaplan & Sadock, 1998). Antidepressants have proven to be a very effective form of treatment for moderate to severe depression, but are not the first line of treatment for cases of mild or sub-threshold depression. Contrarily, there also exists literature that asserts that people suffering from mild to moderate depression, are more likely to benefit from psychotherapy than from pharmacotherapy (Beckham & Leber, 1985).

However, anti-depressants have negative side effects, such as, headaches, nausea, feeling sick to your stomach, difficulty sleeping and nervousness, agitation or restlessness and sexual problems (Stimmel & Aiso, 2005). Furthermore, pre-emptive or pre-mature

prescription of depression medication may sometimes hinder psychological growth of an individual, and thus prior to taking medical prescription, it will be helpful to allow psychological or spiritual growth to take place. This is substantiated by Carson and Butcher (1992:408), who stated that "...modest distress or unhappiness should not be an occasion for taking drugs, but for rigorously examining one's life". It has been argued in empirical literature, that past depression has served a relatively positive function by encouraging people to restructure their lives, turn to God, or to find healing in poetry or song. The practice of instant medication to alleviate sad feelings may prevent psychological growth (Bullard, 2002).

2.5.3.5.2 Cognitive-behavioural therapy

Cognitive-behavioural therapy has also been identified as an effective intervention for depression. It has been established to be an effective means of treatment for unipolar, non-psychotic depression (Hawton et al., 1989; Kaplan & Sadock, 1998). The pioneers of the cognitive-behavioural therapy are the Beck, Rush, Shaw & Emery (1979), who assert that early human experience can lead to the formation of dysfunctional cognitions (Beck, 1967, as cited in Robertson, 2006). In the face of stress, these cognitions are activated and in turn lead to what Beck calls 'negative automatic thoughts', negative in that they are unpleasant, automatic in that they race around a person's mind in an uncontrollable manner. According to Robertson (2006), "these uncontrolled thoughts lead to other symptoms of depression: behavioural symptoms (withdrawal, loss of energy), motivational symptoms (loss of interest), emotional symptoms (anxiety, guilt, feelings of worthlessness), cognitive symptoms (poor concentration, difficulty in making decisions) and physical symptoms (insomnia or hypersomnia, loss or increase of appetite)" (p. 60).

The more one experiences these negative thoughts, the deeper one goes into depression, falling into a vicious cycle. The cognitive-behavioural therapist thus intervenes in the midst of the vicious circle, by questioning automatic thoughts and challenging the assumptions on which these are founded. This then infuses positive

thoughts. The more positive thinking pattern helps restructure the cognitive-behavioural thought processes, by lifting the depressive thought feelings. This takes place by education and the transferring of skills learned into the person's environment through homework assignments (Beck, 1967). Cognitive-behavioural therapy has been found to be effective for long-term interventions and much more effective than pharmacotherapy.

2.5.3.5.3 Psychoanalytical therapy

Psychoanalytical therapy has developed divergently both in theory and in practice. It follows the Freudian approach, which subscribes to two therapeutic approaches which are the transference and resistance, can be viewed as psychoanalytic. Transference can be defined as "the distortion of significant others in current experience in order to fit personality patterns and expectations deriving from important individuals in past experience, while resistance is the attempt to block memories that cause psychic pain from reaching consciousness. Therapy consequently encompasses working through the resistances and uncovering transference in an attempt to make the unconscious conscious (Bemporad, 1992; Corey, 1996). It is not without challenges. One of which is that, psychoanalytic therapy is a time-consuming exercise. For instance, Rosenberg (1985), in describing 'brief' psychoanalytic therapy, suggests up to 40 sessions to be conducted. Furthermore, this type of therapy also lacks adequate empirical research that is sufficiently large and objective to indicate long term effectiveness (Bemporad, 1992). Nonetheless, Kaplan and Sadock (1998) point out that, psychoanalytic therapy, while more time-consuming, is just as effective as cognitive-behavioural approaches in treating depression.

2.5.3.5.4 Interpersonal psychotherapy

Interpersonal psychotherapy relieves depressive symptoms by equipping people with the capacity to deal with depression more effectively with current interpersonal problems that are related to the onset of depression. It seeks to focus on four problem areas which are

usually associated with depression, which are; grief, role disputes, role transition and interpersonal deficits (Kaplan & Sadock, 1998; Klerman & Weissman, 1984). Interpersonal psychotherapy involves three fundamental processes; symptom formation, social functioning, and personality dimensions (Carson & Butcher, 1992).

Group psychotherapy has been widely adopted by many psychotherapists; nonetheless research on its application to major depressive disorder is limited. It has been established to be essential and effective in treating a large group of people. According to Laube and Trefz (1994), supportive group therapy has been suggested to have utility in the treatment of major depressive disorder. For instance, in a study involving HIV-positive patients with mild to moderate major depressive disorder, structured supportive group therapy plus placebo, yielded similar decreases in depressive symptoms to structured group therapy plus fluoxetine. Furthermore, medication maintenance support groups may also offer benefits, although data from controlled trials for patients with major depressive disorder are lacking (Laube & Trefz, 1994).

Psychotherapy interventions are derived from psychodynamic theories about the etymology of psychological vulnerability, personality development and symptom formation as shaped by development and conflict occurring during the life cycle from earliest childhood forward. Psychodynamic psychotherapy may be brief but usually has a longer duration than other psychotherapies, and its aims extend beyond immediate symptom relief. These goals are to modify underlying psychological conflicts and deficits, which increase the patient's vulnerability to depressive feelings and the development of major depressive disorder. On the other hand, there are also time-limited, structured psychodynamic psychotherapy which may focus more on understanding the psychological basis of the presenting symptoms or on a selected underlying conflict. Sometimes a goal of psychodynamic psychotherapy, brief or extended, may be to help the patient accept or adhere to necessary pharmacotherapy.

Looking at empirical literature, structured forms of psychotherapy have also been proven to be effective. For instance, a study in Uganda found that group interpersonal psychotherapy substantially reduced the symptoms and prevalence of depression among 341 men and women meeting criteria for major or minor depression (Bolton et al., 2003). In addition, trained lay counsellors, who are to lead interventions, can lead to an improvement in recovery from depression (Patel et al., 2010). Trained counsellors, health counsellors under the supervision of mental health specialist, and medication from a primary care physician can facilitate trials of case management and psychosocial interventions conducted to test the effectiveness to improve outcomes for people with depression and anxiety disorders (Patel et al., 2010).

Researchers in trial of a psycho-educational group intervention put forth that structured and systematic follow-up and drug treatment for those with severe depression can also make a positive contribution. The trials were conducted on 240 low-income women diagnosed with depression. The depression test administered at the six months follow up point showed that 70% of the stepped-care group had recovered, as compared with 30% of the usual-care group (Araya, Flynn, Rojas, Fritsch & Simon, 2006).

2.5.3.5.5 Systematic therapy

Systemic therapy is sometimes called family therapy (Corey, 1996). This form of therapy treats depressed people by contextualizing treatment according to peoples' surrounding systems, such as: the marriage, the family, and friends, work and so on. Systematic therapy is of the view that an individual is part of a system and plays a significant role within the system. The advantage of systematic therapy is that it is not only cost effective (Jones, 2003) as compared to other methods in therapy, but it allows for the integration of other methods of therapy during interventions (Robertson, 2006). Integration allows for the gathering of a repertoire of possibilities that can be used within a particular context at a given time (Corey, 1996; Rost & Smith, 2001).

Empirical studies by Marcus et al. (2012) have established that systemic therapy compared favourably in effectiveness with pharmacotherapy and cognitive-behavioural therapy, especially with regard to fewer dropouts, improvement in levels of depression at the end of therapy and on follow-up.

Innovative approaches involving self-help books or internet-based self-help programs have been shown to help reduce or treat depression in numerous studies in Western countries (Andrews, Kornstein, Halberstadt, Gardner & Neale, 2011). “Effective community approaches to prevent depression can be adopted to focus on several actions surrounding the strengthening of protective factors and the reduction of risk factors. For example, measures can include concerted efforts of strengthening protective factors that include school-based programs targeting cognitive, problem-solving and social skills of children and adolescents as well as exercise programs for the elderly” (Marcus et al., 2012:7). Furthermore, interventions for parents of children with problems aimed at improving parental psychosocial well-being by information provision and by training in behavioural childrearing strategies may reduce parental depressive symptoms, with improvements in children’s outcomes (Marcus et al., 2012). This is in-line with family therapy, which is commonly used in the course of mood disorders, and comprehensive treatment often demands assessing and addressing these problems. However, it has been criticized as it may also increase vulnerability to developing major depressive disorders or retard recovery from it. It therefore needs to be highlighted that it is essential to educate and support those who suffer from depression and other chronic mental disorders. Hence it is fundamental to adopt depression preventative measures.

Additionally, social and educational community interventions may be important given that poverty, HIV and intimate partner violence are also common in settings associated with depression (Ketchen, Armistead & Cook, 2009). However, it is not likely that depression of this severity would respond to social support interventions alone (McKee et al., 2001). Pharmacological interventions are likely important and increasing evidence that complex medical regimes such as Highly Active Anti-Retroviral Therapy (HAART) can as

effectively be delivered and monitored by community health care workers as professionally trained providers (Selke et al., 2010). Alcohol and distorted belief systems are accounted as major contributory factors towards new HIV infections (Dlomo, 2010).

Passing on the responsibility of primary care and prevention to community healthcare workers offering decentralized care at a community level can go a long way in improving health outcomes of populations at sensible costs (McPake & Mensah, 2008). This includes successful delivery of treatment for depression by community health workers servicing postnatal women (Rahman, Malik, Sikander, Roberts & Creed, 2008).

2.5.3.5.6 Person-centred therapy

The Person-Centered therapy was pioneered by Carl Rogers in the 1960's. It has the basic elements as follows:

- A patient takes central stage and ought to take responsibility for her or his own change (Corey, 1996; Moore, 2003).
- The task of the therapist is to create a growth-facilitating climate that involves congruence (the therapist must be himself or herself, thus encouraging the same in the client), and unconditional acceptance and empathy, including compassionate listening and understanding that picks up experiences just below conscious awareness (Kaplan & Sadock, 1998; Moore, 2003).
- Rogers advocated, "The importance of a mystical, and spiritual dimension, where the 'spirit' of the therapist reached out to touch the 'spirit' of the client" (Moore, 2003); as cited in Robertson 2006:63.

Contextualized and applied in the treating depression, the 'person-centred therapy' will assist the depressed person to actualize, or grow, beyond depression (Corey, 1996). The

latest empirical research with regard to the effectiveness of person-centred therapy in treating depression is indecisive or rather inconclusive. Teusch, Bohme, Finke, Gastpar and Sherra (2003) established that the person-centred therapy proved as effective as antidepressant medication in treating a sample of adults with depression. Whereas other researchers, found that, using the person-centred therapy, resulted in a decline in reported symptoms of depression as well as improved self-esteem and emotional processing skills, hence benefiting from better clarification of problems and more insight of problems (Pos, Greenberg, Goldman & Korman, 2003).

2.5.3.5.7 Combined Psychotherapy and Pharmacotherapy

Combined treatment has also been found to be effective, mostly towards chronic depression patients. For instance, dual treatment combines the unique advantages of each therapeutic modality. While pharmacotherapy may provide earlier symptomatic relief, psychotherapy yields broader and longer lasting improvement. Psychotherapy can also be used to address issues that arise during pharmacotherapy, such as decreased adherence. However, the advantage of routinely combining interventions may be modest for patients with less severe depressive symptoms (Fainman, 2005).

Weissman (1979) established that combined therapy was superior to psychotherapy or pharmacotherapy alone. Whereas, Luborsky, Singer and Luborsky (1975) in a comparative study of psychotherapies, concluded that combined therapy was more effective than either component alone, or that psychotherapy was more effective than pharmacotherapy alone. Conte, Plutchik, Wild and Karasu (1986), provided more empirical evidence which supports that the notion of combined therapy methods in a study they conducted that analysed all controlled studies of outpatients treated for unipolar depression reported between 1974 and 1984, and established that combined treatments were slightly superior to psychotherapy and pharmacotherapy alone. Various other researchers have confirmed the effectiveness of a combined therapy methods (Fainman, 2005; Fitzpatrick & Sharry, 2004; Sadock & Sadock, 2003). Rost and Smith (2001), call

for a holistic treatment of depression: medication, cognitive therapy, family therapy, psychoeducation and using intrinsic spirituality.

2.5.3.6 Spirituality and HIV/AIDS interventions

The “relationship between religious coping and psychological outcomes across diverse populations have been increasingly addressed by researchers for the last decade or so” (Lee, 2012:18). Assessment of the role of spirituality on the adjustment to living with HIV/AIDS in South Africa is crucial. Van Dyk’s research (2001) pointed out that spirituality plays an important role in Africans’ conceptualization and understanding of illnesses such as HIV/AIDS. Research regarding the relationship of HIV/AIDS and spirituality in the South African context is very limited. Simoni and Ortiz (2003) found that spirituality was inversely related to depression. Ironson et al. (2002) found spirituality directly related to survival. Biggar et al. (1999) revealed higher reports of prayer for HIV/AIDS-infected women than non-infected women. While research pertaining to the relationship between HIV/AIDS and spirituality is very limited, exploration of an HIV/AIDS patient’s spirituality is important.

Recent literature in the United States suggested that individuals affected by a stressful event cope well if they were spiritual or religious. Various studies indicated that religious and spiritual beliefs and practices are associated with greater psychological well-being among people suffering with severe illness (Meisenhelder & Marcum, 2004; Pargament, Smith, Koenig & Perez, 1998). Furthermore, research concluded that HIV/AIDS patients who belonged to an organized religion and used their religion to cope with their illness experienced greater optimism, self-esteem, and life satisfaction (Paley, 2008; Tarakeshwar et al., 2006; Ai, Tice, Peterson and Huang, 2005; Cotton et al., 2006; Cohen & Koenig, 2002). This augments existing literature which asserts religious coping has been found to mediate the relationship between global religiosity and health outcomes, which suggests that religious coping strategies are more immediate and stronger predictors of health in stressful situations than global dispositional religious variables. This

confirms the importance of religious/spirituality in coping with health problems including HIV/AIDS.

Saleh and Brockopp (2001) asserts that whether HIV/AIDS is viewed as a terminal disease or chronic illness, individuals with HIV have reported relying on religiosity and spirituality as a source of comfort support, and hope. Furthermore, there is also empirical research that has established a significant link between spirituality/religiousness and coping with HIV/AIDS, as patients with HIV/AIDS have expressed their view with regard to this correlation (Lorenz et al., 2005). Research in the United States indicated that 85% HIV-infected adults receiving care in the United States, expressed that spirituality was 'somewhat or very important' in their lives (Lee, 2012). In a study conducted by Suzuki-Crumly et al. (2010) it was found out that in comparing the associations between religious practices and biopsychosocial outcomes (e.g., mood, social support) in homosexual vs heterosexual PLWH using SEM, the results showed that religiosity was positively related to social support among homosexual PLWH, but religiosity did not mediate any of the outcomes in heterosexual PLWH. Similarly, the associations between religion/spirituality and outcomes have been shown to differ by race and age. Older African Americans appear to have higher spirituality and, in turn, higher levels of social support; however, religiosity does not seem to mediate psychosocial outcomes among Caucasians (Ackerman et al., 2009, as cited in Szaflarski, 2013).

It has also been found that a majority of the sample indicated that they sometimes or often rely on religious or spiritual means when making decisions (72%) or confronting problems (65%) (Lee, 2012). This has brought to light specific spiritual coping measures used by people with HIV/AIDS which include spiritual transformation (Schwartzberg, 1993), church attendance and prayer/meditation (Siegel & Schrimshaw, 2002), believing in a higher power (Richards, Michael & Folkman, 1999), and collaboration with God (Woodard & Sowell, 2001). Moreover, it has been indicated that individuals with HIV/AIDS often found deeper meaning in life through a spiritual perspective after the diagnosis, and also experienced enhanced quality of life (Fryback & Reinert, 1999).

Hence, spirituality and religiousness has become associated or correlated to a decrease in emotional distress and depression and improved quality of life amongst women with HIV/AIDS (Sowell et al., 2000). In a study by Trevino et al. (2010), it was established that that positive religious coping was associated with greater self-esteem, spiritual well-being, and the life satisfaction subscale of quality of life, but not with depression or overall quality of life. However, negative religious coping was consistently associated with poorer quality of life, higher levels of depressive symptoms, and higher levels of HIV symptoms at baseline and follow-up.

A study by Cotton et al. (2006) showed that positive religious coping was significantly associated with subscales of quality of life, including a positive association with life satisfaction and negative associations with overall functioning and HIV mastery, hence with the implication of decreasing or avoiding depression. Cotton et al. (2006), contrast with those who researched HIV/AIDS. According to Yi et al. (2006) those who have low spiritual well-being (sense of meaning, purpose, and peacefulness in life) were all associated with significant depressive symptoms in bivariate analyses. Complementary to the effectiveness of spirituality and religiousness, Ano and Vasconcelles (2005) found that positive forms of religious coping were associated with positive psychological outcome (a cumulative effect size= .33) and less emotional distress (effect size = -.12). Kremer and Ironson (2007) showed that spirituality affected the view of HIV as a positive or a negative turning point in one's life. It can thus be asserted that people living with HIV integrate religion/spirituality as a way to cope, to promote positive thinking, to help re-frame one's life, and to bring a sense of meaning and purpose in the face of an often-overwhelming situation (Kremer & Ironson, 2009; Kremer & Ironson, 2007; Ridge, Williams, Anderson & Elford, 2008).

Research states that in contrast to those who do not have or align themselves with religion or spirituality, they tend to adopt negative thinking. The negative thinking may be aligned with lifestyles or behaviours such as homosexual relations or drug use, that violate religious norms and that are stigmatized within religious and ethnic circles (Ellison & Levin

1998; Kreymer & Ironson, 2009; Pargament, Koenig, Tarakeshwar & Hahn, 2004; Trevino et al., 2007). Thus, the fear of being rejected, isolated and victimized drives the non-religious HIV/AIDS patients into hiding. Additionally, previous research points out that there are potentially harmful effects of religion/spirituality for persons with HIV/AIDS who may have been ostracized from their religious institutions or their own communities of faith due to lifestyle issues, or the stigma/ prejudice associated with being HIV-positive (Brown, Macintyre & Trujillo, 2003; Beckley & Jerome, 2002).

Empirical studies have established that there are various aspects of religion/spirituality salient in patients with HIV, including a relationship with a supreme being, prayer and meditation, healing and religiosity (Sowell et al., 2000); connectedness, belief systems and transcendence (Belcher et al., 1989); peace and love (Guillory, Sowell, Moneyham & Seals, 1997); and comfort, strength, social support, self-acceptance and reduction of self-blame (Siegel & Schrimshaw, 2002). Furthermore, it was found out that most persons with HIV exposed used spiritual beliefs and they were not related to a formal church or organized religion (Jenkins 1995). This could be attributed to the multidimensionality of the construct of religion/spirituality (Szaflarski et al., 2012).

2.5.4 Impediments in HIV prevention, care and support

Several obstacles have been encountered in the fight against HIV/AIDS, including poverty and drug abuse, trust, culture, care and people living with HIV and AIDS (PLWHAs) involvement.

a) Poverty/Developed Communities

Social scientists see HIV/AIDS as closely linked to poverty and development, as well as a lack of appropriate strategies to prevent and control HIV/AIDS accounts for its rapid spread in Africa. Researchers consider the health education model, of IEC (Information Education and Communication) which was applied in western countries to be beneficial

for self-control and self-efficacy and enhances behaviour change at an individual level. These suggestions are different with Africa where AIDS is not an individual disease but a society disease requiring group psychology approach strategies. The locus of control is within society. Modification of society's perception and structures that enhance or mitigate the impact of the disease are paramount before individual behaviour change can take place. Furthermore, the need to address the social and behavioural factors can either enhance or restrict the spread of HIV. More particularly, regional co-operation and policy formulation focusing on the multi-sectorial approach as well as research, technical support and advocacy at the highest level are also strategies that seem effective for the prevention, control and management of the future course of the epidemic (Radulich, 2002).

In wealthy communities; HIV/AIDS spread is associated with drug abuse. More than 43% of the notified cases of HIV/AIDS are associated to intravenous drug use. Considering the group of drug users in the poorest strata of society, the HIV/AIDS prevalence oscillates between 48% and 50%. From 1997 to 2001, three HIV/AIDS prevention programs with active participation of drug users and their communities of reference in Buenos Aires, in Argentina have been conducted. The Asociacion Somos Ciudadanos (ASOCI) complements its community interventions with systematic research and specific studies (Radulich, 2002).

In Ireland, part of the HIV/AIDS Prevention Campaign involved placing small poster style adverts in toilet/washroom facilities in a way that those who use the facilities would be exposed to the message. A particular attraction of this strategy is that it allows tailor made messages to be placed in specific locations with specific target audiences in mind.

These messages also give results and analysis of effective strategies used by other countries in Western Europe (Metcalf, 1993).

b) Trust

Research has also shown that one of the obstacles to HIV/AIDS prevention has been inconsistent use of the condom among partners, especially for fairly permanent relationships. The reasons for the inconsistent use of the condom include: maintained regular and sexual relationships which the demand for trust proof, because to continue asking for condoms is like a distrust proof; increased knowledge and use of oral contraceptives to prevent unwanted pregnancies, to mention but a few. Hence, the values, norms and emotions involved in relationships, sexuality, love, romance, and intimacy does not change with the discussion of scientific information (Silva & Stanton, 1996).

c) Culture

In Kenya, Rwanda, Swaziland and Zimbabwe, which operate AIDS awareness and prevention project campaigns, results reveal that even though most respondents know about AIDS, they see it as a problem for others and not themselves. Furthermore, most people know that sexual contact is a mode of HIV transmission, but they also hold misconceptions about transmission. For example, some believe casual contact transmits HIV. Moreover, many never use a condom and believe there is no need to use a condom. Several organisations use focus group discussions (FGDs) to gather much needed qualitative data. A common belief in Zimbabwe is that bad air spreads diseases, which may be the reason for the common fear of getting HIV through casual contact. Another belief in Zimbabwe is that men and women must have children to be accepted into the spirit world. This could explain why women do not require partners to wear condoms or choose to have children if they are HIV positive. All role players responding to HIV/AIDS must understand the local cultural and social context of AIDS (Scott & Mercer, 1994).

In the remote village of Kyakatwire in western Uganda, people stick rigidly to their traditional customs and cultural behaviours that include Polygamy, inheritance of widows,

sharing of wives among brothers and high dowry charges. A group of 15 people were trained as AIDS counsellors for two months. Counselling by oral interviews with individuals and discussions with clan heads and elders were carried out to influence traditional customs and cultural behaviours. Although the AIDS counselling programme has been well received in the rural community, changes of traditional customs are difficult to achieve. One reason for these obstacles to the HIV/AIDS intervention is the fact that women in this rural setting have no final word on sex to their partners. Slowly, men are educated through counsellors to share ideas on sexual issues with their female spouses. Traditional habits that favour the spread of HIV/AIDS can be changed only slowly in a remote rural African community (Rwegiza, 1998).

In Cameroon, according to Kemmegne, Touko and Kamta (1996), HIV/AIDS prevalence rose from 0.5% in 1987 to 5.5% in 1994. In reaction to such a threat, the Ministry of Public Health through the AIDS Programme has initiated a multi-sectorial mobilization plan that associates religious forces (FBOs) and traditional healers to the social communication programme for AIDS prevention. It was revealed that the emergence of controversial views, especially within the ranks of religious sects and traditional healers who claim to possess a cure for AIDS, distorted the public understanding of the scientific message. These traditional healers claim special powers that can enable them to cure all believers who are infected by HIV/AIDS. Worst of all, they even claim to have successfully healed AIDS patients through intense prayers. On the other hand, imposing sign boards can be found on strategic points in big cities, inviting HIV seropositive and AIDS patients to speedy and accurate treatments by traditional practitioners. Such messages are considered with much attention, in our society where some diseases believed to be induced by sorcery, are treated only by traditional healers. In this light, there is an increasing demand for the services of traditional healers by AIDS patients that are rendered at exorbitant prices. Hence, in the present state of biomedical research on HIV, these messages and practices are likely to disturb social communication and to influence negatively the success of education campaigns (Kemmegne et al., 1996).

d) Care

Stigma affects access and utilization of preventive and treatment services by delaying appropriate help seeking. Studies by Okemgbo and Odimegwa (2004) found that some people cannot care for a family member who is infected by AIDS; some would not want or allow an infected person to continue working in factory; some students discontinue schooling in the same school with infected student, refuse to kiss or hug a person living with HIV/AIDS, to mention but a few. Hence, an integrated community and religious-based (FBOs) initiative would tackle the problem of HIV/AIDS-related stigma by challenging societal attitudes and beliefs that underlie stigma (Okemgbo & Odimegwu, 2004).

HIV/AIDS is regarded as a highly medical issue and as a result of lack of understanding, it has caused major obstacles in addressing the HIV/AIDS problem in Azerbaijan. Situation analysis was carried out through the review of HIV/AIDS-related activities undertaken by the government and NGOs. Ibrahimova and Alekperov (1998) pointed out the following: registered HIV rate remains at a low level; blood safety is not ensured; official sexually transmitted disease (STD) rates have risen greatly since 1991; 10-fold increase in registered drug users was recorded from 1989 to 1995; there was an increase in commercial sex activities.

Other factors contributing to the spread of HIV/AIDS include: a lack of awareness about safe sex practices; family life education is not introduced in schools; very few activities were implemented poor relationship between the government and NGO sector; lack of financial resources to ensure supply of disposable equipment; lack of technical capacity in formulation and development of strategic HIV/AIDS planning. It was recommended to: establish a national inter-ministerial AIDS committee to develop a comprehensive strategic plan on HIV/AIDS prevention and care; as well as active support to strengthen the capacities of nascent NGO sector to launch an efficient outreach programme targeted at the vulnerable groups of the population (Ibrahimova & Alekperov, 1998).

There are greater involvement of people living with HIV and AIDS (PLHA). It is a critical aspect of the response to the HIV/AIDS epidemic. A diagnostic study by Cornu and Attwell (2003) examined PLHA involvement in NGO prevention and care programs in Burkina Faso, Ecuador, India and Zambia. Extensive qualitative data were collected through interviews and focus group discussions (FGDs) with over 800 respondents. Participants were service providers of NGOs, PLHA and people affected by HIV/AIDS who use services, relatives of PLHA involved in NGOs, health workers, policymakers and community leaders. According to respondents, major factors limiting PLHA involvement include fear of stigma and discrimination as a result of being identified as HIV positive through involvement in AIDS organizations, limited education and skills to plan and deliver services, and high morbidity and mortality. Poverty is also a key-limiting factor, and the need to earn a living and inability to meet even basic needs hinders involvement. Organizational obstacles include a lack of policies, resulting in a lack of opportunities for PLHA involvement (or lack of PLHA information on these), lack of or inappropriate allocation of resources, and judgmental and discriminatory attitudes of service providers. It was suggested that the NGOs need to build an environment that helps PLHA overcome social and organizational obstacles to their involvement in programs by ensuring confidentiality and providing psychological support to PLHA; making peer support available to reduce the fear of stigma; giving material support to PLHA, including direct provision of care and/or a referral that guarantees access to care; and by networking with other organizations to fight discrimination and facilitate referral (Cornu & Attwell, 2003).

2.5.4.1 Socio-economic barriers to HIV/AIDS interventions

Research by Roys (1995) and Sandman (1996) pointed out a strong relationship between HIV/AIDS infection and one's ability to achieve economic stability. HIV/AIDS infected individuals are likely to lose their current employment and experience excessive financial strain due to the medical costs associated with HIV/AIDS-infection. Also, research by UNAIDS (1999) indicated that HIV/AIDS infected individuals often suffer loss of productivity, income, savings, and assets. LoveLife (2000) suggested that persons

infected with HIV/AIDS often incur an increase in medical expenses and transportation costs. The plight of increased costs occurs simultaneously with a reduced capacity to work, thereby creating a double-economic burden. Teljeur (2002) indicated that these effects are stable over time, as HIV/AIDS continues to have a major socioeconomic impact on individuals and families. Research clearly substantiates the correlation between HIV/AIDS and a lack of economic stability in South Africa.

The Southern African Regional Poverty Network (2002) identified the lack of housing for HIV/AIDS infected mothers as a significant concern. According to Sandman (1996), individuals infected with HIV/AIDS risk losing their current housing. Many HIV/AIDS infected individuals in South Africa reported being placed in a small shack, being kicked out of their home, and being locked in a separate room upon family members' discovery of their HIV/AIDS-status (Russell & Schneider, 2000). In Southern Africa, a culturally accepted practice is for widows with HIV/AIDS to lose their property upon their husband's death, thus making housing for women with HIV/AIDS a major problem (Teljeur, 2002). The above research suggests that HIV/AIDS status may directly impact an individual's housing.

Russell and Schneider (2000) found that people with HIV/AIDS are reluctant to use healthcare services because of a perceived lack of confidentiality by counsellors and other health care personnel. In addition, they found that these services did not help in managing their disease. The South African social-political context and the level of stigma associated with HIV/AIDS causes decreased access to healthcare services by people who are HIV/AIDS infected. A study conducted in Uganda by McGrath, Ankrah, Schumann, Nkumbi and Lubega (1993) pointed out that decreased medical access occurs at times when the women desperately need these services. Goudge and Govender (2000) indicated a need for further empirical research examining the impact of HIV/AIDS infection as it relates to healthcare access. Bhat et al. (2010) found that patients tend to default on their prescribed medication. This is due partly to stigma which has been confirmed by other empirical studies both locally and internationally.

The Department of Health in South Africa (2001) posits that HIV/AIDS often leads to lowered food intake. Research indicates that HIV/AIDS patients have decreased food intake as a direct result of decreased appetite, mouth and throat infections, and social isolation associated with HIV/AIDS-infection. The Department of Health (2001) also points out that HIV/AIDS patients experience physical problems that impact nutritional intake, such as gastro-intestinal deterioration, malabsorption and diarrhoea. A combination of these symptoms increases the HIV/AIDS-infected individuals' risk for nutritional problems. Individuals with HIV/AIDS are more likely than non-infected individuals to experience nutritional impairment and progressive weight loss (Kelly, Dick & Montgomery, 2002; van Niekerk, Smego & Sanne, 2000).

Suttman et al. (1995) pointed out that nutritional difficulty is associated with increased morbidity and mortality rates while nutritional education and dietary counselling effectively stabilizes and/or increases body weight. UNAIDS (1999) postulates that when families face economic difficulties associated with having an HIV/AIDS infected family member, a primary economic coping mechanism is to decrease the number of meals and to buy inexpensive and less nutritious foods. Further research on specific means to avoid malnutrition among HIV/AIDS infected individuals is warranted.

The above researchers indicated that individuals suffering from HIV/AIDS also encounter personal and economic instability with regards to housing, healthcare and nutrition. Limited access to material resources further impacts psychological functioning and increases psychological distress. To further exacerbate the situation, many individuals face the compounded burden created by a lack of economic stability and increased healthcare prices.

A study carried out by Brouwer, Lok, Wolffers and Sebagalls (2000) in Africa indicated that women with HIV/AIDS worry about poverty and its impact on their ability to provide appropriate food and medicine for themselves and their children. Russell and Schneider (2000) pointed out that people living with HIV/AIDS reported feeling as though they are

living in desperate poverty and are no longer of value to society. Also, many HIV/AIDS patients are unable to work or create an income; as such, their sense of worth is challenged. Data on this topic certainly needs further exploration and research.

Folkman and Lazarus (1980) pointed out two styles of coping with HIV/AIDS: problem-focused coping and emotion-focused coping. Problem-focused coping attempts to alter the cause of stress by taking goal-directed and action-oriented steps. Emotion-focused coping strategies aim to manage the emotions aroused by stressors. Research examining these coping styles among HIV/AIDS-infected patients in the United States indicated that both coping styles may be useful. Problem-focused coping is associated with better psychological adjustment in HIV/AIDS infected individuals (Friedland et al., 1996; Pakenham et al., 1994). Research conducted by Moneyham et al. (1998) suggested that forms of emotion-focused coping, coupled with support and optimism, also improved psychological functioning. Fewer depressive symptoms are exhibited by persons using either coping style (Ball et al., 2002; Grassi et al., 1998; Moneyham et al., 1998). In the United States, an important determinant of psychological adaptation to HIV/AIDS infection is one's ability to cope with the diagnosis and the disease. Currently, South African research examining the coping-functioning relationship in HIV/AIDS infected individuals is not available.

Researchers in the United States established that HIV/AIDS infected women are more likely than similar non-infected women to report a number of different types of stressful life events such as sexual assault, partner abuse, separation and divorce (Jones et al., 2003; Zierler, Witbeck & Mayer, 1996). Some research studies did not find significant differences between HIV/AIDS infected and non-infected women in terms of traumatic experiences (Catalan et al., 1996). When comparing the studies, ample evidence indicates that a strong relationship between stressful life experiences and psychological functioning exists among HIV/AIDS infected individuals in the United States.

Jones, Beach, Forehand and Foster (2003) found that a high level of stressful family events was associated with depressive symptoms. Also, researchers established a relationship between physical assaults and depressive symptoms (Murphy et al., 1999). Other research indicates a correlation between general negative life events and psychological distress (Catalan et al., 1996; Kimerling et al., 1999; Mellins et al., 2000; Silver et al., 2003). Further research illustrated that cumulative stressful life events are associated with a faster progression to AIDS (Leserman et al., 1999; Leserman, 2003) and poorer antiretroviral treatment adherence (Mellins et al., 2003).

South Africans have examined the rates of stressful life events among HIV/AIDS-infected women; however, only a few studies exist which assess the relationship between stressful life events and psychological functioning. Dunkle et al. (2004) examined the gender-based violence rates among HIV/AIDS-infected women in Soweto and discovered that the only type of trauma predicted by HIV/AIDS status was intimate partner violence. The study indicated that 38% of women experienced intimate partner physical abuse; 27% experienced intimate partner sexual abuse; and 40% experienced both physical and sexual abuse by an intimate partner. The study (Dunkle et al., 2004) also revealed that HIV/AIDS infected women experience high rates of trauma: 35% of these women reported a history of childhood sexual abuse; 38% reported a history of forced first sexual intercourse; and 32% reported a history of an adult sexual assault by a non-partner. Dunkle et al. (2004) research did not assess the relationship between these stressors and psychological functioning. Other studies found a relationship between negative life events and depression in individuals with HIV/AIDS-infection (Olley et al., 2004). Research by Pretorius (1998) and Spangenberg and Pieterse (1995) found a relationship between stressful life events and psychological distress.

Data from South Africa highlights that the previously established relationship between stressful life events and psychological distress in the United States may also hold true in South Africa. Further research on the relationship of life stressors in HIV/AIDS patients might prove helpful.

Researchers hypothesised that the United States and South Africa are patriarchal societies, in which men are typically responsible for leadership, policy formation, resource allocation and decision-making (Jobson & Wyckhoff-Whell, 2002; Travers & Bennett, 1996). In the United States and South Africa, women are traditionally responsible for tasks such as child-bearing and homemaking. Travers and Bennett (1996) pointed out that when women are in these roles, characteristics such as dependence, passivity, nurturance and other-centeredness are considered extremely desirable. In addition, Travers and Bennett (1996) states that these socially defined roles and their associated characteristics clearly influence the dynamics in male-female relationships, wherein heterosexual relationships are often characterized and defined by power inequalities.

Researchers pointed out that the patriarchal society and power inequalities in relationships contribute to the vulnerability of woman to contract HIV/AIDS in South Africa. Various studies indicated that the patriarchal power system and the inequities in male/female relationships put women at a larger risk for HIV/AIDS (Jobson & Wychoff-Wheller, 2002; Lewis, 2003).

Additional research has focused on the family relationship that expresses power over those infected with HIV/AIDS. Jewkes, Levin and Penn-Kekana (2003) and Lawson (1999) identified the impact of HIV/AIDS infection on a woman's power in the home. The above studies revealed that HIV/AIDS infection in Black South African women has been associated with partner rejection, family abandonment, loss of social status and loss of access to family economic resources. These losses inevitably decrease the HIV/AIDS infected woman's power and status within her family and diminish the woman's control and power with her husband. An HIV/AIDS infected woman loses her sense of empowerment and feels powerless in the home, which negatively impacts her psychological functioning. While research regarding the correlation between patriarchal power societies and psychological function is limited, additional research, conducted in the South African cultural context, could prove helpful.

Patients infected with HIV/AIDS face diminishing access to family social support, which negatively impacts psychological functioning (Ndlela, 2002). Data indicated that HIV/AIDS infected individuals, especially South African women, are often blamed by family members for their husband's HIV/AIDS infection and the devastation. Consequently, these infected women are punished by their extended family through the removal of financial and emotional support (Ndlela, 2002).

Ntozi (1997) found that the loss of emotional support from family members may further compromise the care the individual would usually receive from family, as well as diminish the assistance the individual would normally receive with childcare responsibilities. Family support, according to Foster and Williamson (2000) research, is critical and relevant in the South African social context. Most South African cultures rely on the nuclear and extended family system, which traditionally served as the security system. Family members in a nuclear system are expected to care for their poor and sick family members.

Russell and Schneider (2000) pointed out that numerous South African women described significant loss of family support. Upon disclosure of HIV/AIDS infection, some women described being kicked out of their home or being placed in a small shack on the plot outside of the main family's home. Additional studies are needed pertaining to the relationship between family support and psychological functioning in South Africa.

Kalichman, DiMarco, Austin, Luke and DiFonzo (2003) and Klein et al. (2000) suggested that among HIV/AIDS-infected men and women in the United States (72% African-American), support from family (fathers, brothers, extended family), was inversely related to depression. Schrimshaw (2002) pointed out that data on HIV/AIDS infected women in the United States indicated a significant positive association between unsupportive social interactions and depressive symptoms. Jennings, Mulaudzi, Everatt, Richter and Heywood (2002) pointed out that the relationship between family social support and psychological functioning is evident in South Africa. They also found that 37% of HIV/AIDS infected individuals interviewed did not think their family would believe them if

they disclosed their HIV/AIDS infection status. In addition, 42% stated that their family would likely blame them for their infection; 38% stated that their family would likely be scared of them if they knew they were infected; and 18% feared rejection if they disclosed their HIV/AIDS-status. The above data indicates that HIV/AIDS positive patients are afraid to lose their immediate and extended family in response to disclosure. Upon disclosure of one's HIV/AIDS status, many people lose family support and experience great psychological distress.

Bollinger (2002) suggested four reasons why people with HIV/AIDS are likely to experience high levels of stigma. First, HIV/AIDS is a fatal disease and people in the community experience a high level of fear of infection. Secondly, HIV/AIDS is often associated with behaviours that are already stigmatized, such as men having sex with men, women engaging in sex work or drug use. Therefore, the association between HIV/AIDS and these already stigmatized behaviours further enhances the level of stigma associated with this disease. Third, individuals often believe that HIV/AIDS infected people contracted the disease as a result of poor lifestyle choices. On the contrary, with beliefs about other diseases, such as cancer, people presume that affected individuals have less control over becoming sick. Fourth, he points out that people often view HIV/AIDS as being a form of punishment for a deviant behaviour. According to research by Herek, Capitano and Widaman (2002), HIV/AIDS infected people in the United States also experienced this same stigma.

The stigma is one of the largest barriers to coping with HIV/AIDS. Stigmatization is exacerbated due to prejudice toward members of the homosexual community, certain minority ethnic groups, drug users and sex workers, all of whom are at increased risk of being infected with HIV (Bacha, Pomeroy & Gilbert 1999; Molassiotis et al., 2002). The stigma raises various issues regarding disclosing status, seeking social support, and developing and sustaining close interpersonal relationships (Clark, Lindner, Armistead & Austin 2004; Massey, 2010; Paxton, 2002). In comparison to other chronic diseases, HIV/AIDS is shadowed with stigma, such that those infected with the epidemic often find

themselves secretly living with the disease with the fear of being rejected by their own families and friends. This hence closes down opportunities for support from immediate environment.

Empirical literature has asserted that greater occurrence of perceived stigma and experiences of discrimination were correlated with the likelihood to disclose HIV status to a partner, such that the negative experience associated with stigma is likely to make one to be not inclined to reveal their HIV/AIDS status to their life-partners. In addition, this happens because HIV/AIDS positive individuals perceive disclosure of one's disease status to others as a complex and ongoing stigmatizing process (Simbayi et al., 2007; Chenard, 2007). Researchers such as Venable, Carey, Blair and Littlewood (2006), suggest that there is a large result in social isolation and lower levels of emotional support. Furthermore, the fear of revealing one's HIV/AIDS status is also attributed to stigmatization and fear of internal shame and feelings of guilt because of past risky behaviours (Smiley, 2004). Research has also shown that drug use and unprotected sexual activity prompts shame (Molassiotis et al., 2002). Religious resistance of addressing HIV/AIDS has also contributed to stigmatization of those with HIV (Szaflarski, 2013). This is attributed to moral judgments about HIV. Survival, guilt, feelings of undeserved life or happiness, or anxiety or hopelessness about attracting another partner (Bor, Elford, Perry & Miller, 1988) make people with HIV vulnerable to mental problems. Such shame and humiliation drives people with HIV/AIDS into depression and fast progression of the disease.

Insideout Research (2004a), which focused on HIV/AIDS stigma in South Africa, pointed out that stigma is often conceptualized and manifested in two ways: external stigma and internal stigma. Recent research conducted in conjunction with the Centre for the Study of AIDS, USAID, and the POLICY Project indicated that external stigma was defined as actual experiences of discrimination towards people with HIV/AIDS, including things such as domination, oppression, the exercise of power or control, harassment, categorizing, accusation, punishment, blame, exclusion, ridicule or resentment (Insideout Research,

2004a). External stigma focuses on the way that people in the community react to or categorize people with HIV/AIDS.

The Inside-out research team (2004b) in South Africa conducted 23 focus groups with a total of 205 HIV/AIDS-infected and non-infected participants throughout the country in order to assess external HIV/AIDS-stigma. The research team identified numerous themes which could qualify as external HIV/AIDS-stigma: (1) avoidance; (2) rejection; (3) moral judgment; (4) stigma by association; (5) unwillingness to invest in people living with AIDS; (6) discrimination and (7) abuse. Clearly, the presence of these external stigmas indicated that HIV/AIDS-stigma is prevalent throughout South Africa.

On the other hand, internal stigma focuses on the individual's experience of being HIV/AIDS positive and the feelings associated with having this disease. Inside-out Research (2003) suggested that an internal stigma is defined as the shame or fear that a person feels in association with being HIV/AIDS-positive. Using a focus group and random household survey methodology, Jennings et al. (2002) conducted a study in South Africa to determine the level of external stigma toward people living with HIV/AIDS. Ultimately, the study indicated a high level of external stigma towards people living with HIV/AIDS. People were questioned regarding interactions between HIV positive people and the general public. Research by Jennings et al. (2002) revealed that 84% of people sampled stated that couples with a partner who has HIV/AIDS should not have children; 26% believed that people with HIV/AIDS should have separate healthcare facilities; 22% believed HIV/AIDS testing for jobs should be compulsory; 17% believed that the country should publicize names of HIV/AIDS infected individuals; 15% believed that people with HIV/AIDS should be restricted in their work options or disallowed to work; and 8% believed that people with HIV/AIDS should be separated from others in the community so as to protect non-infected individuals.

The study by Jennings et al. (2002) showed stigmatizing beliefs about people with HIV/AIDS: 39% of people believe that HIV/AIDS infected people brought it upon

themselves; 38% believe that HIV/AIDS is a punishment from God; 27% believe that people with HIV got what they deserved; and 12% believe that HIV/AIDS only affects homosexuals. In addition, participants endorsed numerous myths surrounding HIV/AIDS, which may also impact the stigma surrounding this disease. People expressed a wide variety of beliefs such as HIV/AIDS is caused by witchcraft (3%); that HIV/AIDS is a lie by foreign governments in order to control African sexual behaviour (22%); that HIV/AIDS is spread only by whites (40%); and HIV/AIDS is a young person's disease (54%).

Jennings et al. (2002) speculated that women with HIV/AIDS experienced greater stigma than men infected with HIV/AIDS. The South African National Council for Child and Family Welfare (1999) reported that as a result of HIV/AIDS infection, women were sometimes abandoned by their families or labelled as witches and killed. Additional research regarding the risk for HIV/AIDS stigmatization and its impact on psychological functioning among South African's is needed.

Research conducted in the United States by Clark et al. (2004) found perceived stigma to be associated with poorer psychological functioning in general. Other studies revealed a significant increase in anxiety, depression, hopelessness and suicidal thoughts among HIV/AIDS patients (Berger, Ferrans & Lashley, 2001; Heckman, Kochman & Sikkema, 2002; Lee, Kochman & Sikkema, 2002).

Research regarding HIV/AIDS stigma and its impact on psychological functioning among people in South Africa is very limited; this is an area in which research is desperately needed. This augments empirical literature, which asserts that people with HIV/AIDS experience different types of daily life stressors and need progressive health management. However, despite some serious side effects of the medication, concerns about changing physical appearance and bodily functioning all add to stressors associated with HIV infection. Calls for strict adherence to treatment regimen are necessary to maintain optimal health. Failure to address this medical pandemic leads to

the mutation of the virus, giving it strength to resist anti-HIV medications in general (Kalichman, Kelly & Rompa, 1997).

There have been measures that have been identified that can alleviate stigmatisation. One measure has been the education of clergy and engaging them in the development of community interventions. Pastors are the most influential people close to communities that have the ability to shape the opinions and views about HIV/AIDS and people affected or infected by the epidemic (Nunn et al., 2013; Szaflarski, 2013). Previous studies have established that faith leaders emphasized the importance of creating safe environments for people living with HIV to disclose their status for their benefit, and to increase HIV awareness in congregations (Coleman, Lindley, Annang, Saunders & Gaddist, 2012).

African samples suggested that, perhaps as a result of stigma, HIV/AIDS infection leads to a breakdown in social support systems and withdrawal from existing social networks (Key & DeNoon, 1995; Osei-Hwedie, 1994; Strebel, 1996). Research pointed out that in South African urban areas, individuals with HIV/AIDS tend to isolate themselves from non-infected individuals; infected individuals in rural areas tend to isolate themselves from all non-family members (SANCCFW, 1999). Isolation decreases the availability of social support. Very little research is available regarding the relationship between HIV/AIDS infection and decreased non-family social support in South Africa. Studies which examine the impact of loss of social support on psychological functioning are not available.

Recent research conducted in the United States suggested a strong relationship between non-family social support and depression among HIV/AIDS infected individuals (Blaney et al., 2004; Honn & Bornstein, 2002; Klein et al., 2000; Mizuno, Purcell, Dawson-Rose, Parsons, the SUDIS team, 2003; Schrimshaw, 2002; Schrimshaw, 2003). Additional research indicated that a lack of social support correlates to a faster progression of the disease (Leserman et al., 1999) and a poorer quality of life (Klein et al., 2000). Additional research pertaining to the impact of nonfamily social support on an HIV/AIDS infected South African is needed.

Recent studies found that interventions aimed at increasing social support are being implemented throughout Africa (Key & DeNoon 1995; Krabbendam, Kuijper, Wolffers & Drew, 1998). Campbell and Williams (1999) pointed out that African countries are implementing programs that seek to increase community involvement and awareness, and facilitate cooperation between community-based organizations. According to Kaleeba et al. (1997) these programs appear to have some success in increasing social support. Additional research suggested that organizations in the community may play a pivotal role in responding to the needs of HIV/AIDS infected individuals (Sewpaul, 2001; USAID, 2002).

Due to the stigma associated with this disease, HIV/AIDS infected individuals may experience difficulty accessing community resources. UNAIDS (2002) research data in South Africa indicated that a lack of confidentiality about HIV/AIDS limits infected individuals' desire to seek help from health care professionals. Russell & Schneider (2000) pointed out in a South African qualitative focus-group study that HIV/AIDS infected participants reported significant stress around social workers and healthcare providers due to a lack of helpfulness or sympathy regarding their situation. Individuals infected with HIV/AIDS hesitate to participate in religious organizations due to the perception that HIV/AIDS might be a punishment from God (Population Council, 2002). Examination of the relationship between HIV/AIDS and the perception of community support and the role spirituality plays on the levels of psychological functioning require additional research.

Having explored a vast body of information on spirituality, religiosity and HIV/AIDS, literature review will now focus on the theoretical and conceptual approaches to the study and will conclude with some discussion on gaps for further inquiry, before finally closing the chapter with a summary.

2.6 Theoretical approach to the study

There are a number of different versions of ecological models, but in general, they recognise that successful activities to promote health, including HIV risk reduction, should not only address changing individual behaviours, but also multiple levels surrounding individuals, such as families, communities, institutions and policies.

2.6.1. The Ecological Systems Theory (EST)

The Ecological Systems Theory (Bronfenbrenner, 1979) was used to inform this study. This theory has been widely adopted in HIV/AIDS interventions because of its focus on not only the individual and his behaviour, but also the environment that surrounds him or her.

The Ecological Systems Theory (Bronfenbrenner, 1979) can be traced back to the biological theories that explain how organisms adapt to their environments. Bronfenbrenner (1979) suggests four levels of ecological components as a useful framework in understanding how individual or family processes are influenced by hierarchical environmental systems in which they function: The Micro system is the most basic system referring to an individual's most immediate environment, for example, the effects of personality characteristics on other family members. The Meso system is a more generalised system referring to the interactional processes between multiple micro systems. For instance, the effects of spousal relationships on parent child interactions. The Exosystem consists of settings on a more generalised level, which affect indirectly on Micro, Meso and Macro system. The theory recognizes the fact that successful activities to promote health, including HIV risk reduction, involve changing individual behaviours, but also advocacy, organisational change, policy development, economic supports, environmental change and multi-method programs. The comprehensive approach to HIV/AIDS prevention is care and support, which is a good example of multi method programs.

According to the EST, human behaviour is viewed as being determined by five factors or levels of influence and interventions are more successful if they intervene within most, if not all, levels of influence. These factors include; interpersonal factors; interpersonal processes; institutional factors, community factors; and public policy.

- Intrapersonal factors: This refers to characteristics of the individual such as knowledge, attitudes, behaviour, skills or intention. Interventions here should therefore focus on changing these characteristics to comply with certain behavioural norms.
- Interpersonal processes: This includes formal and informal social networks/social support systems. This involves relationships with family, friends, neighbours, co-workers and acquaintances. An individual can belong to one or more social networks. Through these ties in social networks, people acquire norms upon which change-seeking efforts should concentrate.
- Institutional factors: These are social institutions with organizational characteristics as well as formal and informal rules and regulations for operation. Organizational characteristics can be used to support behavioural change. Organizations, such as school, work, church, professional or neighbourhood groups, may have positive or negative effects on the health of their members (Bronfenbrenner, 1979).
- Community factors: Since they are important sources and transmitters of social norms and values, organizations can provide the opportunity to build social support for a desirable behaviour change. The assumption here is that organizational changes are needed to support long-term behavioural changes among individuals. Community factors refer to the face-to-face primary groups to which an individual belongs. These 'mediating structures', such as family, church, informal social networks, and neighbourhoods, may provide social identity and resources. A Community can also be concerned with the relationships among organizations

within a political or geographic area. Many organizations competing for scarce resources usually result in the inefficient use of these resources, unless there is coordination and coalition building among community agencies in planning health education interventions.

A community can also be defined as a population, which is political and has one or more power structures. These power structures play a crucial role in defining a community's health problems as well as allocating its resources. Often those with the most serious health problems in a community are also those with the least access to its power structures (e.g. poor, rural, uneducated, homeless, the unemployed, minorities, and handicapped) (Bronfenbrenner, 1979).

- Public policy: this includes local, state, and national laws and policies. Within the public health sector, the health of the population has been emphasized. Regulatory policies, procedures and laws have been passed (national, state or local) to help protect the health of communities. These policies have been traditionally focused on reducing death and disease from infectious agents. Interventions are more successful if they intervene within most, if not all, levels of influence (Bronfenbrenner, 1979).

Unlike most behavioural and psychological theories, the Ecological Systems Theory focuses on interrelation transactions within and between systems and stresses that all existing elements within the eco system play an important role in maintaining a balance of the whole. However, some scholars argue that the ecological theory is not a theory in the formal sense. Rather, it is a structured framework for identifying influences at numerous levels. Thus, it is not falsifiable. Its value is in alerting clinicians to factors that otherwise might be neglected.

Furthermore, this study is underpinned by the Models in which spirituality exists as an imbedded concept which occurs in the research of Schaefer and Potylycki (1993); Alligood and Marriner-Tomey (1997); and O'Brien (2013).

2.6.2. Levine's model

According to Schaefer and Potylycki (1993), Levine views human beings as highly adaptive creatures in constant interaction with their environments. Humans are also seen as integrated wholes whose behaviours respond to internal. The external environment is comprised of three components: the perceptual, the operational, and the conceptual. The conceptual environment includes a person's culture, language, thinking, personal styles and spirituality. Using Levine's model, a study conducted by Schaefer and Potylycki (1993) measured spirituality and the fatigue associated with heart failure. Participants identified that spiritual activities as an intervention to manage fatigue, but unfortunately there was no explicit identification of what these activities were or how, specifically, they helped in relieving fatigue.

2.6.3. Newman's Systems model

Margaret Newman (1995) identified spirituality as one variable that contributes to the client's basic structure and wellness state. Newman (1995) views humans as unique patterns of consciousness. Implicit in her notion of human consciousness was its movement towards a higher level of insight that facilitates a transcendence of the spatial-temporal self to a spiritual realm. Newman (1995), notes that spiritual awareness can occur at any point in the life cycle and that the development of spiritual awareness empowers the client system towards well-being by positively directing spiritual energy to the mind and then to the body (Newman, 1995). Furthermore, Clark, Drain and Malone (2003) used Newman's model to guide a qualitative study of spiritual needs in adults with previous hospitalizations. In depicting energy flow between nurses and patients, the participants included spirituality as part of the basic structure of energy resources, thus

illuminating Newman's notion that a spiritual variable is basic to all organisms. Additionally, Rajakumar (1995) applied the model to perceptions of health from individuals with terminal illnesses. These findings suggested that the spiritual aspect of a person's life is connected to having a relationship with a higher power, recognizing one's mortality and striving for self-actualization (Rajakumar, 1995).

2.6.4. Watson's theory of Human Caring

The spiritual dimension in her theory is the elaboration of the soul, which is identified as the inner-self, spiritual self or Geist. The theory focuses on nurse-patient interactions and is based on spiritual-existential and phenomenological orientations. Furthermore, Watson (1988) emphasizes that an empathetic caring relationship facilitates the patient's movement towards a higher state of spiritual awareness. Stiles' (1994), phenomenological study of nurse-family interviews in a hospice, identified themes of positive spiritual experiences in the relationship between these families and the nurses. Additionally, caring is considered the essence of nursing practice and requires the nurse to be personally, morally, and spiritually engaged. The one caring and the one being cared for are considered co-participants in self-healing; they each have the power to heal themselves (Martsolf & Mickley, 1998; Saewyc, 2000; Watson, 1988).

2.7 Conceptual framework of the study

The Biomedical Interventions for HIV/AIDS forms a conceptual framework that serves as a foundation for guiding this research and examining the treatments for HIV/AIDS. Smith and Nicassio (1995) pointed out that until the 1960s, when trying to understand patients with chronic and/or terminal health conditions, the biomedical model suggested that to understand a person's disease progression and functioning, one must only understand that person's biological status. First, the biomedical model suggested that only a biomedical understanding is needed to understand the disease progression and symptoms of HIV/AIDS in order to predict the functioning and health of infected

individuals. Second, the biomedical model suggested that HIV/AIDS illness is the result of biological malfunction and, consequently, the disease progression can be predicted by understanding biochemistry and physiology.

However, there are weaknesses in the biomedical model. The biomedical model cannot explain how two individuals with HIV/AIDS can have different clinical presentations and symptoms. Over the last century, Winiarski and Winiarski (1997) indicated a progression away from the biomedical model and toward the biopsychosocial model in an attempt to understand and predict individuals' functioning in a healthcare context. Unfortunately, the biomedical model fails to take into consideration that an individual's psychological factors, social factors and spiritual factors may also have a large impact on the wellbeing of HIV/AIDS patients. The biomedical theory can be seen as a reduction theory that excludes other factors such as psychological, social and spiritual factors or sees these as irrelevant factors.

Engel's (1977) proposal of a bio-psycho-social model suggested the existence of a major weakness with the biomedical model. First, the biomedical model experienced difficulty explaining why different individuals with HIV/AIDS have different clinical presentations, symptom developments, and disease progressions. Second, although the biomedical model led to many significant medical discoveries, it did not fully explain patients' functioning. However, scientists like Engel began to discuss the idea that other factors were likely interacting with biological factors and impacting patients' functioning. Engel's bio-psycho-social model pointed out the need for a broader understanding of illness in the fields of medicine and psychiatry.

Engel's (1977, 1980) bio-psycho-social model suggests that the onset, course and treatment of physical illness are best understood by examining the patient at three levels: 1) biologically, 2) psychologically and 3) socially. The biosocial model was highly influenced by von Bertalanffy's (1968) principle in general systems theory, which stated that nature is organized in hierarchical units which increase in complexity. The

hierarchical units are unique and distinctive. The units at each level interact with each other, and units at one level can influence the units at levels both above and below it. Smith and Nicassio (1995) highlight the interdependence of hierarchical systems and assert that to understand one system; one must understand the surrounding, interconnected systems.

Engel (1980) applied the general systems principle when developing the bio-psycho-social model. First, he asserted the importance of thinking about a patient's functioning at multiple, interacting levels. Second, he presented the interacting, hierarchical units (from lowest to most complex) that should be examined when working with a patient: cells, tissues, organs, nervous system, person, two-person, family, community, and culture/subculture. Third, the bio-psycho-social model affirmed that these units can be addressed by considering a patient's biological, psychological, and social aspects when attempting to understand an individuals' functioning.

Winiarski and Winiarski (1997) breaks down the bio-psycho-social model by providing aspects that needs to be considered when understanding an individual. He provides steps for evaluating a patient. First, consider the biological aspect of a patient by considering the impact of flesh, blood, bone, organism and viral problems. Second, consider the psychological aspects of a patient by seeing the intrapsychic processes of the patient, including factors such as emotions, self-judgments, motivations and coping styles. Third, consider the social aspects of a patient, by considering family involvement, social support, community influences, and societal pressures and influences. Winiarski and Winiarski (1997) also pointed out that, traditionally, individuals in the healthcare setting consider only some of these aspects or consider each of these aspects separately. However, Winiarski and Winiarski (1997), highlighted that the bio-psycho-social model asserts the importance of looking at these processes together, rather than just examining each one in isolation.

Subsequently, when understanding prevention and a cure for those suffering with HIV/AIDS, it is beneficial to use the bio-psycho-social model to guide the evaluation and understanding of the way that HIV/AIDS impacts South Africans. When dealing with HIV/AIDS it is important to consider numerous psychological and social factors when trying to predict the impact of HIV/AIDS, rather than just examining biological factors alone.

This research is interested in examining psychological functioning of HIV/AIDS individuals, and the bio-psycho-social model is relevant in providing a framework for identifying which factors may be important for this research. Researchers in the United States found the bio-psycho-social model to be helpful in understanding and guiding research and practice around HIV/AIDS and functioning (Cohen, 1990; Cohen & Weisman, 1986; Marcus et al., 2000; Thomason et al., 1996; Wolfe et al., 1991; Schlebusch & Cassidy, 1995).

2.8. Gaps for further inquiry

From the above discussion of literature, it is evident that many studies have been done on FBOs and HIV/AIDS, however, most literature focuses on the influence of FBOs in promoting and enforcing less risky behaviours as a way of preventing HIV/AIDS, and support for orphans. Perhaps, there could be sound reasons for choosing this path, but more importantly to that, FBOs are doing it very well in this as their area of specialisation, and all they need is support from other players to help them cover gaps. However, this is not all that FBOs are doing to respond to the challenges posed by HIV/AIDS. A lot more uncovered work is being done, in as far as HIV/AIDS prevention, care and support.

The South African government has acknowledged the involvement of churches in issues related to HIV, and in 1995, the Department of Health invited religious bodies to collaborate in addressing the epidemic. Later, religious organizations were invited to become members of the South African National AIDS Council (SANAC), in order to

increase the provision of care for people living with HIV (Joshua, 2010). It is difficult to generalize about the 'Christian response' to the HIV epidemic in South Africa, since different Christian denominations provide a diversity of services to different client groups. A mapping study in the South African national HIV database found 162 FBOs working in HIV prevention and care related to AIDS, 96% of which had a Christian orientation (Birdsall, 2005).

These faith communities and FBOs have diverse institutional profiles, ranging from small-scale projects run by religious groups at the community level to national religious structures. Although policies on HIV are formulated within many FBOs, these may not translate into plans of action and implementation. Poor documentation of existing programmes contributes to poor monitoring and evaluation of implemented programmes (Eriksson et al., 2011). The Roman Catholic Church has taken numerous initiatives to respond to people infected and affected by HIV. The AIDS office of the Southern African Catholic Bishops' Conference (SACBC) collaborates with the government's Department of Health and FBOs, and leads the response to the HIV epidemic in a five-country region. The 'Choose to Care' initiative has supported 140 projects with a focus on HIV education in Catholic schools, home-based care, services for orphans and vulnerable children, and treatment. An evaluation in 2003 concluded that the Catholic Church runs a comprehensive response to the HIV epidemic through its established network among congregations (Eriksson et al., 2011). Between 2000 and 2005, the Catholic Church intensified its care and treatment activities and became the largest care provider to people living with HIV, next to the government (Joshua, 2010). Although in the early stages of the epidemic, local faith communities in KwaZulu-Natal were slow to respond, they have gradually increased their engagement on the epidemic (Joshua, 2010).

2.9 Chapter Summary

In summary, there is a significant amount of HIV-related stigma in South Africa, and evidence indicates that individuals who are HIV-infected may experience a decrease in

their social support and/or a decrease in access to community organizations. However, this research has been limited to the empirical research examining the spiritual impact on the levels of depression in HIV/AIDS in the specific South African context.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides a detailed description of the adopted research methodology for the study. The chapter further provides a concise narrative of the research philosophy. This ensures that there is quality and significance of the procedures used in the study. It outlines procedures and techniques used in the collection, processing of data such as the research design, target population, sample design, data collection instruments, data collection procedures, data validity and reliability, and finally data analysis.

3.2 Research design

Research design refers to the method used to carry out research. It outlines the methodology used for data collection and analysis. According to Mouton and Marais (1988), the aim of research design is to plan and structure a given research project in such a manner that the eventual external and internal validity of the research findings is maximized. Research methodologies can be classified as qualitative and/or quantitative. For the purpose of this study, the quantitative research method was therefore used.

3.3 Research philosophy

There are two main research philosophies namely positivism and interpretivism (Saunders, Lewis & Thornhill, 2009). The interpretivist approach looks for culturally derived and historically situated interpretations of the social world. Interpretivism is often linked to the thought that in the human sciences we are concerned with understanding. This has been taken to mean that the interpretative approach (understanding) needed in the human and social sciences with the explicative approach (explaining), focused on causality, that is found in the natural sciences (Saunders et al., 2009). It can thus be said that the interpretive philosophy is based on the belief that science is subjective and

therefore allows alternative models of reality. It emphasizes the creative aspects of science, and is in many ways the polar opposite of the positivist philosophy.

On the other hand, there is positivism. The positivism philosophy adheres to the view that only 'factual' knowledge gained through observation (the senses), including measurement, is trustworthy. In positivism studies, the role of the researcher is limited to data collection and interpretation through objective approach and the research findings are usually observable and quantifiable. According to the principles of positivism, it depends on quantifiable observations that lead themselves to statistical analysis. It has been noted that as a philosophy, positivism is in accordance with the empiricist view that knowledge stems from human experience. This study shall take a positivistic approach because it is quantitative and it seeks to get a deeper understanding of the impact of succession planning on employee retention through quantitative data collection techniques, and will use statistical analysis to analyse the obtained data.

3.4 The Quantitative research strategy

Quantitative research is a deductive method that makes use of questionnaires, surveys and experiments to gather data that is revised and tabulated in numbers, which allows the data to be characterised by the use of statistical analysis (Terre, Durrheim & Painter, 2006). The purpose of quantitative research is to establish a relationship between variables. Stainback and Stainback (1988: 317) list three basic purposes of quantitative research: "to describe, to compare and to attribute causality." Quantitative researchers measure variables on a sample of subjects and express the relationship between variables using effect statistics such as correlations, relative frequencies, or differences between means; their focus is largely on the testing of theory. Procedures are established before a study commences and a hypothesis is formulated before research can begin. In other words, procedures are standard, and replication is assumed. The researcher is ideally an objective observer who neither participates in, nor influences what is being studied. Analysis proceeds by using statistics, tables, or charts, and discussing how they relate to the hypotheses (Babbie, 2007). Quantitative research is aligned to the positivism

philosophy, in that there is little, if no interference on the research phenomena. A Quantitative research approach often involves manipulation of reality with variations in only a single independent variable so as to identify regularities, and to form relationships between some of the constituent elements of the social world, which is the premise of positivism. With positivism, predictions can be made on the basis of the previously observed and explained realities and their inter-relationships, just as quantitative research seeks to establish correlation between variables, with the manipulation of the independent variable (Patton, 2002).

3.5 Other research strategies

The purpose of research can be oriented on exploratory, descriptive and explanatory research strategies. These strategies are however not mutually exclusive; they are a matter of emphasis. This study is to use explanatory and descriptive research.

3.5.1 Explanatory research

The explanatory research strategy seeks to provide an understanding of the relationships that exist between variables. The main role of exploratory research is to clarify why phenomena occurs and to foresee future events (Saunders, Lewis and Thornhill, 2003). Explanatory research goes further than merely indicating that relationships exist between variables (Mouton & Marais, 1988). It indicates the direction of the relationships in a causal relationship model. The researcher seeks to explain the direction of relationships. This form of research will be applicable in the empirical study of the relationship between HIV and spirituality. The end-goal of the research is to formulate a conclusion on the relationship between HIV and spirituality.

Explanatory studies are described by research hypothesis that indicate the nature and direction of the correlation between or among variables being evaluated. Probability sampling is typically a necessity in exploratory research in light of the fact that the

objective is regularly to sum up the outcomes to the population from which the sample is chosen. The data are quantitative and require the use of a statistical test to establish the validity of the relationships (Babbie, 2007).

3.5.2 Exploratory research

This research strategy involves a literature search or conducting focus group interviews. The objective of exploratory research is to identify key issues and key variables and it also focuses on the relationships among these factors. This strategy is meant to describe relationships, predict the effects of one variable on another, as well as to test relationships that are supported by clinical theory. In other words, this strategy also involves the exploration of new phenomena with deeper understanding, testing the feasibility of more extensive research, and determination of the best methods to be used in subsequent studies (Terre, Durrheim & Painter, 2006).

3.5.3 Descriptive research

Descriptive research seeks to provide an accurate description of observations of a phenomenon (Durrheim, 1999). The objective of much descriptive research is to map the terrain of a specific phenomenon. The purpose of descriptive research strategies is to document the nature of existing variables, evaluate how they change over time as well as setting guiding questions (Terre et al., 2006). Descriptive data provides the basis for classifying data and for further questions. The object of the collection of data is to accurately describe basic information, translating it from the sample to the population at a particular point in time (Babbie, 2007).

3.6 Target population and sampling

The proposed study targeted respondents from the KwaZulu-Natal Province community-clinics, where they receive their medication. Respondents were also enrolled from Non-

Government Organization (NGO) non-medical clinics. A portion of the respondents were also drawn from HIV/AIDS clinics located on the various university campuses. A quantitative research method was used to analyse the impact of religion or spirituality on depression among HIV and AIDS victims.

It is necessary for the researcher to determine the population of the study. Selecting the population and subsequently the sample, helps determine whether to use the entire population of elements to be studied or only a sample of elements of the population. Using samples is less time consuming, less costly, and provides quality information, and plays an important role in designing questionnaires. According to Struwig and Stead (2001:109), "obtaining information from a sample is often more practical and accurate than obtaining the same information from an entire universe or population". The use of samples saves time, is cost efficient and results in quality information; and thus plays a crucial role in the design of the questionnaire. The sample should be conducted using sound scientific methods (Spatz & Kardas, 2008). Thus, the whole population should be carefully outlined so as to represent the total population, thus enabling the results to be generalised to the entire population.

There are a number of sampling methods that are used in research. There are two types of sampling methods that are widely used, namely probability and non-probability sampling (Spatz & Kardas, 2008). Probability sampling is observed when single unit elements in the sampling frame have a known, calculable chance of being included in the sample (Saunders, Lewis & Thornhill, 2003). Thus, probability sampling represents procedures that randomly select elements from the population. Probability sampling methods include simple random sampling, systematic sampling, stratified random sampling and cluster sampling (Spatz & Kardas, 2008). Whereas in non-probability sampling, the probability of any particular member of the population being chosen is unknown. The selection of the sample is arbitrary, as one has to rely on personal judgement (Struwig & Stead, 2001). According to Struwig and Stead (2001), some of the

methods that are used in non-probability sampling are quota sampling, convenience sampling and purposive sampling.

The sampling plan describes the sampling unit, sampling frame, sampling procedures and the sample size for the study. In view of the sensitivity of the topic, the researcher used the convenience sampling. The sample size was 240 participants; for according to Cooper, Schindler and Sun (2006:550) “when sample size approaches 120, the sample Standard Deviation becomes a very good estimate of the population standard deviation; beyond 120 the t (the normal distribution with more tail area than in a z normal distribution) and z (the normal distribution of measurements assumed for comparison) distributions are virtually identical”.

3.6.1 Probability sampling

Probability sampling is observed when single unit elements in the sampling frame have a known, calculable chance of being included in the sample. Thus, probability sampling represents procedures that randomly select elements from the population. Probability sampling methods include simple random sampling, systematic sampling, stratified random sampling and cluster sampling. The methods will thus be discussed in the following section (Spatz & Kardas, 2008).

3.6.1.1 Stratified random sampling

Stratified sampling involves the division of the target population into different subdivisions, called strata, and the selection of samples from each stratum. Stratified sampling is similar to segmentation of the defined target population into smaller, more homogenous sets of elements. Therefore, the method is particularly useful for ensuring representativeness when dealing with a population that is heterogeneous (Spatz & Kardas, 2008).

3.6.1.2 Simple random sampling

Sampling using this method allows each member of the population to have an equal opportunity of inclusion in the sample, and each sample of a particular size has the same opportunity of being chosen. All elements in the population can be allocated numbers and the numbers are randomly selected.

3.6.1.3 Systematic sampling

Systematic sampling is very similar to simple random sampling. However, it requires that the defined target population be ordered in some way, for example, in the form of a customer list or membership roster. Therefore, instead of relying on random numbers, it is based on the selection of elements at equal interval, starting with a randomly selected element on the population list.

3.6.1.4 Cluster sampling

This sampling technique is used when it is not practical to compile an exhaustive list of the elements composing the population of interest. It involves dividing sampling units into mutually exclusive and collectively exhaustive subpopulations called clusters. Once the clusters have been identified, the prospective sampling units are selected for the sample by either using a simple random sampling method, or by canvassing all the elements within the defined cluster. Cluster sampling therefore encompasses repetition of two basic steps; listing and sampling. Hence it is sometimes called multi-stage sampling.

3.6.2 Non-probability sampling

With non-probability sampling, the probability of any particular member of the population being chosen is unknown. The selection of the sample is arbitrary, as one has to rely on personal judgement (Struwig & Stead, 2001). According to Struwig and Stead (2001),

some of the methods that are used in non-probability sampling are Quota sampling, Convenient sampling and Purposive sampling.

3.6.2.1 Quota sampling

In this form of sampling, respondents are chosen by qualities, such as age, income, financial status. The respondent needs to follow the criteria before meeting all requirements for incorporation in the sample. The final sample needs to have the same extents of the qualities as the populace. On the other hand, an important issue with this sort of sampling is that it depends intensely on unplanned decision rather than random sampling (Struwig & Stead, 2001).

3.6.2.2 Convenient sampling

In this case, sampling is done purely on the basis of availability. Respondents are selected because they are accessible and articulate. Although the method is cheap and easy, it can only be used in special cases, mostly when the universe is sufficiently homogenous. Using this method presents the researcher with the problem of representatively (Struwig & Stead, 2001).

3.6.2.3 Purposive sampling

In purposive sampling, researchers rely on their experience, ingenuity and/or previous research findings to deliberately obtain units of analysis in such a manner that the sample they obtain may be regarded as being representative of the relevant population (Saunders, Lewis & Thornhill, 2003).

3.7 Data Collection Methods

Data for this study was collected using three means: the Beck Depression Inventory; the Religious Coping scale; and the questionnaire survey.

3.7.1 The Beck Depression Inventory (BDI-II)

3.7.1.1 Description

The Beck Depression Inventory (BDI-II) was developed in 1996, by Beck, Steer and Brown, (1996) and was derived from the BDI. The 21-item survey is self-administered and is scored on a scale of 0-3 in a list of four statements arranged in increasing severity about a particular symptom of depression, bringing the BDI-II into alignment with DSM-IV criteria. The cut-offs used differ from the original scale: 0-13: minimal depression; 14-19: mild depression; 20-28: moderate depression; and 29-63: severe depression. Higher total scores indicate more severe depressive symptoms. It has two subscales: Affective and Somatic subscales which consists of 8 for affective; 13 for somatic (Beck et al., 1996).

In the questionnaire, the BDI-II was chosen to assess the severity of depression on HIV/AIDS victims. The BDI-II is presently one of the most commonly used scales for rating depression and to indicate the level of distress the respondent is experiencing. The BDI-II is a relevant psychometric instrument, showing high reliability, capacity to discriminate between depressed and non-depressed subjects, and improved concurrent, content, and structural validity. Based on available psychometric evidence, the BDI-II can be viewed as a cost-effective questionnaire for measuring the severity of depression, with broad applicability for research and clinical practice worldwide (Wang & Gorenstein, 2013).

The BDI-II has significant strengths. Firstly: it is easy to use, widely known, results are easy to interpret. Item content improved over BDI-II to increase its correspondence with DSM-IV. Moreover, it also has its own weaknesses, which include several items;

assessing physical symptoms which may be elevated inpatients due to motor neuron+ degeneration and not depression. However, non-ALS clinical studies have provided evidence of the presence of at least two factors, a cognitive-affective factor and a somatic depressive symptom factor, which is more stable than in the BDI. However, this factor structure requires confirmation in ALS.

3.7.1.2 Scoring and interpretation

Scoring: Each of the 21 items corresponding to a symptom of depression is summed to give a single score for the BDI-II. There is a four-point scale for each item ranging from 0 to 3. On two items (16 and 18) there are seven options to indicate either an increase or decrease of appetite and sleep. Cut-off score guidelines for the BDI-II are given with the recommendation that thresholds be adjusted based on the characteristics of the sample, and the purpose for use of the BDI-II. The total score of 0-13 is considered as a minimal range; 14-19 is mild, 20-28 is moderate, and 29-63 is severe (Beck et.al., 1996).

To interpret the scores, the scores are to be added up. The highest possible total for the whole test would be 63. This would mean you circled number three on all 21 questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circled zero on each question. The scale can be interpreted as the following levels of depression; 1-10-These ups and downs are considered normal; 11-16- Mild mood disturbance;17-20- clinical depression; 21-30- Moderate depression; 31-40; Severe depression; over 40 - Extreme depression (Beck et.al., 1996).

3.7.1.3 Reliability, validity and feasibility

Reliability: The BDI-II high coefficient alpha of (.92) with a sample of 140 psychiatric patients. Test-retest over a week with stability is high (.93). Internal consistency

(coefficient alpha) is (.92 .94) depending on the sample size. (Storch, Roberti & Roth, 2004).

Validity: The BDI-II was found to be more positively correlated with the Hamilton Psychiatric Scale. Construct validity was high for the BDI (.93) when compared to the Hamilton Psychiatric Scale for Depression (Storch et al., 2004).

Feasibility: The BDI-II is easy to complete, relatively short compared to interview-based assessments (Beck et al., 1996).

3.7.2 Religious Coping (RCOPE) scale

3.7.2.1 Description

To assess spirituality among people living with HIV, the study used the Religious Coping (RCOPE) scale. The RCOPE and the Brief RCOPE (which grew out of this larger measure) were designed to address many of the limitations associated with these initial approaches to the assessment of religious coping. The RCOPE was intended to provide researchers with a tool they could use to measure the myriad manifestations of religious coping and to help practitioners better integrate religious and spiritual dimensions into treatment. In other words, the RCOPE was designed to provide something long overdue—a detailed, comprehensive assessment of religious coping for researchers and practitioners. RCOPE is set to be useful to researchers and practitioners interested in a comprehensive assessment of religious coping, and in a more complete integration of religious and spiritual dimensions in the process of counselling (Pargament, Koenig & Perez, 2000).

As a multifunctional instrument, the specific religious coping items included in the RCOPE were selected and designed to reflect five religious functions: meaning, control, comfort, intimacy, life transformation and the search for the sacred or spirituality itself. RCOPE is

also a multi-modal instrument. Scale items were selected that represent how people employ religious coping methods cognitively through thoughts and attitudes (e.g. “Saw my situation as part of God’s plan”; “Thought that the event might bring me closer to God”), behaviourally through actions (e.g. “Prayed for a miracle”; “Confessed my sins”), emotionally through the specific feelings they express (e.g. “Felt my church seemed to be rejecting or ignoring me”; “Sought God’s love and care”) , and relationally through actions that involve others (e.g. “Offered spiritual support to family or friends.”; “Sought a stronger spiritual connection with other people”) (Pargament, Feulle & Burdzy, 2011: 54).

Furthermore, the multi-valent nature of the RCOPE is built on the assumption that religious coping strategies can be adaptive or maladaptive. Hence religious coping items were selected that reflect positive religious coping methods. The items rest on a generally secure relationship with whatever the individual may hold as sacred. The religious coping items also have negative religious coping methods, such as reflective of tension, conflict, and struggle with the sacred things. However, we did not assume that the positive coping methods would be invariably adaptive or that the negative religious coping methods would be invariably maladaptive. Religious coping theory posits that the efficacy of particular coping methods can be determined by the interplay between personal, situational, and social-cultural factors, as well as by the way in which health and well-being are conceptualized and measured (Pargament, 1997; 2007). Thus, a ‘positive’ religious coping method that might be helpful in one situation or context might very well be more problematic in another, as illustrated by the recent work of Phelps et al. (2009), who found that positive religious coping by end-of-life patients was predictive of the pursuit of expensive and invasive life-prolonging care.

Conversely, a ‘negative’ religious coping method might be linked not only to immediate signs of psychological distress, but also to longer term growth and well-being. For this reason, the term ‘religious struggle’ has been used interchangeably with negative religious coping because the notion of struggle embodies the possibility of growth and transformation through the process of coping (Pargament et al., 2011).

3.7.2.2 Reliability: Internal consistency

The Brief RCOPE has demonstrated good internal consistency in a number of studies across widely differing samples. Reliability estimates were generally high, indicating good internal consistency of .80 or greater.

The Brief RCOPE has demonstrated good concurrent, predictive and incremental validity. It is most strongly and consistently related to measures of positive psychological constructs and spiritual well-being, whereas Negative Religious Coping (NRC) is consistently tied to indicators of poor functioning, such as anxiety, depression, PTSD symptoms, negative affect, and pain. NRC is occasionally associated with constructs representing well-being. However, when such a correlation is significant, it is usually negative. This depicts concurrent validity. It has also been established that it also has predictive and incremental validity, with alpha ranging from alphas 0.75 and 0.60, respectively. RCOPE predicts various criteria above and beyond the effects of demographic, psychological, social and health-related variables, hence incremental validity (Pargament et al., 2011).

Brief RCOPE uniquely predicts outcomes even after controlling for secular variables and indicators of general religiousness. For instance, there is evidence for the incremental validity of PRC in predicting well-being after controlling for age and gender as well as a number of other secular variables, including race, financial worries, having children, and other psychosocial constructs. There are studies that have provide initial support for the capacity of Positive Religious Coping and Negative Religious Coping to predict greater well-being and poorer adjustment, respectively, over time, hence predictive validity.

3.7.3 The questionnaire survey

Data was collected using a questionnaire (Appendix B). The questionnaire was administered to respondents in English, and was interpreted by a fluent African language

speaker. The questionnaire was designed by the compilation of two research instruments which were to measure the research variables; 'Spirituality and HIV'. The aim of the questionnaire construction was to try to extract the appropriate data by asking relevant questions in relation to the phenomenon being studied. The questionnaire was constructed alongside the complementary cover letter (Annexure A), which stated the purpose of the research. The questionnaire consisted of three sections. Section one consisted of questions related to biographical information of the respondents. The second section comprised of standardized questions in relation to spirituality and the third section related to the questions relating to HIV/AIDS. The questionnaire allowed respondents to remain anonymous and was constructed so that all responses addressed the research questions

Contact was established with the respondents. The facilitator adhered to the guidelines relating to the administration of the questionnaire and as appearing on the covering letter discussed previously. The research questionnaire was administered to respondents by handing them out personally in local community (medical and non-medical) clinics and university clinics. The bulk of the questionnaires were administered and completed at the clinic sites, under the supervision of an adequately trained HIV counsellor/facilitator. Some questionnaires were handed to the respondents to take to their homes. To achieve a high response rate, with the collaboration of contact persons, a timeline of the completion and collection of the questionnaire was set at three months. The completed questionnaires were returned by respondents to the clinics and facilitator in sealed envelopes.

3.8 Data analysis

The research used descriptive statistics, inferential statistics and the Wilcoxon rank sum test. Inferential statistics are based on an assumption of random or representative selection of cases, and error rates in derived estimates of population characteristics are proportional to sample size. Sample selection and sample sizes therefore limit the kind of

statistical procedures that might legitimately be used and the capacity to generalise to a larger population (Bazely, 2002).

3.8.1 Descriptive statistics

Descriptive data analysis provided a useful examination of data and a means of presenting the data in a transparent manner. Descriptive data describes the phenomena of interest (Sekaran, 2003). Descriptive statistics enable the researcher to explain many pieces of data without indices. If such indices are calculated for a sample drawn from the population, the resulting values are referred to as statistics. If they are calculated from the entire population, they are referred to as parameters.

Descriptive statistics are a collection of measurements of two things: location and variability. Location tells you the central value of your variable (the mean is the most common measure). Variability refers to the spread of the data from the centre value (i.e. variance, standard deviation) (King, 1989). The major types of descriptive statistics are measures of central tendency, measures of variability, measures of a relative position and measures of relationship (Sekaran, 2003). Data is depicted from the descriptive statistics in the form of tables and graphs, and/or uses of frequency distributions or measures of central tendency and variability. This will help present the data in summary form.

3.8.2 Inferential statistics

Inferential statistics are used when generalisations from a sample to the population are made (Sekaran, 2003). Inferential statistics were used in this study, to enable the researcher to make inferences on the relationship between the dependent variable and the independent variables. In other words, it enabled the researcher to identify important patterns of correlation and to make data analysis more meaningful. Inferential statistics can take the form of t-test, chi-square test, F-test, correlation and Anova, just to name a few.

3.8.3 Wilcoxon rank sum test

The Wilcoxon rank-sum test is a nonparametric alternative to the two-sample t-test which is based solely on the order in which the observations from the two samples fall. The Wilcoxon test is valid for data from any distribution, whether normal or not, and is much less sensitive to outliers than the two-sample t-test. The Wilcoxon test is based upon ranking the $n_A + n_B$ observations of the combined sample. Each observation has a rank: the smallest has rank 1, the 2nd smallest rank 2, and so on. The Wilcoxon rank-sum test statistic is the sum of the ranks for observations from one of the samples. When one performs a Wilcoxon test by hand, tables are required to find P-values. Tables are provided to interpreting the results and those who are not interested in this level of detail should proceed to the notes at the end of the subsection. For small sample sizes, tables for Wilcoxon rank-sum test are given. This is supplemented with a normal approximation for use with larger samples. The Wilcoxon rank-sum test does not require the population to have an equal distribution.

However, if one is primarily interested in differences in location between the two distributions, the Wilcoxon test has the disadvantage of also reacting to other differences between the distributions such as differences in shape. Furthermore, when the assumptions of the two-sample t-test hold, the Wilcoxon test is somewhat less likely to detect a location shift than is the two-sample t-test. However, the losses in this regard are usually quite small (Bhattacharyya & Arnold, 1977).

“Nonparametric confidence intervals for $\theta = \mu_A - \mu_B$, the difference between the two population medians (or any other measure of location), can be obtained by inverting the Wilcoxon test, provided one is willing to assume that the two distributions differ only by a location shift” Bhattacharyya and Arnold (1977:525), because the two population distributions are assumed to be identical. Under the null hypothesis, independent random samples from the two populations should be similar if the null hypothesis is true. Because their population distributions are allowed to be non-normal, the rank sum procedure must

deal the possibility of extreme observations in the data. One way to handle samples containing extreme values is to replace each data value with its rank (from lowest to highest) in the combined sample-that is, the sample consisting of the data' 0.04 from both populations. The smallest value in the combined sample is assigned the rank of 1 and the largest value is assigned the rank of $N = n_1 + n_2$. The ranks 0.0 are not affected by how far the smallest (largest) data value is from next smallest (largest) data value. Thus, extreme values in data sets do not have a strong effect on the rank sum statistic as they did in the 1-based procedures.

The calculation of the rank sum statistic consists of the following steps:

1. List the data values for both samples from smallest to largest.
2. In the next column, assign the numbers 1 to N to the data values ranks 1 to the smallest value and N to the largest value. These are the ranks of the observations.
3. If there are ties-that is, duplicated values-in the combined data set the ranks for the observations in a tie are taken to be the average of the ranks for those observations.
4. Let T denote the sum of the ranks for the observations from population 1.

Nonparametric inference is largely restricted to simple settings. Normal inference extends to methods for use with complex experimental designs and multiple regression, but nonparametric tests do not. We stress normal inference in part because it leads on to more advanced statistics. Normal tests compare means and are accompanied by simple confidence intervals for means or differences between means. When nonparametric tests are used to compare medians, confidence intervals are also given, though they are awkward to calculate without software. However, the usefulness of nonparametric tests

is clearest in settings when they do not simply compare medians (Hollander & Wolfe, 1973).

In these settings, there is no measure of the observed effect that is closely related to the rank test of the effect. The robustness of normal tests for means implies that we rarely encounter data that require nonparametric procedures to obtain reasonably accurate values. The end tests give very similar results in our examples. There are more modern and more effective ways to escape the assumption of normality, such as bootstrap methods (Hollander & Wolfe, 1973).

3.9 Validity of the study

It is the obligation of the researcher to ascertain which factors may pose a threat to the validity of the findings. Thus, the researcher ought to ensure that the research is internally and externally valid. The first essential quality of a valid test is that it should be highly reliable. Reliability of a test can be estimated by repetition of measurements; while validity of a test can be obtained by comparison with some standard criterion. According to Mouton and Marais (1988), for research to be internally valid, the constructs must be measured in a valid manner, and the data measured must be accurate and reliable. The analysis should be relevant to the type of data collected, and the final solutions must be adequately supported by the data. By paying attention to nuisance variables in a critical and systematic manner, it is possible to ensure that the ultimate findings are likely to be more valid. The findings must be valid for similar studies other than the one under review (Mouton & Marais, 1988).

According to Freeman and Brundin (2006), An index of validity shows the degree to which a test measures what it purports to measure, when compared with accepted criteria. Validity represents the strength of a conclusion, inferences or proposition. According to Cook and Campbell (1979) it can be asserted that that validity is the reflection of the best available estimate of the truth and falsity of the given inference, proposition or supposition

(Delpont, 2002; Huysamen, 1998). There are different types of validity; for example, criterion validity examines the relationship between two or more scores that appear to be similar. The construct validity refers to the degree to which an instrument measures the theoretical construct or abstract variable it was intended to measure. There is also face validity and content validity. Internal validity refers to the degree to which changes in the dependent variable are indeed due to the independent variable rather than to something else. External validity refers to the generalizability of the conclusions made by the researcher in a particular study to the general populations, different settings and times (Saunders et al., 2003).

3.9.1 Criterion prediction validity procedures

Criterion-related validity makes a prediction about how the operationalization will perform based on the theory of the construct. It is inclusive of concurrent validity, convergent validity, and predictive validity.

3.9.2 Concurrent validity

Concurrent Validity refers to the degree to which the operationalization correlates with other measures of the same construct that are measured at the same time. Concurrent validity assesses the operationalization's ability to distinguish between groups that it should theoretically be able to distinguish between.

3.9.3 Convergent validity

Convergent validity examines the degree to which the operationalization is similar to (converges on) other operationalisations that it theoretically should be similar to (Campbell & Stanley, 1963).

3.9.4 Predictive validity

Predictive validity evaluates the operationalization's ability to predict something it should theoretically be able to predict.

3.9.5 Discriminant validity

In discriminant validity, what is examined is the degree to which the operationalization is not similar to (diverges from) other operationalisations that it theoretically should be not be similar to (Gergen, 2002).

3.9.6 Construct validity

Construct validity is the approximate truth of the conclusion that your operationalization accurately reflects its construct. Construct validity refers to the degree to which inferences can legitimately be made from the operationalisations in a study to the theoretical constructs on which those operationalisations were based. Like external validity, construct validity is related to generalizing. But, where external validity involves generalizing from a study context to other people, places or times, construct validity involves generalizing from your program or measures to the concept of your program or measures.

3.9.7 Content validity

Content validity, essentially checks the operationalization against the relevant content domain for the construct. This approach assumes that you have a good detailed description of the content domain, something that is not always true. This concept of match is sometimes referred to as alignment, while the content or subject area of the test may be referred to as a performance domain.

3.9.8 Face validity

Face validity looks at the operationalization and sees whether 'on its face' it seems like a good translation of the construct. In other words, it looks like a reasonable test for whatever purpose it is being used. This common-sense approach to validity is often important in convincing laypersons to allow the use of a test, regardless of the availability of more scientific means. This is probably the weakest way to try to demonstrate construct validity (Cohen, 1988; Delpont, 2002).

3.10 Reliability of the study

Reliability refers to the magnitude in which the repeated use of the same measuring instruments results in the same or similar results under dissimilar environments (Delpont, 2002). Hence, this goes a long way into establishing the efficiency of the inquiring questions and determination of the level of understanding. Reliability of an empirical study can be ensured when a truly representative sample is used. There are also different types of reliability. For example, there is the test-retest reliability that refers to establishing the reliability of the instrument by administering the instrument to the same respondents on two (or more) occasions and comparing the results (Delpont, 2002). Whereas the split-half reliability refers to dividing the items in the instrument into two, say odd and even numbers to come out with two 'half instruments' (Yin, 2003). The scores on these separate 'half instruments' are then compared by means of a correlation coefficient. While internal reliability also called internal consistency is the measure of the degree of similarity among items in an instrument meant to measure a certain construct (Babbie, 2007). Moreover, the parallel forms of reliability, is used to assess the consistency of the results of two tests constructed in the same way from the same content domain (Babbie, 2007).

3.10.1 Test-re-test reliability

The test-retest refers to establishing the reliability of the instrument by administering the instrument to the same respondents on two (or more) occasions and comparing the results. In other words, the same test to the same sample on two different occasions. This approach assumes that there is no substantial change in the construct being measured between the two occasions (Delpont, 2002). The amount of time allowed between measures is critical. It is known that if the same thing is measured twice, the correlation between the two observations will depend in part by how much time elapses between the two measurement occasions. The shorter the time gap, the higher the correlation; the longer the time gap, the lower the correlation (Babbie, 2007). This is because the two observations are related over time and the closer in time we get, the more similar the factors that contribute to error. Since this correlation is the test-retest estimation of reliability; one can obtain a considerably different estimation depending on the interval. The test-retest approach can be used if a researcher only has a single rater and does not want to train others. The test-retest estimator is especially feasible in most experimental and quasi-experimental designs that use a no-treatment control group. In these designs, you always have a control group that is measured on two occasions (pre-test and post-test). However, the main problem with this approach is that one does not have any information about reliability until you collect the post-test. Figure 3.1 shows the scale.

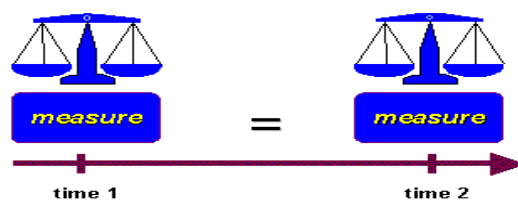


Figure 3.1 Test retest

Source: Adopted from Web Centre of Social Science Research Methods

3.10.2 Split-half reliability

Split-Half Reliability is a common statistical method used to determine the reliability of a typical test. It is most often used for multiple choice tests, but it can be used on any test

that can be divided in half and scored consistently. Split-Half Reliability assumes that, if a test is reliable, a sample should score equally as well or poorly on two randomly selected halves of the test. The test is administered to a sample of people and total score is calculated for each randomly divided half. The split-half reliability estimate, is simply the correlation between these two total scores (Delport, 2002). Figure 3.2 illustrate the split reliability method.

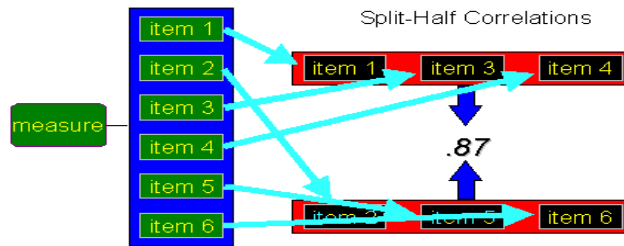


Figure 3.2 Split half reliability

Source: Adopted from Web Centre of Social Science Research Methods

3.10.3 Parallel-Forms Reliability

In parallel forms reliability, first the researcher should have to create two parallel forms. And then administer both tools to the same sample. The correlation between the two parallel forms is the estimate of reliability. The parallel forms estimator is typically only used in situations where you intend to use the two forms as alternate measures of the same thing. In other words, it can be asserted that, to create two parallel-forms, one has a large set of questions that address the same construct, and then randomly divides the questions into two sets. It is then, that the tests (instruments) are administered to the same sample of people. The correlation between the two parallel forms is the estimate of reliability). One major challenge with this approach is one uneasy feat, which is that one has to be able to generate lots of items that reflect the same construct. The parallel forms approach is very similar to the split-half reliability described in Figure 3.3. The major difference is that parallel forms are constructed so that the two forms can be used independent of each other and considered equivalent measures (Terre et al., 2006).

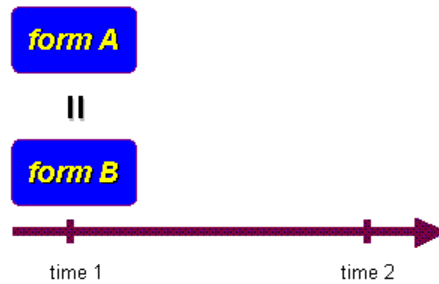


Figure 3.3 Parallel reliability

Source: Adopted from Web Centre of Social Science Research Methods

3.10.4 Internal consistency

In internal consistency reliability estimation uses a single measurement instrument administered to a group of people on one occasion to estimate reliability. In effect, it judges the reliability of the instrument by estimating how well the items that reflect the same construct yield similar results. What is observed is how consistent the results are for different items for the same construct within the measure. There are a wide variety of internal consistency measures that can be used. The average inter-item correlation uses all of the items on the instrument that are designed to measure the same construct (Babbie, 2007). Firstly; the correlation between each pair of items is incomplete. The average inter-item correlation is simply the average or mean of all these correlations. Additionally, there is the average item total correlation which is also used in this approach. In addition, the total score of the six items is calculated and used as a seventh variable in the analysis. All internal consistency measurements have one thing in common, namely that the measurement is based on the results of a single measurement.

3.11 Ethical considerations

The study observed and complied with the three keys of ethical concerns, the ethics of data collection and analysis, the ethics of treatment of human subjects, and the ethics of responsibility to society (Reese & Fremour, 1984). Thus, ethical consideration was

observed during data collection. Approval for the proposed study was obtained from the institutional ethics committee. The participants were informed about the purpose of the study and assured of confidentiality in the management of information obtained from them. Furthermore, to ensure compliance with the ethical principle of informed consent, participants were informed of the true nature of the study as well its objectives, in order to aid them to make an informed decision of deciding whether to partake in the research or not.

This involved observing and following a number of ethical practices:

- Non-deception of research respondents;
- Debriefing of respondents regarding the study;
- Contribution of the research to the general good of the organisation;
- Obtaining respondents' consent that is fully informed and voluntary (done mainly by means of the covering letter);
- Individual rights to privacy were observed, by ensuring the confidentiality of research results;
- Transparency of research methods (Sekaran, 2003).

3.12 Conclusion

This chapter delineated the research methodology undertaken to obtain data in support of the research topic. It defined and provided the framework for the research population, sampling technique and the questionnaire design as a method of collecting data and a measuring instrument. The next chapter will present the findings and the data obtained from the respondents.

CHAPTER FOUR: RESULTS

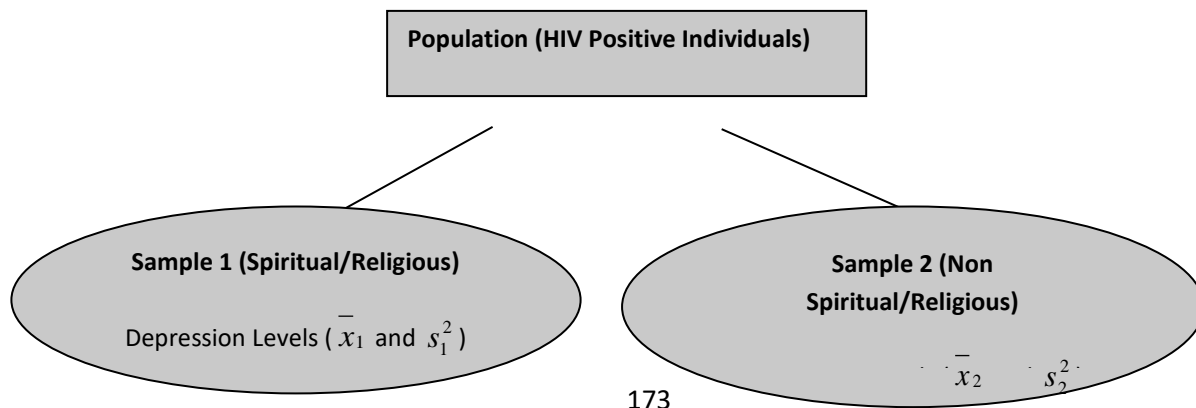
4.1 Introduction

This research sought to understand the link between spirituality and depression in people who already have the HIV virus. In other words, it is hypothesized that people who are more religious/spiritual will be less likely to exhibit signs of clinical depression, even though they are aware of their HIV status.

In order to test this hypothesis, the population under consideration was HIV positive individuals in South Africa. In other words, every single respondent in the study was/is HIV positive and the respondents were chosen randomly. The sample size was 240 respondents of varying demographics – see descriptive statistics further on in this chapter.

From the overall population, two sub samples of 120 respondents each were drawn as shown in Figure 4.1. Sample one was HIV positive individuals who were deeply spiritual/religious, while Sample two respondents were HIV positive individuals but whom displayed (or lacked) low levels of spirituality/religious affiliation. The type or path of the spirituality or religious affiliation was unimportant in the case of Sample one individuals, but suffice to state that these respondents followed and practiced some faith. The overall sample was then separated into a sub sample using religion/spirituality as the filter.

Figure 4.1: Sampling Approach



By splitting the overall sample into two sub samples and filtering it through spiritual/religious affiliation, the study could then test the hypothesis that individuals who are HIV positive and deeply spiritual/religious are less likely to display clinical depression than individuals who are HIV positive but lack spiritual/religious belief. This is based on the understanding that religion/spirituality serves as an important role/function/outlet for individuals experiencing trauma and in doing so, lessens the likelihood of depression. Empirical studies have established that there was an association between higher religiousness and lower levels of depressive symptoms Smith, McCullough and Poll (2003), Baetz, Griffin, Bowen, Koenig and Marcoux (2004), demonstrating that religion or spirituality may play a role in attenuating negative affect, decreasing stress, or enhancing relaxation or distraction.

As mentioned in chapter three, the research instrument used to test the hypotheses was a questionnaire. Respondents were asked to complete a questionnaire which asked questions pertaining to both spirituality/religious affiliation and depression levels. Any respondent who lacked spiritual/religious affiliations was rejected from Sample one, whilst deeply spiritual/religious respondents were excluded from Sample two. By setting up the study in this manner, estimation and testing of the differences between two population means can be undertaken.

4.2 Analysis and Test Statistics Calculated

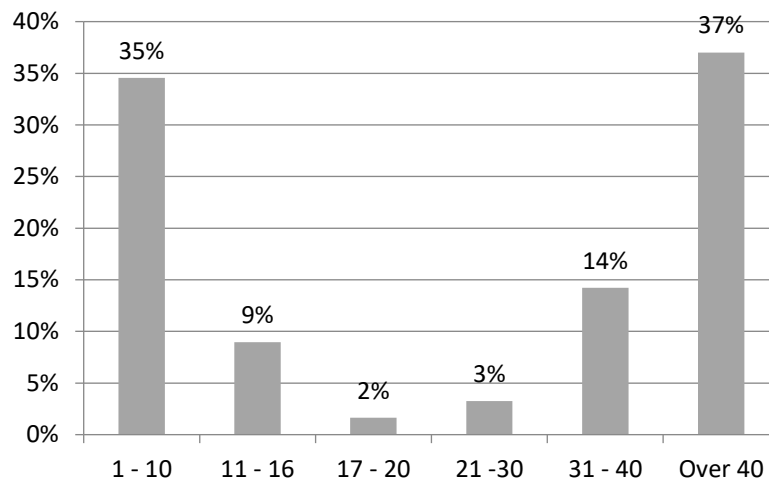
Descriptive Statistics - the analysis can be largely divided into three focus areas. The first level of analysis related to overall descriptive analysis of the overall sample ($n_1 + n_2$) and presents information regarding the demographics (i.e. gender, age, race, etc.) of the overall sample. Where possible; important observations are highlighted as possible 'explanatory variables' for differences in depression scores.

Depression Scores - two test statistics were of predominate importance to the study. The first statistics used was Beck's Depression Inventory score used to test for depression. In essence, and when using the Beck's scale of depression, a raw score for each respondent

was calculated in order to determine that respondent's degree of depression. The higher the score of the respondent, the more severe would be the degree of depression in the respondent. An important consideration in analysing the depression scores of the sample respondents is that these individuals are HIV positive and are more likely to display levels of depression. In other words, it is unlikely that people who are HIV positive will display the same depression profiles as the general population and thus there is likely to be a rightward bias or skewness – towards higher scores in these individuals.

The depression level of each respondent was calculated and then categorised using the Beck Depression Inventory scale. This information is depicted in Figure 4.2 and in accordance to the Beck Depression Inventory scale. Note that the class widths are NOT equal and set according to the scale.

Figure 4.2: Sample Depression Profiles



About 35% of the sample indicated normal depression levels, and this is somewhat remarkable given their HIV status. Given the relative narrow class widths in the middle, one can expect few numbers in the middle classes. A quick summation of the frequencies from the second and third classes indicates that 11% of the sample had mild or borderline clinical depression. A total of 3% of the sample had moderate depression, 14% severe depression, and 37% extreme depression. The large percentages on the outer ends of

the histogram possibly indicates the while some people have made peace with their HIV status and are coping well living with it, others find their status an enormous burden to live with. The frequencies could also be informed by timing in that people who have just been recently made aware of their status could likely exhibit higher levels of depression and those who have been aware of their status for some while. Clearly, other factors such as the role of religion could also influence the depression levels and/or categories.

Spiritual/Religious Scores - the second important test statistic was a respondent's spiritual/religious quotient, calculated using a similar approach as above (as in the case of Beck's depression scores). The approach incorporated calculating a respondent's spiritual/religious level by weighting various components of religious practice, and then summing up these components to derive an overall spiritual/religious score. Activities or practices seen as being more spiritual/religious were weighted higher than activities or practices less aligned to religion/spirituality. For example, a respondent was asked how often he/she prayed and provided with fixed response categories-once a month, once a week, every day, more than one time a day, etc. Respondents then choose the options closest to their own behaviour. It is reasonable to assume that more frequent praying (or any other religious activity) meant someone is more spiritual/religious, thus these activities were weighted higher. The overall spiritual/religious score was then calculated by summing across the various activities and higher overall scores meant that respondents were more spiritual/religious.

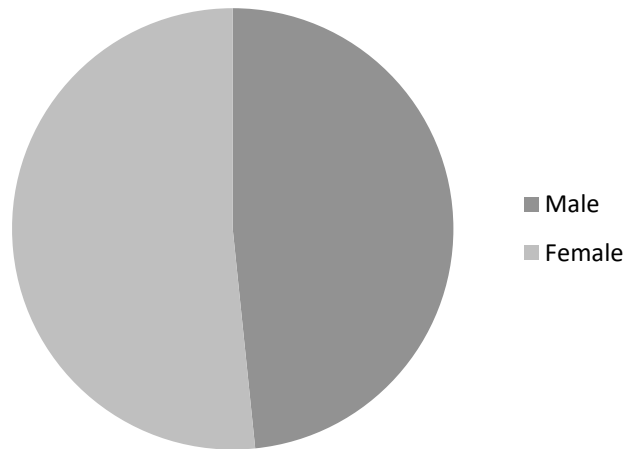
4.3 Descriptive Statistics

The study emitted descriptive information on gender, race, marital status, age and educational level of the participants.

4.3.1 Gender

The sample was almost equally split into males (48%) and females (52%) as shown in Figure 4.3.

Figure 4.3: Sample Gender Profiles



There were some noticeable differences between gender, depression levels, and spirituality/religious affiliation in Table 4.1. As expected, females are more likely to be both depressed and religious. Literature has established that, it has been established that (i) HIV-positive women are more likely to experience depressive symptoms compared with seronegative women of the same age (19.4% vs. 4.8%);²⁷ (ii) 1.9– 35.0% of seropositive hospitalized women present depression symptoms;⁵ and (iii) 30–60% of seropositive women not hospitalized, suffer from depression (Ickovics et al., 2001). Researchers reported chronic depressive symptoms in 42% and intermittent depressive symptoms in 35% of a sample of 765 HIV-positive women (Arseniou et al., 2014). Additionally, in a study by Saadat, Behboodi and Ebrahim Saadat (2015) it was established that HIV infection is related with psychiatric disorder like depression or anxiety, of which women are more vulnerable and need more care.

Table 4.1 Gender Depression index

Variable (Average Score)	Male	Female
Depression Index	27	30
Spirituality/Religious Index	33	35

4.3.2 Race

The sample was almost exclusively Black (97%) and had very limited representation from the other races. While this may be seen as a possible weakness, it is nevertheless in keeping with the general population statistics as well as the incidence rates of HIV positive people amongst the various race groups in South Africa.

Another reason for the disproportion was the fact that the sample was only conducted in KwaZulu-Natal (KZN) where the Black population makes up 70%. Given the skewed nature of the sample in terms of racial proportions, calculating the average depression and spirituality/religious values per race would be meaningless.

4.3.3 Marital status

Most of the respondents were single (91%) and this could be largely related to the fact that they were HIV positive. Only 8% of the sample were married and just over 1% were widowed. There were no respondents that were divorced. Interestingly, when comparing the marital status against the two test statistics under consideration, single people were less likely to be spiritual/religious when compared to their married counterparts, but at the same time, considerably more depressed. This provides first-round 'evidence' regarding the study hypothesis in that being more spiritual/religious displays lower levels of depression. Clearly within the sample, single people are less spiritual/religious and more depressed while married people are more spiritual/religious and less depressed when compared to each other. Table 4.2 illustrates this situation. This is in contrary to literature which asserts that that religion is a complementary trait within marriage. Religion affects many activities that husband and wife engage in as a couple beyond the purely religious sphere (Becker, 1998). It has thus been established that marriage and religion influence various dimensions of life, including physical health and longevity, mental health and happiness, economic well-being, reduced stress and depression (Waite & Lehrer, 2003).

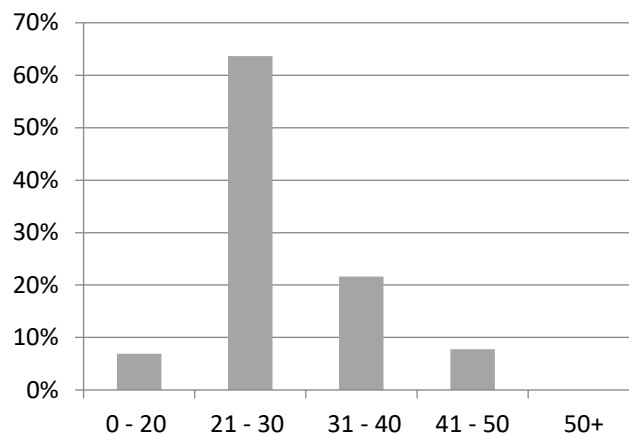
Table 4.2 Marital status depression index

Variable (Average Score)	Single	Married
Depression Index	30	22
Spirituality/Religious Index	34	35

4.3.4 Age

The majority of the sample was between 21-30 years as shown in Figure 4.4. There were representations from the other age cohorts although no respondent came from the over 50 categories. This is not surprising as the life expectancy of a person living with HIV in South Africa is low, although average life expectancy at birth is 52 years (World Bank, 2009).

Figure 4.4: Sample Age Profiles



When one looks at the differences in depression and age, a familiar expectation is identified in table 4.3. That is, the youth are far less depressed than mature individuals. This is probably due to their sheer 'irresponsible' nature or assumption that a cure for HIV will be found soon and within their life time. As in keeping with many studies regarding depression, depression seems to increase with age. In a study conducted by Hinkin et al. (2003) of 131 HIV positive people, of whom 25% were over the age of 50, it was found

that there was a higher rate of current depressive disorder in the older patients (20%) compared with the younger ones (12%).

Table 4.3 Age depression index

Variable (Average Score)	0 - 20	21 – 30	30 - 40	40 – 50
Depression Index	16	27	33	37
Spirituality/Religious Index	31	34	36	33

Interestingly, spiritual/religious affiliations increase moderately with age but starts to decline as a person moves beyond 40 years old. Noticeably, this trend when analysed in conjunction with the depression index seems to run counter to the study hypothesis. In this case it seems that spiritual/religious quotient and the level of depression in people are unrelated. As can be seen from the above table, younger people are less spiritual/religious but also less depressed. There seems to be a positive correlation between depression and spirituality within the various age groups. This runs counter to the study hypothesis that spirituality/religious and depression are inversely related.

This phenomenon could quite likely be as a result of other explanatory factors (such as the innate exuberance of youth, social media, support structures, etc.) which could quite easily distort the results.

4.3.5 Educational levels

There was no respondent from within the sample that had any form of educational qualification beyond a Honours degree. In fact, 99% of the sample had either a below matric or matric qualification. The remaining 1% had an Honours level qualification.

Given the skewed nature of the sample in terms of educational levels, calculating the average depression and spirituality/religious values per educational category would be

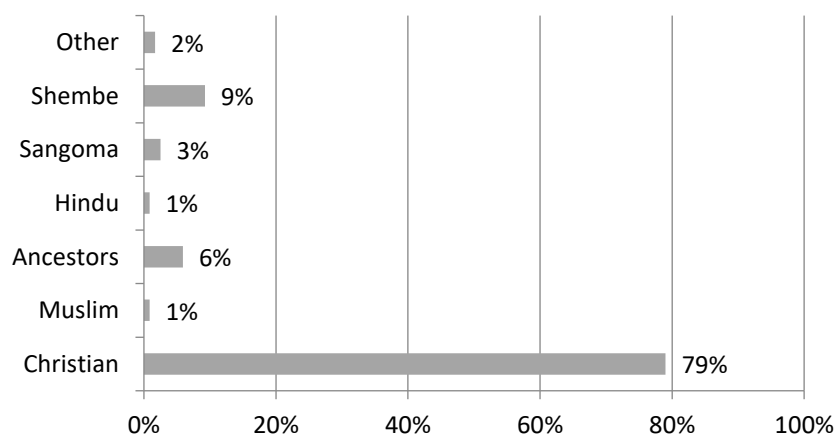
meaningless. In a study by Nyirenda, Chatterji, Rochat, Mutevedzi, and Newell (2013) primary or higher level of education was associated with decreased likelihood of a depressive episode.

4.4. Spirituality

As explained earlier, the overall sample was broken into two sub samples ($n_1 + n_2$) with n_1 being individuals who were spiritual/religiously inclined and n_2 individuals who did not either believe in religion/spirituality, or had considerable low levels of spirituality/religious beliefs. This part of the analysis relates exclusively to the former category n_1 only.

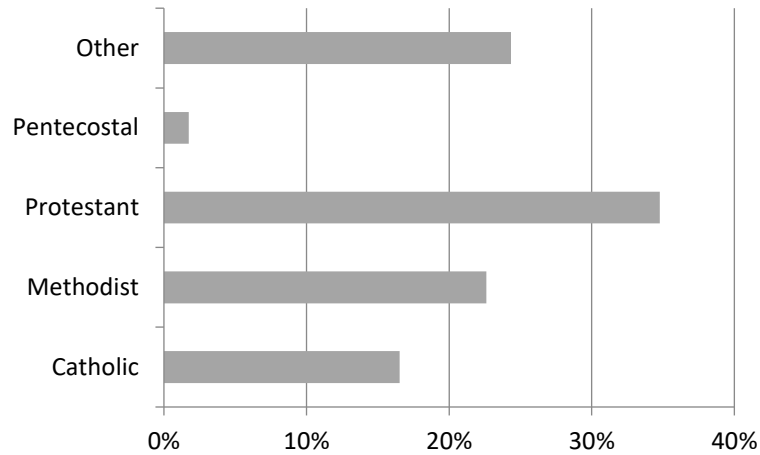
While most of the respondents belonged to the various religious denominations, the Christian faith enjoyed the highest proportion (79%), followed by Shembe (9%) and Ancestors (6%). This is not surprising as these are the spiritual/religious paths followed by mainly the Black population in South Africa (given that 97% of the sample was Black - see Descriptive Statistics: Race Profiles above). Figure 4.5 illustrates the distribution in terms of religion.

Figure 4.5: Religion Profiles



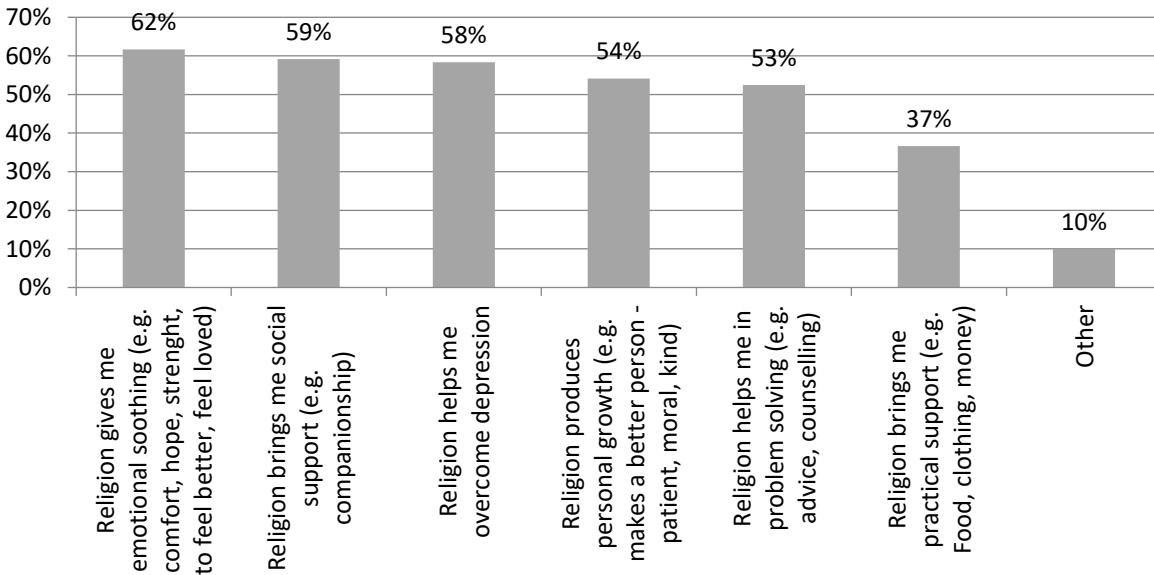
Furthermore, within the Christian faith, the Catholic, Methodist, Protestant, Pentecostal and other Christian denominations were most popular as illustrated in Figure 4.6.

Figure 4.6: Christian Denominations



The respondents who practiced some form of religion/spirituality found that they enjoyed various ‘benefits’ from following a religion. These include having some sort of society structure, providing emotional soothing, overcoming depression, and assisting in problem solving. Illustrated in Figure 4.7 are the most popular benefits cited by respondents.

Figure 4.7: Benefits from being Spiritual/Religious

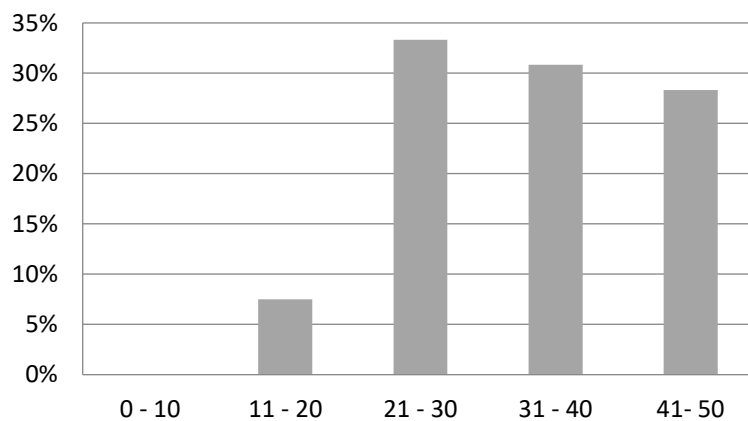


Almost 60% of the respondents who followed some sort of spiritual/religious beliefs considered religion as a vital part of their lives in dealing and overcoming depression.

This is again suggestive that spiritual/religious practices have an inverse relationship on depression levels. That is, people follow a particular spiritual/religious path given that they know this would lead to lower levels of depression in them.

Having calculated the spiritual/religious scores, it was evident that some respondents were relatively less spiritual/religious than others with spirituality/religious scores ranging from a minimum score of 4 to a maximum score of 33. Most respondents fell within the score range of 21-30 points, suggesting a moderate but not fanatical relationship with religion and/or God as shown in Figure 4.8. While not immediately observable, the spread of scores does approach some degree of normality with scores clustering around the mean and sparse on the tails. Descriptive statistics for the spiritual/religious scores are provided in the Appendix.

Figure 4.8: Spiritual/Religious Scores Distribution*



- Note: Only Sample 1 considered.

4.5 The relationship between religion/spirituality and depression

The main focus of this study is to determine if religion/spirituality influences one's degree of depression. At a precursory level and based on previous empirical studies, there seems to be a definite link between one's spiritual/religious patterns and levels of depression. In other words, people seem to derive some sort of calming benefit from following a spiritual/religious path and in doing so, display lower levels of depression. However, this

claim still needs to be tested in the context of the study and the rest of this chapter is based on the approach and tests used to test this claim. However, spirituality and religiousness plays a significant role in the lives of patients with depression and HIV, and is the corner stone of coping strategies and longevity. It has been noted that patients become more spirituality/religious after diagnosis, hence it should be prioritized in coming up with intervention coping strategies (Koening, 2012).

Earlier, the depression levels for the entire sample ($n_1 + n_2$) were illustrated using the criteria as set by the Beck Depression Inventory. Before proceeding to undertake a statistical testing, a visual display of the results from both samples is advised in order to check for differences, albeit at a visual level. Figure 4.9/4.10 shows the scores distribution.

Figure 4.9: Sample 1 Depression Scores Distribution

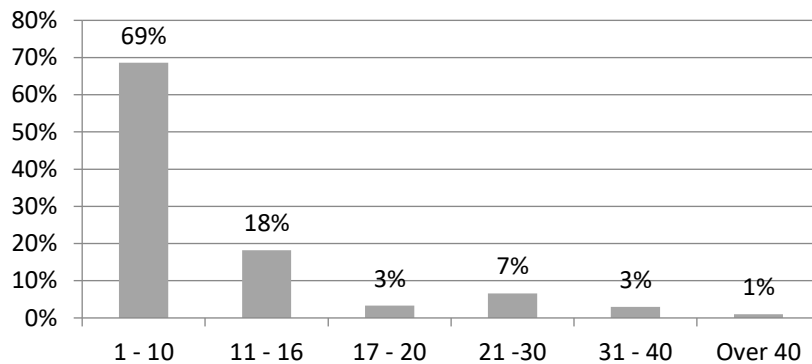
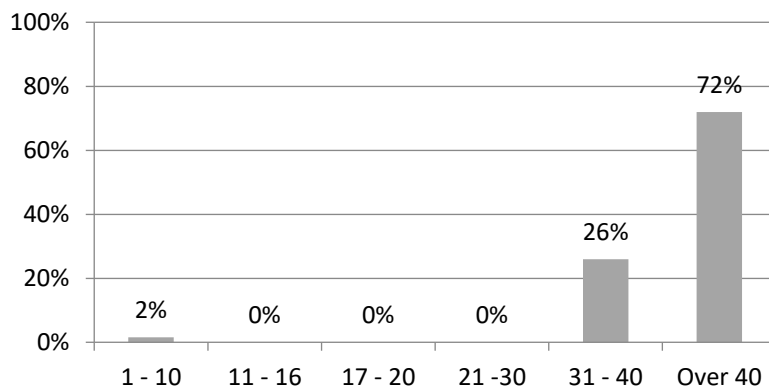


Figure 4.10: Sample 2 Depression Scores Distribution



When comparing the two samples, it is immediately evident that the depression scores from sample 1 (the spiritual/religious group) are far lower than those of sample 2 (non-spiritual/religious group). In fact, most of the respondents in sample 1 display normal or mild disturbances in terms of depression. In comparison to sample 2, only 2% of the sample displayed normal depression levels. In fact, no respondents fell into the middle classes and the remainder fell into severe and extreme depression categories.

4.6 Statistical analysis

Before proceeding to undertake any statistical analysis, two important statistical considerations have to be addressed.

Normality-the first one is that both samples assume a normal distribution. The difference of means test used to compare populations is only appropriate when the underlying populations display normality. In fact, both the equal-variances and unequal-variances techniques require that the populations be normally distributed (Keller, 2005). When the normality condition is unsatisfied, nonparametric techniques such as the Wilcoxon rank sum test for independent samples can be used. However, the Wilcoxon rank sum test can only be used as a substitute in cases of equal-variances and there is no alternative to the unequal-variances test when the populations are non-normal (Keller, 2005; Diehr & Lumley, 2002).

Usually, large samples can overcome the effects of extreme nonnormality as cited by Keller (2005). In practice, the abovementioned techniques are still valid as long as the population is not extremely non-normal (Keller, 2005). The study under consideration has relatively 'large' samples and do not display any extreme non-normality and hence the issue of normality could be somewhat circumvented. However, in order to make sure of any conclusions reached, as a backup test the Wilcoxon rank test is also performed.

The second condition relates to the sample variances and determines which of the two 'difference in means' tests to administer. In the first case, the independent samples are assumed to have equal variances and hence incorporate an equal-variance test statistic calculation. This assumption of equal variances will have to be tested statistically before administering the equal-variance test (Steyn et al., 2000).

The second case assumes that the two samples have unequal-variances and hence an unequal-variance test statistic is calculated. Again, the assumption of unequal variances has to be tested statistically before proceeding any further and testing for differences in the population means (Steyn, Smith, Du Toit & Strasheim, 2000).

As previously mentioned, the sample had been split into two sub samples, namely $n_1 + n_2$. In each of these sub samples, the means (\bar{x}_i) and sample variances (s_i^2) have been calculated. Using the derived variances, we then proceed to test whether these samples have equal or unequal variances. In this case the null hypothesis states that the variance of the first sample is equal to the variance of the second sample, while the alternative hypothesis states that the variances are not equal.

$$H_o : \sigma_1^2 = \sigma_2^2$$

$$H_1 : \sigma_1^2 \neq \sigma_2^2$$

Using a level of significance of $\alpha = 0.05$ the critical values are 0.7 and 1.43 respectively (using sample sizes of approximately $n = 120$ in both cases). The test statistic calculated equalled 0.82 and based on this, the null hypothesis cannot be rejected. The p-value of 0.26 also suggests that the null hypothesis cannot be rejected in favour of the alternate hypothesis. Table 4.4 illustrates the variance test results.

Table 4.4 Equivalence variance test

	Sample 1	Sample 2
Mean	7.2149	49.1840
Variance	87.4534	107.2643
Observations	121	125
Df	120	124
F	0.8153	
P(F<=f) one-tail	0.1308	
F Critical one-tail	0.7412	

This means that the two samples have equal variances and we can now proceed to test the differences in means using (1) the equal variances means test proved both populations have not violating the normality assumption, or (2) the Wilcoxon rank test when the normality assumption has been violated.

Test for a Difference between means for large samples, given $\sigma_1^2 = \sigma_2^2$

The sample mean for the first group (spiritual/religious inclined) was 7.2 while the sample variance was 87.5 as shown in table 4.5.

Table 4.5 Mean scores (religious)

Sample 1	
Mean	7.215
Standard Error	0.850
Median	3
Mode	0
Standard Deviation	9.352
Sample Variance	87.453
Kurtosis	2.510
Skewness	1.593
Range	45
Minimum	0
Maximum	45
Sum	873
Count	121

The sample mean for the second group (nonspiritual/religious) was 49.2 while the variance was 107.3 as shown in table 4.6.

Table 4.6 Mean scores (nonreligious)

Sample 2	
Mean	49.184
Standard Error	0.926
Median	53
Mode	57
Standard Deviation	10.357
Sample Variance	107.264
Kurtosis	5.278
Skewness	-1.609
Range	63
Minimum	0
Maximum	63
Sum	6148
Count	125

At face value, it can easily be seen that the mean depression scores between the two groups are considerably different. The mean score for the spiritual/religious group is far lower than the mean depression score of the nonspiritual/religious group. In other words, $\mu_1 < \mu_2$ ($7.2 < 48.2$) is markedly different when compared to each other. In accordance to the Beck Depression Inventory, depression levels from sample 1 are considered normal while depression levels in sample 2 warrants clinical intervention as it displays extreme depression levels. Given the differences in religion/spirituality, such differences could suggest that religion/spirituality played some role in decreasing the depression scores of the respondents. While both groups include respondents who are HIV positive, of similar composition in terms of size and demographics, the only discernible difference between the groups was the levels of spirituality/religious affiliation.

However, making such a bold statement based on rudimentary comparisons can be misleading or sanguine. Rather a proper statistical test-the equal variances means test-has to be performed. In the equal-variance means test, the null hypothesis assumes that

there are no discernible differences in the sample means while the alternate hypothesis assumes that the two samples are considerably different and belonging to two independent and unique populations. The null and alternate hypothesis is therefore stated as:

$$H_o : \mu_1^2 = \mu_2^2$$

$$H_1 : \mu_1^2 \neq \mu_2^2$$

The critical significance levels at $\alpha = 0.05$ and $\alpha = 0.025$ equals 1.645 and 1.96 respectively based on the sample sizes. The test statistic is – 33.3 with the p-value being significantly small as pointed in Table 4.7. This provides ample ground to reject the null hypothesis in favour of the alternate hypothesis. In other words, the depression levels (or scores) from either sample differ considerably suggesting that samples are uniquely different and likely coming out of different populations.

Table 4.7 Sample comparison mean scores

	Sample 1	Sample 2
Mean	7.2149	49.184
Variance	87.4534	107.2643
Observations	121	125
Pooled Variance	97.5212	
Hypothesized Mean Difference	0	
Df	244	
t Stat	-33.3243	
P(T<=t) one-tail	4.30328E-93	
t Critical one-tail	1.6511	
P(T<=t) two-tail	8.60656E-93	
t Critical two-tail	1.9697	

Wilcoxon Rank Sum Test, given $\sigma_1^2 = \sigma_2^2$

As mentioned above, when the normality assumption has been violated, then the Wilcoxon Rank Sum Test is used to compare the populations. The output of this test is

provided in the appendices but in essence the Z-value was -9.4954 with a corresponding p-value of 0. The result is significant at $p \leq 0.05$ and we can conclude that the populations are different, even if they are considered non normal. The W-value was 19.5 which suggests that the distribution is approximately normal and therefore the Z-value above could be used to test for differences in populations.

4.7 Limitations

The samples of the study were obtained from the KwaZulu-Natal province only. The samples were predominantly Black and the spiritual/religious sample was predominantly of Christian faith. The way the spirituality/religious quotient was calculated was novel and could be open to criticism, especially given the fact that a respondent's spiritual/religious score could be quantified. The relationship between religion/spirituality and depression could be spurious. The study ignores other possible explanatory variables which could indeed explain this relationship more proficiently.

4.8 Conclusions

Based on the above findings in both the equal-variance difference in means test and/or the Wilcoxon Rank Sum test, it is concluded that despite both sample respondents having a HIV positive status, the depression levels within the spiritual/religious cohort are different from those of the nonspiritual/religious cohort. Expressed differently, spirituality or religion seems to have a calming effect on the respondents to the extent that it lessens their level of depression.

The strength of the relationship (i.e. correlation) between religion/spirituality and depression is also significant (see Table 4.8 below).

Table 4.8 Religion/spirituality depression index

	Religion/spirituality	Depression
Religion/spirituality	1	
Depression	-0.85	1

Within the context of the study there seems to be a considerably strong inverse relationship between religion/spirituality and depression. In fact, the correlation coefficient is -0.89 suggesting a near perfect negative relationship between the variables. In other words, as one's spirituality/religious quotient increases, one's depression levels decreases. For example, in a study conducted by Michael, et al. (2006: 25), it was established that, "controlling for other significant factors, a 1-point increase in the measure for spiritual well-being (FACIT-SpEx; range 0 to 92) was associated with a 5% decrease in the odds of reporting significant depressive symptoms.

CHAPTER FIVE: DISCUSSION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter discusses the main findings of the study, in relation to the aims and objectives of the study. This will be followed by the detailed discussion of the implications of the results of the study. Furthermore, the limitations of the study will also be explored. This will be followed by the discussion of the recommendations and direction of future research.

5.2 Main findings

The study established that there is a significant relationship between Religion/spirituality and depression: there seems to be a definite link between one's spiritual/religious patterns and levels of depression. It is such that the more one is depressed, he or she is likely to be spiritually or religiously inclined. "This is consistent with the mobilization effect (Pargament, 1997) in which severe stress may prompt individuals to increase their religious coping, whether positive or negative" (Lee, 2012:47). The strength of the relationship (i.e. correlation) between religion/spirituality and depression is also significant. Within the context of the study there seems to be a considerably strong inverse relationship between religion/spirituality and depression. In fact, the correlation coefficient is -0.89 suggesting a near perfect negative relationship between the variables. In other words, as one's spirituality/religious quotient increases, one's depression levels decreases.

The study conducted by Michael et al. (2006:25), established that, "controlling for other significant factors, a 1-point increase in the measure for spiritual well-being (FACIT-SpEx; range 0 to 92) was associated with a 5% decrease in the odds of reporting significant depressive symptoms". Although it cannot be inferred that the inverse relationship

between spirituality and depressive symptoms is causal, it is plausible that, beyond 'traditional' approaches to the prevention and treatment of depression in patients with HIV/AIDS, addressing the spiritual needs of patients could potentially serve as another facet of an integrated and comprehensive approach to the clinical care of these patients.

In relation to religion/spirituality and depression of people with HIV/AIDS, it has been established that, most patients with HIV/AIDS belonged to an organized religion and use their religion to cope with their illness (Cotton et al., 2006). Empirical studies have established that, there an association between higher religiousness and lower levels of depressive symptoms (Smith et al., 2003; Baetz et al., 2004), demonstrating that religion or spirituality may play a role in attenuating negative affect, decreasing stress, or enhancing relaxation or distraction. In other studies, it has also been established that, individuals with chronic pain and fatigue and generally depressed were more likely to use prayer and seek spiritual support as a coping method than the general population. Moreover, depression sufferers who were both religious and spiritual were more likely to have better psychological well-being and use positive coping strategies (Baetz et al., 2004). This can be augmented by that, once an individual accepts the illness, it becomes easier to cope with. Acceptance of illnesses is thus associated with better psychological well-being in chronic fatigue syndrome and chronic pain (Van Damme, Crombez, Van Houdenhove, Mariman & Michielsen, 2006). Acceptance may be enhanced by religious or spiritual strength and reframing of the chronic illness. All in all, the study has revealed that, expressed differently, spirituality or religion seems to have a calming effect on the respondents to the extent that it lessens their level of depression.

The depression levels within the spiritual/religious cohort are different from those of the non-spiritual/religious cohort, in that those who were spiritual had lower levels of depression than those who were not spiritual or religious. On the other hand, it has also been established that, in prior smaller studies in patients with HIV, however, spirituality, but not religiosity, was associated with lower levels of depression (Biggar et al., 1999; Simoni & Ortiz, 2003).

Empirical research has established that religious beliefs can have a dramatic effect on HIV/AIDS patients. For example, Anozie (2011) is of the opinion that faith based interventions are effective in dealing with distressing conditions. Those who believed God is loving and forgiving had significantly slower disease progression over 4 years than did those who viewed God as harsh and punishing (for them the disease progressed 5 to 8 times faster based on the two measures used), (Wood, 2012). In another study, it was established that, people who feel connected to a higher power (God) and who find comfort in faith or spiritual beliefs had better cardiovascular health, as measured by a range of indicators, including blood pressure and cholesterol. They were also less likely to experience stress or depression. The connection between spirituality and these factors remained even when the effects of other factors was removed (Wood, 2012).

Cancer patients who were both spiritual and religious had the highest levels of wellbeing and suffered the least depression. Those who were spiritual but not religious also had good wellbeing. Those who were neither religious nor spiritual were more likely to be depressed, and the religious but not spiritual fared worst of all (Wood, 2012).

In contrast, religious and spiritual people had a higher incidence of depression, with those whose spirituality wasn't connected to a religion being most prone. The study recognised that this was contrary to the findings of previous studies (Per sand & Briggen, 2013).

The findings of the study echo those from earlier studies that showed that greater levels of spirituality were associated with health outcomes such as fewer mental health problems, fewer reported HIV-related symptoms, and better overall functioning in people with HIV/AIDS (Cotton et al., 2006).

The study also established that, those respondents whom practiced some form of religion/spirituality found that they enjoyed various 'benefits' from following a religion. These include having some sort of society structure, providing emotional soothing, overcoming depression, and assisting in problem solving. This is in line with extensive

literature, which has asserted that, organized and non-organized religious activity, intrinsic religiosity, overall spirituality, meaning/peace, faith, and positive religious coping were all also associated with greater levels of optimism. It has been established that, family or close unit support and its relationships increased levels of spiritual beliefs and practices, suggesting that people living with HIV seek an environment that is both familiar and accepting of them (Somlai et al., 1996). What can be learnt from the study is that, social support, in turn, has long been known to protect against disease and increase longevity. Empirical literature, has established that, by reducing stress and negative emotions, increasing social support, and positively affecting health behaviours, spiritual/religious involvement should have a favourable impact on a host of physical diseases and the response of those diseases to treatment (Koenig, 2012).

While causality cannot be established, it appears that more spiritual patients are also more optimistic; a quality that may help them to cope with the unpredictability, grief, and anger that can be associated with having HIV/AIDS, as they benefit in the form of emotional soothing and social support by adopting a spiritual stance in the coping with the disease. Having an optimistic outlook on life and a 'fighting spirit' against a terminal illness has been shown to improve patients' well-being, both physically and emotionally, in a variety of illnesses, including cancer and HIV/AIDS (Cotton et al., 2006). In an empirical qualitative study of 30 HIV-infected older women aged 60 years and older, it was demonstrated how a psycho-socio-environmental support model was useful in helping older people come to terms with their physical, mental and social well-being in the context of HIV (Gilbert & Walker, 2002).

In a study by Szaflarski, (2013) it was established that one-third of patients with HIV/AIDS believed that their life is better now than it was before they were diagnosed with HIV; several factors, among their spirituality, are associated with believing that life has improved, owing to the supportive spiritual environment experienced. Such a supportive environment provides the greatest opportunity for the expression of one's personal spiritual beliefs and practices which aid in coping with depression amongst HIV/AIDS

patients (Somlai et al., 1996). This augments the argument that religion/spirituality has a direct or indirect impact on patients' perceptions of living with HIV/AIDS, and is an active coping strategy.

Does education level affect depression? The study also revealed that HIV 1% had formal education. Thus, inferring that the lack of or the lower level of education is correlated to the likelihood of one getting HIV/AIDS and depression. In a study by Nyirenda et al. (2013) and primary or higher level of education was associated with decreased likelihood of a depressive episode. The youth are far less depressed than mature individuals. This is probably due to their sheer 'irresponsible' nature or assumption that a cure for HIV will be found soon and within their life time. Literature supports the assertion that older HIV individuals are more prone to depression than younger individuals. In a study conducted by Hinkin et al. (2003) 131 HIVpp, of whom 25% were over the age of 50, found that there was a higher rate of current depressive disorder in the older patients (20%) compared with the younger ones (12%). Contrarily, in another study it was established that, HIVpp teenagers have an up to fourfold greater risk of developing depression than their peers in the general population; this risk is higher than other groups with chronic diseases such as diabetes or cancer, and are more likely to abuse drugs and alcohol.

The study also established that, most of the respondents were single (91%) and this could be largely related to the fact that they were HIV positive: single people are less likely to be spirituality/religious when compared to their married counterparts, but at the same time considerably more depressed. This is in contrary to literature which asserts that that religion is a complementary trait within marriage. Religion affects many activities that husband and wife engage in as a couple beyond the purely religious sphere (Becker, 1998). It has thus been established that Marriage and religion influence various dimensions of life, including physical health and longevity, mental health and happiness, economic well-being, reduced stress and depression (Waite & Lehrer, 2003). Furthermore, one of the strongest, most consistent benefits of marriage is better physical health and its consequence, longer life. Married people are less likely than unmarried

people to suffer from long-term illness or disability and depression (Murphy et al., 1999), and they have better survival rates for some illnesses, which is also includes depression (Goodwin, 2006).

The study also established that HIV-positive females are more likely to be both depressed and religious. Prevalence of HIV and AIDS has been more prevalent in men in as much as women are also prone to be HIV positive and affected by significant depression with estimated ranges that vary accordingly to the racial group or country in which the study was conducted (Arseniou et al., 2014). However, it has been established that “(i) HIV-positive women are more likely to experience depressive symptoms compared with seronegative women of the same age (19.4% vs. 4.8%);²⁷ (ii) 1.9-35.0% of seropositive hospitalized women present depression symptoms;⁵ and (iii) 30-60% of seropositive women not hospitalized, suffer from depression. Ickovics et al. (2001) reported chronic depressive symptoms in 42% and intermittent depressive symptoms in 35% of a sample of 765 HIV-positive women (Arseniou et al., 2014). However, those with significant spirituality tend to have established mechanisms of coping with the epidemic and consequential depression. Additionally, in a study by Saadat et al. (2015), it was established that HIV infection is related with psychiatric disorder like depression, anxiety, of which women are more vulnerable and need more care. “It has long been known that women are particularly vulnerable to both depression and HIV, and it seems likely, given that women carry a disproportioned burden of caregiving in most low and middle-income settings, that the effects of depression extend to impact on the family and the quality of care, rather than being limited to the individual” (Nyirenda et al., 2013: 35). Thus, depression negatively influences women’s health status, thoughts, perceptions and problem solving (Patel et al., 2010).

However, women have been found to have coping strategies, more so being more spiritual and religious in the managing their predicaments. Literature asserts that, spirituality (i.e. prayer, formal religions, and spiritual beliefs) was found to be related to being female, receiving support from family, and engaging in active problem solving

(Somlai et al., 1996). Hence, management of these psychiatric disorders is very important and requires innovative comprehensive approaches.

In people with HIV/AIDS, higher levels of spirituality have been associated with improvements in life satisfaction, functional health status, health-related quality of life (HRQoL), and overall well-being, even when controlling for other salient factors (e.g., age, HIV symptoms) (Cotton et al., 2006).

5.3 Limitations

Limitations of the study include the cross-sectional nature of the data, which restricted inferences regarding causality. The demographic characteristics of the study sample must be taken into account before the results can be generalized. The measure of importance of spiritual values was likewise limited to one question. No measure of pain severity or level of disability relevant to the present study was available. Ultimately, replication and longitudinal studies with more sensitive measures need to be conducted, with the aim of further examining these findings.

The findings, therefore, cannot be generalized. In addition, while the longitudinal findings lend support to a possible causal relationship between religion/spirituality and other variables, it is not possible to conclude that the relationships are causal. In other words, the non-experimental study design prevents us from making inferences regarding causality between the significant independent factors and depressive symptoms. Furthermore, the sample of the study was small and not diverse hence, the generalizability of the findings of the study to patients receiving care in other centres is uncertain. Moreover, the study did not ascertain whether if the respondents were taking depression medication during the course of data collection, hence the estimation of the effects of the antidepressant medication cannot be ascertained. Further, the levels of depression reported are based on self-reports of depression symptoms rather than a formal clinical diagnosis, and participants could have over or under-reported their

symptoms, which seems to be a trend from extensive literature (Nyirenda et al., 2013). Findings of the study may well be limited to individuals coping with HIV/AIDS who are more responsive to issues of religion and spirituality while individuals who are not as interested may have been under-represented in the sample. Thus, findings should be interpreted with caution because this sample was made up entirely of HIV/AIDS patients.

5.4 Future research

Future research should examine the feasibility of deriving a spiritual history, referring to clergy, or otherwise providing spiritual support and the relative impact such interventions may have on improving the lives of patients with HIV/AIDS (Cotton et al., 2006). Future longitudinal research should also investigate issues such as how fluctuating depression level affects social support status, substance use, and progression to AIDS in HIVpp and how in turn these factors influence depression (Arseniou et al., 2014). Furthermore, future research may focus on investigating the reasons for involvement in or disengagement from religion and religious activities, as it has been established that people with HIV engage or disengage in religious or spiritual activities for various reasons (Michael et al., 2006). Future research may also focus on establishing whether spiritual or religious interventions can ameliorate depression amongst HIV/AIDS patients, and identify groups of HIV patients that that could benefit from such interventions.

Additionally, more systematic research must examine how a broader range of indicators of health practices, belief systems, role identity, the clergy, social support, and other social and psychological resources may mediate the relationship between religious involvement and health, amongst people with depression and HIV/AIDS. For instance, the extent to which spiritual and religiousness can be a source of and purpose of living, has not received adequate academic attention. Furthermore, little research has also been conducted in trying to ascertain how biological mechanisms are influenced by religion (Somlai & Hackman, 2000). Future research also warrants, targeted systematic reviews and meta-analyses to integrate knowledge about specific populations, sociocultural, and

geographic contexts from across various disciplines. Certain populations (e.g., bisexual men, trans genders) and ethnic/religious contexts (e.g. non-Christian religions) have been neglected and further research on these groups is warranted (Szaflarski, 2013).

Future research can also focus on the quality of life of people living with HIV/AIDS and it may be influenced by preconceived gender and racial biases, and how they cope with depression emanating from being associated with the HIV/AIDS pandemic. Moreover, a more in-depth assessment of religious/spiritual factors in the lives of people with HIV/AIDS is critical to provide more targeted information to be used in interventions and clinical interactions aimed at promoting health and improving Human Related Quality of life (HRQoL) for people with HIV/AIDS (Cotton et al., 2006). It is imperative to address the limitations of the sample of the study, by conducting a similar study in a diversely populated environment.

5.5 Implications

The results of the study established that religion/spirituality is important to patients with HIV, and that religious coping is rife. Because greater levels of spirituality (meaning/peace, positive religious coping, and intrinsic religiosity) are associated with various psychosocial characteristics and because patients expect their providers to know about the spiritual/religious aspects of their lives, they tend to be stronger. A potentially life-threatening diagnosis, such as HIV/AIDS, can trigger deep spiritual questions about the meaning of the illness, purpose in life, and relationship with God and others, which trained providers can elicit through inquiring about spiritual or religious issues during a clinical encounter (Cotton et al., 2006). Few studies have assessed whether spiritually based interventions aimed at reducing religious struggle (often present in those who utilize negative religious coping strategies) or generating a sense of meaning and purpose in life could improve overall life satisfaction in people with a chronic illness such as HIV/AIDS (Cotton et al., 2006).

The results of this study suggested several clinical implications. Because religion is a significant resource for people living with HIV, assessing their religious coping strategies will be beneficial in understanding their level of functioning and providing them with appropriate care (Lee, 2012). The current study is imperative as it adds to the current literature by identifying fundamental relationships between spirituality/religiousness and the role it plays in social supports, and active problem solving towards people with HIV suffering from depression (Somlai et al., 1996).

5.6 Recommendations

The positive coping mechanisms included attitudinal and active strategies, such as looking on the bright side, doing something enjoyable or talking to others. Religion and spirituality increase feelings of control and self-efficacy, which appear to be related to increasing pain tolerance and encouraging more active coping techniques (Keefe et al., 1997). There is need to facilitate positive religious coping interventions and decrease negative coping strategies, that could be of benefit to people with HIV/AIDS (Lee, 2012). Thus, it may be particularly helpful to encourage spiritual practices and beliefs that are likely to promote coping with HIV, as association between positive religious coping strategies brings about decrease in depression. A case in point was the implementation of a psycho-spiritual intervention by Tarakeshwar et al. (2006). In their pilot study they reported that participants experienced decreased religious struggle and depression over the course of the intervention in which participants had an opportunity to identify personally relevant positive religious coping strategies and express their spiritual struggle. Such an intervention might have provided an important step to rebuild a relationship with God and to find meaning and direction in participants' lives, hence reduced depression (Lee, 2012).

Early diagnosis and treatment of depression improves the quality of life and contribute positively to HIV disease progression. Furthermore, clinicians treating HIV should be able to evaluate possible signs of depression and refer symptomatic patients for psychiatric

assessment whenever necessary. Given the adverse progression of untreated depression in HIV illness, identification and management of depression are integral components of comprehensive HIV care (Arseniou et al., 2014). Psycho-social support similar to that of HIV treatment programmes around HIV-infected and affected older people may be useful in reducing their vulnerability to depression (Nyirenda et al., 2013).

Helping to address the spiritual needs of patients in the medical or community setting may be one way to decrease depressive symptoms in patients with HIV/AIDS (Michael et al., 2006). Improved spiritual well-being may facilitate more positive and 'healthy' personal and social behaviours, may provide an overarching and unifying framework with which to deal with unexpected and difficult situations, and may give a greater sense of coherence between the individual and their environment, all of which may provide protection against depression or other psychological problems (Michael et al., 2006). Potential spiritual or religious interventions could entail a structured program in the context of patients' ongoing clinical care (Pargament, 1999). Interventions could target patients interested in spiritual counselling and support and could be tailored to one's particular religious and spiritual traditions. "Another model could employ interventions in the context of HIV support group meetings or retreats at regular intervals. A less intensive approach would involve informing patients of community services or of religious congregations with a more in-depth understanding of the spiritual needs of patients with HIV" (Michael et al., 2006:26). Higher levels of religion/spirituality have also been associated with less psychological distress, less pain, greater energy, and will to live, better cognitive and social functioning, and feeling that life has improved since HIV diagnosis.

Clinicians ought to strive to assess spirituality in HIV patients and make referrals for empirically supported treatments and/or pastoral/clinical counselling to address spirituality as indicated (Trevino et al., 2010). In other words, clinicians may need to include an in-depth assessment of spiritual and religious practices as a part of their routine in-take of people living with HIV/AIDS, so as to facilitate successful adjustment, coping strategies, and support for people living with HIV/AIDS (Somlai et al., 1996).

Clinicians will have to be up-skilled through training, with the skills of administering and interpreting of measures measuring spirituality, religiousness, spiritual coping, religious issues, and religious traditions that affect the quality of life and care needs of HIV infected people. Furthermore, spiritual counsellors and clergy may need to be considered as part of a multidisciplinary mental health team responsible for providing information on religious and cultural opportunities that improve the quality of life of people infected with HIV (Somlai et al., 1996).

5.7 Conclusion

The study establishes that, people with HIV are more likely to be depressed, thus infers they are more likely to use health care services than non-depressed people. However, spirituality and religiousness plays a significant role in the lives of patients with depression and HIV, and is the corner stone of coping strategies and longevity. It has been noted that patients become more spiritual/religious after diagnosis, hence it should be prioritized in coming up with intervention coping strategies. Hence, consideration of an individual's spirituality and/or religion, and how it may be used in coping may be an additional component to the overall management of depression and HIV progression. There is the need for multimodal approaches to depression amongst HIV/AIDS persons. Spirituality is an important factor in their lives, as most indicated some sense of meaning/purpose in their lives and reported deriving comfort from their spiritual beliefs. Spiritual and religious beliefs and practices are common in a majority of patients with HIV/AIDS, are associated with a variety of clinical and psychosocial characteristics, a religious affiliation, and optimism, less alcohol use, self-esteem, life satisfaction, decreased depression, and overall functioning and remain stable. This is in line with empirical literature, which asserts that people who are more spiritual/religious have better mental health and adapt quicker to health problems compared to those who are less spiritual/religious (Koening, 2012).

Treatment of depression can improve quality of life and lead to a better prognosis of HIV infection (Arseniou et al., 2014). Hence, controlling for certain health status and psychosocial factors, spiritual well-being was associated with fewer depressive symptoms, and thus may serve as a potential target for interventions for patients with HIV. It can also be asserted that patients become more spiritual or religious by virtue of having HIV/AIDS, and half of the patients believe that their religion/spirituality is helping them to live longer.

Spirituality and religion are important to many people living with HIV/AIDS and affects their HIV outcomes, including disease progression, physical/mental health, and quality of life. The study explores literature and argues the importance of spirituality, empirical literature asserting that, that higher spirituality has been associated with less pain and increased energy, less psychological distress, less depression Coleman, 2004; Simoni and Ortiz (2003), better mental well-being (Coleman, 2004), better cognitive and social functioning, and fewer HIV symptoms (Coleman, 2004). Thus, the study infers that higher frequency of spiritual/religious worship facilitates the development and implementation of sustainable interventions to curb depression amongst people with HIV/AIDS. In other words, this study augments the study conducted by Koenig (2012), who asserted that religion provides resources for coping with stress that may increase the frequency of positive emotions and reduce the likelihood that stress will result in emotional disorders such as depression, anxiety disorder, suicide, and substance abuse. It can therefore also be deduced that an optimistic outlook on life and a 'fighting spirit' against a terminal illness can improve a patients' well-being, both physically and emotionally, in a variety of illnesses, including cancer and HIV/AIDS. Furthermore, understanding the unique stressors associated with HIV and how individuals with HIV cope with the challenges they face is crucial in helping individuals with HIV maintain optimal physical and psychological well-being.

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APPENDIX A

CONSENT FORM: HIV/AIDS AND DEPRESSION

University of Zululand

My name is Jaganathan Moodley and I am a Clinical Psychologist PhD student at the University of Zululand. I am conducting research on HIV and depression in the Psychology department.

My research includes an empirical component of which this questionnaire is one of the research instruments used for data gathering.

The purpose of this questionnaire is twofold.

- Firstly, it will assist people who are suffering from HIV/AIDS to voice their feelings of depression.
- Secondly, it will provide data which will help us to develop better ways of dealing with the different forms of stress that are attributed to HIV/AIDS.

Please note:

- The data you provide will be recorded anonymously and your participation in this study will be held in the strictest confidence. If a summary of the results is used for educational or publication purposes, individuals will not be identified.
- Your participation in this research is entirely voluntary and you can withdraw from the survey at any time. For ethical reasons, this research is aimed at adult participants only (persons aged 18 and above).
- You also have the right to skip any particular question or questions if you do not wish to answer them but you are strongly encouraged to answer all questions.
- You have the right to ask questions before, during and after the administration of this questionnaire.

I shall appreciate it if you assist the project by providing your personal views or opinions in the questionnaire.

Informed Consent

I hereby give my permission for the use of my views and opinions for research purposes.

Signature: _____ **Date:** _____

My Email is jrmoodley@aol.com

Thank you so much.

***QUESTIONNAIRE OF RELIGION /
SPIRITUALITY AND DEPRESSION***

PROI. PROFILE OF THE RESPONDENT

Q.1. Gender:

Male	1	Female	2
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Q.2. Race:

African 1	Indian	2	White	3	Coloured	4
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Q.3. Marital Statute:

Single	1	Married	2	Divorced 3	Widow	4
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Q.4. Age:

Q.5. What is your occupation or Job?
.....

Q.6. Highest education level: (e.g.: none, less than Matric, Bachelor degree, Honours, Masters, etc.)

I- SPIRITUALITY ASSESSMENT

Q.6. Do you have religious/spiritual

Yes	1	No	2
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 beliefs?

(If yes, continue; if no, stop.)

Q.7. If yes; what is your religion or spiritual belief?

(e.g.: Christian, Muslim, ancestors, Hindu, Sangoma, Shembe, etc.

Q.8.If you are Christian please specify your belonging group

Catholic Church	1
Methodist Church	2
Protestant Church	3
Pentecostal Churches	4
Others (Specify).....	

Q.9. Think about other people in your community. Compared to them, how religious/spiritual are you?

Not at all	A little	Enough	Very much
1	2	3	4

Q.10.How often do you practice religious activities alone/by yourself (prayer, meditation, talking to ancestors)?

Once a year	Once a month	Once a week	More than once a week
1	2	3	4

Q.11.How often do you participate in religious activities with other people? (E.g. prayer group, Church, bible study, religious ceremonies, etc.)

Once a year	Once a month	Once a week	More than once a week
1	2	3	4

Q.12. In the following statements please describe your spirituality; if you believe in something else than “God”, just replace “God” with that belief when answering.

	Not at all	Somewhat	Quite a bit	A great deal
I am someone who looks for a stronger connection with God	1	2	3	4
I am someone who seeks God’s love and care	1	2	3	4
I am someone who seeks help from God when I have a problem	1	2	3	4
I am someone who tries to put my plans into actions together with God	1	2	3	4
I am someone who practices religious activity alone(prayer, meditation, talking to ancestors)	1	2	3	4
I am someone who participates in religious activities with other people (E.g. prayer group, Church, bible study, religious ceremonies, etc.)	1	2	3	4
I feel punished by God when I lack devotion	1	2	3	4
I try to follow the rules and commandments of God	1	2	3	4

II- DEPRESSION ASSESSMENT

Instructions: Please read each group of statement carefully, and then pick out the one statement in each group that best describes the way you have been feeling the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including item 16(changes in sleeping pattern) or 18 (changes in appetite).

<p>1- Sadness</p> <p>0 I do not feel sad</p> <p>1 I feel sad much of the time</p> <p>2 I am sad all the time</p> <p>3 I am so sad or unhappy that I can’t stand it</p>	<p>5- Guilty feelings</p> <p>0 I don’t feel particularly guilty</p> <p>1 I feel guilty over many things I have done or should have done</p> <p>2 I feel quite guilty most of the time</p> <p>3 I feel guilty all the time</p>
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<p>2- Pessimism</p> <p>0 I am not discouraged about my future</p> <p>1 I feel more discouraged about my future than I used to be</p> <p>2 I do not expect things to work out for me</p> <p>3 I feel my future is hopeless and will only get worse</p>	<p>6- Punishment feelings</p> <p>0 I don't feel I am being punished.</p> <p>1 I feel I may be punished.</p> <p>2 I expect to be punished.</p> <p>3 I feel I am being punished.</p>
<p>3- Past failure</p> <p>0 I do not feel like a failure</p> <p>1 I have failed more than I should have</p> <p>2 As I look back, I see a lot of failures</p> <p>3 I feel I am a total failure as a person</p>	<p>7- Self-dislike</p> <p>0 I don't feel disappointed in myself.</p> <p>1 I am disappointed in myself.</p> <p>2 I am disgusted with myself.</p> <p>3 I hate myself.</p>
<p>4- Loss of pleasure</p> <p>0 I get as much pleasure as I ever did from the things I enjoy</p> <p>1 I don't enjoy things as much as I used to do</p> <p>2 I get very little pleasure from the things I used to enjoy</p> <p>3 I can't get any pleasure from the things I used to enjoy</p>	<p>8- Self-criticalness</p> <p>0 I don't criticize or blame myself more than usual.</p> <p>1 I am more critical of myself than I used to be.</p> <p>2 I blame myself all the time for my faults.</p> <p>3 I blame myself for everything bad that happens.</p>
<p>9- Suicidal thoughts or wishes</p> <p>0 I don't have any thoughts of killing myself.</p> <p>1 I have thoughts of killing myself, but I would not carry them out.</p> <p>2 I would like to kill myself.</p> <p>3 I would kill myself if I had the chance.</p>	<p>15- Loss of energy</p> <p>0 I have as much energy as ever</p> <p>1 I have less energy than I used to have</p> <p>2 I don't have enough energy to do very much</p> <p>3 I don't have enough energy to do Anything</p>
<p>10- Crying</p> <p>0 I don't cry any more than usual.</p> <p>1 I cry more now than I used to.</p> <p>2 I cry over little thing.</p> <p>3 I used to be able to cry, but now I can't cry even though I want to.</p>	<p>16- Change in sleeping pattern</p> <p>0 I have not experience any change in my sleeping pattern</p> <p>1a I sleep somewhat more than usual</p> <p>1b I sleep somewhat less than usual</p> <p>2a I sleep a lot more than usual</p> <p>2b I sleep a lot less than usual</p> <p>3a I sleep most of the day</p> <p>3b I wake up 1-2 hours early and cannot get back to sleep</p>

<p>11- Agitation</p> <ul style="list-style-type: none"> 0 I am no more restless or wound up than usual 1 I feel more restless or wound up than usual 2 I am so restless or agitated that it is hard to stay still 3 I am so restless or agitated that I have to keep moving or doing something 	<p>17- Irritability</p> <ul style="list-style-type: none"> 0 I am no more irritable than usual 1 I am more irritable than usual 2 I am much more irritable than usual 3 I am irritable all the time
<p>12- Loss of Interest</p> <ul style="list-style-type: none"> 0 I have not lost interest in other people or activity 1 I am less interested in other people or things than before 2 I have loss most of my interest in other people or things 3 It's hard to get interested in Anything 	<p>18- Change in appetite</p> <ul style="list-style-type: none"> 0 I have not experience any change in my appetite 1a My appetite is somewhat greater than usual 1b My appetite is somewhat less than usual 2a My appetite is much less than before 2b My appetite is much greater than usual 3a I have no appetite at all 3b I crave food all the time
<p>13- Indecisiveness</p> <ul style="list-style-type: none"> 0 I make decisions as well as ever 1 I find it more difficult to make decisions than usual 2 I have much greater difficulty in making decisions than I used to do 3 I have trouble making any decisions 	<p>19- Concentration difficulty</p> <ul style="list-style-type: none"> 0 I can concentrate as well as ever 1 I can't concentrate as well as usual 2 It's hard to keep my mind on anything for very long 3 I find I can't concentrate
<p>14- Worthlessness</p> <ul style="list-style-type: none"> 0 I do not feel I am worthless 1 I don't consider myself as worthwhile and useful as I used to do 2 I feel more worthless as compared to other people 3 I feel utterly worthless 	<p>20- Tiredness or fatigue</p> <ul style="list-style-type: none"> 0 I am no more tired or fatigued than usual 1 I get more tired or fatigued more easily than usual 2 I am too tired or fatigued to do a lot of things I used to do 3 I am too tired or fatigued to do most of the things I used to do
	<p>21- Loss of interest in sex</p> <ul style="list-style-type: none"> 0 I have not noticed any recent change in my interest in sex 1 I am less interested in sex than I used to be 2 I am much less interested in sex now 3 I have loss interest in sex completely

IV. CONTRIBUTION OF RELIGION IN LIFE

Q.15. Please indicate how your religion (or spiritual belief) helps you in your life

Religion brings me social support (e.g. companionship)	1
Religion brings me practical support (e.g. food, clothing, money)	2
Religion helps me in problem solving (e.g. advice, counseling)	3
Religion gives me emotional soothing (e.g. comfort, hope, strength, to feel better, feel loved)	4
Religion produce personal growth (e.g. makes me a better person-patient, moral, kind)	5
Religion helps me overcome depression	6
Other (please describe)	
.....	
.....	

Thank you so much for your participation

APPENDIX C

Descriptive statistics – Spiritual/Religious Scores

Sample 1: Descriptive Statistics	
Mean	22.842
Standard Error	0.758
Median	22.5
Mode	33
Standard Deviation	8.304
Sample Variance	68.958
Kurtosis	-1.204
Skewness	-0.216
Range	29
Minimum	4
Maximum	33
Sum	2741
Count	120

Wilcoxon Rank Sum Test

Wilcoxon Rank Sum Test

W-value: 19.5

Mean Difference: -49.79

Sum of pos. ranks: 19.5

Sum of neg. ranks: 7361.5

Z-value: -9.4954

Mean (W): 3690.5

Standard Deviation (W):
386.61

Sample Size (N): 121
