Spirituality, Coping, and HIV Risk and Prevention in a Sample of Severely Mentally Ill Puerto Rican Women

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ABSTRACT *Hispanics have been disproportionately impacted by HIV/AIDS. Although HIV risk is significantly elevated among severely mentally ill persons (SMI), the risk of infection appears to be even greater among those SMI who are Hispanic, reflecting the increased risk of HIV among Hispanics. We report on findings from the first 41 participants in a qualitative study examining the context of HIV risk and risk reduction strategies among severely mentally ill Puerto Rican women residents in northeastern Ohio. Individuals participated in a baseline interview, two follow-up interviews, and up to 100 hours of shadowing. Interviews and shadowing activities were recorded and analyzed using a grounded theory. The majority of individuals reported using identification with a religious faith. A large proportion of the participants reported that their religious or spiritual beliefs were critical to their coping, had influenced them to reduce risk, and/or provided them with needed social support. Several participants also reported having experienced rejection from their faith communities. The emphasis on spirituality among Puerto Rican SMI is consistent with previous research demonstrating the importance of spirituality in the Hispanic culture and reliance on spiritual beliefs as a mean of coping among SMI. Our results support the incorporation of spiritual beliefs into secular HIV prevention efforts.*

KEYWORDS *Coping, HIV, Latinas, Spirituality.*

BACKGROUND

HIV and HIV Risk among Hispanics

Hispanics have been disproportionately impacted by HIV/AIDS. Although comprising 13.7% of the U.S. population in 2003, Hispanics accounted for 20.3% of new AIDS cases and 21.7% of all AIDS-attributable deaths that year.¹⁻³ In 1996, HIV became the second leading cause of death for Latinas aged 25 to 44.⁴ Additionally, a trend has been observed of increasing AIDS cases among foreign-born Hispanic men and women and heterosexual U.S.-born Hispanics.⁵ HIV

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infection among Latinos has been attributed primarily to heterosexual transmission and injection drug use.⁶

Numerous barriers to HIV risk reduction and prevention have been identified. Hispanics have consistently demonstrated lower levels of HIV knowledge compared to other groups.⁷⁻¹⁰ Barriers to HIV education among Hispanics include language and cultural differences,¹¹ low literacy levels,¹² strong antihomosexual¹³ and machista attitudes,^{13,14} a denial or minimization of risk,¹⁵ and an emphasis on traditional gender roles and differences.¹⁶ Condom use by Hispanic women is typically low,^{14,17,18} particularly among foreign-born¹⁹ and less acculturated persons.^{18,20} Compared to non-Hispanic white and African American women, Latinas have been found less likely to use condoms in the context of casual sexual relationships,²¹ although Puerto Rican women specifically have been found less likely to use condoms in relationships of longer duration and greater emotional investment.²² The relative lack of condom utilization has been attributed to cultural norms^{23,24} and the reduced likelihood that Hispanic men will use condoms with their primary sexual partners.^{17,25,26} Among Puerto Rican women, low resource power as measured by level of education and employment appear to be related to lower levels of condom use.²² Hispanic men have also been found to be more likely to have sexual contact with prostitutes, further increasing their risk for HIV.²⁷

HIV Risk among Severely Mentally Ill (SMI) Persons

HIV prevalence among SMI has been found to be 5% among females and 10% among males, compared to 0.24% to 0.35% in the general population.^{28,29} The rate of HIV among SMI ranges from 3% to 23%, or between 8 and 70 times higher than the national rate.^{28,30} Among SMI, the prevalence of HIV among Hispanics has been found to be three times that among whites,³⁰ reflecting the increased risk of HIV among Hispanics.³¹

Lower levels of disease severity appear to increase the likelihood of being sexually active. Although greater symptom severity and sexual dysfunction associated with psychotropic medications³² may reduce individuals' desire for sexual activity, they may be more likely to engage in survival sex due to an inability to manage resources; as a result, they may be increasingly vulnerable to coercion.³³ Individuals' levels of affective instability and behavioral impulsivity are also relevant; a correlation between higher excited symptoms and number of sexual episodes has been noted.³³

Increased risk may also be attributable to little fear of HIV and a low perception of personal risk.^{34,35} Cognitive impairments associated with SMI may negatively affect individuals' ability to make decisions in their own best interest or appropriately weigh the risks versus benefits of specific sexual behaviors.³⁶ The prevalence of homelessness among SMI persons may be as high as 45%,³⁷ while the prevalence of HIV infection among SMI homeless persons has been found to be as high as 19%.³⁸ Sexual relationships in these circumstances are often transient, casual, and may be offered in exchange for shelter and/or food.³⁹

Religiosity, Spirituality, and Coping

Spiritual and religious practices and beliefs are important to some Hispanic groups. Catholicism has played a major role in the lives of Puerto Ricans in Puerto Rico and

on the U.S. mainland.^{40,41} Various evangelical Protestant sects have experienced an upsurge in the number of adherents;⁴² one-third of all Puerto Ricans now self-identify as Protestant.⁴² Many Puerto Ricans may practice Catholicism, *Santería*, and *Espiritismo* simultaneously.⁴³

Spiritual beliefs and/or religion may be important in coping with mental illness,^{44,45} particularly for Hispanics. Hispanic Americans have been found twice as likely as Non-Hispanics to seek church assistance to address family problems, depression, worry, and fear.⁴⁶ Spirituality and religion are often critical to recovery among individuals with SMI^{47,48} and may contribute significantly to individuals' well-being⁴⁸ by providing hope, comfort, love, and acceptance,^{49,50} and a sense of control and meaning.⁵¹ Religious/spiritual activities may have positive effects^{51,52} by providing role models for behavior, contact with other individuals, and material assistance,^{49,53} and may be especially important for those with heightened levels of stress and debilitation.⁵¹

HIV prevention research efforts have not adequately examined the role of religious/spiritual beliefs in reducing HIV risk among either Hispanics or SMI persons. Our study examined contextual factors relevant to HIV risk among a sample of Puerto Rican and Mexican women diagnosed with SMI. We report our findings related to the role of religiosity and spirituality among our initial 41 Puerto Rican study participants.

METHODS

Sample

Eligibility for participation required a diagnosis of major depression, bipolar disorder, or schizophrenia; Puerto Rican ethnicity; residence in any of six enumerated counties of northeastern Ohio; and age between 18 and 50 years at enrollment. Information about the study was disseminated within the Puerto Rican community through presentations conducted in diverse settings (e.g., language and vocational classes) and the distribution of flyers to a broad spectrum of venues (e.g., churches, nightclubs, government assistance offices). We also contacted clinicians and counselors serving mentally ill Puerto Rican women to apprise them of the study. The presentations and flyers advised individuals that we were conducting a study to understand how to reduce HIV risk among Puerto Rican women who were *deprimida* (depressed), who had suffered from *ataques de nervios* (nervous or panic attacks), or who had emotional troubles, and provided contact information for additional information about the study. We used these terms to avoid stigmatizing or embarrassing interested individuals who might signify their interest in a public forum.

Interested individuals were provided with details about the study and were asked for their consent to a baseline interview to assess eligibility for study participation (see Methods, below). Eligible individuals were invited to join the study and were asked for their informed consent for an additional two-part baseline interview, a follow-up interview each year for two years, and 100 hours of shadowing. No situations involving questionable capacity arose. Our study procedures were approved by the IRB.

Participants ranged in age from 19 to 51. Almost three-quarters of the 41 participants were born in Puerto Rico; 51.2% relied on Spanish as their primary language. Slightly over one-half of the women had less than a high school education, 65.9% were unemployed, and 58.5% relied on social security disability

as their primary source of income. Almost three-quarters of the women were married or living with a partner and 90.2% had one or more children.

Data Collection

Interviews were conducted by one of several trained bilingual female interviewers in English and/or Spanish, as indicated by the participant. Interviewers received training on questionnaire administration and the conduct of interviews, which were designed to maximize privacy and confidentiality. Individuals' qualifying diagnosis was made using the Structured Clinical Interview for Axis I DSM-IV Diagnoses. The two-part baseline interview following this assessment focused on acculturation level, migration history, demographic information, sexual and drug use histories, and HIV knowledge. Observations during shadowing supplemented these data and allowed us to understand participants' viewpoints regarding key concepts, such as risk, religiosity, spirituality, love, and commitment.

Shadowing required that the interviewer accompany each participant in the course of her life's activities. Interviewers observed similar situations among all study participants, including: interactions with romantic and/or sexual partners, children, and other family members; social situations; appointments with medical and mental health care providers; inpatient hospitalization episodes; everyday activities such as church attendance, grocery shopping, and interactions with children's school personnel; and interactions in the course of obtaining publicly funded services, e.g., Social Security. Some participants were shadowed while using drugs and/or approaching men to exchange sex for money or drugs.

All participants were aware when shadowing occurred, as were most third parties. In order to minimize safety risks to the participants and the interviewers, interviewers' true purpose was not revealed to persons selling drugs to the study participants or to those with whom they were engaging in other illegal activities. Interviewers were instructed not to participate in any way in observed illegal activities and to leave any situation in which their safety was at risk.

Data Analysis

Most shadowing activities were tape recorded, transcribed in their original language, and translated into English if they were originally in Spanish. Shadowing activities were not tape recorded in situations that would compromise the safety of the participant, the interviewer, and/or others who might have been present. In such instances, the interviewers tape recorded their observations immediately after leaving the shadowing activities and then transcribed them for analysis, noting that they reflected the interviewer's observations as direct recording was not possible. Translated interviews and shadowing encounters were retranslated into Spanish to ensure accurate translation.

We developed an initial codebook using a grounded theory approach, which permits a continuous interaction between the data and the hypotheses until a stable cultural pattern appears.^{54,55} Accordingly, the codebook was based partly on predetermined themes and on topics and perspectives that arose from the data. We initially assigned codes on a line-by-line basis and subsequently recoded emerging themes. The resulting codebook was tested by two coders using the same interview. We refined the codebook through debriefing sessions to address non-matches, until we achieved 80 to 85% agreement on assigned codes. The

resulting codebook consisted of general categories and subcategories of topics. Every paragraph in every interview was assigned as many codes as was necessary to describe accurately the contents of that paragraph. Data were coded on an ongoing basis. We examined the data for patterns, themes, and categories that were developed and articulated by the participants and concepts brought to the study from a theoretical perspective.

RESULTS

Identified Themes

Themes identified in the transcripts of the shadowing activities included (1) having faith, that is, religiosity and spirituality; (2) defining the character or nature of God and the universe; (3) the practice of spiritism; (4) religious or spiritual belief as a coping strategy; (5) the influence of religious and spiritual belief in the decision-making process; and (6) the role of religion and/or spirituality with respect to social support.

Having Faith: Religiosity and Spirituality in the Context of Mental Illness The concepts of religiosity and spirituality have often been used interchangeably in the context of research.⁵⁶ When distinctions have been made, there has been tremendous variability across studies with respect to the definitions that have been used. Studies have conceived of spirituality as a focus on God or other power that guides the universe, faith in mystical or transcendental experiences, and/or adherence to certain moral values and belief about relationships with people and a higher power.^{57,58} Spirituality has been defined as “a basic aspect of human existence ... [encompassing] human activities of moral decision making, searching for a sense of meaning and purpose in life, and striving for mutually fulfilling relationships among individuals, society and ultimate reality...;”⁵⁹ “one’s personalized experience ... pertaining to a sense of worth, meaning, vitality, and connectedness to others and the universe;”⁶⁰ and “a striving for and infusion with the reality of the interconnectedness among self, other people, and the Infinite/Divine.”⁶¹ Religion has been said to represent “the external expression of faith ... comprised of beliefs, ethical codes, and worship practices that unite an individual with a moral community.”⁶² Spirituality and religion have been viewed as two dimensions of the same construct, with spirituality representing the inward, individual experience and religion its external manifestation.⁶³

The adherence of most of our participants to a faith or religious or spiritual precepts reflects the ongoing importance of religion in Puerto Rican culture.⁴¹ More than two-thirds of the women currently identify with a particular faith. Many had changed their religious affiliation from that of their upbringing. Of the 28 women (68.3%) who had been raised in the Catholic faith, 9 of the 28 (32.1%) indicated a present affiliation with another faith and an additional 8 women (28.6%) raised as Catholics have ceased practicing religion altogether; two women who had not been raised with any religion have begun practicing Catholicism. Although only three women were raised in the Pentecostal faith, 10 now claim membership in that faith community.

Many participants distinguished between their religious beliefs and the practices of their espoused faiths. One woman observed: “I’m Catholic. I don’t go

to church. I don't think I'm religious. I know there's a God but I don't like to go to church but I truly believe in God."

Several participants emphasized their faith in God, despite feeling ostracized from their churches because of their same-sexual orientation. One participant stated, "Yo no voy a la iglesia pero sigo los 10 mandamientos que Dios nos dio" [I don't go to church but I follow the 10 commandments that God gave us]. Another participant, angered because of her church's exclusion of her female partner for dressing inappropriately, distinguished between church-going and a belief in God:

I believe you don't have to go to church to praise Him. Every religion has something wrong ... I believe in God, I read the Bible. I want to go to church that is not judgmental.

Others appeared to equate their beliefs in religious teachings with religion itself. One woman equated the church with her religious beliefs in describing the events that followed her suicide attempt:

I tried to kill myself. I was depressed. The kids started giving me problems ... I found out he was with another woman. I got out of church. I was in the back porch. I had a cup of pills, ten muscle relaxers I was gone. I was seeing things They gave me charcoal. My nerves was twitching. Then they put me in the psych ward I read the bible. I thanked God. God gave me strength. *When you are out of church you are on your own.*

Defining the Character or Nature of God and the Universe Almost 25% of our participants viewed the universe as a struggle between good and evil, God and Satan, angels and demons. They perceived the conflict between these forces played out through their own and others' illnesses, in their relationships with others, and in their own internal struggles. One woman explained that her sexual partner began using drugs because "he did not believe in God and worshipped Satan. He was possessed He made a pact with the devil." Another participant, speaking of her own drug usage, cried, "El Diabolo no me suelta ... no me deja vivir la vida quieta" ["the devil does not let me go ... he doesn't let me live peacefully."] This participant stopped going to church because, she claimed, "seven demons came back to haunt [her]." The participants may have intended this reference to the devil as both a metaphor for the (evil) power that the drug (heroin) has over them and their lives and as an explanation of why some people turn to drug use. The devil, or evil, takes over, causing individuals to turn to drugs; they are then possessed by the (evil) drug (devil). It is also possible that the participant may have had frank psychotic symptoms.

These struggles between the forces of good and evil were sometimes magnified through the interpretations of events by fellow church members. As an example, one woman wished to leave her church picnic early, but was told by members of her church that these thoughts were really "los demonios tratando de atarcarse" [the demons trying to attack her]. Another woman who was experiencing frightening nightmares turned to her pastor for assistance. He advised her that demons and "the devil [were] in the house," and that she was to "pray and stop sinning" if she wished to rid her house of them. It is unclear to what extent, if any, these statements affected the thinking or actions of our participants.

Previous reports indicating delusions or hallucinations with religious content or themes are not uncommon among individuals with psychotic symptoms, regardless of their religious affiliation.^{44,64–66} The hallucinations and delusions that our participants experienced sometimes contained religious content and reflected the women's belief in the struggle between the good and evil forces of the world. One woman experienced frightening visions of demons who implored her to kill her daughters and then to drink Clorox; on other occasions she believed that she had power over the devil and could drink the bleach and then fight him. She explained:

The dark angels use peoples' bodies. They enter people's bodies who have mental illnesses, people who are in psychiatric facilities, and homeless people. They also enter the bodies of emotionally abused and sexual offenders. "Las almas estan torturadas" [The souls are being tortured] I can smell and see sexual demons in my house. I see them in people. I am careful who I bring to my house. I eventually get them all out "con ayuno y oración" [with prayer and fasting]. God takes care of me always. He protected me from getting AIDS. Back then I slept with men because I didn't know that sex was a bad thing.

These excerpts highlight the existence of an interface between delusions and religious convictions. For example, the pastor in the transcripts identified the devil as a spiritual force. However, an individual may take the concept a step further and perceive the devil as a physical person or entity that she sees and hears. In some cases the division between delusions (false, fixed beliefs held by an individual) and shared faith-based beliefs are not easily separated. This can cause either comfort or distress for individuals with psychosis depending on the context.

Spiritism Four participants indicated that they practice spiritism. One participant kept dolls that she believed would help individuals become pregnant. A family member regularly consulted with *brujos* (witches) for advice about her romantic affairs and to cast spells on the men to whom she was attracted. Another participant explained that her relationship with her sexual partner had ended because a woman "did witchcraft and put a spell on me."

Puerto Rico has a long history of reliance on popular healers, such as *brujos*, and many individuals who practice *espiritismo* (spiritism) do so simultaneously with another faith, such as Catholicism.^{43,67} The practice of *espiritismo* may include rituals that are modeled after church rituals, such as the maintenance of small altars, prayers, and the recitation of the rosary.⁶⁷

The practice of *espiritismo* was important for these participants, who also practice other faiths and attended church services. They seemed to rely on these practices to give them a sense of control over uncontrollable events or persons or to provide explanations where they had none.

Religious or Spiritual Belief as a Coping Strategy Research suggests that many psychiatric patients consider themselves spiritual or religious and rely on religion as a source of strength.^{49,68,69} Twenty percent of our participants reported that they turn to God to help manage their mental illness symptoms. One woman explained

how she sought God's assistance: "Everything comes out wrong. I did not sleep crying and I pleaded with God to take the stuff [voices] out of my mind. I am thinking about how to kill myself." On another occasion, she described how she prayed for relief: "It's one voice and it's always the same voice. I stayed up praying for God to take those thoughts away." Another woman described her use of prayer:

It's been seven year. The monster can still come out. By saying the monster I refer to the [mental] illness. One minute I can fall. My guards have to be up at all time For the grace of God I pray.

Others attributed their survival to God's intervention. One woman, hospitalized following another suicide attempt, remarked,

God has done wonders for me because with me being so small, those 11 pills should of killed me. The only thing they did was make me dizzy. Muchas veces traté de intentar contra mi vida. [Many times, I have made attempts against my life.] I know that I am here because of God's grace.

A belief in God gave many participants hope that they thought they would not otherwise have. One woman's explanation is representative of the comments made by several:

God tells you not to worry about tomorrow because tomorrow is not promised. The birds don't have any clothes but God provides. We are his children and he will provide. Sometimes we feel sad because we are human, but you ask God and you will feel better.

Some spoke of God's forgiveness, despite their past deeds. One woman said,

I met God and I like going to church I feel God knowing me. He has mercy over me. I'm serving God for my salvation ... I want to go to heaven.

One-eighth of our participants indicated that their belief in God gave them a sense of purpose and meaning despite their mental illness and life's difficulties and helped them to make decisions. One woman stated, "Maybe God has something planned for me." Another stated simply, "God has something for me."

The Influence of Religious and Spiritual Belief in the Decision-Making Process Spirituality and religion may indirectly influence health by steering individuals away from risky or inappropriate behaviors,^{70,71} or assisting them in their recovery efforts.⁷² A perception that outcomes are just and can be controlled by personal behavior may support efforts to reduce HIV risk behaviors.⁷³ Faith or spiritual beliefs and practices, such as prayer, may be important for some individuals in their efforts to remain abstinent from substance use and to avoid risk behaviors for HIV infection.^{72,74,75}

One-third of our study participants indicated that they had changed their behavior because of their faith's or church's proscriptions. New behaviors included

several that may decrease HIV risk: abstaining from sex outside of marriage, refusing to engage in sexual relations with drug-using partners, and refraining from substance use. One woman explained her decision to marry:

I always had money to party. Whenever I didn't have it I would find it. My sister used to work the cash register at a store and we would steal the money to party. My friends would all chip in for the liquor so we can all have fun. We would also stay at hotels I will never go back to those days because now I'm a different person. I have God ... with me. I know in order for me to be right with God I need to get married. I'm living in fornication. Yes, when you live with someone without marriage.

However, this participant's decision to engage in sex only within marriage reduced her HIV risk only to the extent that she and her husband both refrained from sexual relations outside of marriage. Many women have believed that they were in monogamous relationships, only to find later that they had contracted HIV from their husbands or other sexual partners, who had professed monogamy.

Several participants reported that, because they had turned to God, they had been able to stop drinking and using drugs. One woman who had previously been involved with a married man explained, "Before I was in the church I was a different person but I repented for the things I had done and gave my life to Christ." Another reflected,

When I was in the ... you smoke, you drink, you think you are happy. I met God and I like going to church. I feel God knowing me. He has mercy over me. I'm serving God for salvation I want to go to heaven.

Prayer, in particular, appeared to help many of the women continue with their new directions. One woman commented, "I pray so I won't go back ... To drugs, alcohol, and bad stuff ... I'm not taking pills."

Religion, Spirituality, and Social Support Many participants received material support from their churches or members of the church congregations, such as clothing or food. One woman received a donation of clothing from her Catholic church that enabled her to enjoy Thanksgiving. Participants who were members of a congregation often turned to their churches when they needed food.

Other women received emotional support and encouragement from their churches to make positive changes in their lives. One participant recounted how she had effected change in her life through the support of her pastor: "The pastor came over and told me God loves me. I'm getting ready to go back to church. He came by and help with some things." She also received referrals from her pastor for financial assistance with housing and utilities.

DISCUSSION

Our findings are limited by the small sample size and the focus on SMI persons of a particular sex, ethnicity, and educational level. Participants' relatively low level of income is common to many SMI, who often have difficulty maintaining employment because of illness symptoms. Nevertheless, our data suggest that in-

cluding a spirituality/religiosity component in HIV prevention programs designed for Latinas may be critical to the initiation and maintenance of risk reduction behaviors, e.g., reducing the number of sexual partners and abstaining from drug use.

Including a spiritual component in such programs may encourage Hispanic SMI participants to utilize their religious and spiritual beliefs in coping. Coping may include self-acceptance regardless of past actions (e.g., substance use); identification of effective strategies to address the challenges of mental illness (e.g., medication management adherence, social isolation, unstable living circumstances); and the development of skills to identify and effectively address situations that may heighten HIV risk.

Many of our participants used religious precepts to establish behavioral standards for themselves. The incorporation of spiritual or religious routines into daily living regimens may provide SMI persons with structure and predictability in their lives, which are often characterized by disorganization and unpredictability. Gradually, the increased predictability and structure may help to decrease impulsivity, establish boundaries, and reduce HIV risk behaviors.

Participation in spiritual or religious activities with others may also provide a sense of community for SMI individuals who have been socially isolated, institutionalized, or victimized in exploitative relationships.⁷⁶ The resulting social support may help individuals to transform their core identity from that of victimized mentally ill persons to that of loved and valued individuals. This metamorphosis may be critical to the development of a sense of self-efficacy in decisionmaking. This enhanced sense of community may be particularly important to Hispanic SMI who may have lost a sense of community or support as the result of migration. The development of a healthy social support system may provide assistance with tangible needs, thereby reducing the need to engage in survival behaviors that may increase HIV risk, such as trading sex for food, shelter, or safety.

The inclusion of spiritual elements into HIV prevention efforts with SMI will present substantial challenges to the individuals responsible for such programs, including social workers, HIV educators, and nurses. Many patients may not willingly divulge information about their religious beliefs. A study of spirituality and religious practices among patients with schizophrenia and their clinicians found that most patients identified religion as an important aspect of their lives, but only slightly more than one-third had so advised their clinicians, and the perceptions of most clinicians regarding the patients' religious practices were inaccurate.⁴⁴ Variations in behavioral norms exist across faiths and among individuals of the same faith. Accordingly, the spiritual components of an HIV prevention intervention must encompass elements of faith that may be common to a wide range of individuals and be sufficiently broad to suggest and allow diversity of belief, including a conceptualization of spirituality that does not require a belief in a higher power.

Although some SMI may benefit from their involvement with a faith community,⁷⁷ others may experience a deepening sense of guilt or rejection.^{49,78} Latina SMI, in particular, may face potential rejection from their communities if they are unable to fulfill social role expectations.^{79,80} Still others may experience psychotic symptoms, such as delusions or hallucinations, that are reflective of their religious beliefs.^{44,49,64} Practitioners must have sufficient familiarity with the relevant religious precepts to allow them to distinguish their patients' religious beliefs and rituals from delusions and compulsions.^{81,82}

Including a religious history in the initial assessment of individuals beginning counseling or therapy is one strategy to gain this knowledge.^{76,83,84} This history may include information about the individual's religious background and the meanings that the individual attaches to various religious symbols, beliefs and rituals. In the context of group work, relevant spiritual issues may be explored through sensitive discussions that focus on participants' views regarding connections between people and/or a divine presence and responsibility towards others.

Many of our participants relied on their churches and church activities for support and assistance, which suggests that collaborations with clergy members may be a useful strategy to broaden and enhance HIV prevention efforts. This may present challenges in some circumstances, as evidenced by both the difficulties that several of our participants encountered with their clergy and previous research findings. One study of 147 patients diagnosed with bipolar disorder reported that 19% had received conflicting advice from their physicians and their spiritual advisers regarding the need for medications.⁵² Another study of 100 outpatient participants with schizophrenia reported that a proportion believed that their religious practice was incompatible with treatment.⁸⁶

The inclusion of spiritual issues in HIV prevention with SMI efforts raises significant ethical issues for the therapist or educator.^{49,60,87} Therapists, counselors, and HIV educators utilizing spiritual beliefs as a strategy in such efforts must examine and address their own spiritual and religious issues and conflicts outside of the counseling/education context.⁸⁸ Discussions of spiritual issues with clients must be done in a manner that does not seek to have clients redefine or reinterpret their religious beliefs.

Our findings support the importance of allowing the client/patient to speak in her own words. Although *ataques de nervios* has been identified as a common idiom of distress among Hispanics⁸⁵ and we utilized this term in our recruitment materials, none of our participants utilized this phrase or referred to this construct in speaking about their illness or illness experience. However, participants used the term *deprimida* frequently. This observation underscores the importance of utilizing grounded theory in research, in order to understand events and states of being from the participant's perspective and, in the research and clinical contexts, the danger of inadvertently imposing stereotypes and expectations on individuals based on knowledge of group characteristics.

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