THE RELATIONSHIP OF SELF TRANSCENDENCE, SOCIAL INTEREST, AND SPIRITUALITY TO WELL-BEING IN HIV/AIDS ADULTS

by

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This dissertation was prepared under the direction of the candidate’s dissertation advisor, Dr. Paul Peluso, Department of Counselor Education, and has been approved by the members of his supervisory committee. It was submitted to the faculty of the College of Education and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

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This study investigates the relationship of three protective factors: self-transcendence, social interest, and spirituality to well-being among adults living with HIV or AIDS. It is the first study to explore the relationships of these protective factors to well-being. A convenience sample of 115 adults living with HIV or AIDS completed the Self-Transcendence Scale, the Social Interest Index- Short Form-Revised, the Spiritual Perspective Scale, and the Index of Well-Being. The participants were adults diagnosed with HIV or AIDS residing in a large southeastern U.S. city. Data were analyzed with correlational and multiple regression methods. Statistically significant positive moderate to strong relationships were found between well-being and self-transcendence ($r= .66$, $p<.001$), social interest ($r= .51$, $p<.001$), and spirituality ($r= .39$, $p<.001$). A stepwise regression demonstrated that self-transcendence held the highest variance on well-being among the three protective factors (43%). Additionally, Self-transcendence and social interest accounted for 45% of the variance in well-being. In
short, the hypothesized positive relationship among these protective factors with well-being was supported. This study provides theoretical and empirical support for linking self transcendence, social interest, and spirituality to well-being among adults living with HIV or AIDS. The clinical implications of these findings are also discussed.
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CHAPTER ONE
INTRODUCTION

Human Immunodeficiency Virus (HIV) is a serious and worsening worldwide epidemic with significant economic and political consequences. Approximately 1,106,400 Americans are living with diagnosed or undiagnosed HIV/AIDS (Center for Disease Control and Prevention, 2010). In 2009, the U.S. federal government spent an estimated 12.3 billion dollars on HIV care and treatment (2010). HIV continues to be a major cause of mortality in the United States. Within a decade of the identification of HIV in 1983, the disease had reached pandemic proportions globally. While the use of antiretroviral medications continue to help individuals with HIV/AIDS live longer, approximately 50,000 Americans die every year of HIV related illnesses (Center for Disease Control and Prevention, 2006).

HIV/AIDS also has significant psychological and medical consequences, and unclear implications for the practice of counseling and psychotherapy. A recent study estimated that 50% of patients with HIV have significant depressive symptoms (Yi et al., 2006). These symptoms are associated with greater health worries, more HIV related symptoms, less social support, and lower spiritual well-being (2006). Swindells et al. (1999) found that health related quality of life among HIV–infected persons is determined by their satisfaction with social support, degree of hopelessness, and coping style.
Ironson, Stuetzle, and Fletcher (2006) reported that persons living with HIV/AIDS (PLWHA) who were depressed, saw their CD4 cells decrease twice as fast as those who were not depressed. CD4, or t-cells, are part of the body’s immune system that helps fight off viruses (such as HIV or AIDS) and tumors. They also found that a spiritual outlook on life may offset the negative immunological effects of depression or psychosocial stressors on individuals with HIV/AIDS. They reported that depression is a significant barrier to well-being in the HIV/AIDS population and that spirituality may be a key factor in maintaining and even restoring an overall sense of well-being.

HIV/AIDS raises many existential issues and often influences people to question “Why me?” or “What kind of God would do this to me?” (Tarakeshwar, Khan, & Sikkema, 2006). Many people with HIV/AIDS seek meaning or a greater understanding of their illness through spiritual and/or religious means (Koenig, McCullough, & Larson, 2001). Several studies demonstrated that individuals with HIV/AIDS who experience spiritual struggles are at risk for declined physical and mental health (Jenkins, 1995; Pargament et al., 2004; Cotton, Puchalski et al., 2006).

Psychosocial stressors were found to negatively impact the immune system functioning of individuals with HIV/AIDS which can increase disease progression (Ironson, Stuezle, Fletcher, and Ironson, 2006). Further, these researchers reported that individuals with HIV who felt abandoned by God after their diagnosis lost CD4 cells at a rate 4.5 times faster than individuals who relied on God to cope with their HIV diagnosis. They also found that participants who felt “abandoned by God” had an increase in their viral load. Viral load is the amount of HIV in a person’s body, which means that as viral load increases health usually declines. The Ironson study posited that turning to God, a
higher power, or spirituality appears to boost immune system functioning and fight
disease five times as effectively, compared to participants who rejected God, spirituality,
or a higher power.

Today, with early detection of HIV infection and highly active antiretroviral
therapy (HAART), the majority of HIV/AIDS patients are living longer (Reiter, 1998).
Researchers are becoming more conscious of the importance of well-being and quality of
life among persons with HIV. PLWHA are living longer as a result of medications, style
of life, and spirituality (Ramer, Johnson, Chan, & Barrett, 2006). Combination
antiretroviral medication therapies, such as highly active antiretroviral therapy (HAART)
have increased the survival rate for HIV/AIDS patients (Palella et al., 1998) allowing
individuals to live a median of 9 years longer (Morgan et al., 2002). As individuals with
HIV/AIDS continue to live longer, the need for further research on well-being is in high
demand.

The physical symptoms, social impact, emotional consequences, and economic
hardship of having HIV/AIDS takes a toll on an individual’s quality of life (Riedinger et
al., 2001). Threats to an individual’s sense of security, connectedness, and belonging are
important considerations in providing health care services to PLWHA. The infection of
HIV clearly affects a client’s overall sense of well-being. The ability of individuals to
achieve some sense of well-being may be related, to the utilization of protective factors
such as social interest, self transcendence, and spirituality. Protective factors enable
PLWHA to cope with challenges such as disability, stigmatization, spiritual crisis, and
declining health status.
Protective Factors

Protective factors are biological, psychological, social, spiritual, and/or environmental processes that influence the prevention of an adverse stressor, lessen its impact, or improve it more quickly (Gitterman, 2001). All people are susceptible to experiencing stress and/or adverse situations at any stage of life. In spite of vulnerabilities and risk factors, many people mature into adequately functioning, healthy, and happy adults. How individuals cope, adapt, and meet the challenges of life is in part, influenced by their utilization and presence of protective factors in their lives.

The capacity for individuals with HIV/AIDS to achieve and maintain a sense of well-being appears to be related to their utilization of their protective factors. Specifically, social interest, self transcendence, and spirituality are protective factors that can assist individuals in coping with adverse situations, so they can experience a higher level of well-being. While more adults with HIV/AIDS are living longer than any other time since the pandemic began, social interest, self transcendence, and spirituality may be the link to a quantitatively and qualitatively improved sense of well-being among individuals with this disease. Although each of these factors has been shown to have some baring on well-being, no previous study has considered the relationship among these factors as they influence an individual’s well-being.

Problem Statement

HIV is a serious and worsening problem with unclear implications for counseling and therapy. Medications, spirituality, social interest, and self transcendence appear to influence or reduce the morbidity of HIV. These changes have been demonstrated by markers such as well-being, and biomarkers of HIV/AIDS such as CD4 and viral load.
Protective factors such as self transcendence, social interest, and spirituality conceptualized as spiritual perspective, are variables that are linked to well-being. Further study of these variables among the HIV/AIDS population will add to the research on protective factors and the importance of incorporating them in psychotherapy practice. So far, research has examined the influences of only one or two of these variables and their impact on HIV/AIDS patients in regard to their sense of well-being. These findings appear to have little or no place in counseling practice with the HIV/AIDS population.

Contribution of the Study

This dissertation study is expected to make the following contributions to research and clinical literature:

1. To examine the combined effect of three variables (spiritual perspective, social interest, and self transcendence) on well-being in HIV/AIDS adults. The combined effect on well-being has not previously been studied and reported.

2. To provide clarity of the operational definitions of self transcendence, spiritual perspective, well-being, and social interest as they relate to well-being in HIV/AIDS adults. Currently, there is considerable conceptual and definitional overlap among these variables, which results in unnecessary confusion and delimits construct validity. Presumably, this study has the potential of adding definitional clarity.

3. To extend the research literature pertaining to the impact of protective factors among HIV/AIDS adults and how it is translated to counseling practice. While
these variables have been studied individually, this is the first study to examine their collective impact.

4. To expand the clinical literature regarding the various counseling implications of these variables. Incorporating these variables (as protective factors) in counseling practice with HIV/AIDS adults can reduce unnecessary suffering and declining health status.

5. To assess the Adlerian Psychology construct of social interest in a population of HIV/AIDS adults. This study offers the first investigation of social interest with the HIV/AIDS population.

Research Questions and Purpose of the Study

The purpose of this study is to explore the relationships of self transcendence, social interest, and spirituality to well-being of adults with HIV/AIDS.

Research Questions

The research questions are derived from the theories of self transcendence, spiritual perspective, and social interest for the purpose of examining the significance of self-transcendence, social interest, and spiritual perspective to well-being of PLWHA.

The research questions are:

1. What are the relationships between self transcendence, social interest, spiritual perspective, and well-being in adults with HIV/AIDS?

2. Which of these variables (self transcendence, social interest, and spiritual perspective) best explain wellbeing in PLWHA?

Hypotheses

Hypothesis 1:
H₀: There will be no significant relationship among the variables of self transcendence, social interest, and spiritual perspective to well-being in PLWHA.

Hₐ: There will be a significant relationship among the variables of self transcendence, social interest, spiritual perspective, and well-being in PLWHA.

Hypothesis 2:

H₀₂: Self transcendence, social interest, and spiritual perspective together will not explain wellbeing in PLWHA.

Hₐ₂: Self transcendence, social interest, and spiritual perspective together will explain a significant amount of variance of well-being in PLWHA.

Definitions

*Human Immunodeficiency Virus (HIV):* HIV is a viral infection that has a progressive detriment to the body’s immune system. CD4 and viral load are two biological measures or “biomarkers” that measure the amount of HIV in an individual’s body. Individuals with HIV have a CD4 or t-cell count above 200 cells per cubic milliliter of blood. CD4 cells, or t-cells, are part of the body’s immune system that help fight off viruses and tumors (Hagerty, 2009). The HIV virus attacks the CD4 cells or “fighter cells” which weakens the body’s immune system. A higher CD4 cell count in an individual results in a higher level of immunity to HIV. The amount of HIV within an individual’s system is called the HIV viral load. An increase in viral load correlates with a decrease in health and immunity.

The Center for Disease Control and Prevention (1993) identified three categories of HIV infection, specifically: asymptomatic, symptomatic, and AIDS related conditions. The asymptomatic stage includes HIV individuals with a CD4 count of 200 cells per
cubic milliliter of blood or above, without any HIV symptoms (category A). The
symptomatic group includes HIV individuals with a CD4 count between 200 and 500
cells per cubic milliliter of blood, with an HIV symptom (category B). Category C
consists of individuals who have AIDS as indicated by a CD4 count below 200 cells, with
the presence of one or more AIDS-related illnesses.

**Acquired Immunodeficiency Syndrome (AIDS):** AIDS is the progression of HIV in
which can be accounted for with a t-cell count of 200 or below and/or the presence of 2
or more AIDS-related illnesses. Viral loads are often in the range of 100,000 and above
among individuals with AIDS.

**Self Transcendence:** This refers to expanded boundaries of the self. This study is
based on Reed’s (1991a, 2003, and 2009) theory of self transcendence in which self
transcendence was found to influence well-being among individuals who face adverse
life experiences or mortality as measured by the Self Transcendence Scale (STS). Reed
defines Self transcendence as “a characteristic of developmental maturity whereby there
is an expansion of self-boundaries and an orientation toward broadened life perspective
and purposes” (1991b, p. 64). Examples include finding meaning and value in past and
present life experiences, connecting with others by helping and receiving help, reaching
out to a higher entity or purpose, having an interest in learning, living fully in the present,
and being able to adjust to difficult situations (Reed, 1991b, 2003, 2009).

**Spirituality:** Spirituality is “an awareness of one’s inner self and a sense of
connection to a higher being, nature, others, or to some purpose greater than oneself”
(Reed, 1991b, p.74). This study will observe Reed’s definition of spirituality as
conceptualized by spiritual perspective. Spiritual perspective refers to a sense of
connection with a purpose or dimension greater than the self that empowers the self (Reed, 1992) as measured by the Spiritual Perspective Scale (SPS).

**Social Interest:** This is defined as “one’s willingness to participate in the give-and-take of life and to cooperate with others” (Carlson, Watts, & Maniaci, 2006). Social interest refers to the construct Alfred Adler called, *Gemeinschaftsgefühl* (Ansbacher, 1991), which is translated as “social feeling, community feeling, fellow feeling, sense of solidarity, communal intuition, community interest, social sense, and social interest” (Ansbacher & Ansbacher, 1956, p. 134). The term is ultimately a feeling of connectedness and belonging that individuals have with one another.

**Well-being:** Well-being is a subjective experience of overall life satisfaction with one’s current life situation (Campbell, Converse, & Rogers, 1976). Well-being has physical, social, spiritual, and/or psychological dimensions, but this particular study will focus specifically on well-being as defined as a person’s subjective cognitive and affective evaluation of his or her own life situation. This dimension of well-being is defined as subjective life satisfaction with one’s current life situation.

**Protective Factors:** These are biological, psychological, social, spiritual, and/or environmental processes that influence the prevention of an adverse stressor on a person, and lessen its impact more quickly (Gitterman, 2001).

**Limitations**

The following limitations of this study are imposed by the researcher:

- The researcher is an employee at the agency from which the data is to be collected.

The following limitations of this study are imposed by the situation:
The self-report element of each of the independent variables. A concern with responses to the inventories is social desirability. Social desirability can cause threats to the validity of the data.

The data will be collected from a non-probability convenience sample from only one agency.

The instruments are all written in English. The participants who speak only Creole, Spanish, or any other language will not be able to participate in this study.

Study Design

This study intends to examine the relationship of self transcendence, social interest, and spirituality to well-being of adults with HIV/AIDS. The researcher will sample participants with paper and pencil inventories in a private interviewing room at the HIV/AIDS affiliated agency. A descriptive, correlational study will be implemented. Data will be analyzed using descriptive and correlational statistics and a multiple regression.

Dependent Variable

The following dependent variable will be included in the study:

- Perceived well-being as measured by the Index of Well-Being (IWB), a self report.

Independent Variables

The following independent variables will be included in the study:

- Self transcendence as measured by the Self Transcendence Scale (STS), a self report.
Spiritual Perspective as measured by the Spiritual Perspective Scale (SPS), a self report.

Social Interest as measured by a revised version of the Social Interest Index-Short Form- Revised (SII-SF-R), a self report.

Summary and Organization of the Study

Aside from the physical symptoms of HIV and AIDS, the social impact, emotional consequences, related stigma, and economic hardship of being positive for HIV/AIDS can take a toll on an individual’s quality of life (Riedinger et al., 2001). Social interest, self transcendence, and spirituality are protective factors that can allow individuals to cope with adverse situations and also experience a higher level of well-being. So far, research has examined the influences of only one or two of these variables and their impact on HIV/AIDS patients in regards to their quality of life and sense of well-being. This study will explore the relationships of self transcendence, social interest, and spirituality to well-being of adults with HIV/AIDS.

Transition Statement

The study is presented in five chapters. Chapter 1 introduces the study and explains the need for the research. Chapter 2 is a literature review that reports relevant research on well-being and quality of life among the HIV/AIDS populations. Literature on self transcendence, spirituality, and social interest will be discussed by defining each term, providing information about the competing models of each variable, and contrasting the similarities and differences among each variable. Research reporting the effects of each variable on well-being among chronically ill and PLWHA is also included. Chapter 3 consists of an explanation of the methodology for the study.
Psychometric information on all instruments is reported. Chapter 4 includes results from the study. Implications and limitations of the study are discussed in Chapter 5.
CHAPTER TWO
LITERATURE REVIEW

The rationale for a study of the relationship of self transcendence, social interest, and spirituality to well-being of adults living with HIV/AIDS was presented in Chapter 1. This chapter presents a review of literature linking the well-being of HIV/AIDS individuals to three independent variables, self transcendence, social interest, and spirituality. The chapter also reviews empirical studies which provide support for these theoretical linkages. The chapter concludes with a rationale for the need of a study that examines the relationship of self transcendence, social interest, and spirituality to well-being of adults living with HIV/AIDS.

Well-being

Well-being is a subjective experience of overall life satisfaction with an individual’s current life situation (Campbell et al., 1976). This section includes definitions of well-being, research on well-being in the HIV/AIDS population, and implications of stress on the well-being among PLWHA. It also discusses the influence of protective factors on well-being among PLWHA.

Defining Well-being

Well-being refers to the subjective evaluation of an individual’s health and wellness. Cloninger (2004) defined well-being as “a stable condition of coherence of personality that leads to a full range of emotions and no negative emotions regardless of
external circumstances” (p. 8). Essential to well-being is coherence, which is defined as
the integration of the body, mind, and spirit (Cloninger, 2004). He posits that any
treatment that ignores any aspect of the body, mind, and spirit are inadequate to facilitate
the development of biopsychosocial health and well-being.

Myers, Sweeney, and Witmer (2000) defined wellness with an incorporation of
well-being from a counseling perspective as:

a way of life oriented toward optimal health and well-being, in which body, mind,
and spirit are integrated by the individual to live life more fully within the human
and natural community. Ideally, it is the optimum state of health and well-being
that each individual is capable of achieving. (p. 252)

Recently, well-being has become central to the movement known as positive
psychology (Diener, 2000; Seligman, 2002). Specifically, well-being is defined as a
person’s subjective cognitive and affective evaluation of his or her own life situation
(Campbell et al., 1976). From the positive psychology perspective, well-being is based
on an individual’s experience of physical and psychological health.

Carol Ryff linked biological correlates (cardiovascular, neuroendocrine, and
immune system functioning) of psychological well-being to health benefits associated
with living a life with meaning and purpose, continued growth, and quality relationships
(Ryff & Singer, 2008). She has also developed a psychological well-being inventory that
measures psychological adjustment (Ryff & Singer, 1996). Ryff’s well-being measure is
a cognitive adaption inventory that measures a person’s ability to positively evaluate
themselves, find meaning and purpose in life, and have a sense of mastery and self-
determination. Ryff distinguishes between hedonic well-being (moods and feelings) and
eudaimonic well-being, which is related to having purpose in life, continued personal
growth and development, and good relationships with others. In short, Ryff (1989) and
Ryff and Singer (1996) have incorporated theories that measure health and well-being
beyond the “absence of illness.”

Ryff’s current, ongoing study may be the most ambitious research ever conducted
on well-being. Named the Midlife in the United States, or MIDUS II study (Reichhardt,
2006), it assesses adult well-being and health. Research may determine whether well-
being or ill-being (depression, anxiety and so on) have distinct biological correlates, or
whether well-being or ill-being are essentially opposite ends of the same psychological
continuum (Reichhardt, 2006). By measuring hormone levels, immune-system
functioning, and blood pressure levels, Ryff continues to expand the research basis of the
physiological underpinnings of psychological well-being and distress. While interesting
and somewhat similar to the construct of well-being utilized in this dissertation, it should
be noted that Ryff’s research has not yet been extended to the HIV/AIDS population.

Finally, Runquist and Reed (2007) reported that well-being can be influenced by
physical, social, spiritual, and/or psychological realms. Specifically, well-being is defined
based on the dimension of health that an individual finds most important. The scope of
this study operationalizes well-being as an affective and cognitive variable measured by
the “Index of Well-being” (Campbell et al., 1976) and is based on the dimension of
health that an individual finds most important.

Well-being in the HIV/AIDS Population

As individuals with HIV/AIDS continue to live longer, research in the area of
well-being with this population becomes increasingly important. While approximately
50,000 Americans die every year of HIV related conditions (Center for Disease Control and Prevention, 2006) the majority of HIV/AIDS patients are living longer with the assistance of antiretroviral medications (Reiter, 1998). Aside from the physical discomfort of the progression of HIV and AIDS, the social impact, emotional consequences, related stigma and economic hardship of having HIV/AIDS can take a toll on an individual’s quality of life (Riedinger et al., 2001). Not surprisingly, quality of life has become an essential component in the evaluation of an individual’s well-being with HIV. Improving quality of life and well-being are the premier goals in psychological and medical treatment of HIV/AIDS individuals. Thus, it is important to identify which area of an individual’s life is most affected by HIV/AIDS (Rai, Dutta, & Gulati, 2010).

Well-being and quality of life issues of HIV/AIDS individuals can be influenced by their experience of physical symptoms, the social impact, emotional consequences, and other biopsychosocial and spiritual stressors. Grant and De Cock (2001) reported that physical illness can have adverse effects on the well-being of individuals living with HIV/AIDS. Rai, Dutta, and Gulati (2010) investigated quality of life among PLWHA (n=90) across different stages of HIV and found that asymptomatic HIV-infected participants reported a higher quality of life as compared to individuals that were symptomatic or AIDS, who reported a lower level of quality of life. The above studies established an empirical link between physical health and well-being in PLWHA, and also identified different variables that influence well-being.

Long-term nonprogressors are people with HIV who live many years with minimal increase in their HIV biomarkers and minimal decline in their sense of well-being. Long-term nonprogressors with HIV are an important group of individuals to
observe when considering well-being among PLWHA because they often utilize many of the available protective factors that enhance their biopsychosocial and spiritual health. 

Individuals with HIV can progress to AIDS due to an unhealthy lifestyle, and various environmental and psychological stressors.

Barroso (1999) interviewed 25 men and women (age 25-59) who were long-term nonprogressors who were HIV positive for 7 or more years, CD4 cell count greater than 500, and no reported opportunistic infections. Barroso's study identified themes of active utilization of psychological, social, and environmental protective factors, including spirituality, human connectedness, and active physical and emotional self care. The study represented significant themes from the psychological domain of protective factors, such as having strategies to adapt HIV into their lives and having the belief that HIV is a manageable illness. This research demonstrates that active coping skills are linked to improving and maintaining well-being and quality of life among the HIV/AIDS population. In short, active utilization of protective factors appears to be a commonality among nonprogressors (Barroso, 1999).

Stress and Well-being among PLWHA

Stigmas associated with HIV/AIDS, contribute to anxiety, depression, and interpersonal distrust (Rai et al., 2010). The social and emotional impact of feeling alienated due to perceived societal views impacts the well-being of individuals who have HIV/AIDS. Sowell, Moneyham, Hennessy, Guillory et al. (2000) conducted a study with 184 HIV positive women and found that HIV related stressors have significant negative effects on quality of life and emotional distress. Other research reported that HIV stigma and the lack of social support can lead to suicide, increased rates of depression, and a
decrease in preventative behaviors (e.g. use of condoms) (Brown, Macintyre, & Trujillo, 2003).

Stress has been demonstrated to have other effects on PLWHA. For instance, a study observing cortisol (stress hormone) levels of 40 HIV-positive men and women reported that the group of participants with increased cortisol levels had a tendency towards higher depression, higher anxiety levels, and higher HIV viral load (Barroso et al., 2006). A similar study (n=96) reported that participants who scored higher anger scores were associated with higher cortisol levels, and faster progression towards AIDS (Lesserman et al., 2002). PLWHA who experience stress are at risk for a decrease in well-being, while individuals who actively cope with stressors and practice well-being promotion can enhance their biopsychosocial health.

Protective Factors

Protective factors are biological, psychological, social, spiritual, and environmental processes that influence the prevention of an adverse stressor, lessen its impact, or improve it more quickly (Gitterman, 2001). This section describes these factors and their effects. Protective factors are included in this study because they are processes that promote well-being among PLWHA.

Ryff, Singer, Love, and Essex (1998) identified three categories of protective factors: psychological factors, social or relational factors, and sociological or environmental buffers (Table 1). The first protective factor area is psychological, which refers to how an individual copes and responds to challenges or adversity in life. The second area is social or relational factors such as family, peers, and other social supports.
### Table 1

**Protective Factors and Buffers in a Client’s Life**

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<thead>
<tr>
<th>Client Domain</th>
<th>Protective Factors and Buffers</th>
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<tr>
<td><strong>Psychological Factors</strong></td>
<td>Spirituality</td>
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<td>Sense of Belonging</td>
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<td>Flexibility</td>
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<td>Range of problem solving skills</td>
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<td>Self-esteem</td>
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<td>Feeling useful, valuable</td>
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<td>Sense of potency</td>
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<td>Compensatory strengths</td>
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<td>Sense of humor</td>
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<td><strong>Social, or Relational, Factors</strong></td>
<td>Family Characterized as psychologically healthy, communicative, stable, and supportive</td>
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<td>Adaptive family belief systems, organizational patterns, and communication processes</td>
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<td></td>
<td>Performs well in academic and/or vocational settings</td>
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<td></td>
<td>Positive, supportive peer and/or intimate partner relationships</td>
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<tr>
<td><strong>Sociological or Environmental Buffers</strong></td>
<td>Network of community relationships</td>
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<td></td>
<td>Available and appropriate professional resources and knowledge about how to access help</td>
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<td></td>
<td>Adequate environmental resources (such as housing, transportation, food)</td>
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<td></td>
<td>Supportive ethnic/cultural belief system and values</td>
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The third area is sociological or environment factors, which are referred to as social buffers. Examples of social buffers are resources, community relationships, ethnic/cultural belief systems and values, and social structures and institutions. The domains of protective factors listed below act as buffers to enhance people’s abilities to cope with life’s stressors, transitions, and challenges (Ryff, Singer, Love, & Essex, 1998).

Sagor (1993, 2002) described the experiences of children who continued to persevere despite the numerous challenges and obstacles in their lives. Sagor’s results exemplify the psychological and relational dimensions of protective factors (1993, 2002). He reported that the children he observed had the following personality characteristics: a sense of belonging, feeling useful and valuable, a sense of autonomy (described as the confidence in their ability to change what occurs in their lives), and an optimistic attitude.

Research on resilience and protective factors has become increasingly important in mental health literature. Early research on protective factors promotes that counselors should assess and take note of client’s protective factors, as they improve outcomes (Rutter, 1985, 1987, 1988). In addition, protective factors have been shown to interact with risk factors and influence positive outcomes (Rutter & Caesar, 1991; Zimmerman & Arunkumar, 1994). The specific protective factor domains that are relevant to this study are specifically psychological (spirituality and sense of belonging), relational factors (support groups, family, supportive peers and/or intimate partner relationship), and environmental factors (HIV/AIDS agencies, church, and spiritually related groups). These protective factors parallel the independent variables in this study: social interest, self transcendence, and spirituality, conceptualized as spiritual perspective.
In summary, HIV related stressors are linked to a decline in well-being (Sowell, Moneyham, Hennessy, Guillory et al. 2000) and are also linked to anxiety, depression, and interpersonal distrust (Rai et al., 2010). The link between increased physical illness and decreasing quality of life was also reported (Rai et al., 2010). Barroso (1999) discussed protective factors that were linked to long-term nonprogressors with HIV. The independent variables in this study are protective factors that have each been linked to well-being or quality of life among PLWHA.

The following sections will highlight the literature discussing the studies linking one or two of the variables and will also discuss the usefulness in studying the relationship that spiritual perspective, social interest, and self transcendence have to well-being among PLWHA. The first protective factor that will be discussed is self transcendence.

**Self Transcendence**

This section reports various descriptions and definitions of self transcendence. The theoretical and empirical research relating self transcendence to chronic illness and well-being are identified. The links of self transcendence and spirituality are also explored. Finally, empirical and theoretical links of self transcendence to chronically ill populations and PLWHA are identified.

Victor Frankl’s (1946) writings offered that an individual’s optimal functioning when encountering adversity depends on that individual’s ability to find meaning in challenge and suffering, and to find a transcendent or spiritual purpose. Frankl’s experience of self transcendence parallels that of Reed’s theory of self transcendence. Both definitions are related to a person’s ability to step out of a subjective experience to
find meaning in adverse life situations. Reed’s (1991a, 2003, 2009) theory of self transcendence refers to expanded boundaries of the self. Reed defines self transcendence as “a characteristic of developmental maturity whereby there is an expansion of self-boundaries and an orientation toward broadened life perspective and purposes” (1991b, p. 64).

Reed’s definition of self transcendence was initially defined as a developmentally based resource for mental health among older adults (1991a). Her research in the mental health nursing literature on self transcendence has grown over the past two decades and has been applied to various populations, and cultures. Reed stated that “The theory of self transcendence was developed in part from theoretical, empirical, and clinical knowledge, as well as a philosophical belief in the enduring human potential for well being” (Reed, 2009, p. 397). Runquist and Reed (2007) reported that the theory of self transcendence is based on the assumption of an individual’s potential for development and creative use of existing resources (e.g. spirituality and self transcendence) to achieve a sense of well-being.

Transcending an individual’s physical limitations when confronted with illness often influences them to seek well-being. Reed’s (2009) self transcendence theory posits that individuals who face vulnerability or mortality develop a capacity for self transcendence, which has a positive influence on well-being and mental health. Individuals who are faced with mortality or adverse situations can cope with situations using self transcendent behaviors or attitudes to relieve their anxieties or fears. An example that can foster self transcendence to be activated is receiving news of an HIV or cancer diagnosis. The premature fear of death from a cancer or HIV diagnosis can
influence a high level of stress on individuals, which can foster an increased sense of spirituality and self transcendence. Reed (1991b, 2003) offered examples of self transcendent behaviors and attitudes, including adjusting to difficulty, having an interest in learning, connecting with others by helping and receiving help, and finding meaning and value in the past and present life. Reed reported that self transcendence is greater among people who are facing end-of-life issues and that self transcendence is positively correlated with well-being (Reed, 1991b).

Hamer (2004) defined self transcendence as a term that describes spiritual feelings independent of traditional religiousness; specifically, the nature of the universe and a person’s place in it. Hamer discussed self transcendence:

Self transcendent individuals tend to see everything including themselves, as a part of one great totality. They have a strong sense of “at-one-ness” of the connections between people, places, and things. Non-transcendent people, on the other hand, tend to have a more self-centered viewpoint. They focus on differences and discrepancies between people, places, and things, rather than similarities and interrelationships. (p. 18)

Cloninger (1994) defines self transcendence as a character trait and created a self transcendence scale alongside several other scales that measure personality. Cloninger identified personality as temperament and character, which can be measured in his seven-factor model, the Temperament and Character Inventory (TCI). Cloninger’s TCI (1994) is a psychobiological model of personality that monitors both temperament (novelty seeking, harm avoidance, reward dependence, and persistence) and character (self directedness, cooperativeness, and self transcendence).
Cloninger postulated that personality is made up of temperament and character. Temperament is the components of personality that are heritable, developmentally stable, emotion based, and uninfluenced by sociocultural learning (Cloninger, 1994). Character is what people make of themselves intentionally (Kant, 1796) and is a reflection of an individual’s goals and values. Cloninger’s TCI measures self directedness (i.e. responsible, purposeful, resourceful), cooperativeness (i.e. tolerant, helpful, compassionate) which are character traits. It also measures novelty seeking (i.e. impulsive, extravagant, disorderly), reward dependence (sensitive to social clues and dependent on responses of others), and persistence (i.e. diligent, hard working, overachieving) which are temperament traits. Cloninger identified that individuals scoring high in self directedness, self transcendence, and cooperativeness tend to experience more positive emotions and experience fewer negative emotions (2006).

Self transcendence according to Cloninger’s TCI-ST has three sub factors: self-forgetfulness (vs. self-conscious experience), transpersonal identification (vs. self-isolation), and spiritual acceptance (vs. rational materialism). Cloninger (2004) reported that individuals who score high on the character trait of self transcendence are judicious, idealistic, transpersonal, faithful, and spiritual. Individuals who score low are repressive, practical, dualistic, skeptical, and materialistic. Cloninger also discussed that individuals with mature personalities are most often self-directed, cooperative, and self transcendent (Cloninger, Svrakic, & Przybeck, 1993).

Cloninger (2006) postulated that spirituality is a critical component to well-being and that an individual’s level of spirituality and more specifically, self transcendence is an indicator of well-being. A healthy personality reflects increased scores on the three
character traits of Cloninger’s TCI, while low scores on the three traits are reflective of personality disorders. The character trait self transcendence was found to be to lower in psychiatric patients than adults in the general community (Svrakic, Whitehead, Przybeck, & Cloninger, 1993). It is useful to note that Cloninger defines self transcendence as a personality and temperament trait while Reed defines it as a developmental process (Levenson, Jennings, Aldwin, & Shiraisha, 2005).

Self Transcendence and Chronically Ill Populations

Self transcendence has been linked to well-being among chronically ill populations in a significant amount of empirical nursing research. Self transcendence was found to be correlated with positive life outcomes among people who are near the end of life (Chinen, 1986; Coward, 1990a, 1990b, 1991, 1994; Coward & Reed, 1996; Mellors, Riley, & Erlen, 1997; Reed, 1987, 1991b). Reed’s theory of self transcendence posits that engaging in self transcendent activities that expand personal boundaries can enhance well-being (1991a). Bean and Wagner (2006) discussed that self transcendence is a complex developmental process reflecting spiritual growth and maturity, while it is associated with positive life outcomes.

Coward and Reed (1996) discussed the process of healing that can occur through the use of self transcendence exemplified through the experience of a sixty year old woman with advanced breast cancer whose sense of well-being improved as a result of reaching beyond her own boundaries. Ellerman and Reed (2001) studied the relationship of self transcendence to depression in middle aged adults (n=133) and found a significant inverse correlation between both variables. The study reported that the younger subgroup scored significantly lower on the self transcendence measure than did the older
participants. Coward (1996) investigated self transcendence in a population of healthy 
adults (average age 46, range 19-85) and found a positive relationship between emotional 
well-being and two measures of self transcendence.

Mathews and Cook (2009) identified that during breast cancer treatment (n=93) 
the effects of optimism on emotional well-being were partially mediated by the 
participants level of self transcendence. Runquist and Reed (2007) found a strong, 
positive correlation between spiritual perspective, self transcendence, and well-being 
among 61 homeless adults. Runquist and Reed reported that self transcendence and 
health status explained 60% of the variance in well-being among the homeless adults 
sampled.

Self Transcendence and HIV

Having chronic health conditions such as cancer, HIV, and AIDS increases the 
need for a greater sense of connectedness to processes that transcend an individual’s 
current situation or limitations. Facilitating this awareness can enhance well-being among 
individuals with HIV/AIDS on a holistic level. Research links the significance of self 
transcendence across a wide range of human health conditions such as HIV/AIDS, breast 
and prostate cancer, chronic liver disease, advanced age and disability, and clinical 
depression, which present threats to physical and emotional well-being (e.g., Bean & 

Mellors, Riley, and Erlem (1997) conducted a study with 46 HIV/AIDS adults 
and reported that as self transcendence increased, quality of life increased among 
participants of all stages of HIV and AIDS. Mellors (1999) conducted a cross sectional
study with 50 persons living with AIDS, which revealed a positive relationship between self transcendence and quality of life. Ramer, Johnson, Chan, and Barrett (2006) studied 420 HIV/AIDS multicultural patients and found that self transcendence was significantly related to well-being. Coward (1994) conducted a qualitative study with 10 men and 10 women with AIDS and found that an increased sense of well-being correlated with self transcendent behaviors.

In summary, the research reported supports the positive influence that self transcendence has on well-being among chronically ill populations. The studies offered a link between increased self transcendence and emotional well-being of older adults (Reed, 1991b), HIV quality of life (Mellors, 1999; Mellors et al., 1997), emotional well-being among healthy adults (Coward, 1996), decreased depression among middle aged adults (Ellerman and Reed, 2001) and subjective well-being among homeless adults (Runquist and Reed, 2007). The link between self transcendence and well-being has been made in multiple populations including HIV/AIDS. The literature has yet to observe the relationships of self transcendence, spirituality, and social interest on well-being of HIV/AIDS adults.

Spirituality

The next protective factor discussed is spirituality. Operational definitions of spirituality are identified. This study will measure spirituality as conceptualized by spiritual perspective. A section on spiritual perspective is included in chapter 3. The links between spirituality, chronic illnesses, well-being, cortisol, and HIV/AIDS are identified. Spiritual changes experienced by PLWHA since being diagnosed are identified. This section will close with the contrast and comparison of self transcendence to spirituality.
Awareness of the basic human need to find meaning beyond oneself through spirituality supports the usefulness of incorporating spirituality in psychotherapy.

Defining Spirituality

Moberg (2002) reported that there are a variety of confusing definitions of spirituality and that the concept of spirituality is imprecise due to the broad range of definitions. Gray (2006) discussed that the lack of conceptual clarity for spirituality is a threat to construct validity. Cashwell (2005) offered that various definitions have arisen because spirituality means something different to each person. Holifield (1983) identified spirituality to be “less a method than an attitude, a posture of one’s very being that allows seeing not different things but everything differently” (p. 88). Elkins, Hedstrom, Hughes, Leaf, and Sanders (1988) discussed that spiritual values honor the sacredness of life, a balanced appreciation of material values, altruism, a desire for improving the world, and an awareness of the tragic side that life can possess.

Reed (1991b) defined spirituality as “an awareness of one’s inner self and a sense of connection to a higher being, nature, others, or to some purpose greater than oneself” (p. 74). Chandler, Holden, and Kolander (1992) defined spirituality as “any experience of transcendence of one’s former frame of reference that results in a greater knowledge and love” (p. 170). Booth (1992) identified spirituality as an “inner attitude that emphasizes energy, creative choice, and a powerful force for living” (p. 25). Cervantes and Ramirez (1992) proposed that spirituality includes the search for harmony and wholeness in the universe. Hinterkopf (1994) identified spirituality as something that is felt in the body, which involves an awareness of the transcendent life, which brings new meanings and leads to growth. Frame (2003) discussed that spirituality may or may not include a
Higher Power or Supreme Being. Spirituality is the process in which a person searches for meaning, purpose, and value in life (Frame, Uphold, Shehan, & Reid, 2005). While spirituality is difficult to operationally define due to its broad range of definitions, this researcher will use Reed’s (1986a) definition of spirituality because of its significance among individuals that are faced with chronic illnesses, and are reminded of their own mortality.

Spirituality signifies both the way an individual finds meaning in life, and in the many events that happen throughout one’s life. Frankl (1959) stated that an individual who loses his spiritual hold lets himself decline and becomes susceptible to mental and physical decay. McKay, Peate and Mansager (2009) suggested that questions such as “Why am I here”?, “Does it matter at all that I am here”? , “Why is there something instead of nothing”? , “How does it all work”? are questions at the heart of spirituality.

Spirituality can fit within the domain of religion, but is also a broader term that goes beyond the context of religion. Religion is defined through the lens of an organized faith with traditions, rituals, and values, while spirituality is defined as a search for meaning and purpose in life (McKay, Peate, & Mansager, 2009).

Spirituality and Chronic Illness

Receiving a positive HIV diagnosis is clearly a stressful and life changing event, which can be emotionally devastating. Spiritual beliefs have been found to be helpful coping resources to persons with chronic or terminal illnesses (Ramer et al., 2006). O’Neil and Kenny (1998) reported that spirituality is existential in meaning and composition, multidimensional, and is paramount to the well-being of chronically ill individuals. Spirituality is significant among terminally ill individuals because it
increases their awareness and ability to cope with the concept of mortality (Reed, 1986b). Somlai and Heckman (2000) reported that individuals with HIV/AIDS who had high levels of spirituality were associated with social support, active problem solving, and life satisfaction. The link between spirituality and well-being among individuals with chronic illnesses has been reported and growing research on spirituality and wellbeing is being extended to the HIV/AIDS population.

**Relationship of Well-being and Spirituality**

Paragament et al. (2004) reported that global measures of spirituality are increasingly associated with positive psychological outcomes. The study of the human need for spiritual meaning, with direct ties to well-being, continues to grow in current literature and research (Chin-A-Loy & Fernsler, 1998; Coward, 1990b, 1991, 1995; Coward & Lewis, 1993; Ellerman & Reed, 2001; Reed, 1986a, 1986b, 1987, 1989). Individuals with increased levels of spirituality are frequently noted as experiencing less physical illness and are also noted for recovering quicker from disease (Piedmont, Ciarrochi, Dy-Liacco, & Williams, 2009). Spiritual beliefs and practices appear to function as active coping mechanisms, which help individuals cope with adversity.

Reed (1987) conducted a study with 3 groups of 100 adults (aged 20-85) and found that terminally ill hospitalized adults reported higher levels of spirituality than non-terminally ill hospitalized adults and healthy non-hospitalized adults. Participants from the group of terminally ill group reported a change towards increased spirituality, while the healthy participants did not. Martin and Sachse (2002) studied spirituality characteristics of 28 kidney transplant patients, measured by Reed’s Spiritual Perspective Scale and Ellison’s (1983) Spiritual Well-Being Scale. The study indicated that high
levels of spirituality among participants had a moderate correlation between spiritual perspective and spiritual well-being. It was also reported that older participants had higher levels of spiritual perspective. Fryback and Reinert (1999) reported that individuals with potentially deadly diseases, such as HIV and breast cancer, who found spiritual meaning in their disease perceived an increased level of quality of life.

Yi et al. (2006) reported that higher spiritual well-being is associated with more social support, having fewer health worries, less discomfort with how one contracted HIV, and fewer HIV-related symptoms, and fewer depressive symptoms. Greene et al. (1999) sampled over 1,000 clients with HIV/AIDS and found that 56% found prayer helpful to their mental health. Forty-six percent identified meditation, 36% noted breathing exercises, and 33% mentioned spiritual activities as the most common practices that influenced their mental well-being. Somlai et al. (1996) found strong associations between spiritual dimensions and mental health, psychological adjustment, and coping among 65 PLWHA.

Dalmida, Holstad, Diiorio, and Laderman (2009) examined the associations of spiritual well-being, depressive symptoms, and CD4 cell count percentages among 129 HIV-positive African American women in a cross sectional study. They found positive associations between existential well-being, CD4 cell count, spiritual well-being, and religious well-being. Yi et al. (2006) reported that the majority of patients with HIV/AIDS also presented significant depressive symptoms in a study with 450 HIV/AIDS participants. Yi et al. identified that in multivariable analyses, lower spiritual well-being, less social support, having greater health worries, less comfort with how one
contracted HIV, and having more HIV-related symptoms, was linked with significant depressive symptoms.

Spiritual Changes Following HIV Diagnosis

Individuals who perceived an HIV diagnosis as a positive turning point were linked with having an enhanced spirituality after being diagnosed (Kremer, Ironson, & Kaplan, 2009). Participants in Kremer’s study who perceived themselves as hitting rock bottom with drugs or alcohol primarily viewed their HIV diagnosis as a “wake-up call” from a Higher Power or God to positively change their lives. Other studies also found that individuals with increased spirituality following their HIV diagnosis were associated with positive health outcomes (Ironson, Balbin et al., 2005; Ironson, O’Cleirigh et al., 2005; Ironson, Stuetzle, & Fletcher, 2006; Ironson, Stuetzle, Fletcher, & Ironson, 2006; Ironson, Solomon et al., 2002). Two key factors that were associated with viewing HIV as the most positive turning point in their lives were an enhanced spirituality after diagnosis, and feeling chosen by a Higher Power or God to have HIV (Kremer et al., 2009). Spirituality was reported to be linked to slower disease progression among individuals with HIV/AIDS (Hagerty, 2009). Among women with HIV, a link between engagement in spiritual activities is linked to decreased emotional stress (Sowell, Moneyham, Hennessey, Hennessy, Guillery et al., 2000), lower depression (Simoni & Ortiz, 2003), greater optimism (Biggar et al., 1999), and better psychological adaption (Simoni, Martone, & Kerwin, 2002).

Cotton, Tsevat et al. (2006) conducted a study with 347 adults with HIV or AIDS from 4 agency sites measuring the changes in religiousness and spirituality since receiving a diagnosis of HIV/AIDS. The study concluded that eighty-eight participants
(25%) identified being “more religious” and 142 (41%) identified being “more spiritual” since being diagnosis with HIV/AIDS. A total of 174 participants (50%) believed that their spirituality/religiousness helped them to live longer. Additionally, 1 in 4 participants reported that they felt more alienated by a religious group since their diagnosis. A similar study reported that spirituality/religion continues to be an important factor in how HIV/AIDS individuals perceive their quality of life (Tsevat et al., 2009). They concluded that many patients with HIV feel that their life is better than it was before their HIV/AIDS diagnosis.

Cotton, Puchalski et al. (2006) studied spirituality and religion characteristics in a large and diverse sample of 450 HIV/AIDS individuals. The study identified that 339 (75%) patients said that HIV/AIDS had strengthened their faith at least a little, and 143 (32%) engaged in prayer or meditation at least once a day. The researchers concluded that patients with greater optimism, self esteem, and life satisfaction were found to be more spiritual and religious. Furthermore, minorities and patients who drank less alcohol tended to be both more spiritual and religious.

Ironson, Stuetzle, and Fletcher (2006) found that individuals with HIV who felt abandoned by God after their diagnosis lost CD4 cells at a rate 4.5 times faster than individuals who relied on God to cope with their HIV diagnosis; their viral load also increased. These findings suggest that turning to God rather than rejecting God appears to boost immune system functioning and fight disease five times as effectively. In a different study, Ironson, Stuetzle, Fletcher, and Ironson (2006) concluded that individuals who held a positive view of God maintained CD4 cells twice as long as those who had a negative view of God. The same study reported that individuals, who believed that God
loves them, maintained the CD4 cells three times longer than those who felt that God did not love them.

The empirical studies above identify that there are relationships among the news of an HIV diagnosis to an increased sense of spirituality (Kremer et al., 2009), positive health outcomes (Ironson, Stuetzle, & Fletcher, 2006), and slower disease progression (Hagerty, 2009). Additionally, Ironson found that a positive view of God was correlated with an increase in immune system functioning (Ironson, Stuetzle, Fletcher, & Ironson, 2006). The above studies provide evidence that spirituality is linked with well-being among individuals with HIV/AIDS.

HIV and Cortisol

Scientists agree that thoughts and beliefs about one’s HIV status affect the progression of HIV (Hagerty, 2009). Stress hormones, such as cortisol and norepinephrine, accelerate how quickly the HIV virus can replicate. Ironson, Solomon et al. (2002) found that cortisol was lower among HIV individuals (n=279) who identified having a “sense of peace” through meditation, a belief in God, helping others, and other spiritual practices. She also reported that individuals, who scored high on two dimensions of spirituality, altruism, and compassion, had lower levels of norepinephrine. Ironson’s research connected the growing link between spiritual beliefs, chemicals in the brain (cortisol), and immune system functioning.

Relationship of Self Transcendence and Spirituality

Hamer (2004) reported that self transcendence is the simplest way to measure spirituality and Emmons (2000) identifies self transcendence as the essence of spirituality. Spirituality is a characteristic that any human being has the potential to
possess, while by definition; self transcendence is a mindset and behavior that typically reflects the last developmental stage in life. Ramer et al. (2006) reported that engaging in self transcendent or spiritual behaviors can positively influence the lives of individuals with terminal illness.

Several studies have identified the link between well-being, self transcendence and spirituality among the homeless population (Runquist & Reed, 2007) as well as HIV/AIDS patients (Ramer et al., 2006). Somlai et al. (1996) and Sowell, Moneyham, Hennessey, Hennessy et al. (2000) found that spirituality and self transcendence can be effective coping strategies. Spirituality and self transcendence can provide purpose and meaning to adverse situations in life, which can enhance one’s emotional well-being and overall quality of life (Ramer et al., 2006).

Cotton, Tsevat et al. (2006) reported that having a deadly illness such as HIV/AIDS raises existential issues, which can manifest as changes in religiousness and spirituality. Individuals experiencing terminal illness, disease, or disability may experience a high level of well-being due to their spiritual and self-transcendent resources (Coward & Kahn, 2004; Reed, 1987). Reed (1991a) reported that self transcendent behaviors can result as an influence of the aging process, a terminal illness, or confrontation with end-of-life issues.

The link between self transcendence, spirituality (conceptualized as spiritual perspective), and their positive relationship with well-being, was discussed. Individuals who experience end of life issues, especially, can utilize spirituality and self transcendence to cope with biopsychosocial stressors. Theoretical and empirical research have made the connection between spirituality and self transcendence to well-being,
while no studies have observed the relationships of social interest, self transcendence, spirituality and their collective influence on well-being among adults with HIV/AIDS.

Social Interest

The discussion of the relationship between social interest and well-being, self transcendence, and spirituality is provided in this section. Operation definitions of Social Interest are identified. Also indicated is how social interest is incorporated into this study.

Alfred Adler explained this social construct as social interest (Ansbacher & Ansbacher, 1956). Social interest is an essential construct in Adler’s theory of Individual Psychology. Adler suggested that social interest at its core is “to see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (Ansbacher & Ansbacher, 1956, pp. 135). Social interest refers to the construct Alfred Adler called, Gemeinschaftsgefühl (Ansbacher, 1991). The German word translating as “social feeling, community feeling, fellow feeling, sense of solidarity, communal intuition, community interest, social sense, and social interest” (Ansbacher & Ansbacher, 1956, p. 134).

In reviewing multiple definitions of social interest, operational definitions appear unclear and inconsistent. Manaster, Cemalcilar, and Knill (2003) discussed that there has been difficulty in determining one exact definition of social interest. Adler continued to build on the definition of social interest up until his death, and theorists and writers continue to add to the definition of this concept today. Definitions of social interest are reported below.
Defining Social Interest

Adler defined social interest as “feeling with the whole…under the aspect of eternity. It means striving for a form of community which must be thought of as everlasting, as it could be thought of if mankind reached the goal of perfection” (Ansbacher & Ansbacher, 1973, pp. 34-35). Social interest is the valuing of something outside the self without ulterior motives: a true absence of self-centeredness, egocentricity, and self absorptions (Crandal, 1981). Slavik (1995) identified social interest as the key to “inner freedom,” because it enables one to contribute to the welfare of society and others (p. 168). Social Interest is one indicator of mental health, which can be defined by a person’s willingness to cooperate with others and participate in the give-and-take of life (Carlson et al., 2006). Carlson, Watts, and Maniaci (2006) assert that social interest is a tendency of mentally healthy individuals to contribute to their community.

Social interest is found in individuals who have the ability to have fellowship, and cooperate with others. Kanz (2001) suggested that everyone is born with the desire to be involved with others. His suggestion implies that human beings are hard wired to belong and feel connected with others. Social interest emerges from a sense of belonging and connectedness with other people. A person with social interest feels that helping others is natural; they allow others to help them, and do not feel alone in the world.

Social interest is fundamental to mental health according to Adlerian publications. Considering the value that Adler placed on social interest as being a sign of well-being and mental health, it is important to add definitional clarity to the concept. Adler stressed that social interest is necessary for healthy functioning and well-being (Leak, 2006b).
This study will add to the literature by reporting outcomes regarding the links between spirituality, social interest, and self transcendence to well-being among HIV/AIDS adults. Further research on social interest and its relationship with other well-being related variables will increase definitional clarity. Several significant social interest measures are reported below.

Bass, Curlette, Kern, and McWilliams (2002) conducted a meta-analysis on social interest, examining 124 studies from 1977 to 2000, and reported that five different scales were used consistently to measure social interest. Within this meta-analysis, the instruments and the number of articles associated with each scale were reported: Social Interest Scale (SIS) - 109, Social Interest Index (SII) - 73, Sulliman’s Scale of Social Interest (SSSI) - 23, Life Style Personality Inventory Social Interest Index (LSPSII) - 32, and the Belonging/Social Interest (BSI) subscale of BASIS-A -32. The researchers ran correlations between all five scales to examine the relationships of each. Small to moderate correlations were reported, with results being .08 to .22. They were not surprised by the outcome, identifying that it is the nature of the construct, and that each scale measures a different aspect of social interest.

Relationship of Well-being and Social Interest

A considerable amount of research identifies the link between well-being and social interest. Sweeney and Witmer (1991) reported that individuals who are socially interested will often have good health. Yalom (1982) identified that altruistic activities that are personally meaningful, can facilitate an increased sense of self-worth and purpose, which can influence increased healing. Factors related to well-being such as less stress, higher levels of mental health and a greater internal locus of control are related to
a prevalence of higher levels of Social Interest (Ashby, Kottman, & Draper, 2002; Crandall, 1981; Post, 2005; Schwartz, Meisenhlder, Ma, & Reed, 2003; Zarski, Bubenzer, & West, 1986). Schwartz (2007) discussed that altruistic social interest behaviors enhance subjective well-being for both chronically ill and healthy adults.

Similarly, Crandal and Putman (1980) found that social interest was found to be significantly correlated with cognitive and affective global measures of well-being among University of Idaho staff members and students. Ryff (1991) found that people with high social interest and a positive attitude have greater coping resources and less vulnerability to disease. Schwartz Meisenhlder, Ma, and Reed (2003) reported that altruistic social interest behaviors were associated with better physical and mental health among 2,016 members of the Presbyterian Church throughout the United States. Schwartz, Keyl, Marcum, and Bode (2009) reported that altruistic social interest behaviors were positively associated with health and well-being outcomes among teenagers. Kobasa (1979) also found that individuals with increased social interest have higher levels of life satisfaction, even when working in stressful environments.

Zarski, Bubenzer, and West (1986) conducted a study that examined the association between social interest and physical health (n=1,350). Social interest was measured with the “Task of Life Survey” that assessed social interest in relation to Adler’s life tasks. They reported that social interest was a predictor of overall health status, somatic symptoms, and energy level. This study noted that social interest promotes health to the general population and the health of individuals. Although Schwartz et al. (2003) concluded that social interest was linked to poorer health; other research discussed in this section has identified the opposite.
A cross-sectional study with 457 teens from the Presbyterian Church found that altruistic social interest behaviors were positively associated with health for females and well-being for both males and females (Schwartz, Keyl, Marcum, & Bode, 2009). A similar study with 2,016 members from the Presbyterian Church also uncovered that both helping others and receiving help were significant predictors of better mental health than participants who did fewer altruistic social interest behaviors (Schwartz et al., 2003).

Relationship of Social Interest and Self Transcendence

Little theoretical and empirical literature to date discusses the relationship between social interest and self transcendence (Leak, 2006a). The significance in observing both constructs will help clarify operational definitions. Self transcendence and social interest have significant amounts of overlap in both operational definitions, but they have some clear distinctions.

Adler’s view of social interest and its attendant qualities like empathy and compassion are grounded in self transcendence (Leak, 2006a). Ansbacher & Ansbacher (1956) suggested that social interest is “the absence of self-centeredness…an ongoing transcendence of the limits of the self and of physical individuality” (p.137). This statement displays the highlights between social interest and self transcendence by referencing the expansion of boundaries beyond oneself, as identified in Reed’s definition for self transcendence (1991a, 2003, 2009). Social interest demonstrates a significant relationship with multiple spiritual dimensions, “authentic spirituality, a sense of universality and connectedness with others, a high level of daily goal strivings that are self-transcendent rather than self focused, and having a center of value or “ultimate concern” in things that transcend the self… (Leak, 2006a, p. 66).
Leak (2006a) identified that high levels of social interest are an indicator of individuals with a sense of faith or spirituality, which is founded on self transcendence. Few studies have observed the relationships of social interest and self transcendence, but some research has focused on the relationship between self transcendence to variables similar to social interest such as social support, connectedness, and giving and receiving help. Coward (1990a, 1990b) conducted a study with 107 women with advanced breast cancer and found that self transcendence was correlated with psychosocial resources, such as spiritual perspective, perceived personal control, and perceived support from others.

Two qualitative studies observed self transcendent experiences of men and women with AIDS that linked similar themes to social interest and self transcendent behaviors to well-being (Coward, 1995; Coward & Lewis, 1993). Participants experienced “reaching out” and self transcendence through sharing their experiences of living with AIDS, helping others with AIDS, and assisting in AIDS education. This experience offered them a sense of connectedness, a sense of purpose for living, a sense of healing, and increased worth.

One young man in a qualitative study about change occurring in life among gay men after being diagnosed with HIV/AIDS stated “I’ve learned to embrace all of me, including my HIV, to grow” (Coward & Lewis, 1993, p. 1365). For most of his life he felt alone, but through helping others with AIDS he found a reason for living. He believed his experience with AIDS had influenced him to become “less self centered”, and now had had the opportunity to help others and leave his own legacy. Both of Coward’s studies seemed to foster well-being through the participants’ social interest and
self transcendence related experiences of reaching beyond their own experiences to make a difference in others lives (Coward, 1995; Coward & Lewis, 1993).

Mellors, Erlen, Coontz, and Lucke (2001) examined how five (aged 39-54) AIDS patients transcended physical and emotional suffering in their daily lives. This qualitative study resulted in three main themes: creating a meaningful life pattern, connectedness, and self-care. This study identified suffering associated with AIDS can be transcended through connecting with others (social interest), self-care, and finding meaning in life (spirituality, self transcendence). The above studies make the connection between social interest and self transcendence, and display the overlap among their operational definitions.

The Relationship of Spirituality and Social Interest

Adler posed three life tasks that all individuals strive to achieve: love, friendship, and work (Sweeney, 1998). Adlerian theorists and researchers identified that getting along with ourselves and spirituality are additional life tasks (Mosak & Dreikurs, 2000). Since social interest is needed to achieve the life tasks, spirituality is a striving that individuals need others to experience.

Mosak and Dreikurs (2000) discussed five subtasks of spirituality as a life task. These tasks are the relationship of the individual to God, what does the individual do with religion, the place of person in the universe, immortality, and does life have meaning inherent in it. Each of these subtasks carries dimensions of both spirituality and social interest. The inclusion of spirituality as an additional life task links the importance of promoting spirituality with clients who desire to explore meaning and purpose in their life challenges.
Coward’s (1994) phenomenological study holds themes of social interest, well-being, and spirituality. Coward conducted a qualitative study with 10 men and 10 women with AIDS, and asked them to describe experiences that led to feelings of increased self-worth, purpose, and meaning in their lives. Participants provided oral and written descriptions of experiences linked with feelings of increased connectedness with others, sense of well-being, and hope for longer life. Themes expressed by men were: experiencing fear, engaging in self care, seeking out challenge, creating a legacy, accepting what cannot be changed, connecting with others, letting go, accepting help, and having hope. Themes expressed by women were: experiencing fear and aloneness, experiencing uncertainty, using others as role models, finding inner strength, reaching out, having purpose, viewing AIDS as an opportunity, and having hope.

Moneyham et al. (1998) conducted a study that measured the effectiveness of active coping strategies (spiritual activities, seeking social support, and managing HIV) and passive coping strategies (avoidance) among 264 HIV-positive women. The findings indicated that active coping strategies were positively related to physical symptoms and negatively related to emotional distress. The immediate impact of active coping served as a protective function, because emotional distress decreased with an increase of active coping strategies, even as physical symptoms increased. The study also reported that as physical symptoms increased the use of avoidance coping decreased, and active coping increased. This study illustrates the impact that social interest and spirituality offer HIV individuals, who are seeking well-being when coping with HIV related psychosocial stressors or health challenges.
No published studies to date, have observed social interest among the HIV/AIDS populations, however, several studies discussed above compared variables in the HIV/AIDS population with social interest themes (social support, connectedness, and asking for and receiving help). This study will examine how social interest correlates with well-being, and will examine levels of social interest in the HIV/AIDS population for the first time. Information regarding social interest, and its link to well-being in the HIV/AIDS community, could offer clinicians more empirically supported applications to foster well-being in their clients.

Summary

It is clear that physical symptoms, social impact, emotional consequences, and economic hardship of having HIV/AIDS can have a debilitating effect on individuals living with this deadly disease. The level of stress on patients can clearly impact their well-being, as evidenced by empirical research discussed above. The links of self transcendence, spirituality, and social interest to well-being were summarized and discussed, and were noted for their relationship to well-being among PLWHA and individuals with chronic illnesses. The independent variables in this study are identified as protective factors that are linked to increased well-being among individuals who utilize them. As noted above, this study will be the first to examine levels of social interest among the HIV/AIDS population. Moreover, the ability of counselors to assess and respond to risks factors and protective factors (social interest, self transcendence, and spirituality) among HIV/AIDS clients is a critical area of clinical practice that needs further research. To date, there have been no studies examining the hypothesized
relationships of self transcendence, spirituality, and social interest to well-being among PLWHA.
CHAPTER THREE

METHODOLOGY

In chapter two, the literature on well-being, self transcendence, spirituality, and social interest was explored, and the need for a study of the relationship between these four variables was discussed. In this chapter, the methodology for this study examining self transcendence, spirituality, and social interest to well-being among adults living with HIV/AIDS are reported. The following topics are covered in this chapter: (a) study design; (b) participants; (c) instrumentation; (d) procedures; (e) variables; (f) and data analysis.

Study Design

This study examined the relationship of self transcendence, social interest, and spirituality to well-being of adults with HIV/AIDS. A quantitative, descriptive, non-experimental design was implemented, and variables were measured in a manner congruent with the theoretical framework. Data were analyzed using descriptive and correlational statistics and a multiple regression. The researcher administered paper and pencil instruments to participants in a private interview room at an HIV/AIDS affiliated agency. Data collection occurred over a one month period, in which the researcher met with participants by appointment and on a walk-in basis. This study sought to examine to relationships of self transcendence, spirituality, and social interest to well-being among adults living with HIV/AIDS.
Participants

The population of interest in this study was adults living with HIV/AIDS. The sample population in this study is adults who are living with AIDS or HIV, and receive health care services from an HIV/AIDS outpatient clinic in the Southeastern United States. The agency is known to be a microcosm of the HIV/AIDS population in the area. The county is home to more than 16,235 documented individuals living with HIV and AIDS (Florida Department of Health, 2010). Information of individuals living with HIV/AIDS in the area is as follows: 13% of individuals living with HIV/AIDS are Hispanic, 50% are Black, and 35% are White. Of the individuals living with HIV/AIDS in Broward County, 70.3% are male and 29.7% are female (Florida Department of Health, 2010).

All participants were living with HIV or AIDS, as evidenced by a positive confirmatory HIV laboratory test. Participants were required to be at least 18 years old and were required to be able to understand written instructions. Individuals were recruited by advertisements posted in waiting rooms of service facilities, and also by verbal communication from HIV/AIDS medical case managers.

Participants in the study were taken from a convenience sample at an agency that serves PLWHA in Southeastern Florida. A total of 115 individuals participated in the study. The sample was composed of 92 individuals who reported an HIV diagnosis, 18 reported having AIDS, and 5 individuals reported that they were HIV, but were not sure if they were in the AIDS range. Participants’ ages ranged from 21 to 76 with a mean age of 47 (SD=9.90). The sample included 81 men (70.4%), 33 women (28.7 %), and one
transgender (0.9%) participant. The participants mean age at the time of their HIV diagnosis was 33.79 ($SD=10.04$).

The racial composition of the sample consisted of 49 Black African Americans, 48 Caucasians, 17 Hispanics, 2 Asians, 1 American Indian, and 14 participants identified as “other.” Eight participants did not answer the ethnicity question. Due to the relatively small number of racial categories, it was necessary to combine Indian American, Alaskan Native, Native American, and Asian to perform the appropriate necessary statistical analysis.

Employment, income, and education are reported below. Eighty-nine, or 77.4%, of participants stated that they were unemployed at the time of the study. Twenty-two participants identified working part-time or full-time, while three participants indicated being retired and one participant indicated that they volunteer full-time. Participants with an education of 11th grade or less ($n=25$) accounted for 21.7% of the sample, while participants with a high school education or G.E.D. ($n=39$) accounted for 33.9% of the sample. Participants with one-to-three years of college ($n=30$) accounted for 30% of the sample, participants with a four year college degree ($n=13$) accounted for 11.3% of the sample, and participants with a graduate degree ($n=6$) accounted for 5.2% of the entire sample.

Fifty-eight participants, or 50.4%, identified as being single. Another twenty-three participants, or 20%, were currently involved with a significant other and four participants, or 3.5% reported that they are married. Fifty-two, or 43.5%, participants reported being heterosexual while fifty, or 43.5%, participants reported being
homosexual. Nine, or 7.8%, participants identified being bisexual. Four participants indicated “other” as their sexual orientation. See Table 2 for the sample demographics.

Table 2
Demographics of Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>% of sample</th>
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<tr>
<td>Gender</td>
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<tr>
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<tr>
<td>Female</td>
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<tr>
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<td></td>
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<td>0.9</td>
</tr>
<tr>
<td>Native American</td>
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<td>0</td>
</tr>
<tr>
<td>Asian</td>
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<tr>
<td>Black</td>
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<td>0.9</td>
</tr>
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</tr>
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</tr>
<tr>
<td>Gay/Lesbian</td>
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<tr>
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<td>20.0</td>
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<tr>
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<td>50.4</td>
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<tr>
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</tr>
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</tr>
<tr>
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<tr>
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<tr>
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<td>11th grade or less</td>
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<tr>
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</tr>
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<td>4 Year College Graduate</td>
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<td>1.7</td>
</tr>
<tr>
<td>HIV Medications</td>
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<td></td>
</tr>
<tr>
<td>Not Taking</td>
<td>19</td>
<td>16.5</td>
</tr>
<tr>
<td>Taking</td>
<td>96</td>
<td>83.5</td>
</tr>
</tbody>
</table>
Health Status and HIV Status

Clients were asked about how they would describe their present health from the following range: poor, fair, good, or excellent. Participants in this study responded to the health status question with a mean response of “good”. Participants were asked their most recent viral load and CD4 count. The mean CD4 count for the sample was 535.46, with a large standard deviation (273.10) which indicates considerable variability among participants. The mean viral load for the sample was 8,163.37, with a large standard deviation (35,292.24). Only 78 participants identified their viral load, while 80 identified their CD4 count. Due to the lack of responses of these biomarkers, both viral load and CD4 count were removed from the statistical analysis.

HIV Medications

The majority of participants were prescribed medications during the time of this study (n =99, or 86.1%). Fewer clients were actually taking medications during the study (n =96, or 83.5%). This slight discrepancy might be explained by funding problems that were occurring during this study which impacted many PLWHA who were on waiting lists to receive medications that were funding by the federal government.

A response of 86 participants at minimum was needed according to statistical consultation and an a priori power analysis by G*Power (Faul, Erdfelder, Lang, & Buchner, 2007; Faul, Erdfelder, Buchner, & Lang, 2009). The researcher input an alpha level of 0.05, a power level of 0.80, and is anticipating a medium effect size of 0.50 (Cohen, 1988). The researcher obtained approval from Florida Atlantic University’s Internal Review Board (IRB) for the protection of human subjects before data collection began. The researcher completed the Collaborate Institutional Training Initiative (CITI).
Instrumentation

The instruments are paper and pencil self reports. Four instruments were used in this study: the Self-Transcendence Scale (STS), the Social Interest Index-Short Form-Revised (SII), the Spiritual Perspective Scale (SPS), and the Index of Well-Being (IWB). The demographic data sheet asked participants to indicate their perceived health status and their HIV/AIDS biomarkers (HIV viral load and T-cell count).

Self-Transcendence Scale

The Self-Transcendence Scale (STS) measures a person’s expansion of personal boundaries through interpersonal, intrapersonal, and through temporal experiences (Coward & Reed, 1996). The corresponding fear of health deterioration and death associated with an HIV/AIDS diagnosis makes Reed’s Self Transcendence Scale (STS) a useful measure with the population being sampled in this study.

The STS is a 15-item instrument developed by Reed (1986a) to measure self transcendence. Participants rate themselves on each of the 15 items using a 4-point, Likert scale. STS responses will be averaged to find a range from 1.0 to 4.0, whereby a higher number indicates greater self transcendence. Cronbach’s alpha in previous studies were in the range of .77 to .85 (Coward, 1991, 1996; Reed, 1991b), and within an acceptable range for reliability coefficients for an established scale (Carmines & Zeller, 1979).

Spiritual Perspective Scale

The Spiritual Perspective Scale (SPS) measures the degree to which spiritual views and beliefs affect an individual’s life (Reed, 1987). It measures an individual’s perceived connectedness to a purpose or process greater than self (Reed, 1992), and to the
extent they engage in spiritually-related behaviors (Reed, 1986b, 1987). Reed’s SPS and STS are commonly used in research settings where the participants are experiencing a heightened sense of vulnerability. The SPS was utilized in this study due to vulnerabilities, such as stigmatization and alienation that many individuals with HIV/AIDS encounter. Spiritual perspective emphasizes a spiritual form of self-transcendence (Reed, 1992).

Reed developed the Spiritual Perspective Scale to measure spirituality among seriously ill individuals (Reed, 1987). She identified spiritual activities as organizational (i.e., church or ceremonial attendance, church group affiliation) or non-organizational (i.e., prayer, meditation, philosophical beliefs, reading religious or spiritual literature, and interacting with others about spiritual awareness) (Reed, 1987). Reed’s earlier studies reported that participation in religious activities are actually behavioral manifestations of spirituality that are linked to well-being (Reed, 1986a; 1986b; 1987). This study will measure spirituality with Reed’s Spiritual Perspective Scale.

The SPS is a 10-item questionnaire that measures participant’s spiritual views and the extent to which they hold those views and engage in spiritually-related behaviors (Reed, 1986b, 1987). Examples of questions that inquire about frequency of spiritually related behaviors include “How often do you engage in private prayer or meditation?” and “I seek spiritual guidance in making decisions in my everyday life.” Participants will rate themselves on each of the 10 items, using a 1 to 6 on a Likert scale. Responses are averaged to find the participant’s spiritual perspective score, which can range from 1.0 to 6.0. A higher number indicates greater spiritual perspective. Reliability for the SPS from
past reliability findings ranged from .89 to .95 (Brush & McGee, 2000; Reed, 1986b; 1987; Runquist & Reed, 2007).

Social Interest Index

The Social Interest Index (SII) is considered among the best instruments to measure social interest, according to a meta-analysis of 124 studies of social interest conducted by Bass et al. (2002). The SII is a 32-item instrument which utilizes a 5-point Likert type scale: 1-not at all like me, to 5-very much like me (Greever, Tseng, & Friedland, 1973). The SII measures overall social interest, and includes the four life tasks identified by Alfred Adler: love, friendship, work, and self-significance. There are eight questions for each of the life tasks, with each having a range score of 8 to 40, with a total range score of 32 to 160. A higher score indicates a higher level of social interest. For the purpose of the current study, only the total social interest score will be used.

Greever, Tseng, and Friedland (1973) developed the SII and conducted analyses to test for reliability with 83 college students and found an internal consistency of .81. A test-retest coefficient of .79 for a two week time interval was reported. More recently, other researchers have assessed for reliability and have found consistent results (Leak, 2006a, 2006b). The SII has also been positively correlated with marital adjustment, inner-directedness, self-significance, self-actualization, and interpersonal control. The SII was negatively correlated with depression, anger, and autonomy (Watkins, 1994).

Leak (2006b) created a shortened version of the SII called the Social Interest Index- Short Form (SII-SF) that was found to be psychometrically equivalent to the SII. Compared to the 32 items of the SII, the SII-SF has 11 items. Items eliminated were considered “only a marginal connection with the concept of social interest” (Leak, 2006b,
p. 448). It appears that three questions in the SII-SF could be considered culturally insensitive to the homosexual participants in this research project. Accordingly, the researcher slightly modified the referents of these three questions to be more culturally sensitive. For example, the item “I feel a man and a woman have equally important roles in a marriage” was modified to read “I feel both partners have equally important roles in a committed relationship.” The original plus the revised version of these three questions are included in the instrument for the purpose of ascertaining whether the difference in wording is psychometrically significant.

Index of Well-Being

The Index of Well-Being (IWB) measures a generalized sense of well-being with life, as a person currently experiences it. The IWB ultimately measures a person’s subjective sense of life satisfaction in the present tense. The IWB is a 9-item instrument that measures current or existential life satisfaction in regards to both cognitive and affective dimensions of general well-being (Campbell et al., 1976). Responses are provided on a 6-point semantic, differential type scale in response to a stem question about their present life. Examples of items include: my present life is full to empty and my current life is rewarding to disappointing. The total score is calculated by summing two scores: the average of the first 8 responses and the weighted score of the last question, a single-item indicator of overall life satisfaction.

The instrument is scored as the sum of two means: the single score of the item on life satisfaction (item 9 on the IWB), and the average score of the eight items measuring affective quality of life (items 1-8 on the IWB). Scores for the IWB can range from 2.1 to 14.7, with a higher score indicating greater well-being. Previous alpha coefficients for the
IWB in the examined literature ranged from .89 to .95 (Campbell et al., 1976; Reed 1986b, 1987; Runquist & Reed, 2007).

Procedure and Data Collection

The investigator approached potential participants in an HIV/AIDS clinic and provided them with a brief verbal and written explanation of the study (Appendix A and B). All questionnaires were completed at various clinics, and were collected by the investigator immediately after completion. Their participation was voluntary, and they were sampled in waiting rooms at several locations of a non-profit agency that serves PLWHA.

All participants completed the Self-Transcendence Scale (STS), the Social Interest Index-Short Form-Revised (SII) (Appendix D), the Spiritual Perspective Scale (SPS), and the Index of Well-Being (IWB). Demographic information for the participants is reported in Table 2. Ethnicity, age, biological sex, marital status, sexual orientation, employment status, age of HIV diagnosis, HIV viral load and CD 4 count, HIV/AIDS medication adherence, and education levels were calculated. Participants were recruited by posted advertisements (Appendix C) from the study and also from direct verbal contact with the researcher. Each participant completed four questionnaires that yielded demographic, behavioral, and attitudinal information. See Appendix E for the demographic sheet.

One outpatient HIV/AIDS clinic was utilized to gather data for this study. The case managers, therapists, and outreach staff were educated about the study. The service workers educated clients from the agency about the study and referred interested clients to the researcher. Only participants who were interested and agreed to participate in the
study were given the research materials. Advertisements were posted in several of the agency locations to promote the study and its intentions. In order to increase response rate, participants were given a small gift certificate for a free coffee at a local cafe.

Once a client contacted or was referred to the investigator, information contained in the consent form was reviewed and all of the client’s questions were answered. Once participants understood the nature of the study and expressed a desire to participate, they were given two consent forms, one to sign and return to the investigator and one for them to keep. A disclaimer was used with potential participants to explain their rights as human subjects. Participants were informed of their right to withdraw from the study at any time, without penalty or interference with the services that they receive at the agency. Four inventories were given to the participants to complete. The investigator was nearby to answer any questions. The data collection took place in a comfortable and confidential area in the agency. Once completing the packet, the participants returned their packet to the researcher and they were given a modest gift certificate. All efforts were made to maintain confidentiality of information collected. Data is stored on the researchers password protected computer.

Variables

Dependent Variable

The following dependent variable was included in the study:

- Perceived Well-Being, as measured by the Index of Well-Being (IWB), a self report.

Independent Variables

The following independent variables were included in the study:
• Self transcendence, as measured by the Self Transcendence Scale (STS), a self-report.

• Spiritual Perspective, as measured by the Spiritual Perspective Scale (SPS), a self report.

• Social Interest, as measured by a revised version of the Social Interest Index-Short Form-Revised (SII-SF-R), a self report.

Data Analysis

In order to determine the relationship between self transcendence, spiritual perspective, and social interest to well-being in adults with HIV/AIDS, the following analysis were conducted on the data gathered using PASW (2010). In the first question, the relationships of the variables: self transcendence, spiritual perspective, social interest, and well-being were examined with a correlation matrix. The second research question was addressed with a stepwise multiple regression, with the independent variables being self transcendence, spiritual perspective, and social interest, while well-being was the dependent variable. Through the regression, the mediating role of self transcendence, spiritual perspective, and social interest to well-being was determined.
CHAPTER FOUR
RESULTS

The purpose of the present study was to investigate the relationships of self-transcendence, social interest, and spiritual perspective to well-being among adults living with Human Immunodeficiency Virus (HIV) or Acquired Immune deficiency Syndrome (AIDS). First, the psychometric data of each instrument is reported, and descriptive statistics for each instrument are presented. Next, the results of the hypothesis testing are presented. Finally, the chapter concludes with the post hoc analyses and a summary of the results.

Psychometric Data on Instruments Utilized in the Study

Descriptive statistics were calculated for each instrument. Frequencies, mean scores, percentages, and standard deviations were computed. Results of the descriptive statistics for the Self-Transcendence Scale (STS), the Social Interest Index-Short Form-Revised (SII-SF-R), the Spiritual Perspective Scale (SPS), and the Index of Well-Being (IWB) are reported in this section and presented in Table 3.

The PASW 18 statistics package (2010) was used for all analyses, in which the significance level was set a priori at $p < .05$. Scoring of the STS, SPS, and SII-SF-R was done by calculating the arithmetic mean across all items scored. Each inventory was computed according to its respective scoring protocol (described in chapter 3). The IWB was scored by summing two scores: the average of the first 8 responses and the weighted
Table 3

Central Tendency Measures of Self Transcendence, Social Interest, Spiritual Perspective, and Well-being

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Actual Range</th>
<th>Possible Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>STS</td>
<td>115</td>
<td>3.29</td>
<td>0.55</td>
<td>1.4 - 4.0</td>
<td>1.0 - 4.0</td>
</tr>
<tr>
<td>SPS</td>
<td>115</td>
<td>4.75</td>
<td>1.24</td>
<td>1.0 - 6.0</td>
<td>1.0 - 6.0</td>
</tr>
<tr>
<td>SII-SF-R</td>
<td>115</td>
<td>4.12</td>
<td>0.66</td>
<td>1.6 - 5.0</td>
<td>1.0 - 5.0</td>
</tr>
<tr>
<td>IWB</td>
<td>115</td>
<td>9.31</td>
<td>2.64</td>
<td>2.4 - 12.6</td>
<td>2.1 - 12.6</td>
</tr>
</tbody>
</table>

Note. STS = Self transcendence scale (Reed, 1986a); SPS = Spiritual perspective scale (Reed, 1986b, 1987); SII-SF-R = Social Interest Index Short Form Revised; and IWB = Index of Well-being (Campbell et al., 1976).

score of the last question. For all four instruments, a higher score indicated a higher level of the construct observed in each participant. For measures with missing responses, replacement by means method was utilized to allow for computation of the total measure. Missing items were assigned the mean value of the other items on that particular scale.

Reliability

Reliability of the four instruments was evaluated using Cronbach’s alpha coefficient as an estimate of internal consistency. The alpha coefficient for the Index of Well-being in this study was 0.95. Alpha coefficients in previous studies ranged from .89 to .95 (Campbell et al., 1976; Reed 1986b, 1987; Runquist & Reed, 2007). Previous alpha coefficients for the STS in the examined literature ranged from .77 to as high as .94 (e.g., Bean & Wagner, 2006; Chen & Walsh, 2009; Coward, 1990a, 1991; Reed, 1989; Reed, 1991a; Thomas, Burton, Quinn Griffin, & Fitzpatrick, 2010). The alpha coefficient for the STS in this study was .91. Cronbach’s alpha for the SPS in the current study was .95,
which is consistent with past reliability findings which ranged from .89 to .95 (Brush & McGee 2000; Reed, 1986b; 1987; Runquist & Reed, 2007). Cronbach’s alpha for the Social Interest Index-Short Form-Revised was .87. Alpha coefficients in previous studies ranged from .89 to .95 (Campbell et al., 1976; Reed 1986b, 1987; Runquist & Reed, 2007). All instruments demonstrated adequate reliability in this study. The alpha coefficients ranged from .87 to .95, above the .80 minimum for established instruments (Nunnally, 1978). Table 4 summarizes these values.

Table 4

Cronbach’s Alpha Coefficient for Instruments

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Cronbach’s Alpha</th>
<th>Items in scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Transcendence Scale</td>
<td>.91</td>
<td>15</td>
</tr>
<tr>
<td>Social Interest Index-Short Form Revised</td>
<td>.87</td>
<td>14</td>
</tr>
<tr>
<td>Spiritual Perspective Scale</td>
<td>.95</td>
<td>10</td>
</tr>
<tr>
<td>Index of Well-Being</td>
<td>.95</td>
<td>9</td>
</tr>
</tbody>
</table>

Well-being was operationalized through the Index of Well-being, the mean score of the sample was 9.31 ($SD=2.64$) (see Table 3). Higher scores suggest increased subjective well-being. The possible scores on the IWB ranged from 2.1 to 12.6. Self transcendence was operationalized through the Self Transcendence Scale, the mean score of the sample was 3.29 ($SD=.55$). Higher scores suggest increased self transcendence. The possible scores on the STS ranged from 1 to 4. Spirituality was operationalized through the Spiritual Perspective Scale, the mean score of the sample was 4.75 ($SD=1.24$). Higher scores suggest increased attitudinal and behavioral spirituality. The
possible scores on the SPS ranged from 1 to 6. Social Interest was operationalized through the Social Interest Index- Short Form-Revised, the mean score of the sample was 4.12 \((SD=.66)\). Higher scores suggest increased social interest. Possible scores on the SII-SF-R ranged from 1 to 5.

Runquist and Reed (2007) observed the relationships of self transcendence, spiritual perspective, health status, fatigue to well-being among a sample \((N=61)\) of homeless adults. They found very similar results to this current study in reference to the mean scores among self transcendence, spiritual perspective, and well-being. Runquist and Reed found a mean score of 9.50 \((SD=3.34)\) among well-being scores, while the present study found a mean of 9.31 and a standard deviation of 2.64. A mean score of self transcendence scores were 3.11\((SD=.50)\), while the present study found a mean of 3.29 and a standard deviation of .55. And finally, a mean score of 4.78 \((SD=1.24)\) was found among spiritual perspective scores, while the present study found a mean of 4.75 and a standard deviation of 1.24. Results from the Runquist and Reed’s study are consistent and similar with the findings in the present study. In short, the high degree of consistency of the results of the present study with other cited studies adds considerable support to the study's findings.

Results of Hypothesis Testing

This section identifies the results of the hypothesis testing. The first research question was tested using Pearson’s correlations. The second question was analyzed using a stepwise multiple regression. The first hypothesis was that there would be a significant relationship among the variables of self transcendence, social interest, spiritual perspective, and well-being in persons living with HIV or AIDS (PLWHA). The second
hypothesis was that self transcendence, social interest, and spiritual perspective together would explain a significant amount of variance of well-being in PLWHA. The extent to which each hypothesis was supported is discussed below.

Hypothesis One

The first hypothesis identified that there would be a significant relationship among the variables of self transcendence, social interest, spiritual perspective, and well-being in PLWHA. Self transcendence, social interest, well-being, and spiritual perspective were all expected to correlate positively. Correlations among certain demographic variables and the four instruments were calculated using Pearson’s correlations. All six of the bivariate correlations were positively correlated and were also statistically significant (see Table 5). Self transcendence \( (r = .66, p < .001) \), social interest \( (r = .51, p < .001) \), and spiritual perspective \( (r = .39, p < .001) \) were positively correlated with well-being. As expected, self transcendence and social interest were correlated, \( r = .57, p < .001 \), while social interest also correlated with spiritual perspective, \( r = .49, p < .001 \). Likewise, self transcendence was positively correlated with spiritual perspective, \( r = .39, p < .001 \). All four of the variables were shown to have a significant relationship with each other. Thus, the Null Hypothesis was rejected.

Montcalm and Royse (2002) indicated that multicollinearity issues are likely if two variables have a zero-order correlation higher than .60. Accordingly, multicollinearity was monitored when analyzing the relationships of well-being, self transcendence, social interest, and spirituality. This was accomplished by examining the intercorrelations among variables that had a zero-order correlation of .60 or higher. The intercorrelations (see Table 5) ranged from .39 to .66. The intercorrelation between self
transcendence and well-being ($r = .661; p < .001$) was the only relationship to exceed the .60 condition. Myers (1990) suggested that if the variance inflation factor (VIF) exceeds 10 or has a tolerance level < .10, multicollinearity is likely an issue. The tolerance level among self transcendence and well-being was .65, well above the .10 range; the VIF was 1.53, well below the 10 value that can be cause for multicollinearity concerns (Pedhazur, 1997).

Table 5

*Correlations and Significance Levels between Study Variables*

<table>
<thead>
<tr>
<th></th>
<th>IWB</th>
<th>SPS</th>
<th>STS</th>
<th>SII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index of Well-Being (IWB)</td>
<td>1.00</td>
<td>0.39**</td>
<td>0.66**</td>
<td>0.51**</td>
</tr>
<tr>
<td>Spiritual Perspective Scale (SPS)</td>
<td>1.00</td>
<td>0.39**</td>
<td>0.49**</td>
<td></td>
</tr>
<tr>
<td>Self-Transcendence Scale (STS)</td>
<td>1.00</td>
<td></td>
<td>0.57**</td>
<td></td>
</tr>
<tr>
<td>Social Interest Index-Short Form Revised (SII-SF-R)</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Correlation is significant at the .01 level (2-tailed).

Hypothesis Two

The second hypothesis postulated that self transcendence, social interest, and spiritual perspective together would explain a significant amount of variance of well-being in PLWHA. The second research question sought to discover which independent variable accounted for the most variance on well-being among the participants. A stepwise multiple regression was utilized to identify which independent variable would correlate most strongly with well-being. In the stepwise multiple regression, self transcendence explained 43% of the variance on well-being, while spirituality dropped
out of the model. Self transcendence entered on the first step, \( F(1,113) = 87.92, p = .000 \), adjusted \( R^2 = .433 \) (see Table 6). In social science research, Cohen (1977) concluded that findings that explain 10% of the variability should be considered a good outcome.

Social interest entered on the second step \( F(1,112) = 4.84, p < .030 \), and increased the explained variance to a total of (adjusted) \( R^2 = .451 \). The beta weights for social interest were .186 and .661 for self transcendence.

Table 6

*Multiple Regression Analysis of Independent Variables and Well-being*

<table>
<thead>
<tr>
<th>Step</th>
<th>( p )</th>
<th>( R )</th>
<th>( R^2 )</th>
<th>( AdjR^2 )</th>
<th>( F )</th>
<th>( df )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.000</td>
<td>.661a</td>
<td>.438</td>
<td>.433</td>
<td>87.916</td>
<td>(1,113)</td>
</tr>
<tr>
<td>Step 2</td>
<td>.030</td>
<td>.679ab</td>
<td>.461</td>
<td>.451</td>
<td>4.842</td>
<td>(1,112)</td>
</tr>
</tbody>
</table>

Note. a. self-transcendence, b. social interest. Dependent variable: well-being.

Social Interest Index Findings

A comparison of the reliability coefficients among the Social Interest Index-Short Form-Revised (SII-SF-R) responses was conducted. The SII-SF-R used in this study included several re-worded questions. Because three questions in the SII-SF could be construed as culturally insensitive to the gay, lesbian, and bisexual participants in this research project, the researcher slightly modified the referents of these three questions to be more culturally sensitive. For example, the item “I feel a man and a woman have equally important roles in a marriage” was modified to read “I feel both partners have equally important roles in a committed relationship.” The original plus the revised
version of these three questions were included in the instrument for the purpose of ascertaining whether the difference in wording is psychometrically significant.

Cronbach’s Alpha varied among the different versions of the Social Interest Index. Leak’s original version with eleven questions displayed a lower level of reliability than the culturally sensitive version with three re-worded questions. All participants completed Leak’s (2006b) original SII-SF questions plus the three modified questions. Leak’s Social Interest Index Short Form was used with the addition of three culturally sensitive questions to the address the participant’s sexual orientation. The new version was computed by removing three of the culturally insensitive questions (SII –SF-R) which displayed a slightly higher level of reliability as compared to Leaks original version (see Table 7).

Table 7

*Social Interest Index-Short Form Version Comparison of Alpha Coefficients*

<table>
<thead>
<tr>
<th>Version of SII</th>
<th>Cronbach’s Alpha</th>
<th># of Questions</th>
<th>Mean</th>
<th>Ave.</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SII-SF (original)</td>
<td>.82</td>
<td>11</td>
<td>44.88</td>
<td>4.08</td>
<td>7.08</td>
<td>35.00</td>
</tr>
<tr>
<td>SII-SF-R (all questions)</td>
<td>.87</td>
<td>14</td>
<td>57.60</td>
<td>4.11</td>
<td>9.21</td>
<td>47.00</td>
</tr>
<tr>
<td>SII-SF-R2 (new version)</td>
<td>.86</td>
<td>11</td>
<td>45.90</td>
<td>4.17</td>
<td>7.16</td>
<td>39.00</td>
</tr>
</tbody>
</table>

Note. SII-SF = Social Interest Index, Short Form; SII-SF-R = Social Interest Index, Short Form Revised (all questions); Social Interest Index, Short Form Revised 2 (3 culturally insensitive questions removed).

Zarski, Bubenzer, and West (1983) questioned the usefulness of distinguishing the life tasks through subscales in the original Social Interest Index (SII). Similarly, Leak
(1982) identified that challenges with replicating the factor structure are the greatest weaknesses of the SII. The present study did not monitor subscale outcomes, but it globally related each question to social interest. Leak’s (2006b) version, the Social Interest Index Short form (SII-SF) was created by eliminating conceptually and statistically flawed items from the original Social Interest Index. The SII-SF was derived from three of the four original subscales, but Leak identified that the SII-SF lacks subscale information.

A principal components analysis was conducted to observe the factor loadings of the SII-SF-R questions. The loadings ranged between .47 and .84, while the two components accounted for 51% of the variance. After rotation, the first factor accounted for 39.24% of the variance while the second factor accounted for 12.14%. The first factor contained items relating to social interest from a belonging dimension (self significance and the friendship life tasks), while the second factor included items that were about marriage, relational commitment, and equality in relationships (the life task of love) (Table 8). The second factor held all of the re-worded questions and the original versions. The factor loadings in the current study differed with past research studies wherein the factor structures of scales were inconsistent and problematic (Watkins, 1994).

The revised version of the SII –SF displayed a slightly higher level of reliability as compared to Leaks original version (Table 7). Indeed, a large number of responses of gay, lesbian, and bisexual participants (n=59) were found to differ from those of heterosexual participants. Mean scores of three different versions of the SII were
calculated and the culturally sensitive version held the highest mean score among the entire sample (Table 7). Participants responded with higher levels of social interest when culturally insensitive questions were removed from the analysis. Therefore, it could be concluded that the revised version of the SII–SF may be more appropriate to use in studies with participants who identify as gay, lesbian, or bisexual. More research in this area will be needed to validate the use of this instrument among research with the gay, lesbian, and bisexual population.
Additional Analyses

This section lists the additional analyses that were not hypothesized in chapter 1. The various scores of the independent and dependent variables were observed in regards to the following demographic subgroups: gender, participants living with HIV or AIDS, and sexual orientation. The \( t \)-test failed to reveal a statistically significant difference among protective factor scores between the HIV and AIDS groups. Interestingly, \( t \)-tests revealed that women and heterosexual participants typically scored higher on the majority of the protective factor instruments.

Women held higher mean scores of STS, SPS, SII-SF-R, and IWB than men (Table 9). Women held higher scores when observing the overall means scores among the STS, SPS SII-SF-R, and IWB; however, the \( t \)-tests (see Table 10) revealed that the spiritual perspective scale (\( p = .000 \)) and the Index of Well-being (\( p = .02 \)) were the only mean comparisons that were statistically reliable. Therefore, women identified practicing more spiritual attitudes and behaviors than men, and also held a higher sense of well-being.

Gay and lesbian participants held lower mean scores among the STS, SPS SII-SF-R, and IWB scores of spiritual perspective than did the heterosexual group (Table 11). A \( t \) test revealed a statistically significant difference among STS, SPS SII-SF-R, and IWB scores between homosexual participants and heterosexual participants (See Table 12). All means score comparisons held a significance level of \( p \leq .05 \). One explanation could be that the gay and lesbian participants interpreted the SPS questions from a more religious perspective than spirituality. For example, several comments were made by participants, such as “what is with all of these religion questions?” and “is this a study on religion”?
Table 9

Descriptive Statistics of the Variable Gender with Self Transcendence, Social Interest, and Spiritual Perspective

<table>
<thead>
<tr>
<th>Gender</th>
<th>STS</th>
<th>SPS</th>
<th>SII-SF-R</th>
<th>IWB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>3.27</td>
<td>4.50</td>
<td>4.07</td>
<td>8.93</td>
</tr>
<tr>
<td></td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>.55</td>
<td>1.31</td>
<td>.61</td>
<td>2.65</td>
</tr>
<tr>
<td></td>
<td>.06</td>
<td>.14</td>
<td>.07</td>
<td>.29</td>
</tr>
<tr>
<td>Women</td>
<td>3.35</td>
<td>5.34</td>
<td>4.24</td>
<td>10.20</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>33</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>.58</td>
<td>.80</td>
<td>.77</td>
<td>2.47</td>
</tr>
<tr>
<td></td>
<td>.10</td>
<td>.14</td>
<td>.13</td>
<td>.43</td>
</tr>
</tbody>
</table>

Note. STS = Self transcendence scale, SPS = Spiritual perspective scale, SII-SF-R = Social Interest Index Short Form Revised, and IWB = Index of Well-being.

Table 10

Equality of Means for Gender

<table>
<thead>
<tr>
<th></th>
<th>t</th>
<th>df</th>
<th>Significance (2-tailed)</th>
<th>Mean Differences</th>
<th>Std. Error Differences</th>
<th>95% Confidence Interval of the Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Interest Index Short Form Revised</td>
<td>-1.26</td>
<td>112</td>
<td>.211</td>
<td>-.17</td>
<td>.14</td>
<td>-.44 to .09</td>
</tr>
<tr>
<td>Self transcendence scale</td>
<td>-.75</td>
<td>112</td>
<td>.453</td>
<td>-.09</td>
<td>.11</td>
<td>-.31 to .14</td>
</tr>
<tr>
<td>Spiritual perspective scale</td>
<td>-3.42</td>
<td>112</td>
<td>.001*</td>
<td>-.84</td>
<td>.24</td>
<td>-1.33 to -.35</td>
</tr>
<tr>
<td>Index of Well-being</td>
<td>-2.38</td>
<td>112</td>
<td>.019*</td>
<td>-1.27</td>
<td>.54</td>
<td>-2.34 to -.21</td>
</tr>
</tbody>
</table>

Note. 1=Equal Variance Assumed.
Table 11

*Comparisons of Means: Sexual Orientation and Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>STS</th>
<th>SPS</th>
<th>SII-SF-R</th>
<th>IWB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>Mean</td>
<td>3.17</td>
<td>4.24</td>
<td>4.01</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>.58</td>
<td>1.43</td>
<td>.63</td>
</tr>
<tr>
<td></td>
<td>Std. Error Mean</td>
<td>.08</td>
<td>.20</td>
<td>.09</td>
</tr>
</tbody>
</table>

| Heterosexual | Mean  | 3.43  | 5.31     | 4.29  | 10.02 |
|              | n     | 52    | 52       | 52    | 52    |
|              | Std. Deviation | .51   | .70      | .64   | 2.64  |
|              | Std. Error Mean | .07   | .10      | .09   | .37   |

Note. STS = Self transcendence scale, SPS = Spiritual perspective scale, SII-SF-R = Social Interest Index Short Form Revised, and IWB = Index of Well-being.

Table 12

*Equality of Means for Sexual Orientation*

<table>
<thead>
<tr>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>t</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td>Social Interest Index Short Form Revised</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>Self transcendence scale</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>Spiritual perspective scale</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>Index of Well-being</td>
</tr>
<tr>
<td>1.</td>
</tr>
</tbody>
</table>

Note. 1=Equal Variance Assumed.
Summary of Results

Two hypotheses were tested in this chapter. The first hypothesis was that there would be a significant relationship among the variables of self transcendence, social interest, spiritual perspective, and well-being in PLWHA. The Null Hypothesis was rejected and the alternative hypothesis was accepted. The second hypotheses stated that self transcendence, social interest, and spiritual perspective together would explain a significant amount of variance of well-being in PLWHA. A stepwise regression demonstrated that self transcendence held the highest variance on well-being among the three protective factors (43%). Additionally, Self transcendence and social interest accounted for 45% of the variance in well-being. Again, the Null Hypothesis was rejected and the alternative hypothesis was accepted. Finally, the revised version of the SII–SF was found to be more appropriate to use in studies with participants who identify as gay, lesbian, or bisexual.
CHAPTER FIVE

DISCUSSION

To date, this is the first study to investigate the relationship of the protective factors of social interest, self transcendence, spiritual perspective, and subjective well-being among HIV/AIDS clients. Chapter 4 described the findings of this study, particularly the strong intercorrelations among self transcendence, social interest, spiritual perspective, and subjective well-being. Accordingly, there is research support for counselors focused on increasing well-being in HIV/AIDS clients to consider incorporating interventions that foster these protective factors. Furthermore, additional focused research can conceivably close the knowledge gap involving protective factors that influence well-being among this population. This chapter describes the contributions and implications of the present study for counseling theory, counseling practice, and future research. Then, it discusses the limitations of the study. Finally, it concludes with a summary of the findings.

Contributions

This section briefly describes a number of contributions the present study makes to the professional literature. First, it links the three protective factors of social interest, self transcendence and spirituality to well-being among individuals living with HIV/AIDS. This study found that self transcendence held the highest variance in well-being among clients living with HIV/AIDS. As noted in Chapter 2, a number of other
studies have examined the relationships of one or two of these three protective factors among various populations, but the present study is the first to examine the combined effect of all three protective factors on well-being among individuals living with HIV/AIDS. It is important to note that although spiritual perspective dropped out of the regression model, it positively correlated with well-being in the correlation matrix.

Second, the present study also found significant correlations among social interest with spirituality, self transcendence, and well being. Previous research on long-term nonprogressors who were HIV positive for seven or more years found that that spirituality and social interest, which was designated as human connectedness, were commonalities among this population living with HIV in contrast to progressors (Barroso, 1999). By implication, nonprogressors exhibited well-being. While Barroso did not formally study self transcendence among nonprogressors it is likely that nonprogressors would have displayed higher levels of self-transcendence than progressors. By contrast, the present study explicitly measured social interest, self-transcendence, and well being in HIV/AIDS individuals.

Third, the current research identified social interest as a critical protective factor and a correlate of well being, among the HIV/AIDS clients studied. This study supports and adds to research by Schwartz et al. (2009) and Sweeney and Witmer (1991) that found that individuals with high levels of social interest were likely to experience good physical and psychological health (analogs of well being) in a general population, while the present study found that social interest was highly correlated with well-being among individuals living with HIV/AIDS. Gabriel (1996) discussed the growing research that supports the link between social support and increased immune system functioning.
Extrapolating from the results of the present study, HIV/AIDS clients with high levels of social interest are more likely to seek social support and thus increase their immune functioning.

Fourth, the current research found high correlations among spirituality and well-being among female clients with HIV/AIDS. There has been relatively little previous research on females with HIV/AIDS and protective factors. In fact, the only protective factor reported has been spirituality. Previous research has linked spiritual practices with decreased emotional stress (Sowell, Moneyham, Hennessy, Guillory et al., 2000), lower depression (Simoni & Ortiz, 2003), greater optimism (Biggars et al., 1999), and better psychological adaption (Simoni, Martone, & Kerwin, 2002). In contrast, the present study found that the three protective factors of social interest, self-transcendence and spirituality were correlated with well being. Of particular note is that women had higher spiritual perspective scores and subjective well-being scores than men.

Lastly, it is noteworthy that the modified version of the Social Interest Index (the SII-SF-R) developed in this study was found to be a culturally sensitive measure of social interest among gay and lesbian individuals as evidenced by its high reliability coefficient. This improved version will allow future researchers to measure social interest more accurately among gay, lesbian, and bisexual participants in future studies.

Implications

Research summarized in Chapter 2 indicates that with increased life expectancy, well-being becomes a pressing concern among PLWHA. The presence of protective factors, such as social interest, self transcendence, and spiritual perspective, appear to be important in increasing well-being in PLWHA. This section discusses the theoretical,
clinical practice, and research implications of these protective factors for the counseling profession.

Theoretical Implications

This dissertation adds to the understanding of self transcendence, spirituality, and social interest among clients with HIV/AIDS. Hopefully, it has added some definitional clarity to these factors. The apparent concordance of the independent variables suggests that self transcendence, spiritual perspective, and social interest share a number of similarities. Similar themes among the three variables are: altruism, searching for meaning, relationships, feeling connected to others and self acceptance.

In addition, the present study contributes to theoretical literature of Adlerian Psychology by establishing a relationship between social interest and well-being among HIV and AIDS clients. This is the first empirical study to examine the Adlerian construct of social interest in these clients. Besides being an indicator of well-being, social interest is also a key indicator of mental health (Leak, 2006a). Participants in this study who scored higher on the social interest instruments scored higher on well-being, spiritual perspective, and self transcendence. The present findings support past research that links social interest with increased physical health (Sweeney & Witmer, 1991) and well-being (Crandal & Putman, 1980). Similarly, Zarski et al. (1986) found that social interest was a predictor of overall health status, somatic symptoms, and energy level. The current study extends Adlerian theory with an increased understanding of social interest among HIV/AIDS clients. This study links social interest to well-being among these clients, and additional research may demonstrate that this link extends to PLWHA and possibly to individuals living with chronic illnesses.
Research on social interest seems to be largely confined to psychology and counseling (Carlson, 2000). Spiritual perspective, self transcendence, and well-being are well studied constructs in nursing and medicine. Since the present study found links among these three and social interest, it would not be unreasonable to expect that social interest will also be studied in those fields too. Utilizing constructs from different domains of the helping profession serves to inform other professionals of relevant research and therapeutic tools that could then enhance client well-being.

The findings of this study also reflect with Runquist and Reed’s (2007) suggestion that self transcendence can increase an individual’s potential for development and creative use of existing resources (e.g. spirituality and self transcendence) to achieve a sense of well-being. Furthermore, Reed (2009) and Coward & Reed (1996) assert that self transcendence can enhance well-being among vulnerable populations by engaging in spiritual practices and everyday activities that expand personal boundaries. The current study also supports theoretical literature contending that spirituality and self transcendence engenders purpose and meaning in life amid adverse situations resulting in enhanced well-being and quality of life (Ramer et al., 2006). Finally, this study supports existing theoretical literature linking protective factors and well-being with strong, positive correlations found among these factors and well-being.

Implications for Counseling Practice

The results of this study support the first hypothesis that self transcendence, spiritual perspective, and social interest have a positive correlation with well-being among clients with HIV/AIDS. Accordingly, it would not be unreasonable for counselors endeavoring to increase subjective well-being to utilize counseling interventions that
foster self transcendence, spirituality, and social interest. For example, spirituality can be incorporated by the use of prayer in counseling sessions. A counselor could encourage a client to use prayer for coping, and if appropriate, to pray with the client (McCullough & Larson, 1999). Social interest can be incorporated in counseling by asking a client to provide some service for another person who is not in their immediate family, such as volunteering at a local soup kitchen (Carlson, 2011). Likewise, self transcendence can be incorporated in counseling by assisting a client to practice coping attitudes such as humor and compassion to give meaning to suffering or challenges (Cloninger, 2006). Finally, counselors could routinely assess client’s levels of self transcendence, spiritual perspective, and social interest at the outset of counseling, and subsequently monitor changes in these levels over the course of treatment.

These three protective factors hold considerable promise in counseling HIV/AIDS clients, particularly when counselors collaborate with these clients to increase subjective well-being. Counselors can also foster empowerment in clients to improve their lives by focusing on protective factors (Gitterman, 2001). Utilizing counseling interventions that enhance these three protective factors contribute to the goal of empowerment. In addition, knowledge of self transcendence, spiritual perspective, and social interest can help explain, predict, monitor, and enhance well-being among the lives of those with HIV and AIDS. Furthermore, the findings in this study encourage counselors to help clients to find meaning during challenging times and to move towards relationships rather than retreating from them.

Coward and Reed (1996) identified that the following behaviors have self transcendent and spiritual implications among PLWHA: positive reappraisal and life
review therapy, developing a hobby or favorite pastime, spiritual growth through prayer and meditation, engaging in volunteer work or other altruistic activities, becoming a buddy to another PLWHA, and participating in civic groups, community, church, and support groups. The behaviors identified could assist PLWHA in finding meaning, purpose, and an increased level of well-being. Mental Health professionals can also use this information to assist clients with other chronic illnesses. In short, the incorporation of self transcendence, social interest, and spiritual perspective in counseling encourages clients to seek purpose, reach out to others, and go beyond their typical perspectives to attain a higher level of well-being.

Perhaps the most important clinical implication of this study is the strong link between well-being and social interest. This study links Adler’s construct of social interest to clinical counseling practice among clients with HIV/AIDS. Counselors can utilize techniques to assist HIV/AIDS clients in increasing their sense of well-being by practicing social interest behaviors and attitudes. If social interest is linked to well-being, as the current study suggests, then interventions that foster social interest can enhance well-being among HIV/AIDS clients.

Implications for Future Research

Besides theoretical and clinical implications, this study has research implications. While this study was limited to HIV/AIDS clients, and it seems reasonable that these same protective factors are also operative among PLWHA, additional research is needed to test this hypothesis. Likewise, further investigation could address the direction of causation between self transcendence, social interest, and spirituality to well-being.
Larger cross-sectional and longitudinal research studies can further clarify the role of the protective factors in increasing well-being that was the focus of the current study. Research of the combined impact of self transcendence, social interest, and spirituality on well-being could also identify specific counseling and other interventions that are particularly effective in promoting well-being among PLWHA and those with other chronic diseases. Furthermore, research measuring the link between self transcendence, social interest, and spiritual perspective to CD4 count would link these variables to biomarkers. Presumably, ongoing research on protective factors promoting well-being among PLWHA will lead to an increased sense of well-being for this population and may reduce needless suffering. Other reliability and validity studies of the Self-Transcendence Scale, the Social Interest Index, the Spiritual Perspective Scale, and the Index of Well-Being can extend and refine the psychometric properties of these instruments. Furthermore, studies of psychometric properties of instruments can also increase definitional clarity and further refine the operational definitions of each variable.

Longitudinal studies on the variables in this study could offer increased understanding of the relationships of each protective factor and their influence on well-being among PLWHA. Replication of this dissertation with diverse socioeconomic levels in different geographic areas can increase its generalizability. The limitation section discusses further limitations of the current study and recommends how future research can improve upon the current findings.

Limitations of the Study

The findings in this study present useful information to researchers and clinicians, although there are limitations that need to be identified. Limitations are discussed below.
The following limitations of this study are imposed by the situation:

- The self-report element of each of the independent variables. Social desirability can threaten the validity of the data.
- The instruments were written in English. The participants who were monolingual in a language other than English were not able to participate in this study.
- The sample consisted of participants primarily from a low socioeconomic category.
- The study was voluntary, limiting the data to individuals interested in participating.
- The use of convenience sampling reduces the ability to generalize findings to the entire HIV and AIDS population.

Increased levels of social interest among participants are a limitation to this study. Individuals who have high levels of social interest are more apt to participate in a study on HIV/AIDS. Socially interested individuals are more inclined to contribute to knowledge of well-being among PLWHA than individuals who have lower levels of social interest. Individuals that make meaning out of their own challenges with HIV/AIDS are more likely to participate in research studies that could potentially enhance the understanding of HIV/AIDS, which could help others in the future.

Researchers can respond to these limitations in future studies by including:

- measurements of the different variables with peer ratings as well as self-report ratings. Funder (1995) identified that peer ratings are the best strategy for establishing validity.
• versions of the instruments in multiple languages.

• participants from various socioeconomic groups by sampling at various HIV/AIDS clinics in different regions.

• higher participation incentives to attract participants who are less likely to contribute to increasing knowledge of HIV/AIDS.

Conclusion

In summary, the protective factors of self transcendence, spiritual perspective, and social interest were significantly related to subjective well-being in this study. Overall, self transcendence and social interest explained 45% of the variance in well-being among HIV/AIDS clients studied. Further, the study found that self transcendence accounted for the most variance on well-being among clients living with HIV/AIDS. It appears that these factors can help individuals with HIV or AIDS to live longer and also experience an increased sense of well-being. Furthermore, this study was the first to investigate the relationship of social interest to well-being among HIV/AIDS clients.

Although no causal relationships of self transcendence, social interest, and spiritual perspective on well-being are implied, the significant correlations of these variables alerts therapists that self transcendence, social interest, and spiritual perspective can be meaningful resources among HIV/AIDS clients. Hopefully, subsequent research will further investigate the relationships of these protective factors in psychotherapy practice. Increased knowledge of self transcendence, spiritual perspective, and social interest will foster the counseling profession’s capacity to explain, predict, monitor, and enhance well-being in such clients.
To the extent that living with HIV/AIDS is extended through medical advances, issues of well-being become increasingly important. Counselors can assist such clients to better transcend their feelings of despair to a life of meaning and increase their well-being through social interest, spirituality, and self transcendence. The capacity to transcend difficult situations, relate to others, and connect to a higher purpose or power has been linked to an increased sense of well-being in this study. Finally, this study contributes to counseling research and practice with its finding that increased well-being is possible among PLWHA.
APPENDICES
APPENDIX A

VERBAL CONSENT SCRIPT

I am Jon Sperry, a doctoral student, from Florida Atlantic University in the department of counselor education working on my dissertation. I am conducting a research study on the relationship of self transcendence, spirituality, and social interest to well-being among adults living with HIV/AIDS. The research will help me understand further information about variables that influence well-being among adults living with HIV/AIDS.

Today you will be participating in a brief paper and pencil survey which should take approximately 15 minutes. Your participation is voluntary. If you do not wish to participate, you may stop at any time. Responses will be completely anonymous and your name will not appear anywhere in the final write up. Data for this project will be stored in a password protected computer and will be destroyed after 3 years. The risks in this study are no more than one would experience in regular daily activities. Taking part in this brief self report inventory is your agreement to participate.

If you would like a copy of this letter for your records, please let me know and I will give you a copy now; email, mail, or fax it to you. If you have any questions regarding the research, contact Jon Sperry at 954-523-9454 x 3218 or by emailing at jsperry@fau.edu or Dr. Paul Peluso from the department of counselor education at Florida Atlantic University by calling (561) 297-3625. If you have any questions regarding your rights as a research subject, please contact the Florida Atlantic University Division of Research at (561) 297-0777. Thank you again for your help.
APPENDIX B

CONSENT FORM

1) Title of Research Study: The relationship of self transcendence, social interest, and spirituality to well-being of adults with HIV/AIDS.

2) Investigators: Principal investigators, Paul Peluso, Ph. D. and Jonathan Sperry, LCSW, Ed S.

3) Purpose: The purpose of this research study is to explore the relationship of self transcendence, social interest, and spirituality to well-being of adults living with HIV/AIDS.

4) Procedures: Participation in this study will require participants to complete 4 surveys and a demographic sheet. The surveys will take approximately 10-15 minutes to complete. After all of the questions are completed, participants will receive a $2 gift certificate to Wendy’s.

5) Risks: The risks involved with participation in this study are no more than one would experience in regular daily activities. Should you experience any emotional difficulty during your participation in this study, please speak with the researcher and he will refer you to a mental health provider for counseling, or call Gary Sullivan (Director of behavioral health at Broward House) at 954-523-9454 extension 3212.

6) Benefits: Potential benefits from participating in this study include a greater knowledge of the relationship of self-transcendence, social interest, and spirituality to well-being among adults with HIV/AIDS. Further research on the variables in this study will lead to knowledge about well-being among the HIV/AIDS population.

7) Data Collection & Storage: All of the results will be kept confidential and secure and only the people working with the study will see your data, unless required by law. The data will be kept for 3 years in a password-protected computer in the investigator’s office and then destroyed.

8) Contact Information: *For related problems or questions regarding your rights as a research subject, contact the Florida Atlantic University Division of Research at (561) 297-0777. For other questions about the study, you should call Jon Sperry at 954-523-9454 x 3218 or by emailing at jsperry@fau.edu or Dr. Paul Peluso by calling (561) 297-3625.

9) Consent Statement: *I have read or had read to me the preceding information describing this study. All my questions have been answered to my satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the study at any time without penalty. I have received a copy of this consent form.
You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice. Your participation is entirely voluntary. Your privacy will be protected because you will not be identified by name as a participant in this project.

Signature of Subject: ___________________________ Date: _____________________
Signature of Investigator: ________________________ Date: _____________________
IS WELL-BEING IMPORTANT in HIV/AIDS?

Research shows that certain attitudes and behaviors do increase well-being in persons living with HIV/AIDS.

Sign up now to be part of an important research project that is studying some other personal factors.

- Survey takes 10 to 15 minutes
- Participants will receive a $2 gift certificate to Wendy’s.
- All information is confidential
- Participants must be diagnosed with HIV or AIDS to participate in this study.

For more information contact your case manager or Jon Sperry at jsperry954@gmail.com or 561-237-7411.
Here are a number of statements people might make about themselves. Read the statements and rate them on the scale, depending on how much the statement applies to you. For example, if the statement does not apply at all to you, circle a “1”, if the statement is very much like you, circle a “5.” Use any number from 1 to 5 to reflect the degree to which the statement describes you. Be sure to circle your rating.

1 = Not at all like me
2 = A little bit like me
3 = Somewhat like me
4 = Like me
5 = Very much like me

1 2 3 4 5 1. My friends are very important to me.
1 2 3 4 5 2. I am generally satisfied with my decisions.
1 2 3 4 5 3. Once I decide something I find a way to do it.
1 2 3 4 5 4. My plans generally turn out the way I want them to.
1 2 3 4 5 5. I feel I have a place in the world.
1 2 3 4 5 6. I do my best most of the time.
1 2 3 4 5 7. I feel both partners have equally important roles in a committed relationship.
1 2 3 4 5 8. I am in or looking forward to being in a committed, long-term relationship.
1 2 3 4 5 9. I have warm relationships with some people.
1 2 3 4 5 10. I feel family decisions need to be made jointly.
1 2 3 4 5 11. As far as I am concerned, a deeply committed to relationship is for life.
1 2 3 4 5 12. As far as I am concerned, marriage is for life.
1 2 3 4 5 13. I feel a man and a woman have equally important roles in a marriage.
1 2 3 4 5 14. I am looking forward to getting married.

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APPENDIX E

DEMOGRAPHIC AND HEALTH QUESTIONNAIRE

Please complete the following questions by making a check mark or circling the answers.

1. Date of Birth __/__/__   Age:_______________

2. Gender:       Male ◊   Female ◊   Transgender ◊

3. Relationship Status:
   - Divorced
   - Involved with significant other
   - Married
   - Separated
   - Single
   - Widowed

4. Race:
   - American Indian/Alaskan Native
   - American Indian
   - Asian
   - Black/African American
   - Native Hawaiian/Pacific Islander
   - White
   - Other_______________

5. Ethnicity:
   - Hispanic/Latino/a
   - Non-Hispanic/Non-Latino/a

6. Sexual Orientation:
   - Bisexual
   - Gay or lesbian
   - Heterosexual
   - Other_______________

7. What is the highest grade you completed in school?
   - 11th grade or less
   - High school graduate/ GED
   - 1-3 years of college
4-year college graduate
Graduate school or degree
Other______________________

8. Are you working right now? Yes ☑ No ☑
   If Yes, Full-time
   Part-time
   Retired
   Volunteer (full-time)
   Volunteer (part-time)
   Other ____________

9. What is your monthly income?__________________________

10. What is your HIV/AIDS Status? (mark below)
    HIV+ not AIDS ☑
    HIV+, AIDS status unknown ☑
    CDC defined AIDS ☑
    I do not have HIV/AIDS ☑

   This study is specifically researching different variables among individuals who have HIV or AIDS. If you do not have HIV or AIDS, please give your packet to the researcher now. Thank you for your participation.

11. How old were you when you were diagnosed with HIV? _____________

12. What is your most recent T cell count (CD4 or T -lymphocyte)__________
    Indicate date of lab work from items listed above____________________

13. What is your most recent viral load?_______________________________

14. Are you currently prescribed medication to treat HIV or AIDS? Yes ☑ No ☑

15. Are you currently taking medication to treat HIV or AIDS? Yes ☑ No ☑

16. How would you describe your present health?
    Poor ☑ Fair ☑ Good ☑ Excellent ☑
REFERENCES


