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E. James Baesler

Old Dominion University, jbaesler@odu.edu

Valerian J. Derlega

Old Dominion University, vderlega@odu.edu

Barbara A. Winstead

Old Dominion University, bwinstea@odu.edu

Anita Barbee

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*INTEGRATING SPIRITUALITY, HISTORY,
AND WOMEN'S WAYS OF KNOWING
INTO THERAPY*

Prayer as Interpersonal Coping
in the Lives of Mothers with HIV

E. James Baesler
Valerian J. Derlega
Barbara A. Winstead
Anita Barbee

E. James Baesler (PhD, University of Arizona) is Associate Professor of Communication in the Department of Communication and Theatre Arts, Old Dominion University. Valerian J. Derlega (PhD, University of Maryland) is Professor of Social Psychology in the Department of Psychology at Old Dominion University. Barbara A. Winstead (PhD, Harvard University) is Department Chair and Professor of Clinical Psychology in the Department of Psychology at Old Dominion University. Anita Barbee (PhD, University of Georgia) is Associate Professor of Social Work in the School of Social Work at University of Louisville.

Address correspondence to: E. James Baesler, Department of Communication and Theatre Arts, Old Dominion University, Norfolk, VA 23539 (E-mail: jbaesler@odu.edu)

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SUMMARY. The spirituality of 22 mothers diagnosed with HIV was explored through face-to-face interviews and revealed that 95% of the mothers pray. Active prayers (e.g., talking to God by adoring, thanking, confessing, and supplicating) were more frequently reported than receptive prayers (e.g., quietly listening to God, being open, surrendering). Supplicatory or petitionary prayers for help and health were the most frequent type of prayer, and adoration was the least frequent. The majority of mothers in the sample perceived prayer as a positive coping mechanism associated with outcomes such as: support, positive attitude/affect, and peace. Overall, results supported expanding the boundary conditions of the interpersonal coping component of the Social Interaction Model (Derlega & Barbee, 1998) to include the spiritual dimension of prayer. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Mothers, women, HIV, prayer, religion, spirituality

Many people with HIV live with a kind of invisible disability, an illness that remains unknown to others unless purposely or unintentionally disclosed. With the passage of time HIV, the infection that causes AIDS, becomes increasingly disabling and visible to others in the form of rashes, unintentional weight loss, fatigue, and other health problems (Hoffmann, 1996; Kalichman, 1995). Thus, those living with HIV/AIDS carry a double burden, that of an initially invisible disease which eventually manifests itself through visibly disabling symptoms. In recent years, with the development of antiretroviral combination therapies (Joyce, 1997), many individuals with HIV can live for years without developing any AIDS-defined clinical symptoms. However, there is the stark reality that HIV eventually becomes a disabling and life-threatening disease.

Statistics on HIV in the U.S. population revealed that women comprised about 32% of the reported cases of HIV last year (10,469 cases) according to the Center for Disease Control and Prevention's (CDCP) *HIV/AIDS Surveillance Report* (2000).¹ This trend has remained consistent over the last several years (women made up 32.4% of the HIV cases in 2000, 31.9% in 1999, and 31.9% in 1998 according to CDCP data). As with any serious illness, women living with HIV deal with a

number of critical issues: physiological (e.g., health complications), psychological (e.g., anxiety and worry about health, work, and child care), and social (e.g., conflict and disruption in relationships). For physiological issues there is medical treatment, and for psychological and social issues there is individual counseling, group therapy, and a variety of other types of social support including close interpersonal relationships.

The social support coping mechanisms relevant to women living with HIV has been described in the Social Interaction Model of Coping with HIV infection (Derlega & Barbee, 1998). The model described several factors relevant to women coping with HIV: reactions to the diagnosis, self-identity issues, personal coping, interpersonal coping, and outcome issues. The “interpersonal coping” component of the model includes three variables that influence relationship disclosure and seeking social support: (a) characteristics of the HIV-infected person, (b) characteristics of the relationship, and (c) characteristics of partner. The present inquiry proposes to expand the boundary conditions for the “interpersonal coping” component of the model by adding a spiritual/religious dimension. The addition of a spiritual dimension is justifiable for at least two reasons. First, more of the social science disciplines, such as psychology and communication, are arguing for the study of spirituality as a legitimate area of social inquiry in the academy and for the importance of investigating religion/spirituality as a variable in health studies. For instance, a recent issue of *Journal of Community Psychology* presented several articles that proposed the integration of spirituality into community psychology (Hill, 2000), and a recent meta-analysis of 41 research studies found that religious involvement was significantly related to lower mortality (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000). A second reason for the study of spirituality is that 60% of Americans consider “religion” to be highly important in their lives (Newport & Sand, 1997), and as many as 93% identify themselves as “spiritual” (Zinnbauer et al., 1997). Thus, religion and spirituality are important facets in the lives of most Americans. To further understand the spiritual dimension of interpersonal coping within the context of the Social Interaction Model, the literature relevant to spiritual relationships and prayer was examined.

Spiritual beliefs and experiences, for many individuals in the west, presuppose a relationship between the believer and, for example, Allah (Islam), Yahweh (Judaism), or the Trinity (Christianity). This “relationship with God” is usually created and sustained through some type of communication called prayer. Heiler’s (1932) classic work in religion

described several characteristics of prayer, including conversation, fellowship, mutual intercourse, and communication. These terms highlight the essential relational quality of prayer, namely that prayer is a social phenomenon reflected by an understanding of close personal relationships such as the relationships between child and mother (Heiler, 1932), bride and bridegroom (Talbot, 1985), and friend to friend (Kempis, 1955). Thus, prayer is a specialized type of communication that occurs in the context of a spiritual relationship.² Approximately 90% of Americans report that they pray, according to Gallup poll research, and this percentage has not changed more than plus or minus 2% in the last 40 years (Gallup Organization, 2001). There are a number of examples of prayer occurring in a variety of contexts: (a) personal prayer between an individual believer and God, (b) prayer with a small group of believers and God, and (c) corporate, liturgical, and other types of public prayer. Among these contexts, we chose to limit the scope of this initial inquiry to the personal prayer between a believer and God since this is the fundamental building block for all other types of prayer. In sum, we are interested in exploring the impact of personal prayer in the lives of women living with HIV as one spiritual facet of interpersonal coping in the context of the Social Interaction Model.

The empirical landscape describing the relationship between prayer and HIV is quite sparse with the exception of one study which found that, while HIV-infected women pray more than non HIV-infected women, HIV-infected women reported that prayer is less effective in coping with a "chronic illness" than non HIV-infected women (Biggar et al., 1999). This latter finding deserves some explanation. The mean scores for both HIV and non-HIV women were well above the mid-point of the 1-4 point scale ($M_s = 3.65$ and 3.88 , respectively), meaning that both samples of women believed that prayer *was effective* in coping with chronic illness. In addition to this single study on prayer and HIV, there are a number of empirical studies that examined the relationship between prayer and non-HIV health issues such as chronic pain, life stressors, the death of a spouse, and other medical problems (see review by McCullough, 1995). In general, this line of research on prayer and health has demonstrated the positive impact of frequency of prayer on physiological (e.g., cardiovascular, brain electrical activity, muscle relaxation) and psychological health outcomes (e.g., structure meaning, provide hope, appraisals of stress). One limitation of these research studies on prayer and health is that prayer was operationalized as a single global estimate which does not address the different types of prayer. Perhaps some types of prayers provide more physiological or

psychological comfort/relief than others. There is also the possibility that particular types of prayer during an illness can facilitate a closer relationship with God just as one can experience a closer relationship through the pain of working through conflict in human relationships. No research was found that examined the relationship between types of prayer and relationship with God for individuals living with HIV, but some research has examined the relationship between types of prayer and closeness to God.

The only programmatic empirical research on different types of prayer using large samples is the work of Poloma and her associates (Poloma, 1993; Poloma & Gallup, 1991; Poloma & Pendleton, 1991). Poloma et al. asked individuals if they pray in particular ways and found, across all three studies, that meditative prayer was the best predictor of a single item measure for "closeness to God." Among other efforts to categorize various types of prayer, Baesler (1999) described a Model of Interpersonal Prayer³ that outlines the developmental process of prayer, beginning with active and culminating with receptive prayer. Active prayer emphasizes the "activity" of the believer during prayer such as presenting God with a litany of needs/wants, and trying to resolve some problem by talking it over with God. One way to categorize types of active prayer is to employ a functional typology, describing the purposes of prayer as ACTS: Adoration (worship and praise), Confession (also called reconciliation), Thanksgiving (such as counting one's blessings), and Supplication (petitions for self and others). Other writers on prayer have developed categories of active prayer similar to the ACTS typology (Ai, Dunkle, Peterson, and Bolling, 1998; Kreeft, 1991). In contrast to active prayer, receptive prayer places less emphasis on outward activity and more emphasis on a contemplative attitude of openness, cooperation, and receptivity. The contemplative attitude is generally the fruit of a mature prayer life and predisposes the believer to receive the infusion of God's grace, described in the Interpersonal Prayer Model as a range of experiences from gentle/peaceful to rapture/ecstasy.

In summary, prayer as a spiritual dimension of interpersonal coping in the lives of women living with HIV will be tested and explored through the following hypotheses and research questions:

- H1: The majority of women living with HIV will engage in more active than receptive types of prayer.
- RQ1: What is the rank order frequency for active prayers as denoted by the ACTS prayer typology (adoration, confession, thanksgiving,

and supplication), and what is the rank order frequency of particular types of receptive prayers?

H2: The majority of women living with HIV will report that prayer functions as a positive interpersonal coping mechanism.

RQ2: How do women living with HIV describe their relationship with God?

RQ3: In addition to prayer, are there other spiritual activities reported by women living with HIV that assist them in coping with their illness?

METHOD

Participants

Twenty-five mothers⁴ (64% African American and 36% European American) ranging in age from 18-54 years (average age 35 years) were recruited from HIV/AIDS service organizations in Virginia during 1997-1998. The participants had known their diagnoses for 1-12 years (average 5 years).

Interviews

Semi-structured interviews lasting from 60-90 minutes were conducted by the second author as part of a larger study (Winstead et al., 2001). One of the questions asked participants about their "spiritual beliefs." This open ended question was designed to determine if prayer emerges with sufficient frequency to be considered an important dimension of mothers' spiritual life. Participants were also asked how having HIV had affected their close relationships, including their relationship with God. If the premise that prayer is the spiritual communication link in an interpersonal relationship between the believer and God, then participants will not only reveal that they pray, but also how prayer functions (positively or negatively) in coping with HIV. This question was also designed to explore the quality of mothers' relationship with God. After collecting the data, all of the interviews were transcribed and a coding scheme was inductively developed to identify all of the issues that emerged in the data. Two trained coders independently rated the issues in terms of frequency with coder percentage agreement ranging from 80-100%. The spiritual issues in the coding scheme were categorized by the first author into various spiritual subcategories such as

types of prayer, types of coping, and so on. Samples of the subcategories were independently coded by one other individual and compared to authors' coding, resulting in inter-coder reliability (Phi coefficient; Scott, 1955) ranging from .73-.95. The results section includes excerpts from the original narratives to illustrate the content of the spiritual subcategories based on the coding scheme.

RESULTS

Of the 22 participants who were asked about their spirituality, 95% of them reported engaging in one or more activities that could be classified as personal prayer. Prayer was described by 18 of the 22 mothers using the term prayer or a derivative thereof (e.g., prayed, praying), three respondents used other terms to describe prayer as "talking to God," "feeling God's presence," and "worship," and one participant did not describe any activity related to prayer, maintaining that, ". . . it [religion] wasn't a big issue." Fifteen participants disclosed information regarding the frequency of their prayer with 93% praying at least once a day (e.g., "once a day," "every single day," "on a daily basis"). Several participants reported praying more than once a day (e.g., "every morning and every evening," "constantly," "all the time"). Based on a total of 65 responses related to prayer, 83% were categorized as active prayer and 9% receptive prayer (8% unclassifiable) (see Table 1). These frequency estimates support H1, indicating that the majority of mothers living with HIV engaged in more active than receptive prayers.

RQ1 was addressed by performing frequency counts for the subcategories of active and receptive types of prayer. The rank order frequency (low to high) for active prayers accounted for by the ACTS typology was as follows: adoration, confession, thanksgiving, and supplication (see Table 1 for percentages). The rank order frequency (low to high) for receptive prayers was: silence, feeling God's presence, and surrender to God (e.g., "put in God's hands," "turn it over to God," "give it to Him"). Of the 31 supplicatory prayers, the most common content themes were prayers for the health of self and others (23% of all prayers), and help of various kinds not related to health (e.g., guidance, safe travel, financial, worries) (25% of all prayers). There were 21 additional responses that could not be classified by the ACTS functional typology since the content of the prayer was not specified, but given the information regarding the prayer "form," all but one of these prayers could be categorized as active types of prayer (see Table 1).

TABLE 1. Prayer Types by Percentage and Frequency

<i>Active Prayers</i>	<i>Percent</i>		<i>Receptive Prayers</i>	<i>Percent</i>	
Supplication	47.7	(31)	Surrender	4.6	(3)
Talking to God	18.5	(12)	Feeling God's Presence	3.1	(2)
Thanksgiving	6.2	(4)	Silence	1.5	(1)
Crying	4.6	(3)	Subtotal	9.2	(6)
Confession	3.1	(2)			
Adoration	1.5	(1)			
Singing	1.5	(1)			
Subtotal	83.1	(54)			

Note. Percentages were based on a total of 65 prayer responses from 21 mothers living with HIV. Numbers in parentheses represented frequency counts. One type of prayer was unclassifiable (praying on one's knees, 7.7% (5)).

H2, predicting that prayer functions to help women living with HIV cope with their illness and life in a variety of positive ways, was supported. Mothers with HIV turned to God via supplicatory prayers for help and health in 48% of the prayer responses. In addition, participants attributed particular positive outcomes in their life to the action of God as facilitated by prayer. Positive outcomes that represented a theme of general spiritual support (frequency = 17) included: "God is helping me," "God takes the burden off me," "God keeps me going," "Prayer is helping me cope," "After prayer things just work out." Along with spiritual support, other common themes suggesting that prayer functions as a positive coping mechanism were: positive attitude (e.g., "feel good," "life is more positive," "feel happy," "enjoy life," "feeling blessed") (frequency = 18), sense of peace ("peace of mind," "peace in my heart," "load off my heart," "more peaceful") (frequency = 9), and improved health ("health got better," "not as sick," "feel healthy") (frequency = 7). We noted two cases of mothers who reported praying but did not perceive prayer as a positive coping mechanism, describing their experiences of prayer as: frustrating ("I can't finish [my prayer]," "My mind wanders"), confusing ("It's just so confusing with Him [God]"), and uncertain ("I don't know [re: help from God]").

Beyond the observations that a majority of the participants affirmed a belief in God, and that they were in relationships with God, there was not much specific information on the quality of participants' relationships with God to answer RQ2. Several participants reported positive images associated with God, such as Creator, Healer, Father, and All

Loving, which suggested that their relationship with God was a positive one. But, beyond indirect support for the idea of a benevolent God that helps them cope with HIV and life, the data are not explicit enough to describe any details of mothers' relationships with God.

RQ3 asked if there were any other spiritual activities in addition to prayer that might help mothers cope with HIV. The spiritual activity of church attendance⁵ was the only theme that emerged with sufficient frequency to answer RQ3. Frequency of church attendance was reported by 14 of the 22 participants. Twelve of the 14 mothers reported attending church, and two participants did not attend church. Representative responses for the 55% of mothers that attended church were phrased as follows: "I started going to church," "I go to church more often," or simply "I go to church." Among these responses three participants reported feelings of "love," "specialness," and "support" by the church members or congregation. We also noted two reports where social support was *not* evident in the church, possibly due to the stigma associated with HIV that resulted in negative consequences for two of the mothers (reaction of "fear" by a pastor, and refusal to baptize by immersion).

DISCUSSION

Women living with HIV were asked a series of questions related to types of social support and, in response to an open ended query regarding their spiritual beliefs and practices, many women reported that their *relationship with God* was an important type of interpersonal support that helped them cope with their illness. What is noteworthy about this finding is that the majority of women discussed their personal *prayer lives* vis-à-vis their relationships with God. Specifically, 95% of the mothers living with HIV engaged in one or more activities that could be described as prayer, the spiritual communication between a believer and God. While the 95% figure from this study appeared somewhat higher than Poloma and Gallup's (1991) national survey finding that 91% of women pray, the qualitative data from the specialized sample in this study is not statistically comparable to the quantitative polling data from Poloma and Gallup's sample. However, at least one study (Biggar et al., 1999) has shown that women with HIV pray more ($M = 4.43$ on a 1-5 scale, 5 = pray several times a day, $n = 99$) than a comparable sample of women without HIV ($M = 4.08$), $t(203) = 2.39$, $p < .05$.

We expected in H1, and the data supported, that active prayers (especially supplication) were more typical than receptive prayers in this

sample of mothers living with HIV. Given the myriad of life changing issues that HIV creates, turning to God for support via supplicatory prayer seemed logical, but why were receptive prayers in comparison so infrequently reported (only 9% of the total prayers)? According to the Interpersonal Prayer Model, receptive prayer is the fruit of a mature prayer life. Spiritual growth generally progresses over the course of time from “active only” prayers to “receptive and active” prayers. For at least one-third of the sample, participants reported recently beginning a relationship with God or renewing their relationship with God. Thus, these relationships have not developed the growth needed to sustain a receptive life of prayer. For others in the sample, perhaps the receptive prayers of quiet, simplicity, and openness were not modeled or taught to them. Future research could test the model’s hypothesis that women with mature relationships with God engage in more receptive types of prayer than those with less mature relationships.

Not all types of active prayer were reported with equal frequency. For instance, the active prayer of adoration was reported only once in the sample of 65 reports of various types and forms of prayer. This is unfortunate since the prayer of adoration has been shown to predict closeness/intimacy with God better than any other type of active prayer in Poloma and Gallup’s national study (1991)⁶ and in a study of two samples of college students ($n_s = 84$ and 107 , Baesler, 2001). There were several instances in the present investigation of mothers’ reporting a desire for a closer relationship with God. To address this need, future research might explore different models for teaching/learning various types of prayer and then evaluate their effectiveness in facilitating a closer relationship with God.

Consistent with McCollough’s (1995) finding that prayer generally functioned as a positive psychological coping mechanism for non-HIV illnesses, this investigation found that prayer functioned as a positive interpersonal coping mechanism for mothers living with HIV. One explanation for this finding is that, in cases of serious illness such as HIV, individuals experience a shift of priorities. Material things become less important and relationships become vitally important. As individuals turn to others for social support during their illness, so too, for people of faith, there is a turning to God in prayer for spiritual support. Several findings from the present data supported this line of reasoning. All but one participant in the sample reported that they engaged in one or more forms of active prayer. When the content of these prayers were analyzed, many participants asked God for guidance, help, and good health in addition to thanking God for blessings. There was a sense of opti-

mism in the attitudes of the majority of women as they described the specific outcomes of prayer and their attribution to God's work in their life: feeling supported by God, a positive attitude, a sense of peace, and physical health. These results are also consistent with the finding by Biggar et al. (1999) that women living with HIV rated prayer as an effective method of coping with HIV. Related to these positive outcomes were descriptions of positive images of God as: creator, healer, father, and all loving. Within the overall positive portrait of the effects of prayer, we noted two cases in which mothers reported that prayer was *not* a helpful coping mechanism, producing feelings of frustration, confusion, and uncertainty.

In summary, the frequency, type, content, and outcomes associated with the personal prayer lives of women living with HIV in this sample supported the claim that prayer generally functions as a positive interpersonal coping mechanism. Thus, we recommend the expansion of the Social Interaction Model to include prayer as a spiritual dimension of interpersonal coping. In addition to prayer, attendance at church services was another type of spiritual support reported by 12 of the 22 mothers. Curiously, the two participants that reported *not* attending church both indicated that they still pray, and that their reason for not attending church was: "You don't have to go to Church to praise God" and "I don't need Church because God's already in the [my] house." Future research could examine church attendance by religion/denomination to uncover the dynamics of prayer during church services that might impact coping with HIV.

The present investigation of the prayer lives of mothers living with HIV represents the recognition and renewed interest of spirituality as a legitimate area of inquiry in the social sciences. The benefits of exploring spirituality as an important variable in the field of women's health in this study had theoretical and practical implications. Theoretically, the finding that women with HIV pray in the context of a personal relationship with God provided evidence for the inclusion of a spiritual dimension in the Social Interaction Model of coping with HIV, and the active and receptive prayer categories posited by the Interpersonal Prayer Model were able to account for the majority of prayers. Pragmatically, the findings showed that prayer generally functioned in a positive manner, assisting mothers in coping with their illness and life. Perhaps future research can investigate how specific types of prayer function to help mothers cope with HIV.

NOTES

1. CDC data for women included U. S. states reporting adolescent and adult cases of HIV which had *not* developed into AIDS.

2. The human-Divine relationship has similarities with human interpersonal relationships, including: (a) dyadic relationship between entities developing over time, (b) initial intent to communicate, and (c) specific types of communication. There are also points of contrast, including: (a) the nature of the relational beings, (b) locus of initial intent, and (c) empirical verifiability of communication (see Baesler, 1999).

3. The original model was entitled, "Interpersonal Christian Prayer Model" (Baesler, 1999). The current version of the model reads, "Relational Prayer Model" (Baesler, 2001).

4. Of the 25 participants, 22 were asked about their spiritual beliefs; thus, results were based on 22 of the original participants.

5. All of the mothers who disclosed information relating to religious/spiritual activities with others used the term "church" or "congregation." None reported other places of religious worship (e.g., synagogue, mosque, or temple).

6. Poloma and Gallup's term "meditative prayer" represented a cluster of prayers: thinking about God, feeling God's presence, worshiping and adoring God, and listening to God speak. "Worshiping and adoring God" in meditative prayer directly corresponded with the active prayer of adoration in the present study.

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