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Charles Barber July 11, 2019

It's Complicated: Religion and the HIV/AIDS Epidemic Among Black Same-Gender-Loving Men in the South

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Abstract

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By Charles Edward Barber II

Through a phenomenological-ethnographic lens, this dissertation examines the ways religion and spirituality intersect with the HIV/AIDS epidemic among Black men who have sex with men, BMSM, in Atlanta, GA. The goal of this work is to draw attention to the cultural and phenomenological aspects of lived religious and spiritual experience, which are not normally taken into account or measured by those in the health sciences or in healthcare provision. Through the unique power of personal narrative, this dissertation highlights the complexities of the intersections of religion and spirituality in the lives of HIV-positive BMSM, who are in care at one of Atlanta's leading providers comprehensive of providers of HIV/AIDS care. Coupled with the narratives of healthcare providers, this work gives a rare glimpse into the way lifeworlds of providers and patients intersect. It thickly describes how religion and spirituality can overlap with the health of BMSM in ways that can be health-positive, e.g. engaging in safer sex practices, getting into/remaining in the HIV care continuum, feeling as though they have social support, and/or a greater sense of emotional or physical well-being. Conversely, it also points to how religion and spirituality can overlap with the health of BMSM in ways that are health-negative, e.g. engaging in risky sexual activity or drug use, leading to a culture of silence and shame around same-sex sexual desire and HIV/AIDS, which can result in: the lack of HIV status disclosure, lower engagement in the HIV continuum of care, the loss of social support and social capital, and/or decreased emotional or physical well-being.

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Introduction to an Epidemic

Darius[1]

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

In a sterile, beige, medical exam room with an exam table and two chairs, I interviewed Darius, a 6'2", former Marine, who wore his hair pulled up into a fluffy bun, and had his black and pink outfit impeccably color coordinated with his French manicure. We discussed his journey with his sexuality, Christian faith, spirituality, and HIV/AIDS. He stumbled through his words, took long pauses, and held back tears as he described one of the most traumatic moment's he remembers in his life, which happened in church. When he was around 22 or 23, shortly after he finished his stint in the Marine Corps, Darius went with his mother to her new church in their hometown in Florida. At altar call, he walked to the front of the church along with a group of about twenty other congregants to receive prayer from the female lay-minister of this particular Church of God in Christ, COGIC, congregation.

A hush fell over the room when the prayer began, and the lay minister went around to each person, laying hands on them, praying for them, and anointing them with oil in the shape of a cross. With his eyes closed in a posture of payer, he felt the presence of other congregants slowly move back from around him. The lay minister asked him to step forward, and so he walked up to her. She embraced him, putting one arm behind his back. He thought that she was just whispering a prayer in his ear. However, in her hand behind him was a microphone, and she prayed, "Lord, we

[1] The names of those whose narratives undergird this dissertation and references to any other readily identifiable information, including people, place names, locations, etc., directly tying them to the study have been changed to protect confidential information shared by study participants.

ask you to remove this demon of homosexuality out of this child." The prayer was broadcast across the whole church. This moment Darius recalled, "just fractured everything, totally."

When his love of God and his faith were used against him during that cutting moment, a deep existential wound was gouged that led into a "grey" period of his life. For the next three or four years he remarked, "The sun was just gone, gone, gone." During this time he was diagnosed with AIDS, and for several months was confined to his mother's house because he had to be on oxygen. He went into a deep depression. Darius reflected, "In my mind, like I wasn't going to make it. So, why not go out with a bang?" Through his next-door neighbor, he got access and became addicted to "street drugs," namely crack cocaine. He questioned God, "Why are you making me continue to live? I don't want to be engaged. I don't want to participate. I don't feel like it is worth it any more." When I asked him if he was mad at God, he said "hell yeah I was mad at God . . . . It's like this, I put him on the top of glass shelf . . . like I don't need [him], only until the real trouble happens, then I will get [him] down and dust [him] off.

Getting into an HIV and addiction recovery support group helped Darius out of his depression and enabled him to overcome his addiction to drugs. In this group he felt empowered because he could be open about his HIV status and sexuality and because the group was God centered. He said, "For me this was like perfect, because we could create our own [notion] of God. I didn't know we had that option . . . I wish someone had told me that when I was 22." A part of the program was writing down

the resentments he had for the “whole church hurt thing.” He credited the program with giving him the chance to rebuild his faith system.

One evening, he went to a church event with his sister, who was photographing an event there. He was a bit skeptical, but what happened that night changed his health journey for the better. The pastor of the church took him aside to speak to him. She looked at him like she was “peering into his soul,” and she said, “I want to apologize for anyone that ever hurt you in God’s name.” He described the weight that had been lifted from him as “like three-hundred pounds of all that gunk just fell away,” and he remembered, “ I just bawled for like three days.” Darius believes his restored faith in God and his renewed sense of spiritual wholeness have kept him healthy by giving him accountability, helping him remain adherent to his HIV medications, and providing him with hope.

Religion, Spirituality, and the Health Journey

The vignette above is just a small glimpse into the world in which Darius has navigated his health journey. It illuminates the power personal narrative has to help us understand the lived experiences of both suffering and hope that can accompany religious and spiritual beliefs and practices for BMSM. Additionally, it points to the complex ways in which religion and spirituality have impacts the HIV epidemic in this population.

In the summer of 2018, Darius and 15 other HIV-positive, black men who have sex with men, BMSM, shared their experiences with religion, spirituality, sexuality, and illness with me in exam room three on the research floor at The Clinic, Atlanta, Georgia’s leading provider HIV/AIDS medical care for this population of

men. The Clinic is a hospital-like facility located in a historically black area of Atlanta that is rapidly gentrifying. All of the patients served by the clinic have HIV/AIDS. Well over 90 percent of the thousands of unique patients seen at The Clinic live far below the federal poverty level, many are homeless or housing insecure, and the majority are African American. The Clinic provides comprehensive healthcare, including pharmacy services, routine medical examinations, addiction recovery, religious and spiritual care, and much more. It nationally renowned for its high standard medical care and research on HIV/AIDS, and therefore represented a benchmark setting in which to conduct this study.

Two seemingly distinct worlds, those belonging to religion and spirituality and the other belonging to science and medicine, united powerfully as the men shared their illness narratives in the interview room. Their stories help us to become attuned to the fact that they are not just medical patients seeking treatment, but rather they are health seekers. Their health journeys are burdened by an existential heft that only an ethnographic, narrative-driven approach to exploring their illness experiences can do justice to. These men's stories highlight not only the processes by which they have negotiated life at the intersections of being black, same-sex attracted, HIV-positive, men, but also how they have been affected by traumas in life, such as the murder of loved ones, sexual abuse, rape, violence, homelessness, attempted suicide, and rejection in multiple forms. Importantly, their stories also tell how they found hope, humor, and the strength to live, even if it is just day-by-day. The sum of their experiences—often heavily influenced by religion

and spirituality—are brought to bear on their illness experiences with HIV and into each interaction with their healthcare providers.

For the BMSM whose stories undergird this work and others like them, HIV/AIDS is linked to a magnitude of suffering with roots that extend back in time to the Middle Passage and through an American context of structural racism, violence, and homophobia. We know from public health and sociological data that constellations of macro and micro level social, political, economic, physical, and psychological forces are at play in the epidemic. The narratives presented in this dissertation provide entry into another dimension of the world of many BMSM, which shows how religion and spirituality play a part in their health journeys with HIV. That dimension is too often kept separate from the medical and health sciences worlds they depend on to treat them and to address the epidemic bearing down on their communities.

The men's stories open windows into their health journeys that are often kept closed. Through these openings, we gain insight how the religious and spiritual aspects of their lives have shaped their health journeys across the lifecourse in ways that have been both detrimental and beneficial to their health. These openings can help us to refine our knowledge of how these aspects of their lives are deeply intertwined historically, culturally, and personally in ways that influence their health-related and health-seeking behaviors. Through descriptions of their lived experiences, we gain deeper understanding of the world in which these men live, and the ways religion—primarily Black Protestant Christianity—and spirituality often go unaccounted for in relationship to their health journeys with HIV/AIDS.

The space opened by their stories and subsequent analysis has been created out of a moral impetus to do away with value-neutrality and professional distance, which often accompanies health sciences approaches to examining and intervening in the HIV epidemic among BMSM. Situated in a space of lived experience, this dissertation affords readers a deeper and richer understanding of the ways religion and spirituality are at work in this epidemic. Importantly, it provides a framework for assessing and addressing the phenomena of lived religious and spiritual experiences on the health of BMSM. This framework emphasizes that these essential components of the lives of many BMSM are far more nuanced and complicated than what has been distilled in current research, which tends to reduce religious and spiritual experience into their most basic and functional elements. For these men, religion and spirituality are inescapable realities that have complex implications for their health, especially in the South and in a Bible Belt city like Atlanta, Georgia.

The Realities of HIV Among BMSM in the South and Georgia

Black men who have sex with men, BMSM, is the term used in health and social science discourses to capture the experience of African American men who have sex with other men but do not necessarily identify as gay or bisexual.[1] This group of men has the highest rates of HIV prevalence, i.e. number of those living with the virus, and HIV incidence, i.e. number of new diagnoses, per capita of any other subset of the U.S. population.[2] From 2010 to 2016, new HIV cases among BMSM increased an alarming 40% for those aged 25-34, and HIV-related illness has remained in the top 10 leading causes of death for those over the age of 44.[3] Nearly half, 48%, of BMSM live in the South, the region most impacted by HIV/AIDS.[4]

Outside of the District of Columbia, the state of Georgia has the highest overall rate of HIV incidence in the U.S.[5] The Atlanta metropolitan area is home to a sizable number of Georgia's HIV-positive BMSM, and the majority of those living with HIV in the state.[6] Georgia is known for its rich history of black Christian leadership. The state has the highest number of Black Protestant congregants,[7] and is among the top five states in number of distinct Black Protestant congregations.[8] Thus, religion and spirituality intersect with the HIV crisis in a variety of macro-level and micro-level contexts in the state and its capital city, which shape the health journeys of BMSM like those whose stories appear in this work.

Cultural Constructions of HIV/AIDS and the Place of BMSM

As Paula Treichler notes, "our social constructions of [HIV/AIDS] are not based on objective scientifically determined 'reality' but on what we are told about this reality."[9] Before the illness was named AIDS in 1982 and before its viral cause, HIV, was discovered in 1985, it bore such labels as Gay Related Immune Deficiency, GRID, among health professionals, and was heartlessly referred by some as Wrath of God Syndrome, WOGS, or the Gay Plague. As this illness disproportionately began to impact the gay community, one that was already marginalized and othered by dominant heterosexual norms, the gay body became the site of a viral plague.

The scientific and popular commentary on AIDS at the time portrayed homosexuality as the cause of AIDS. The national HIV/AIDS discourse was focused predominantly on white gay men, as this was the group that was most visibly publically impacted by AIDS at the time. Little attention was paid to the effects that it was having on

African Americans. In part, this was because white gay men and their allies had greater access social and political power in regards to raising awareness about the HIV/AIDS.

As African American scholar Cathy Cohen points out, the absence of any specific focus on HIV/AIDS in the African American community resulted from "the white media [telling] the black community that AIDS was not happening to them." [10] The structural forces of racism and homophobia at play in the nation related to the lack of access to healthcare and heavy stigma about the disease meant data about HIV/AIDS among African Americans was not accurately reflecting the impact of the epidemic on black communities at the time. [11] When combined, these factors led to a deadly lack of initial understanding of how HIV/AIDS was affecting African American communities during these early years.

In this early part of the epidemic African Americans infected with HIV had to rely on traditional mechanisms of support, as there were only a handful of community-based AIDS services geared specifically to them. Most of the HIV/AIDS services targeted the white gay community and were provided by whites. As more became known about how the epidemic was ravaging African American communities in the late 1980s and early 1990s, increased support was dedicated to helping alleviate the burden of the epidemic facing African Americans. However, many black leaders and organizations, like those associated with black churches, held on to beliefs that stigmatized and demonized those living with HIV/AIDS, especially BMSM. These beliefs have endured remain an ever-present reality for many BMSM today.[12]

In the early 1990s, a politics of respectability around HIV/AIDS began to emerge when certain high-profile celebrities like Magic Johnson and Arthur Ashe publically acknowledged that they were HIV-positive; Johnson stating he contracted HIV through

heterosexual intercourse and Ashe through a blood transfusion. Therefore, these "respectable" ways of contracting HIV further stigmatized those black men who contracted HIV through same-sex intercourse.[13] It is within this context of stigma that the concept of "the down low" emerged in the mid-to-late 1990s, and the term MSM was coined in the field of public health to capture the sexual realities of those men who had sex with other men but did not identify as gay. The phenomenon of the down low has taken on a life of its own in popular culture.

Everyone from Christian-Right leader Pat Robertson to Oprah Winfrey has talked about the down low in black culture. This concept is particularly damaging because it associates black, male, homosexual desire with duplicity.[14] Discourse circulating about the down low has effectively led same-sex desiring black men to be characterized as "predatory liars, cheaters and 'mosquito-like' vectors of disease when it comes to HIV."[15] This salacious categorization has resulted in BMSM being further marginalized within their communities, as they are often blamed by black leaders for the presence of HIV in the black community, especially among women. Homophobia and stigma, which often force BMSM to hide their sexuality in order to remain in their communities of support, are key drivers of the epidemic among African Americans. Tragically, a partially related effect of these powerful and destructive forces is that African American heterosexual women are the group of women most at risk for contracting HIV in the country. Nationally black women are over 4 times more likely to be living with HIV than their white counterparts, and in Atlanta they are fifteen times more likely to be living with the virus than their white counterparts.[16] The pervasiveness of down low discourses, as African American transgender scholar C. Riley Snorton notes, "evidences a desire to understand why black

people are so deeply affected by HIV/AIDS and the need to create (and disidentify) with a secretly queer subset of black folks responsible for it all."[17] It is within this discursively mediated reality that BMSM must negotiate their lives at the intersections of multiple minority statuses.

In the Community: Church, Religion, and Spirituality

Same-gender attracted African American men are significantly more likely than their white and Latino counterparts to be part of religious communities and identify that religion is important in their lives.[18] Historically, black churches have been some of the most enduring and important cultural institutions in African American communities. Cornell West states, "The unique variant of American life we call Afro-American culture germinated in the bosom of this Afro-Christianity, in Afro-Christian church congregations."[19] For these men, especially in the South where there are the greatest numbers of Black Protestant churches and adherents, religion and spirituality are historical and cultural realities.[20] Within this context, these forces can play integral roles in shaping their health in relationship to HIV/AIDS for good and for ill.

Black churches have served as essential pillars of support for African American communities. These churches are places of communal belonging and provide social support for many African Americans. Within these institutions, "individuals [are given] multiple roles to play . . . . these roles provide feedback, self-esteem, and social recognition, all of which provide a sense of wellbeing as well as material and emotional support when they are needed."[21] For a people who have been marginalized in society, these churches have served as beacons of hope, providing necessary social support and social capital, as well as being institutions of social control, which continue to shape a variety of social and

moral stances within African American communities.[22] Historically, black churches and institutions have been positioned in a society dominated by white political power and social norms. These norms have a deeply rooted tradition of racializing sex by equating both blackness and homosexuality with sexual deviance. African Americans have had to be diligent in efforts to sever these links in the quest for equality and justice.[23] It is from this position of marginality that traditional black elites, particularly black religious and spiritual leaders, have responded to HIV/AIDS in their communities.

These responses have been primarily two-fold. One response has been centered in the long-standing tradition of provision of services and care to those in need, and the other has been based on more conservative interpretations of Christian scriptures, such as Leviticus holiness codes (18:22; 20:13), Sodom and Gomorrah (Gen. 19:1-9), and Paul's Epistle to the Romans (1:26-27),[24] which deem homosexuality to be sinful. The same-sex attractions of BMSM place them outside of black norms of both Christianity and manhood.[25]

In churches that many these men attend, it is not uncommon for them to hear sermons that rage against homosexuality as a grave sin and denounce it as demonic. Despite both implicit and explicit homophobia, many BMSM remain in and are often integral figures in black churches.[26] Being part of church communities is often central to their lives from childhood, providing them with social networks, support, and helping them cope with the general hardships of everyday life facing African Americans. [27] Being excluded from these communities can be socially, psychologically, and politically damaging for many BMSM because the broader LGBTQ community cannot provide them with equivalent social, political, and/or psychological resources.[28]

Study Design, Recruitment, Implementation, and Limitations

This dissertation is a qualitative formative research study that draws attention to the cultural and phenomenological aspects of lived religious and spiritual experience, which are not normally taken into account or measured by those in the health sciences or in healthcare provision. Through semi-structured, narrative history interviews with BMSM and their healthcare providers, its goal is to highlight the complexities of the intersections of religion and spirituality on the health journeys of BMSM infected and affected by HIV/AIDS.[29] Its primary aims are to: 1) show how lived religious and spiritual experiences shape the processes by which BMSM negotiate their lives at the intersections of multiple minority statuses and managing life with HIV 2) generate formative research data about how religion and spirituality operate alongside other social determinants of health in the lives of BMSM, which can be used in future research to design more effective and relevant modes of public health practice and healthcare provision 3) contribute to interdisciplinary, bridge-building scholarship that examines the intersections of religion and health, particularly in relationship to the ever-growing domestic HIV/AIDS crisis facing BMSM. In order to be included in this study, men had to be over 18, self-identify as African American, Christian or formerly Christian, HIV-positive, having grown up in the United States, and living in metro-Atlanta at the time. The inclusion criteria for healthcare providers were that they had to provide care to HIV-positive BMSM and work at The Clinic.

At the end of July in 2018, I began study recruitment at The Clinic. Two infectious disease doctors I was acquainted with through Emory University connected me with clinical research staff members there. In our discussions, these researchers and several

clinicians expressed skepticism about how a study seeking Christian and formerly Christian BMSM would be received. I placed flyers advertising the study at strategic locations around The Clinic, and we also asked several other researchers around Atlanta to help recruit to ensure the study would draw enough participants. The study was full within the first few days, and news about the study had circulated so widely around the community that I had well over 50 men on a waiting list. For weeks after recruitment ended, I received phone calls at all hours of the day and night from men who wanted to take part. They were drawn to the study because they wanted to discuss their experiences with religion, spirituality, and their journeys with HIV, which were not subjects they felt free to talk about regularly, yet were fundamental parts of their life experiences.

Throughout the month of August 2018, I conducted the 15 interviews with the men in a small medical exam room at The Clinic. These semi-structured life history interviews were designed to elicit their stories about how religion and spirituality played a role in their lives from childhood to the present, and how they felt these aspects of their lives shaped their identities and affected their health, particularly in relationship to HIV. I also asked them how, if at all, they thought these aspects of their lives should be addressed in the healthcare setting.

To attest to how important these topics were to these men, most came in sat down and talked for over an hour about their lives, and they answered nearly all of the questions on my semi-structured research guide with little interjection from me as the interviewer. Distinctly aware of my presence as a white, male, researcher in the clinical setting, I noted the power dynamic that context implied as I asked questions that often triggered painful and traumatic memories. Throughout these interviews the men and I would talk about

common experiences of Southern cultural roots, our religious backgrounds, and our experiences as same-gender attracted men. Several of them remarked they would not have felt comfortable sharing the most intimate details of their lives with a straight person, man or woman. What emerged from this process were over 450 pages of transcripts containing rich life history narratives that documented the ways lived religious and spiritual experiences have been integral to their health journeys with HIV long before they even contracted the virus.

In September and October of 2018 I interviewed seven care providers at The Clinics: the chaplain, a clinical social worker, a physician's assistant, a nurse practitioner, and three infectious disease doctors. This was shy of my goal of 10 provider interviews. These were life history narratives as well. The providers discussed their own lived religious and spiritual experiences, which for many were directly connected to their desire to work in the healthcare field with those infected and affected by HIV/AIDS. These interviews were also designed to elicit how they addressed religion and spirituality in their patients' lives, particularly BMSM, as well as how they thought these aspects of their patient's lives could be better incorporated into provider/patient relationships and in the broader healthcare setting of The Clinic. To my knowledge, this is the only study conducted in a healthcare setting that examines the intersections of lived religious and spiritual experiences on the lifeworlds of HIV patients and their healthcare providers. These intersections shape the health journeys of BMSM with HIV/AIDS and impact their health-related and health-seeking behaviors.

This study has several limitations. One primary limitation is that it only examines the lived religious and spiritual experiences of those men who are already HIV-positive

and in care. It does not look at the experiences of BMSM who are HIV-negative and examine how their lived religious and spiritual experiences inform their health-related and health-seeking behaviors. It also does not examine the lived religious and spiritual experiences of HIV-positive BMSM who are not in care and explore connections between those experience and their health-related and health-seeking behaviors. However, the diversity of these men's life experiences provides generalizable insight about the impacts of lived religious and spiritual experiences on the spiritual, mental, and physical health of BMSM broadly. This study also does not purport to provide insight into the lived religious and spiritual experiences on health of those BMSM who have not had some connection with the Christian faith, and future studies are needed to explore similar themes with BMSM who identify with Islam or other faith traditions.

Religion, Spirituality, and Life with HIV in Their Own Terms

The men and healthcare providers often use the terms religion/religious and spiritual/spirituality interchangeably in their narratives. Depending on the context, the meaning of these terms may or may not overlap. However, for the purpose of analysis that accompanies these narratives, the terms religion/religious are used in the Durkheimian sense to refer beliefs, practices, and rituals relative to the Sacred that bind people together in an organized community or group, such as a Black Protestant church.[30] Following Dalmida et al. (2012), in a study that assessed the role of spirituality in the health of women living with HIV, the terms spiritual/spirituality are used in a broad sense to denote an individual quest for meaning and purpose in life. This may include a belief system about a higher power, elements of religious beliefs and practices, and/or a focus directed beyond the physical world.[31]

Religion and spirituality are integral to the historical and cultural ethos in which many BMSM live and form their identities. Through examination of current data from the health sciences, this dissertation fills gaps in our knowledge of how to assess and address religion and spirituality in the lives of BMSM, which can improve health-related and health-seeking behaviors among this group of men at risk for or diagnosed with HIV/AIDS. Accounting for lived religious and spiritual experiences is essential for the development of more effective and culturally relevant public health interventions and healthcare practices that are geared towards this group of men.

In the proceeding chapters, this dissertation builds a new framework for conceptualizing how religion and spirituality are accounted for in regards to the health of HIV-positive BMSM, which is grounded in their experiences of illness. These chapters provide a multi-faceted framework that present subject-centered understandings of these men's religious backgrounds, including acute experiences of ostracism and marginality, as well as positive experiences of hope, belonging, and love. Through their own words, you will come to know the stories of several HIV-positive BMSM, who are living with HIV in Atlanta, Georgia; a city where HIV in their communities rivals many cities in Africa hardest hit by the epidemic.[32] Some have lived their whole lives in Atlanta, others moved to the city from other parts of the South and the U.S.—many because the city's large gay population offered them a chance to have community and to be themselves.

Chapter 1 provides a review of health sciences literature, which details how religion and spirituality are most commonly assessed and addressed in public health and healthcare related discourses about the HIV epidemic facing BMSM. This data highlights the deleterious health consequences that religiously rooted homophobia and HIV-related

stigma can have on the health of those in this population. It also highlights the positive aspects of religious and spiritual beliefs and practices that can improve health outcomes for those with HIV. Through the review of this literature, it draws attention to the limitations of health sciences research in accounting for the lived religious and spiritual dimensions of the lives of BMSM. It then discusses the ways in which I draw upon and ground this dissertation in religious studies methodologies that examine the phenomenological aspects of lived religious and spiritual experiences. My approach is influenced by the psychiatrist and medical anthropologist Arthur Kleinman's phenomenological study of illness experiences.

In Chapter 2, the men describe defining life moments from childhood to the time they contracted HIV. These accounts chart the impact of religiously rooted homophobia encountered in their churches, communities, and/or families on their health journeys. Their stories demonstrate the importance of Afro-Christian traditions in black communities, and point to the strength of social cohesion formed around religious and spiritual beliefs and practices. They also offer valuable knowledge about cumulative effects of externalized and internalized homophobia, and how these effects carry over into adulthood, shaping the ways BMSM negotiate their identities, same-sex attractions, sexual lives, and helps contextualize the circumstances through which they contract HIV.

The illness narratives continue in Chapter 3, as the men describe what their lives were like following HIV diagnosis and how they have managed life with chronic illness. Their stories confirm health sciences data that demonstrates broad ranging negative and positive health outcomes related to religious and spiritual beliefs and practices in HIV-positive BMSM. These accounts are thick descriptions of what life was like for them

following diagnosis and the overlapping ways in which religious homophobia and HIV-related stigma contributed to issues, such as depression, drugs and alcohol abuse, engagement risky sexual behaviors, non-disclosure of HIV status to sexual partners, and even homelessness in their lives. Critically, their experiences show the diverse processes whereby they have negotiated their religious and spiritual beliefs and practices in ways they find health-affirming living with HIV.

Chapter 4 shows the limitations of the biomedical frameworks that tend to permeate the culture of healthcare settings when assessing and addressing the religious and spiritual dimensions of the illness experiences of BMSM. In the patient/provider relationship, these dimensions of patients' lives can be devalued in relationship to what Kleinman describes as "the 'scientifically hard,' therefore overvalued, technical quest for control of symptoms."[33] In order to improve the provision of religious and spiritual care and resources within the healthcare setting, the men share their thoughts and opinions on accessing them, and they also describe barriers to access and utilization. Their insights offer direction about best practices for incorporating religious and spiritual care in healthcare settings that have arisen out of their own lived experiences.

In Chapter 5, seven healthcare providers from The Clinic discuss their lived religious and spiritual experiences, how they account for religion and spirituality in provider/patient relationships, what challenges they face in caring for these dimensions of their patients' lives, and how they think that these aspects of healthcare provision could be improved at The Clinic. The professional diversity of these providers is also important. They represent a variety of healthcare provisional capacities including: chaplaincy, social work, nursing, physician's assistantship, and infectious disease medical care. Their

narratives and observations demonstrate a pressing need for additional research that examines how the lifeworlds of providers and patients intersect, and they serve as a building block for future work in this area.

Chapter Six, the final chapter, draws observations and conclusions from the lived experiences of the men and their healthcare providers to expound on the importance of the narrative-driven phenomenological approach I utilize in this dissertation. It highlights how the approach I have taken in this dissertation provides a framework for evaluating how religion and spirituality—two of the most important ways of making meaning of and finding coherence in their life—intersect with the health journeys of BMSM in ways that shape the HIV epidemic facing this population. It draws attention to the processes of how, when, and why they have negotiated their lives in relationship to religious and spiritual beliefs and practices. In conclusion, I describe how the approach I have taken can help foster the creation of more effective public health interventions and healthcare approaches to treatment and prevention of HIV/AIDS in BMSM.

The narratives of the men and healthcare providers whose voices undergird this dissertation provide unique contributions to the field of religious studies. They highlight the much needed and potentially life-saving power of the phenomenological study of lived religious and spiritual experiences for BMSM infected and affected by HIV. These narratives represent an as yet undocumented account of the lived religious and spiritual dimensions of the illness experiences of BMSM, as well as showing how the lifeworlds of these men and their healthcare providers intersect in the healthcare setting. Additionally, they bolster the findings of health sciences research that describes the negative and positive ways religion and spirituality can impact health outcomes of BMSM. By utilizing

data from lived experiences, this dissertation builds a framework that pushes beyond the purely functional viewpoints on religion and spirituality that tend to dominate health science discussions. Through its ethnographic and analytical data, it can strongly contribute to the creation of more culturally relevant and comprehensive approaches to HIV prevention and post-diagnosis care for BMSM that are not only more effective but also more socially just.

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Chapter 1

Conceptualizing the Role of Religion and Spirituality in the Health Journey with HIV

The HIV epidemic facing BMSM is one of the most pressing public health challenges in the United States today. To improve the relevance and effectiveness of care that HIV-positive BMSM receive, as well as the overall testing rates, prophylaxis use, and communal wellbeing of this group of men, it is essential that those in the health sciences and healthcare fields become attuned to the threads of common experience of these men. To do so will require exploration of life histories of specific people and places. This project focuses narrowly on the relationship between Black Protestant Christianity—including religiously grounded homophobia and HIV-related stigma—and the lived realities of being black, same-sex attracted, men.

For some BMSM, their religious and spiritual beliefs and practices support better health outcomes. For others, these benefits are counterbalanced by experiences of rejection, abuse, and even violence that are justified by religious logics that deem homosexuality to be sinful and/or that HIV is the product of such sin. In the health sciences and healthcare fields, the central roles that religion and spirituality play in the health journeys of BMSM, remain to be adequately accounted for when examining the HIV epidemic in this population. Understanding these dynamics requires first-hand insights from the illness experiences, i.e. the culturally and relationally mediated ways in which illness is embodied, [1] of HIV-positive BMSM that describe their religious and spiritual histories, and also requires the perspectives of their healthcare providers.

Using an interdisciplinary approach, this dissertation offers religious studies-based qualitative description and analysis of the lived experiences of HIV-positive BMSM in order

to explore the impact of religion and spirituality on their health. Personal narratives orient and drive the project's ethnographic phenomenological perspectives. The core of this phenomenological approach privileges individuals' self-knowledge. The voices of the BMSM and their healthcare providers who carry this dissertation attest to the impact of lived religious and spiritual experiences upon the health journeys of many men in this population with HIV/AIDS. The prominence with which religion and spirituality factor into the accounts of these men's health-related and health-seeking behaviors compel us to re-think public health interventions and healthcare delivery for BMSM in the South and around the nation.[2]

This dissertation is based on narratives from 15 HIV-positive BMSM, most of whom are in care at The Clinic. Their accounts of their lives illuminate the ways that religion and spirituality intersect with their illness experiences with HIV, which are hidden by the functionalist perspectives taken by health sciences research that examines the HIV epidemic facing BMSM. Coupled with seven narratives from The Clinic's healthcare providers representing various levels of patient care, this dissertation furnishes a rare and detailed glimpse into the intersections of the lifeworlds of patients and healthcare providers in the healthcare setting, and it describes how the healthworlds of BMSM seeking care and treatment are shaped through these intersections.

From these narratives a more comprehensive analytical framework for evaluating the roles that religion and spirituality play in the lives of BMSM emerges. This framework bridges two seemingly disparate worlds. One is the world of the health sciences, which is guided by medical paradigms that are grounded in the pragmatics of biological facts. The other is the study of religion and spirituality that acknowledges transcendental

understandings as a form of factual knowledge for believers. This framework allows for the complex and often contradictory nature of religion and spirituality in these men's lives to be explored and accounted for when studying the epidemic and/or providing them with care. Ultimately, examining the lived religious and spiritual experiences of BMSM and their healthcare providers helps us begin to assess meanings of and address needs for religious and spiritual care to be more effectively integrated into public health interventions and healthcare provision for BMSM.

Religion and Spirituality in the Health Sciences

Numerous studies have reported greater levels of internalized homophobia in BMSM, which has been associated with higher rates of HIV in this population. Overall, black men "have the lowest life expectancy and highest mortality rate of any racial group in the United States," which is due to the impacts of social and structural marginalization.[3] As a result, they are subject to greater health disparities than their white counterparts, including mental health problems and disorders, such as depression, anxiety, and suicidal ideation.[4] The impact of this marginalization is compounded for BMSM because of their same-sex attractions. The resulting strain on their identities for failing to meet cultural norms of masculinity, i.e. gender role strain, means that many of these men repress or camouflage their same-sex attractions by modifying their behaviors depending on social conditions.[5] These cultural and social conditions lead to significantly higher rates of depression and mental illness than their heterosexual counterparts, which has been associated with increased sexual risk taking.[6]

Stigma, often based on religious homophobia, is a critical driver of this epidemic. It encompasses both external prejudicial actions by others and internalization of feelings of

fear and shame at the thoughts of others treating them adversely.[7] The effects of such stigma have been negatively associated with HIV testing and engagement in the HIV care continuum, which is "the series steps from the time a person receives a diagnosis of HIV through the successful treatment of their infection with HIV medications."[8] It has also been associated with engagement in risky behaviors like those associated with unprotected sex or drug use, which could lead to greater exposure to HIV and other illnesses. [9]

In the largest cohort study of BMSM that consists of data collected from six major U.S. cities, Mayer et al. (2014) acknowledge, "the factors associated with this concentrated epidemic are not fully understood."[10] Their study was designed to assess how various individual determinants of health interact in ways that explain the disproportionate burden of HIV in this population. In congruence with national level epidemiological data, the researchers found that BMSM newly diagnosed with HIV in this study tended to be younger. Their study participants reported lower educational attainment, were housing and food insecure, and had less access to healthcare. The participants also reported multiple manifestations of stigma and discrimination related to racism and homophobia. Exposure to non-affirming religious viewpoints may have contributed to this homophobia, as 76% of the men reported identification with religion growing up and just under half, 44%, were involved in a faith community at the time of the study.[11] Other studies conducted with BMSM confirm the same intersections of individual level health determinants. In an Atlanta-based study, Sullivan et al. (2015) found many of these same individual level determinants in their study population of BMSM. They also point to how these individual level determinants intersect with macro-level social determinants of health—the larger set of conditions in which people are born, grow, live, work and age—

that include structural inequalities, which affect communities, neighborhoods, and sexual networks these men are part of. Within these micro-level contexts, income inequality, housing and food insecurity, lower educational attainment, diminished access to healthcare, health disparities, and higher rates of HIV are prevalent.[12]

Religion and Spirituality, The Negative

Homophobia grounded in religiously rooted precepts about human sexuality often exacerbates the stigmatization and marginalization of BMSM. High levels of religiosity among African Americans have been associated with consistent opinions among blacks that homosexuality is "always wrong" on the General Social Survey. A recent study found that the percentage of blacks that indicated this opinion has remained relatively stable from 1970 to 2008 at well over 60%; only in 2018 did it drop just below 50%. This stands in stark contrasts to whites whose opinions that homosexuality is always wrong declined from as high as 77.8% in 1988 to around 54.7% in 2008 and was around 28% in 2018. Black MSM are twice as likely as their white counterparts to report that homosexuality is always wrong, 57.1% to 26.8% respectively.[13] Thus, religion is often a source of stigma and homophobia in the lives of BMSM, even if they themselves are not religious.

Stigma associated with higher rates of communal religiosity may manifest in some of the most important relationships and sources of social support for BMSM, like their families, friends, churches, and communities.[14] This stigma is often enduring because they tend to remain in their own communities rather than residing in areas that have larger populations of LGBTQ individuals, as these areas tend to be whiter and have a higher cost of living.[15] For those men remaining in non-gay affirming communities, there is a higher correlation with feelings of identity conflict and lower levels of social support.[16]

Though religion has been shown to increase life satisfaction and result in better health outcomes for African Americans as a whole, this is not necessarily the case for BMSM.[17] Links have been shown between increased religiosity and internalized homophobia, as well as feelings of incompatibility between same-sex attraction and religious or moral frameworks. Detrimental effects of such homophobia have been linked to behaviors that can cause increased exposure to HIV, such as unprotected sex and drug use. Additionally, they are linked to lack of disclosure of HIV status, delays in testing, delayed entry into/retention in the HIV continuum of care, and fears related to losing essential sources of social support.[18]

Religion and Spirituality, The Positive

There are many positive health benefits associated with religious and spiritual beliefs and practices for BMSM. In studies from around the country, prayer and faith in God have been shown to promote mental and physical wellbeing for BMSM. These practices and beliefs are more individualistic in nature and can occur outside of the bounds of institutionalized religion. Thus, BMSM can use such tenets of their religiosity and spirituality in ways that enable them to cope with adversity, homophobia, and the realities of managing their lives with HIV.[19] A study conducted using data from the CDC found that BMSM that were more religious and spiritual were less likely to have HIV and also less likely to engage in risky behaviors that may lead to potential exposure to the virus; though it was not noted if these men were involved in a faith community.[20] Engagement in religious communities that are affirming of same-sex attracted individuals and do not condemn those with HIV/AIDS my help address stigma and homophobia in this community, thereby promoting better health outcomes for BMSM. [21]

Among those living with HIV/AIDS, spirituality and faith have been associated with better health outcomes. In a study of men and women living with HIV from diverse Christian backgrounds in three U.S. cities, the majority of patients used religion and spirituality to cope with their HIV status; 75% even reported their illness had strengthened their faith. African Americans in this study were also more likely to use religious coping skills, like looking for stronger connections with God, rather than using negative religious coping strategies that were not health-affirming. Additionally, increased levels of spirituality were found to be associated with having secure housing, less depressive symptoms, and having lived longer with an HIV diagnosis.[22] The relationship between increased spirituality and depressive symptoms is important to note, as there have been documented relationships in HIV-positive people between greater depressive symptoms and worse HIV-related measures of health, such as lower CD4 counts and higher viral loads of HIV in the body that are indicative of suppressed immune system functioning.[23]

Religion and Health Partnerships

Given the historical importance of black churches in African American communities, those in the field of public health have identified black churches and faith-based organizations as prime partners for engaging HIV prevention for BMSM.[24] However, the stigma that surrounds same-sex attraction keeps most churches and faith-based interventions from addressing HIV in this population.[25] Fortunately there are already black churches and affiliated organizations that have been modeling successful strategies that combine public health practices with religious approaches in some of the areas of the Deep South where black MSM are most impacted by HIV.

Project Fostering AIDS Initiatives that Heal, FAITH, in South Carolina began 2006 and lasted until 2011. The goal of Project FAITH was to create horizontal partnerships between state resources and those of African American churches and organizations in order to develop and implement self-sustaining, locally applicable HIV/AIDS prevention interventions. These interventions sought to directly address issues with stigma and attitudes that had for so long prevented many community members, black MSM included, from accessing HIV-related resources.[26]

Another successful program that combined public health messages of prevention, stigma reduction, and increase access to HIV-related resources is Churches United to Stop HIV, CUSH, which began in Broward County, Florida in 1999. CUSH brought together the resources of the Florida Health Department and those of local churches to educate teens about HIV/AIDS. It provided HIV prevention for tens of thousands of people and trained nearly 3,000 faith leaders to empower African American churches to act as conduits for important health related information. Though neither one of these programs was designed specifically to address the needs of black MSM, they were designed to create safe spaces for culturally appropriate, open, pragmatic discussions of about safe-sex and HIV/AIDS prevention.[27]

William Jeffries, a foremost public health scholar in the area of HIV/AIDS among BMSM, has highlighted the importance of Interdenominational Church in Nashville, TN, which uses scripture to combat HIV among BMSM, and has helped inform the NAACP's HIV strategy for handling the epidemic in this population. The NAACP formed *The Black Church and HIV Initiative*, to help draw African American communities of faith together to help fight the epidemic by providing resources for denominations, pastors, and churches to

combat the illness through education and prevention. This initiative also draws attention to the impact of homophobia on the epidemic in African American communities. [28]

The Health Sciences on Religion and Spirituality and HIV/AIDS among BMSM

Current health sciences and biomedical research about the HIV epidemic among BMSM explores the conditions that contribute to disproportionate burden of the disease in this population. It shows demonstrable proof of the enduring legacy of social and structural racism on the overall health of African Americans, highlighting broader, macro-level structural inequalities that help account for the epidemic.

The interventionist modalities of the health sciences have led to successful strategies for assessing and addressing the HIV epidemic among BMSM, which have helped slow the epidemic in this population. However, what is missing is effective engagement with the lifeworld narratives of these men, who live "emotional, relational, historical, and cultural lives that are expressed in countless ways."[29] Religion and spirituality are integral parts of the processes that shape these men's identities, provide meaning and coherence in their lives, and impact their health-related and health-seeking behaviors. Therefore, they are irreducible components of their health journeys in relationship to HIV and must be accounted for.

The surveys, questionnaires, and behavioral checklists used in public health and healthcare provision tend to reduce the complexities of these experiences into causes, effects, correlations, and associations. They distance us from the lived experiences of the health journeys of these men. Ultimately, they do not afford an opportunity to go alongside these men in their health journeys, allowing us to see the development of their illness experiences and ways they make sense of and manage their lives with chronic illness.

Through the lived religious and spiritual experiences of the men's stories presented in this dissertation, a more robust understanding of the HIV epidemic facing BMSM is afforded. It enables us to fully appreciate how these forces impact the health journey with HIV. These journeys take place over a lifecourse; they are dynamic; and they have many interlocutors.

Current research in public health and healthcare provision also does not take into account the importance of the lived religious and spiritual experiences of some of the most important interlocutors in the health journeys of BMSM, their healthcare providers. Just like the men, providers bring the sum of their own life experiences into relationships with patients. For many, religion and spirituality factor into the way they approach their professions and treat their patients, which can have a profound impact on the care that BMSM receive. What is needed is a different approach that can examine the disproportionate impact the epidemic is having on BMSM, drawing on existing frameworks and paradigms in the field, yet accounting for how lived religious and spiritual experiences impact the health of BMSM in relationship to HIV/AIDS.

Evaluating the Effects of Religion and Spirituality on Health through Narrative

Existing conceptual frameworks from the health sciences and biomedicine capture the most concrete and functional intersections of religion and spirituality on the health journeys of many BMSM. However, religion and spirituality are not simply functional elements of these men's lives. They cannot be stripped from their historical, communal, and personal contexts, as they are part of the continual processes of living and meaning making. It is necessary that a more integrative approach be developed for exploring these intersections in order to capture the dynamic nature of the lived religious and spiritual experiences that shape the health journeys of many BMSM over the lifecourse. In this

dissertation, I build a framework that enables these lived realities to be more thoughtfully interrogated. This framework is guided by the authenticity of their embodied experiences that comes from their life narratives descriptions of their health journeys. Through this framework, the impact of religion and spirituality on the illness experiences of these men can be more effectively and meaningfully assessed and addressed to promote better health outcomes.

A narrative-based phenomenological approach grounded in religious studies best supports investigation of this dissertation's key questions and issues. This approach also supports the dissertation's analytic framework because it methodologically seeks to describe the religious and spiritual phenomena in terms used by the men themselves. Though this approach involves interpretation through a religious studies perspective, it remains attuned to the experiential dimensions of religious and spiritual life as embodied aspects of these men's health. Importantly, this narrative-based phenomenological approach does not force these experiences to be put into rigid categories that flatten the dynamic processes of how many BMSM make sense of their illness experiences.

By utilizing narratives as the footing from which to build analyses and conclusions, this methodology allows for religious and spiritual phenomena to be perceived from the perspective of the men who live them. Thereby, the framework that emerges intuits new ways of looking at the broadest dimensions of these men's health journeys. It provides a more complete understanding of the ways individual level and social level determinants of health impact the spiritual, mental, and physical health of BMSM.[30] A narrative-based phenomenological approach also reflects the historical emphases of this analytic framework, pushing back on scientific and medicalized assessments of religion and

spirituality that flatten the complexities of human experiences. This methodology reaches beyond what is physical and observable. It pushes into metaphysics of self-knowledge and embodied experience, meaning making, cultural histories, and the discursively mediated realities that guide these men's actions along their journey with HIV.[31] These discursively mediated realities, as black queer studies scholar E. Patrick Johnson notes, take into account the embodied experiences of racialized sexuality on LBGTQ people of color.[32]

In order to more substantively examine the impact religion and spirituality on the health journeys of BMSM in relationship to HIV/AIDS, I draw specifically from the work of Arthur Kleinman. Kleinman's narrative-based approach in his work *The Illness Narratives: Suffering Healing & The Human Condition* (1988). Illness narratives, like those of the HIV-positive BMSM featured over the next several chapters, "edify us about how life problems are created, controlled, and made meaningful."[33] An essential part of these narratives for Klienman are life histories, which include religion and spirituality, and how the sum of these histories are brought to bear on the illness experiences of patients. By narrating their illness experiences, those whose illness narratives guide this work explain their health journeys with HIV as mediated by the socio-cultural web of relations, including religious and spiritual relations, practices, and materials, in which their lives have been enmeshed. As health seekers, these BMSM bring the sum of their life experiences into the patient/provider relationship.

Kleinman posits that illness narratives give coherence to patients' experiences and the long-term course of suffering with chronic illness.[34] He argues that it is essential for practitioners to draw out and value these illness narratives, as they provide explanatory models for how patients negotiate their life circumstances in relationship to disease, which

includes their actions in relationship to their health. Rather than the practitioners being the experts on the illness experiences of patients, this model allows patients to be the experts of their own illness experiences. By giving patients this ownership, practitioners can learn more about the social environment in which patients experience illnesses, and how their environments impact their management of life with chronic illness. To have a dissocialized story of illness that does not take into account patients' illness narratives, Kleinman argues, impedes the most effective treatment because it does not allow practitioners to see the world behind patients' illnesses. It effectively leaves out how the sum of their life experiences have influenced their health up to and after contracting a chronic illness, which influences how they perceive and relate to their own health.[35] He also highlights how certain elements of professional training that are focused on scientific facts and treatment distance practitioners from their patients, which can be both self-preserving for the practitioner and detrimental to the overall health and wellbeing of the patient.[36]

The illness narratives of the men whose voices guide this work help them make sense of life events, how they have managed to live life at the intersections of compounding minority statuses, as well as how they have grappled with the effects of chronic illness. Religion and spirituality are woven throughout these narratives. To not account for that in public health interventions and healthcare provision would be at the very least to ignore and at the worst to completely misinterpret how they perceive themselves, their social environments, their illness, and their health. I use Kleinman's narrative-based phenomenological approach to foreground an experiential phenomenology of illness that opens a door into the social and metaphysical worlds of HIV-positive BMSM. This

methodology sheds crucial light on the ways religion and spirituality have intersected with their health journeys with HIV.[37]

In order to assess the impact religion and spirituality have on the health journeys of BMSM in relationship to HIV/AIDS and the socio-cultural spaces they occupy, I draw from public health and religion scholars Gary Gunderson's and James Cochrane's concept of the healthworld as derived from Jürgen Habermas's concept of the lifeworld. The lifeworld consists of "culture, society, and personality, mediated respectively by cultural reproduction, social integration, and socialization."[38] We are embedded in these dynamic lifeworlds through a web of interrelations, and this embeddedness frames the full range of our modes of being and our actions. The structural and social forces of racism and homophobia are part of this web of interrelations in the lives of BMSM. For many BMSM, whether they identify as religious or not, religion and spirituality, particularly tied to Black Protestant Christianity, are integral parts of their lifeworlds and play important roles in their experiences of their same-sex attractions and their health.

The healthworld is a component of this lifeworld and includes the socio-cultural relations people are embedded in, which impact health for better or worse. Gunderson's and Cochrane's concept of the healthworld includes the ways in which religion and spirituality affect people's embodied experiences of health, specifically how these forces inform patterns of health-related and health-seeking behavior that affect comprehensive wellbeing.[39] In the lives of many BMSM, religion and spirituality shape their healthworlds in significantly important ways that the narratives in the proceeding chapters illuminate.

A unique contribution of this dissertation is the fact I place the lifeworld narratives of BMSM alongside those of healthcare providers. Their narratives offer a glimpse into the

rarely documented lifeworlds of healthcare providers, including how their specialized knowledge, skillsets, and their own religious and spiritual beliefs and practices intertwine with the healthworlds of BMSM. Through their own words, we learn about the "felt experience of doctoring" and the "stories of what it is like to be a healer," which may or may not include religion and spiritualty.[40] Some of these providers have had to grapple with their own opinions about homosexuality, which have been informed by their faith traditions. Other providers view working with this marginalized group of men as part of the essential mission of their faith traditions. Yet, there are other providers for whom religion or spirituality are not significant in their own lives, but they acknowledge the general importance of these forces in the lives of their patients.

These healthcare provider narratives give much needed perspective about the intersections of the lifeworlds of providers and patients, and how these intersections shape the healthworlds of BMSM. These intersections inform the types of discussions that occur in the examination room, the kinds of care provided, as well as the types of resources to which the men are referred. Through their narratives, a more complete picture of the patient/provider relationship is painted. They also afford an opportunity to see places of concordance and disconnect in the treatment of these men, which can illuminate areas where the work of treatment and healing can be strengthened.

Ultimately, using a narrative-based phenomenological approach informed by a lifeworld model provides the required flexibility to get to know the health journeys of the HIV-positive, black, same-sex-loving, men on their own terms. It also welcomes the life stories of some of the most important interlocutors in these men's journeys with chronic illness, their healthcare providers. Using this approach allows for explicit and often

unnamed tensions that have been present in the lives of BMSM related to their race, gender, and sexuality to be fully explored. Additionally, it gives crucial insight into the negotiations that occur between the boundary lines of institutional forms of Black Protestant Christianity and their own personal religious and spiritual beliefs and practices in relationship to their journeys with HIV.[41]

The narratives in the proceeding chapters demonstrate the benefits and potentially life-saving power of a phenomenological, lifecourse, narrative-driven approach to examining lived religious and spiritual experiences on the health of BMSM in relationship to HIV. We learn from their experiences, which show pivotal moments in their lives when their health has been at risk because of religiously rooted homophobia and HIV-related stigma. We also learn from the processes by which they have negotiated their religious and spiritual beliefs and practices in ways they find healt-affirming. By gaining a better understanding of these processes, we can more clearly articulate the ways religion and spirituality intersect with the epidemic facing this population, and begin to more effectively assess and address these dimensions of the lives of BMSM in healthcare provision and public health interventions.

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Chapter 2

In The Life: Growing Up and Life before HIV Diagnosis

In this chapter, the men share stories about their childhoods, formative years, and reflect back on their lives just prior to the time they contracted HIV. Their accounts highlight the diversity of their life experiences and the circumstances under which they became HIV-positive. In spite of these differences, they share one critical attribute, which is that Afro-Christian traditions—mainly Black Protestant Christian traditions—shaped their identities and impacted the processes of negotiating their identities at the intersections of black manhood, same-gender attraction, and health.

Their stories reveal how exposure to communal religious beliefs and practices about homosexuality from an early age intersected with their spiritual, mental, and physical health prior to contracting HIV. Though BMSM do not engage in greater sexual risk taking behaviors than their counterparts from other racial or ethnic backgrounds, they are a minority within a minority who tend to have sexual partners of the same race and sex. Therefore, they are statistically more at risk for contracting HIV.[1] Given the immense burden of the epidemic on this population, it is important to understand facets of the lives of BMSM not normally accounted for, like lived religious and spiritual experiences, which can serve as barriers to or facilitators of HIV prevention, testing, and/or treatment.

The men's narratives presented in this chapter are divided into three sections: "Childhood," "Life Before HIV," and "Life at Infection." Each of these sections highlight junctures they identified as critical to the trajectories of their health journeys. These

defining moments draw attention to ways religiously rooted homophobia in their churches, communities, and/or families impacted their spiritual, mental, and physical health. Their stories offer first-hand knowledge about how they formed and negotiated their identities from childhood into adulthood in contexts in which their same-sex attractions placed them at odds with religious and communal norms.[2] Through their own words, we hear how lived religious and spiritual experiences impacted their health journeys with HIV long before they contracted the virus, which includes things like grappling with external and internal homophobia from young ages, how they dealt with their same-sex attractions as they got older, and how they felt about their relationships with God because of their sexual orientations.

Childhood

BMSM grow up in an American social context in which they form their identities at the intersections of dual systems of oppression. They have to grapple with the devastating effects of structural and cultural racism and homophobia at a young age.[3] Thus, in many ways they are "negatively defined before they can even define themselves."[4] From childhood on, they often have to try and hide their same-sex attractions or mask certain behaviors perceived as homosexual in order to avoid being ridiculed or rejected.[5] Studies have shown that BMSM experience conflicts between their gender identities and same-sex attractions because of perceptions that homosexuality is effeminate, weak, and counter to social and religious norms about black manhood when growing up.[6] The effects of externalized and internalized homophobia are identified as drivers of the HIV epidemic in this population.[7] Beginning at a young age this stigma can

have a negative impact on the spiritual, mental, and physical health of BMSM, which can endure over the lifecourse.

Given the historical importance of black churches in African American communities, religious and cultural teachings play a critical role in the formation of the lifeworlds and healthworlds of BMSM, which is the case even in non-religious contexts.[8] They often encounter religiously rooted homophobia in their churches, families, and communities. These dynamics can be especially traumatizing because these institutions and communities are sources of social support and social capital that are frequently essential to their lives.[9]

The narratives presented below document the childhood years of Drayton, Chris, Darius, Elisha, Try, Jamiell, and Adrion, focusing on how they navigated their lives in the midst of social and religiously rooted homophobia. During their formative years, these men's identities and those of their families were closely tied to church attendance.[10] With the exception of Jamiell and Adrion, all of the men heard negative messages in church about homosexuality. Chris noted, "I had difficulties the majority of my upbringing from every avenue; the church being probably the worst." They all encountered religiously rooted homophobia in their communities and even in their own families. These negative messages caused internalized stigma that created social and psychological tensions for them regarding cultural and religious expectations of masculinity. They had to cope with the stresses of hiding their true identities out of fear that their families, friends, and communities would turn their backs on them. Jamiell's statement made this point very clear. He recalled, "I wouldn't have acted on [my same-sex attractions] . . . . because of a fear of being discriminated against with friends, losing friends, my family disowning me."

The cultural and psychological angst associated with internalized homophobia manifested in these men's embodied experiences of same-sex attraction. Some, like Drayton, were racked with fears about being doomed to hell. Chris was so despondent from fearing that he was eternally damned and would be rejected by his family that he tried to commit suicide at age 13. Sadly, older boys or adult men sexually abused Drayton, Elisha, Trey, Jamiell, and Adrion as children. They hid these abuses from their families in large part because of negative messages they had internalized about homosexuality. Trey and Adrion were able to cope with the homophobia they faced because of their faith in God. Adrion emphasized, "He raised me in love because all my life as a child, he kept showing me . . . He would just show me how to love people."

These accounts of their childhood years provide powerful personal insights into crucial times of identity formation. They show how lived religious and spiritual experiences impact the ways BMSM negotiate the intersections of multiple minority identities during their formative years. It is during these years that lived religious and spiritual experiences can contribute positively and negatively to the health journeys of BMSM, which can impact their lives well into and even throughout adulthood.

Drayton

• 48 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed 1999 •

Drayton grew up in Las Vegas in a "tight-knit family." Christian beliefs were incredibly important to him during is childhood because of his grandmother. They went to church every Sunday when he would stay with her during the summers. He remembered:

> I would visit and it was Sunday School, 11:00 o'clock service, and evening service and it was quite—I enjoyed it, but at times it was kind of timing

> because we would have to rush home, eat breakfast, then we would have to rush and eat lunch and then go back to church, then we'd go eat dinner late, then we'd go back to church.

He heard negative messages about homosexuality preached from the pulpit. The pastors in his church "talked a lot about condemnation of homosexuals," but Drayton and other gay and bisexual men just endured this abuse. He noted:

> We didn't stand our ground and they would verbally bash us and some of the men that were in the choirs and stuff that were openly or blatantly gay, they would bash them even though they were a pillar of the community or society of the church.

When Drayton was a young child the next-door neighbor, a white man, molested him. He recognized he was same-sex attracted at an early age, which created complicated feelings about how this molestation may have shaped his sexuality. He remarked:

> I kind of found myself—so I won't say that he pushed it up on me. I figured that I would have a hate for it later on in life, but I just feel that he thrust something that I think should've naturally formed within me if I decided to have that experience.

As a teen, Drayton was torn by his attractions to other males. He said, "I would fight it, try to stay away from it." He feels the origins of this denial came from anti-gay messages he heard in the church and echoed in the community around him.

He reflected:

> When I was younger, I used to say, "Oh, I'm going to hell, I'm gonna truly die, I'm gonna burn in hell!" Because that's all you were taught, you know, you're homosexual, then you are going to die.

When praying did not remove these his attractions, he contemplated suicide because he felt doomed. He remembered feeling:

> Ashamed and dirty . . . really shame and dirty—I felt less than because I was doing this great sin, this ultimate sin that was against God and human nature. So, it was very conflicting. It was a point about suicide, you know, hating yourself—self-loathing.

Drayton's family was not affirming when he told them about his sexuality in high school. His mother tried to convince him that he was not gay, and his father made homophobic remarks whenever he could. His grandmother's reaction, which affected him most, was grounded in her biblical understanding of sexuality. He recalled:

> I remember my grandmother saying, "If you do this, or you are that way, I'm gonna still love you, but you need to read the Bible—it condemns men sleeping with men, woman sleeping with woman." Then I started thinking. It really weighed on my soul, and I was torn. Even though I did like women, I never had anything against women and I lust women like I lust men, so I did have children. I never grasped the idea of just loving one sex or the other.

Over time, his parents, grandmother, aunts, uncles, and siblings accepted his sexuality.

Chris

•46 • Gay • Contracted HIV via Homosexual Intercourse• Diagnosed in 2002

Chris grew up in 1970s suburban Ohio in a "very conservative" home. His family was steeped in several generations of conservative Baptist beliefs that shaped the atmosphere of "very little tolerance" in which he was raised. He explored other faiths, like those of his Jewish and Catholic friends, which displeased his mother and created tension in his family. Chris recalled, "My mom was like, 'you need to be Baptist . . . you're just Baptist, that's what you are—don't question faith.'" Ultimately he has remained Christian, though he is no longer Baptist.

He heard anti-gay messages preached, which were challenging and hurtful for him to hear. Chris remarked, "I had difficulties the majority of my upbringing from every avenue; the church being probably the worst." When the pastor made homophobic statements, congregants would make a point look at him. His family treated him differently because of his perceived sexuality. He noted, "When family treats you a certain

way, it is much more difficult than the church. You're gay, so you feel like your family doesn't really love you . . . you feel like they tolerate you." Chris "was always being compared" to his twin brother who was "really masculine," which further compounded his feelings of difference. He felt like a "Martian from another planet " and wanted desperately to be like everyone else, but he "didn't know how to fix it." At just 13 years old, Chris was so despondent and hopeless about his life that he tried to kill himself.

Jamiell

• 38 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Jamiell is originally from Georgia, but his family moved to Ohio when he was a young child. His grandmother raised him, as his mother was a drug addict. He has a sister and a brother who are much younger than him, and he often acted more like a parent for them, which put a lot of pressure on Jamiell growing up.

Church was a big part of Jamiell's family life. He went to a predominantly black Baptist church. He recalled, "[I was] heavily in the church, you know, every Sunday, every Wednesday, you know, performing in every play, reading every time—whatever—I was in the church." Even when his grandmother didn't go to church, he and his sister would go by themselves. Jamiell did not hear homosexuality discussed in the church. He recalled:

> I don't remember even a sermon condemning it. I remember the story of David, you know, the friendship that they had. I remember hearing about that, but I really don't recall hearing anything about homosexuality, HIV and AIDS, prostitution, none of those until I was in my twenties and I met my first boyfriend.

Jamiell credits the positive experiences he had in church with his close relationship with God. He emphasized, "It's the reason why I'm still God fearing."

The majority of the homophobia he experienced growing up was communal. His peers in school bullied him because of his effeminate nature. He remembered, “You always heard, you know, back then – faggot this, faggot that, you know, it was the it thing to call anybody who was a little flamboyant. I was called it constantly.”

Jamiell was exposed to sex around age 7 when a male coach raped him. He recounted, “The only thing I know is somebody holding my neck down and laughing while his boys watched him stick his dick in my ass.” An older male cousin began repeatedly sexually abusing him when he was 11 years old. It was around that time Jamiell first found out about HIV/AIDS. He thought to himself, “Oh my gosh, I'm going to die . . . you know how the thought process was back then.”

During high school Jamiell did not act on his same-sex attractions because of his fears of being rejected. He stated:

> I wouldn't have acted on it . . . . because of a fear of being discriminated against with friends, losing friends, my family disowning me. Because now I'm old enough to watch TV and see that is what's happening. I didn't want that to happen. I didn't want nothing to happen in church because I was still there. I didn't want to lose anything going on because I mean, I'm a 3.8 student. I know I'm going to graduate. I'm going to be a doctor. You know, there were so many plans I had and I felt like if I did act on it because according to TV, it's wrong and I didn't want anything to be lost. So that's more when I can say I denied and didn't act on it.

During these years, he enjoyed church and was actively involved in church productions. His church served as an extension of his family. He noted:

> They gave me a scholarship, helped me with getting into college. They always had my back. Like I said, I think for me, it wasn't to save him mentality. The church didn't have that. Even if they turned and talked about me behind my back, I never knew, so my experience in church was actually wonderful.

After he graduated high school Jamiell stopped going to church because his pastor died, and he was afraid to go anywhere else because he feared he would be rejected because of his sexuality and more effeminate appearance and mannerisms.

Adrion

• 37 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1999 •

Adrion was born in Decatur on the outskirts of Atlanta, and was raised by his mother and grandmother. He thinks of God as his father. He remarked:

> Because I was a love child, God raised me. The reason I say He raised me in love because all my life as a child, He kept showing me . . . He would just show me how to love people.

He recalled, “The only thing I can remember about Decatur growing up is just church—we went to church like seven days a week.” His grandmother would take him to choir rehearsal and the myriad church activities in which she participated. She was the most religious person in his family, and the two of them were very close. He emphasized:

> I always knew as a child she understood . . . . I have an older brother and a younger sister but she saw something different . . . . not just the physical things or the spiritual things but she would always stay on me about religion and my spirituality more than anything so she always kept me grounded.

Adrion joined the church when he was in third grade. He remarked, “It’s like once I made the commitment to join the church, it’s like I knew God was pursuing me from that day forward.” He never heard messages about homosexuality in the church, but he encountered a lot of homophobia in the black community. He recalled hearing messages like, “Oh yeah, if you’re gay, you’re going to hell or, God doesn’t like gays.” He prayed to God to take away his homosexuality when he was young, questioning many times, “Why is it still here?”

Adrion's mother questioned him about his sexuality from the time he was in second or third grade. She got more forceful as he got a little older. He remembered:

> When I got to like fourth or fifth grade she asked me again. This time she asked me with more hostility. She was like, "I'm gonna tell you what, if you're one of them little faggots and you walk around here and catch AIDS and die, I ain't coming to your funeral." I said, "Okay, whatever." I said, "That's on you."

When he was 12 years old, Adrion's 17-year-old cousin began sexually abusing him. He knew he was attracted to other males at this point, but his cousin "took his choice away." Adrion hid the abuse from his family, and eventually "got familiar with it and got used to it." He began acting on his same-sex attractions in 8th grade with one of his friends. He thinks he "put something on [his friend] he wasn't really ready for." Later, Adrion found out that this friend raped a younger boy, and he believes he is "partly to blame for planting that seed."

In 10th grade Adrion came out, and decided to live openly as a gay. When he told his mother, she was frantically angry with him. He thought back:

> My mom, when she first found out, she literally tried to hit me with a hammer. She grabbed a hammer in the kitchen and she was like, "I'm gonna beat it out of you". . . . She put the hammer down and I grabbed all my stuff that I could grab, and I walked 'til I got to my grandma's house.

Adrion was shocked by his father's reaction to his coming out. He recalled that his father said, "I understand you may not like what I do and I may not like what you do but we're still blood; we still love each other."

After he came out Adrion went to church less, but his relationship with God remained steadfast. He recalled, "I didn't feel like I would be accepted in church, so I kind of stepped back." However, stepping-back created a distance between he and God, which caused him emotional and spiritual distress. He enjoyed going out with his gay friends to

clubs, partying, drinking and doing drugs, but he had a persistent nag in his heart. He reminisced:

> Sometimes I'd be at the club; it'd be like Saturday night going into Sunday morning. So, I was up hearing gospel on the radio, and I'm feeling like pain in my heart. I'm like, I'm supposed to be in church right now . . . . I'm supposed to be in church somewhere singing in the choir. [Instead,] I'm riding in cars doing drugs with my friends or drinking or whatever. I felt so bad doing it, but it was God tugging at my heart telling me to come back. I didn't know it at the time. Now, I realize it. That's why I had to come back.

Elisha

• 30 • Gay • Contracted HIV via Homosexual Transmission • Diagnosed in 2017 •

Elisha grew up on the South Side of Chicago in a conservative Pentecostal household. His father was physically abusive to his mother, yet served as a minister in their Pentecostal church. His family's religious practices and beliefs extended over every facet of home life. He recollected:

> We couldn't do anything. We couldn't watch certain shows on TV. We couldn't listen to music, or we would get in trouble. My mom could not wear pants. It was crazy! So I grew up—one thing that I fell in love with was music, so I started singing and then I was like the leader of the choir and all that stuff. And, my church was a big—it was like it was my life. Outside of school that's the only thing I did . . . but, um, that's where I'd spend most of my time.

He spent multiple days a week at the church. Being so enmeshed in his community and church environment had a major impact on the formation of his gender and sexual identities. Elisha noted:

> First and foremost, you're dealing with my culture so there is already a difference in what it means to be a man culturally when you're an African American person. Even like being of African descent, just like . . . it's a difference . . . . Then you have to like bring it even smaller to being in church, and it's like you're definitely supposed to be with a woman . . . . Mom told me things about what it means to be a man. I was very confused because she was a woman, but, she was like, yeah, you gotta walk a certain way, you should hold your head up. Just different things like really

> hypermasculine shit. I'm just like, but this is how I feel natural. It was just a hypermasculine thing, and being gay or anything outside of what you were born to be was out of the question.

He heard negative messages in his church and community about gay people, which made him feel at odds with the expectations of his faith and culture.

Elisha's family moved to Georgia when he was 13. His older male cousin started to molest him around this time. He thought back:

> I still didn't understand it. I was still a kid. I just knew that what was happening when it first happened was not right. And then when it kept happening, I just got used to it . . . . What he did to me, I knew that was wrong. I didn't understand why it was happening. But like, I knew that it was not right. Like from what I heard, you were not supposed to be fucking with another dude.

Elisha did not tell anyone about this sexual abuse. As he got older, he recalled, "I was very confused because I was like I don't know if I'm attracted to guys on my own, or I don't know if I'm attracted to guys because of this experience. This bitch fucked my life up."

Trey

• 29 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2018 •

Trey grew up in coastal Georgia in a middle-class family. Many of Trey's fondest memories from childhood are about going to church with his grandmother. Anytime he was at his grandmother's on the weekend they went to her Baptist congregation, where the feeling of community was strong. The older he got, the more Trey enjoyed going to church and growing his relationship with God. He emphasized:

> So for me it was just a good experience. That's how I want to raise my kids in the future. To have the inspiration of Christ in your life is just a beautiful thing. It really is.

Around age 6 Trey was molested by one of his aunt's friend. He realized that he was attracted to men at this young age. He said:

> I was touched by one of my auntie's friends, but this was when I was like 6 or 7. So for me, it brought a lot out of me that I always knew, even before then, before I was touched, I always knew . . . . It wasn't nothing that I could change. But when I was touched, then that made me really realize that that person that was touched me was sick because I was a child. It made me realize that I really do want to be with a man. So out of that, that disgusting situation, it did make me realize and see who I really was.

He had anxiety about his same-gender attractions because he knew what the Bible said about homosexuality from church. He recalled:

> I had a lot of conflicting feelings because of the fact I had grew up in a church, a Baptist church, and my grandma would have killed me if she knew that. I think my family knew what was going on but they just didn't want to say, "Okay, I think that you're going to be gay."

Trey kept his sexuality a secret. He began dating a girl because that was "how he was raised." He remarked, "I always knew that my family knew, but they just didn't push the fact and they didn't say anything."

He came out to his mother in high school because she caught him looking at images of naked men. His mother was angry when he first told her. He recollected:

> I could tell that she was mad. She would just stand there—"Well, it's just something we're gonna have to pray about because I don't believe that you are, I don't believe that you are." She said, "I want you to pray, and I want you to pray hard and strong because it's a demon on you." And I tried to tell her, "No, it's not a demon on me, this is just how I am." I don't think it's no demon on me. I mean we prayed and we prayed and we prayed and we prayed.

The fact Trey's mother equated his sexuality with demonic possession did not impact his faith. He interpreted the Bible differently because of his personal relationship with God, which he did not believe was impacted by his sexual orientation. His father, who was living in a different household, was very supportive of him. His father said, "Whoever you go with, whatever you want to do, I'm gonna be happy for you."

Oppression that BMSM face as the result of growing up at the intersections of compounding minority identities follows them into adulthood. For many, the rejection they experience in their families and communities is justified by religiously rooted homophobia. This type of homophobia can cause internal discord between the sexual orientations and religious beliefs of BMSM. As the men describe in detail in this section of narratives, such strains can cause deleterious spiritual, mental, and physical health issues that impact their health as adults.[11] Internalized homophobia in adulthood has been associated with poor mental health outcomes, particularly in relationship to depression, lower self-esteem, and feelings of psychological distress. It has also been shown to impact health-related behaviors that can expose BMSM to greater risk for contracting HIV, such as engaging in risky sexual encounters and substance abuse. [12]

As adult identities are cemented around certain aspects of sexuality that are accompanied by positive and negative social sanctions, the impact of religiously rooted homophobia can be especially dire.[13] Failing to conform to expectations of compulsory heterosexuality can mean social rejection, isolation, and in some cases social and moral death for these men, as their same-gender attractions place them in opposition to religiously grounded cultural norms that have defined their place within their communities since childhood. They may also negotiate their religious and spiritual beliefs and practices in ways that affirm their sexual orientations, choosing to leave the churches and/or beliefs of their childhood behind.[14]

The narratives in this section illuminate the unfolding of processes that many BMSM go through as they enter adulthood negotiating their same-sex attractions

alongside stigma and religiously rooted homophobia, which can carry over from when they were children. Into adulthood all of the men whose stories guide this section, with the exception of Leon, had deep-seated anxieties regarding their religious beliefs and developing sexual orientations, which caused them to feel isolated from God or eternally doomed. John recalled, "[I felt] like I was just the worst person in the world, like I'm some demon going straight to hell, there's no turning back." Elisha was in such spiritual and emotional turmoil that he tried to commit suicide. He also abused alcohol as a result of the anxiety and depression caused by external and internal homophobia, which caused him to engage in risky sexual behavior. Chris tried to "fix himself" by marrying a woman.

Leaving their families and communities of their childhoods behind was a common theme for most of these men. Moving away allowed them to live openly in regards to their sexuality. However, like John's, Chris's, and Elisha's stories demonstrate, even though they were enjoying aspects of their new found gay communities, they were still challenged by internalized homophobia they felt in relationship to their religious beliefs. Chris remembered "being beaten up with the belief that homosexuality is a sin, and it is an abomination."

These men's accounts of their lives in the time between their childhood years and when they contracted HIV as adults give a glimpse into how their health journeys were affected by religiously rooted stigma and homophobia that followed them into adulthood. They describe how they dealt with this homophobia as adults like moving away, turning to drugs and alcohol, renegotiating their religious beliefs, or simply living life on their own terms. In these early adult years, the ways in which many BMSM deal with the continuation of externalized and internalized homophobic religious viewpoints are

important factors when assessing their vulnerability to poor spiritual, mental, and physical health outcomes, particularly in relationship to HIV.

Paul

• Gay • 57 • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Paul was the only man interviewed who identified as Catholic. He spent the majority of his childhood in Louisiana, where going to church was central to his family's life. Homosexuality "was not a topic to be discussed," so he kept his sexuality "very, very depressed." Going to college in the mid-1980s offered him a chance to explore his developing sexuality. He began acting on his same-sex attractions, but he was conflicted about these actions because of his religious beliefs. Paul recalled, "Well, with that, it was a fight—I was fighting myself." Though he questioned God about why he was having same-sex attractions, he "didn't get no answers."

After he graduated college, Paul worked for an oil company in Texas. A few years into his job he was laid off, and he took a vacation to Atlanta and never returned to Texas. Up until his move to Atlanta, Paul never considered himself gay, even though he acted on his same-sex desires. He remarked, "Once I came to Atlanta, I think then—at that particular time—was when I made a definite decision to put a mark on gay. Let's put it like that. That's been thirty years."

Leon

• 56 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2006 •

Leon grew up in Atlanta with his mother and went to New York in the summers to spend time with his father. Church was a fixture of his childhood because his mother would take him with her each week. The church experience was "kind of strict." He

recalled, “It was something I had to do. I mean I believe in God and all that, but it wasn’t something that—I mean I would go but I didn’t want to go, but I would go.”

In the mid-1980s, Leon dropped out college and moved to New York to live with his friends and be closer to his father. He met his first boyfriend, and they lived together with roommates for about three years. After moving back to Atlanta in his early 20s, Leon began cosmetology school. One night his boyfriend from New York called, and that is when he finally told his mother that he was gay. He remembered, “She just went off—she was slamming pots and pans and going crazy,” and she said to him, “You need to pray to God to take them feelings way, it’s an abomination.” Shortly after telling his mother she got him an apartment, and they did not talk anymore about his sexuality until his brother also came out as gay several years later; she was much more compassionate in her response to him.

Leon worked in a hair salon in Atlanta during the 1990s. He remembered, “I was having fun, doing hair, working, and having fun with my friends.” He watched as several of his friends died from AIDS during that time. Still, he found spiritual connection to God through prayer. Other people in his family and community told him that his same-sex attractions were wrong and sinful. However, Leon felt that God made him the way he was. He pointed out, “I never felt like I had to stop what I was doing or I would go to hell.”

John

• 49 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1997 •

John was raised by his mother in Florida in a town just a couple of hours away from Orlando. He was picked on for being effeminate, and realized he was same-sex attracted when he was very young. He began acting on these attractions at age 14. The

negative messages he heard about homosexuality when he was an adolescent made him feel, as he recalled, "like I was just the worst person in the world, like I'm some demon going straight to hell, there's no turning back."

In 1986, when John was "basically a kid" of 17 years old, he left home and moved to Orlando to live openly as a gay man. He was "like a kid in a candy store" in his new hometown. He went to gay bars, met new people, and explored his sexuality. He enjoyed his newfound gay community, but was saddened by the loss that accompanied leaving his family behind. This dynamic left John "extremely lonely". He turned to drugs in order to cope with his feelings. He remembered:

> I felt like a lost soul. Like if I passed away, nobody would know I'm gone, nobody would care. It was rough . . . The drugs, I would go on little sprees where I would just be—it was really a dark time, it really was a very dark time.

John went to church and tried to rekindle the spiritual connection that he had once had with God, but he recollected, "I would be feeling so good . . . . the definition of gay, happy and joy. I would always be like that until I go to church and then I come out feeling so bad and just doubt." These conflicting feelings stemmed from religious homophobia that was embedded in him from a young age. It took him years before he told himself, "I'm not gonna listen to that, I am just gonna do what I want to do."

Chris

•46 • Gay • Contracted HIV via Homosexual Intercourse• Diagnosed in 2002

At 19, Chris married a woman because he thought that would "fix the problem and make [him] normal." His family was totally against the marriage. Chris and his wife were married for 6 years. Shortly after his divorce, a relative took him to a gay bar in Cleveland. Walking into the bar was the moment that his "whole life changed" because he realized

that he was not alone. He traveled to Atlanta in the late 1990s with a group of men he met at the bar, and he "fell in love with [Atlanta], went back home, packed up, and [has] not left since."

After coming out, Chris went through a two-year period when he felt he was "damaged goods" because he still experienced internalized homophobia rooted in the religious beliefs of his childhood. He was still constantly "beaten up with the belief that homosexuality is a sin, and it is an abomination." He recalled his struggles at the time:

> If you're gay, you are going to hell, and who signs up on that line? So you don't know, and you look for what to do about. And, the only solution they give is that you have to turn away from the behavior and ask God for forgiveness, which makes you feel like you are damaged goods in need of repair. That's depressing because religion is where you're supposed to go to get inner strength, not where it's taken away. So I went through a period, oh my God, God doesn't love me. At one point, I was like, okay, I'm gong to hell. I'm just gonna have to get used to that.

Nathan

• 45 • Gay • Contracted HIV via Injection Drug Use • Diagnosed in 2015 •

Nathan grew up in Michigan. Church was not important to his parents, but they did go occasionally. Nathan "found religion" by going to a Baptist church with his best friend and his friend's mother when he was about 7 years old. He was very involved in church, sang in the choir, and took part in church performances. He experienced deep conflicts between his faith and his same-sex attractions from a young age. His parents did not respond negatively when he came out to them at 19, but he continued to feel torn between his sexuality and his religious beliefs.

Throughout his late teens and into his early 20s, Nathan remained conflicted about his same-sex attractions. Statements made in church that AIDS was God's curse for homosexuals further exacerbated his anxieties. He questioned God, "How could you create

me to be who I am?" He cried frequently and wondered if the bad things that had happened in his life stemmed from his sexual orientation.

Nathan moved to Chicago in the 2000 at the age of 21 to work as a back up singer in a gospel group. He became much more spiritual and attuned to his beliefs at that time. He stated, "Through religion, I found my faith and through the faith I found spirituality which religion in itself as far as four walls kind of can shut you out." He grew frustrated with what he saw as hypocrisy in the church, even those churches he went to that were LGBTQ-affirming.

He moved to Georgia in 2004 to take care of his father, who had moved from Michigan some years prior. Nathan had a desire to get back into church that struck him one evening while he was out at the club. Something inside him said, "If you don't get your butt up and go to church—you're going to dance all night but you can't go to church when you told somebody you were going to be there?" The next day he went to church and had a spiritual intercession. He remarked, "From that point on I committed to accept my gifts [of singing and performing], and I knew that I was good with God." Nathan remained at that church until his father passed away a couple of years later. He then found a new church that was committed to LGBTQ inclusion, where he felt "it was the true following of Christ [because] the worst to the best were there and it didn't matter who you were." Nathan eventually stopped attending that because he was busy pursuing his career as a flight attendant.

Elisha

• 30 • Gay • Contracted HIV via Homosexual Transmission • Diagnosed in 2017 •

Though he began sexually exploring his same-sex attractions in high school, "trying to figure it out," Elisha began acting on these attractions when he went to college. However, he was extremely conflicted about his sexual orientation during that time. He joined a college ministry, but an internal war was waging between his sexuality and his faith. This turmoil eventually led him to attempt suicide. Elisha remembered:

> It's like two different people being in one body, so I have two different mindsets because it's like you're trying to fight—you're trying to live what you've been taught to be correct but what naturally is happening inside of you, you can't control. So it's literally in a war and it's like your true self is literally fighting the person that society, people around you have told you you should be. That's really what it is. So that's daunting. It's tiresome. It causes you to seem like your schizophrenic and you're not. It's really like a fight. I always felt that. I could cry. I tried to kill myself.

He stated, "The only reason I did that—that I even attempted [suicide]—was because how I felt like after I had sex with that guy. So after I had sex with him, I just felt bad."

Elisha's feelings of guilt and shame intensified his thoughts that God would abandon him. He emphasized:

> The whole idea and concept of God was everything. But if he doesn't accept me, then like oh my God, I'm gonna be fucked up . . . But like that had me just, I don't know, I was just in a place like this can't be real. If this is really the case, I need to go because I'm like, I'm not gonna be able to live.

His mother's reaction to his disclosure about his sexuality compounded his feelings of shame, guilt, and inadequacy. He recalled:

> She's like, "You're a disgrace. You better not tell anyone because if you tell anybody, I'm gonna disown you!" But, I was like, "I'm not gonna tell anyone. Why would I tell anyone? Look at how you just responded." But, I was still in church. She still wanted me to go to church. She was like, you know, "God is gonna fix you. He's gonna heal you from this. He's gonna deliver you."

The strain of trying to come to terms with his sexuality not only impacted Elisha negatively in regards to his spiritual and mental health, but also manifested negatively in regards to his physical health.

He drank heavily to escape the anguish he was going through because of the conflict he experienced between his sexuality and his faith, as well as the pain of his mother's rejection. He noted, "Yeah, I was definitely a drunk." Drinking heavily made him unsure at times that he actually used protection during sex. He stated:

> Sometimes I can tell you like I wasn't sure but I'm pretty sure I used a condom anyway because I had blacked out. I would wake up with people and say, like, how did I get here?

He had a lot of questions for his college minister to answer, and was told to look up certain biblical passages about sexuality and homosexuality. However, the answers and responses he got were not satisfying to him. His belief in God and his feelings about church and Christianity began to evolve, and they eventually became more universalistic. He noted:

> I believe that there's a higher being, but I believe that everyone that walks on earth is part of that being. I also believe that we live in a life where it's more of an energy-type thing. We can try to name it and mystify it and put something to it; if you don't understand it, you just don't understand it but us as human beings, we just have a problem with not understanding stuff so we have to make some type of explanation. You don't have to fucking know what it is. Just accept what it is and go. That's what I believe.

This act of reinterpreting his beliefs helped Elisha come to terms with his sexuality and find self-acceptance.

Life at infection

The effects of having to manage stigma, much of it religiously induced, can continue to have a negative impact on the health of BMSM as they age, especially in relationship to risk behaviors that increase the likelihood of getting HIV. Increased religiosity in this group of men may be associated with substance abuse and/or engagement in risky sexual behavior. Due to stigma, they may be less likely to arrive at high-risk locations, e.g. nightclubs, hook-up sites, etc., with prevention and/or less likely to engage in safe sex practices. The effects of stigma may also contribute to less monogamous, long-term sexual relationships.[15] Furthermore, because their communities of support reject many BMSM, they often lose the social capital and resources that their heterosexual peers are granted. This social capital deficit has been associated with greater sexual risk behaviors.[16] Ultimately, stigma and homophobia grounded in religious teaching and precepts affect the health outcomes of many BMSM well into adulthood.

The narratives presented in this section reveal what life was like for the men at the time that they contracted HIV, and focus on how lived religious and spiritual experiences intersected with their health. For Rodney, Darius, Greg, and George, religiously rooted homophobia impacted their health-related behaviors, such as engaging in substance abuse and/or risky sexual behavior around the time they contracted HIV. Darius's account is particularly important because it emphasizes the power that faith leaders have over the lives of their congregants, particularly as he had never felt tension between his sexuality and his faith prior to a negative church experience. Greg's story points to the diversity of ways in which BMSM contract HIV, as his then girlfriend infected him. Elisha's story reveals how he was able to reconcile his sexual identity and his spiritual beliefs. It also

highlights one of the common ways many BMSM contract HIV, which through non-disclosure of their partners that can stem from fear of rejection or shame about having the virus.[17]

These men's accounts of when and how they contracted HIV draw attention to the intersections of religion and spirituality on their health-related and health-seeking behaviors at that time. For many of them, the turmoil of feeling cut off from God because of their same-gender attractions was so painful that they turned to health-destroying behaviors as a means of escape. These narratives demonstrate the multiple ways religion and spirituality can be implicated in the health BMSM at the time of infection.

Rodney

• 52 • Gay • Contracted HIV via Homosexual Rape •Diagnosed in 1984 •

Rodney, the youngest of 15 brothers and sisters, "kind of didn't fit" and "knew something was different" about him from a young age. He grew up in a Church of God in Christ congregation, where he heard messages condemning homosexuality. He began acting on his attractions to other males at the age of 18, which caused him to have anxieties related to his religious beliefs. He recalled, "I went through this real crazy place of self-condemnation and you're going to hell and God doesn't love you anymore, you know, you're abnormal." These anxieties about being doomed to hell and distanced from God got worse as he entered into adulthood and his same-sex attractions showed no signs of going away.

Rodney went to clubs, drank, and did drugs to escape the pain caused by the internal battle happening between his sexuality and his faith. He recalled, "I would still go to church but, you know, my pastor would preach so hard and so much condemnation."

He tried to hide his sexuality from those around him, which exacerbated the pain and anxiety he felt. He was constantly scared, crying, and could not talk to anyone about what was going on in his life. Rodney remarked, “I didn't know how to be honest with it, and I really didn't think God loved me. I never thought God loved me.”

Feeling removed from God was unbearable for him. When Rodney was in his late teens and early twenties during the mid-to-late 1980s—a time when the AIDS epidemic was sweeping the nation—his life began downward turn. He noted:

> I was trying to pray and ask God for help. I was doing it a lot, like, “God help me, I don't know how to do this, I don't know how to get out of this, but I know you really don't hear me because you don't hear sinners' prayers.” I was like in that kind of battle constantly. It was like I'm praying but I know he's not hearing me, and then I'd go drink or I would go—and then I became real sexual because I didn't know how to tell guys no because I always felt like they had more power than me.

One night Rodney was out with friends drinking at the gay bar he frequented. There, he met a man he became enamored with who offered to drive him home. Instead of driving Rodney home, the man took him to his house and the situation turned violent. The man beat Rodney viciously and brutally raped him. Once the assault was over, the man said something that Rodney he would later connect as the moment that forever changed his life. Rodney recalled:

> He's like, “Now, I'll treat you like that bitch treated me.” I was like, “What are you talking about?” He said, “I'm giving it to everybody.” At that time, I didn't know what he was talking about, but that's when I got infected by this guy.

Darius

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

Darius grew up in a home where his mother supported his sexual orientation long before he even realized that aspect of himself. Even though he encountered homophobic

remarks in church and in his community, he recalled, “Well honestly, I just told myself that I was special and like there isn’t anything wrong . . . I didn’t feel bad . . . I didn’t feel guilty or anything.” His relationship with God was very strong; he and God “palled around” together. Darius entered the Marine Corps in the mid-1990s after he graduated high school. His time in the military gave him the strength he needed to come out to his family and friends. His mother was accepting, and he felt like his relationship with God was also on firm ground.

One weekend when he was around 22 years old, Darius went with his mom to her new church, a Church of God in Christ congregation. The experience he had at alter call unsettled his faith and changed the course of his health journey for life. He painfully reflected back on this moment:

> They were doing the invitation for prayer, so about twenty-five people went up there, and I went up there as well. So, I'm standing a little further back and they're leading the prayer so, you know, you normally close your eyes and all this stuff. Well, unbeknownst to me, this person is going around to each person and praying for them or with them and putting like oil on their forehead, like a little cross or whatever, and so when I opened my eyes and realized—because you know you can feel people moving around you if your eyes are closed—and so everyone has pretty much dissipated from the alter and when I opened my eyes, she asked me to come forward. So, of course I did out of respect and reverence because it's prayer time. And, so, she puts the oil on my head, and she leans over, and she whispers in my ear. So, I thought she was whispering in my ear, but she had a microphone, like, in her hand behind her—and she said, "Lord, we ask you to remove this demon of homosexuality out of this child," and it just fractured everything totally. I was so embarrassed—beyond belief embarrassed—and I don't think I ever recovered. I didn't recover from that until like three years ago. It took that long!

This experience completely unsettled Darius’s faith and feeling that God was close to him. He noted:

> I did talk to God after it. I voiced my opinion, my objection, and said some very choice words to him. I just kind of fumbled through life for the next few years going on pure self-will, and that didn't all work out so great.

He recollected, "Yeah, so that was like a very gray time because the sun was just gone, gone, gone, and so then around three or four years later, still kind of doing what I wanted to do—kind of sowing my wild oats [having unsafe sex]." It was during this time that he contracted HIV, and his life began to take a downturn.

Greg

•60 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 2004 •

Greg grew up in a "dysfunctional household," as the child of an alcoholic mother and father, who was a disgraced former pastor. His grandmother raised him in church. However, he stopped attending when he was 15 because he "had responsibility" after the arrival of his first child. He did not turn back to his religious practices until he was nearly 60.

Throughout his life, Greg has been "back and forth" between men and women. He never told is ex-wife about his attraction to other men, and he has not told any of his children. He left his family behind when he was in his early 40s after his youngest daughter graduated high school. In 2004, he began a relationship with Joanne. She was HIV-positive, but did not tell Greg about her status. She and Greg were living together, and for the first time in his life he was able to be open about his sexuality. He "had the best of both worlds" because his male lover was also living with them. Eventually, his male lover moved out because "he couldn't take it." Greg noticed Joanne going back and forth to the hospital, and one day he went with her to the doctor. Her doctor wrote Greg a note that told him to go to the local health department to get tested for HIV.

George

• 47 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed 1991 •

George grew up in Pennsylvania, but did not elaborate very much on his childhood during our interview. Church was a part of his life growing up; "We're church folks, Christians," he remarked. His mother would make him go to church every Sunday. He went mainly because he "had to go." George heard negative messages about homosexuality there, but he did not discuss the types of things that were said.

He felt like an outsider because of his same-sex attractions, and he hid them from his peers and family. George was "homeless for a minute" at the age of 18, though he did not elaborate on the reason. During this time he entered into this first same-sex relationship, but was experiencing depression related to anxieties about his sexuality and the religious and cultural beliefs he was exposed to growing up. He recalled:

> I was confused. I was confused because I didn't know nothing about sex or nothing and that was my first time ever having that so I didn't really know what I wanted. I was just confused. I was just trying to find what was making me happy.

In 1991, when George was in his early 20s, these anxieties were still affecting him. He dated women to try and meet cultural and religious expectations of heterosexuality, but he also had sexual relationships with men. During that time he contracted HIV from sex with another man, and he also went to prison.

Elisha

• 30 • Gay • Contracted HIV via Homosexual Transmission • Diagnosed in 2017 •

After Elisha's spiritual beliefs began to evolve in college, he distanced himself from the Christian faith of his childhood. He became more universalistic in terms of his beliefs

and outlook about a higher power. Through this renewed spiritual path, he found peace and acceptance within himself.

Once Elisha felt like he could embrace his sexuality, he found a male partner who he built a life with. They were together for many years, though the relationship was volatile at times. His partner hid his HIV status from Elisha from the very beginning, and it was through his dishonesty that Elisha contracted HIV.

Wendell

Wendell's narrative stands apart from those of the other men because he has kept his same-gender attractions and relationships strictly compartmentalized from the everyday life he leads as heterosexual, married man. Neither his ex-wife nor his current wife or children have ever known of his same-sex attractions. Both of his current same-sex relationships have been the most enduring relationships in his life. They began in the early 1990s after he contracted HIV from a brief relationship with a woman. Though his story was unique in this set of interviews, it is most likely not unique among BMSM, who often do not feel they can openly express their same-sex desires and attractions due to fear of rejection, not only by society but by God.

Stories like his can be used to fuel dangerous rhetoric about life on the down-low, whereby BMSM are portrayed as villainous, sneaky, and are blamed for the disproportionate burden of HIV in black communities.[18] To read his story in that way would be a misreading and irresponsible. Rather, it must be read with a carefully attuned eye to the presence of homophobia—structural, communal, and religious—thinking about how that could have affected the actions he has taken in his life.

Wendell

• 49 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed In 2002 •

Wendell grew up in a rural Southern town in a close-knit and relatively large family with brothers, sisters, numerous cousins, and many aunts and uncles. He was very close to his grandmother, the family matriarch. Her faith and her church were very important parts of her life, and she made it a point to make sure they were important to her family as well. He reminisced:

> Like you walk in my grandma's house, you will see pictures of Jesus, pictures of the family dressed up in church clothes. Now every Sunday, no every Saturday, my grandma would start cooking us dinner for Sunday on Saturday because we had a big family. Everybody would leave the church and come down to our house. Man, it was so . . . coming up man, religious, if I could change it back, I really would, because I wouldn't be in the shape I am now. I'd probably be a more better person if I had just stayed closer to him.

When Wendell was 21 he began drinking and going to nightclubs and partying with his friend, which was much to the chagrin of his grandmother. She told him, "I want you to be somebody. I don't want you going out here and then throw your life away, you know, and be nothing. Boy, I see some good in you; make me proud of you." From that day on when he was staying with his grandmother, he was awake and ready to go to church with her on Sunday mornings.

In 1991, Wendell met a woman ten years his senior. He recalled, "I had been wanting to get with this lady for years." After she went back to New York from his small town, she sent him a bus ticket and he went to stay with her. Eventually he became sick, and he thought he had a cold. Her two children told him that their mother had HIV, but when he confronted her, she denied it. Shortly thereafter, Wendell left New York and moved Michigan, where his father was living at the time.

There was a different side to Wendell's life that paralleled the story above beginning in his early 20s. He has had two long-term relationships with men. He said:

> The women, don't get me wrong, the women, I love women, but a woman can't do what a man can do. But, like they say, a man can't do what a woman can do. I find that out to be true. That's the truth.

In the late 1990s, Wendell began two of his most significant and enduring relationships with Louis, a preacher, and Oscar, who lives mostly as a woman; Wendell refers to Oscar by male pronouns. Both men are HIV-positive. Wendell is like a part of both of their families, and has remained close with them over the decades, despite often living in different states and being in two marriages. He also has an extensive network of gay friends, and he noted, "They'll come to me quicker than any woman!"

Wendell was about 28 years old when he met Louis, who is at least a decade older than him. They met just after Wendell had gotten out of the relationship with the woman from New York. Wendell "really just wanted to turn against women" at that time. They have remained closely connected over the decades, even after Wendell married his first and second wives. He has always gone to be with Louis for periods of time when he goes back to visit his family in his hometown, but his wives have never known. Louis's family is close with Wendell, and they refer to him as Louis's partner.

Oscar also lives near Wendell's hometown, and they have been close since Wendell married his first wife in the late 1990s. He considered leaving her to be with Oscar. Before Wendell was "out of the drug game," he and Oscar used together. They have remained close over the years and see each other as often as possible.

Wendell has managed to keep these two relationships from both of his wives and his family, except for his mother. His mother has been non-judgmental about his

relationships with men. She told him, “God forgives you, but you got understand in the real world, not many people will forgive you like that man (God).” Wendell has never committed to living life with either Louis or Oscar, and he prefers to keep these relationships secret. He sadly noted, “the thing about the world that I’ve learned, the less the world knows, the better off you’ll be.”

Wendell associates acting on his desires for other men with being sinful. He said:

> Well I look at it like this, I know there’s a lot of stuff we do that’s a sin. I want to tell you what my belief is. It don’t matter what I do in life, I could say, “God, forgive me,” and he’s gonna forgive me . . . . But, I know he is a forgiving God. So I said, “Forgive me, I ain’t gonna do it again,”and I try not to. But, I’m gonna tell you, when something’s good, it’s just hard to just say you ain’t gonna do it again. I’m just being honest.

Despite his same-sex attractions, he feels that God will “still treat [him] the same regardless.” The Christian faith is a cornerstone of the relationship he has with his wife; they read the Bible and pray together everyday for their lives with HIV to remain healthy.

Religion and Spirituality Summative Effects on Health

Rodney, John, Chris, Nathan, Darius, and Elisha explicitly attributed their negative mental, spiritual, and physical health outcomes to the homophobic religious messages were exposed to and internalized. The cumulative effects of homophobia and stigma worsened as they matured and their sexuality became a central component of their adult lives. The extremes of these emotions were compounded by past traumas of abuse, rejection, and feeling distant from and/or doomed by God, which predisposed and even pushed them into alcohol abuse, drug abuse, and risky sexual behaviors. Chris and Darius directly linked experiences with religious homophobia to their own disregard for caution in sexual behavior, increasing their risk of contracting HIV. When Nathan contracted HIV

from using injection drugs after a personal tragedy, he felt that God might be punishing him because of his sexuality.

Paul, Drayton, George, and Trey, also encountered homophobic messages within their respective churches, families and communities. However, they did not explicitly attribute their engagement in substance abuse or risky sexual behaviors to conflicts they felt with their religious beliefs. While the painful effects of religiously rooted homophobia impacted their spiritual and mental health into adulthood, they described their health behaviors that exposed them to HIV in terms of personal choices. The theme of childhood sexual abuse wove through their stories. Adult men repeatedly molested Drayton and Trey when they were children, but they felt ashamed about the homosexual nature of the abuse alongside their own same-sex attractions, so they never told anyone. As a teenager, Drayton even attempted suicide because he felt sinful, dirty, and beyond redemption.

Greg, Leon, Jamiell, and Adrion did not recall hearing homophobic messages in church during their formative years. Rather, they encountered homophobia in their communities and families. Though, it was nevertheless couched as religiously based judgment. These experiences negatively impacted their mental and spiritual health at times, but none of them directly attributed externalized or internalized homophobia with engagement in health adverse behaviors.

Childhood sexual abuse figured sadly in their stories as well. When Greg told his father, a disgraced former pastor, about suffering years of sexual abuse by an adult male neighbor, his father beat him and expressed no empathy for him. His father was angry because of the homosexual nature of the molestation, accusing Greg of associating with the "wrong kind of people." Adrion shared another story of misplaced blame related to

sexual abuse. His 17-year-old male cousin was caught assaulting him and blamed the temptation and subsequent abuse on Adrion's perceived sexual orientation. Jamiell never disclosed his repeated childhood experiences of rape by adult males to anyone because he was ashamed about the homosexual nature of the abuse.

Wendell's narrative is unique among this sample of men. He has kept his same-sex desires completely compartmentalized over the decades, maintaining two separate same-sex relationships and a group of gay friends apart from his life as a heterosexual married father. He repeatedly referred to his same-sex attractions and relationships as sinful and needing forgiveness. This duality in his life is rooted in his struggles with both externalized and internalized homophobia, which have created mental and spiritual anxiety. He did not discuss whether these stresses contributed to his substance abuse and/or risky sexual behaviors he has struggle with over the years.

Religion and Spirituality Affecting Health

The men's stories from these three sections illuminate the processes by which they negotiated their lifeworlds from childhood, into adulthood, and up until the time of they contracted HIV. Through these accounts, we gain a deeper understanding of how their self-knowledge as same-gender attracted men developed over time, as well as how their experiences of these attractions placed them at odds with cultural and religious ideas that demanded compulsory heterosexuality. Their stories put flesh on the bones of the health sciences data by describing ways in which stigma and homophobia, often religiously rooted, serve as powerful determinants of health that catalyze the HIV epidemic among BMSM.

Critically, these stories give needed insight into the process by which lived religious and spiritual experiences impact the health journeys of BMSM across life stages. They highlight the cumulative nature of the deleterious effects of religiously rooted homophobia and stigma on their spiritual, mental, and physical health, which placed these men at greater risk for contracting HIV. [19] For those men that were able to reconcile their religious and/or spiritual beliefs with their sexuality, their stories also point to the positive impact these beliefs and practices can have on health, such as feeling connected to God or a higher power, using their beliefs to deal with stigma and homophobia, and increased feelings of self-worth and inner strength.

The health of BMSM is tied to macro-level issues of structural racism and homophobia, which contribute to their disproportionate burden of health inequalities. Current data from health sciences points to a variety of social determinants of health: lower rates of educational attainment, income inequality, housing insecurity, lack of access to health care, higher rates of incarceration, the statistically higher rates of HIV among this already small population, which negatively impact the health of BMSM and contribute to the burden of HIV/AIDS in this population. Given the historical importance of religion—particularly black Protestant Christianity—in African American communities, the data also shows the deleterious impact religiously rooted homophobia and stigma can have on mental and physical health of these men.

However, health science data does not provide strong first-hand insight into the cumulative effects religiously rooted homophobia on the processes that impact the health-related and health-seeking behaviors of these men. The narratives in this chapter provide this understanding by allowing us to see how the lived religious and spiritual

experiences of BMSM impact their health journeys from childhood until they contract HIV. In the next chapter, these men's lifecourse narratives continue by giving us a glimpse into their health journeys with HIV post-diagnosis, and exploring the intersections of religion and spirituality with chronic illness.

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Chapter 3

In The Life: Responding to Life with HIV

This chapter explores the pivotal moment of HIV diagnosis and life with HIV, as the men describe the tragedies and triumphs of living with such a highly stigmatized chronic illness. Post-diagnosis, the lives of BMSM are mediated by systems of cultural meaning making around HIV, which mark them with unwanted and undeserved social stigma that is not easily warded off or coped with.[1] This stigma is often substantiated by religious and cultural beliefs about the sinful nature of homosexuality and the deviance of those who have the virus. The narratives in this chapter expose the internal world of coping with the illness. They shows how the lifeworlds and healthworlds of these men were devastated by diagnosis and charts their journeys toward rebuilding them, as they have adapted to the lifelong processes of living with HIV. These men's stories reveal how BMSM can make meaning and find coherence in their lives by negotiating their religious and spiritual beliefs and practices in ways that enhance their health and wellbeing.

The three sections of narratives in this chapter: "Life at Diagnosis," "Life with HIV," and "Religion and Spirituality in Life with HIV," illustrate how and why these men have attempted to evolve their religious and spiritual beliefs and practices to better manage life with HIV—sometimes in ways that may appear contradictory to observers. Their stories bolster current health sciences claims about the varied impacts of religion and spirituality on the health of BMSM. They also underscore the serious need for more extensive and sophisticated assessments of religion and spirituality on the health of this group of men, and the need for these forces be better addressed in public health interventions and healthcare delivery.

Life at Diagnosis

When BMSM are diagnosed with HIV they are confronted not only life with chronic illness, but often times with the well-worn religious and cultural tropes that connect homosexuality and HIV/AIDS with sinfulness, and depravity. Drayton's statement elucidated this point. He remarked, "This is all about you're not living right, God is punishing you." The experience of having HIV involves betrayal. The body betrays and this impacts how the self relates to that body. But more than a body that is ill, the ways BMSM related to their own bodies and presence in the world are profoundly mediated by culture, religion, and spirituality.[2]

For many BMSM, contracting HIV compounds the cumulative effects of cultural and religious homophobia. There is often a sense of spoiled identity, as internalized effects of stigma and shame are magnified and contribute to increased suffering.[3] Their anxieties can manifest in deleterious health-related and health-seeking behaviors.[4] The cumulative effects of externalized and internalized homophobic religious stigma must also be dealt with for a great deal of these men. Despite encountering religiously rooted homophobia and HIV-related stigma, many BMSM utilize their religious and spiritual beliefs and practices to cope with adversities in their lives with the illness.[5]

In the narratives below, Paul, Leon, Rodney Wendell, Drayton, George, Chris, Darius, and Tray describe how they immediately dealt with their diagnosis. The most common reaction among all the men involved being upset with or feeling abandoned by God. Rodney felt that God was punishing him because he acted on his same gender attractions. Initially, Wendell believed God gave him strength, but not long after his diagnosis he began to feel hopeless and that God was "fake." Darius's anger with God stemmed from a negative

experience he had in church after which he “felt depleted.” For Drayton and George, life after diagnosis was so hopeless in the early 1990s—a time when diagnosis was practically a death sentence—that they thought about or attempted suicide. Others, like Paul, Leon, and Trey, were not mad at God, but rather more upset with themselves. Paul took his diagnosis as a chance to introduce Christ back into his life. Trey, the interviewee most recently diagnosed, turned to God immediately to give him strength. He said, “I had to get on that boat and pray and pray and pray and ask God to forgive me, ask God to give me strength.”

Narratives accessing their responses immediately following diagnosis illustrate the kinds of reactions that BMSM have after learning they are HIV-positive. Most of these men, even Drayton who contracted the virus heterosexually, were forced to confront their same-sex attractions once diagnosed. Their stories show how diagnosis triggers complex responses to religiously rooted homophobia for many BMSM, such as linking HIV/AIDS to punishment from God for sinful behavior. Chris noted that he felt God “never had [his back] in the first place because of the life that [he] was living.” Their assumptions and connections to the disease and their behaviors starkly reveal the power of external and internal homophobia on the illness experiences of BMSM. Importantly, they provide rich detail about the processes many BMSM go through in order to cope with life with HIV.

Paul

• 57 •Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Paul was taken aback by his HIV diagnosis at the age of 46, especially given his 25-year career as a healthcare worker. He had to be picked from the floor by the doctor when

he was told that he had the virus. Naturally, Paul began to question why this happened to him. He recalled:

> That's where the religion part came in because when I couldn't understand why. I was blaming myself. I was taking self-blame, saying that it was because I was homosexual . . . . So, I felt like I was being punished at one point.

He prayed for God to help him figure out what to do with his life. Paul noted, "that's when I decided to get educated, and I reintroduced or brought Christ back into my life."

Leon

• 56 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2006 •

Leon went in for a routine physical and blood work in 2006. He got an unexpected call a few days later to return to his local health department. When he went back, he learned that not only was he HIV-positive but he also had AIDS. This diagnosis took him completely by surprise because he did not feel sick. The health department referred him to The Clinic to help him get in treatment. Leon "didn't really freak out" because he knew of the advances that had been made in medications, which were unlike the medications in the early 1990s when several of his friends died from AIDS. He was "ashamed" to go to The Clinic because, as it meant that he had to face the reality of his illness and confront his internal stigmas about those with virus.

He was never angry with God for getting the virus, but rather accepted it as "[his] fault" because he was not using protection during sex, even though the person he contracted it from denied having HIV. Leon made sure to take the medicine he was prescribed as part of his treatment plan so that he could stay healthy. His family was supportive, and his mother constantly encouraged him to take his medication. Leon was

worried about telling his boyfriend at the time, Joshua, that he was HIV-positive, but Joshua assured Leon that he loved him "just the same."

Rodney

• 52 • Gay • Contracted HIV via Homosexual Rape •Diagnosed in 1984 •

Not long after attempting suicide in college because he felt so at odds with his sexuality and his faith, Rodney went with a friend of his to their local health department to get tested for HIV. This was in the mid-1980s, and Rodney knew that AIDS was sweeping the gay community. When he went back to get his test results, he learned he was HIV-positive. Rodney was "frantic," and he asked the nurse what were the next steps. He remembered her saying, " I don't know and I don't really care, I can't stand you people . . . you're going to die, that's just what you're going to do." He did not take medication because the only treatment available was AZT, which he knew had terrible side effects. He recalled, "I just lived my life like I never knew I had the disease." Rodney "couldn't deal with it," so he left school, got a job, and "went on this drinking and screwing spree for about 10 years."

Rodney felt like he was "supposed to be punished" for loving men. He was upset with God, and he would question, "Why do you hate me so much? Why would you put me through this?" He was acting out his frustration by having promiscuous sex with men, drinking heavily, and abusing drugs. Rodney never told the men he was sexually active with at that time about his HIV status. It was also during this time that he went to jail for committing petty crimes.

In jail, Rodney met a doctor who put him on a new HIV treatment regimen, which was no longer as harsh as AZT. He "felt like a person again," and "started really trying to seek this God they said [he] couldn't talk to." He remembered:

> I saw God reaching his hand out to me for some reason through that, you know, because I was in this place of despair that I know God's killing me. He's taking me out because I won't change, and then he reaches his hand out and gives me these medications that work, that'll help me. So I saw the light of day for some point, and that's when I started reading my Bible again and I started venturing toward church.

Wendell

• 49 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed In 2002 •

When Wendell was hospitalized and diagnosed with HIV in 2002, he prayed on his knees “like [he] ain’t never prayed before.” Everything around him felt like it stood still after he found out. He felt like God gave him immediate strength. He thinking, “God, you work fast, but I didn’t know you work that fast.” When he got out of the hospital, Wendell was adherent to his medications. Shortly thereafter, however, he went into a dark period of depression because he had numerous women, and because of what the diagnosis would mean for the rest of his life.

He began “having big doubts,” and he felt like God was “fake.” Wendell questioned God, “Why am I still here?” He was angry with God. He started using cocaine heavily to try and kill himself, but he kept surviving despite of the massive amount of drugs he was putting into his body. Eventually, he reached a point of desperation, and the only thing he could do was pray. He recalled:

> One day I got down on my knees and prayed and he just showed me. He said, “I’m still God.” He said, “I’m still with you.” He said, “I’m not going to call you home until I know you’re ready to come home.”

Drayton

• 48 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 1994 •

Drayton found out he was HIV-positive in the mid-1990s when his daughter was in her teens. He went to the local health department where Sister Coates, a lady from his

church, worked. She suggested he take an HIV test because of another sexually transmitted infection he had contracted. They did a blood test, and it took about 10 days for the results to arrive. She called Drayton and asked him to come back to the office. She sat him down in an exam room, and the doctor came in a few minutes later. Drayton could tell the news was bad because "[the doctor's] expression just gave it away." When he heard the word "infected," he thought to himself, "I am just going to fucking kill myself—how the fuck am I going to tell my family?"

Sister Coates called Drayton's mother to make sure he got to her house safe. Drayton tearfully recounted how his mother reacted to the news of his diagnosis:

> She held on to the sink and she just screamed . . . . It was un-describable. It had messed me up for years that I had to have psychological counseling because I always hear her scream . . . . And, she turned around and she looked at me and she was crying and she said, "What gave you the right to kill my son, what gave you the right to kill my baby?"

Drayton left his mother's house thinking, "you need to get a gun and you need to shoot yourself in the head 'cause you're gonna die." He went to his sister's workplace and told her. After telling them both about his diagnosis, he drove to a nearby mountain in Nevada, where he planned to drive his car off the edge. His sister kept paging him, and he eventually called her back. She convinced Drayton to come home. When he returned, his sister comforted him and reassured him of his family's love. He then told his daughter's mother, from whom he was separated, and she very supportive.

Drayton wasted no time getting into care. The doctor put him on the only treatment at the time that was effective, AZT. It made him incredibly sick. He thought to himself, "this shit is toxic," and he stopped taking. He continued on with his life until he started to get sick. Eventually, he was hospitalized and put on the AIDS floor, where he refused to stay

because of the stigma attached to those with the illness. He was put on a cocktail of drugs, which brought him "back to life." He remembered:

> I kept on thinking, this is what they're talking about, you know, you live that life you're gonna die that life, this is all about you're not living right, God is punishing you . . . . You know, that's what they were saying, everybody gay got it and that's what God is doing, he's destroying all the gays, this is his wrath.

Drayton drew closer to God than he had been before. He wanted to change his life so that he could get into heaven because—like so many others he was seeing around him at the time—he was sure he was going to die. He noted:

> I went on this like really—okay, I'm not doing nothing with no men, no women, and I was just celibate. And, I got really spiritual. I was going to church three times a day on Sunday, going to Bible study on Wednesday, doing prayer service, just everything to keep me from lusting, yearning for men and women and, you know, I'm gonna get saved, I'm gonna get myself right so I can get in heaven kind of thing.

George

• 47 • Bisexual • Contracted HIV via Homosexual Intercourse • Diagnosed in 1991 •

After being diagnosed with HIV early in 1991, George "couldn't tell nobody," because of the stigma associated with the virus. He did not take medication at the time because the only treatment available was AZT, and he did not want to endure its side effects. George got mad at God because he "thought [he] always had a good heart," and did not deserve what essentially amounted to a death sentence. He recalled, "I had cussed God and everything. I thought he like didn't love me because I was a bad person. I was ready to die. I didn't care. I tried to kill myself a few times." George began to take drugs to numb the anguish he felt. He remembered, "I was like, well, I might as well—I'm just gonna die anyway so what is the difference." Coupled with the stigma and shame of having HIV, he was constantly confronted with the idea of death when he looked at his body, which was frail and weak from the virus.

George went to prison in Pennsylvania not long after his diagnosis. It was standard practice to conduct an HIV test on inmates. When it came back positive, he got on a mandatory treatment regimen. On medication, he gained weight and felt better. He also, “started reading the Bible, going to church, and started getting more and more with God.” George found comfort in the Bible and identified with the suffering of Jesus. He felt “like a lot of burden” was lifted, and he found peace within himself. His renewed spiritual outlook motivated him to take care of himself, and he planned to remain on his medication when he was released.

Chris

•46 • Gay • Contracted HIV via Homosexual Intercourse• Diagnosed in 2002

While living in his newfound Atlanta gay community in 2002, Chris was partying and feeling sexually liberated, but he was not always careful with his sexual health. One evening at a local nightclub he took an HIV test in exchange for a free drink ticket. A few days later he received a phone call because his test was positive. This diagnosis sent him into a period of depression. He recalled:

> So yet again, I’m back into I’m damaged goods, I’m never gonna get rid of it so I’m probably gonna end up dying a lot sooner than I expected to, so why not do the things that I normally wouldn’t have done because I wanted to have a long healthy life. Now I’m gonna die anyway, so why say no to this, why say no to that?

When asked if he felt like God had turned his back on him, Chris replied:

> Not necessarily that he turned his back on me so much, as much as He never had it in the first place because of the life that I was living. It was difficult because on one part I was happy to discover who I was and discover I wasn’t alone, but at the same time I thought all the bad things that were happening to me were happening because of it (homosexuality).

Chris began using drugs as a means of escape from depression, and his life spiraled out of control. He eventually lost his job and his home. Faith in God was nowhere to be found in his life. He remarked:

> So it wasn't even a thought process anymore once you join the life of those that life has just beaten up to the point where just getting through the day is difficult. I almost tried to commit suicide a second time. It was just a horrible existence. I was just miserable. So religion at that time, I didn't feel like I had any.

Darius

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

Darius no longer felt connected to God after his relationship with his faith was shaken by his experience in a Church of God in Christ congregation. He was engaging in risky sex with men and "kind of doing what [he] wanted to do." Shortly before he turned 24 years old, Darius got ill with abscesses on his body, flu-like symptoms, and lost a lot of weight. One day when he could not get his breath after walking out of the house, his mother took him to the hospital, where he was diagnosed with AIDS. He was released once he was strong enough.

The HIV/AIDS diagnosis made Darius feel hopeless and mad at God. He remembered:

> It was like the pilot light that was left of what little bit of things I was, but I was trying to go to different churches and stuff—that last kind of shred of hope was like somebody was trying to blow it out. That's just what I felt. I just felt depleted. Frustrated because maybe I wasn't strong enough or didn't have enough knowledge about what God really was to me to be able to maneuver through people not putting the message out properly.

Trey

• 29 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2018 •

Trey was diagnosed with HIV a month prior to being interviewed. He recalled that a couple of days after an unprotected sexual encounter with another BMSM that he started feeling sickly. He did not think too much about it because the man he had been with was supposedly HIV-negative. Eventually, he got so ill that he went to the hospital. After tests were run, Trey found out he was HIV-positive. The only thing he could do at that moment was pray, and he asked the Lord to "hold [him] until [he] got to the house." Once he got home he "cried and cried." He questioned, "Oh my God, how could I do this to myself?" Trey became depressed, wanting to be alone and stay in bed all day.

He missed several of his doctor's appointments because he felt like he could not cope with life. He remarked:

> I had to keep praying. I had to get on that boat and pray and pray and pray and ask God to forgive me, ask God to give me strength. And He did. He really did and I started going back to see the doctor. I started coming back, started taking my pills, and my energy and my health started to come to me . . . . He brought everything that I didn't have and everything that I let go, he brought all that back to me. He's bringing it back. He hasn't finished. He hasn't finished. But, I'm a strong believer, and I keep believing it, and I feel like it's always a win to every situation.

Trey is "constantly praying" to God because he wants to find a loving, long-term relationship with another man. He noted:

> I want to get closer to God and I want to find somebody because I want to be close to God. That might be the only guy that I need, you know. But I want to get closer to God—I want to get closer to God.

Responding to Life with HIV

Responding to life with HIV is challenging for BMSM, as it is accompanied by myriad illness problems. These problems are the symptoms of living life with chronic illness. They

not only include physical health challenges, but also the spiritual and mental difficulties of never being better, lost trust in the body, fears of death, and the dangerous effects of cumulative homophobic and HIV-related stigma.[6] The lifeworlds of BMSM must be reconfigured around the realities of chronic illness. How they manage their religious and spiritual lives in conjunction with their sexual orientations and disease statuses are critical to the health journeys of many of these men.

The accounts below confirm that a life-threatening diagnosis like HIV/AIDS can trigger a plethora of spiritual questions about the meanings of the illness. Additional worries about purpose in life confounded how these men thought about themselves in relationship to God and others in their communities.[7] Struggling with HIV related stigma and homophobia negatively impacts the mental and physical health of many BMSM. It also increases their likelihood of engaging in risky sexual behaviors after diagnosis, as well as other behaviors that are detrimental to life with chronic illness.[8] Chris recalled, "I was on a rampage, and that rampage was I'm gonna help speed up my process of death." However, for Chris, responding to life with HIV also included harnessing the positive aspects of religious and spiritual beliefs and practices to cope with the challenges he faced. He recalled, "Over the years I've noticed that I've served Him, my life has only gotten better." Drawing on positive religious and spiritual beliefs and practices has been shown to improve health outcomes BMSM with HIV. [9]

The narratives in this section give a glimpse into the worlds of Greg, Drayton, George, Chris, Darius, Jamiell, and Adrion as they came to terms with their lives with HIV. For Greg, Chris, Darius, and Jamiell, HIV diagnosis and managing life after HIV proved burdensome, and they struggled with feelings of God's abandonment and apathy. Despite

the extreme highs and lows, often brought on or compounded by their religious and spiritual beliefs and practices, all these men credited their faith in God with keeping them alive.

These men's accounts of how they responded to life after their HIV diagnoses demonstrate the need to better comprehend the process by which BMSM negotiate their religious and spiritual beliefs post-diagnosis. Their stories show that their religious and spiritual beliefs were deeply foundational to their lifeworlds and personhood, and that these convictions could not be abandoned. They also point to how these men were able to reconfigure these aspects of their lives, and provide valuable insight into ways health interventions and healthcare provision can draw on the positive dimensions of religion and spirituality to enhance the health of this population. The men's experiences give insights into how lived religious and spiritual experiences, such as those related to stigma, depression, self-loathing, etc., can delay entry into or interrupt the HIV care continuum for some BMSM. But, they also speak how these experiences can help facilitate entry into and retention in the HIV care continuum by enabling them to feel affirmed, empowered, loved by God, and integral to their communities.

Greg

•60 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 2004 •

Greg's life took a downturn after he contracted HIV from his girlfriend. Their son was born HIV-positive, an older son of his from a prior relationship died, and death of his girlfriend followed shortly thereafter. He was desperately trying to cope with these tragic events, but he felt like his world was coming apart at the seams and that God did not care. He stated:

> I was sleeping with any and everybody. I was running the streets like I had lost my damn mind. I was hopping from bar to bar, getting drunk, and waking up in who knows bed. I was on a rampage, and that rampage was I'm gonna help speed up my process of death. [God] don't care. But, he cared all along.

When Greg first enrolled in HIV care at The Clinic in 2005, his immune system was so compromised that his doctors were not sure if he was going to live. Now, his CD4 count his high, and his viral load in his body is undetectable. It has been challenging for Greg to remain on his medications and stay healthy, as he has gone through bouts of homelessness due to mental health issues for several years. He has fought hard to "come back" and to be healthy, and believes his "heavenly father" has kept him alive.

Drayton

• 48 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 1994 •

Drayton was having AIDS-related complications by 2001 because his medications stopped working. He could not walk to the bathroom on his own, and he was so frail that his bones would rub together causing unbearable pain. He wanted to die because he was so miserable. His doctor recommended he go to Atlanta to inquire if he could enroll in a clinical trial for new HIV medication at The Clinic, which is well known for medical research on new HIV treatments. In 2002, he moved to Atlanta and was enrolled in a clinical trail. Drayton "was just thanking God he was in the study." He started to see results in just a few months; his CD4 count was up, and he went from 130 pounds to 189 pounds.

Drayton joined a spiritual support group for those with HIV, which helped him find community. He also got involved in an LGBTQ-affirming, predominantly African American, church. He became "a dedicated follower, usher and everything." Being in this church environment gave him a new perspective on his faith and the love of God. He recalled:

> It felt like I had been touched by God. If God, like he was telling me, "I love you regardless, no matter what." I started thinking like a child, you will let a child go through certain things just to teach them a lesson but you will never harm the child, you will never kill them—not something that you create, not something that you love, and you wouldn't do things to your children just to hurt them. And I knew, I said a God like that, I can't see him no longer at a point where he said I put AIDS on your because you're gay. Our father wouldn't do it.

George, 47, Bisexual, Contracted HIV via Homosexual Intercourse

• 47 • Bisexual • Contracted HIV via Homosexual Intercourse • Diagnosed in 1991 •

In the late 1990s, George married a woman, and he was attempting to live a heterosexual life. His wife knew about his HIV status but not his sexual orientation. They went to church regularly because she "was just a church person—all she did was go to church." Throughout their marriage, he tried to rid himself of same-sex attractions, which he still tries to remain free of. He said:

> I just tried to wash it out of my brain like it never happened because I feel like now I would never do that again. I hope I don't . . . . Because I just don't like that way. I don't want to be that way.

George moved to Atlanta in 2012 to be near his daughter and grandchild. For part of 2016, he was homeless due to addiction and mental health issues. He recalled, "I was just tired of walking the streets and it was cold—I just wanted to die, man." He lost his government issued identification, which meant he could not re-enroll in HIV treatment. His "body was like going downhill." He had skin rashes, and he got down to 121 pounds, which was gaunt for his over 6-foot tall frame. George was able to enroll in care at The Clinic after he obtained his documents. Since then, he has been able to live with his best friend, and has been attending a non-LGBTQ-affirming, African American church. He credits God with keeping him healthy. He emphasized, "I know God is watching over me and I just want to—don't want to like disappoint him."

Chris

•46 • Gay • Contracted HIV via Homosexual Intercourse• Diagnosed in 2002

Chris became well acquainted with life in the homeless community living on the streets. He remarked, "You'd be amazed at what the human body can become accustomed to or what it can adjust to." This life was a far cry from anything he could have imagined with his exclusive private college education and well paying jobs. One day when Chris was in a homeless shelter in Atlanta he made a plan to kill himself by jumping in front of a transit train.

It was during this dark time that Chris turned to God, and a miracle happened in his life. He remembered:

> I sat in the chair and I said, "You know what, I'm gonna pray." I said, "What else do I have to lose at this point?" And, I prayed for two things. I said, "God, if this is not the life I was meant to have, I don't know whose life I'm living but it's not mine, but I can't live it anymore. So, if this is your will for me to live like this, I'm letting you know I'm gonna commit suicide. If I see you, I see you; if I don't, I don't. I just don't care anymore. But if this is not the life for me, if there is some better plan, if there is something better for me, please make something happen, just anything, make something happen so I know you're real." And all of a sudden, this bus pulled up in front of the shelter, and this guy got out yelling, "Anybody who wants to work, anybody who wants to change your life, anybody who wants to get off the streets, get on this bus" . . . . I could've been human trafficked for all I know. But, because it happened right after I said the prayer, I thought that was—so I got on the bus. And once again, my whole life changed and that's when I knew God is real. That's when I knew.

Chris rode the bus to New Orleans, where he enrolled in a rehab and work program run by a Christian ministry. He was immediately assigned a caseworker by the ministry, and he was provided with an apartment, food, and medical care. Chris also began attending school to become pharmacy technician. Going out and participating in gay life was much

different for him in New Orleans, as he felt like he was getting his life back on track with a career and a place to live.

Part of what made him feel stable was his renewed relationship with God. He became part of small congregation in where he felt welcome, even though it was not explicitly LGBTQ-affirming. Looking back, he believes God saw a "greater purpose" for his life through the challenging times he had experienced. He stated:

> For that reason, I knew that he was real. Nobody will ever convince me otherwise and the more over the years I've noticed that I've served him, my life has only gotten better . . . . just because God's been in it.

Darius

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

Darius was almost totally confined to his home for months following his hospitalization with AIDS. It was "just dark" during this period in his life. While he was homebound, a neighbor introduced him to crack cocaine. Darius recalled, "I put it in my mind that I wasn't going to make it. So, why not go out with a bang?" He began using crack as a way to remove himself from the physical and emotional pain he was in. He remembered thinking, "I just don't want to be engaged; I don't want to do this; I don't want to participate." He questioned God, "Why are you making me live when I don't feel like it's even worth it anymore?"

Just when he thought HIV was going to alienate him from everyone, he connected with a service agency specializing in support for those with HIV/AIDS struggling with drug addiction. Darius enrolled in a support group. He recollected, "It was like a beehive if you will, and all this positive energy was going around." His life began to change once he got

involved, and he decided, "This death thing isn't going to work anyway because all I'm doing is wasting a lot of money, and it's just not working; I'm not comatose."

The program was based on the good orderly direction or G.O.D. paradigm. It helped him reframe his own relationship with God, which had been fractured by the hurt he experienced because of a lay pastor's actions in an AME congregation. Darius noted, "It was really like building my whole faith system all over again, and that helped." His relationship with God continued to grow because of an experience he had when he went to a church for a work function with his sister. The pastor of the church came over while he was standing at the back. She looked at him straight in the eye, "like peering through [his] soul," and said, "I want to apologize for anyone that ever hurt you in the body of Christ." This one act changed Darius's life and his overall wellbeing for the better. He recalled that it was "like three hundred pounds of just all that gunk" fell away, and it "freed" him from the anger he had with the church and with God.

Jamiell

• 38 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Jamiell became depressed after he was diagnosed with HIV. He was ashamed of his diagnosis because he had been heavily involved in HIV awareness and prevention efforts. Jamiell was in the hospital constantly with sores on his legs. For months, he would sit in his basement and turn the lights off. He was not accessing HIV treatment. Jamiell said that he "rebelled" during this time and "[looked] to the comfort of a man." He increasingly turned to sex as an escape from feelings of shame and impending doom. He recalled, "I wasn't messing around unprotected, but I wasn't telling people my status." Jamiell did infect one of the men he had sex with. Though the man is "not even bitter about it anymore," Jamiell is

"paying for it" because he has to live with the fact he unintentionally infected someone else. He noted, "There was that nice gap during that timeframe where I wasn't talking to God. I wasn't seeking any kind of assistance. I just knew I had to live day-to-day before the days were gone."

It took him about six months to start managing his life with the virus in a healthy way. Around that time, "a little snap in [his] head happened," and he began "trying to get better and better." In 2004 he moved to Atlanta, and he enrolled in treatment as soon as he arrived. He was hospitalized in 2009 for HIV-related complications, which meant he had to move back to Ohio briefly before returning to Atlanta.

Adrion

• 37 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1999 •

Adrion graduated high school at the top of his class with a perfect grade point average. After diagnosis during his senior year, he took the fact he was successful in school was a sign "that God was working through the situation to get [him] ahead." He did not elaborate too much on his life beyond his high school days, except in terms of those situations in which he believed God was calling on him and working through him. He emphasized the importance of these spiritual experiences in relationship to the trajectory of his life and health. He emphasized, "I know that if I didn't have faith in God that I [would have been] taken out by me just wallowing in my own sorrow."

One instance that has defined Adrion's life happened a couple of years prior to our interview. He was severely beaten on his way home from the store, and he woke up in the hospital with his jaw wired shut and his eyelids sewn together because of traumatic injuries to his eye sockets. Adrion prayed to God, "Just let me die in my sleep." He thought

God was “testing” him. He remembered God saying to him, “Why do you keep saying that if I’m gonna let you die, you don’t feel like you’re dying right now . . . . just stay calm until later.” At that point, Adrion relinquished control in his life to God. He remarked:

> I just stopped trying to control it because I can’t control everything. It’s not for me to do . . . . That’s when my t-cells started going up viral load going down, everything’s going right, I’m healthy and I’m gaining my weight back like . . . . It’s all because of God.

Religion, Spirituality, and Life with HIV

Health sciences data shows that self-affirming religious and spiritual beliefs and practices can improve the health of HIV-positive BMSM. Getting to a place of self-affirmation often requires intense confrontations and negotiations with certain beliefs about the incompatibility of homosexuality with Christianity. The additional religious significance of the stigma that accompanies life with HIV can exacerbate the difficulties of finding self-acceptance. Many BMSM utilize individualistic elements of their Christian upbringings, such as prayer and reading scriptures, to enhance their spiritual, emotional, and physical health. These practices can occur outside the context of organized religion. Still other men prefer to maintain their religious and spiritual beliefs and practices by attending churches, which may or may not be LGBTQ-affirming. Communal contexts like churches provide emotional and relational support. However, there are also other BMSM, like Elisha, who abandon the homophobic religious teachings of their childhood to pursue spiritual practices beyond the bounds of an organized religious context,[10] which validate their personhood and help them cope adversities in life.

Studies show that greater spiritual wellbeing is correlated with lower rates of depression, which are linked with better measurements of health, such as higher t-cell

count and lower viral load, among those with HIV.[11] Increased spiritual wellbeing has also been positively linked to improved life circumstance, such as stable housing, life satisfaction, social support, and life outlook.[12] Incorporating religious and spiritual coping strategies into their lives can help HIV-positive BMSM reframe their lives with chronic illness and find meaning in an otherwise dire circumstance. Adrion noted, "I've been through so much, and I've seen so much. . . . That's why I believe God has given me more insight, more insight and more clarity."

The narratives in this section show transformations that happened in the lives of Paul, Leon, John, Wendell, George, Nathan, Darius, Adrion, and Elisha, which enabled them to draw on religious and/or spiritual beliefs and practices to better manage their lives with HIV. All of these men found needed strength through these dimensions of their lives, which have helped them remain in the HIV continuum of care. George noted, "I don't have to worry about anything anymore. As long as I keep doing that and keep putting God first and everything, I think I'll be all right." The HIV-related health measurements of these men have improved, they feel less depressed, and a renewed sense of purpose because of self-affirming religious and spiritual beliefs and practices.

These men's accounts illuminate the processes by which BMSM can overcome religiously rooted homophobia and HIV-related stigma, leading to better health outcomes with HIV. They also draw attention the fact that BMSM can remain vulnerable to old patterns of doubt about God's love because of their sexual orientations and the stigmatizes illness they must live with. Nathan had such doubts when tragic events struck his life, and he believed God was punishing him. Their stories speak to continued importance of religious and spiritual beliefs and practices on the healthworlds of BMSM after diagnosis,

and they describe ways in which these beliefs and practices are evolving across the lifecourse.

Paul

• 57 •Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Paul's religious and spiritual practices, guide his daily life. He noted:

> I don't go to church every Sunday, and I don't jump up and down and holler going down the street and do whatever they do, you know. But, I do believe. I have a belief system. I know there has to be a supreme being. There's someone looking after you. There has to be because many times I'm laying down in my bed, I'm like where would I be? I wouldn't be here. In jail or dead, you know? Yeah, so I do think religion has a lot to do with the way a person thinks and operates on a daily basis. I wake up in the morning, and I thank God, "Thank you, Jesus, amen and hallelujah I made it another day!" So, there has to be religion in there somewhere.

His religious practices include going to his LGBTQ-affirming Catholic Church for occasional services and listening to televangelists, such as Creflo and Taffi Dollar, each morning when he wakes up. These nurture Paul's spiritual connection with God, which he believes are tied to all facets of his health and life with HIV.

Leon

• 56 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2006 •

Leon has been going to the same LGBT-affirming church since before he was diagnosed with HIV. He stopped attending for a while after he broke up with his boyfriend, but he eventually returned. He finds a sense of community at the church because "you can come as you are," and because the congregation is diverse. His faith helps in "keeping [him] on track" in his life. He remarked:

> It keeps me motivated, you know, things are possible. I noticed when I was going to church more and I was praying more, my life was more—I was more on track, and my life was more productive when I was going to church. I was always doing stuff. I was more productive, positive. I wasn't depressed, I was always doing stuff and I was doing good. Stuff was just happening out of

> nowhere because I was going to church, and I was praying. Then when I stopped doing that, I noticed a difference. Stuff started being like off track. I wouldn't take my medicine on time, [and] I wasn't doing things right. Things were off track. Now I'm starting to get back on track.

John

• 49 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1997 •

John moved from Maryland to Atlanta, where he had been for 3 months at the time of the interview, to get out of an abusive relationship. He had only been back in the HIV care continuum for one day when he shared his story with me. He noted, "I want to care for myself because I want to be here as long as I can, but I mean this lifestyle is a very, very lonely lifestyle being gay . . . . It's hard to find long-term relationships in this lifestyle."

One of the most enduring relationships he has had, however troubled, is with God. Though at times he has felt extremely distant from God, the core of his faith has remained through depression, drug addiction, and even when he felt like his sexual orientation cut him off from God. Over the years, he has made friends along his faith journey who have been "very God fearing," and he has gone to "different churches along the way that was gay friendly." His friends have also helped him to gain "a better understanding of what it means to be saved and give your life to God and respect God and stuff like that."

Much of the mental and spiritual trauma in John's life has been related to his experiences with homophobia originating in the church. He noted, "[these experiences] definitely had a big effect on me because I was familiar with the church, and I accepted a lot of what was said [about homosexuality] growing up. He still sometimes questions his "lifestyle" and whether or not being sexually active with other men is sinful. Being gay "still kind of feels wrong" to him.

John's relationship with God is not as fractured as it once was when he would go to church and leave feeling terrible about himself. He has disagreements with his best friend, who he used to have a sexual relationship with, about whether or not homosexuality is a sin. John's friend claims that he is no longer gay, and he tries to get John to turn away from his same-sex attractions. His friend calls it a demonic spirit inside of John. He emphasized, "I'm not a demon. It's hurtful, it's very hurtful to hear that constantly from someone whose opinion matters to you."

He contends that God knows his heart, and he said emphatically:

> So, I don't believe that. I really don't believe that. Even if I die right now still being gay, I do not feel as though I'm gonna burn in hell for eternity because I've done nothing to deserve that. Nothing.

Wendell

• 49 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed In 2002 •

Wendell eventually came to a place in his life where he felt that God was with him, after a period of feeling abandoned. He has gotten more comfortable telling others about his HIV status, but he has not fully embraced his same-sex attractions. He keeps his sexual relationship with his long-term male partners secret from his wife and most everyone in his life.

Since Wendell had only been living in Atlanta a couple of months at the time of the interview, he and his wife had not found a church to attend. His main religious and spiritual practices consist of reading the Bible, watching televangelists, and praying. His relationship with God motivates him to stay on treatment. Wendell remarked, "He is everything to me today." He emphatically believes his relationship with God is what keeps his life going in a positive direction. He noted:

> I got strong belief, real strong. I believe in that man before I believe in you. That man could lead me anywhere, and I will follow him; because my belief man, he's a good God, he is a forgiving God, and I always will…I always will believe that he's the one that got me still here. Me, I'd been gone.

George, 47, Bisexual, Contracted HIV via Homosexual Intercourse

• 47 • Bisexual • Contracted HIV via Homosexual Intercourse • Diagnosed in 1991 •

George has been actively involved in a local African American Protestant congregation for two years. His faith is the "the main key in [his] life," which he believes helps sustain him. He remarked:

> I just want to be a good person because I think about when I die, what is my family gonna say, what is people gonna say about me, and I don't want them to say nothing bad. I want them to say some good things so now all I do is try to be good for people.

He believes bad occurrences in his life were the result of "when [he] left God." He emphasized, "Now I put God first." By attending church, reading the Bible, and praying, George is able to lead a healthy life with HIV. He said:

> It just makes me feel good. It's like I can't even describe it. It's like I wake up, I'm happy all the time. I don't wake up miserable just because I'm HIV. I don't even look like I'm sick. I look like a normal person. I don't even think about it. All I do is take my medication . . . . I don't have to worry about anything anymore. As long as I keep doing that and keep putting God first and everything, I think I'll be all right.

George has never heard anything negative about HIV in his congregation, but he is scared of people finding out about his status. Except his sister, no on in his family knows that he has the virus. He is afraid to tell his daughter and his best friend that he has HIV out of fear of being rejected. Fortunately, he attends a long-term HIV survivors support group in which he can "share and open up" because "everybody's in the same situation.

Nathan

• 45 • Gay • Contracted HIV via Injection Drug Use • Diagnosed in 2015 •

Three and a half years before our interview, a man Nathan was using drugs with purposefully infected him with HIV. The man switched Nathan's clean needle for one contaminated by his HIV-positive blood. Nathan began an HIV treatment regimen immediately, but he went through a 3-month period where he "just didn't care anymore." His nephew was murdered, several family members died, and he also lost his career. These events tested his faith in God for nearly two years, and he reverted back to an old pattern of thinking that God was punishing him for being gay.

These devastating experiences pushed Nathan to the brink of survival. He became so depressed and distraught that he purchased a gun and tried to shoot himself. He fired the gun four times and then turned it on himself, but the bullet got stuck in the chamber. He then tried to kill himself again by cutting a major artery, but he healed quickly. He saw these events as a tangible sign that God was active in his life. From then on, he has turned to God during periods in his life that have been too difficult to bear alone. He noted:

> Every time I get on the path of going down this really dark place, something happens and it reconfirms me. So, my faith is very strong. God for some reason keeps me here and let's me know that he is watching. That's the only way I can express it, because I shouldn't be here. I should be dead the first time when I pulled that trigger, but I'm still here.

Coming back from these terrible circumstances confirmed to Nathan that God was keeping him alive for a purpose. His attitude changed from not wanting to live to one in which the thought to himself, "So if I'm going to be here, I can't just continue not doing. I wouldn't be a godly person if I didn't take care of myself and take the medicine."

Darius

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

When Darius moved to Atlanta in 2012 he started going to a predominantly African American, LGBTQ-affirming church. He feels like God is "real again, a full-fledged hologram, interactive that is." Darius's renewed relationship with God and his church has helped his spiritual, mental, and physical health. His overall levels of stress are "way down" from what they used to be because he "feels freedom to participate" more in life as his authentic self, especially in church. He can bring his whole self before God. He and his partner are welcomed fully into their congregation. Darius has also met many friends by being actively involved in church life. He believes his connection with God and the accepting community helps him to be accountable and proactive in regards to his health with HIV.

Adrion

• 37 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1999 •

Adrion has felt that his sexuality distanced him from God in the past. Looking back, he feels God has had a purpose for him all along. He stated:

> If God wants to use me—how can he use a gay man? Why would he want to use me? So, I had to get it out of my head because that's my physical self telling me I can't be used. I can be used. I'm the purpose to be used because of my situation . . . . I've been through so much, and I've seen so much . . . . That's why I believe God has given me more insight, more insight and more clarity about some of the things I had been having questions about. It's like everything is like a puzzle—it's all gonna come together.

Adrion attends a Presbyterian congregation that is not LGBTQ-affirming, but he feels comfortable there. However, it can be stressful for him when people ask about his personal life. He said:

> I feel like, okay, I can be me, but I can be discreet about it. Everyone doesn't have to know what I do. I'm a very private. My personal life is private. In a

> way it kind of caused me more stress because I feel like people around me are trying to pry into what's going on in my personal life.

Elisha

• 30 • Gay • Contracted HIV via Homosexual Transmission • Diagnosed in 2017 •

For Elisha, finding peace has been more about his individual spiritual journey, especially because he has not been part of a religious or spiritual community since college. He said, "I thought about going to church not too long ago, but it wasn't for me." He has a spiritual connection with the Divine, which incorporates elements of his past Christian belief system, such as prayer, music, and some connection with the Bible. Having a more universalistic belief about a higher power has helped him cope with his sexuality, spirituality, and life with HIV in health-affirming ways.

Religion and Spirituality, Summative Effects on Health Post-Diagnosis

These men's narratives highlight the processes by which they have been able to negotiate their religious and spiritual beliefs in ways that they find health-affirming. For most of them, it was a long process punctuated by periods of anger with God or feeling spurned by God. Several important and often overlapping themes emerged that are detailed below: depression, health-averse behaviors, homelessness, reconnection with God, and finding a place of healing through religion and spirituality.

With the exception of Leon and Elisha, the men discussed periods of depression following their diagnosis. Most felt angry with or abandoned by God and burdened by the stigma and chronicity of their illness. This was even the case for George, Paul, and Nathan, who had all been able to reconcile their sexuality with their religious and spiritual beliefs before contracting HIV. Contracting HIV forced these men to confront their same-sex attractions, though not all have come to terms with them. Rodney and Jamiell were so

ashamed and feared rejection that they did not disclose their HIV status to their sexual partners, which meant they infected other men. Adrion described feeling so “dirty” that he bleached his home to try and feel clean again after being diagnosed. Leon and Elisha’s religious and spiritual beliefs enabled them to respond to their diagnoses in healthy ways. Leon had the added support of his family, boyfriend, and LGBTQ-affirming church.

After being diagnosed with HIV, several men contemplated or attempted suicide. George, Drayton, Chris, Wendell, Greg, Darius, and Nathan thought dying would be the only release from their suffering, which was compounded by feelings of God’s absence in their lives. Their unbearable anguish caused these seven men and John to turn to drugs, alcohol, and/or engage in risky sexual behaviors to numb their emotional pain or to speed up impending death, as Greg, Darius, and Nathan remarked.

For George, Adrion, Chris, and Greg, homelessness was an extra burden they coped with in addition to their disease. Adrion did not elaborate on how he became homeless as a young adult, but he found purpose through God in his situation by working for a local homeless ministry. Addiction and mental health issues contributed to the experience of homelessness in the lives of George, Chris, and Greg as well. At the time of the interview, Greg was still struggling to find living accommodations through a local agency that works with those affected by HIV.

All of the men negotiated their religious and spiritual identities alongside their same-sex attractions and HIV-status in ways they believe have benefitted their health. For several of them, this renewed relationship with their religious and spiritual beliefs happened at times of great distress. Chris and Greg both reconnected with God during times of homelessness and their lives seemed hopeless. Chris prayed to God to come

through one night while sitting in a homeless shelter, as he planned to kill himself. Greg reconnected with his faith when was homeless and sick because he was out of the HIV continuum of care. Rodney and George both rekindled their Christian belief system when they were incarcerated. Rodney felt like God was reaching out when he got started on anti-retroviral treatment and his HIV ravaged body began to recover. George began reading the Bible in jail, identifying with the suffering of Jesus. He still has not reconciled his faith and sexuality, and he does not act on his same-sex attractions.

For Drayton, Nathan, and Adrion, it was near death experiences that brought them back to God after their HIV diagnoses. Drayton drew closer to God when he was hospitalized with AIDS. Adrion "gave up control to God" over his life when he was feeling like he was ready to die from the pain he was in after being hospitalized after being brutally attacked by two men on his walk home from a store. Nathan felt a deep connection with God after two failed suicide attempts.

For others, renegotiating their religious and spiritual beliefs, sexual orientation, and HIV status happened gradually and under less duress. Wendell spoke to his mother, who reminded him God had a purpose for his life. This new outlook helped him reconnect with his faith, and over time he became less upset with God about having the virus. Paul questioned and prayed to God after his diagnosis, and "invited Christ back into [his] life," which helped him come to terms with his life with HIV. Darius's experience happened over months through his 12-step drug recovery program, where he reconfigured his entire notion of God. However, the catalyst that brought him back into relationship with God and his faith was an apology from a pastor for the pain the church had caused him.

Leon, Elisha, and Trey were never angry with God about contracting the virus, but rather were more upset with themselves. Leon and Trey have both relied on their Christian beliefs to help them adapt to their lives with HIV. Elisha had already begun to have more universalistic religious and spiritual beliefs, which he felt allowed him to accept life with the virus and find peace within himself.

Rodney, John, Jamiell, Wendell, Greg, Nathan, and Trey were not attending church or any sort of spiritual community at the time their interviews. However, they found Christian beliefs to be essential to their overall health and wellbeing. Prayer is the central way they connect with God, though Wendell noted that he and his wife read the Bible and watch Christian programming on television every day. Rodney and Jamiell are at a point where they may try and venture back into church. Neither George nor Wendell has been able to fully reconcile their sexual orientations with their Christian beliefs. George does not act on his attractions. Wendell believes acting on his attractions is sinful, but he maintains a double life between his wife and the two men he has been in relationships with for decades.

Both George and Adrion attend churches that are not LGBTQ affirming. George had been attending his church years prior to contracting HIV. Neither one of them are out in their congregations about their same-sex attractions or their HIV status. Both men like the sense of community they have in their respective congregations. Attending church enables them to feel more connected to God and their faith, as well as finding comfort in the social support they receive within their respective congregations.

Paul, Drayton, Chris, Leon, and Darius attend LGBTQ-affirming congregations in the Atlanta area that are predominantly African American. Through attending church, they feel more connected with God, and they find social support within their congregations, as they

have found deep friendships and have roles to fulfill. Chris and Darius both attend church with their partners. Combined with their own prayer lives and other spiritual practices, religion has been essential in keeping them healthy.

Elisha was similar to the other men in that he felt his relationship with God keeps him healthy in multiple areas of his life. However, he adopted a universalistic approach to religion and spirituality prior to contracting HIV. Though he does draws on certain former Christian beliefs and practices, he also connects with the Divine through beliefs and practices of other religious traditions. His new belief system has allowed him to find peace within himself and has helped him manage life with the virus.

Religion and Spirituality Affecting Health

The health sciences data show the concrete realities of the negative health effects that religiously rooted homophobia and HIV-related stigma can continue to have on BMSM post-diagnosis, such as depression, anxiety, alcohol an drug abuse, increased likelihood of engaging in risky sexual behaviors, lower retention rates in the HIV care continuum, and generally worse health outcomes with HIV. They also detail the positive dimensions of religious and spiritual beliefs and practices on the lives of those that have HIV, such as reduced depressive symptoms, better HIV-related health measures, and even other positive life outcomes, such as being more likely to have stable housing. Yet, little is known about the processes by which BMSM manage their lives with HIV, particularly in relationship to how religion and spirituality factor into those processes.

The lifeworlds of BMSM have to be entirely reconfigured after they are diagnosed with HIV. In the preceding narrative sections, the men's recounting of the processes by which this reconfiguration occurred demonstrated the ups, downs, and instability that

comes from the existential and spiritual weight of being diagnosed with such a stigmatized illness. They highlighted the lengthy and trying processes that BMSM often go through in order to live healthier lives with HIV. These accounts give us insight into the diverse ways in which BMSM manage their religious and a spiritual identities by giving glimpses into their lived religious and spiritual worlds, which usually go unexplored in the health sciences data.

Perspective gained from these narratives point to crucial moments, like the moment of diagnosis, in which providing LGBTQ-affirming religious and spiritual care and resources in the healthcare setting could prove potentially life-saving for BMSM. They point to the need for religion and spiritual to be better incorporated into care along these men's HIV journeys to encourage retention in care and to promote better health outcomes. The next chapter continues the development of this lifecourse grounded framework, as the men discuss their viewpoints about and experiences with religious and spiritual care provision and resources within the healthcare setting.

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[1] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition.* (New York: Basic Books, 1988), 26.

[2] Kleinman, 27.

[3] Kleinman, 160.

[4] William L. Jeffries IV et al., "HIV Stigma Experienced by Young Men Who Have Sex with Men (MSM) Living with HIV Infection," *AIDS Education and Prevention* 27, no. 1 (February 1, 2015): 59, https://doi.org/10.1521/aeap.2015.27.1.58.

[5] William L. Jeffries IV et al., "An Exploration of Religion and Spirituality among Young, HIV-Infected Gay and Bisexual Men in the USA," *Culture, Health & Sexuality* 16, no. 9 (October 21, 2014): 1076, https://doi.org/10.1080/13691058.2014.928370.

[6] Kleinman, *The Illness Narratives*, 4.

[7] Sian Cotton et al., “Spirituality and Religion in Patients with HIV/AIDS,” *JGI Journal of General Internal Medicine* 21, no. S5 (2006): S11.

[8] Sari L. Reisner et al., “Clinically Significant Depressive Symptoms as a Risk Factor for HIV Infection Among Black MSM in Massachusetts,” *AIDS and Behavior* 13, no. 4 (August 1, 2009): 799, https://doi.org/10.1007/s10461-009-9571-9.

[9] Jeffries IV et al., “An Exploration of Religion and Spirituality among Young, HIV-Infected Gay and Bisexual Men in the USA,” 1076; Cotton et al., “Spirituality and Religion in Patients with HIV/AIDS,” S5; Safiya George Dalmida et al., “Spiritual Well-Being, Depressive Symptoms, and Immune Status Among Women Living with HIV/AIDS,” *Women & Health Women & Health* 49, no. 2–3 (2009): 122.

[10] Jeffries IV et al., “An Exploration of Religion and Spirituality among Young, HIV-Infected Gay and Bisexual Men in the USA,” 1071–76; William L Jeffries IV, Brian Dodge, and Theo G. M. Sandfort, “Religion and Spirituality among Bisexual Black Men in the USA,” *Culture, Health & Sexuality* 10, no. 5 (June 1, 2008): 467, https://doi.org/10.1080/13691050701877526. Jeffries IV et al., “An Exploration of Religion and Spirituality among Young, HIV-Infected Gay and Bisexual Men in the USA,” 1071–76; Jeffries IV, Dodge, and Sandfort, “Religion and Spirituality among Bisexual Black Men in the USA,” 467.

[11] Cotton et al., “Spirituality and Religion in Patients with HIV/AIDS,” 11.

[12] Cotton et al., S5–11.

Chapter 4
In Their Words: Religion and Spirituality in the Healthcare Setting

Over the course of this chapter, the men give examples of the types of religious and spiritual care they would have liked or would like to receive during their healthcare journeys with HIV. They also detail which religious and spiritual care resources they have found helpful, and share concerns about inaccessibility of these resources in healthcare settings. Insights provided in this chapter can aid in assessing and addressing the lived religious and spiritual realities of BMSM at critical points along their journeys with HIV in the healthcare setting. Accounting for them in health interventions and when providing treatment can bolster the prevention of HIV transmission, encourage HIV testing, strengthen retention in the HIV care continuum, and promote better health outcomes.

The narratives presented in the three following sections are grouped as: "Bringing Religion and Spirituality into the Healthcare Setting," "Hesitations about Bringing Religion and Spirituality into the Healthcare Setting," and "Reflections on Accessing Religion and Spiritual Care." These stories highlight the changes required of those in healt-related fields to ensure delivery of more holistic and effective care for BMSM, which includes care of their religious/spiritual lives. Critically, they show the need for those in public health and healthcare provision to recognize that the religious and spiritual aspects of many BMSM's lives can both contribute to and help quell the rising tides of the epidemic in in this group of men.

The phenomenological aspects of the men's narratives in this chapter are unique contributions that can be built upon, as the men give personal insights derived from their lived religious and spiritual experiences, which are aspects of the epidemic among BMSM that are not extensively documented or studied. These narratives bolster the work of

current health sciences data that demonstrate the positive impact religion and spirituality can have on the health outcomes of HIV-positive BMSM. They show how BMSM utilize religious and spiritual beliefs and practices to increase their own health and wellbeing. The directives from the men point to how those in the healthcare setting can foster a more integrative approach to care by drawing on the positive dimensions of religious and spiritual beliefs and practices. Their stories make needed connections for conceptualizing the dramatic potential for increasing the health outcomes of BMSM through the provision of culturally relevant religious and spiritual care in health interventions.[1]

Bringing Religion and Spirituality into the Healthcare Setting

HIV-positive BMSM live in a world in which they come face-to-face with power, privilege, homophobia, racism, and stigma related to HIV. These oppressive forces make managing life with chronic illness that much more challenging. [2] As self-affirming religious and spiritual beliefs and practices can positively impact the health of HIV-positive BMSM, it is critical that these dimensions of their lives be encouraged and supported in the healthcare setting and through health interventions. Because these dimensions of patients' lives can dramatically impact their health for the worse, negative religious and spiritual messages must not be repeated. Thus, religious and spiritual care and resources offered to these men as believers must be affirming regardless of their sexual orientations. By drawing on and emphasizing the positive aspects of religious and spiritual beliefs and practices, those within and outside of the healthcare setting can help BMSM to foster a greater sense of self-worth and feel empowered to engage in treatment and other health-positive actions.[3]

In this section, stories from Leon, Drayton, George, Nathan, Chris, Elisha, and Trey, detail why it is important for religion and spirituality to be addressed in the healthcare setting. They also provide direction about best practices for religious and spiritual care based on their own religious, spiritual, and illness experiences. Each of them feels strongly that religious and spiritual care should be integrated into patient care; if patients identify that these aspects of their lives are important. Elisha stated, "Some people believe religion is very important to them. And that's not to be knocked . . . . So I think it would behoove any type of place [to address it]." Yet interestingly, none of them have accessed the religious or spiritual care resources within the healthcare setting. With the exception of Nathan and Darius, all of the men received their HIV-related medical care at The Clinic at the time of their interviews.

The LGBTQ-affirming nature of religious and spiritual care provision is essential to the health and wellbeing of BMSM, which is documented by Leon, Rodney, George, Chris, and Darius in their stories. Having this type of support can help BMSM living through the ill effects of religiously rooted homophobia and HIV-related stigma. Affirming spiritual leaders Darius has known have helped him to more effectively manage his life with HIV. Both Leon and George discussed the importance of being able to talk to spiritual care providers in the healthcare setting, as it is often the case that BMSM do not feel comfortable talking about matters of sex, sexuality, and HIV with pastors or other spiritual leaders in their communities. George noted, "I would like to ask questions like, am I going to hell because I got this virus, and stuff I can't ask my own pastor and talk to him about."

Beyond spiritual care providers, George, Nathan, Chris, Elisha, and Trey emphasized that medical care and clinical care providers should be able to discuss religion and

spirituality with their patients if it is something that is important in their lives. Nathan said that these discussions could help patients to know, "There is something bigger than you and bigger than that pill that can help you and sustain you and keep you going and on the pill." Although others, like Chris, are somewhat skeptical of medical care and clinical care providers having deep faith centered conversations with patients, like others interviewed, he believes at the very least that healthcare providers should be equipped to provide patients with linkages to religious and spiritual care within and outside of the healthcare setting.

Additional aspects of the significance of LGBTQ-affirming care and best practices for religious/spiritual resources for these men are documented in their stories. Some of these relate to past traumas and hardships directly associated with religiously rooted homophobia and HIV-related stigma. Others focus on the roles religion and spirituality can play in healthy management of life with the virus. From these stories, we glean critical insights into how health interventions and healthcare provision can draw on positive aspects of religious and spiritual beliefs and practices to promote better HIV-related health outcomes for BMSM.

Leon

• 56 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2006 •

Leon has not accessed religious or spiritual care resources in the healthcare setting since he was diagnosed in 2006. However, given his own lived religious and spiritual experiences, he believes it would be beneficial for other HIV-positive BMSM to have these types of care directly incorporated into healthcare provision. He emphasized that diagnosis is a crucial time for religious and spiritual care providers to speak with patients. Leon

noted that these discussions with religious and spiritual care providers can enable those newly diagnosed to ask questions and process the diagnosis with someone who is affirming, providing a level of care that most doctors and other healthcare workers are not equipped to. He explained that when he was diagnosed he went to a pastor outside of the healthcare setting who helped him process the realities of the illness. However, he brought up the point that many BMSM may not feel comfortable seeking outside care based on previous negative experiences with religion.

Rodney

• 52 • Gay • Contracted HIV via Homosexual Rape •Diagnosed in 1984 •

Rodney has finally taken to heart that "The disease lives with you, [and] it's not going to kill you unless you allow it to." He has not accessed religious or spiritual care resources at The Clinic. However, he believes such resources are essential for other BMSM, especially those who are newly diagnosed and may feel hopeless. Rodney is confident that his religious and spiritual beliefs and practices have helped him live a healthy life with HIV. He emphasized:

> It's about living because most people, when you hear HIV or AIDS, you automatically think death, and they need to know that God loves them, no matter what they're dealing with. Those two things I think make the difference in how you approach living. If you know that it is about life and that you're not condemned by a God that you want to love, it makes a difference. The hope is there. There's a faith that will push you to another place of trying.

He wishes such resources were available to him when he was diagnosed with the virus at the age of 18, and he believes they would have helped him cope better with the stigma and shame associated with his sexuality and HIV status. Rodney noted that it is

essential for those with HIV/AIDS in the healthcare setting to have access care that affirms them:

> It's okay to be dealing with whatever your issue is and that he will help you because I think in our lifestyle, we don't have hope. I think that's the major issue when you're dealing with this disease is you lose hope. You lose faith that you can make it another day.

Drayton

• 48 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 1994 •

Drayton's renewed relationship with God helped him through challenging times that have come from living with HIV. Though he has not accessed religious or spiritual care in the healthcare setting, he believes these resources could dramatically change the lives of people diagnosed with HIV/AIDS because:

> People need something to grasp onto. They have to have some kind of faith. They have to have some kind of beliefs whether it be God, a supernatural higher power, whatever it may be, they need it. It helps them cope a lot knowing that there's something out there that's pushing them to get better, to thrive, to do better, to see better.

Religion and spirituality have been integral to Drayton's health journey throughout his life. Drayton, who was once on his deathbed with AIDS, emphasized, "I can't explain how—it was like walking and talking with God and I used to be so—I used to tell my mom, it's so amazing to see something go dead and then come back alive."

George

• 47 • Bisexual • Contracted HIV via Homosexual Intercourse • Diagnosed in 1991 •

In the nearly 30 years since he has been diagnosed with HIV, George has neither received nor sought out religious or spiritual care in the healthcare setting. At the time of our interview, he was not aware of the resources available at The Clinic. He noted that he would like to talk to the nurse he sees regularly about the importance of his faith in his life:

> I think I'll talk about it with her because that's the only way I'm gonna stay healthy and sane, is to let her know what's going on with me because trust me, I do not want to fall back into depression. I do not want to fall back in that. I done felt it, I know how it makes me feel and when I'm depressed, I don't take my HIV medication.

George would be interested in speaking with the The Clinic's chaplain. He said, "I would like to ask questions like am I going to hell because I got this virus and stuff I can't ask my own pastor and talk to him about."

He credits his faith in God with keeping him alive. He said emphatically, "Without faith, I would be dead." George's priority is to maintain a strong relationship with God, which he believes keeps his life on track and helps him stay healthy. Accessing religious and spiritual care resources within the clinical setting would help him with this goal because he could talk with spiritual care providers about his life in an affirming space, as he is not open about his HIV status or sexual orientation with anyone except his sister.

Nathan

• 45 • Gay • Contracted HIV via Injection Drug Use • Diagnosed in 2015 •

Nathan does not receive care at The Clinic, but rather goes to another HIV care provider in the Atlanta. He feels comfortable enough with his healthcare provider to discuss how important his religious and spiritual beliefs are to him, and how "God keeps [him]." He and his nurse talk about religion, faith, and God every time they see one another. This openness about his faith in the healthcare setting was not something that Nathan ever imagined would be possible. He reflected:

> I had never experienced that in my life where a doctor—or even heard about where a doctor, your doctor, prays with you and says let's try this instead of medicine. What doctor does that? But yeah, me and Nurse Kaufman talk about everything, especially religion.

Because of his experiences with his healthcare providers, Nathan believes that patients should have the ability to talk to healthcare providers about their religious and spiritual beliefs, and for providers to be able to refer them to appropriate religious and spiritual care resources. During the interview, Nathan looked over at a magazine rack with all types of magazines and pamphlets about living a healthy life with HIV, and he noticed there was not a slot devoted to religious or spiritual care resources. He commented:

> But like having a pamphlet—one slot about religion because some people go on the darkest path when they find out and it's dangerous and then so that just having something that says faith on it, it takes you a long way, or if you need help, call on God or something, just something that shows that it's not just a magazine about health and taking pills but there is something bigger than you and bigger than that pill that can help you and sustain you and keep you going and on the pill, and even having faith allows you—I think it provides comfort in knowing who you are and that you're going to be okay to be able to tell somebody else. You understand what I mean? Because it's about knowing your truth and being complete and for people who don't have it as an option, you find out you're positive and God was never an option, that little pamphlet could change a person's entire life. It's just that simple.

Chris

•46 • Gay • Contracted HIV via Homosexual Intercourse• Diagnosed in 2002

Chris's religious and spiritual beliefs and practices are intrinsically connected to his health, and he believes his relationship with God has gotten stronger since being diagnosed with HIV. For him, going to church for his spiritual health is analogous to going to the doctor for his physical health. Though he has not accessed any religious or spiritual care resources at The Clinic, he believes such resources should be incorporated into the healthcare setting from the beginning of patients' healthcare journeys with the illness.

In an ideal healthcare setting, Chris noted the importance of having an LGBTQ-affirming chaplain. He thought back on the time he was diagnosed, and remarked, "So had there been someone there to say, 'Oh, God loves you,' maybe I wouldn't have made as bad

decisions at the time." He was more hesitant about having religion and spirituality enter the doctor/patient relationship because of the dichotomy that is often present between science and religion. He said, "So much of what I learned from science is what can be proven and factual, and so much about religion is faith-based and belief without any scientific proof." Chris thinks the easiest way providers could help in these areas of their patients' lives would be to have resources, such as pamphlets that can guide patients to churches or spiritual communities where they would be welcomed and affirmed.

Darius

• 42 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2014•

Darius is in care at another local HIV care provider. As he reflected on his journey towards better health with HIV, he emphasized that having affirming spiritual leaders and support groups focused on faith and spirituality have helped him immensely in his journey. He voiced that he would like to see an LGBT-affirming spiritual support group in the healthcare setting because it could:

> . . .provide you first of all maybe with a group of people to get to know in a safe environment, and then just the exposure of being around those people kind of has an unintentional effect on you because you start looking forward to seeing those people; so it kind of helps you with your accountability.

From a place of spiritual wholeness and good health, he offered a piece of advice for those who have felt the burden of religious stigma:

> I don't think people tell that to themselves enough that you are worthy, you deserve it, and every opportunity is out there for you. Don't let people talk down on you. Don't let a religious leader person, whomever it may be, don't allow them the space. Don't let them rent space in your head to help dismantle your faith like that, you know? But I can only say that on this other side because I couldn't say that five years ago.

Elisha

• 30 • Gay • Contracted HIV via Homosexual Transmission • Diagnosed in 2017 •

Elisha believes that religion and spirituality should be integral components of healthcare provision for those with HIV/AIDS. He remarked, "Some people believe religion is very important to them. And that's not to be knocked . . . . So I think it would behoove any type of place [to address it]." He also believes strongly that healthcare providers must do all they can to hear and understand the religious and spiritual needs of their patients, regardless of whether the providers themselves are religious or spiritual. He emphasized:

> I just think a care provider, regardless, like your response should always be, like, if it was coming from me as a patient, I think whatever your response is, it should always be in benefit for me and really with a concern and a feeling that you do make me feel, like, and a feeling that, like okay, what you're saying to me is important, let's try to see what we can do. That's important because you're dealing with a life and death situation.

Because of his negative experiences with religion growing up and the inner peace he has found from renegotiating his own religious and spiritual beliefs, Elisha views these two forces as integrally linked to health, especially when it comes to a highly stigmatized and potentially deadly illness like HIV/AIDS.

Trey

• 29 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2018 •

Trey had not yet accessed religious or spiritual care resources at The Clinic. When asked if these resources would be something of interest to him, he said that he would feel most connected to God by going back to church. However, he remarked that going to a spiritual support group in the healthcare setting with others who are HIV-positive could help him feel connected to God and find support network. He wants to be able to bring his

spiritual connection with God into his patient/provider relationships because it sustains him.

Hesitations About Bringing Religion and Spirituality into the Healthcare Setting

Because of multiple manifestations of stigma that many BMSM endure, they may fear further discrimination and negative treatment from religious and spiritual care providers in the healthcare setting.[4] These fears can cause reticence to discuss the crucial aspects of their religious and spiritual beliefs and practices with their healthcare providers. They can also act as barriers to engaging in religious and spiritual care offered in the healthcare setting. However, BMSM may engage in private religious and/or spiritual practices that they find beneficial to their lives with HIV. [5] The accessibility and comfort found in these private practices may dissuade them from bringing these dimensions of their lives into the healthcare setting.

The narratives presented in this section from Paul, John, Wendell, and Jamiell, highlight best practices and challenges BMSM face in regards to accessing religious and spiritual care. Like the men from the preceding section, these four men have not accessed religious or spiritual care within the healthcare setting. Paul, Wendell, and Jamiell noted that their individual religious and spiritual beliefs and practices are set apart from the religious and spiritual care resources available at The Clinic. John emphasized, “I don’t see where that starting point is at because just my experience, any time you try to question stuff related to God or the Bible, it turns into you’re being disrespectful.” In general, the men believe that religious and spiritual health resource provision is critical to patients’ flourishing.

These men's stories describe factors that can contribute to BMSM not accessing religious and spiritual care resources available to them in healthcare settings. Their accounts are important because they demonstrate that religiously rooted homophobia and HIV-related stigma can have hold over the lives of many BMSM when they are in the HIV continuum of care, which could potentially keep them from accessing resources that would benefit their health. These men's directives emphasize the importance of offering LGBTQ-affirming religious and spiritual care within the healthcare setting, as well as the need to provide connections to affirming religious and spiritual resources within the community. Assuring that the religious and spiritual aspects of the lives of patients who are BMSM are affirmed, and that they have the necessary resources to nurture these parts of their lives, could help them achieve better health outcomes and also contribute to slowing the spread of HIV to others.

Paul

• 57 •Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Paul knows about the religious and spiritual care resources available at The Clinic, but prefers to keep his religious and spiritual lives separate from where he goes to receive medical care. He is actively involved in an LGBTQ-affirming Catholic congregation, and follows other individual religious and spiritual practices each day. However, he does think that accessing these types of resources would help other BMSM "get back to [their] roots." From his perspective, the religious and spiritual needs of patients could be better addressed in The Clinic by linking people to religious and spiritual care resources within and outside of the clinical setting.

John

• 49 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1997 •

John's renewed belief in God and self-acceptance motivates him to be in care at The Clinic. In facilities where he has received care, John has never utilized any religious or spiritual care resources, such as the chaplain or support groups. When asked if utilizing resources that were religiously and/or spiritually affirming would interest him, John was hesitant because of homophobia he has experienced in religious settings. He remarked:

> I think it would be, but I don't see where that starting point is at because, just my experience, any time you try to question stuff related to God or the Bible it turns into you're being disrespectful or, I don't know, it turns into an argument, and you're just trying to understand or get a better understanding of why. Because, I mean, I still don't understand. If it's all of that, then why am I like this? I didn't ask to be gay. I didn't ask for it. That's how it came out. I have no control over that at all, even though people may think that's a lifestyle it's as simple as that, it's not. It's not.

He does not think that doctors should talk about religion or spirituality with their patients, and he noted, "I don't think doctors should not enter that realm; I think they should just stay in their lane." John is afraid a medical practitioner may "bash" him in regards to his sexual orientation. The ideal situation for John would be for providers to refer patients to an LGBTQ- affirming chaplain or have a pamphlet explaining available religious and spiritual care resources.

Wendell

• 49 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed In 2002 •

Wendell's relationship with God is what motivates him to stay in care and on his medications. He emphatically stated, "He is everything to me today." At the time of our interview, he was not aware of the religious and spiritual care resources available at The

Clinic, but he would like to see The Clinic's chaplain to talk about his life and his relationships, especially given that the chaplain is LGBTQ friendly.

Jamiell

• 38 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 2004 •

Jamiell has been offered religious and spiritual care in the healthcare setting, but he is hesitant to access it because of an underlying fear that his sexuality will not be affirmed. He remarked:

> Even if you walked in just like, "Hey, I'm the chaplain, I'm just here to see how you're doing." But, I guess, I'm kind of fearful to ask for it. For one, I don't really think—I don't want to say I don't need it because I do believe I need it, but it's not what I wanted at the time. And I have my own relationship with God in my conversations that I have with Him.

Jamiell emphasized, "I believe wholeheartedly, like I will never stop believing in God." This relationship sustains him spiritually, and it drives his desire to care for himself and to live a healthy life with HIV.

Reflections on Accessing Religious and Spiritual Care

Greg and Adrion are the only two of the 13 men receiving care at The Clinic who have accessed religious and spiritual care resources there. They have had positive experiences, which have enhanced the management of their lives with HIV. Their narratives show first-hand how accessing LGBTQ-affirming religious and spiritual care can cultivate better spiritual, mental, and physical health outcomes for BMSM.

Greg

•60 • Bisexual • Contracted HIV via Heterosexual Intercourse • Diagnosed in 2004 •

Greg has accessed pretty much every available resource at The Clinic since he has been in care there, including the available religious and spiritual care resources. He first came to know the chaplain of The Clinic when he was having a "breakdown" about his

finances and being unable to afford life essentials. He told the chaplain, "I think God hates me." The chaplain affirmed God's love for him, and let him "do a time of healing." Greg has been regularly visiting the chaplain for a number of years. However, he finds it hard to imagine that religion and spirituality could enter into the patient/doctor relationship. He noted, "you got some [doctors] coming across accepting the spiritual wellbeing, then you got the science part of it where they don't."

Greg's faith in God has given him the strength to keep going along his health journey through some of his darkest times. Today he has close relationships with his remaining children and grandchildren, and his belief system serves as a sustaining force in his life. He remarked:

> [I've] come in full circle. Oh, man, let me tell you something. I don't have much but what little I got, I appreciate it. I got peace, I got happiness, I got joy, I got somebody I can go to will love me unconditionally. People ain't gonna do that.

Adrion

• 37 • Gay • Contracted HIV via Homosexual Intercourse • Diagnosed in 1999 •

Since he has been in care at The Clinic, Adrion has utilized chaplaincy services and has also attended group sessions for mental health support. He goes to the group as much as he can, typically with a Bible in his backpack. Adrion noted:

> I try to make it down here as much as I can—I want to be a vessel. I've been praying to God to see how he wants to use me because I do want to be in in some kind of ministry, but I don't know how he wants me to do that ministry.

He believes that the challenges, like his HIV status, homelessness, and homophobia, he has faced have given him purpose, and he wants to help others with HIV find the strength he has found through God. The spiritual resources he has utilized in the healthcare setting have bolstered his belief in his purpose as well as his determination to remain

healthy so he can achieve it. Adrion views all aspects of his life as inseparable from God; his health is no exception.

Religion and Spirituality in the Healthcare Setting, Summative Findings

Several of the men discussed the importance of having an LGBTQ-affirming chaplain providing religious and spiritual care in the healthcare setting. George brought up the point that he would be more comfortable talking to a chaplain in the healthcare setting versus his own pastor, as he does not want anyone to know about his sexual orientation or his HIV status at his church. Darius remarked that having such an affirming faith leader could help other BMSM not be robbed of their faith, which was the case for him and so many others who endure stigma surrounding homosexuality and HIV/AIDS.

Paul, who finds religious and spiritual support outside of the clinic, even emphasized the importance of having explicitly affirming resources provided in the healthcare setting. Having an affirming faith leader to host religious and spiritual support groups at the site of healthcare provision is a something that Leon and Trey also believed would help them. Such a group can create a space for sharing and accountability that comes through the encouragement, social support, and social control that comes from being part of a group. Yet, both John and Jamiell cited fear of encountering homophobia by the chaplain or others providing religious and spiritual care in the healthcare setting. These hesitancies can keep them and others from seeking and accessing religious and spiritual care resources.

The stories of Adrion and Greg, who have accessed religious and spiritual care at The Clinic, speak to the benefits of the LGBTQ-affirming religious and spiritual care provided to them. The care they have received has helped them feel affirmed, find hope,

and given them strength to endure challenges. Adrion has also found accountability and support in a mental health support group he attends at The Clinic in which he feels free to bring his religious and spiritual beliefs.

One of the areas where many of these men were hesitant about religion and spirituality entering into healthcare provision was the patient/provider relationship. John feels these types of concerns are not within in the "realm" of the type of care healthcare providers should give. Chris's and Greg's hesitation about providers giving religious or spiritual care point to a commonly perceived dichotomy between the fact-based nature of science and medicine versus the faith-based nature of religion.

Both John and Chris believe it would be helpful for doctors to be able to provide them with linkages to religious and spiritual care, such as telling them what resources are available in the healthcare setting, assisting them in speaking with the chaplain, and linking them with other resources available within the community. John and Nathan even brought up the idea of having pamphlets that affirm God's love for patients, which can direct them to clinical and community resources—a simple but potentially life-changing resource for patients, as Nathan noted.

Nathan and Elisha believe that healthcare providers should be able to discuss the religious and spiritual dimensions of their patients' lives, regardless of the provider's personal beliefs. Elisha even remarked about the life-saving capacity the having these discussions might have on the lives of patients because HIV/AIDS can be a matter of life and death. Their religious and spiritual beliefs and practices can make a difference in whether or not they make healthy decisions about their lives with the virus. Trey and George would like to bring the religious and spiritual dimensions of their lives into the

healthcare setting because they find these aspects of their lives help in the management of chronic illness.

Religion and Spirituality Affecting Health

The men's stories and directives above offer a deeper understanding of the religious and spiritual needs of many BMSM who are in care at The Clinic and other healthcare settings. They speak to the types of religious and spiritual care that the men feel would benefit them the most, and they also point barriers that they and other BMSM face that keep them from accessing such potentially life-saving resources. These men's accounts draw attention to how religion and spirituality can benefit the health of HIV positive BMSM, providing them with the impetus to stay in care and the fortitude to deal the challenges of living with the virus.

Their directives fervently speak to the fact that religious and spiritual care incorporated in the healthcare setting must affirm the sexual orientations of BMSM, which can provide them with hope, and show them, as Rodney noted, "it is about life." Their insights show what critically important figures chaplains or spiritual care providers are in the healthcare setting, as they can provide care that doctors and nurses are not equipped to do. They can give spiritual assurance to combat internalized religiously rooted homophobia. They can also be someone BMSM can confide in to ask questions about religion, sexuality, and discuss various aspects of living with the virus, which they would otherwise not feel comfortable asking spiritual leaders in their own communities.

These men discuss the moment of diagnosis as a particularly important time when introduction of religious and spiritual care can dramatically alter the health journeys of HIV-positive BMSM. Their accounts emphasize the dynamic nature of lived religious and

spiritual experiences, and demonstrate why it is critical for religious and spiritual care to be offered for men at different stages in life with the virus. One way they suggest this can be done is to have religious and spiritual support groups for men with HIV at all stages of life. These groups can offer communal support, spaces for sharing, and help BMSM with accountability when it comes to remaining in care.

The greatest tensions that emerged from these narratives were in regards to how healthcare providers should approach religion and spirituality in their patients' lives. Regardless of the providers' beliefs, it can be beneficial for them to be able to have a conversation about these aspects of their patients' lives. These conversations can help them learn more about potential barriers patients face to remaining in care, or alert them to potential health benefits that religious and spiritual beliefs provide to their patients. Equipping providers with resources, such as pamphlets and general knowledge about sources of religious and spiritual care provision inside and outside of the clinical setting, can help BMSM connect to resources in ways that feel most comfortable to them.

The men's directions for best practices show a need for religious and spiritual care resources to be made available in visibly LGBTQ-affirming ways, as many of BMSM have experienced trauma in their lives resulting from religiously rooted homophobia and HIV-related stigma. One important theme that came up was that healthcare providers should to make linkages to LGBTQ-affirming religious and spiritual resources within the community. These resources could be more convenient for BMSM, offer greater chances of social networking within their own communities, and allow their lives a sense of normalcy by giving them the freedom from being in healthcare settings so much. These directives also

draw attention to a variety of avenues for further research to be done on how religious and spiritual care resources can better match the culturally specific needs of BMSM.

These men's stories provide a chance for those—administrators, doctors, resource workers, and spiritual care providers—within healthcare settings to see how religious and spiritual care resources already present can be strengthened. Additionally, the directives offered by the men provide opportunities to address areas of weakness, often unrecognized and unconsidered, which demand creative thinking by the full range of health providers. The next chapter gives a glimpse into the lived religious and spiritual experiences of healthcare providers, which shows the mostly unseen ways in which lifeworlds of patients and providers come together in healthcare provision.

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[1] Courtenay Sprague and Sara E. Simon, "Understanding HIV Care Delays in the US South and the Role of the Social-Level in HIV Care Engagement/Retention: A Qualitative Study," *International Journal for Equity in Health* 13, no. 1 (December 2014): 2, https://doi.org/10.1186/1475-9276-13-28.

[2] Le'Brian Patrick, "Vagrant Frontiers: Black Gay Masculinity and a Quest for Community - The Issues That Shape My Viewpoint," in *Hyper Sexual, Hyper Masculine?: Gender, Race and Sexuality in the Identities of Contemporary Black Men*, ed. Brittany C. Slatton and Kamesha Spates, 1 edition (Farnham, Surrey ; Burlington, VT: Routledge, 2014), 70.

[3] William L. Jeffries IV et al., "An Exploration of Religion and Spirituality among Young, HIV-In[3]fected Gay and Bisexual Men in the USA," *Culture, Health & Sexuality* 16, no. 9 (October 21, 2014): 1039, https://doi.org/10.1080/13691058.2014.928370.

[4] William L. Jeffries IV et al., "HIV Stigma Experienced by Young Men Who Have Sex With Men (MSM) Living With HIV Infection," *AIDS Education and Prevention* 27, no. 1 (February 1, 2015): 59, https://doi.org/10.1521/aeap.2015.27.1.58.

[5] Safiya George Dalmida et al., "Spiritual Well-Being, Depressive Symptoms, and Immune Status Among Women Living with HIV/AIDS," *Women & Health Women & Health* 49, no. 2–3 (2009): 135.

Chapter 5
Provider's Stories: Religion and Spirituality in the Healthcare Setting

This chapter focuses on the experiences of some of the most important interlocutors in the health journeys of HIV-positive BMSM, healthcare providers. It brings awareness to the little known intersections of the lifeworlds of healthcare providers and their patients. The accounts highlighted here delve into the religious, spiritual, and professional worlds of seven healthcare providers at The Clinic. They represent a variety of healthcare roles at: chaplain, physician's assistant, nurse practitioner, clinical social worker, and infectious disease doctor. Descriptions of their personal and professional journeys, including their lived religious and spiritual histories, show how their approaches to the religious and spiritual facets of patients' health journeys have been informed by their own experiences.[1]

The narratives of three infectious disease doctors Henry, Robert, and Andrew; a physician's assistant, Lanie; and a nurse practitioner, Suzy; highlight the differences in practices of medical care providers. They highlight various ways medical providers address the scientifically "hard" facts of illness versus the "soft" socio-cultural dimensions of their patients' illness experiences, such as religion and spirituality.[2] Their accounts demonstrate how interpretive schemes of illness and disease are informed by professional training. These internal dynamics impact the interactions medical providers have with their BMSM patients. Narratives from a clinical social worker, Naomi, and The Clinic's chaplain, Desmond, exemplify approaches of non-medical clinicians for assessing and addressing the roles of religion and spirituality in patients' journeys with HIV/AIDS. Through these interviews, the weight placed on the chaplain—who oversees the religious and spiritual care for patients at The Clinic—is made evident. This burden on the chaplain at The Clinic

further exemplifies how lines are often drawn between the worlds of medical care provision and non-medical care provision in healthcare settings.

The narratives in this chapter are organized into three sections: “A Passion for Care,” which describes providers’ professional journeys; “Partners in the HIV Journey,” which examines provider/patient relationships; and “Strengthening Religious and Spiritual Care,” which offers providers’ directives for improving religious and spiritual assessment and care at The Clinic. Desmond’s, The Clinic’s Chaplain, story leads each section, as other providers routinely refer to him in their interviews.

These healthcare provider’s accounts reveal how their relationships with patients who are BMSM are structured. Taken together, they indicate an acute need for integrating religious and spiritual care at each level of healthcare provision, which can foster more effective and culturally relevant approaches to care needed for improving these men’s HIV-related health outcomes. These narratives offer unique contributions to the field, as they help paint a more complete picture of the health journeys of BMSM by including the interactions and experiences of their healthcare providers.

A Passion for Care

In this section, Desmond, Naomi, Suzy, Robert, and Andrew describe how they came to their respective healthcare professions, and they discuss how their religious and spiritual beliefs and practices have shaped their approaches to care. Desmond details his religious and spiritual journey as an out, gay, African American, man, which in many ways parallels the stories of the BMSM patients he works with. He affirmed, “. . . all that entire journey to the point of here—I think, yeah, God has used me in amazing ways.” Suzy shares how her deep sense of spirituality guided her to a career path in caring for those with

HIV/AIDS. Both Robert and Andrew, who identify as Catholic, have had to deal with tensions between the sexually conservative doctrines of the Catholic Church and the pragmatic approaches to sexual health they promote. Robert noted, "I've had to overcome some of my own biases from the faith I was raised in to provide non-biased care to my patients."

In contrast to the other providers, Lanie and Henry do not identify as religious, though religious and spiritual beliefs and practices shaped their lives growing up. The stories describe experiences in which they felt drawn to their respective professions. Lanie remembered the moment in college when she was an emergency medical technician that she thought to herself, "This is what I was brought to this earth to do." With the exception of Lanie and Naomi, all of the providers remember vividly the AIDS epidemic during the 1980s and 1990s. Suzy recalled, "It was just a very different time and place; we basically had condoms and lots of funerals."

Desmond

• Chaplain •

Religion was the cornerstone of Desmond's family life as a child. His family attended a Church Of God In Christ Congregation, where they were in services seven days a week. His family was, "very, very, very conservative." This conservatism permeated all aspects of family life from strict gender roles to the types of movies and music that they were allowed to enjoy. In church, he heard messages preached about the ills of homosexuality, hearing it "referred to as demonic behavior." His same-sex attractions "scared" him "because it was a sin." His father denounced homosexuality as "sick, sick, sick," which heightened Desmond's anxiety and fear of being rejected by his family. As his sexuality began to develop further in

early adulthood, he sought "reparative therapy," and he was involved in ex-gay ministries to try to become heterosexual.

Desmond felt a religious calling to pursue church ministry in the early 1980s. He started seminary in 1985 to become a Presbyterian minister. While in seminary, he interned at a hospital in San Francisco, where he was assigned to the AIDS floor. The virus was basically a death sentence at that time, and San Francisco was one of the cities hit worst by the epidemic. He was somewhat hesitant to work with AIDS patients, but as he recalled, "It ended up being the best experience of my life." Many of the patients had no one because their families "wanted nothing to do with them." They were grateful for Desmond's non-judgmental presence, "reminding them that they were loved and cared for by God." He desperately wanted to share the truth about his sexual orientation with the dying men, but he was scared what would happen to his ordination process if anyone were to find out.

Desmond's sexual orientation eventually interfered with his ordination process because he could not lie when directly confronted by questions from those in the church. He began a career as an associate pastor and got engaged to a woman, but later called off the engagement. Desmond was desperate. His sexuality continued to plague him, and he saw no way forward with his life. So, he contemplated suicide. He recalled thinking to himself, "God, at least if I die, I'll go to heaven, you know, I won't be sad anymore, I'll be okay. I won't have to get married anymore and live a lie."

At this make-or-break point, Desmond connected with a therapist, who helped him embrace his sexuality. He remembered sitting in the therapist's office hearing music playing in the background with the words fearfully and wonderfully made from Psalms 139:14 in the lyrics. He believed God spoke to him through this song saying, "You're fine

just the way you are. You're fearfully and wonderfully made." That experience in his mid-30s helped him to overcome the shame he felt about his sexuality. He threw all the ex-gay books and manuals in his trashcan and "never looked back."

In 2008, Desmond moved to Atlanta and worked as a hospice chaplain. However, the position did not resonate with what he felt was his God-given calling to help those with HIV/AIDS. He was hired to work as the chaplain for The Clinic two years later. Desmond loves being the chaplain because he can be out and self-identify with patients who are BMSM, and because he can utilize his personal and professional experiences when caring for patients. He credits God with giving him the experiences he needs to help patients. He remarked:

> . . . all that entire journey to the point of here, I think yeah, God has used me in amazing ways here, particularly with I think a lot of our patients with HIV, gay men, you know. He has been really—he's really put me in the right places for that . . .

Naomi

• Clinical Social Worker •

Naomi works as a clinical social worker within the clinic. She and her family are originally from Ethiopia, but they moved to Washington D.C. when she was 11 years old. Her faith has been "very important" to her life from the time she can remember. When she went off to college in Tennessee, her father was insistent that she had to marry an African descended Christian man, which she has. She completed her college degree and her master's degree in social work in Atlanta.

Her Christian faith played an integral part in Naomi's decision to become a clinical social worker. When she was in her master's degree program, she worked in in communities in the Atlanta area impacted by HIV/AIDS. Naomi reflected, "at that time I

found my passion providing for people in need." Working at The Clinic was a natural next step for her career because she wanted to continue helping those with the virus that she saw disproportionately impacting minorities.

Suzy

• Nurse Practitioner •

Suzy is an Atlanta native, but she has lived in various parts of the country from Texas to upstate New York. She spent summers in Atlanta with her grandparents. When she was with them, she attended their Presbyterian Church in which they were heavily involved. Suzy and her husband raised their children Quaker, but she does not attend Quaker meetings regularly. She considers herself to be guided by her deep sense of spirituality, and she feels a sense of spiritual wholeness with God in her career as a nurse practitioner caring for those with HIV/AIDS.

Suzy was drawn to her profession because of its helping nature, which she sees as "being with people and being with people when they are vulnerable." She noted:

> I'm so grateful. Like, I'm so grateful that's what I chose. It almost brings tears to my eyes because with, you know, with the changes in our culture over the years, maybe people don't necessarily have a faith home, but maybe you can be with them in a way that's like ministry, like service, but not ministry.

Suzy has been working in the field of HIV healthcare since the 1980s when she was in college and worked as a volunteer doing HIV testing and counseling. She recalled, "it was just a very different time and place; we basically had condoms and lots of funerals." She has been a nurse practitioner for 18 years and has been at The Clinic for 7 years.

Lanie

• Physician's Assistant •

Lanie is a physician's assistant, who described herself as a "bit of an oddball" because she grew up in Japan until age 13 and then came to the United States for high school and college. Her father was Buddhist and her mother was Shinto, but she said these beliefs were "very cultural and traditional, but not necessarily religious" in regards to their presence in her life as a child. Lanie went to an international school in Japan, where she had a diverse group of friends; she attended Catholic worship services regularly with one of them.

Living in the Southeastern U.S. for college, Lanie noticed how "people are not treated the same" because of their race, sexual orientation, or gender identities, particularly in comparison to her upbringing in Japan and her experience at boarding school in the Northeast. She was exposed to medicine in college, where she joined the emergency medical technician team at her university. There, she began to experience what she described as a spiritual calling for medicine. On the job, she remembered thinking to herself, "This is what I was brought to this earth to do." After finishing college, she went to medical school and graduated as a physician's assistant in 2008. She completed her medical training in Atlanta at Grady Hospital, and then she moved to South Africa. She worked in HIV programming, and she trained healthcare workers to deliver treatment for HIV for a number of years. After returning from her work in Africa, Lanie began working at The Clinic to continue helping those impacted by HIV/AIDS.

Henry

• *Infectious Disease Doctor* •

Henry grew up in university towns in North Carolina during the late 1970s and early 1980s. Though he was baptized Episcopalian, religion was not all that important in his family life. Henry described the towns he grew-up in as somewhat more progressive than other parts of the state. Though, they were culturally conservative like other Southern towns where Christianity played a major role in civic life.

Henry was not aware of what HIV/AIDS was until later in his childhood. In the mid-1980s, once it became clear that the disease was sexually transmitted, Henry's mother admonished her children to "practice safe-sex and so forth." The illness became more personal to him when his cousin passed away of AIDS in the late 1980s. In 1989, he moved to the West Coast to attend college in California. He volunteered at a hospital in a nearby hospital, where he took care of those sick and dying from AIDS. This experience shaped his desire to go to medical school. When During his medical residency in North Carolina in the early 2000s, he witnessed a profound shift in the medical treatments available for HIV. He emphasized, "that was just remarkable going from before where it was a death sentence to now it's a treatable disease, you know, I wanted to be a part of that." Henry started working at The Clinic as an infectious disease doctor in the mid-2000s. He wanted to work at The Clinic because of its intense focus on HIV treatment and research.

Robert

• *Infectious Disease Doctor* •

Robert grew up in North Carolina as the only child of upper middle class parents in a Catholic home. He attended Sunday school each week, was actively involved in church youth group, and played on his church's sports league. While in high school in the mid-

1990s, Robert volunteered with a local non-profit that helped people with HIV/ AIDS. He developed a friendship with a gay, Latino, Catholic, man he helped care for. Robert was struck by the man's "very deep faith," as well as with the compassion of the local priest who would bring his friend's communion to his home because he was to sick to attend services. Robert recalled, "That was actually very nice to see coming from inside the church, an individual that I think was kind of expressing the compassion and love that I think Christ brings. So, I saw it in a very real way."

There was a time when Robert contemplated joining the priesthood instead of practicing medicine. However, he felt a strong desire to practice medicine from the time he was young, as it was a family tradition. His decision to become a doctor was guided by "trying to search out what God was calling [him] to do." The Beatitudes in the Gospel of Matthew in the Bible resonated with Robert, as it resounded with his experiences working with people with HIV who were "the lepers of the 21st century." He completed his medical residency in Miami, where he worked with AIDS patients in the latter stages of the disease. He started work at The Clinic in 2012. He felt working there offered him the opportunity to "get as close to the HIV population as possible."

Robert's faith, which for him is set apart from the formal dogma of the Catholic Church, guides his interactions with his patients. He noted:

> I think at the heart of my faith, what I believe is that Jesus calls us to love one another. So, in each of my interactions with people, in particular my patients, that's what I'm trying to do . . . I've wrestled with kind of stepping away from the faith and more of the teachings and the dogma of the Catholic Church in particular.

As a healthcare provider, he has had to wrestle with the teachings of the church, like those surrounding sexual activity and homosexuality that do not promote pragmatic messages

about sex. He noted, " I've had to overcome some of my own biases from the faith I was raised in to provide non-biased care to my patients." Robert does not "really feel [those teachings] are appropriate for the 21st century." He looks to science to see what actually promotes the flourishing of human health, which "the teachings of the church just don't match up with."

Andrew

• *Infectious Disease Doctor* •

Andrew, an Iraq War veteran, grew up in Florida as a third generation Italian-American, Catholic family "interestingly embedded within a very Protestant reality in the South." Andrew remembers the worst part of the AIDS epidemic in the late 1980s and early 1990s. He had a cousin who passed away from the disease, which "dramatically affected" his family. During this time, two young boys who contracted HIV from blood transfusions relocated to his hometown because their family's house was purposefully burned down and they were harassed in another Florida town. Andrew remembered that the boys and their family were welcomed in their town, and they even shopped in his grandmother's store. When he came home from college in the summers during the early 1990s, Andrew worked as a phlebotomist. He was the only person who would draw blood from those with HIV.

During medical school in Maryland from 1996 to 2000, Andrew witnessed the revolutionary way new medicines could help people with the virus. However, he also noticed that these medicines often did not work due to structural inequalities many patients faced in the inner city context. While in Massachusetts for his medical residency, he saw a dramatic shift in what access to quality healthcare meant for people's health

outcomes with HIV. He recalled, " It opened my eyes . . . . to the entire reality of the social behavioral context that a person grows up in, and lives in, and their identity, and all these things. If those are completely disrupted, the medicines don't work."

Andrew became more aware of the harm caused to certain groups of people, particularly those in the LBGTQ community, by the church when he was in medical school. He had to grapple with his beliefs and come to a new understanding of what his Catholic faith meant to him. This change meant following Jesus's teaching of "this amazing and beautiful love of everyone; be good to your enemies, and do not cause harm." These principals guide his interactions with all his patients.

Andrew is attuned to the ways that religion and spirituality operate within the context of health. He remarked, "The way I do my healthcare is largely a spiritual practice." Though, he was very clear that it is up to the patient as to how comfortable they feel in regards to discussing their religious and spiritual journeys with him. He further explained:

> And to be quite clear about it, I don't come in there and start praying with people. A lot of people don't understand how that works. It begins inside me, and it comes through the way patients want to receive that or not receive that. They're in control. They're driving the boat. But, where that comes out is the way that's practiced.

Partners in the HIV Journey

The narratives in this section document how the religious and spiritual beliefs and practices of healthcare providers can influence how they assess and address these aspects of their patients' lives. They also spotlight the dichotomy that is often present between science and religion within the healthcare field. Several of these providers discussed the difficulties they face when speaking about religion and spirituality with patients because of this separation. Other than Desmond, the chaplain, all the providers noted feeling

underequipped to address these dimensions of their patients' lives, particularly who have often experienced a great deal of "church hurt," as Lanie put it.

Desmond's narrative further underscores a sense of separation present between those in medical care provision and those in religious and spiritual care prevision. He has witnessed first-hand the transformative power of affirming religious and spiritual care on the lives of HIV-positive BMSM. His story gives needed perspective regarding how the positive aspects of religion and spirituality can be incorporated into the care of these men.

The providers' narratives show that they are well aware of the negative health impacts religiously rooted homophobia and HIV-related stigma cause in the lives of their patients who are BMSM. It is the negative effects on health are most readily apparent in the provider/patient relationship. As both Henry and Robert explained, these behaviors become obvious when patients are experiencing poor health. However, medical providers routinely witness the positive roles that religion and spirituality can play in their patients' lives. Their accounts also draw attention to the varying degrees with which providers feel comfortable and/or able to explore religious and spiritual experiences and understandings.

The provider accounts in this section reveal how religious and spiritual care and resources are provided to patients in a world-class healthcare setting. They give unique and much needed first-hand insight into how providers' religious, spiritual, and professional orientations facilitate their understandings of the lifeworlds of their patients. Through their stories, we learn more about what patients, like the men whose narratives guided the last chapters, discuss with their providers regarding their religious and spiritual beliefs and practices, and how healthcare providers specializing in various modes of care provision can and do account for these dimensions of their patients' lives. Most

importantly, these narratives exemplify the compassion these healthcare providers have for their patients.

Desmond

• Chaplain •

Desmond has witnessed the transformative power of connecting with patients and bringing the love of God they have often felt excluded from back into their lives. He often opens up to them about his own struggles. He clarified:

> I can say, "I understand that, I get that, and I've been there too." They're like, "Really? Wow!" So, it gives a connection, and then they can say, "Wow, I don't have to abandon my religion, I don't have to feel like God hates me or that I'm an abomination or that I need to drive the demons out. I can be just who I am—a man in love with a man or in love with a woman, you know, and I'm okay."

He sees the impact of religious and spiritual struggles on the health of the BMSM that he works with, as many men " feel like they are damned to hell." Desmond noted they often act "reckless" in their behaviors or don't take their medications like they should. However, he has also observed the men who have come to accept themselves and think, "I know I am a child of God," are more like to stay in care and be adherent to their medications. Desmond reflected on the positive impact of religious and spiritual beliefs as crucial for these men's health saying:

> They're hopeful. They have lives where they are connected with people. They're connected with a church. They're connected with an organization that they can be themselves in. They're in relationships, and I think they're more engaged in their overall healthcare, you know, with things they need to do. They're more committed to that. Again, that's what I see. You know, I think when there's that acceptance of, you know what, yeah, I don't have to hide, I don't have to pretend not to be afraid, I am loved and cared for by God; it gives them a sense of power.

Desmond has close working relationships with many healthcare providers at The Clinic, who refer their patients to him, especially BMSM who may be struggling with their sexuality and need religious and spiritual care. However, he connects with the majority of patients he sees just by being present around The Clinic and having conversations with them. As a chaplain, entering into the health journeys of BMSM with HIV/AIDS can prove challenging for Desmond because the men have often been hurt in the name of religion. Their reactions to seeing a chaplain can make them "scared." If he notices patients are responding to his presence in ways that indicates stress, he tries to put them at ease immediately saying:

> I am not here to give bad news. That is not my job. I'm not going to come to tell you things like that. My job is to provide you with encouragement. My job is to listen to you. My job is to give you hope. My job is to sit with you. That's my job, that's what I do here.

Many of his patients who are BMSM are "struggling with [the notion that] HIV is God's punishment because they've been told by their churches, even family members who are very religious and very spiritual and Christian. Conservative churches tell them that it's a sin, and they will tell them this is God's punishment." Desmond remarked with exasperation that when he began his career he thought the stigma about homosexuality and HIV would dwindle, but, many years later, it is still impacting the health of BMSM.

Naomi

• Clinical Social Worker •

Regardless of her patients religious or spiritual beliefs and practices, Naomi emphasized that she is "not there to judge." As a clinical social worker, her primary role is to collect as much information about her patient's lives as she can in order to "enhance their lifestyle and to get them connected with resources and treatment." One of Naomi's

patients, who has been living with the virus nearly 40 years, credits his health to his Christian faith. Conversely, another one of her patients thinks that people who believe in God are "very delusional."

Naomi noted that BMSM often tell her about being rejected by their families because of their sexuality, which is justified by anti-gay religious viewpoints. She hears stories about parents rejecting their children, and even children rejecting their parents who come out as gay later in life. Some of her patients are "really strong and they're very resilient." Yet, for others the stress associated with rejection manifests in drug or alcohol abuse, depression, not being able to sleep, and/or not eating enough. Naomi refers those patients who desire religious and spiritual care to the Desmond.

Suzy

• Nurse Practitioner •

Though Suzy's current work is in women's health and HIV, she has worked with many BMSM throughout her time as a nurse practitioner and at The Clinic. She noted that the hard part about the epidemic in relationship to religion is its connection to "sex and death and shame." She remarked, "I think that those things are so core to an individual's feelings about themselves, and they are so developed by their own faith experiences and their own religious experiences." Many of the patients she sees "come with a strong faith history and they have to, like, in addition to everything else in their lives, they have to make their diagnosis make sense within the context of their religious and spiritual background." As a healthcare provider, she is one of the privileged few that her patients may discuss these parts of their lives with, particularly if their families or communities have disowned them. These moments of disclosure are something that helps Suzy learn more about the

contexts of her patients' lives, and she treats their experiences with "such honor and respect."

She is often struck by the religious and spiritual experiences of her patients. Many have endured stigma put forth by religious leaders in their communities, which makes them feel "sort of rejected by God." On the opposite end of the spectrum, there are those patients who feel like they get strength from their relationship with God and their communities. She noted that some of her other patients have a strong individual faith in God, but they are no longer part of religious communities. She often prays with her patients, and she feels that these deep connections help them better deal with their lives with HIV. Suzy remarked, "It's really just so meaningful; probably one of the most meaningful things I've ever done professionally."

Lanie

• Physician's Assistant •

Lanie became more attuned to "that whole inequity and injustice and just the different lives that people lead because they're black, because they're gay" since she has worked at The Clinic. The more she began to "dig deeper, the more nebulous" the causes of the [HIV] epidemic seemed to her. She remarked, "Really, it's also nothing about medicine." As a medical care worker, she finds the structural and social forces of racism on the epidemic "challenging in a very frustrating way," because she encounters the brunt of these forces when patients are sick and in dire need of help. She noted:

> When I see all these patients who are coming in, but I know that it's deeply rooted, you know, the reason why they got infected with HIV in the first place, the reason why they aren't willing to take HIV medicines is deeply rooted in historical reference and things that have happened to them generations and generations ago. What can I do to influence that and to help them in the way that they want to accept the help?

Religion and spirituality are parts of her patients' lives that Lanie believes she has to address. What she credits with helping her relate to the beliefs of her patients' is the fact that she does not have a faith of her own. She pointed out, "I have nothing, no agenda of my own—I'm a blank slate, so they can kind of help me fill in the gaps." Lanie does not directly ask patients about their religious or spiritual belief and practices, but these aspects of their lives often come up in the conversations she has with them about their life histories.

As Lanie pointed out, she is a small, young, Asian woman, and she feels like that helps patients feel that she is approachable. If they mention that religion or spirituality is important to them, she asks them questions to see how their beliefs or practices may be related to their health. For these patients, she often finds that certain aspects of religious and spiritual beliefs impact their abilities to embrace who they are, which can "cause complex responses to diagnosis and treatment."

One patient stood out in her mind because of the issues he was having in regards to his sexuality and his health. The man was part of a Baptist family, and he was shunned because he could not "pray the gay away." Subsequently, he tried to commit suicide and then became an alcoholic. Seeing this patient struggle, especially with the faith that was so important to him impacted Lanie. It made her think more about the relationship between religion, spirituality, and the health of those she treats. She emphasized:

> It's painful for me to watch because it's like I know that he wants this so badly—to be reconnected and to express that part of him. But, I don't know how to help him. So, I know that the answer is some form of religious congregation that he can belong to that he feels safe being in and can be accepted in, but I don't have the resources.

It is often challenging for her when she asks these men if they want to talk to Desmond, as they may not self-identify as religious because "they've been burned by the

church." It is "rare" that she has patients who are BMSM that desire to start a conversation around religion or spirituality, even though she knows these aspects of their lives are important to them based on what they tell her about themselves.

Henry

• Infectious Disease Doctor •

Henry is very concerned about the HIV crisis in Atlanta among BMSM and in the broader African American population. He views issues like lack of education, particularly sexual education, lack of health insurance, and also less stable employment as contributing factors to this epidemic. In regards to the crisis facing BMSM Henry remarked, "I do know that we have a major problem with it, and that if we're going to really get this under control we have to try to reach those people more and get them in care."

Occasionally, he will delve deep into patients' histories because he knows some religious beliefs and practices put them at risk for poor health with HIV, such as those patients who feel their faith will cure them of HIV. Henry noted that it is harder for him to address religion and spirituality in general conversations because "[he] wasn't trained to do that," as well as the time and professional constraints placed on the patient/provider relationship. When he is working with patients, religion mainly comes up "if it's getting in the way or if a patient is very ill and has a poor prognosis." He lamented, "We just aren't asking those people why are you doing so well, when I'm sure it plays a role there too—that it's a positive thing and keeps them grounded and fulfilled and that kind of thing." When patients bring up religion, Henry usually asks if they would like to see the Desmond. He believes that patients who are BMSM trust that The Clinic's chaplain will be someone

who will provide them with affirmation, as opposed to "some fire and brimstone person, who is, like, really going to make your life miserable."

Robert

• Infectious Disease Doctor •

Robert is deeply troubled by the HIV epidemic among BMSM in Atlanta and around the nation. He remarked, "In the Deep South, you can't have this conversation without talking about history and racism, and a historically-embedded mistrust around medicine in the African American community." Another area he feels contributes significantly to the disproportionate burden of the epidemic is a lack of education around HIV. He is repeatedly amazed that patients who are BMSM are not "hyper aware of the type of risk that they were under solely because of the color of the skin, their sexuality, and where they live."

Religion and spirituality are routine topics of discussion in the context of his provider/patient relationships with BMSM. These conversations happen mostly when he is working with new patients and learning about their lives and social worlds. They also happen when "patients aren't necessarily doing that well with managing their virus," and he tries to find out why. He hears stories about how these men have been shunned by the faith communities they grew up in. He noted this rejection happens "not so much because of the HIV, but more so because they are gay. And, of course, because they made a quote-unquote choice to live that way, and the repercussions of that can be eternal damnation." However, many of his patients have told Robert about the support they receive from their families and churches.

Robert is quick to provide patients with religious and spiritual care resources, which mainly consists of connecting them with the Desmond. Robert informs them that the

care they receive will be affirming, regardless of how they identify their sexual orientations or gender identities. Many of his patients do not even know that there is a chaplain in The Clinic, as other healthcare providers or patient resource workers have not told them prior to coming into his exam room.

Andrew

• Infectious Disease Doctor •

Faith is a "big part of [Andrew's] patients' lives," especially for many of the BMSM he works with. In comparison to his patients he saw in the Northeast, he noted that it is fairly uncommon for patients at The Clinic not to have had "a major connection with church or religion, especially Christianity, at some point in their lives." Andrew sees that many of his patients who are BMSM struggle with feelings of shame, which are often rooted in religious beliefs they have internalized or encountered. This sense of shame leads many of these patients to have what he called a "passive death wish," whereby they act in ways that can harm their health, such as using drugs, engaging in risky sexual behaviors, and being involved in other behaviors that put them at risk. He emphasized, "So that sense of loss of wellbeing and feeling good about yourself, sadly, is intricately woven into their experience in church because that's fundamental to who they are." These behaviors associated with "the shame and guilt, the feeling that HIV was a curse from God because of what they did . . . have very much played a deep role in [his] experience with patients."

Andrew also sees the positive role that religion and spirituality play in the lives of many of his patients. In his work in South Africa, he has observed how those with active faith practices, even those not necessarily associated with organized religion, have been linked to with viral suppression of HIV, greater success with HIV treatment, and increased

likelihood of remaining in care. In Atlanta, he recalled an interaction with a patient who was extremely motivated by his faith to stay healthy. There are others he has seen that fall along a spectrum of how they deal with their faith in relationship to their sexuality and HIV-status; some try to shun their same-sex attractions altogether and others hide their sexuality around their faith communities. Andrew remarked that many BMSM that are in non-affirming faith communities benefit in a plethora of ways from being part them, even if their sexual orientation can prove problematic.

He identifies himself as a "holistic practitioner," meaning he incorporates practices that acknowledge the mind, spirit, and body connection into the care he provides. When Andrew meets a patient for the first time he discusses life with HIV and treatment options, but he also talks about a philosophy of health and wellness that encompasses the body, the mind, and the spirit. The spiritual side does not necessarily have to accompany religious beliefs, but involves people being spiritually connected in some way like prayer, meditation, or other practices that nourish their emotional being. The other spiritual component to that Andrew emphasizes to his patients is how important it is for them to have community. This approach towards holistic health is supported by data, which he shares with them. His introduction with his patients becomes "touch points for discussions all along their journey with [him]," and they touch back on each area of this plan for wellness during their time in care with him. Andrew emphasized:

> So that is where spirituality has always got a space within our discussions and often becomes a big part of it. It may be emotional wellbeing they want to talk around but it often circles back to what is their understanding of God and how are they practicing community. . .

Strengthening Religious and Spiritual Care

At The Clinic, religious and spiritual care is primarily the domain of the chaplain, as is common practice in many healthcare settings. An important theme that emerged from the narratives in this section was that the healthcare providers, excluding Desmond, need to build their knowledge base about common approaches to religious and spiritual care, and also to be trained to more effectively assess and address the religious and spiritual needs of their patients. Robert made a critical observation that is probably felt by many healthcare providers. He underscored that such training can give healthcare providers and other clinical staff "permission" to talk with patients about these aspects of their lives. It can help relieve providers of a "fixing your problem" mentality that emerges from the medical mindset, as Lanie noted, and foster deeper connections with patients. These connections in turn can enable providers to learn more about the individual and social worlds in which their patients experience chronic illness, thereby promoting better health outcomes for patients through more effective treatment and resource provision.

These providers also attested to a vital need for being able to connect these men more effectively with the religious and spiritual care resources within and beyond the healthcare setting. As many of the providers noted, there needs to be promotional material and signage throughout the clinic that makes BMSM aware that LGBTQ affirming chaplaincy services are available. There are those patients, like Andrew explained, who prefer to keep their religious and spiritual lives separate from the healthcare setting. By enhancing the ability of healthcare providers to share information about outside religious and spiritual care resources that are LGBTQ and HIV affirming—even if just in the form of a simple pamphlet—they can help patients connect to that provide many forms of support.

Finding these supportive communities can be live saving for BMSM, who are often ostracized by their families and communities. Henry alone was hesitant about telling patients what communities are or are not best for them. But, just as healthcare providers choose the most effective treatments, they must also choose the most effective religious and spiritual care resources for BMSM that do not expose them to further religiously-based homophobia or stigma.

This section of narratives offers pragmatic suggestions from healthcare providers at various levels of patient care for improving how the religious and spiritual care needs of BMSM are assessed and addressed within the healthcare setting. They highlight a crucial need for the religious and spiritual dimensions of the health of HIV-positive BMSM to be taken into account from the moment they enter into the HIV care continuum. Also, they point to a need for open channels of communication between providers at various levels, which could help advance the most effective solutions for promoting patient health.

Desmond

• Chaplain •

Desmond would like for religious and spiritual care to be integrated more fully in the clinical setting. Given The Clinic's patient load, he believes there is a need to have a chaplain available on "an around-the clock basis," as opposed to his current two day per week schedule. He notes that many of the patients he sees who are BMSM "battle with spirituality," and that they need to be able to access religious and spiritual care when they are in the midst of such moments. Timing in such circumstances is critical because they can have an immediate impact on the physical and psychological wellbeing these men.

Though he works closely with various healthcare providers at The Clinic, he thinks that the importance of the patients' religious and spiritual beliefs and practices are undervalued in regards to how they impact their overall health. He remarked:

> I don't think they understand the importance of that and how it does make a huge difference in their lives when they connect—how it has changed a lot of people. For MSM men, I think again back to what I said earlier, I think about taking their medication, accepting themselves. I think that's the chaplain piece, the spiritual piece, the religious piece that ties and that helps them accept that, but I don't know if [some providers] are able to see how all that works.

In order to promote thorough integration of religious and spiritual care, Desmond believes it would be beneficial for providers to be trained on the fundamentals of referral and resource delivery. He would also like to see a support group formed at The Clinic for BMSM at various stages of life with HIV to so that they could share their stories and form community.

Naomi

• Clinical Social Worker •

The most integrated way that Naomi sees religious and spiritual care currently being brought into the clinical setting is through palliative care, which brings together a multi-disciplinary team, including the chaplain, to provide support to patients. Naomi believes that religious and spiritual care provision at The Clinic could be strengthened by helping providers get patients connected with resources both within and outside of the clinical setting. For those patients for whom going to church is important, she sees value in trying to help them get the connected to religious communities that "don't discriminate." She emphasized, "You go to church to worship God, not to be stereotyped by other people."

Lanie

• *Physician's Assistant* •

Lanie finds one of biggest obstacles to addressing religion and spirituality in the patient/provider relationship is a mindset common among providers that "we came to medicine to prescribe medications, to fix your problems with medicine and treatment according to guidelines." She thinks to ask providers to delve into other areas of patients' lives challenges what they are taught, and they may thus find it hard to inquire about religion and spirituality. Lanie remarked:

> The ironic thing is, and I wish my colleagues somehow could understand, like, if you were to be able to kind of drop the medical hat somehow and wear these other hats, your job, I think, gets easier in a way, and, I think, the fear there is that it actually gets harder because you're going to delve into their lives and, you know, you kind of invest in them as a person and you build these connections and so where's the boundary, and that's scary and also you shouldn't go there. But in a way, when you do that, I think your job becomes easier because you understand where they are.

Lanie sometimes feels she has had to "unlearn what [she] was taught" in medical school to be able to have conversations about religion and spirituality with her patients. However, these conversations help her to understand how they relate to and make sense of their illness.

She also works as part of an administrative team in addition to her position as a physician's assistant. In her administrative work, she observes that providers at The Clinic need to be made more aware of how to utilize the religious and spiritual care resources available effectively. This awareness would help create a multidisciplinary approach to addressing patients' needs, especially if they are related to health behaviors influenced by their religious or spiritual beliefs. Lanie thinks sustained community partnerships must also be created to ensure that patients, particularly BMSM, have support systems outside of

the healthcare setting. She emphasized that the worst problem in patients' journeys with HIV are feelings of isolation.

Suzy

• *Nurse Practitioner* •

Suzy brought up that often times there are other programmatic and budgetary priorities that are pressing and immediate needs, which can take precedent over the development of religious and spiritual resources at The Clinic. She thinks that the ways that religion and spirituality enter into the provider/patient relationship in many ways go unnoticed. She remarked:

> There's enough people walking around in that building that I know have a Bible, and a well-worn Bible, in their backpack. And, there's enough people who before they clock-in in the morning, you know, are drinking their coffee and reading their daily devotional. I know that happens.

The fact that the resources of the chaplain are quite limited is something that Suzy is well aware of. She thinks that there may be untapped resources within the community of healthcare providers, as noted above, who could help facilitate religious and spiritual care resource provision, such as by volunteering to lead spiritual support groups for BMSM. She hypothesized that perhaps the easiest and least resource intensive way of enhancing the quality of care for patients would be to have some idea of "faith communities that would be warm and welcoming" to refer patients to. She noted, "whatever their beliefs are, everybody deserves to have the love of God or Spirit or universe or Goddess or whatever, everybody deserves that."

Henry

• Infectious Disease Doctor •

Henry sees a divide between science and religion in the medical and public health fields. Areas where this stands out to him are the negative health consequences associated with religious viewpoints about sex-negativity, homophobia, and policies that promote abstinence only sexual education. He also finds it is challenging to address religion and spirituality in the clinical setting, as he and other providers lack training equipping them to deal with issues that pertain to those areas of their patients lives.

In terms of religious or spiritual resources available to patients, Henry primarily utilizes Desmond. He remarked that he would find it helpful to learn more about additional resources available to patients within and outside of The Clinic. However, he is hesitant to have pamphlets or resource guides that promote LGBTQ-affirming religious congregations or spiritual communities over others that may not be as inclusive. Within the provider/patient relationship, it would be most helpful for him to understand how patients' health-related behaviors are "driven by their spirituality" through some type of assessment.

Robert

• Infectious Disease Doctor •

Robert's "deep dive approach" into patients' lives is not necessarily something that doctors are trained for, though he noted all physicians, nurse practitioners, and physician's assistants are trained to do a social history, which include typically includes things like tobacco, alcohol, elicit substances and sex. However, he pointed out, "the degree and depth of those questions will vary greatly by clinician." Robert remarked that the time those social histories are conducted would be an excellent point to insert questions about

religion and spirituality, as opposed to waiting until the patient may not be doing well. There are many screenings and assessments patients at The Clinic go through before they get to Robert. He believes that it could prove useful to him and other providers if these tools were to incorporate questions about experiences with religion and spirituality in relationship to health behaviors, which could then be assessable to appropriate healthcare providers. Having that information could open up new ways of relating to patients about how their life circumstances impact their health. It could also help providers in referring patients to spiritual care resources. Robert emphasized that providers must be trained to discuss religion and spirituality and to utilize the religious and spiritual care resources available at The Clinic. He concluded:

> . . . we should be doing this for our patients then, I think everybody in our care team should understand that, and be given the tools or be given—whether it's the tool or the permission—to inquire about religion in their life and how it has affected them so that then referrals can be made if they need to be.

Andrew

• *Infectious Disease Doctor* •

The primary religious and spiritual care resource that Andrew utilizes is The Clinic's chaplain. When he is with patients for whom faith is important, he asks questions about the types of communities they are part of and if they feel comfortable there, as well as if they have someone in that community they can talk to. The vast majority of the patients he sees want to manage their religious and spiritual lives on their own through resources outside of The Clinic. For others who may not have these resources available to them, he asks if they want to talk with Desmond; Andrew is sure to acknowledge that Desmond is and LGBTQ-affirming chaplain.

There are several ways that Andrew thinks that religion and spirituality could be more effectively incorporated into patient care at The Clinic. Both new and re-enrollees could benefit from meeting with the chaplain as part of the process of getting into care. This could be a very quick interaction, but it would help the patients get know the resources available to them and emphasize the LGBTQ affirming nature of those resources. He also thinks that healthcare providers need to be trained on how to draw on the positive aspects of religion and spirituality to enhance the wellbeing of patients for whom those components of their lives are important. Additionally, he would like to see more community partnerships with LGBTQ-affirming and HIV-affirming churches in the community, which could help connect patients who are BMSM to resources outside of the healthcare setting. For Andrew, the most important part of care is connecting with patients as people. He stated:

> This is just getting to know people, and it doesn't seem like a lot but it's transformative for folks. It really, really is. They get to connect, they get to see you're a real human and there's not an agenda because that's another piece, like what is going on, what are they trying, and it demystifies the institution. So, that would be a really big thing to help in the future.

Religion and Spirituality at In The Healthcare Setting

These stories contribute to a framework for more fully evaluating the intersections of religion and spirituality on the health journeys of HIV-positive BMSM. They offer a rare glimpse into the intersections of the lifeworlds of providers and patients. They highlight how providers and patients bring the sum of their own lived religious and spiritual experiences and interpretive frameworks into these relationships. These stories provide a deeply human perspective on the felt experiences of healthcare provision. We learn about the paths in life lead healthcare provider to their respective professions. By hearing these

providers reflect on their own treatment practices and patient relationship skills, as well as speaking to some of their weaknesses and vulnerabilities when discussing the role of religion and spirituality in their patients' lives, more is learned about what can be done to equip healthcare providers to better assess and address these forces that shape the health of many BMSM. Such aspects of healthcare provision are rarely explored in studies about epidemic facing BMSM.

Through discussions of the guiding biomedical frameworks that undergird the culture of the healthcare setting, these healthcare providers grapple with potential benefits and detriments of religion and spirituality. The impact of these forces often confounds the hard, scientific, fact-based orientation of healthcare provision. Too often within this biomedical perspective religion and spirituality are not thought of as assets or even as realities. Rather, they are seen either as liabilities to the health of BMSM, or as distractions from the certainties of infection and illness. The negative health impact of religiously rooted homophobia and HIV-stigma is well documented in health sciences research. It is seen in the broader structural influences of Christian conservatism that inform policies and education that do not pragmatically address sexual health, particularly for LGBTQ people.[3] Attention is primarily drawn to the deleterious effects of religious and spiritual beliefs and practices in medical contexts only when patients present with problems because of them. However, these narratives demonstrate the positive aspects of religious and spiritual beliefs and practices for BMSM, and providers' recognition of their impacts in patients' lives. They show the need for The Clinic and other institutions like it to train healthcare providers—other than religious and spiritual care providers—to assess and address the

religious and spiritual realities of patients, which can help them to determine more effective and relevant modes of treatment and care.

By being able to better assess and address the religious and spiritual aspects of their patients' lives, healthcare providers can create more appropriate treatment plans that adequately account the realities of their patients' lifeworlds. Doing so can also enable them to help patients frame their life with chronic illness in relationship to their religious and spiritual beliefs in positive, health-affirming ways. Bolstering religious and spiritual care resource provision within the healthcare setting for all patients, especially BMSM who have often experienced external and internal traumas of rejection and abuse validated by religion, can be life and health-affirming in ways that not only improve their health outcomes, but also can play a part in slowing this epidemic.

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[1] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition.* (New York: Basic Books, 1988), 2010.

[2] Kleinman, *The Illness Narratives*, 8.

[3] G. Gunderson and J. Cochrane, *Religion and the Health of the Public: Shifting the Paradigm*, 2012 edition (New York: Palgrave Macmillan, 2012), 46.

Chapter 6

Concluding Perspectives: Addressing Religion and Spirituality through Lived Experience

This chapter relays findings drawn from the narratives of the men and healthcare providers whose voices have carried this dissertation. Their rich, experience guided insights demonstrate the significance of the phenomenological, narrative-driven framework I have used to explore the impact of lived religious and spiritual experiences on the health journeys of BMSM. This framework illuminates aspects of these health journeys, which tend to remain hidden and are often "explained away" by the approaches taken in the health sciences that tend to categorize or quantify the impact of religion and spirituality on health.[1] Becoming attuned to these aspects of the religious and spiritual lives of BMSM can help create potentially life-saving and more potent public health and healthcare approaches to fighting the HIV epidemic in this population.

The framework that supports this dissertation is guided by a moral imperative to address the disproportionate burden of the HIV epidemic facing BMSM by bringing the goals of public health, healthcare, and religion together to preserve hope and promote healing. For too long, arbitrary divides between the scientific and the metaphysical have separated the fields of public health, medicine, and religious studies when it comes to addressing this epidemic. However, as illustrated by the health sciences data and the narrative data presented, it is essential that these divides be bridged in order to help quell the epidemic among BMSM. A phenomenological approach to lived religious and spiritual experiences of BMSM, such as the one taken in this dissertation that situates the illness experiences of BMSM within the lived realities of their social and metaphysical worlds, can help bridge this divide. It also gives credence to the historical importance of Black

Protestant Christianity in African American communities, exploring how religion and spirituality at the cultural level shape the healthworlds of many BMSM, whether or not they are believers. Importantly, this framework draws attention to the positive dimensions of religious and spiritual beliefs and practices that can enhance the health outcomes of BMSM. It is not afraid to venture into the fray of social life and moral experiences of these men and those who provide care for them because it advocates for an ethic of care that can mean life or death for some BMSM.[2] In so doing, it promotes multidisciplinary collaboration that can foster more effective, culturally competent, and socially just ways of assessing and addressing the roles of religions and spirituality on the health of BMSM infected and affected by HIV.

The Health Sciences on Religion and Spirituality

The last several chapters have presented health sciences research that highlights the disproportionate burden of the domestic HIV crisis on BMSM.

African Americans account for over 40% of people with HIV in the U.S., yet they make up only 13.4% of the population.[3] Among subpopulations most impacted by HIV, BMSM have the highest HIV incidence rates, accounting for nearly 31% of all new cases.[4] The data also points to the challenges of examining this epidemic because it occurs in environments in which the social determinants of health coalesce to create a grim picture of health for this group of men.[5] Community level-determinants combined with structural and social homophobia have deleterious health consequences for BMSM. The CDC estimates that BMSM will face a fifty-fifty chance of being diagnosed with HIV in there lifetime if current incidence rates persist.[6] Health sciences research does, however, take seriously the impact

of religion and spirituality on the health of BMSM, given the historical significance of Black Protestant Christianity for African Americans.

A great deal of existent health sciences data focuses on the negative impact that religion and spirituality can have on the health of BMSM. Greater levels of communal religiosity among African Americans have been associated with higher rates disapproval of homosexuality and HIV-related stigma. These factors mean that BMSM often encounter religiously rooted homophobia within their churches and outside of religious contexts in their communities, families, and among friends.[7] Religious precepts make homophobia particularly powerful because they legitimate beliefs derived from what adherents regard as an unquestionable sacred source, the Bible, transmitted to them with ultimate authority.[8]

BMSM often grow up and form their identities in contexts where religiously supported homophobia creates feelings of incongruity between fundamental elements of their identity like race, gender, sexual orientation, and religious beliefs. Drayton's point about the anxiety he felt as a teenager illuminated the impact of these tensions. He stated, "I felt less than because I was doing this great sin, this ultimate sin that was against God and human nature." These psychological conflicts can manifest in negative spiritual, mental, and physical health outcomes over the lifecourse. The cumulative effects of external and internal homophobia have been linked to depression, lower-self esteem, and psychological distress. These mental health issues are correlated with increased substance abuse, likelihood of engaging in risky sexual behaviors, increased risk for contracting HIV, and lower rates of accessing the HIV care continuum. John's reflection on life as a young adult drew attention the effects of enduring internalized and externalized homophobia. He

stated, "I felt like a lost soul. . . . It was rough . . . The drugs, I would go on little sprees where I would just be—it was really a dark time."[1]

Being diagnosed with HIV means BMSM men must reconfigure their lifeworlds and the ways in which they relate to God, themselves, and others in light their sexual orientations coupled with chronic illness. The challenges associated with religiously rooted homophobia and HIV-related stigma have been linked to deleterious health effects, such as depression, anxiety, risky sexual behavior, lack of disclosure about HIV status, and substance abuse, which lead to poor health outcomes with HIV and potentially spreading the virus to others. Rodney's statement about his life after diagnosis, which included abusing drugs, engaging in risky sexual behavior, and going to jail emphasized the lived experiences behind these more concrete facts offered by health sciences data. He stated, "I was in this place of despair that I know God's killing me. He's taking me out because I won't change. . ."

Current research also points to positive ways in which religion and spirituality foster beneficial health outcomes for BMSM. Many BMSM use the tenets of their religious and spiritual beliefs and practices in self-affirming ways, which can help in overcoming the adverse effects of homophobia and HIV-related stigma. Positive religious and spiritual coping strategies have been associated with better spiritual, mental, and physical health outcomes, such as lower rates of depressive symptoms, engagement with and retention in the HIV continuum of care, and living longer lives with HIV diagnosis. George's statement

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[1] Quotes in this chapter are featured in other areas of this dissertation. They are meant to help with recall of the specific ways that this narrative-driven approach has charted the impact of religious and spiritual beliefs and practices on the healthworlds of BMSM, which also importantly includes the life and professional experiences of their healthcare providers.

about the strength he gets from his faith points to these benefits. He emphasized, "I don't have to worry about anything anymore. As long as I keep doing that and keep putting God first and everything, I think I'll be all right."

Beyond The Concretized Effects of Religion and Spirituality

Health sciences methodologies and data analysis tend to concretize and quantify the effects of religious and spiritual beliefs and practices on the health outcomes of BMSM. They convey critical information about how these forces shape the epidemic facing this group of men at a population level, and they also describe both social and individual determinants of health. This data clearly shows that religion and spirituality can impact the health of BMSM in both negative and positive ways. However, it is inadequate when it comes to creating frameworks of analysis that seek to more fully assess and address how religion and spirituality intersect with the lifeworlds and healthworlds of these men. It effectively separates these forces from the lived conditions of social life and the worlds of morality and politics in which the health of BMSM are embedded.[9] Thus, health sciences data is limited in its ability to facilitate public health interventions and healthcare provision that sufficiently account for the fullness of lived religious and spiritual experiences on the health of BMSM.

There is a paucity of health sciences research that examines how the complex lifeworlds of HIV-positive BMSM and some of the most important interlocutors in their journeys with HIV, their healthcare providers, intersect. It is essential for attention to be devoted to examining the patient/provider relationships. These relationships are sites in which the building and rebuilding of these men's lifeworlds occur, as they negotiate life with a highly stigmatized and potentially deadly chronic illness.[10] The healthcare provider

narratives from The Clinic, a renowned provider of comprehensive HIV/AIDS healthcare and research, give us a glimpse into the worlds of these relationships, and they demonstrate a need for additional research to be done in this area.

Examining Religion and Spirituality through Lived Experience

The stories of HIV-positive BMSM that ground this dissertation affirm that religiously rooted stigma about homosexuality and HIV drive this epidemic and present a formidable challenges in fighting it.[11] Addressing this stigma in ways that account for the lived religious and spiritual experiences of BMSM can enhance their overall health outcomes. The men and the healthcare providers spoke to the critical need for the prevision of more effective and relevant religious and spiritual care for BMSM within the healthcare setting. They noted the importance of having easily accessible, LGBTQ-affirming religious and spiritual care provided in clinical settings. Nathan brought up the point that something as simple as a pamphlet expressing God's love and directing patients to religious and spiritual care resources inside and outside of The Clinic "could change a person's entire life."

Building on Nathan's discussion, there are several other pragmatic suggestions that emerged for integrating religious and spiritual care across the clinical setting. One of the simplest ways to improve access to and utilization of religious and spiritual care within the healthcare setting is to ensure that BMSM know that they will receive care that affirms them, and that they will not encounter further religious stigma. This means that the LGBTQ affirming nature of religious and spiritual care offered should be well publicized on signage, in any resource guides, and also by healthcare providers in their interactions with patients.

Within provider/patient relationships the narratives make evident that providers—particularly those in medical care and social work—need more training on the best practices for addressing the religious and spiritual needs of their patients. Henry spoke to this point in his statement, "I wasn't trained to do that." Additionally, there is a need for knowledge of resources both within and outside of the healthcare setting. It is also important that providers are empowered to engage with the religious and spiritual dimensions of patients' lives, as certain aspects of professionalization seem to inhibit this type engagement.[12] Being trained to ask appropriate questions about the ways in which religion and spirituality have impacted their patients' health journeys is crucial in the provision of care for many BMSM. These questions can enable providers to learn about barriers to treatment and retention in care. They can also help providers discover if patients use positive religious and spiritual coping strategies to manage their lives with the virus. Being able to assess and address these aspects of patients' lives can better equip providers to refer patients to appropriate resources, which can help patients maintain the positive coping strategies they may use. Desmond, The Clinic's chaplain, noted the effects of positive religious coping mechanisms in his observation about those patients who are BMSM that use them. He said, "They're hopeful. They have lives where they are connected with people . . . . I think they're more engaged in their overall healthcare, you know, with things they need to do."

Imperatively, providers must commit to hearing how their patients make sense of their own illness experiences. This commitment entails helping patients make sense of their experiences in ways relevant to their lives and fit within the parameters of how they make meaning and find coherence, which is often through religion and spirituality. The

providers must act as partners in the health journeys of their patients in order to help patients in this way, compassionately responding to embodied dynamics of the lived experiences that comprise the unfolding of their patients' lives with HIV. It also requires continual refinement of the questions they ask and approaches they take in assessing and addressing the religious and spiritual dimensions of their patients' lives. Andrew models this dynamic in his provider/patient relationships. He lays the groundwork for his holistic care approach with patients, describing his focuses on mind, body, and spirit. These elements then become "touch points for discussions all along their journey with [him]."

Outside partnerships can act as catalysts for social and spiritual support for these men, who often face rejection in their own churches, communities, and families. By forming horizontal partnerships with churches, and FBOs, resource sharing can take place, and assets already present in the community can be strengthened. These partnerships can promote health-affirming messages that reduce stigma, strengthen HIV/AIDS prevention interventions, and raise awareness about the resources and services that are available to BMSM at The Clinic.[13] By partnering with spiritual leaders, FBOs, and churches in the communities in which BMSM live, those in public health and healthcare settings can expand their capacities for care provision. These outside resources are often trusted sources of information and indigenously valued community opinion leaders.[14]

An Improved Approach to Healing

Throughout this dissertation, health sciences data has been presented as context for the personal narratives of BMSM and their healthcare providers. The insights gained from this narrative-driven phenomenological framework reaffirm much of what is already known about the intersections of religion and spirituality on the health outcomes of BMSM

infected and affected HIV. Moreover, this framework has opened new pathways to exploring the lifeworld processes that shape the health of these men. These processes are informed by their own understandings of their illness experiences, which push far beyond the restrictive confines of academic and scientific discourses that delimit them as medical. Being less restricted enables this framework to account for religious and spiritual aspects of their illness experiences, which are embodied and not purely functional components of the health journeys of many BMSM.

In the lives of BMSM for whom religion and spirituality are important, this phenomenological narrative-driven framework offers a starting point from which those in public health and healthcare provision can build more effective and culturally relevant approaches to care. By caring for BMSM in ways that attend more fully to the richness of how their health is often shaped by religion and spirituality, wellness, coherence, and a sense of wholeness can be restored to their physical, mental, and spiritual health.[15]

It is fitting that a framework like the one developed here would use Atlanta, Georgia as its case study. The city is impacted by one of the worst HIV epidemics in the nation, which disproportionately impacts African Americans, BMSM in particular. It is home to some of the greatest numbers of Black Protestant adherents in the nation, whose churches can be complex sites of both healing and hurting for BMSM. Also, it is home to the most important public health institution in the U.S., the Centers for Disease Control, as well as other world-renowned HIV/AIDS research institutions and comprehensive healthcare providers like The Clinic.

In many ways the HIV/AIDS epidemic in the city represents a paradox. The network is firmly in place to create public health interventions and models of healthcare provision

that more fully address all the elements—religion and spirituality included—that drive this epidemic. This dissertation shows that in order to more comprehensively address the epidemic new perspectives are needed; perspectives that draw from the self-knowledge of the men whose realities are often quantified and categorized in ways that ignore their lived experiences, especially the religious and spiritual experiences that are so often integral to their health journeys.

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