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HIV and religion in HIV-positive Asians: A qualitative study

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INTRODUCTION & BACKGROUND

As the number of Asians in the United States continues to grow, health professionals are beginning to notice obvious gaps in knowledge among health providers caring for this population, especially where sensitive diseases like HIV/AIDS are involved (New York City Department of Health and Mental Hygiene, 2014). According to a report published by the Centers for Disease Control, the Asian population in the United States grew 24% between 2005 and 2014 (2018). In addition, the Asian immigrant community in the United States is diverse. Eighty-five percent of these Asian immigrants came from Chinese, Filipino, Indian, Vietnamese, Korean, and Japanese backgrounds (Malik, 2015). The Asian population growth rate is three times that of the American population generally. During this same time, in New York City, the rate of HIV diagnosis among the Asian American population increased by nearly 70%, making it the only racial group to experience a statistically significant percentage increase (2018).

The Asian American identity varies greatly depending on the country of origin and degree of assimilation, with a spectrum running from those who strongly adhere to their cultural heritage to those who have fully embraced American culture and society (Lee, Chen, Jung, Baezconde-Garbanati, & Juon, 2014). Some of the difficulties to consider when working with this population include cultural factors and the limited research on successful disease prevention and interventions (Shi Shiu et al., 2015). Therefore, it is important to note the diversity that exists within this population (Miller et al., 2013).

HIV/AIDS is a disease associated with a large amount of stigma and other taboo subjects among Asian Americans (Sen, Nguyen, Kim, & Aguilar, 2017). The taboo nature of homosexuality, substance use, and promiscuity, particularly within Asian society, prevent Asians from having a better understanding of HIV/AIDS (Yu, Chan, & Zhang, 2016).

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Particularly, HIV-infected individuals, including men who have sex with men (MSM), suffer from shame and self-stigmatization (W. T. Chen & Barbour, 2017). Many of them struggle with disclosing their sexual preferences and HIV status to their family members, and these men tend to experience higher levels of depression (Qiao et al., 2015). In addition, Asian MSM may experience pressure to marry, since it is a strong expectation in Asian society that men will marry and produce children to carry on the family line (Li et al., 2017). For HIV-infected Asian men who are single or are married but childless, the family can thus become an additional source of stress (Wang et al., 2016).

Many HIV-infected individuals might therefore look to religion as a source of serenity and emotional support (Oji et al., 2017). This provides religious institutions and faith communities with a unique opportunity to support these men in a culturally relevant manner (Chin & Neilands, 2016). Religiosity is “the degree to which individuals adhere to the prescribed beliefs and practices of an organized religion” (Mattis, 2002, page 310). Spirituality generally relates to deriving purpose from life and is characterized by feelings of hope and self-transcendence (McCormick, Holder, Wetsel, & Cawthon, 2001).

For the immigrant population, religious organizations provide more than spiritual and moral support. These organizations not only enhance the resilience of their members during the processes of acculturation but also offer their members a place where they can exchange opinions and be educated on topics ranging from health promotion to politics (Leung, Chin, & Petrescu-Prahova, 2016). Therefore, religious organizations can be counted one of the important parts of the acculturation process. In addition, they provide basic survival skills for immigrants, including social supports and humanitarian services (Leung et al., 2016).

A study found that roughly 74% of Asian Americans, many of whom immigrated from East and Southeast Asia, reported having a religious affiliation (Liu, 2012). The religious landscape here is diverse, with a majority of this population espousing Christianity or Buddhism (Tomkins et al., 2015). Religion, particularly Christianity, is traditionally associated beliefs and doctrines that are antagonistic toward groups at high risk for HIV/AIDS, including homosexuals and those who are sexually promiscuous (Jenkins, 1995). A study on views of God and disease progression demonstrated a predictive relationship in which those patients with positive views of God (where God is seen as a benevolent and forgiving entity) demonstrated slower disease progression. Conversely, negative views of God (where God is judgmental and punishing) predicted faster disease progression (Ironson et al., 2011).

Culture among Southeast Asian Americans is heavily influenced by Buddhism, especially for immigrants coming from Cambodia, Laos, Myanmar, and Thailand. Buddhism, as an encompassing ideology and civic religion, has provided a unified symbolic system for Southeast Asians to interpret and organize their day-to-day lives (Schober, 2011). For Southeast Asian Americans, nearly all domains of social life have been shaped by the Buddhist worldview(de la Perriere B., 2017). With Buddhism, the principal beliefs are focused on karma and reincarnation, and both may factor into self-management and self-efficacy (Klunklin & Greenwood, 2005). Belief in reincarnation and karma have enabled Buddhists living with HIV to accept the illness and live more positively in hopes of

improving the circumstances of their next lives (Pan, Tang, Cao, Ross, & Tucker, 2017). In addition, meditation can decrease the internal stress and enhance the immune system (Ross, Sawatphanit, & Suwansujarid, 2007).

However, of immigrants from China, a country that in recent decades has experienced dramatic swings in attitude regarding religion and social policy ("Religion ban for China Communist Party ex-officials," 2016), many are atheists. This is partly due to the Cultural Revolution (1966–1976) which led to some of the most dramatic changes to have occurred in modern Chinese society and which redefined the relationship between the individual and the state, family, workforce, society, and religion (Worth et al., 2017). This broad-based social movement, led by students, challenged all forms of religion that did not conform to a radical version of Maoism. This in turn undermined both traditional Chinese folk religion and Western religions throughout the country (Kohrt & Hruschka, 2010).

As the effects of the Cultural Revolution have diminished, the post-Maoist regime has been faced with the challenge of maintaining political control while presenting an image of tolerance to the world. Religion, however, is still often a subject of contention (Zuo, 1991). Official Communist Party policy on religion recognizes five religions that are entitled to some form of government recognition or protection: Daoism, Islam, Buddhism, Catholicism, and Protestantism (Zuo, 1991). Folk religions and other forms of what the Party views as superstition are excluded from state protection under the policy (Y. Chen & Williams, 2016). Despite official recognition of a handful of religions, the main focus of the Party has been to promote atheism through the educational system and also to prohibit Party members from holding religious beliefs, or at least acting on those beliefs (Kohrt & Hruschka, 2010).

In this paper, we present the personal experiences of Asian Americans living with HIV/AIDS and their experiences with faith and religion throughout the course of their disease in order to understand this unexplored area of research. This study focuses on the participants' reported experiences to reveal and explain the variety of roles religion can play in the progression of a highly stigmatized chronic disease. In addition, the study will explore participants' views of family relationships. Narrative samples and summarized responses will be used to highlight themes that emerged from the participants' anecdotes.

METHODS

Design

We recruited 30 Asian Americans with HIV in San Francisco (n=16) and New York City (n=14). One participant declined to be audio-taped so detailed notes were typed during the interview. The remaining interviews were audio-recorded. Study participants could choose their preferred language (English and/or Mandarin) for the in-depth interview. Study consent was secured before the interview started. After completion of the interview, every study participant was given a small reimbursement for their time and effort. The inclusion criteria were (a) self-identified as Asian, (b) confirmed HIV-infected, (c) willing to share their personal stories, and (d) at least 18 years old. Content analysis was used to analyze the in-depth interviews.

Interviewers used an interview guide to prompt participants as they talked about the immigration process, their religious practices (both before and after the HIV diagnosis), and the role of religion in their lives. Specific questions included the following: “Tell me when and how you decided to come to the United States.”, “Do you belong to any religion? If yes, what is it?”, “How do you practice your religion?”, “How important is religion in your life? Has that changed since you received your diagnosis?”, and “What has your relationship with your family been like, before and after the diagnosis of HIV?” The interviewer also asked each participant to describe one specific experience that happened to them while they were practicing their religion. Experiences might include, for example, a feeling of being able to communicate directly with God or a powerful feeling of well-being. Generally, study participants led the discussion, with the interviewers prompting them as needed.

Settings and Participants

This research was conducted at three different institutions, including (a) the Asian & Pacific Islander Wellness Center (A&PI Wellness Center) in the San Francisco Bay area, (b) the Chinese-American Planning Council, Inc. (CPC), and (c) the Asian/Pacific Islander Coalition on HIV/AIDS Community Health Center (APICHA Community Health Center) in New York City. The A&PI Wellness Center is a pioneer in providing HIV-related service to Asian communities in North America and is located in downtown San Francisco. CPC comprises several units, including HIV/AIDS services, and provides case management for HIV-infected Asians in the tri-state area (New York, New Jersey and Connecticut). The APICHA Community Health Center is located in the heart of Chinatown, New York City and is one of the largest facilities providing HIV and sexually transmitted disease treatment and education for Asians.

The larger part of the study was involved with antiretroviral therapy (ART) adherence, mental health and acculturation, and other factors that potentially influence the life experiences of persons with HIV/AIDS(W. T. Chen et al., 2015). For this paper, we focus on how faith and religion influence the outcomes of HIV-infected Asian Americans in the United States and their family relationships.

Ethical Considerations

This study was approved by the involved institutional ethical review boards. Research staff discussed the study objectives and the potential benefit and risk of this study before data collection, according to the applicable informed consent regulations. Study participants who met the inclusion criteria and decided to join the study provided signed informed consent. All 30 in-depth interview study participants signed consent forms.

Data Collection

Potential study participants who were interested in this study were referred from collaborating institutions. Upon contacting potential participants, researchers introduced the project, discussed the risks and benefits of the study, answered questions, and collected the signed consent forms. Then, the semi-structured in-depth interviews were carried out in Mandarin or English. The interviews were audio-taped and transcribed to Chinese or English for data analysis. Bilingual researchers, fluent in both Mandarin and English, conducted the

interviews at locations selected by the study participants. Each interview lasted from 60–90 minutes.

Data Analysis

Atlas.ti 7 qualitative analysis software was used to code the data and do qualitative content analysis (Hsieh & Shannon, 2005). First, the authors generated reports summarizing the range of responses after coding the data into broad topic categories focusing on faith and religion. Second, the transcripts were examined separately, and we identified codes from the code list to correspond to themes that emerged in the narratives. Third, the authors discussed the coding to resolve any discrepancies in the meaning and assignment of codes as well as general patterns observed in the data. Last, quotations related to faith and religion were chosen and translated to English for publication.

RESULTS

More HIV-infected men than women participated in this study (26 male and 4 female). Participants came from China (n=10), the Philippines (n=6), Japan (n=2), Vietnam (n=4), Malaysia (n=2), Burma (n=1), Cambodia (n=1), Taiwan (n=1), Laos (n=1), Indonesia (n=1), and Hawaii (n=1).

Three distinctive groups emerged from the narratives of the participants and their treatment of religion. These groups were (a) those who did not adhere to any organized religion, (b) those of tenuous religious faith with conflicted feelings, and (c) those of strong religious faith with congruent beliefs. Within these three groups, various themes were synthesized from the members' perceptions and past experiences with religion. Within each group, participants displayed various stages of reconciliation with their current faith-related beliefs. Each participant's story serves to remind us of the vast range of human understanding and faith experiences.

Those without an organized religion

Five study participants shared about not having any organized religious beliefs. Within those interviews, the main theme identified was relinquishing one's fate to a greater power. For example, one of the participants, a 54-year-old Chinese man, found comfort in believing that his fate was predetermined by an unknown power. He gave examples of people who appeared to be doing very well in life and who had financial, physical, and social advantages. However, his observation on his own and others' experiences demonstrated to him that death does not discriminate with regard to a person's social position:

> I have a cousin who arrived [in America] by a fake marriage. We are the same age, but he died at 45 years old, yet [I] am still alive at 54, while he has been dead for 9 years. He had colon inflammation, colon cancer, and died. To put it another way, life is predetermined by fate. I have had this disease for 10-plus years, and I am still alive. He suddenly got this colon cancer and was dead within a few months. [We] cannot say for certain that we will quickly die from this disease. We cannot calculate how long we will live with this disease. Currently, I believe in life and that fate will determine how long you will live. You cannot resist.

This 54-year-old Chinese American man was able to identify a method of meaning making congruent with his beliefs. He actually found comfort in his lack of control over his fate. Therefore, he decided to focus on maintaining his relationships with his family members, instead of practicing religion.

The interview with the other subject in this group, a 50-year-old Chinese American man, illustrated a unique perspective on the Asian American immigrant experience and its impact on religion. He felt that religious belief is determined by upbringing and geographical location. He stated that growing up in China brought him to believe in a combination of traditional Chinese religious beliefs, including Buddhism, ancestor worship, and worship of local village gods. However, since he had come to America, he had stopped religious activities associated with these beliefs. He believed that in America, people are Christian because of their cultural and familial upbringing. He asserted that social and cultural environment ultimately determine one's religious belief. He did not find comfort for his current circumstance in religious belief but rather in a sense of powerlessness over what is to come:

> America is very helpful in HIV-related assistance, with living expenses, with healthcare. These are the greatest areas of help. If not for these, you would have no way of surviving. Without the assurance of survival, you cannot even consider other things. […] Let's just live day by day; whenever [I] leave will be whenever [I] leave. Go with the flow, whatever will be, will be. There's no other way.

This participant said he copes by knowing that he has his basic needs fulfilled through the U.S. medical system's support programs for patients with HIV. However, there was a hint of despair in his voice whenever he discussed the reality of his situation. Both men had grown up in China during the Mao regime, a time in which the government discouraged religious worship. This is reflected in their belief that counting on oneself is the best strategy when living with HIV.

Those of tenuous religious faith

Half of the participants (n=15) expressed their struggle to understand the congruence between their current life circumstances and their faith. These participants expressed faith in God, allowing their understanding of Him to guide their beliefs. A common theme displayed in these interviews is finding comfort in God, despite the participants' conflicted feelings about their current circumstances. Many of them were Buddhist when they were in their hometown but converted to Christianity after they came to the U.S. One 35-year-old Cambodian man shared that he had deep faith in Buddhism and went to pagoda weekly with his family members when he was still at home. But due to his initial HIV diagnosis in New York City, he was sent to a local shelter. He said, "I was required to go to the chapel inside the shelter every Monday morning at 7 AM, and every afternoon at 5 PM, we were required to pray again in the chapel. For those one and half years while I was in the shelter, I worshipped every day." After he left the shelter, he no longer practiced his religion, but he admitted that he is willing to go back to Christianity if he can find some good company. In this case, religion played an important part of his life, but he acknowledged that he did not get any special blessing from the gods in either of the religions he had practiced.

Some Buddhist participants had converted to Christianity in order to have better access to a community of believers. Buddhist temples are often located in remote areas (e.g., on mountains or in rural settings) which makes them hard to get to compared to Christian churches, which are usually located on street corners in the metropolitan area. Participants who converted for this reason did not do so because their beliefs had changed but because they wanted access to a religious support network that was not only closer but wider. As one 62-year-old Chinese man mentioned, “I go to church regularly as my friends and I use it as part of the senior center activities. I need the support from the other church attendees. They always tell us where the health fairs are that we can participate in and where the good doctors are located in this area if we need one

One of the participants in this group, a 40-year-old Chinese man, reported having a strong religious belief before learning of his HIV-positive serostatus. However, many factors affected his faith after his diagnosis, including an unsupportive community at church, lack of a fervent desire to pray and acknowledge God in his daily life, and hesitation to genuinely express himself in a church community. He described his time in China as one of spiritual fulfillment. He also felt a sense of belonging at his church, which provided a supportive community. He characterized himself as having once been extremely passionate about God and fully immersed in his church community.

He was diagnosed with HIV shortly after arriving in the U.S. One of his greatest regrets was having gone against his religious beliefs by engaging in unspecified extramarital sexual activity that resulted in his positive HIV status. He described a feeling of having a knot forming in him for 2 to 3 years after the risky behavior. (This “knot” is a Chinese metaphor representing an irreconcilable problem weighing on one’s mind.) He struggled to immerse himself in the American church, citing the language barrier and awkward social interactions due to lack of adherence to expected life-stage milestones as obstacles. He felt that not being married and not working had made him a target of gossip by other members in the Chinese community and in American society. Despite his reflections on his American church experience, he said he continues to find peace engaging in religious activities, such as attending services, reading the Bible, and singing worship music.

In contrast to this man, a 53-year-old Vietnamese American woman saw her life, particularly her HIV-positive status and her children’s developmental delays, as an ongoing test by God for a purpose that she did not understand. She believed that God was providing for her despite her struggles by helping her to get treatment in the U.S., to meet her husband, and to have children. She believed that God has good intentions for her life. As she said:

> I believe God forgives me. Of course, I get it that maybe [I got infected with HIV] because He was testing me. I must trust Him, and I think, actually, that at least I will get help from many people, like doctors. I think if I had gotten [HIV] in Vietnam, like by accident, if I had gotten it there, I don’t know how I would be able to live.

However, despite this feeling of gratitude, she reported going to church specifically to complain to God, and said she felt sad and had a deep dissatisfaction with her life. She

discovered her positive HIV status when she had her first child and later gave birth to twins from an unplanned pregnancy while on her HIV medications.

> Yes, I said that. I complain when I go to church. I complain repeatedly: Why is God giving me a hard time? With the first child I had a hard enough time, and now God is giving me more. But I cannot ignore that, you know, and, like, kill myself. I don't want to kill myself, because I think if God gave me this, maybe it means He wants this. I want to run away. Other people, they have good lives, I complain. I thought, when I left Vietnam, that I wanted to come here [to the U.S.] to change my life, but when I came here my life was not better; it actually got more terrible, you know. I complain by myself, and at those moments, I am very sad, and depressed.

Despite the spiritual assurance she derived from believing in God's purposeful work in her life, she displayed great levels of distress that were not relieved by her religious beliefs. Both participants described above were in the process of learning to cope with their disappointments in life and perceived their understanding of God as a source of relief and comfort.

Others viewed religion and family as being one of the major burdens in their lives. One 52-year-old transgender Vietnamese woman said this:

> I came to America at the age of 11. I was born [anatomically] as a boy; my family and my church all told me that I should act like a boy. But deep in my mind, I wanted to be a girl, and I was so uncomfortable staying in this family and going with them to church.

Because of the constrictive culture and judgmental family atmosphere, she ran away and became an IV drug user for a time, until she was diagnosed with HIV. She mentioned that "our family church does not like transgendered people, and also, of course, HIV-infected persons. I made my family lose face.

Those of strong religious faith

Some participants displayed strong religious faith and achieved a great sense of fulfillment from their understanding of the Christian God. Themes from these interviews include finding fulfillment of spiritual and physical needs through prayer and communication with God and having a stable, supportive spiritual community.

A 55-year-old Malaysian woman described the route of transmission as possibly an unclean needle used during a dental procedure at an unlicensed clinic. Believing in Christianity had motivated her and her longtime boyfriend to get married, she said, despite her seropositive status. She shared this:

> We would attend Bible studies every week. The Bible says [we] should be husband and wife. He was divorced and so was I. He had two daughters and one son, and they were all grown. He has always been good to me. After believing in Jesus Christ and being baptized for 2-plus years, he said we should get married. We got married in America. He is very good to me.

This participant demonstrated her strong commitment to a religious community through regular attendance at church activities and through aligning her life to be congruent with the beliefs of her faith community. Through these events, she was able to find space for herself and her current husband to grow deeper in their relationship, despite her HIV-positive status. In addition, their joint religious practice was making their relationship closer.

One HIV-infected woman placed great trust in God and prayed about her circumstances, including her sons' undocumented statuses in the U.S., her disease condition, and her daily activities. She stated:

> That's why I pray often, telling Christ that my children are in Malaysia. The quality [of life] there isn't great. There is also no one to care for them. I kept praying and praying, telling God: "You must bring my two children over here." I really heard a voice saying, "Give these [burdens] to God." I was at home, kneeling to pray, when I heard this small voice saying, "Give these [burdens] to God." [There was an opportunity] to apply for a visitor's [visa] in Malaysia. One hundred people went, not a lot [of people] were granted the visitor's [visa]. My two children were both able to come over [to America].

She praised God for helping her through these difficult circumstances and was able to confirm that God was present in her life as a provider of good things. Her faith in God was a source of comfort for some of the greatest uncertainties in her life, such as the fate of her children.

A Chinese man in his forties recounted that he converted to Christianity shortly after discovering his HIV-positive status. Before his illness, he had thought about God, but it wasn't until his diagnosis, when he experienced much pain and anguish, that he started praying earnestly. He said:

> That day, [I] started praying about whatever came to mind. I asked: "God, can't you save this imperfect sinner?" Then suddenly, an image from a Christian magazine appeared in my head. It was an advertisement for a Chinese-American agency in New York relating to the [HIV/AIDS] service. I quickly found this agency. They unceasingly comforted and enlightened me, saying that America currently has many great treatments and that I just needed to take my medications on time and my body's immune system would slowly heal and that I could live like a normal person.

By going to the HIV/AIDS health agency, he was later able to receive the care he needed, both physical and spiritual, thus solidifying his faith in God. He felt that he had been given many blessings from God: forgiveness from his wife, a stable career, a child, and the ability to continue living with his family without fear of transmitting his infection to them. He believed that God still blessed him with much, despite his unfortunate circumstances. Therefore, he was seeking to help those who had also met with misfortune. He believed that God had a reason for him to continue living even after he had been diagnosed with HIV, which was a great source of motivation for him.

In these participants' experiences, God was the ultimate source of comfort and reassurance, which manifested in the form of a supportive church community or local health agency. These participants were able to successfully reconcile their unfortunate circumstances with their religious beliefs by recognizing that their gains in life outweighed the misfortunes and made the family closer.

In this study, we were not surprised to find that many of the study participants attended religious gatherings in the U.S. to enhance their acculturation process but did not follow through and practice the beliefs. As the dialogue on HIV continues in Asian American communities, the opportunities it creates for researchers to shape the conversation is important. Healthcare providers should obtain a basic understanding of the different faith-based practices and should compare them among various religions, because their influence on healthcare is crucial for clinical practice, future intervention design, and overall policy implementation (Tomkins et al., 2015).

DISCUSSION

This paper highlights the need to understand intricacies of patients' spirituality and religiosity in order to provide the best care for those with chronic disease and to incorporate that with their view of family relationships. These findings are an example of how positive HIV status, immigrant status, family relationships, Asian American identity, and religious support or disapproval play varying and complex roles in the lives of these individuals.

Addressing the mental health aspect of this disease becomes a top priority due to the roles that stigma, social and religious commentary, self-stigma, and guilt (or self-blame) for acquiring the disease play in the lives of those affected. In addition, recent studies have shown that the frequency of prayer, meditation, or chanting and the level of acculturation are predictors for young Chinese immigrants to promote HIV prevention skills (Chin & Neilands, 2016). Similar to our study, it identified several factors that religious institutions could consider for adapting any HIV prevention education in their mission. These factors include attendees' support of their institution's involvement in HIV education, their experiences of HIV care, and stigma reduction initiatives (Kang, Delzell, Chin, Behar, & Li, 2013).

Some participants' experience illustrates how their perception of religion is simultaneously affected by their HIV status, past interactions in religious settings, and personal faith. As we saw with participant statements above, there is often an internal struggle that arises from the knowledge that one has acted against one's beliefs and must then bear the consequences of that, in the form of an infection with HIV. Some study participants said that they go to church to "blame" God for not treating them better. Meanwhile, many churches have moved to a different position on HIV, going from openly stigmatizing those with the disease to slowly accepting the situation and even acting on HIV prevention for their community (Chin & Neilands, 2016). On the other hand, some participants who were firm believers in Christianity felt that their church was an inclusive one and that no matter what their HIV status, they would always have a place in the church. For the most part the HIV-positive Asians in this study felt that religion could bring peace to their mind. Despite this, the

reactions many participants got from church members after they disclosed their serostatus hurt them. They felt that they had lost their place in the church community and were targets of unwelcome discrimination. However, it was clear that feelings of not being blessed by the God that they believed in were mainly related to the social aspects of Christianity rather than the religion itself.

The wide range of spiritual experiences reported sheds insight on how healthcare providers and other supportive care providers can orient their efforts toward providing the necessary spiritual comfort to patients. Studies have shown that contacting religious leaders was can significantly decrease depressive symptoms and substance use for HIV+ populations (Oji et al., 2017). Similar to our results, study participants who have a religious faith are more accepting of the illness and willing to access HIV service agencies. The themes identified in this paper can serve as checkpoints to determine where the patient may be in the process of reconciling themselves to the fact of having a lifelong, incurable disease. Although each HIV-infected individual will face their unique set of obstacles in coping with HIV, these illustrations speak to common threads of concern prevalent in the Asian understanding of the disease and in the context of religion and the family relationship. By offering an intimate window of cultural understanding, these recounts can help care professionals bring greater cultural relevance to their practice when working with the Asian patient population (Henrickson, Brown, Fouche, Poindexter, & Scott, 2013). Furthermore, the study participants' experiences can guide faith communities in their treatment of this patient population by highlighting the churches' strengths and pitfalls (Chin, Li, Kang, Behar, & Chen, 2011). The strengths include peer support and mental sustenance, which can bring peace of mind for HIV-infected individuals. The pitfalls include the potential loss of privacy and unwanted attention from other church members if a member's serostatus is shared without permission.

Study participants' stories illustrate the importance of good dynamics in the social interaction among church/temple members and HIV-affected families (Tomkins et al., 2015). The recounts of the 40-year-old Chinese man and the 45-year-old Malaysian woman are examples of how a church can provide (or fail to provide) the kind of social interaction conducive to the mental healing of patients who identify with Christianity. The case of the 40-year-old man illustrates the need for religious communities to provide positive supports mentally and physically for the discomforts caused by the disease. He also needed help to navigate the mainstream culture on how to access care and resources in order to get his life back to normal. These can be provided by local religious institutions.

This paper reported similar results to research conducted on the immigrant population comprising other ethnicities who came to the U.S. with little or no awareness of the healthcare system in America and how they face the new healthcare system in the host country (Florez et al., 2015; Leung et al., 2016; Sanchez, Dillon, Concha, & De La Rosa, 2015). Many of this study's participants attended religious gatherings in the U.S. to enhance their acculturation process. Those who had largely acculturated to mainstream American society preferred to attend English-speaking churches, in contrast to those who were less acculturated and preferred to attend Asian-language churches, for example, Indonesian churches and/or Chinese temples. By enhancing the level of social support they get from

religious institutions, PLWHA can enhance their self-management, which will lead to better antiretroviral therapy adherence, decreased mental stress and an improved quality of life (Oji et al., 2017). However, disclosure is still a potential threat. As one participant stated, the risk of possible HIV disclosure in the Asian-language religious community is greater than it is in mainstream (English-speaking) churches.

Limitations

In this paper, there were several limitations. First, the sample size was small. As we know, HIV-infected Asians are one of the hardest to reach populations. Since the prevalence rate is low and stigma is high, many HIV-infected Asians refuse to participate in studies. Therefore, this paper serves as one of the pioneer studies on how religion can assist in HIV self-management. Second, in this study, many participants were ethnic Chinese; therefore, their experiences in religious practice should not be generalized to all Asians, because, for example, people who came from Southeast Asia (e.g., Myanmar, Thailand, or Vietnam) present with stronger religious beliefs, especially among Buddhists, compared to people who came from China where religion is not encouraged. Third, because the recruitment sites were clinics that serve primarily immigrants, many of the study participants were less acculturated. This is especially true for the New York City sites, where study participants were all first-generation immigrants and many of them did not speak fluent English. Different generations of HIV-infected Asian Americans face the disease differently. Those who are better educated, more acculturated, and better able to navigate the healthcare system by themselves will have a very different experience than those who require the services of agencies. Fourth, in this study, no study participant shares their Buddhism view of the disease as many of them had not disclosed their serostatus yet with their religious peers, therefore, the views of the Buddhist are missing. Last, there are several major religions in the Southeast and Northeast Asian populations, including Hinduism, Islam, Daoism, and Shintoism. Even religions that many people tend to think of as unitary, Buddhism for example, can vary widely between one country (Japan) and another (Thailand). We did not intend to explore the differences among these religious; we sought only to understand how the various religious practices influence HIV-infected Asian Americans.

CONCLUSION

Spiritual and religious beliefs can play an important role in HIV-infected individuals' understanding of their disease and can influence their interactions with their communities. Religion comprises a powerful yet perplexing source of motivation in disease self-management. It is therefore important for personnel involved with caring for these individuals to be aware of the common obstacles these patients may face in reconciling their disease with their faith and religious practice. Further research should explore the possibilities for clinicians to cooperate with religious institutions to improve the quality of life for their patients with HIV.

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Highlights

- Providers should understand spirituality to provide a better care for PLWHA.
- For HIV-infected individuals, addressing the mental health becomes a top priority.
- This paper share on how PLWLHA reconcile themselves to a lifelong disease.