Religion and HIV/AIDS Stigma: Considerations for the Nursing Profession

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Nurses' stigmatization of people living with HIV/AIDS hinders effective health care provisions for this sector of the population. Scientific literature on HIV/AIDS stigma has emphasized cognitive, individual, and interpersonal factors that are relevant to the understanding of the stigmatization process among health care professionals (e.g. a health care professional's accuracy in knowledge of the workings of the virus, effectiveness of emotion management, degree of proximity to the stigmatized group, etc.). However, researchers have also examined the socio-structural factors underlying stigma, and religion has consequently emerged as a social phenomenon that may foster it. The role of religion among professional nurses who specifically service people living with HIV/AIDS remains understudied. Focusing on evidence-based literature, we discuss the relationship between religion and HIV/AIDS stigma, explore potential implications of this relationship for the nursing profession, and make recommendations for stigma-reducing interventions.

Keywords: religion, HIV/AIDS, stigma, nursing

Research addressing the role of religious beliefs in interventions of nurses within clinical scenarios has increased in the past decade (Flannelly, Flannelly, & Weaver, 2002; Fowler, 2009; Reimer-Kirkham, 2009). Scientific literature has evidenced the positive implications of religious beliefs among nurses in professional interventions, such as the enhancement of abilities to provide spiritual care for patients who need it and to foster healthy behaviors in patients (Taylor, 2003; Williamson & Kautz, 2009). Nevertheless,

recent scientific literature has also documented the necessity for health professionals to be able to tend to potentially negative outcomes of religious beliefs among people living with HIV/AIDS (PLWHA), such as adverse coping skills and internal struggles resulting from strict religious mandates (Pargament, Murray-Swank, Magyar, & Ano, 2005). In spite of this research, however, little is known about the potential implications of religious beliefs among nurses who provide direct health services to PLWHA.

Researchers have used the traditional definition of stigma as "an attribute that is deeply discrediting" (Goffman, 1963, p. 3). Since this conceptualization of stigma was introduced, investigators have highlighted that stigma functions as an interrelation between individual and social phenomena, resulting in both felt and social manifestations (Jiménez et al., 2010; Rintamaki, Davis, Bennett, Skripkauskas, & Wolf, 2006). Researchers have identified religious beliefs (e.g. beliefs of Catholic, Lutheran and Pentecostal churches) as factors that underlie the process of stigmatization toward PLWHA (Parker & Birdsall, 2005; Zou et al., 2009). Consequently, strongly held religious beliefs have the potential to interfere in the provision of quality health services to this population.

Although little is known about how personal religious beliefs influence nurses' stigmatizing attitudes toward PLWHA, research on sample populations of healthcare providers has identified adherence to religion as a pivotal component underlying this process of stigmatization (Andrewin & Chien, 2008; Varas-Díaz, Neilands, Rivera Malavé, & Betancourt, 2010). Potential outcomes linked with this process include negative nurse-patient relationships, denial of services, and conceptualizations of patients' illnesses as consequences of individual behaviors that violate moral codes in the context of Christian beliefs (Chitando & Gunda, 2007; Taylor & Carr, 2009). These scenarios represent potential implications on the delivery of healthcare services that researchers and health professionals must address. In this article we discuss evidence-based literature in order to address how religious beliefs may foster HIV/AIDS stigma manifestations among nursing professionals. We also provide recommendations for future research and stigma-reducing interventions.

HIV/AIDS and Nursing Care

HIV/AIDS continues to be a global epidemic of an alarming magnitude. UNAIDS (2012) reported that more than thirty million people live with HIV worldwide. In the United States alone, more than forty thousand people were diagnosed with HIV in 2010 (Center for Disease Control and Prevention, 2012). Nurses are at the forefront of service delivery to PLWHA, especially in the areas of prevention, care, and treatment (Relf et al., 2011). In 2007, the National HIV Nurses Association (NHIVNA) identified the personal intervention of nurses as playing a crucial role in the assessment of patients' conditions and the development of care plans related to their physical, social, psychological, and spiritual needs. High-quality interventions potentially improve the adherence of PLWHA to HIV/AIDS treatment (e.g. taking pills on time; Venkatesh et al., 2010). Adherence to treatment can have a significantly positive impact on the well-being of PLWHA, such as improving social support and decreasing depressive symptoms (Wang et al., 2010).

Nurses represent a large number of health professionals in constant interaction with doctors, family, and friends of PLWHA. This makes them an important group that can potentially advocate for the well-being of PLWHA (Vance & Denham, 2008). Nevertheless, stigma toward PLWHA among health professionals represents one of the central barriers to effective prevention and health care (Armstrong, 2003). Nurses are often called to address HIV/AIDS-related stigma (or HIV/AIDS stigma) in the general community as well as in health scenarios (NHIVNA, 2007; Holzemer & Uys, 2004). Therefore, it is crucial to examine how stigma constitutes an obstacle to nurses' effective service delivery and develop a clear understanding of which individual and social factors may foster stigmatizing attitudes in this context.

HIV/AIDS Stigma and Its Relationship with Religion

Since the beginning of the epidemic, HIV has been associated with religious beliefs such as moral failings and sinful behaviors. For example, during the first years of the epidemic in the 1980's, HIV infection received plenty of media attention that linked it to members of "risk groups" (e,g. homosexual men) and labeled the disease as the "gay plague" (Herek, 2014, p. 122; Malcolm et al., 1998). This historical context cemented stigmatizing notions about HIV, sexuality, and drug use which fostered the creation of laws and policies in terms that criminalized the disease. A public health crisis with profoundly detrimental consequences was prompted in large part by the persistent stigmatization of HIV/AIDS. Years later, the need to understand HIV/AIDS stigma finally became evident and gained urgency among researchers, public health officials, and health policymakers.

Recent years have witnessed an increase in the number of identified social components of stigma (e.g. cultural beliefs about homosexuality and drug use) as well as the definition of stigma as a phenomenon inseparable from the socio-historical context of HIV (Malcolm et al., 1998; Scambler, 2006, 2009). This has allowed for a deeper understanding of religious beliefs and their relationship with HIV/AIDS stigma.

Before giving an explanation of the relationship between HIV/AIDS and stigma, we must understand that the manifestation of stigma represents a hierarchical power relationship (Parker & Aggleton, 2003). Unbalanced power relationships cause

some groups to be socially devalued, producing social stigma and inequality. Parker and Aggleton's (2003) analysis of processes of social differentiation and devaluation proposed that religion represents a powerful socio-cultural phenomenon able to promote a hierarchy of values that fosters stigmatization by signaling social distinctions among individuals. For instance, many religious codes classify behaviors associated with HIV/AIDS, such as homosexuality and drug use, as being immoral, thus contributing to socially shared negative perceptions of PLWHA (Chitando & Gunda, 2007; Zou et al., 2009).

Using a conceptual framework that emphasizes the individual cognitive process in manifestations of stigma, Link and Phelan (2001) noted that stigma is present when the following components converge within a context of power: labeling, stereotyping, separation, loss of status, and discrimination. In this way, the individual is first labeled with a characteristic considered out of the norm, such as being diagnosed with HIV. Society often stereotypes PLWHA as drug users, homosexuals, promiscuous persons, or sex workers (Thi et al., 2008). During the process of stigmatization, the individual who suffers a negative stereotype is severed from the norm. In other words, a separation takes place between the so-called normal individual and the stigmatized one. As this separation occurs, the individual loses social status and suffers discrimination. As the loss-of-status component unfolds, "the person is connected to undesirable characteristics that reduce his or her status in the eyes of the stigmatizer" (Link & Phelan, 2001, p. 371). Finally, the individual who has lost his or her social status is discriminated against, and this discrimination may in turn materialize as a rejection of health services or limitation of treatment (Pickles, King, & Belan, 2009). For example, treatment can be provided with lack of empathy or even be completely denied.

Link and Phelan's (2001) framework highlighted how socio-cultural aspects are integral to stigmatization even while research continues to focus on individual cognitive processes. Therefore, conceptual frameworks used in the study of stigma, whether focused on social or cognitive processes, identify socio-structural phenomena as integral to the understanding of stigmatization, which enables a better understanding of religion as a socio-structural phenomenon that can foster HIV/AIDS stigma.

Religious beliefs may perpetuate a negative perception of PLWHA (Varas-Díaz et al., 2010). For instance, people who base their beliefs on rigid religious norms may associate HIV transmission with immorality and sinful behavior (e.g., sexual immorality, promiscuity, and drug use; Chitando & Gunda, 2007; Parker & Birdsall, 2005). Research with Catholic, Lutheran and Pentecostal churches highlighted how people still interpret HIV/AIDS as a punishment from God attaching PLWHA with immoral behaviors (Zou et al., 2009). UNAIDS (2010) identified the need for promoting strategies to reduce HIV/AIDS stigma among religious communities, echoing the concern of researchers. Nevertheless, these same religious beliefs may foster a desire to help among members of the community and health professionals (Lindley, Coleman, Gaddist, & White, 2010; Taylor & Carr, 2009; Williamson & Kautz, 2009). This apparent contradiction only serves to draw attention to the complex nature of religious belief and the myriad ways in which it can affect or even provoke HIV/AIDS stigma as well as influence any subsequent delivery of service. For example, religious beliefs among professional nurses could define and influence their work as a call to give care to others. However, these beliefs could foster HIV/AIDS stigma manifestations in an attempt to address immorality and sinful behaviors associated to HIV during the service provision.

To explain the role of religion in manifestations of HIV/AIDS stigma, we should consider the following: (1) religious moral reasoning fosters socially negative labels related to PLWHA (e.g., drug use and homosexuality; Chitando & Gunda, 2007); and (2) religious communities may stigmatize PLWHA because of their apparent connection with an alleged practice of immoral behaviors (Zou et al., 2009). Varas-Díaz (2011) previously explained the relation between religion and HIV/AIDS stigma by highlighting the role of the body. He stated that both religious and health organizations, albeit for different reasons, prescribe what is considered appropriate behavior for bodies in society. For example, the Seventh-Day Adventist Church follows conservative beliefs for specific practices related to the body, such as dress code, vegetarian diet, and monogamous-heterosexual unions[1]. Consequently, behaviors

considered moral are also deemed important for keeping oneself healthy.   The resulting linkage between morality and health is often established as part of social responses to disease and can produce a perception of people who violate religious rules through their bodies as deserving of disease. This has been well documented in the case of HIV (Chitando & Gunda, 2007; Zou et al., 2009). In this way, PLWHA have presumably violated the moral fundaments of what they should do with their bodies.

Varas-Díaz (2011) identified four features of religious belief that support the manifestation of stigma: (1) stigma as an unavoidable consequence of breaking moral rules (i.e., the moral failure of PLWHA); (2) different mechanisms used by religious institutions to foster the process of stigmatization (e.g., the use of secular sources, such as health care centers, to lay blame on drug users, homosexuals, and PLWHA); (3) activities that perpetuate the moral view of stigma (e.g., the pervasive use of media, such as newspapers and television, to justify HIV/AIDS stigma); and (4) government support (i.e., the use of state-sponsored mechanisms to foster HIV/AIDS stigma). These features of religious belief help to better understand how religion may perpetuate HIV/AIDS stigma.

HIV/AIDS Stigma Among Nurses

When HIV/AIDS stigma is present among health professionals, the delivery of quality services may encounter significant barriers (Nyblade, Stangl, Weiss, & Ashburn, 2009). Researchers have documented many stigmatizing behaviors among health professionals, including nuanced looks, subtle questions, actions indicating fear, awkward verbal exchanges, and refusal to provide care (Zukoski & Thorburn, 2009). These behaviors greatly impact the mental and/or physical health of PLWHA (Nyblade et al. 2009; Thi et al., 2008).

Researchers have particularly identified stigmatizing behaviors toward PLWHA among professional nurses. Thi et al. (2008), documented stigmatizing behaviors such as verbal abuse and the

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[1]More information can be found on the Seventh-Day Adventist Church web page (http://www.adventist.org/beliefs/#17)

limitation of health care among health professionals finding that HIV/AIDS stigma manifestations were most frequent among professional nurses, and that low-quality health care had led some PLWHA to avoid health care facilities entirely. In a study by Tyer-Viola (2007), which documented the presence of negative attitudes toward HIV-positive pregnant women, the nurse participants showed signs of prejudice and were consequently less willing to care for HIV-infected women. Another study on nurses from Nigeria (Adebajo, Bamgbala, & Oyediran, 2003) found that more than half of the participants felt that PLWHA were responsible for their illness, and 32% of the participants felt that HIV was a punishment from God.

One of the main problems of these stigmatizing behaviors is the barrier that this phenomenon represents to the access of health care by PLWHA. Researchers have documented how HIV/AIDS stigma could reduce an individual's adherence to HIV/AIDS treatment (Rivero-Méndez, Dawson-Rose, & Solís-Báez, 2010), which could in turn result in depression and a reduction in psychosocial well-being (Logie, James, Tharao, & Loutfy, 2013).   Additionally, interfering with the health services of PLWHA is a restriction of those individuals' rights (Varas-Díaz, Neilands, Guilamo-Ramos, & Cintrón-Bou, 2008; Yannessa, Reece, & Basta, 2008).

Religion and Its Potential Implications for PLWHA Nursing Care

Religion in the United States defines important socio-cultural values.   Koenig, McCollough, and Larson (2001) defined religion as "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality)" (p. 18). A survey by The Pew Forum on Religion and Public Life (2008) found that more than half of Americans sampled in the study say religion is very important in their lives, attend religious services regularly and pray daily.

Since religion is very important for many individuals, religion and activities associated with it (e.g., praying with patients) have become an integral part of service provision in some health scenarios (Narayanasamy & Narayanasamy, 2008).   During

the past decades, the relationship between religion and health has been extensively studied (Lee & Newberg, 2005). Researchers have highlighted the positive relationship between religion, psychological well-being, and coping strategies among chronically ill patients (Aranda, 2008; Pargament et al., 2004). However, studies have reported some potentially negative aspects of religion in health care, including abuse of power and internal religious struggles (French & Narayanasamy, 2011; Pargament et al., 2005). Reimer and Kirkham (2009) emphasize the presence and effects of religious beliefs in nurse-patient interventions, tending to highlight positive outcomes for patients in general. Still, there is scarce literature regarding the role of religion in nurses who work with highly stigmatized populations, such as PLWHA.

Andrewin and Chien (2008) found that blame and judgment were the components most often present in nurses' stigmatizing attitudes toward PLWHA. Both of these components were previously identified in this paper as parts of the moral reasoning that some religious individuals may use to stigmatize. These researchers also highlight, in a study where 84% of the participating nurses self-identified as religious, mostly Catholics and Anglican, the nonreligious participant nurses were less stigmatizing.

Varas-Díaz et al. (2010) documented the role of religion in manifestations of HIV/AIDS stigma among health professionals and highlighted the need to consider religious practices and beliefs as important factors in the study of HIV/AIDS stigma. Results demonstrated statistically significant differences between participants who took part in religious events (e.g. attending church) and participants who did not do so. Those who participated in religious events scored higher in the following aspects: (1) interpreting PLWHA as lacking in productivity; (2) believing that personal characteristics such as irresponsibility caused the infection; (3) being fearful of becoming infected in everyday social interaction; and (4) having negative emotions associated with PLWHA (shame, pity, anger, etc.). These last two studies point to the need for professional nurses to understand the role of religion in HIV/AIDS stigma and the ways in which religious beliefs and practices may underlie their conceptualizations of HIV/AIDS and their behaviors toward PLWHA.

Considerations and Recommendations for the Professional Nurse

The manifestations of stigma toward PLWHA continue to represent significant barriers to the provision of quality health care services. Understanding the factors that underlie the process of stigmatization would allow the development of effective stigma-reducing interventions. Moreover, developing stigma-reducing interventions represents an ethical issue for professional nurses. The limitation or denial of health care services by any nurse violates human dignity and makes it impossible for all patients to have health care that is "unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (American Nurses Association, 2001, p. 1). As the code of ethics of professional nurses points out, there may be conflicts of interest between nurses' and patients' values. However, according to the American Nurses Association, "nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient interests and preserve the professional integrity of the nurses" (p. 5).

It is important to understand and address these issues in order to: (1) develop more research studies that explore the role of religion in the manifestations of HIV/AIDS stigma among nurses; (2) explore in-depth descriptions of how practicing nurses interpret the role of religion in their health service delivery practices; (3) foster more institutional research to potentially promote a deeper understanding of the implications of religion in HIV/AIDS-related stigma; and (4) provide new scientific data that might inform stigma-reducing intervention models according to varying levels of lived religiosity (e.g., frequency in attendance to church or religious meetings, amounts of time spent praying or worshiping and degree of participation in religious activities).

In relation to the practice of their profession, nurses have a crucial responsibility to implement HIV/AIDS stigma-reducing strategies in health care centers, given that they are in such a strong position to advocate for the rights of PLWHA. Additionally, nursing schools need to prepare nurses with knowledge regarding the effects of religious beliefs on health care involving PLWHA and to implement interventions addressing HIV/AIDS stigma during the formation of nursing students (e.g. Shah, Heylen, Srinivasan, Perumpil, & Ekstrand, 2014).

Discussion

The influence of religion is an important variable for the physical and emotional health of many patients. Moreover, the use of religious beliefs and practices (e.g., praying) in nurse-patient interventions has been documented as being an important factor in patient well-being. However, health professionals must be aware of the potentially harmful effects of religion on HIV/AIDS stigma when they are directly serving highly stigmatized populations, such as PLWHA. Studies on HIV/AIDS stigma have identified the religious socio-cultural phenomenon as playing an important role in manifestations of stigma. Overlooking the potential impact of religion on the development of HIV/AIDS stigma could have detrimental effects on the well-being of PLWHA, such as low adherence to treatment and poor physical and emotional health. Furthermore, nurses who are not aware of these effects risk behaving in an unethical manner while practicing their profession.

Scientific research on nursing should play a more active role in the analysis of social determinants that can foster HIV/AIDS stigma, such as religion. Although only a handful of studies have explored the role of religion in HIV/AIDS stigma manifestations among nurses, some researchers have begun to document an initial understanding of their relation. There is more work to do if professional nurses are to have an in-depth understanding of the implications of social stigma, and its linkages to their religious beliefs.

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