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ORIGINAL PAPER

Unwelcoming: The Church Experiences of HIV-Infected Adolescents and Emerging Adults

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Abstract

Acceptance among family, friends, and within the community is a critical developmental milestone during adolescence. Having a diagnosis of HIV may hinder or impede one's ability to develop socially. The purpose of our original study was to describe the role spirituality may play in HIV-infected adolescents and emerging adults. We interviewed 21 Christian-identified males using constructivist grounded theory methodology. The theory of the church not embracing HIV-infected youth was generated. The theme "unwelcoming" describes young people's attempts to connect with the church. Embracing adolescents and emerging adults in church may offer support and enhance their ability to cope with HIV.

Keywords Adolescents · Emerging adults · Church · Unwelcoming · Stigmatizing

Religion or spirituality and the church are thought to play an important role in the life of African-Americans. Jeffries, Dodge and Sandfort describe the Black church as being a critical component that sustained Africans from the time of their arrival in the USA (Jeffries et al. 2008). The findings in a classic study (Smith and Denton 2005) suggest spirituality is extremely important to American youth. In the exemplary scholarly writings of Smith and Denton (2005) as well as Arnett (2000), it is estimated that 95% of US teens believe in God and religious/spiritual beliefs remain important during emerging adulthood, even when not actually practiced. In the book, Soul Searching: The Religious and Spiritual Lives of American Teenagers, a

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national survey found the majority of American teens believe in God (95%), deem religion important in their life (85%), attend religious services at least monthly (> 50%), and admit to praying alone frequently (50%) (Smith and Denton 2005). Spirituality may be an indicator of well-being and religious affiliation and practices such as prayer may be common among patients living with HIV (Lorenz et al. 2005). The level of spirituality/religion (practices) in adult patients with HIV has been associated both directly and indirectly with feeling that life was better after a diagnosis of HIV (Szaflarski et al. 2006).

Although religion and spirituality are important to many adolescents and emerging adults, their religious or spiritual beliefs are often not reflective of their childhood religious socialization (Arnett and Jensen 2002). Adolescents and emerging adults may either adhere to spiritual beliefs observed in childhood or adopt new beliefs that are congruent with their developing self-identities and world views (Arnett and Jensen 2002).

The purpose of our study was to describe the role of the church for adolescents and emerging adults living with HIV. Additionally, we wanted to understand whether this relationship may have a negative or positive impact on young people living with HIV as spirituality has been identified as a coping mechanism for adolescents and emerging adults with HIV. It was not the original intent of the study to recruit only spiritual or Christian-identified participants; however, all participants admitted to practicing spirituality or identified as Christian.

Background

While tremendous gains have been made in treating HIV, the disease continues to be problematic in the USA, particularly in minority communities. African-Americans, who represent only 12% of the US population, accounted for approximately 44% of new HIV infections in 2016 and Hispanics who make up 18% of the US population accounted for approximately 24% of new infections (CDC, HIV Basic Statistics Online 2016a). Although the rate of new infections remains steady, African-American and Hispanic men who have sex with men, ages 13–24, accounted for most new infections; 54% and 25%, respectively (CDC, HIV by group 2016). It is estimated that as many as 51% of HIV positive youth age 13–24 are unaware of their status; however, youth accounted for 8451 or 21% of the 39,782 people diagnosed with HIV in 2016 (CDC, HIV by group 2016). HIV had been identified as a "youth-driven disease" with over 40% of new infections in the USA occurring in individuals younger than 25 years of age (Benton and Ifeagwu 2008). While great strives have been made in the treatment and prevention of HIV and the rate of mortality has drastically declined, HIV was among the 10 leading causes of death among several groups of youth in 2002, and in 2008, was identified as the sixth leading cause of death among adolescents (Benton and Ifeagwu 2008; Rangel et al. 2006). HIV is now listed as the 15th cause of mortality in adolescents and emerging adults aged 15–24 years of age (Murphy et al. 2017; Heron 2017).

HIV continues to disproportionately affect minorities, including adolescents and emerging adults. Adolescents and emerging adults account for the fastest growing

population of newly acquired HIV infection, particularly among African-Americans and Hispanics (CDC/HIV among youth 2016b). Over a 6-year reporting period on HIV infections in youth, African-American and Hispanic youth accounted for 75% of new infections from 1999 to 2005 in 33 surveillance areas in the 50 states, the District of Columbia and the US Virgin Islands (Rangel et al. 2006). Despite the advances in medications and treatments, these numbers have not improved over time and education around safe sex and HIV prevention has remained a primary focus. In fact, the CDC (CDC, HIV among Youth 2016b) suggest that over 8000 received a new diagnosis with 81% of new HIV cases in youth in African-American and Hispanic gay and bisexual males aged 13–24 and further suggest young men who have sex with men (MSM) have become the new face of HIV. In an effort to understand what perpetuated the spread of HIV in youth, poverty, access to care, stigma, racism, and lack of age appropriate facilities to treat adolescents and emerging adults who HIV positive are among the many challenges and disparities identified for these young individuals (Magnus et al. 2010). Stigma associated with HIV during such a heightened time of social growth and development may create added pressure when disclosing and facing the potential challenges of living with HIV. These factors place them at risk for spreading the virus to other young men who have sex with men, straight or bisexual men or women.

Adolescents and emerging adults are in life stages where they are making efforts to understand who they are, who they may want to become and find a sense of purpose and meaning. This is also a stage of sexual exploration and experimentation (Arnett 2000 and Steinberg 2005). Adolescents frequently begin sexual experimentation when the brain and its executive functioning are still developing, putting them at increased risk for reproductive health problems (Arnett 2000 and Steinberg 2005). During this period of transitioning into adults, adolescents often take risks without fully weighing the consequences acting sometimes on emotions or heightened levels of arousal (Steinberg 2005). These risks often include sex without the use of condoms which may increase the risk of sexually transmitted diseases which ultimately increases the risk of HIV. Having a diagnosis of HIV during this period can present additional challenges for the transition through adolescence and emerging adulthood. A diagnosis of HIV may present new uncertainties for adolescents and emerging adults as many are attempting to find meaning in life and life situations. Youth living with HIV are more prone to be lost to follow-up care which increases viral resistance due to poor medication adherence (Magnus et al. 2010).

Method

Research Design and Setting

A constructivist grounded theory approach was used to elicit the role of spirituality from 21 participants' in two clinics in Southern California. This approach allowed participants to construct their own personal meaning around spirituality in the context of living with HIV. Charmaz describes constructivist grounded theory as an approach to grounded theory that seek to understand how meaning is assigned and

subsequent actions are undertaken in response to a situation (Charmaz 2006). The use of constructivist grounded theory also encouraged new understandings about how adolescents and emerging adults appraise HIV and spirituality in a way that is meaningful to them. It also allowed participants to construct meaning around their experiences of not feeling welcome in places of organized worship and describe their understandings of how the ideology of the church and church teachings were hypocritical and unwelcoming. The young men were allowed and encouraged to construct personal meaning about their experiences in remaining active in their spiritual and religious practices while coping with a chronic illness. The theory was generated from data as discovered and used to explain young HIV positive young men experiences with attending organized religious services in an effort to cope with their diagnosis.

Participants

Participants were recruited during scheduled appointments by clinic staff or through flyers posted in HIV clinic areas. The ability to speak and read English was a requirement of all participants as well as living with HIV and between the ages 13–25. Participant recruitment occurred over a 16-month period of time.

There were a total of 21 participants who agreed to participate in this study, and the sampling was described as purposive. Participants identified as Christian, were gay (90%), men of color (76%) and, on average, 22 years of age (see Table 1). Christian-identified was defined, for the purpose of this study, as an individual who practiced the principles of Christianity but did not belong to an organized religious faith. Participants had some experiences with organized religion and Christian-identified spiritual practices such as praying, meditation, and reading of spiritual material in the form of the Bible and devotions.

Procedure

Approval for this study was granted by the University of California San Francisco Institutional Review board. Participants gave written consent and, if under the age of 18, written parental consents and minor participant assents were obtained. Consents were obtained at the time of interviews by the researcher. Data were collected via semi-structured interviews, attendance at group meetings and outings and from field notes taken during encounters with participants. All interviews were audio-recorded in face-to-face interviews by the first author. A total of 21 males participated in this study, and there were three second interviews to clarify and verify developing themes and concepts. Participants and the first author agreed on locations for the interviews that were conducive to privacy and confidentiality.

A semi-structured interview guide which consisted of eight primary questions and 29 secondary questions was designed to address the specific aims of the study. The questions were open-ended, non-judgmental, and developed to explore the participants' spiritual experiences while living, more specifically, how their spiritual belief may or may not assist them in coping with their diagnosis of HIV.

Table 1 Sample (*N* = *21*)

Age	Mean	SD
17–25	22.19	2.32
	N	%
Race/ethnicity		
Hispanic	7	33
African-American	6	28.5
Caucasian	5	23.8
Bi-racial	3	14.3
Sexual orientation		
Homosexual	20	95
Heterosexual	1	5
History of abuse: sexual, physical, substance		
Sexual	6	28.6
Physical	2	9.5
Substance	11	52.4
Religious affiliation	Youth (%)	Current (%)
Catholic	43	29
Baptist	29	14
Lutheran	4.7	0
Non-denominational	14	14
Church experience	9.5	0
Spiritual	0	43

True to grounded theory methodology, questions were added to the interview guide as themes emerged from the responses of participants. All interviews were audio-recorded by the primary investigator and transcribed verbatim. The majority of the interviews were transcribed by the primary investigator with the remaining interviews transcribed by the use of a professional transcriptionist service.

Data Analysis

We used grounded theory methodology which does not require the researcher to enter the study with a hypothesis but rather, remain open to themes that emerge from the data (Strauss and Corbin 1990). As described by Charmaz, grounded theory methodology is a systematic method for collecting and analyzing qualitative data that allows for flexibility while constructing theories grounded in the data themselves. Simultaneously to data collection and analysis, we coded the data (Charmaz 2006). Charmaz describes coding in grounded theory as a process that seeks to give definition and meaning to the data for the researcher (Charmaz 2006). Coding is usually done in a systematic manner using names to describe segments of data, which is later categorized and summarized (Charmaz 2014). Additionally, we

exercised the multiple levels of coding in grounded theory which are open, axial, selective, and theoretical, to code the transcripts.

During initial or open coding, the data were broken down into categories after being compared for similarities and differences (Strauss and Corbin 1990). Attention was paid to analytic ideas as well as developing concepts that emerged during data collection and analysis (Charmaz 2006). All transcripts were coded line by line by the first author generating over 580 codes. Atlas.ti software for qualitative data analysis was also used to complete data analysis. The research team discussed codes, emerging themes, concepts and data analysis via telephone conferences biweekly. The coding process generated 580 open and in vivo codes, including: "HIV is better than other diseases," "I am normal," "not as bad as thought," "unwelcome," and "life is better."

The data were systematically put back together during the second phase of coding, axial coding. During this process of coding, categories were connected based on the conditions, context, actions/interactions and interactions that were extrapolated from the data (Strauss and Corbin 1990). Examples of such categories that generated from concepts that were similar include stigma, hypocrisy, disclosing, sin, and spiritual experiences. Categories are also known as concepts of the story in grounded theory (Charmaz 2006). Each category consisted of clusters of data that were further broken down into subcategories which provided a deeper level of data refinement and extraction (Charmaz 2014; Saldaña 2009).

For the purpose of this article, African-Americans, Hispanics, and Caucasians as well as adolescents and emerging adults were compared and contrasted to compare themes by different races to compare their responses to interview questions and their responses regarding their experiences with organized religion. This process of comparison laid the groundwork to build categories and offered a deeper description of the role of the church across race.

In what is considered the final step of coding, selective coding, relationships between core categories and other categories were systematically identified. Care was taken by the team to verify these categories and their relationships as we filled in other categories that were in need of further development (Strauss and Corbin 1990).

The fourth and actual final stage of coding, theoretical coding, allowed us to move the data from general themes to theoretical constructs (Charmaz 2014). Examples of theoretical codes that arose from the data included stigma from the church, hypocrisy of the church, and HIV punishment from God.

Memos were written after each interview and throughout data collection and analysis. Field notes were written after each interview as well. These notes provided space for documenting developing concepts. Memos were iterative in nature thus, allowing us to expand upon them as new concepts developed from the data. Working from our theoretical codes: church as a stigmatizing environment, perception of hypocrisy in the church and HIV being seen as a punishment from God from church members or from the pulpit, we developed the theoretical concept of the church being unwelcoming to gay and or HIV positive youth. Participants in this study suggested unwelcoming messages and stigma increased after disclosure of HIV status even to those in leadership within places of organized religion or churches.

Data were collected from a sample size of 21 participants with three second interviews for a total of 24 interviews. Simultaneous to conducting interviews we were coding and constructing theoretical memos. We also engaged in constant comparison and theoretical coding. We conducted three second interviews for verification, clarification, and elaboration on developing concepts and themes. There were no new codes, categories, concepts or themes coming from the data through constant comparison, and we agreed theoretical saturation had been reached (Saldaña 2009). At this point in our sampling and analysis, our data provided both a thick and a rich description of the experiences of the church being unwelcoming. Our methods for determining the sample size in grounded theory studies is consistent with rigor in qualitative research (Holloway and Wheeler 2010).

Assessing Rigor

Qualitative research is deemed trustworthy by assuring rigor (Whittemore et al. 2001). Rigor in qualitative research may be assessed and maintained when attention is paid to reflexivity, quality of interviews, systematic sampling, data-driven coding, and member validation (Whittemore et al. 2001). Acknowledging the real potential for social desirability, the Principle Investigators' (PI) personal spiritual beliefs were not shared with participants. To ensure that the PI's personal spiritual feelings and beliefs were not embedded in the data, other members of the research team checked and verified the data inclusive of codes and themes. As a final step to assure credibility, member checking was done in several interviews.

All interviews were recorded and transcribed from the recordings verbatim by the first author to accuracy of the participant's descriptions of their spiritual experiences. Care was taken by the first author to not share her spiritual beliefs with participants to reduce the risk of social desirability in their responses. Additionally, a very broad definition of spirituality was used reduce the potential for bias by the research team. To verify themes and developing concepts in later interviews, participants were asked their perspectives of these concepts as the interview guide was changed based on the developing concepts. The other members of the research team verified that the personal beliefs, spiritual experiences, and feelings were not embedded in the analysis in their review and discussion of the products of analysis.

Not all participant experiences were positive. Negative and positive experiences were reported as described by participants in their verbatim accounts of the impact of their spiritual beliefs on their diagnosis of HIV. In her role as a family nurse practitioner, the interviewing author has experience interviewing adolescents and emerging adults. During interviews, care was taken to separate this role from that of a researcher. This was achieved in not making any assumptions about the age-group during the research process.

Findings

We used a constructivist grounded theory approach to understand the role of spirituality in HIV-infected adolescents and emerging adults. The theory of the church being unwelcoming to HIV-infected adolescents and emerging adults was generated from the original data. While interviewing 21 male participants, many spoke of their negative experiences in the church after disclosing their status or from the stigma that is disproportionately prevalent in African-American churches. They spoke of hypocrisy, stigma, and HIV viewed as a punishment from God in the African-American community. This concept, unwelcoming, was prevalent and verified in interviews for theoretical sampling as well. All participants spoke of having experiences of participating in organized religion in their youth. They spoke of reconnecting to spirituality and viewing their life as normal with their diagnosis of HIV. These theories and their components are discussed elsewhere (Smith et al. 2016).

While participants of other races shared similar experiences, there were greater understandings of HIV in their communities and their homes when compared to African-American participants. This, however, did not protect them from stigma and hypocrisy when they attempted to participate in organized religion or confide in religious or spiritual leaders.

The hypocrisy, stigma, and HIV viewed as a punishment from God, largely in the African-American churches and communities, played an important role in these young men's decision to not participate in organized religion after their diagnosis. However, youth of other races and ethnicities experienced negative and positive experiences when attempting to reconnect with organized places of worship after their diagnosis as well. Although African-American youth's experience of negative messages and stigma were greater than those of their peers, HIV-infected youth overall did not feel welcomed in organized religious places of worship. The experiences of these young men very much resemble the experiences of adolescent and emerging adult men who have sex with men (Kubicek et al. 2009).

Spirituality has been identified as a coping mechanism for adolescents who are HIV-infected as well as those with other chronic illnesses (Bernstein et al. 2012. Cotton et al. 2009). Smith et at. suggest that spirituality is so important to adolescents and emerging adults after diagnosis of HIV that many reconnect with their spiritual beliefs as a means to cope with the diagnosis and associated stigma (Smith et al. 2016). The response of the church and the spiritual community negatively may hinder this very vulnerable populations' ability to cope and may promote negative outcomes when they feel the one place that was thought to be safe is no longer a safe space.

Participants in this study shared experiences of negative messages and betrayal when turning to spiritual leaders and leaders in the church. There was also a fear and mistrust of disclosing to spiritual leaders. This fear led to participants sitting silently in the church hearing homophobic messages only to leave wrestling with more questions about their spiritual belief and faith.

The Bible Versus Man

Imagine wanting to hold a position in church only to be told that you cannot because of your HIV status. Perhaps you based all of your morals and values on the teachings from the church and now you are left with confusion as you hear and see conflicting views from the pulpit and the Bible. Participants described the church as being a safe place, a welcoming place where you are not judged but rather accepted as you are and for who you are. Participants also shared their experiences of hearing negative messages and receiving negative responses from the church. They described feeling stigmatized by the church and not feeling welcomed after disclosing their HIV status or if their sexuality was known.

> Because I was raised to follow what the Bible was going to say and in the Bible, it says that God doesn't accept homosexuality and that took a while for me to cope with but then, I guess I've found ways to just keep going. Participant (P) #7

> Because a lot of people say that, growing up in the Bible, they say that this, the HIV, is supposed to be one of the plagues for homosexuality. That was just what I was taught in the Bible. I don't believe it. Um, but that being said, that would make me think that, well, since I'm a homo, maybe God's punishing me… I've actually been wanting to go back to church. I just don't know which church to go to. I don't want to go into church where they're always talking about homosexuality. P #13

> God is, its' God's church so I um, what I am trying to get to is that I tried I told one of the priest that I, that I was um, that I was considering becoming a priest and he said I couldn't, that I was HIV positive and um, I take it, I try to deal with it but its' very hard when you think that you can't do something just because of your status. P #14

> I stopped going to the church that I used to go to cause they said people with sickness like that were dangerous, they cannot be around normal people and all that and I was just like I am a normal person. P # 21

Despite these negative or conflicting messages, participants held fast to their spiritual beliefs. However, many practiced these beliefs in settings other than organized places of worship. These negative, unwelcoming messages added another layer or stigma to the stigma these young men already face having a diagnosis of HIV. These unwelcoming messages added another layer of unwelcoming already perceived from their communities and places in society.

Contradictions and Hypocrisy

Contradictions, as defined by participants, are when the church leaders preach against what is deemed a sin and participate in the same sin. Hypocrisy was

defined by participants as the church leaders advising congregants not to participate in certain activities yet, participated in these same activities.

> a couple of people that I know that are HIV positive that know I'm HIV positive, they're holy rollers, as they say, and I kind of, like, want to slap them sometimes because they – okay. With the same breath they'll say "Hallelujah; Thank you, Jesus; Praise the Lord," um, "Holy sanctified, saved with the Holy Ghost, one with the spirit." The same breath, they'll say that they want to suck some and get in they. P # 13

When one participant shared his diagnosis with his spiritual leader, he was not prepared for what came next. These data indicate that participants felt judged for their mistakes (being HIV positive, being gay) when they expected a different response for example, that they would not be criticized or shamed.

> I told like um, probably the priest and probably some other main people that I thought I could trust with that wouldn't criticize me but it ended up being the opposite. P # 21

> So, they told people in the church and that is when people in the church said you couldn't be around them? So how did that make you feel*?* (I)

> It made me feel kind of, well it made me feel bad cause I was like why are people like that you know? But afterwards, I just thought of, maybe, maybe those people are so ignorant that they are scared or something. They think that something can be contracted just by touching people which is not. I think it's hard to be contracted cause it's by blood. You're not going to go and cut yourself just to pass the blood to someone or you know like just go have sex with that person, you know. So, I don't know why people get scared of something like that. P # 21

Another participant had been struggling with his diagnosis and did return to his organized church family for support. Although he knew he could count on feeling accepted, he knew his diagnosis of HIV was something he would have to keep to himself.

> And so, you did tell people in your church? Interviewer (I)

> I feel that if I were to go and tell my pastor or probably tell someone, I feel that I would get looked at. Maybe cause it's just me that I feel that the stigma is just (inaudible) on HIV and the church community and it's just so much that, and the church area or the spiritual belief is so much judgment around that thing that I don't think that you should have been, you know if you wasn't gay you wouldn't have got it. Or you know, I think that a lot, even for my family, I feel that if you are gay, that you are automatically going to get something and I don't, I think that would be hard to come out for the church family as well cause they have a lot of judgment. P # 17

One participant found strength in praying to one of the Virgins that has significant meaning in his religious beliefs. He describes his reasons below:

> I have said it's that whole factor of not being judged, you know, or looked at like you're crazy, you know, cause people tend to react differently. And, um, being able to talk to her, it's like there is no facial expression…. There is nothing to judge you. There's nothing there that could say, well, you did something wrong, stupid you, you know? P # 13

Punishment from God

It seems incomprehensible that a God who is supposed to protect you would allow bad thing to happen to you. While some may view this as punishment from God, others may view it as God not keeping his end of the bargain and therefore must not truly care for them especially when their religious doctrines and beliefs identify "protector" as a primary role.

Having grown up in the church and hearing the teachings from a Biblical perspective on homosexuality, one participant concluded that having a diagnosis of HIV was punishment from God.

> Because a lot of people say that, growing up in the Bible, they say that this, the HIV, is supposed to be one of the plagues for homosexuality. That was just what I was taught in the Bible. I don't believe it. Um, but that being said, that would make me think that, well, since I'm a homo, maybe God's punishing me. You know? So I never really use my spiritual belief, my spirituality into a way to keep me going or recognize or try to keep fighting my HIV. P # 13

One participant left the church because he was taught that God would always be there but saw his diagnosis and other things in his life as a contradiction to who God was supposed to be.

> He's supposed to be there for you. He's supposed to look out for you. You know what I mean. He's your over-looker person, and then I became homeless, and for two of the years that I have been homeless, I still went to church, and I still believed in God, and then it kept getting worse, and worse. More things happened, and more things happened, more things happened, and now I have so many things that are wrong with my body. It's messed up, and he's supposed to look out for you, and take care of you. That shouldn't happen. P # 5

> You felt rejected from the church. So, tell me a little bit more about that. Was it a particular denominational church? (I)

> Um, I believe it was Baptist I think or it might have been protestant. I never really like looked into the actual church I was going to I kind of dragged by my parents but I am pretty sure it was one of those. But because of my sexuality or at least the feelings that I was going through at the time, you know, everyone says that the Bible condemns all of that which I guess it can be taken that way. So, I just naturally felt like I didn't really belong in the church or I was just a demon of sorts that just should you know, should burn. P #18

Discussion

The feeling of not being welcomed in the church or being stigmatized was common among the young men in our study. The theme is not new to individuals diagnosed with HIV and is very similar to the findings in the Kubicek et al. study (2009). Adolescents and emerging adult young MSM are often faced with the challenges and struggles of integrating spiritual or religious beliefs with their sexual orientation in the presence of condemnation from those in their spiritual places of worship or the church (Kubicek et al. 2009). Participants spoke of growing up in with organized religious experiences but after their diagnosis of HIV really felt confused about what they had learned about a loving God and the response from the church regarding their homosexuality and diagnosis of HIV. The messages also left participants feeling unwanted in organized places of worship and questioning the validity of what they had come to know about an all loving God who was accepting of all and loves all for who they are.

Some participants in the study never made a decision to return to a form of organized religion but rather practiced spirituality because of stigma and homophobic views associated with the church and organized religious places of worship. The feeling of not being welcomed in these places or fear of not being accepted played a huge role in their decision to not return to organized religion. Of those who did attend church, disclosure was not an option or their diagnosis was suspected or disclosed by someone other than themselves thus leaving them with a feeling of unwelcoming or unacceptance. Overall, participants also felt they were able to cope with their diagnosis because of their spiritual beliefs in spite of the negative messages and not feeling like they were welcome or belonged (Woodard and Sowell 2001).

A national survey documented that 95% of teens in the USA believe in God and religious/spiritual beliefs remain important during emerging adulthood, even when not actually practiced (Smith and Denton 2005; Arnett and Jensen 2002). Although adolescents and emerging adults often leave the church or make decisions to not participate in organized religion early during transitioning through formative teen years, there is still a desire to be spiritually connected, especially after a diagnosis of HIV (Smith et al. 2016). Participants in this study attributed the negative messages—stigma, hypocrisy, and messages of HIV being a punishment from God—to the unwelcoming experiences in places of organized religion.

African-American participants felt more unwelcomed in their churches when compared to their Hispanic and Caucasian peers. African-American participants also reported hearing negative messages more often from the pulpit than their peers and agreed the lack of knowledge in the African-American community about HIV and the disease process may be responsible for the views of the African-American church. Caucasian participants in this study did not report any negative or unwelcoming messages from the church although some Caucasian participants reported experiencing negative or unwelcoming messages from home or in the community. Findings from this study are consistent with the findings of Kubicek et al. (2009).

Clinical Implications

Realizing the negative impact the church may have on adolescents and emerging adults with HIV offers alternatives in addressing the spiritual needs of this vulnerable population. While healthcare clinicians and providers should take every opportunity to perform a spiritual assessment of their patients, knowing the stigma that is often present in places of organized religion will assist the healthcare team in making appropriate referrals to spiritual leaders and advisors. When diagnosed with a chronic illness, adolescents and emerging adults may reconnect with their spiritual beliefs and practices including the places of worship they once attended. This unwelcoming attitude may increase the depression associated with HIV. These new insights may be instrumental in connecting with spiritual leaders to develop community interventions to increase awareness around stigma in churches and its negative implications toward prevention and treatment. Continued research is needed to understand how stigma and unwelcoming attitudes from the church may hinder adolescents and emerging adults' ability to cope with their diagnosis of HIV.

Limitations

There were several limitations to this study. While the intent of this study was to seek the spiritual experiences and perspectives of male and female adolescents and emerging adults with HIV, we were not able to recruit females into our study. Therefore, the findings are not representative of female adolescents and emerging adults who are HIV positive. Additionally, we were not able to recruit participants in the study less than 15 thus limiting theorizing to young, adolescent males, and emerging adults. We were unable to recruit participants of non-traditional faiths such as Buddhist, Muslim, or of Jewish faith, and therefore, this study does not represent the perspectives of adolescents and emerging adults form these spiritual communities. With only one participant heterosexual, the findings lack the spiritual perspectives of heterosexual males who are HIV-infected. The findings from this study are the perspectives of young Christian-identified adolescents and emerging adults from the Western region of the USA. The study did, however, have a sample that represented a range of spiritual beliefs and practices. Future studies on adolescents and emerging adults who are HIV-infected should employ recruitment strategies to recruit females and younger adolescents to fully understand the impact of spirituality on young people with this chronic illness.

Conclusion

Religious affiliation and spiritual practices such as prayer continue to be important aspects of adolescent and emerging adult lives even with a diagnosis of HIV. Although this study had several limitations, the research design, grounded theory, allowed for and encouraged participants to express their experiences of stigma,

hypocrisy and feeling unwelcomed in places or organized religion and worship. Participants in this study continued to participate in spiritual practices despite the negative messages and conflicting messages and stigma. Very few participants attended places or organized religion or worship due to the unwelcoming feeling but found alternative ways to practice their spiritual beliefs to help them cope with their diagnosis.

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Compliance with Ethical Standards

Conflict of interest The authors report no real or perceived vested interests that relate to this article that could be constructed as a conflict of interest.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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