Reply to Rapose

To the Editor—A map overlay of the US regions most devastated by human immunodeficiency virus (HIV) would largely cover the Southeast, darkening most of the country’s most religious states [1, 2]. As an investigator/clinician at a large HIV clinic in Alabama, I frequently hear patients express fear that their communities—particularly their religious communities—will discover their diagnosis and infer their same-sex orientation. With time, the questions became obvious: “Could religious condemnation and stigmatization of HIV create tension for the churchgoing gay man? Could this tension influence his HIV screening and HIV-related health-seeking behavior?”
We retrospectively assessed the interrelatedness of church attendance and sexual behavior on CD4+ T-lymphocyte count in patients seeking first-time HIV care. During intake, patients were asked, “Do you attend a church, mosque, or synagogue?” Church attendance was dichotomized as yes (current attendance) vs no (never attended, or attended previously but not now). We found that churchgoing men who have sex with men (MSM) were more likely to present with a CD4 count <200 cells/µL than MSM who do not attend church [3].

This association, we noted, lacks a causal link and should be interpreted with caution. But Dr Rapose’s critique—that church attendance is a relatively blunt instrument for dissecting the relationship between religiosity and health—seems belabored. Did we include patients with new HIV infections, in whom low CD4 counts are often transient? Although this is unlikely, we thank Dr Rapose for his comment and will perform this analysis in our ongoing research. Dr Rapose criticized our focus on MSM while we conveniently ignored that churchgoing women report higher rates of previous HIV screening than do non-churchgoing women. Dr Rapose may have missed that the study’s primary endpoint, CD4 count, was no different between churchgoing and non-churchgoing women [3].

Does Dr Rapose’s dissatisfaction stem from the study’s scientific methods or from the answers they produced? Religious participation, he correctly insists, offers benefits to health and health-seeking behaviors [4–7]. But to declare or imply that religious participation is without the potential for untoward consequences is both dangerous and naive—on a near-daily basis, front-page headlines expose this fallacy. Such thinking reinforces complacency and gives us permission to ignore any potential health determinant we (or society) deem unimpeachable.

It is revealing that Dr Rapose condemns us, the National Institutes of Health, and Clinical Infectious Diseases. “Shame” is the whip he wields, and with it, he delivers us an analogue, an introduction to the potential “executioner in the room.” Yes, shame may very well be the problem—that is, shame inflicted by the guardians of religious and societal norms [8, 9]. For gays and persons with HIV, our research suggests that church attendance may have negative consequences on health and health-seeking behaviors. Some may view our findings as an indictment of religion and its role in the continued HIV epidemic. We do not. We, as physicians, investigators, and even churchgoers, see this as an opportunity to understand a potentially real consequence (whether intended or unintended) of a powerful, societal construct on the health of our patients, friends, and family members. Indeed, whose responsibility is it to remove barriers to HIV-related screening and care for MSM and all other vulnerable groups? [10].

Note

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