“Resilience as a Basis for HIV Intervention Design among Gay Men”

Ron Stall and Amy Herrick
Graduate School of Public Health
University of Pittsburgh
Goals of Talk

- To raise interest in the study of resilience as a basis for intervention design among gay men.
- To raise questions about whether deficit-based approaches to intervention design are, by themselves, sufficient to support effective interventions.
- To raise interest in the design of a research agenda to understand and harness resiliences among gay men so that community-wide health levels can be raised.
An Initial Epiphany: Where is the evidence for resilience in this table?

<table>
<thead>
<tr>
<th>No. of Psychosocial Health Problems</th>
<th>0 (n = 1,392)</th>
<th>1 (n = 812)</th>
<th>2 (n = 341)</th>
<th>3 or 4 (n = 129)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent high risk sex</td>
<td>7%</td>
<td>11%</td>
<td>16%</td>
<td>23%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>13%</td>
<td>21%</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

All associations have p’s < 0.001. All p values are two-tailed. From Stall et al., 2003
Resilience is Self-Evident in Gay Men’s Life Histories

- Coming out
- Homophobia management
- Creating safe religious institutions
- Finding and creating families
- Institution/Community Building
- Activism for citizenship rights
- Ability to thrive even through AIDS
Health Resiliencies are Commonly Found among Gay Men

- Lots of substance use, relatively few substance abuse-related problems
- Smoking cessation
- Large proportions of gay men remain HIV negative throughout the life course
- Many HIV positive men remain healthy and productive
- Resolution of substance abuse careers
Trajectories of stimulant drug use from visit 40-48 (Oct 2003-March 2008) in MACS, N=2457

“No use” 68.8%, “Some use” 7.2%, “Increasing” 5.8%, “Decreasing” 8.5% “Consistently high” 10.5%
The Logic of “Deficit-based” Approaches to Intervention Design

- Identify risk factors for poor health outcomes
- Design interventions to address these risk mediators
- Test efficacy of the intervention
- If efficacious, attempt community-based scale-up to achieve effectiveness
Rationale for the Deficit Logic

- It is inarguable that many health disparities exist within gay male communities.
- Understanding “what is going wrong” makes intuitive sense in terms of finding fixes for serious health problems.
- But is this the most effective approach to finding these fixes?
Central Questions of This Talk

- Should the evidence for intervention design be based on analyses that emphasize the experiences of the highest risk men?

- How would intervention design be different if it was driven by insights from men who are lowering risk, or men who are only rarely at high risk?
Central Questions of This Talk

- Which insights provide the most valuable basis for intervention design: insights about trajectories of ongoing/increasing risk or trajectories of relative safety?
- Could insights from both kinds of analyses be incorporated into interventions to increase efficacy?
Limitations of Deficit-Based Approaches

- Trajectories of risk production may have different mediators than trajectories that produce safety.
- Generalizability: By defining intervention content on the experiences of highest risk men are we emphasizing issues that don’t resonate with men at lower risk?
- Does this introduce credibility problems?
Limitations of Deficit-Based Approaches

- Deficit-based approaches produce knowledge about what NOT to do, not what TO do.
- Risk reduction involves exercising strengths; a focus on deficits does not help men access these strengths.
Limitations of Deficit-Based Approaches

- Deficit-based approaches are reactive rather than proactive.
- Deficit-based interventions are designed for men who will remain in high risk environments; once effects disappear, men are left with attenuated resources.
- Explanation for time-limited intervention effects?
Limitations of Deficit-Based Approaches

- May produce uninviting interventions (implicit messages: your sexual habits are life-threatening, you don’t know about HIV, you use too many drugs, your community’s norms are toxic)
- Do such implicit messages inhibit intervention uptake?
Concluding Thoughts:

- Deficit-based approaches have provided crucial insights important to the design of efficacious interventions.
- That said, we need interventions with larger effect sizes if we hope to yield outcomes that are of public health importance.
- Could resilience-based approaches contribute to improving intervention effect sizes?
Resilience Theory

- **Resilience:**

  “the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk.” - Fergus
Protective Factors

- Assets – individual level
- Resources – ecological context

- 3 models of how protective factors contribute to resilience
Compensatory model

- Directly associated w/ resilience
Protective Model

- Moderators of risk

Diagram:
- Y-axis: Negative Outcome
- X-axis: Risk
- Two lines:
  - Low PF: Negative Outcome increases as Risk increases.
  - High PF: Negative Outcome also increases as Risk increases, but at a different rate.
Challenge Model

- Risk as protection
### Protective Factors

Protective factors not necessarily the obverse of risk!

<table>
<thead>
<tr>
<th>Factor</th>
<th>Risk</th>
<th>Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>Low Self-esteem</td>
<td>High Self-esteem</td>
</tr>
<tr>
<td>Friends</td>
<td>Non-supportive Friends (bad influences)</td>
<td>Supportive Friends</td>
</tr>
<tr>
<td></td>
<td>Lack of friends</td>
<td></td>
</tr>
<tr>
<td>Community Involvement</td>
<td>NA</td>
<td>High community Involvement</td>
</tr>
</tbody>
</table>
Ex: Identifying Protective Factors

Deficit Paradigm:

- Adversity
- Syndemics
- HIV Risk
Ex: Identifying Protective Factors

Resilience Paradigm:

- Protective Factors
- Protective Factors
- Adversity
- Syndemics
- HIV Risk
Ex: Identifying Protective Factors

- **Compensatory Model**
  - **Social Support**
    - Family Connectedness
    - Family Support
  - **Skills**
    - Protective Condom Strategies
    - Proactive Coping
  - **Norms/Beliefs**
    - Peer Norms
    - Value Health
    - Social Network Condom Norms

- **Protective Model**
  - **Social Support**
    - Friend Support
  - **Norms/Beliefs**
    - Peer Norms
    - Value Health
    - Social Network Condom Norms
  - **Community**
    - Community Connectedness
    - Gay Community Connectedness
Paper 3
Moderation: Results

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1.60</td>
<td>.318</td>
<td>5.04</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High</td>
<td>.590</td>
<td>.410</td>
<td>1.44</td>
<td>.151</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1.65</td>
<td>.296</td>
<td>5.57</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High</td>
<td>.268</td>
<td>.471</td>
<td>.565</td>
<td>.573</td>
</tr>
</tbody>
</table>
Protective Factors

- Not just variables
  - Interaction of protective factors
  - Factors that generate protective processes
- Levels of risk...thresholds?
- Specific outcome/situation/individual
- Life-course: environment → individual

- Factors may differ for MSM – (Family...)
Ex: Identifying Protective Processes

During the time of coming out: 69.1%

Currently: 22.8%

<table>
<thead>
<tr>
<th>Condition</th>
<th>N (%) of sample w/o condition</th>
<th>OR</th>
<th>(95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No/Low Stimulant Use</td>
<td>1445 (94)</td>
<td>1.01</td>
<td>(.570, 1.79)</td>
</tr>
<tr>
<td>No Depression</td>
<td>1160 (75)</td>
<td>2.14**</td>
<td>(1.57, 2.92)</td>
</tr>
<tr>
<td>No/Low Stress</td>
<td>1091 (71)</td>
<td>1.69**</td>
<td>(1.23, 2.32)</td>
</tr>
<tr>
<td>No Intimate Partner Violence</td>
<td>1047 (68)</td>
<td>1.33*</td>
<td>(1.01, 1.79)</td>
</tr>
<tr>
<td>No/Low Sexual Compulsivity</td>
<td>1281 (83)</td>
<td>1.76**</td>
<td>(1.25, 2.48)</td>
</tr>
<tr>
<td>No Syndemic</td>
<td>1043 (68)</td>
<td>2.15**</td>
<td>(1.58, 2.91)</td>
</tr>
</tbody>
</table>
What do we need from a theory of resilience among gay men?

Ron Stall and Amy Herrick
Graduate School of Public Health
University of Pittsburgh
A Useful Reminder…

“There is nothing more practical than a good theory”

What should the properties of a resilience theory include?

- More than flipping deficit-based variables
  - Generates new variables: testing whether the non-depressed are less risky is not new theory

- Captures new variance
  - Does a better job of explaining risk and safety among MSM than deficit-based variables alone
What should the properties of a resilience theory include?

- Conducive to being used as the basis for intervention design
  - Identifies resiliencies among gay men that are transferrable
- Includes variables beyond the individual level
  - Sexual risk requires more than one person, theory has to address dyadic/ social levels
What should the properties of a resilience theory include?

- Generates interventions that are inviting
  - Interventions that are designed to help men thrive should be naturally inviting

- Leaves participants with long term skill sets that will serve men well who remain in risky environments
What should the properties of a resilience theory include?

- Addresses Life Course Issues
  - Explains resiliencies/ vulnerabilities across the life course

- Produces Variables that Integrate Well with Deficit-Based Interventions
  - Adds to the efficacy of interventions in the field
Hypothesized Resiliencies that May Promote Health among MSM

- Self-regulation of risk
- Resolution of risk without interventions
- Homophobia management
- Shamelessness
- Family creation
- Institution/community building
- Political activism
Goals for Our Discussions

- Raise questions that can become the basis for stronger theory to explain risk and resiliency among gay men
- Risk AND Resilience
- Interface with Stronger Intervention Design