

# Resilience Processes Demonstrated by Young Gay and Bisexual Men Living with HIV: Implications for Intervention

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## Abstract

Given the increasing numbers of young gay/bisexual men (YGBM) diagnosed with HIV, it is important to understand the resilience processes enacted by this population in order to develop interventions that support their healthy development. Qualitative interviews were conducted with 54 YGBM (ages 17 to 24; 57% African American, 22% Latino) living with HIV from four geographically diverse clinics in the United States. Resilience processes clustered into four primary thematic areas: (1) engaging in health-promoting cognitive processes; (2) enacting healthy behavioral practices; (3) enlisting social support from others; and (4) empowering other young gay/bisexual men. These data suggest that YGBM living with HIV demonstrate resilience across multiple dimensions, including *intrapersonal-level resilience* related to individual cognitions and behaviors, as well as *interpersonal-level resilience* related to seeking support and providing support to others. Implications for the development of culturally-appropriate and strengths-based secondary prevention and other psychosocial interventions for YGBM living with HIV are discussed.

## Introduction

ADOLESCENTS AND YOUNG ADULTS between the ages of 13 and 24 years accounted for 25.7% of all new HIV infections in 2010, with 82.8% of these infections occurring among males.<sup>1</sup> Nearly three-quarters of the 12,200 new youth infections in 2010 were attributed to male-to-male sexual contact.<sup>1</sup> Prior reviews of US national HIV seroprevalence studies focused on adolescents and young adults who reported male-to-male sexual contact demonstrated that 86% to 95% of these youth self-identified as gay or bisexual.<sup>2</sup> Unfortunately, rates of HIV infection among adolescent and young adult males who have sexual contact with other males are increasing, with the estimated percentage of infections attributed to this behavior among all adolescents/young adults steadily increasing from 57% in 2005, to 68% in 2008, to 72.1% in 2010.<sup>1,3</sup> Exploring the lived experiences of young gay/bisexual men (YGBM) living with HIV would provide critical insights useful to develop prevention programs for this at-risk population.

The extant literature specific to YGBM living with HIV is relatively limited. Earlier published studies demonstrated that YGBM living with HIV experienced higher rates of substance use, delinquency, stigma, and discrimination, as compared to their heterosexual counterparts living with HIV.<sup>4,5</sup> More recently, larger multi-site quantitative studies from the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau YMSM of Color SPNS Initiative and the National Institutes of Health's Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) have been conducted to explore various patterns and predictors of sexual and substance use risk behaviors among YGBM living with HIV,<sup>6-11</sup> further elucidating patterns of risk among this population.

In addition to more frequent quantitative studies, there are fewer qualitative studies that have emerged in an effort to examine the lived experiences of YGBM living with HIV, with a predominant focus on health challenges and risk behaviors. For example, Flores, Blake, and Sowell conducted a qualitative study of 10 African American and Latino gay/

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bisexual young men (ages 18–24) who were recently diagnosed with HIV and identified four primary themes that focused on deficits and risk factors (intrinsic and extrinsic personal risks, lack of relevant education, accessing the Internet, and the need for mentors) that influenced these young men's lives.<sup>12</sup> In another qualitative study with 27 African American and Latino YGBM living with HIV (ages 16–24), VanDevanter et al. found that substance use, the social-environmental context of the sexual encounter, the psychological impact of HIV on sexual behavior, and partner characteristics were all associated with participation in sexual risk behaviors.<sup>13</sup> Overall, the extant literature on YGBM living with HIV has focused primarily on risk and has underutilized qualitative methodologies, which can offer a more nuanced understanding of the lived experiences of a population. Qualitative methods are especially useful for understanding the lives of YGBM living with HIV since existing quantitative measures may not accurately capture the unique stressors and life circumstances these young men may experience.

Although investigating predictors of health risk behaviors is quite helpful in elucidating specific health concerns in YGBM living with HIV, there are few studies that have examined psychosocial factors.<sup>14,15</sup> Regardless of sexual orientation, youth living with HIV are likely to experience hardship and victimization, which can be further exacerbated due to limitations in structural and institutional support.<sup>16,17</sup> Specific to YGBM, however, the challenges of living with HIV may be exacerbated by social isolation, stigma, and oppression associated with their sexual orientation.<sup>18–20</sup> They also may find a lack of support from family members, peers, and teachers who do not accept and support them as they develop their gay/bisexual identity, and who may even perpetuate verbal and physical acts of violence against them.<sup>21–25</sup> In an effort to understand how YGBM living with HIV can, and do, develop into healthy well-adjusted adults, it is important to empirically explore and understand resilience processes among these youth. Such information will help advance prevention efforts for this population.

Resilience provides a strengths-based framework for understanding the development of adolescents and young adults, and offers insights into why some youth develop into healthy adults despite being exposed to risk.<sup>26–28</sup> Resilience among youth has been viewed as a dynamic process whereby a young person is able to positively adapt within the context of significant adversity<sup>29</sup> and overcome the negative effects of risk exposure.<sup>26</sup> A key requirement of resilience is the presence of risks in the young person's environment, as well as promotive factors, which help the adolescent to either bring about a positive outcome or reduce/avoid a negative outcome.<sup>26,30</sup> Promotive factors are viewed as positive contextual, social, and individual forces that interfere or disrupt the developmental pathway from risk exposure to the development of problem behaviors, psychological distress, and poor health outcomes.<sup>26,30</sup>

Fergus and Zimmerman identified two types of promotive factors—assets and resources.<sup>26</sup> Assets are viewed as positive factors that are internal to the individual and include attributes such as self-efficacy, high self-esteem, competency, and coping skills. Resources, on the other hand, are factors that are external to the individual and include influences such as parental support, natural mentors, community-based organizations, and youth development programs. The

inclusion of resources as a type of promotive factor expands the conceptualization of resilience beyond a singular focus on individual-level abilities or attributes, and emphasizes the importance of socio-ecological factors in influencing the health outcomes of adolescents and young adults. Therefore, resilience is not a static personal trait but is dependent upon the context, the population, the risk, the promotive factor, and the outcome.<sup>26</sup>

Resilience can be differentiated from other similar constructs such as coping, which is often viewed as an active process of directly managing a specific stimulus or event that has been evaluated as stressful. Coping involves a process of recognizing and appraising that the event is indeed stressful, followed by efforts to handle that specific demand.<sup>31,32</sup> Resilience, on the other hand, involves responding positively and adaptively to risk exposure (e.g., peers' substance use), which may or may not involve a direct and specific stressor. Yet, not all stressors represent risk exposure, such as the stress of performing well on an exam. In addition, coping may be a part of the larger picture of resilience—for example, coping skills may be an individual asset that promotes resilience in the face of risk, or people may demonstrate that they are resilient by successfully coping with a negative situation.<sup>26,30</sup> Therefore, resilience is the mechanism that describes how assets (individual factors) and resources (external factors) operate to compensate for or protect against the negative effects of risk exposure.

Although resilience has largely been conceptualized in terms of its implications for youth development,<sup>27,33</sup> and has been applied across a number of health-related contexts among adolescents and young adults, including learning disabilities,<sup>34</sup> health risk behaviors,<sup>35</sup> and cancer,<sup>36,37</sup> it has not been adequately explored among YGBM living with HIV. To date, research that has focused on resilience among people living with HIV in the US has focused almost exclusively on adults,<sup>38–43</sup> with a particular emphasis on older adults.<sup>44–46</sup>

The population and context-specific nature of resilience calls for attention to the potential role of race and ethnicity in the development and promotion of resilience among YGBM living with HIV, especially if such information will be used for the development of culturally appropriate secondary prevention interventions.<sup>26</sup> In addition to the oppressive forces these youth may experience related to their sexual orientation and HIV status, African American and Latino YGBM living with HIV may experience additional layers of oppression related to their social and cultural identities.<sup>2,47–50</sup> Given the complexity of exploring how this intersectionality of oppressed identity statuses may influence resilience among culturally diverse samples of adolescents and young adults living with HIV, the current study used qualitative methods based in constructivist frameworks in order to allow participants to define and describe ecological influences on their well-being “in their own words.”

Additionally, the population and context-specific nature of resilience requires that critical indicators of resilience should also be specific to the risk or health condition being studied in order to apply them to future interventions.<sup>26,29</sup> Wallander and Varni's Disability-Stress-Coping Model of adjustment is a useful framework for studying such phenomena among YGBM living with HIV.<sup>51</sup> This model applies a risk and resilience framework to stress and coping theory and does so

specifically for children and adolescents living with a chronic illness. The model demonstrates that risk and resilience factors interact to impact an adolescent's adaptation to his/her chronic illness and/or disability. As modifiable risk and resilience factors are identified in empirical research studies, they then provide heuristic guidance for new prevention and treatment interventions for adolescents living with chronic illnesses and disability.<sup>51</sup> Since the focus of the current study is on exploring resilience factors among racially and ethnically diverse YGBM living with HIV, and how these factors can be integrated into future interventions, the Disability-Stress-Coping Model served as a useful initial framework.

## Methods

### *Participants*

Participants for this study were recruited from four geographically diverse adolescent medicine clinics that provide a range of services to youth living with HIV and are part of the Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) [Baltimore ( $n=12$ ), Chicago ( $n=14$ ), Memphis ( $n=14$ ), San Francisco ( $n=14$ )]. The inclusion criteria for the study included: (1) biologically male at birth and identified as male at time of study participation; (2) HIV-infected as documented by medical record review or verbal verification with referring professional; (3) HIV infection occurred through sexual or substance use behavior of the participant; (4) between the ages of 16 and 24 years at the time of informed consent/assent; (5) able to understand both written and spoken English; and (6) reported history of at least one sexual encounter involving either anal or oral penetration (either receptive or insertive) with a male partner during the 12 months prior to study enrollment.

### *Design and procedures*

The data for this article are derived from the qualitative phase of a mixed-methods study investigating risk/stressors and resilience/coping mechanisms that impact healthy identity development among gay/bisexual young men living with HIV. The qualitative data presented in this article were collected between June and September, 2008. The research protocol was approved by the institutional review boards at all participating sites, as well as the home institutions of all primary investigators. Since the population of interest for this study was gay and bisexual young men, the institutional review boards of each study site were requested to grant a waiver of parental permission to participate in the study for participants under the age of 18. This was done to avoid the selection biases present in recruiting only youth whose parents are both aware of and comfortable with their sexual orientation.

Young men living with HIV between the ages of 16–24 years, who were receiving care within clinic settings at one of the four participating sites, were approached by study coordinators to assess study eligibility. In order to allay any concern by potential participants that they had been “identified” by the study coordinators as being gay/bisexual, they were informed that all men in the clinic setting who appeared to be between the ages of 16–24 were approached and screened for the study. Study coordinators conducted a brief screening interview in a private room in order to determine

eligibility and then obtained signed consent/assent from participants.

Attempts were made to recruit a purposive sample that consisted of equal numbers of participants in the age ranges of 16–19 and 20–24. An attempt was also made to enroll a sample of youth that was evenly divided among African American, Latino, and “Other” ethnic/racial groups, but since HIV disproportionately impacts African American male youth in the US and the majority of youth who receive care in the participating clinics are African American, the majority of youth in the sample represent this racial group.<sup>1,3</sup>

Interviews were scheduled by study coordinators at each site and conducted by one of four trained qualitative interviewers in private rooms at the participating facilities. The interviewers were diverse with regard to gender, ethnicity, and sexual orientation, and included two doctoral-level investigators and two masters-level graduate students. Since all four interviewers were located in the same city, groups of two interviewers traveled to each site to conduct the interviews. During the course of data collection, the interviewers met on a weekly basis to discuss their experiences in conducting the interviews and to assure consistency across data collection. Interviews were digitally recorded and transcribed verbatim by an external professional transcription service. All transcribed interview files were validated by members of the interview team who listened to the digital recordings and confirmed accurate transcription of the interviews. Original recordings and transcribed interviews were stored on a secure server with access restricted to key research staff at the Principal Investigator's institution.

### *Interview guide*

A semi-structured qualitative interview guide was created specifically for this study by a team of researchers experienced in working with both youth living with HIV and gay/bisexual youth. The interview guide questions were open-ended to elicit specific and contextual data regarding participants' experiences, beliefs, and behaviors; and the semi-structured format allowed participants to partially determine the order and flow of required domains of interest based on their own narratives. Since the larger study from which these data were derived was focused on both risk and resilience, the Disability-Stress-Coping Model was used as an initial framework in order to develop domains and questions that would assess a range of risks/stressors (i.e., psychological stress, functional independence, and disease parameters) and resiliencies/coping mechanisms (i.e., intrapersonal competence, socio-ecological support, and coping strategies) related to participants' HIV and identity development.<sup>51</sup>

The interview guide was also grounded in phenomenological and constructivist frameworks. Phenomenology is specifically focused on inductively describing what a given group of participants have in common as they experience a particular phenomenon.<sup>52,53</sup> Since this type of approach to data collection and analysis is focused on identifying elements of a particular phenomenon by describing both *what* the phenomenon is and *how* it is experienced by a particular group of people, this guided the types of questions and probes. The constructivist approach to data collection and

analysis further influenced the development of the interview guide by assuring that the questions allowed participants to define and fully describe constructs within their own unique cultural context. Thus participants were first asked to define their various identities (e.g., HIV-positive, sexual orientation, racial/ethnic) using their own words and conceptualizations, and then were guided through an in-depth exploration of stressors and coping mechanisms related to each specific identity.

### Data analysis

Data analysis was also conducted using a phenomenological framework.<sup>52,53</sup> The analysis explored the variety of ways in which YGBM living with HIV demonstrated resilience, and then provided textural descriptions of these phenomena based on summaries of the experiences described by respondents. The composite descriptions of the phenomena presented offer an explanation of the underlying structure which exists across the respondents' experiences.<sup>52,53</sup>

Data coding and analysis were iterative and interactive processes conducted by a team of three analysts who resided in the same city and met weekly to discuss findings. The first step involved each analyst reading all interview transcripts to increase familiarity with the data. Content codes were then created collaboratively by the data analysis team to capture the experiences described by participants, and a codebook was created which included operational definitions of all codes. Transcripts were then re-read by all analysts, and pattern codes were created in a similar collaborative manner to connect subsequent concepts under larger headings within each transcript. Following this, consistent patterns in meaning, concepts, and themes across all interviews were identified, and data matrices were created as visual representations of the thematic findings in order to further assist in the analysis process. Once the primary themes and sub-themes were identified, model building analyses were conducted focused on exploring potential temporal connections across the primary types of resilience. This process involved a re-examination of the results of all the preceding analyses and additional exploration of the transcripts for narratives that either specifically stated or suggested temporal ordering of the first occurrences of the four primary types of resilience.<sup>54,55</sup>

Coding and analysis activities were discussed during weekly meetings, and discrepancies in coding and interpretation were resolved through discussion and consensus. Given the study's phenomenological framework, all themes and sub-themes expressed by participants, regardless of their frequency of occurrence, were considered meaningful elements of how each particular phenomenon was experienced by the participant(s) and thus included in the analysis.<sup>52,53</sup>

## Results

### Participants

A total of 54 YGBM were enrolled in the study and completed in-depth qualitative interviews. Over half of the participants were African American ( $n=31$ ; 57.4%), with further representation from YGBM who identified as Latino ( $n=12$ ; 22.2%), white ( $n=7$ ; 13.0%), or multiracial ( $n=4$ ; 7.4%). These ethnic/racial breakdowns are similar to US

prevalence rates among gay/bisexual adolescents and young adults living with HIV.<sup>1,3</sup> The vast majority of the participants identified as gay or homosexual ( $n=45$ ; 83.3%), with the remainder identifying as bisexual ( $n=9$ ; 16.7%). Ages of participants ranged from 17 to 24 years ( $M=21.0$  years,  $SD=2.2$ ). The mean time since diagnosis for participants was 2.5 years ( $SD=1.17$ ), with the following breakdown of months since diagnosis: 1–12 months (26.0%), 13–24 months (25.0%), 25–36 months (18.5%), 36 months or more (27.5%), and unknown (3.0%).

### Resilience processes

Youth in this study reported a variety of ways in which they have adapted to their HIV status and demonstrated resilience in the face of HIV infection. These resilience processes clustered into four primary thematic areas: (1) engaging in health-promoting cognitive processes; (2) enacting healthy behavioral practices; (3) enlisting social support from others; and (4) empowering other young gay/bisexual men. These four areas suggest that YGBM living with HIV demonstrate resilience across multiple dimensions, including those focused on both *intrapersonal-level resilience* related to individual cognitions and behaviors (i.e., engaging in health-promoting cognitive processes and enacting healthy behavioral practices), as well as *interpersonal-level resilience* related to both seeking support and providing support to others (i.e., enlisting social support from others and empowering other young gay/bisexual men). The following offers more details regarding the sub-themes that emerged within the four thematic areas of resilience, along with representative quotes from participants; pseudonyms are used to protect the identity of the participants. Contextual information is also offered in the text prior to the presentation of representative quotes in order to provide the reader with additional background or descriptive information that may appear in other parts of the transcript, but that assist with better understanding the broader narrative offered by the participant.

**Engaging in health-promoting cognitive processes.** Participants discussed engaging in a range of cognitive processes that promoted their health and well being after learning of their HIV diagnosis. Although most participants reported feeling sad and depressed for at least the first 6 months following their diagnosis, many described a newfound outlook regarding their life and future that eventually emerged as a result of these cognitive processes. Three thematic types of health-promoting cognitive processes were reported: (a) re-evaluating life goals; (b) gaining a sense of control through seeking knowledge; and (c) taking responsibility for health outcomes.

Several of the participants described re-evaluating their life goals and aspirations following their HIV diagnosis, resulting in a positive new perspective on their future. For some this was prompted by concerns regarding their mortality and not having as much time to accomplish their goals, whereas others viewed receiving an HIV diagnosis as a "wake-up call" that prompted them to take more immediate action toward life goals. The following quote illustrates one of the ways in which young men discussed their cognitive reappraisal process following their HIV diagnosis:

“So I know that having HIV, you’re going to have it probably for the rest of your life. You have the rest of your life to figure out what you’re going to do, and you need to get over this hump and you need to do what you need to do...you have HIV now, you know, maybe we need to plan out some things a little ahead. Maybe it’s time to start taking steps towards the goals. I mean we don’t have as much time as we thought we did but we still have a lot of time.” (Todd, multiracial gay male, aged 18)

Youth also talked about gaining a sense of control over their HIV and their life in general by learning more about HIV. This active process of acquiring information regarding HIV and how it affects the body provided YGBM with stability in the face of receiving their HIV diagnosis. Some emphasized the importance of understanding basic virologic and immunologic concepts (such as the significance of viral load and CD4 measures), whereas others described holistic approaches to understanding how to “live with the virus” in order to actively maintain and even improve upon the quality of one’s own life. Charles, a 24-year-old black gay young man, described the importance of developing a better understanding of the intersection of HIV, the body, and how one can actively engage in self-care:

“I want longevity. It’s [HIV] not easy on your body. It’s very hard on your body to have HIV and not have guidance and knowledge about what you should be doin’...I make sure—I’m prompt and efficient to get my blood work every three months. I started a medical regimen that I have to take every day.” (Charles, black gay male, aged 24)

The last theme that emerged with regard to health-promoting cognitive processes was related to participants reporting that they made a conscious decision to take responsibility for their own health outcomes. This cognitive process typically involved YGBM becoming aware that their continuing health status was impacted by personal decisions and behaviors, and that taking ownership over their health provided a sense of personal control. These feelings of personal control and self-ownership were expressed by Tyler, a 22-year-old multiracial gay young man:

“It [HIV] makes me want to go to the doctor. It makes me want to get up and take care of myself because nobody’s going to live my life for me but me. So I think about that every day that what can I do to make this day better than the last.” (Tyler, multiracial gay male, aged 22)

**Enacting healthy behavioral practices.** The majority of participants viewed their HIV status as an impetus for enacting a range of healthy behavioral practices focused on health promotion and maintenance. The perceived threat of disease progression was viewed as motivation for taking care of one’s body with specific behavioral changes designed to promote well-being. For many of the YGBM, these changes in health-promoting behaviors were linked to the cognitive processes previously described. They reported actively assessing the benefits of enacting healthy behavioral practices, and then decided to implement specific activities to exercise control over their bodies in order to produce desirable health outcomes. These activities fell into three thematic areas: (a) increasing exercise and improving their diet; (b) decreasing drug and/or alcohol use; and (c) practicing safer sex.

The most frequent category of behavioral practices discussed was related to increasing exercise and improving diet.

Several of the YGBM discussed not monitoring their exercise and eating habits much prior to receiving an HIV diagnosis, but felt that they became more aware of the role that diet and exercise play in maintaining their health after being diagnosed with HIV. Maurice, a black young gay man, offered the following in response to questions about why he had made changes in his health-promoting behaviors.

“So I can live longer...if you want to live, stay healthy. I try to eat less fast food. I try to exercise a little more. I try to make sure I don’t expose myself to situations where I can get sick. I go have regular check-ups at the doctor.” (Maurice, black gay male, aged 19)

Participants also talked about generally decreasing their use of drugs and alcohol after receiving their HIV diagnosis, since they viewed these substances as having a detrimental impact on their immune system. One exception was marijuana use, with some participants viewing marijuana as not having the same level of toxicity on their body as alcohol and other drugs.

“I just can’t go out and binge drink every night, you know, I mean because it effects, you know, it effects the, you know, the medicines, it affects your body too, you know, a different degree than it does if you’re just, you know, totally healthy.” (Aaron, white gay male, aged 22)

Participants also expressed the desire to protect themselves, as well as their respective partners from the repercussions of unprotected sexual activity. Although many stated that they had experienced a significant loss of sex drive immediately post-diagnosis, this trend appeared to reverse itself over time in most cases. Several participants mentioned the importance of safer sex as a means for reducing their chances of acquiring secondary infections or drug-resistant virus strains, while more stressed the need for protecting others from infection with HIV.

“I’m always cautious of...I just don’t wanna be exposed to anything other than what I already have or re-exposed to you know a different type of strain of HIV. I just don’t need it or possibly infecting another person...so my sexual practices are pretty much on the safe side.” (Darryl, African American gay male, aged 24)

Several of the YGBM reported that these changes in health-promoting behavioral practices not only influenced the way that they felt physically, but also gave them a different perspective on their bodies. For some YGBM, living with HIV caused them to reexamine the way that they saw their own bodies and lives, as well as the bodies and lives of others. This is reflected in the following narrative from Marcus, an 18-year-old black gay young man:

“I feel like my—with me being positive now and caring about my body more has given me a different view of my body and other people’s bodies. And I think that prior to me being positive, I think I did have respect for myself and my body, but not as much as I should have. And that seems to then comply [sic] to the people that I was having sex with...I’m just much more cautious and reserved about it now than I used to be...I think I just—I think now I see my body as an asset to myself, whereas I think I used to see it as a means of using people...I recklessly used my body to get what I needed in order to survive. And you know, now it’s like the game is completely different—it’s not the same anymore.” (Marcus, black gay male, aged 18)

Enlisting social support from others. Participants reported enlisting social support from various sources as a way to improve their overall health and well-being. They talked about how having social support networks helped them cope with various aspects of managing their HIV, and also provided them with guidance and support as they addressed general life challenges and stressors. Four specific social support networks were discussed: (a) health care providers and health care organizations; (b) friends and peers; (c) family members; and (d) partners and ex-partners.

The majority of the participants identified specific health care organizations and groups that provided support in the form of relevant health-related information, counseling, support groups, and supportive care. Groups for youth who were newly diagnosed with HIV were mentioned by several participants as being particularly helpful in accepting their diagnosis. Ongoing support groups, especially those led by peers, were also seen as valuable resources for continued coping and management of their HIV. Health care professionals, particularly doctors, nurses, social workers, and case managers, were viewed as instrumental in explaining the implications of HIV on their bodies and lives. These professionals also provided general social support and encouragement, and motivated participants to pursue future life options through education and jobs training. Eduardo, a Latino young gay man, detailed the importance of health care providers in his learning to better manage his HIV, primarily from a medical perspective:

“Informational stuff, supportive stuff, like mental supportive and just participating in active support groups within other youth who are HIV positive and giving that peer support group. Like if you do this and you see the side effects this is what you need to do to reduce them. That was very informative for me.” (Eduardo, Latino gay male, aged 23)

Participants also identified friends and peers as important support networks that helped in navigating the stigma and isolation that may arise as a result of living with HIV. Several YGBM were particularly focused on the importance of developing friendships with other youth who are living with HIV. These connections, as explained by Terrance, appear to highlight how some YGBM better manage their HIV through reciprocal interactions that involve the identification and subsequent management of mutual stressors:

“Getting to basically talk to other people that are HIV positive like, you know, interactin’. Seein’ how—how is it for them dealin’ with HIV and like basically gatherin’ up everyone’s problems and their issues and like lookin’ at mine and it’s like, okay, well we have the same issues so, you know, we’re just gonna help each other...there’s love and, you know, like give each other support, you know.” (Terrance, multiracial gay male, aged 22)

In addition, several participants detailed the importance of developing friendships with older people living with HIV. These individuals, particularly older gay men living with HIV, were described as role models who provided sources of support and inspiration, and appear to provide a distinctly different social support function from peers. Justin talked earlier in his interview about creating a network of older gay male friends who are living with HIV, and had the following to say about the influence of these friends.

“All my friends are HIV-positive...They go to work every day, like have successful lives...it’s not necessarily what they

tell me to do. They “do” and I notice...I associate myself with the people that I want to emulate or be like.” (Justin, white gay male, aged 22)

Some participants indicated that family members assisted in their ability to effectively cope with multiple life stressors. Family members were most often viewed as instrumental in providing YGBM with constructive perspectives on both day-to-day decisions regarding their life course, as well as longer term decisions regarding overall life goals. Nathan, a 17-year-old multiracial gay young man, described how his family provided reassurance and affirmation regarding his life direction:

“Like my grandmother and cousin, they’ll talk to me every day...And they’ll let me know like, I’m gonna be perfectly fine. They’re always gonna be there for me, and they just help motivate me, just—basically to keep, help me keep my head up.” (Nathan, multiracial gay male, aged 17)

For many of the participants, current romantic partners and/or ex-partners provided a sense of comfort and reassurance that was qualitatively different than that received by other friends or family members. Youth attributed differences in the degree of positive support received by partners and ex-partners to the prior or current emotional connectedness they felt with partners/ex-partners. Participants’ descriptions of these relationships generally involved a strong affective component that was not present when discussing other supportive relationships. Even for those YGBM who maintained friendships with prior romantic partners, the level of connection and support received from ex-partners was often greater than that received from other friends. Zach explained the importance of his partner’s support in coping with his own HIV-status:

“My partner said he would do anything for me...But he’s definitely that emotional support, so that’s important. But then everything else has been through [community organization’s] HIV Program. I have nothing. The only person outside of anyone at home that knows about my status is my partner.” (Zach, white gay male, aged 21)

Empowering other young gay and bisexual men. Upon adjusting to living with HIV and developing a positive self image, a number of participants reported the desire to educate other youth about HIV in order to prevent them from becoming infected. In addition, some even shared stories of how they have been able to turn this desire into action, primarily through serving in various supportive and educative roles for other YGBM living with HIV, as well as for YGBM at risk for HIV. These participants shared examples of both paid and volunteer positions as peer mentors, peer health educators, and peer navigators at either LGBT or HIV/AIDS community-based organizations. Most of the YGBM who held such positions described a strong sense of pride and accomplishment in knowing that they were helping others, which gave them further motivation to stay healthy. Some participants discussed wanting to focus their time and energy on helping to prevent HIV among individuals who were from the same community and of similar backgrounds as themselves. This desire was expressed by Todd, who felt a connection to other youth who may be at risk for infection:

“I want to educate people...Knowing that there was a time in my life where I was—I don’t know how to put it, a druggie, maybe...I see those people around and sometimes I feel like

this thing like I want to do something, I want to help them, because I see myself, you know. I'm like, oh my God, like I see you spiraling downward... That motivates me to want to help them. It motivates me to want to educate them and spread awareness." (Todd, multiracial gay male, aged 18)

Participants also reported a strong desire to live a healthy life and to project a positive image for others so as to dispel stereotypes about gay/bisexual young men who are living with HIV. They expressed a desire to serve as role models for other youth and young adults who are either susceptible to HIV, or who are currently living with HIV. As expressed by Thomas, living a healthy life is seen as a powerful way to actively combat the stigma surrounding HIV:

"I gotta do good now because I'm not gonna have all my life to do it, so might as well do it now. I can show people that HIV people can live a long life and do something." (Thomas, black gay male, aged 21)

#### *Differential progression of resilience among YGBM living with HIV*

For many of the YGBM living with HIV, the four thematic areas represented a temporal progression of resilience processes (Fig. 1). Thus, in the early stages of adapting to their HIV diagnosis, YGBM would demonstrate resilience through health-promoting cognitive processes, including gaining a sense of control through seeking knowledge about their HIV, re-evaluating their life goals, and taking responsibility for their health care and health outcomes. For several of the youth, this cognitive reappraisal process resulted in changing their behavioral practices related to health promotion. This took the form of increasing their exercise activity and improving their diet, decreasing their use of drugs and alcohol, and practicing safer sex to protect themselves and their sexual partners.

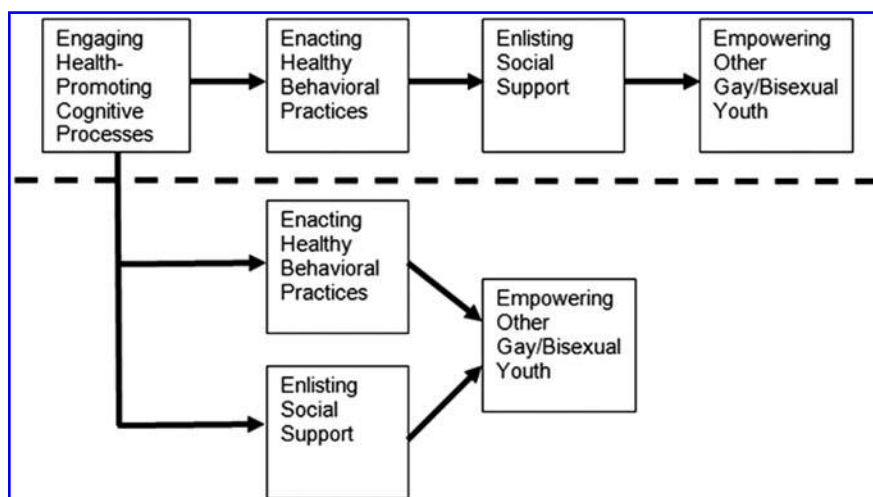
In addition to these intrapersonal-level cognitions and behaviors, YGBM also reported interpersonal-level resilience focused on improving their health outcomes through increasing health-promoting interactions with others. For some, these interpersonal resilience interactions increased after enacting health-promoting cognitive and behavioral strategies (progression above the dashed line in Fig. 1),

whereas for others they occurred at the same time (progression below the dashed line in Fig. 1). Typically the initial type of interpersonal resilience took the form of accessing various health care providers and organizations that provide support and care, as well as reaching out to friends, family members, current romantic partners, and ex-partners for support. Some YGBM moved beyond demonstrating interpersonal resilience focused on accessing supportive social networks for egocentric purposes, and focused on helping other youth. This was accomplished by educating other young people about HIV prevention so that they would not become infected with HIV (typically through community-based organizations), as well as serving as a role model for other youth who were already living with HIV. When these altruistic behaviors were reported they always occurred after youth enacted healthy behavioral practices and enlisted social support.

#### **Discussion**

This study explored resilience processes demonstrated by an ethnically diverse sample of YGBM living with HIV. The qualitative phenomenological nature of the study allowed for a rich exploration of the dynamic and complex ways in which these young men have positively adapted to their HIV status, and have been able to transform a health threat into an opportunity for growth and further development. This study is a departure from the vast majority of empirical investigations of YGBM living with HIV that have focused on risk factors and health-risk behaviors. By focusing on various elements of resilience as described in the narratives of YGBM living with HIV, the findings from this study will provide experience-based guidance for the development of strengths-based public health interventions focused on promoting the healthy development of YGBM living with HIV. Given the increasing numbers of YGBM who are being diagnosed with HIV in the US public health professionals will need to develop an array of interventions to assist these youth to not only adapt to their health condition, but also thrive in the face of such a diagnosis.<sup>1,3</sup>

Findings from this study suggest that YGBM living with HIV demonstrate resilience across multiple dimensions. Four primary thematic areas of resilience processes were reported by participants: (1) engaging in health-promoting cognitive



**FIG. 1.** Differential progression of resilience among young gay and bisexual men living with HIV.

processes; (2) enacting healthy behavioral practices; (3) enlisting social support from others; and (4) empowering other young gay/bisexual men. Thus, in addition to intrapersonal-level resilience related to individual cognitions and behaviors, they also reported interpersonal-level resilience related to both seeking support and providing support to others. These intrapersonal-level and interpersonal-level dimensions are in alignment with the two types of promotive factors described in Fergus and Zimmerman's conceptualization of adolescent resilience; specifically, assets (intrapersonal) and resources (interpersonal).<sup>26</sup>

For many of the YGBM living with HIV in this study, the four thematic areas represented a temporal progression of resilience strategies (Fig. 1). In the early stages of adapting to their HIV diagnosis, YGBM demonstrated intrapersonal-level resilience through engaging in health-promoting cognitive processes, which typically lead to enacting healthy behavioral practices. For some, interpersonal resilience, in the form of enlisting social support from others, occurred after enacting these health-promoting cognitive and behavioral strategies, whereas for others they occurred at the same time. Following the progression of these three forms of resilience, some youth reported empowering other YGBM by educating those who were not living with HIV or supporting those who were living with HIV.

#### *Implications for intervention development*

The findings from this study have implications for the development of secondary prevention and other psychosocial interventions focused on improving the health and development of YGBM living with HIV. The concept of resilience provides guidance for the development of strengths-based health promotion interventions for adolescents and young adults who have been exposed to different types of risk since it focuses on positive contextual, social, and individual variables (promotive factors) that disrupt the negative effects of risk exposure.<sup>30,56</sup> Understanding the assets and resources that have been helpful in promoting resilience within a particular population can offer guidance for the specific targets of future strengths-based interventions.<sup>30</sup>

Therefore, interventions focused on building the resilience of YGBM living with HIV could promote the four primary resilience processes reported by the current sample. This could be accomplished through the implementation of one culturally appropriate comprehensive intervention that addresses all four areas of resilience, or in progressive interventions that gradually build the resilience of YGBM living with HIV. The choice of comprehensive vs. progressive interventions may be related to various factors, such as the length of time that participants have been living with HIV, the developmental and motivational level of participants, as well as the types and progression of resilience processes already demonstrated by participants.

The intrapersonal resilience factors demonstrated in this study could be addressed in future interventions through a variety of means. With regard to supporting health promoting cognitive processes, individual or group-based intervention activities could be developed that assist youth in gaining a greater sense of mastery and control over their HIV through improving their understanding of the physiological and psychological impact of HIV on YGBM. Given the uncer-

tainty about one's own mortality and future life goals experienced by youth who are diagnosed with HIV, presenting realistic information regarding the various modes of treatment and care available for youth living with HIV would be beneficial.<sup>57</sup> This should also include activities that assist youth with learning how they can take control of their health outcomes by becoming truly collaborative participants in their HIV-related care. The issue of future life goals and expectations with regard to career and relationships can also be assessed in interventions through activities that assist youth in developing actions plans focused on short and long-term goals, along with strategies that youth can use to work toward those goals and confront potential barriers that they may encounter.<sup>58</sup>

Promoting healthy behavioral practices can also be addressed through individual or group-based activities. The health-promoting behavioral factors that emerged in the youths' narratives in the current study are those that would typically be the focus of secondary prevention interventions for people living with HIV; specifically, assuring that individuals are eating a healthy diet, engaging in exercise, decreasing their drug and alcohol use, and using condoms during sexual activity. Intervention components that focus on these issues for YGBM living with HIV should approach such behavioral changes from both a developmentally and culturally (both sexual orientation culture and ethnic/racial culture) appropriate perspective.

Social support was a critical interpersonal resilience factor revealed by the participants in this study. Interventions for YGBM living with HIV should assist participants with identifying various sources of social support that will enhance their health and well-being. Since these youth may experience oppression related to their sexual orientation, race/ethnicity, and/or HIV status, it will be important that they find those support networks that will promote their psychological and physiological health and not further oppress or stigmatize them.<sup>2</sup> Health care providers and various community organizations were identified as powerful institutional support structures, therefore, interventions may explore ways to assist youth with identifying and accessing care providers and organizations that will be affirming of their sexuality, race/ethnicity, and HIV status.

Interpersonal relationships with friends, family members, romantic partners, and ex-partners were all viewed as additional sources of support. Thus, interventions should provide youth with the skills needed to accurately assess the actual support being provided by these various relationships, as well as skills to seek additional supports if needed. Youth may not identify the ways in which some of these relationships detract from their health; therefore, interventionists may need to help participants critically analyze their current relationships to see if modifications may need to be made in their current social networks.

The final area for intervention development is related to assisting youth with educating others about HIV and serving as a role model for other young people living with HIV. This is an area that may not be appropriate for all YGBM living with HIV, as these activities require a level of self-acceptance and desire to reach out to others that may not be found in all youth. Thus, interventions may provide youth with skills related to public speaking, prevention intervention delivery, and advocacy, as well as resources for how to engage with



organizations that provide HIV-related services for youth. Interventions should guide youth through a thoughtful exploration of the benefits and consequences of becoming engaged in health promotion and advocacy efforts, as such activities have the potential for negative consequences if youth are not fully prepared to disclose their status to other youth who may not be supportive and affirming.

#### *Strengths, limitations, and future research*

This study represents one of the few investigations focused exclusively on resilience among YGBM living with HIV. The use of Wallander and Varni's Disability-Stress-Coping Model of adjustment in studying resilience among YGBM was beneficial since it provided a guiding framework that offered initial areas of exploration.<sup>51</sup> The phenomenological and constructivist approach to conducting the qualitative interviews allowed for a more culturally sensitive and in-depth exploration of resilience by giving YGBM the opportunity to provide their own definitions based on life experiences, and providing them the opportunity to expand on those areas that were most critical to their lived experiences. The phenomenological analytic framework allowed for indigenous concepts and typologies to emerge from the participants' descriptions of their own resilience-based experiences. Findings from this study provide rich data for the development of future strengths-based interventions focused on promoting the health and well-being of YGBM living with HIV.

Despite the strengths, this study had some limitations. All of the youth who participated in the study self-identified as gay or bisexual. Thus, the findings may not have as much relevance to non-gay/bisexually identified young men who have sex with men living with HIV. In addition, all of the youth who participated in the study were currently receiving HIV-related services at an adolescent medicine care site which provided a range of health promotion services. Thus, the sample did not include representation from those YGBM living with HIV who either were receiving care at less comprehensive service sites, or were not receiving any care at all. Such youth may have additional strengths and even represent higher degrees of resilience since they may be thriving in situations where they are not necessarily receiving professional care and support. Although the sample included youth from four geographic regions of the US (Baltimore, Chicago, San Francisco, and Memphis), these are all major metropolitan areas. Therefore, youth from more rural or suburban communities may not have been represented. With regard to data collection, the qualitative interviews were conducted at one point in time and did not include multiple successive interviews. Thus, there may be resilience factors that are apparent at different points in the youths' progression of accepting their HIV diagnosis that were not identified.

Future research should continue to explore resilience processes demonstrated by YGBM living with HIV from multiple racial/ethnic groups, using both qualitative and quantitative methods. Given the lack of well-validated quantitative measures for YGBM living with HIV, and the challenges of measuring resilience as a dynamic process using self-report quantitative assessments,<sup>26</sup> qualitative methods can offer insights into how resilience develops and functions in the lives of YGBM living with HIV. Qualitative

studies could benefit from following participants over time in order to explore potential temporal fluctuations in resilience factors, as well as the emergence of different factors.

Mixed-methods studies could also illuminate the types of resilience demonstrated by YGBM living with HIV, as well as relationships between types of resilience, and psychological and physiological health outcomes. By combining qualitative and quantitative methods, the limitations and biases inherent in one single methodology can be lessened by using multiple forms of data collection, and the triangulation of the qualitative data with the quantitative data strengthens the validity of the information received.<sup>54</sup> Samples that are used in future studies should consider inclusion of youth from rural and suburban regions, as well as youth who are not currently receiving care at comprehensive adolescent medicine sites. Targeted studies of specific racial/ethnic groups will also be beneficial in the development of culturally tailored interventions. Additional studies should also explore resilience among samples of YGBM that include both youth living with HIV as well as those who are not living with HIV, and compare and contrast resilience factors found in both groups. Future studies also may wish to expand the age range of participants and conduct developmental comparisons regarding the types and patterns of resilience found across age groups. Such studies would offer valuable insights into other resilience processes demonstrated by various groups of individuals who may be at risk for negative health outcomes.

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