“Syndemics, Resiliencies and Successful Aging Among Gay Men”

Ron Stall

Center for LGBT Health Research

Graduate School of Public Health

University of Pittsburgh

Presenter Disclosure

- Presenter: Ron Stall
- Relationships with Commercial Interests:
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- Other: None

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.

Health Profile of Urban Gay Men

Very High Rates of Distress and Depression

Mills, T., et al., Distress and Depression among Urban MSM, Am J Psychiatry, 2004; 161(4):776

Very High Rates of Attempted Suicide

Paul, J., et al., Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. AJPH 2002 92:1338-45.

High Rates of Childhood Sexual Abuse

Paul, J., et al., Understanding childhood sexual coercion as a predictor of sexual risk-taking among MSM. Child Abuse and Neglect 1002 25:557-584.

Health Profile of Urban Gay Men

Very High Rates of HIV Infection

Catania, J., et al., The continuing HIV epidemic among MSM. AJPH 2001 91:907-914.

Very High Rates of Substance Use and Abuse

Stall, R., et al., Alcohol use, drug use and alcohol-related problems among MSM. Addiction 2001 96:1589-1601.

Very High Rates of Partner Violence

Greenwood, G., et al., Battering victimization among a probability-based sample of MSM. AJPH 2002 92:1964-1969.

Intertwining Epidemics among Urban MSM (Significant OR estimates, controlling for age, education, race, income, HIV status and sexual risk)

	Childhood Sex Abuse	Partner Violence	Depression	Substance Abuse
Childhood Sex Abuse	----------	1.9	1.9	
Partner Violence	1.9	---------	1.6	2.2
Depression	1.9	1.6	----------	1.4
Substance Abuse		2.2	1.4	----------

From Stall et al., AJPH 2003 93:939-42

Interconnecting Psychosocial Health Problems among Gay Men

	No. of Psychosocial Health Problems			
	0 (*n* = 1,392)	1 (*n* = 812)	2 (*n* = 341)	3 or 4 (*n* = 129)
Recent high risk sex	7%	11%	16%	23%
HIV prevalence	13%	21%	27%	22%

All associations have *p*'s < 0.001. All *p* values are two-tailed.

From Stall et al., 2003

Syndemic:

- *(n.) a cluster of epidemics that act additively to predict other epidemics*
- *(adj.) of or pertaining to such a cluster**
- *www.cdc.gov/syndemics*

*from Singer, 1994

An Initial Epiphany: Where is the evidence for resilience in this table?

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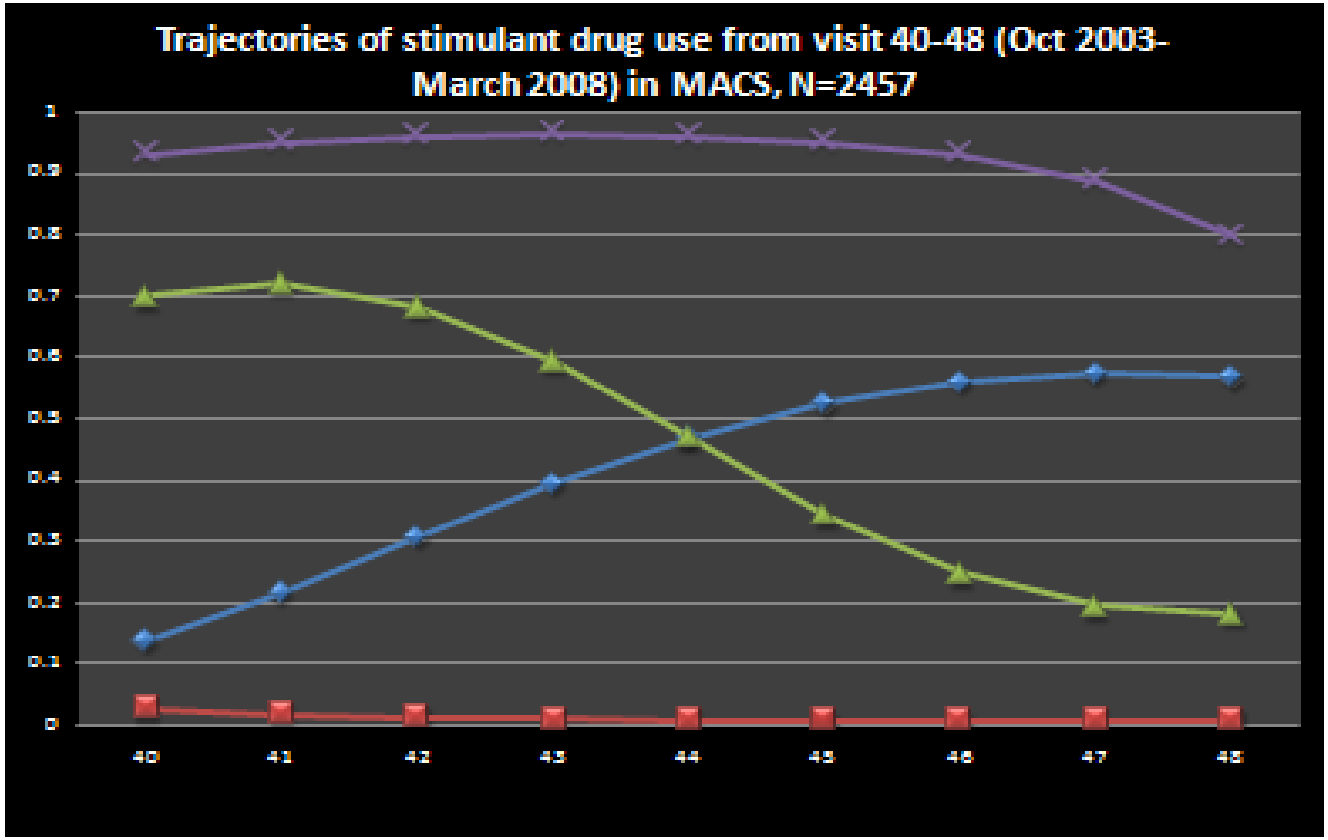
From Stall et al., 2003

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



"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

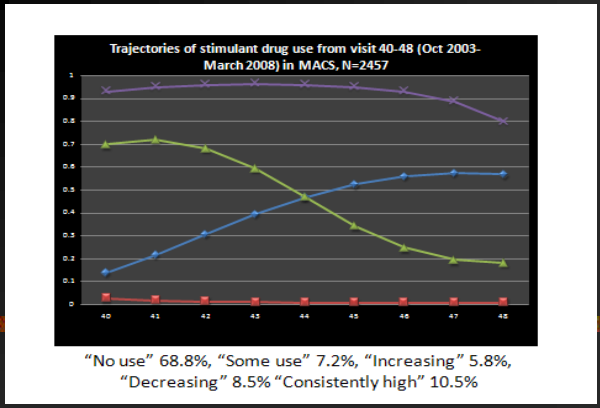
- Identify risk factors for poor health outcomes
- Design interventions to address these risk mediators
- Test efficacy of the intervention
- If efficacious, attempt community-based scale-up to achieve effectiveness

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?

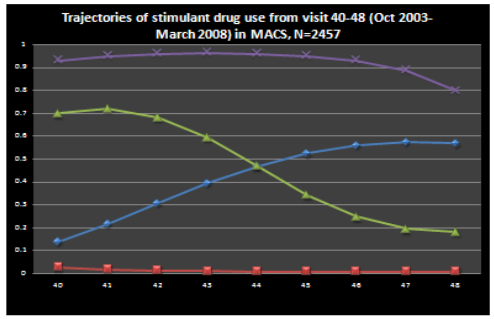
Deficit Assumptions Underlying HIV Intervention Design for Gay Men

- **Raise condom use skills** (*gay men don't know how to use condoms*)
- **Raise condom negotiation skills** (*gay men don't know how to negotiate sex*)
- **Change peer norms** (*gay men have unhealthy peer norms, esp. around sex*)
- **Raise skills to face homophobia** (*gay men have few skills to face homophobia*)



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?



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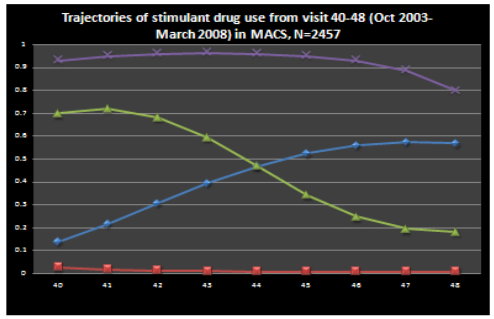
Central Questions of This Talk

- 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?



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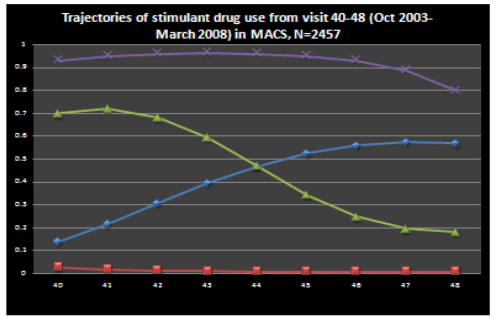
Limitations of Deficit-Based Approaches

- 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?



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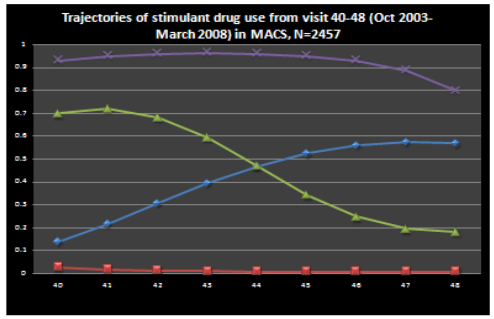
Limitations of Deficit-Based Approaches

- 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



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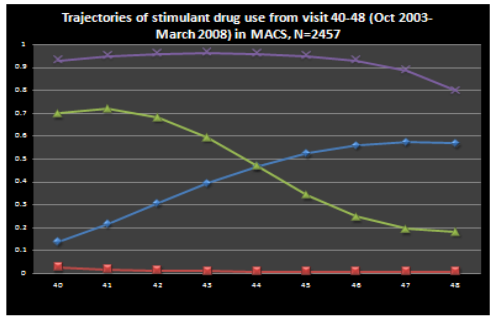
Limitations of Deficit-Based Approaches

- 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?



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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?

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 (2005)

MSM Resiliencies: Pitt/Fenway Conference

- **Individual Level**
  - Internal homophobia management & shame
  - Self monitoring & goal setting
  - Adaptability and coping
- **Dyadic Level**
  - Relationship building
  - Dyadic support
- **Family Level**
  - Biological family resolution
  - Social bonding

MSM Resiliencies: Pitt/Fenway Conference

- **Community Level**
  - Connection to community
  - Institutional support
  - Community building
  - Commitment to community building.
  - Homophobia management
  - External monitoring

Measuring resiliency requires more than flipping deficit variables

Factor	Risk	Protective
Self-esteem	Low Self-esteem	High Self-esteem
Friends	Non-supportive Friends (bad influences)	Supportive Friends
Community Involvement	High community involvement	High community Involvement

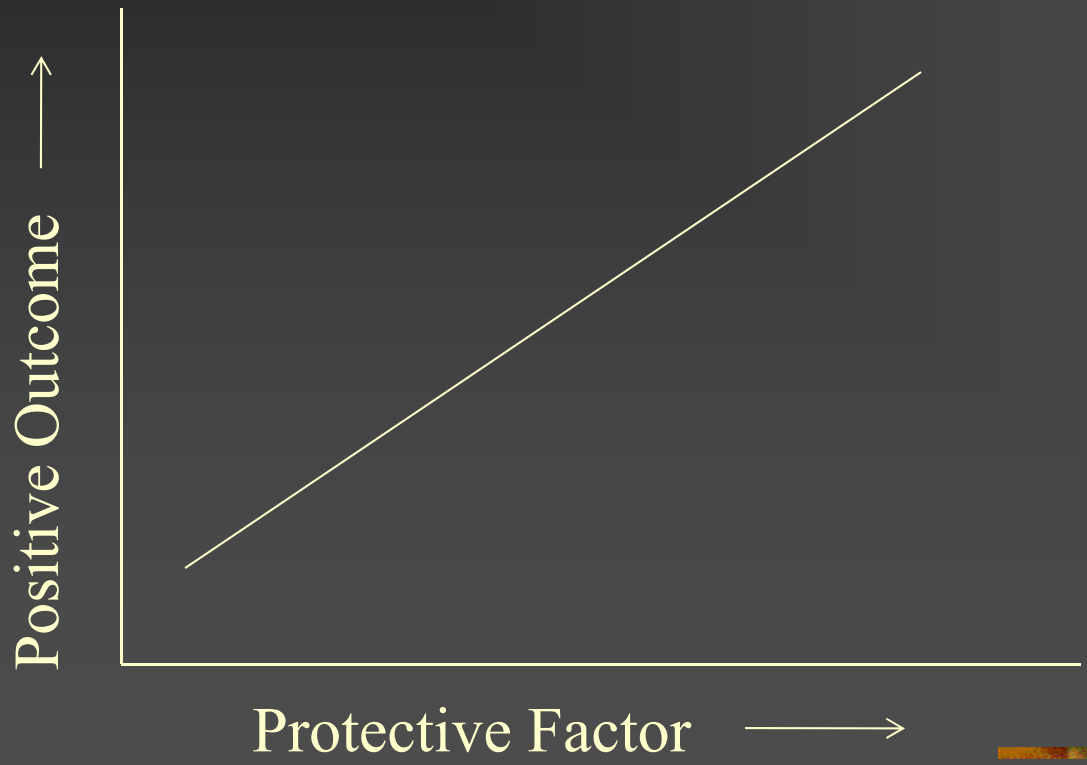
Protective Factors

- Assets – individual level
- Resources – ecological context

- 2 models of how protective factors contribute to resilience

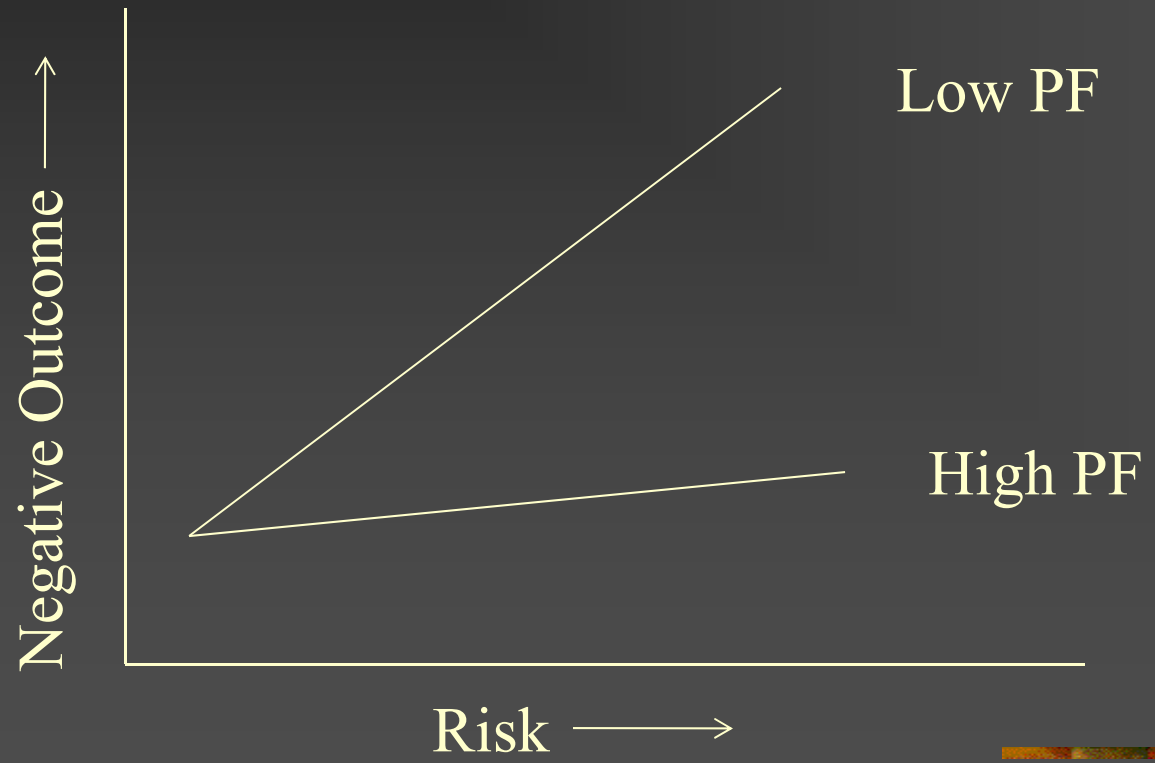
Compensatory model

- Directly associated w/ resilience



Protective Model

- Moderators of risk

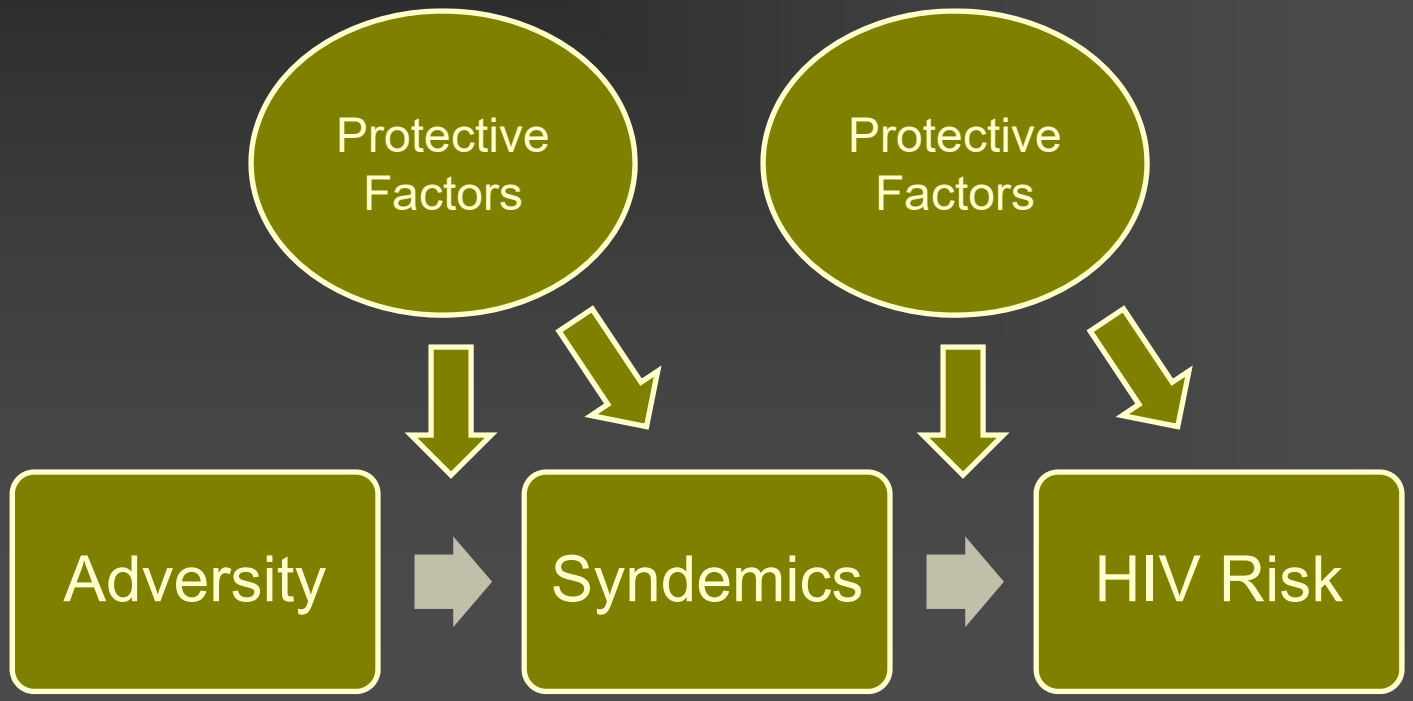


Ex: Identifying Protective Factors

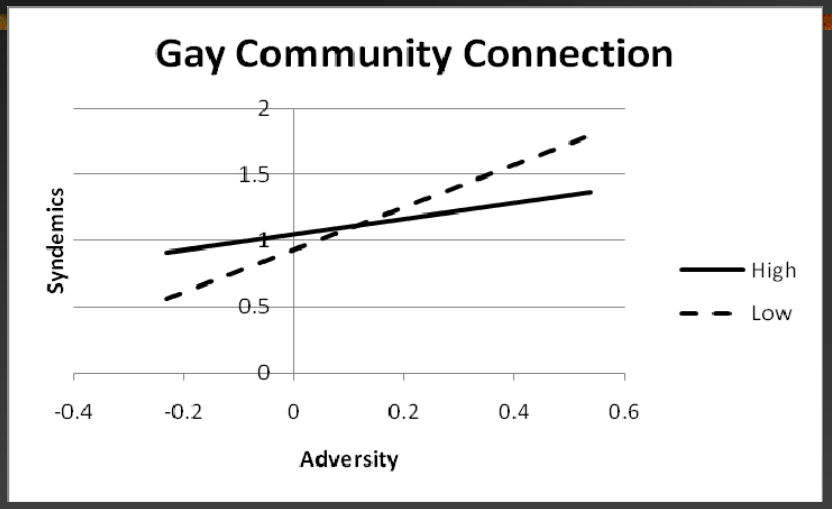
Deficit Paradigm:

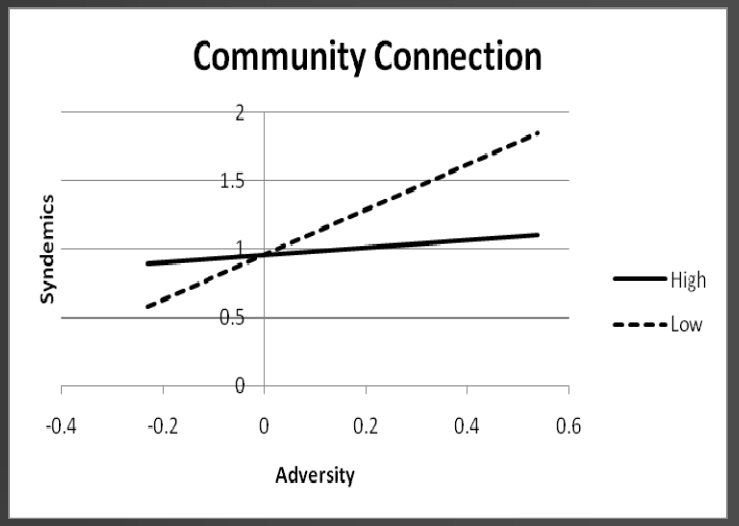
Ex: Identifying Protective Factors

Resilience Paradigm:



Moderation: MACS Results





	B	SE	t	p
Low	1.60	.318	5.04	<.001
High	.590	.410	1.44	.151

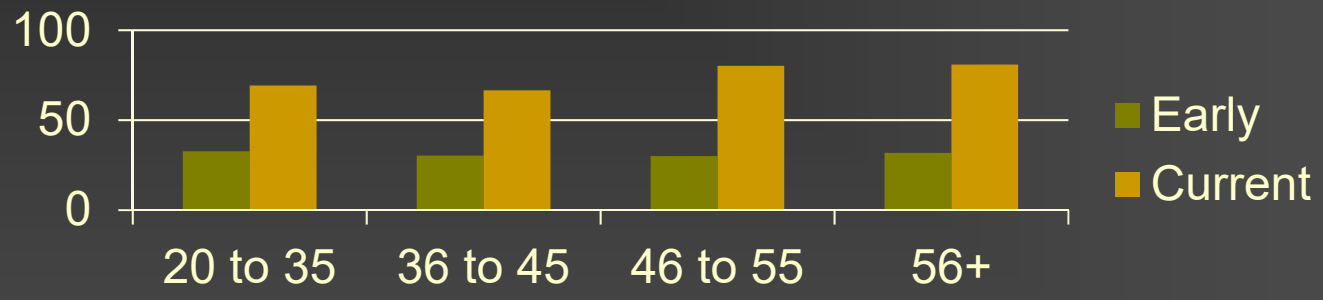
	B	SE	t	p
Low	1.65	.296	5.57	<.001
High	.268	.471	.565	.573

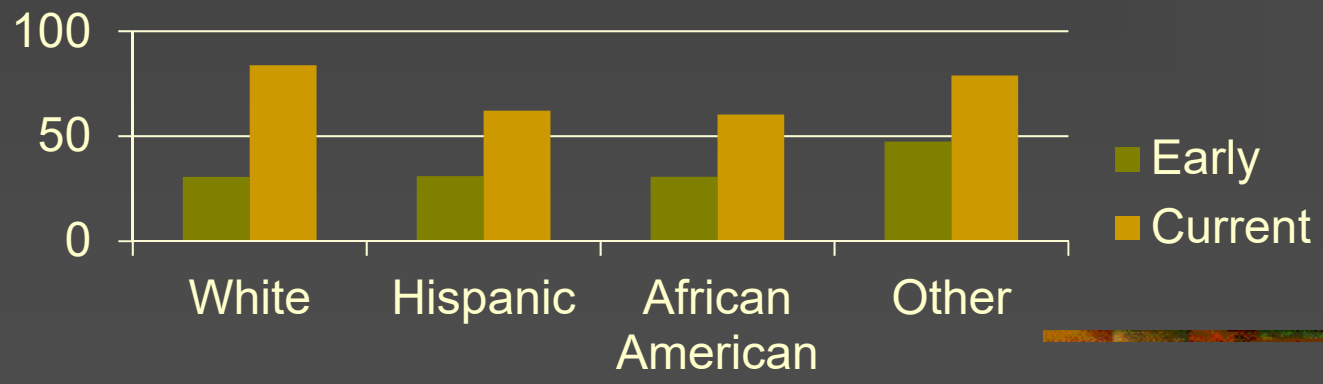
Resolution of Internalized Homophobia

	Time 1 %	Time 2 %
I tried to stop being attracted to men in general.	35.9	5.6
If someone had offered me the chance to be completely heterosexual, I would have accepted the chance.	43.9	12.1
I wished I weren't attracted to men.	39.2	10.0
I felt that being gay/bisexual was a personal shortcoming for me.	42.7	9.0
I wanted to get professional help in order to change my sexual orientation to heterosexual.	14.5	3.4
I tried to become more sexually attracted to women.	38.7	5.3
I often felt it best to avoid personal or social involvement with other gay/bisexual men.	27.5	7.4
I felt alienated from myself because of being gay/bisexual.	30.8	6.1
I wished that I could have developed more erotic feelings about women.	40.1	8.2

Resolution of Internalized Homophobia across groups

- During the time of coming out: 30.9%
- Currently: 77.2%





Resolution of Internalized Homophobia: Syndemic Outcomes

N=1,060	N (%) of sample w/o condition	OR	(95% CI)
No/Low Stimulant Use	1445 (94)	**1.01**	(.570, 1.79)
No Depression	1160 (75)	**2.14****	(1.57, 2.92)
No/Low Stress	1091 (71)	**1.69****	(1.23, 2.32)
No Intimate Partner Violence	1047 (68)	**1.33***	(1.01, 1.79)
No/Low Sexual Compulsivity	1281 (83)	**1.76****	(1.25, 2.48)
No Syndemic	1043 (68)	**2.15****	(1.58, 2.91)

A Useful Reminder…

"*There is nothing more practical than a good theory*"

Lewin, K. (1952). Field theory in social science: Selected theoretical papers by Kurt Lewin. London: Tavistock.

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

“Understanding Patterns of Health Aging among MSM”, R01

- Conducted within the MACS
- Men aged 45+ (men as old as 80 in the cohort)
- Additional questionnaire on syndemics and resiliencies among aging gay men
- Powered to detect effects within the entire cohort, HIV+ men and HIV + Black MSM

Research Design

- Participants in the MACS cohort (>80 % will be aged 50+; about half will be HIV+)
- Longitudinal Design: 6 waves of data collection
- First study to show how strengths and resiliencies change over time among aging gay men
- DV: HIV risk behaviors, HIV viral loads

Variables to be Measured: Aging Study

- Volunteer Work
- Mentoring
- Job Satisfaction
- Aging Satisfaction
- Resiliency (global)
- Gay community perceptions
- Religiosity/Spirituality
- Optimism (global)
- Body Satisfaction
- Health Care Satisfaction
- Physical activity
- Neighborhood attributes
- Social support

Variables to be Measured: Aging Study

- Familial abuse
- Childhood victimization
- Discrimination and victimization
- Mental health (depression, anxiety, loneliness)
- ASS measure
- Sexual Assault
- Partner violence
- Sexual behavior
- Drug/alcohol use
- HIV status disclosure
- HIV stigma

The Case for Studying Resilencies

- LGBT Communities have exhibited remarkable resiliencies for at least the past 30 years and probably far longer.

- Strength-based approaches are unstudied in explaining health and wellness.

The Case for Studying Resiliencies

Interventions should be designed to operate at the individual, dyadic, familial and community level.

- It's time to address weaknesses AND tap strengths in intervention designed to raise levels of health in LGBT communities

Questions?