


# Forging Resilience to HIV/AIDS: Personal Strengths of Middle-aged and Older Gay, Bisexual, and Other Men Who Have Sex With Men Living With HIV/AIDS

American Journal of Men's Health  
September-October 1–12  
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DOI: 10.1177/15579883211049016  
journals.sagepub.com/home/jmh  


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## Abstract

HIV-positive gay, bisexual, two-spirit, and other men who have sex with men (MSM) have exhibited significant resilience to HIV/AIDS in Canada since the start of the epidemic. Since 2012, most of the research that has been conducted on resilience to HIV/AIDS has utilized quantitative methods and deficits-based approaches, with a preferential focus on the plight of young MSM. In order to address apparent gaps in research on HIV/AIDS resilience, we conducted a community-based participatory research qualitative study that utilized a strengths-based approach to examine the perspectives and lived experiences of HIV-positive, middle-aged and older MSM on their individual attributes that helped forge their HIV/AIDS resilience. We conducted 41 semistructured interviews with diverse, HIV-positive, middle-aged and older MSM from Central and Southwestern Ontario, Canada. From our thematic analysis of our interviews, we identified four themes, which represented personal strengths that fostered resilience to HIV/AIDS: (a) proactiveness, (b) perseverance, (c) having the right mindset, and (d) self-awareness with self-control. This article discusses the importance of these personal strengths to fostering HIV/AIDS resilience, and how community-based resources could potentially lessen the need to muster such personal strengths, or alternatively, cultivate them.

## Keywords

resilience to HIV/AIDS, personal strengths, middle-aged and older, men who have sex with men, community-based resources

Received July 5, 2021; revised August 29, 2021; accepted September 8, 2021

Gay, bisexual, two-spirit, and other men who have sex with men (MSM) have continued to be the most at-risk group for HIV/AIDS in Canada since the start of the epidemic in the 1980s (Haddad et al., 2019; Public Health Agency of Canada, 2013). In 2018, MSM represented the highest proportion of all reported adult HIV cases, and in particular, represented almost half of all people living with HIV/AIDS (PLWH) who identified as male over 40 years old (Haddad et al., 2019). Although there was a downward trend in the incidence of HIV cases in Canada annually from 2008 to 2015, a recent 8.2% increase in new HIV cases from 2017 to 2018 prompted renewed interest among researchers to examine protective factors and interventions that promote the health of PLWH, as

well as MSM and other populations at increased risk of HIV/AIDS (Haddad et al., 2019). Existing and ongoing research studies focused on MSM at risk of or living with HIV/AIDS demonstrate a clear acknowledgment that MSM are a crucial population of interest in the

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continuing efforts to end the HIV/AIDS epidemic (Halkitis et al., 2013; Herrick et al., 2014).

In addition to the struggles related to managing their health issues, MSM and other PLWH have faced a variety of social challenges associated with their HIV status and HIV transmission (Amon, 2014; Emlet et al., 2013; Harper et al., 2014). For example, PLWH have been denied life-saving treatment in health-care settings due to history of illicit drug use, which in turn has led to a mistrust in the health-care system among PLWH (Amon, 2014). Social homophobia has also played a major role, as HIV risk behaviors are often associated with same-sex sexual orientation (Emlet et al., 2013). Homophobia has been identified to contribute to poorer health among gay men and has often been compounded by discrimination against those living with HIV/AIDS (Amon, 2014; Handlovsky et al., 2018). The synergistic effects of prejudice and discrimination against MSM and HIV stigma have led to poor mental health, added stress on personal relationships, and maladaptive coping (Emlet et al., 2013; Harper et al., 2014).

A traditional epidemiological paradigm focused on risk factors has dominated extant research on PLWH. This deficits-based approach has been used in efforts to mitigate and eliminate risk factors associated with HIV/AIDS but has also been reported to reinforce stigmas and negative stereotypes against MSM (Barry et al., 2019; Herrick et al., 2014; Rowan et al., 2014). In response to these findings, Herrick et al. (2014) have proposed the alternative option of utilizing an approach that incorporates naturally occurring resilience in MSM communities to HIV prevention work. While evidence of MSM resilience has been reported in deficits-based approaches, the use of a strengths-based approach would be able to more effectively identify protective factors against HIV/AIDS and help create evidence-informed HIV prevention and intervention techniques (Herrick et al., 2014). Some community-based organizations have already begun focusing on naturally occurring MSM resilience in their services and programs but have not been able to evaluate their work due to lack of resources or opportunity (Herrick et al., 2014). Given their real-world insights, it stands to reason that it would be beneficial for academic researchers to collaborate with community-based organizations in the conduct of participatory research on the resilience of MSM to the clinical and social impacts of HIV/AIDS in order to better inform the research process as well as interventions for HIV prevention and care.

Resilience can be expressed on an individual, collective, or community level, with the individual level focused on internal processes (i.e., individual attributes) and the collective/community levels focused on external forces (i.e., community-based resources) (Dulin et al., 2018; Emlet et al., 2010; Torres de Carvalho et al., 2007).

While all levels are important to understanding how MSM cultivate and utilize their resilience to HIV/AIDS, the findings described in this article will focus on the individual level, analyzing personal attributes of MSM living with HIV/AIDS that contribute to their resilience as individuals and as a community.

Resilience has been defined as a response meant to lessen the negative effects of adversity or create positive change (Luthar et al., 2000; Harper et al., 2014; Smith & Hayslip, 2012). In research, the definition of resilience is varied based on the type of adversity faced, and the perceived type of "resilience" used (Luthar et al., 2000). For the purposes of this article, resilience is defined as the capacity of MSM to: (a) survive the clinical and social impacts of living with HIV/AIDS, (b) live full lives despite a chronic illness, (c) thrive despite challenges brought about by HIV stigma and discrimination, and/or (d) purposefully contribute to the goal of ending the HIV/AIDS epidemic.

In the last 8 years, many researchers have focused on MSM resilience to HIV/AIDS, but there is still more to learn when it comes to the context of their older population (Emlet, 2014; Handlovsky et al., 2018; Harper et al., 2014). Emlet and colleagues (2014) have argued that there is an important place for qualitative analysis to help obtain a better understanding of successful aging with HIV/AIDS and the plight of older MSM. This understanding could help produce more effective interventions and prevention techniques for PLWH and groups at high risk of HIV/AIDS, and at the same time avoid perpetuating harmful stigmas (High et al., 2012). The aim of the qualitative study discussed in this article was to identify and examine individual attributes that have helped forge resilience to the clinical and social effects of HIV/AIDS based on the perspectives and lived experiences of middle-aged and older (MAO) MSM living with HIV/AIDS.

## Materials and Method

A community-based participatory research (CBPR) approach (Israel et al., 1998) was utilized in this study. This approach was chosen because it allowed the study to incorporate and underscore the value of community engagement and the meaningful involvement of MAO MSM living with HIV/AIDS in its research process (Travers et al., 2008). Consistent with the CBPR approach, a strong partnership was established with *Realize*, a community-based organization in Toronto, Ontario, Canada, that addresses and responds to the needs of MAO PLWH. In cooperation with *Realize*, the research team created a Community Advisory Board (CAB) to help determine the goals, focus, and conduct of the study. The CAB was composed of MAO MSM, as well as service providers from AIDS service organizations (ASOs)

and non-profit LGBTQ agencies. MAO MSM were involved in every stage of the research process, not only as study participants, but also as members of the CAB and community-based organization collaborators. The Research Ethics Board (REB) of the Center for Addiction and Mental Health in Toronto, Ontario, Canada, reviewed and approved the aim and procedures of the study (protocol reference number 032/2018) before it was conducted.

### Peer Researchers

MAO MSM were also meaningfully involved in the study as *peer researchers*—members of the research team from the community whose lived and work experiences were relevant and invaluable to the research aim and agenda of the study. Two peer researchers were screened, selected, and hired from an applicant pool, and provided with training and financial compensation throughout the research process. Capacity-building aspects of the study that maximize stakeholder involvement and encourage MAO MSM participation in future research efforts were adapted from a published curriculum for peer-researcher training (Eaton, 2019; Eaton et al., 2018; Ibañez-Carrasco, et al., 2020). The peer researchers were significantly involved in the recruitment, data gathering and analysis, and knowledge exchange stages of the study.

### Participants

The study's participant recruitment strategy was implemented based on the recommendations of multiple community collaborators, including members of the CAB. Participants were recruited using REB pre-approved flyers and email recruitment messages posted through the listservs and websites of the study's community partners. Recruitment flyers were also posted on bulletin boards at the premises of multiple ASOs and LGBTQ agencies across Ontario. Prospective participants were considered for the study if they self-identified as MSM, were 40 years of age or older, residing in Central or Southwestern Ontario, and had been living with HIV/AIDS for at least 1 year. The cut-off age of 40 years was decided on by the authors, so as to distinguish the participants from individuals that researchers would arguably still consider as young adults. A total of 41 MAO MSM living with HIV/AIDS participated in the study during the first 6 months of 2019. Participants of the study represented a diverse group of MAO MSM living with HIV/AIDS (Table 1).

### Procedures

Prior to their interviews, participants provided written consent after receiving comprehensive information

**Table 1.** Participant Demographics ( $N = 41$ ).

Age Range	N (%)
40–44 years old	7 (17)
45–49 years old	8 (20)
50–54 years old	10 (24)
55–59 years old	7 (17)
60–64 years old	5 (12)
65–69 years old	1 (3)
≥70 years old	3 (7)
Race/Ethnicity	N (%)
African/Caribbean Black	8 (20)
Indigenous/Aboriginal	2 (5)
Latino/Hispanic	4 (10)
Middle Eastern/West Asian	3 (7)
South/Southeast Asian	7 (17)
White	17 (41)
Geographical Location	N (%)
Downtown Toronto	30 (73)
Greater Toronto Area <sup>a</sup>	8 (20)
Southwestern Ontario <sup>b</sup>	3 (7)
Identifies as	N (%)
Bisexual	7 (17)
Gay	30 (73)
MSM	1 (3)
Two-spirit	3 (7)
Gender Identity	N (%)
Cis	40 (97)
Trans	1 (3)

Note. <sup>a</sup>The Greater Toronto Area includes suburban cities surrounding the city of Toronto, particularly in the regional communities of Durham, Halton, Peel, and York.

<sup>b</sup>Southwestern Ontario is the secondary region of Southern Ontario in the Canadian province of Ontario; it is southwest of the central city of Toronto and the Greater Toronto Area.

MSM = men who have sex with men.

about the study. The participants were then interviewed by the first author and one of the two peer researchers in hour-long sessions. Each session was digitally recorded and held at either the office of an interviewer, or in a secure meeting room of a community-based organization selected by the participant. The interviews followed a semistructured guide that was created and refined by the research team and community partners. The semistructured guide contained open-ended questions for the purpose of exploring three areas of research interest: (1) the lived experiences of MAO MSM living with HIV/AIDS, (2) their individual attributes participants believed helped forge their resilience to the clinical and social effects of HIV/AIDS, and (3) the reasons why

participants believed these individual attributes helped forge their resilience to HIV/AIDS. Participants received financial compensation in the form of CAN\$25 cash for their time and participation.

Participant interviews were conducted until no new information relevant to emerging major themes could be derived from further interviews (i.e., point of data saturation). The peer researchers transcribed the 41 interviews verbatim, and the first author reviewed the transcripts to verify their accuracy prior to the analysis of the data.

### Analysis

Raw data were made accessible only to the first author and two peer researchers. This policy was enforced to protect the identities of the participants, which would have been at greater risk of exposure if more people were granted access to the raw data. Prior to data analysis, the first author reviewed and appraised all 41 interview transcripts, and then chose 10 representative transcripts (i.e., in terms of participant demographics and perspectives) as the basis for the development and creation of a coding manual.

The participants' transcript data were analyzed using thematic analysis (Braun & Clarke, 2006). Thematic analysis was chosen as the analytic method for the study due to its characteristic flexibility and epistemological freedom. The first author and peer researchers identified initial codes as separate coders, compiling emerging themes and subthemes from the data set. Afterwards, the coders met and compared their themes, subthemes, and codes. They collaboratively defined and named themes and subthemes from the data based on their separate analyses. They then used the themes and subthemes to create a working coding manual that they later used to analyze the remaining 31 transcripts.

After this initial coding phase, the coders composed a de-identified report that contained the finalized themes, subthemes, and supporting quotes. The rest of the research team and the CAB members reviewed the de-identified report with aggregated data, and provided feedback on the themes, subthemes, examples, and general quality of the report. The report had also been used for the secondary analysis of the aggregated, de-identified data. These processes used different techniques to test the rigor of the study's findings, and establish confirmability, credibility, dependability, and transferability of the analyzed findings (Lincoln & Guba, 1985).

Several themes and subthemes were identified during the data analyses stages of this study, but for the purposes of this article, the findings and discussion presented will focus on the themes related to the participants' individual attributes, which they believed helped forge their resilience to HIV/AIDS. No actual participant names were

identified in this article, and pseudonyms were used to uphold participant confidentiality.

### Results

After completing the analysis of the 41 interview transcripts, it became apparent that participants believed they possessed or exhibited individual attributes, (i.e., personal strengths), which helped them forge their resilience to the clinical and social impacts of HIV/AIDS. The participants' personal strengths that were identified in the analysis could be categorized into four major themes. The themes were: (a) proactiveness, (b) perseverance, (c) having the right mindset, and (d) self-awareness with self-control. While in reality these themes undoubtedly interact with other sources of resilience to HIV/AIDS (e.g., social protective factors and community-based resources) to produce synergistic positive effects, these themes are described in this Results section separately as independent, personal strengths.

#### Proactiveness

The first theme that was identified was proactiveness. Over half of the participants attributed at least a part of their resilience to HIV/AIDS to being proactive in numerous ways since their HIV/AIDS diagnosis. Almost 40% of participants described the different ways they were proactive when it came to researching information about HIV/AIDS. They researched on what was known about HIV/AIDS at the time of their diagnosis and the kind of treatments that were available during that period. Most participants specifically sought out their physicians and/or HIV specialists. Some of them went out of their way to specifically look for gay or gay-friendly doctors because they felt these health-care providers would be more sensitive and sympathetic to their plight. Those who sought out gay-friendly doctors mentioned that it was vitally important to them to have a physician who had a better understanding of their needs and a genuine sympathy toward them as a patient. Some participants took charge of evaluating and choosing the treatment options they were going to receive. Since there were little to no medications available early in the epidemic, some participants proactively sought out medications from other countries that were not available or easily accessible in Canada.

A quarter of the participants who described themselves as proactive managed all aspects of their care because they genuinely believed that their life depended on it. David (who had been living with HIV/AIDS for over a decade) recalled, "I took charge of my life. . . looked after my health. . . made the right decisions." These participants made regular visits to their doctors, strictly followed medical instructions, consistently



underwent laboratory tests (e.g., for viral load, CD4 count, sexually transmitted infections [STIs]), and stringently followed their treatment plans. Some of them also proactively sought out more information from not-for-profit agencies, ASOs, and reliable online resources. Instead of waiting for services and programs to be publicly offered, they deliberately sought out services and programs as they were becoming available. Aside from being proactive in accessing medical services, a few of them mentioned being proactive socially. They sought out support groups for their mental health, and periodic problematic substance use. Kyle, who was determined to take control of his own fate from the time he was diagnosed with HIV, described how being proactive with both medical and social concerns were important in his journey, “I was proactive. . .being socially engaged in order to find social supports, identifying and addressing [sexual health] issues as they surfaced, and challenging myself in different ways. . . .”

### *Perseverance*

The second theme identified was perseverance. Several participants recognized perseverance as a personal strength that helped forge their HIV/AIDS resilience. Participants described perseverance as a refusal to let any obstacle or challenge stop them from attaining what they needed to get better, or keep themselves healthy. Charlie, an immigrant participant, explained:

I kept looking for help on my own. When I first came to Canada, I got help from [an international humanitarian organization local affiliate]. Then, I got help from [a homeless shelter], and then [a hospital in Toronto], where I was diagnosed with HIV. I was later referred to [housing services] for more assistance. I knew I had to just keep going and looking for help, wherever I could get it to survive.

One participant described perseverance as the determination to not only survive but thrive. Gregory said, “I acquired the will to live! I wasn’t just going to waste away. . . .” Some of the participants described numerous obstacles in their life, such as losing their job, family, or friends after receiving their HIV diagnosis. Perseverance played an important part in their progress as some participants revealed that they needed to be willing to start their lives anew, despite having little to no support to survive. Some encountered more issues while being proactive in seeking a doctor or accessing medications. Vincent, who persevered until he eventually obtained medical attention, explained, “I just kept carrying on till things got better. I refused to give up, and I kept searching for family physicians in different parts of the city until I finally got help.”

Numerous racial and ethnic minority participants felt they needed to have more perseverance than their White counterparts because they also had to manage issues related to additional challenges they encountered in local communities and the health-care system such as language barriers and racism. Edgar, a Hispanic participant who was already living with HIV/AIDS prior to immigrating to Toronto, shared: “It’s rough enough that I had to deal with homophobia and HIV stigma in our own [LGBTQ] community. . .I needed to persevere against all odds because I had to regularly deal with xenophobia and racism too!” Edgar added, “A nurse said to me once, ‘I don’t know why I have to put up with you people if you can’t learn how to speak English’. I was shocked but wasn’t able to answer back in disbelief!” For several participants, they believed their perseverance was the ultimate factor that saved their lives and helped them survive despite these challenges.

### *Having the Right Mindset*

The third theme was having the right mindset. A quarter of the participants declared a crucial aspect of their adjustment to living with HIV/AIDS was having the right mindset. Some noted that this was not immediately apparent to them after their HIV diagnosis, but at some point in their journey, they attained what they believed was the right mindset. The “right mindset” did not necessarily mean exactly the same thing for each participant. What distinguishes this theme from the other themes is that the participants believed that they gained a perspective that was “right” for their particular circumstances. For some, the right mindset was the ownership of their HIV status. Michael, one of the participants who lived in the Greater Toronto Area, explained: “There is no one else to blame. I take responsibility for my own fate and I am at peace with that.” For others, it was being able to lead by example by emulating other MAO MSM whom they recognized had persevered and thrived while living with HIV/AIDS before them. Eric, a trans participant, explained how his HIV status and gender identity interacted in this way:

It was huge for me to see other trans men transition successfully despite the anticipated challenges [associated with living with HIV/AIDS]. Once I saw it as possible because of the example of others, even though I knew it wasn’t going to be easy, I was sure that I could do it too.

Another example of having the right mindset for some participants was being pragmatic and realizing that they were the masters of their own destinies. They expressed the need to be organized and prepared for things to come. Bob from Southwestern Ontario explained, “You create

your own life. It's knowing what you need to do and making it happen." According to participants, having the right mindset was a personal strength that was often complementary to proactiveness and perseverance.

### *Self-Awareness With Self-Control*

The fourth and final theme identified in the analysis was self-awareness with self-control. Unlike the prior themes, self-awareness with self-control were not as commonly mentioned voluntarily by the participants themselves during the interviews when they discussed their personal strengths. However, based on the interviews, it was evident that many participants possessed these attributes. They displayed keen self-awareness with self-control in various ways. A quarter of them revealed that they stopped taking illicit drugs and excessively drinking alcohol because they recognized that they were adding known risks to their health, especially when they used drugs or consumed alcohol before MSM sexual activity. Some participants exhibited self-awareness with self-control by discussing with others (e.g., family, friends, counselors) matters they realized they needed to consistently work on to mitigate their health risks. For example, they shared that they were aware of the feelings of loneliness they occasionally experienced, and how they needed to exert control of their desire for impulsive, random, and potentially risky, MSM sexual activity to overcome their loneliness.

Additionally, a quarter of participants exhibited self-awareness of the inherent risks associated with MSM sexual activity in bath houses. They understood that if they did not curtail their illicit substance or injection drug use while cruising at bath houses that they could end up contracting drug-resistant STIs, or worse, overdosing. Ben explained, "Bath houses are where you could get hooked on [hard] drugs, so I avoid them at all costs."

Some participants were more aware of their own limits pertaining to alcohol consumption or illicit drug use (e.g., limiting their use to marijuana), while others were more selective with their prospective sexual partners, and/or the places they would engage in MSM sex. Apart from limiting potentially risky sexual practices, some also expressed wanting to focus less on sex in their lives. Jake explained, "I have to be a strong, good person. More conversations, less sex." There were also participants who were particularly attentive to practicing safer sex, such as using protection (i.e., a condom), and avoiding the exchange of bodily fluids, even in the heat of the moment. Based on the participants' perspectives, self-awareness and self-control were personal strengths that seemed to work best in tandem.

## **Discussion**

This study sought to understand the clinical and social impacts that PLWH face on a regular basis, and the types of personal strengths they muster to forge their resilience to HIV/AIDS. The type of resilience that the portion of the study described in this article focused on is expressed on an individual level, particularly as internal processes that MAO MSM use to overcome the clinical and social impacts of HIV/AIDS (Dulin et al., 2018; Emler et al., 2010; Torres de Carvalho et al., 2007). Unlike in prior studies where the focus of the research has centered on the successful aging of PLWH (Emler, 2014; Emler et al., 2010), the specific focus of this study was more about exploring the resilience of MAO MSM living with HIV/AIDS. On examining the lived experiences of MAO MSM, the group that has been at most risk for contracting HIV/AIDS in Canada since the start of the epidemic (Haddad et al., 2019), four overarching themes were identified in the study: (a) proactiveness, (b) perseverance, (c) having the right mindset, and (d) self-awareness with self-control.

The majority of previous research conducted on resilience to HIV/AIDS in the past decade has historically utilized quantitative studies that employed frameworks, surveys, scales, and general measures to approximate the concept of resilience to HIV/AIDS, which were neither customized for the context nor established with the perspectives and direct input of PLWH (Dulin et al., 2018; Emler et al. 2013; Gottert et al., 2019). Notably, several research studies on resilience to HIV/AIDS that were conducted in the last 10 years have not exclusively focused on factors nor generated findings specific to individual attributes that PLWH possessed or mustered, but instead have examined and documented the importance of external factors to forging resilience to HIV/AIDS such as social support from family and friends, improved access to HIV treatment and care, and increased use of health services in the community (Emler et al, 2013; Green & Wheeler, 2019; Harper et al., 2014; Harrison & Li, 2018; Liboro et al., 2021; Owens et al. 2021).

Among the research studies that have looked into individual attributes of PLWH in the context of resilience frameworks, several have explored the lived experiences of young MSM living with HIV/AIDS. Interestingly, the findings that have been documented from these studies revealed individual attributes that were similar, akin, or thematically related to the individual attributes that were described in this paper (Barry et al., 2018; Haddad et al., 2019; Harper et al., 2014; Scorza et al., 2017). These included studies that have discussed: (a) the individual attribute *perseverance* or another finding thematically related to it such as patience (Scorza et al., 2017);

(b) other findings that were thematically related to the individual attribute *having the right mindset* (as defined and described in the Results section) such as self-acceptance, optimism, positive outlook, and taking responsibility for their health outcomes (Barry et al., 2018; Harper et al., 2014); and (c) other findings that were thematically related to the individual attribute *self-awareness with self-control* such as sense of control (Harper et al., 2014).

There have also been some research studies that have looked into individual attributes of PLWH in the context of resilience frameworks that have examined the lived experiences of older adults (both men and women) living with HIV/AIDS. Similarly, these studies have also revealed findings that were cognate and thematically related to the individual attributes identified in our study. The findings that have been discussed in these previous studies included thematically related personal characteristics of older adults living with HIV/AIDS such as self-acceptance, self-esteem, self-efficacy, self-management, optimism, will to live, mastery, independence, and generativity (Emlet et al., 2010, 2013; Fang et al., 2015).

Related to these overlapping and overarching thematic connections between the findings of previous studies and our own study's findings, researchers have suggested that future research should be conducted on MAO MSM who have experienced successful aging (Emlet, 2014; High et al., 2012). As far as we could determine from our extensive literature search, only one article discussed study findings that explored the perspectives and lived experiences of MAO MSM living with HIV/AIDS prior to our own study (Emlet et al., 2017). In an article that analyzed quantitative data from the 2014 longitudinal study, the Aging with Pride: National Health, Aging, and Sexuality/Gender Study (NHAS), Emlet and colleagues (2017) focused on a subsample of 335 older, gay and bisexual men living with HIV/AIDS. However, the findings that were described in their article did not focus on individual attributes but instead discussed the value of social support and community engagement in promoting the resilience of older MSM living with HIV/AIDS (Emlet et al., 2017).

Our study sought to add to the emerging research on resilience of MAO MSM to HIV/AIDS. Using a strengths-based analysis (Herrick et al., 2014), our qualitative study examined our participants' lived experiences by focusing on individual traits that MAO MSM muster to forge their resilience to HIV/AIDS. Employing a CBPR approach, this study was able to harness the experiences of MAO MSM living with HIV/AIDS in the community who have exhibited resilience to HIV/AIDS since the height of the epidemic.

The personal strengths that the participants described and exhibited did not necessarily directly affect their health, but rather, led them to information and resources that provided them the assistance and support they

needed. Participants exhibited proactiveness to manage various aspects of their health needs by seeking out medical resources and social support, as well as strictly adhering to their treatment plans. Their perseverance was key to surmounting roadblocks when resources were not as readily accessible to them. Having the right mindset and self-awareness with self-control were often crucial in initiating and forging their resilience, and in particular, were instrumental in overcoming the social stigma that has historically kept PLWH from seeking out support and resources they need (Emlet et al., 2013; Harper et al., 2014). When the participants had the awareness to help recognize what they needed to survive and make better choices for themselves, it was easier for them to muster their other personal strengths.

### *Personal Strengths of MSM, Ties to Community-Based Resources, and Surviving the Clinical Impacts of HIV/AIDS*

While this article identified and described the participants' personal strengths as separate factors that helped forge their resilience to HIV/AIDS, it was apparent during the study's analysis that the value of the participants' personal strengths was intrinsically and firmly tied to community-based resources. Research has identified that community-based resources are often important pieces of the puzzle to forging resilience (Smith & Hayslip, 2012). This focus on community-based resources has suggested that efforts to forge resilience to the clinical and social impacts of HIV/AIDS may rely more heavily on the availability of community-based resources, and that perhaps, the role of personal strengths to accessing community-based resources need to be examined further.

In order to survive the clinical impacts of HIV/AIDS, the participants mustered personal strengths to procure the medical attention they needed, and subsequently, forge their resilience. They became proactive and took charge of their health by researching information about HIV/AIDS online and from the community, searching for and acquiring their preferred community-based health-care providers, scrupulously navigating the health-care system, and personally managing their treatment plans utilizing community-based resources. They persevered to overcome challenges with accessing the medical care and treatments they needed. Their self-awareness and self-control helped them recognize and reduce risks to their health and well-being, and having the right mindset helped them prepare for decisions they needed to make in terms of curtailing their use of illicit drugs, excessive alcohol consumption, and sexual practices that they believed placed them at increased health and safety risks. These personal strengths contributed to their ability to manage their symptoms, and ultimately, their health. Such individual attributes, along with the positive medical and

health services in the community, have been documented to mitigate the clinical impacts of HIV/AIDS by concurrently lowering stigma and discrimination (Green & Wheeler, 2019).

As part of multiple, often-marginalized groups (e.g., older adults, sexual and gender minorities, PLWH, and/or racial and ethnic minorities), the participants were at a greater risk of experiencing negative health outcomes (Anderson & Blossnich, 2013; Fredriksen-Goldsen et al., 2013, 2015)—specifically, poor physical and mental health (Fredriksen-Goldsen et al., 2017). This suggests that personal strengths, positive medical services, and possibly, related essential support services in the community, are necessary to promote healthcare equity among marginalized groups. Marginalized people often face institutional discrimination, so MAO MSM living with HIV/AIDS may have to develop and sustain certain personal strengths to compensate for a lacking medical system (Krieger, 2014). Research has documented that over half of PLWH have had negative experiences with health-care providers, and that MSM living with HIV/AIDS, in particular, have reported greater comfort and trust in sexual minority doctors (Green & Wheeler, 2019). The latter finding was also evident in this study's interviews, as participants have also reported that they purposely sought out gay, or at the least, gay-friendly or nonjudgmental physicians in the community to manage their HIV/AIDS.

Consequently, an increase in sensitivity or cultural competence training for health-care professionals who work with PLWH may be able to help combat some of this inequity. A general increase in knowledge surrounding HIV/AIDS, HIV stigma and discrimination, and the needs of sexual and gender minorities may also support these continuing education efforts by increasing accessibility to knowledge about the more personal needs of PLWH. Rather than having to do sporadic research themselves, an already well-informed health-care worker could recommend or provide positive services and proper treatment more effectively. Another way to support MSM is for community services to provide platforms for PLWH to recommend doctors and other health-care practitioners who are themselves sexual minorities, or at least, gay-friendly or nonjudgmental. By increasing access to positive health-care personnel and experiences, MAO MSM living with HIV/AIDS may not need to muster as much of the personal strengths described in this article to make up for challenges experienced by PLWH in the health-care system.

### *Personal Strengths of MSM, Ties to Community-Based Resources, and Surviving the Social Impacts of HIV/AIDS*

In order to survive the social impacts of HIV/AIDS, the participants mustered personal strengths to overcome

challenges brought about by HIV stigma and homophobia. They became proactive by seeking out community support groups and social services that were free of stigma and homophobia. Their self-awareness and self-control helped them recognize how stigma personally affected them and respond constructively to the effects of stigma. Having the right mindset helped them work past the effects of stigma and homophobia, and reduce the negative feelings associated with their effects. They even persevered in the face of overwhelming struggles such as rejection and loss of social support from family, friends, and work colleagues.

Social support has been documented to have an inverse correlation with the effects that HIV stigma has on PLWH, and thus, the deterioration of their mental health (Emlet, 2014; Fredriksen-Goldsen et al., 2013). In addition to this correlation, Fredriksen-Goldsen et al. (2017) have also reported that the marginalization of one's age, sexuality, gender, and/or HIV status was connected to the quality of one's mental health, and that individuals with multiple marginalized identities were more likely to face greater struggles beyond the social impacts of HIV stigma. This indicates that social support would be a valuable asset to efforts to foster personal strengths and forge resilience to HIV/AIDS, which has also been documented in related prior research work (Emlet et al., 2010, 2013, 2017; Herrick et al., 2014; Lyons et al., 2016).

A notable factor related to overcoming the social impacts of HIV/AIDS that was discussed in the interviews was the presence of peers in the community who served as positive role models. Participants mentioned that they had to conduct their own rigorous research when they made the decision to take on the responsibility for their own health. For some participants, their ability to persevere was significantly influenced in a positive way by the exemplar of peer MAO MSM living with HIV/AIDS. Other participants noted that a lack of role models and social support from laudable peers was a marked challenge they faced. The need to be more proactive, and persevering was often a result of not having readily available information and support from peers or positive examples to emulate. As previous research has noted, having an increased sense of community and social support reduces struggles encountered by PLWH as well as alleviates loneliness and stigma (Fredriksen-Goldsen et al., 2013). At the beginning of the HIV/AIDS epidemic, role models were scarce. Today, those who have since forged resilience in the face of the adverse impacts of HIV/AIDS over the last four decades are now excellent candidates to be role models for MSM who have more recently been diagnosed with HIV/AIDS.

This study aimed to harness new knowledge on resilience to HIV/AIDS from the perspectives and lived experiences of MAO MSM living with HIV/AIDS in order to



inform future policies, procedures, and processes meant to help other MAO MSM forge their resilience to HIV/AIDS. However, the study participants' perspectives and experiences could also potentially have more direct influences on the development or improvement of community programs. Mentorship in MSM communities has been known to provide psychosocial benefits to both mentees and mentors (Sheran & Arnold, 2012), and the addition of mentorship programs in communities of MAO MSM and other PLWH may help directly alleviate the social impacts of HIV/AIDS. Creating specific spaces for mentorship where relevant stakeholders of the community can connect, learn from each other, and empower each other could help alleviate the struggles and the effects of stigma associated with HIV/AIDS (Barry et al., 2018).

## Conclusion

In this study, resilience to the clinical and social impacts of living with HIV/AIDS was reported to be positively associated with personal strengths that MAO MSM possessed, mustered, or utilized. The identified major themes were fundamentally connected with one another. While each was described as distinct personal strengths that the participants either directly credited as characteristics they needed to develop or attributes they naturally possessed, there were apparent overlaps between the influence of each of the four strengths. For example, participants often had to exhibit proactiveness prior to later developing perseverance. Each personal strength seemed to be a building block necessary to achieving their ultimate goal, which was to survive and thrive despite the impacts of HIV/AIDS, and eventually, forge their resilience.

Physical health and mental health tend to be closely intertwined among older MSM, with both aspects of health affecting, and considerably affected by, their resilience (Fredriksen-Goldsen, 2017; Handlovsky et al., 2018). It would be reasonable to surmise that if someone were to struggle with one aspect of their health, they would likely struggle with the other health aspects sooner or later. This may mean that individuals who lack any or all of the four personal strengths described in this article may find themselves with poorer physical and/or mental health compared to those who do exhibit or possess such personal strengths. Discrepancies between the care and support received by MSM living with HIV/AIDS and their heterosexual, cisgender counterparts have been reported in research studies (Handlovsky et al. 2018; Krieger, 2014), and it is highly possible that discrepancies between the care and support received by MAO MSM living with HIV/AIDS who exhibit relevant personal strengths, and those who do not, also exist. Inherent characteristics and circumstantial privileges that are expectedly different for each individual may largely

account for the abundance or significant lack of the personal strengths among MSM that were discussed in this article. An increase in access to the positive community-based resources described earlier would likely allow for the promotion of more equitable use of health and support services among diverse MAO MSM living with HIV/AIDS, and prospectively, either decrease their need to muster personal strengths or help cultivate them, depending on the individual.

Social stigma and a dearth of positive community-based resources still affects PLWH, and the discrimination and marginalization that PLWH face directly contributes to health inequities (Emler, 2014; Fredriksen-Goldsen et al., 2013; Handlovsky et al., 2018; Krieger, 2014). In this study, possible ways to decrease health-care inequity affecting MAO MSM living with HIV/AIDS were discussed. An increase in sensitivity and cultural competence training specific to the needs of MAO MSM for health-care practitioners, especially those who work closely with PLWH, could help limit many adverse effects. Community services for MAO MSM living with HIV/AIDS could incorporate evidence-informed mentorship programs and provide platforms for sharing relevant information based on the lived experiences of those who have already survived and thrived the deleterious impacts of HIV/AIDS for decades. These programs and platforms, in turn, could alleviate the need for developing more personal strengths to help forge resilience, or conversely, supply the necessary elements for cultivating such important personal strengths.

## Limitations of the Study

One limitation of this study is the possible effects of its participant recruitment strategy. Since the study heavily relied on recruitment through ASOs, the recruited participants were likely from the same or adjacent social groups. ASOs and close community partners aided participant recruitment at all stages, so many participants likely came from the same pockets of the community. These participants may have had more bias toward the utility of community-based resources than others from the general population of MSM living with HIV/AIDS who may not have been as engaged with services offered by ASOs. While the study's recruitment strategy allowed for more active participant recruitment, it may have also potentially limited the types of background participants had. Other plausible limitations of the study would involve particular participant sociodemographics. It is important to note that all the participants of the study have had access to universal health care, which could have been a significant factor that affected the development of their personal strengths and other attributes. Knowing that there would be fewer financial obstacles

for them to obtaining medical attention and other health-related services due to the availability of universal health care could have influenced the participants' decisions to be proactive and persevering, as well as their motivations to develop a positive mind set and higher degree of self-awareness. In terms of gender identity, the interview data we obtained almost exclusively represented perspectives and lived experiences of cisgender MSM, as the study was able to recruit only one trans participant.

### Direction for Future Studies

To address these limitations, more research exploring the perspectives and lived experiences of MAO MSM living with HIV/AIDS needs to be conducted. This study sought to fill a gap in HIV/AIDS research by harnessing and examining the lived experiences of MAO MSM in Ontario, Canada. However, more qualitative research in other contexts needs to be conducted to gain a more complete picture of how MAO MSM forge resilience to the clinical and social impacts of HIV/AIDS based on the perspectives and lived experiences of other MAO MSM living with HIV/AIDS. Prospectively, researchers could conduct similar qualitative research on MAO MSM living with HIV/AIDS at different geographical locations and settings to add to this growing body of knowledge, particularly because different geographical locations and settings may yield distinct perspectives from different lived experiences. Based on the study's findings and lessons learned, community-based resources could play a significant role in fostering the personal strengths, and consequently, forging the resilience of MSM living with HIV/AIDS. Further research could focus on how to utilize existing and emerging community-based resources and dedicate their programs and services to fostering personal strengths of MSM living with HIV/AIDS.

### Acknowledgments

The authors would like to acknowledge the invaluable collaboration of Ms. Tammy Yates, Dr. Andrew Eaton, Dr. Francisco Ibañez-Carrasco, Dr. Lori E. Ross, Dr. Paul A. Shuper, our Community Advisory Board, and the various AIDS service organizations and community-based agencies across Ontario, Canada, who supported our study.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was funded by the Canadian Institutes of

Health Research Operating Grant – HIV/AIDS Community-Based Research Program (funding reference # 156917).

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