

Introduction

Gold noted that the self-statements gay men use to describe their high-transmission risk sexual encounters were often rationalizations that may increase the transmission rate of HIV [1]. Gay men in his studies often minimized the risk of each contact, and both HIV-positive and -negative men largely assumed their partners shared their serostatus. In exploring the driving factors underlying continued risk by repeat negative testers, Dilley, et al. [2], noted that these self-justifications (SJs) might be used to develop successful interventions for use with MSM, and developed Personal Cognitive Counseling (PCC) as an intervention that combines challenging these SJs with the responsive, non-judgmental approach of Motivational Interviewing [3]. We have demonstrated that this is an effective approach in reducing the number of partners and proportion of high transmission risk sex among HIV-negative men [2,3], and are currently concluding a clinical trial applying this approach to HIV-positive men.

In both clinical trials, pilot work developed a Self-Justification Questionnaire (SJQ) specific to each population. The following results are the most common SJs identified through the use of this questionnaire in two clinical trials, the first with HIV-negative men [3], and an ongoing application of this intervention with HIV-positive men.

Methods

Recruitment varied slightly for each study, in ways likely to maximize the representative nature of the participants recruited. The HIV-negative sample was recruited through an in-house, well-established counseling and testing program frequented by a large number of MSM [3]. HIV-positive participants were recruited in a variety of settings, including HIV outpatient clinics, fliers around the city, mental health centers that cater toward HIV-positive clientele, etc.

Qualitative Interviews

In each study, a pool of 30 eligible individuals were first interviewed in a semi-structured format [similar to 1, 2, 3] intended to elicit and identify SJs specific to the decision to have unprotected anal intercourse with a partner of unknown or discordant serostatus.

Instrument Generation

Transcripts of the qualitative interviews were analyzed by a team of licensed mental health professionals for content using Grounded Theory [4], and themes identified and coded via *Atlas/ti* software.

Cognitive Interviews

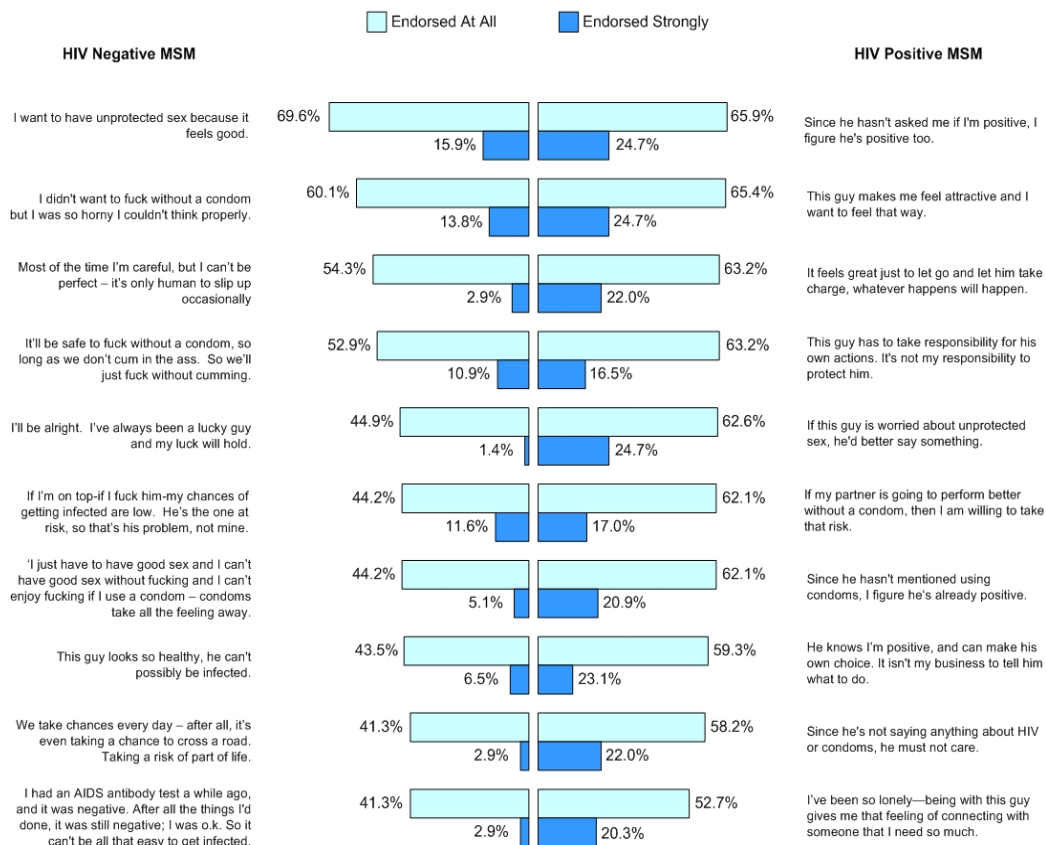
A preliminary format was administered to 16 men in each study, with structured probes [2,3] and think-aloud techniques [2,3] used to determine which items were confusing or unclear, easily recognizable, or merited exclusion.

Scale Construction

Finally, the working format of the SJQ was administered in a paper-pencil format to 70 MSM. Response frequencies were examined with exploratory factor analysis and estimates of scale reliability to further select items for exclusion. The resulting SJQ was used in a clinical trial, with the results depicted here.

Results

Top Ten Most Endorsed Self-Justifications



Characteristics of HIV- MSM Participants

N = 124

	(%) or Mean
Age	32.7
Race	
White	75.8
Asian/Pacific Islander	6.5
African American	3.2
Latino	11.3
Income > \$30,000/year	56.9
Education > High School/GED	75
Anal Sex Partners (past 12 months / lifetime)	5 / 25

Characteristics of HIV+ MSM Participants

N = 190

	(%) or Mean
Age	43.5
Race	
White	42.8
Asian/Pacific Islander	4.0
African American	26.5
Latino	15.0
Income > \$30,000/year	15.0
Education > High School/GED	74.7
Anal Sex Partners (past 12 months / lifetime)	13 / 22

Discussion

A number of central themes were identified for each group. For HIV-negative men, we already have evidence that an intervention focusing on these beliefs, thoughts, or feelings is an effective intervention in reducing high-transmission risk encounters. These differ in some ways for negative men, in which the most frequently endorsed items were related to the pleasurable feelings of unprotected sex, which are underrepresented in the thematic clusters.

Among HIV-negative MSM, the most common SJs were related to:

- Issues of impulse control/desire (I want to have UAI because it feels good; I was too horny...)
- Relationship between intimacy and emotional need for unprotected sex (I love this guy. A condom would spoil all the romance...)
- Inferences that the partner is not likely to be HIV-Infected based on information (...neither of us has symptoms of AIDS, so it will probably be okay)

Among HIV-positive MSM, the most common SJs were related to:

- Assumptions about partner's behavior and serostatus (If he's doing X, he must be positive...)
- Deferred responsibility with regard to HIV transmission (It's his responsibility to take the initiative to be safe...)
- Unprotected sex satisfying some emotional need (I was so needy that I wasn't going to stop things...)

Future Applications

There are a number of avenues yet to be explored in the application of challenging SJs as a model of a brief intervention. Past research has demonstrated that shedding light on these views in the "clear light of day," while couched in a directive yet nonjudgmental framework inspired by Motivational Interviewing [5], is a powerful intervention for HIV-negative men [2]. We'll soon know if it is equally effective for HIV-positive men. Future studies should focus on expanding the intervention for use among women, whose SJs will likely differ, and exploring whether the effectiveness of SJs targeting interventions can be improved among persons of color through identifying more specific self-justifications. Currently, we are working to explore whether it is more effective to tackle those SJs that interfere with serostatus disclosure or discussions of status.

References

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2. Dilley, J. W., et al. (2007). Brief cognitive counseling with HIV testing to reduce sexual risk among men who have sex with men. *J Acquir Immune Defic Syndr*, 44, 569-577.
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