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NARRATIVES OF CHANGE FROM GAY AND BISEXUAL MEN LIVING WITH HIV IN AN EMOTIONAL WELL-BEING INTERVENTION

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Abstract

The emotional burden of an HIV diagnosis can impact HIV outcomes and overall well-being. We piloted a four-session individual-level emotional well-being intervention, offered during HIV care visits, for gay and bisexual men living with HIV in Guatemala City who were recently diagnosed or re-engaged in care. To assess intervention impact in a contextualized manner, we conducted longitudinal qualitative interviews ($n = 3$) with study participants ($n = 10$) over 12 months. Data analysis included thematic coding using NVivo and longitudinal narrative summaries and matrices to identify narratives of change and assess intervention impact. Participants experienced changes in their view of self and diagnosis perceptions, improved physical and mental health, increased interest in sex and relationships, and a clarification of their life goals. The intervention helped participants reach diagnosis acceptance, improve self-esteem, and gain self-efficacy for managing life with HIV. Findings support the importance of integrating emotional well-being into HIV care.

Keywords

HIV; emotional well-being; narratives; gay and bisexual men; Guatemala

INTRODUCTION

In almost every context globally, gay, bisexual and other men who have sex with men (GBMSM) experience a disproportionate burden of HIV (Gama et al., 2017). In recent years, there have been major advancements in access to HIV care and anti-retroviral therapy (ART), which has allowed countries to pursue treatment as prevention (TasP) strategies (the use of ART to prevent HIV transmission) (Cohen et al., 2011). However, beyond access, the emotional burden of an HIV diagnosis and of managing life with HIV can exact a significant mental health toll on people living with HIV (PLWH), which can impact retention in care, adherence to ART, and viral suppression, ultimately reducing the effectiveness TasP strategies (Blashill et al., 2011).

Increased psychological distress caused by an HIV diagnosis has also been found to accelerate disease progression, reducing CD4 counts and increasing viral loads (Ironson et al., 2005). Psychological distress among newly diagnosed GBMSM is heightened due to intersecting HIV and sexual minority-related stigma and discrimination (Blashill et al., 2011). Thus, the time period following a recent HIV diagnosis or re-engagement with care can be a key point for intervening to provide support to address individuals' fears, doubts, and insecurities, with the overall goal of improving their HIV care outcomes (Yang et al., 2018).

In recent years, a growing number of emotional well-being interventions have been developed to promote improved and sustained HIV care and treatment outcomes among PLWH. Many of these interventions for newly diagnosed individuals are centered around motivational interviewing (MI) and cognitive behavioral therapy (CBT) techniques (Brown & Vanable, 2008). For example, Kennard et al. (2014) developed a Health and Wellness CBT intervention, based in MI, CBT, and problem solving, to address issues of non-adherence and to increase overall well-being, which was found to be feasible and acceptable among young adults living with HIV (Kennard et al., 2014). Psychosocial interventions specifically with GBMSM living with HIV have similarly achieved positive mental and physical health outcomes, including significant increases in HIV-related quality of life and reductions in HIV-related distress (Millard et al., 2016; Yang et al., 2018). The Shikamana intervention, which combined provider counseling with support from peers to improve ART adherence among GBMSM living with HIV in Kenya, is a particularly efficacious example of this type of intervention among this population, as it led to a six-fold increase in odds of viral suppression at follow-up (Graham et al., 2020).

Although interventions have been developed to address emotional well-being and HIV outcomes among newly diagnosed GBMSM, to our knowledge, no published studies have been conducted in the Latin American region. Our approach is also unique in that we conducted a longitudinal qualitative study including three interviews spaced at 6-month intervals, which allowed us to look at changes over time. The aims of our study were to: (1) describe the changes experienced by recently diagnosed or re-engaged individuals during their first year of HIV care and (2) determine if and how an emotional well-being intervention contributed to these changes.

METHODS

STUDY SETTING AND INTERVENTION OVERVIEW

Within Guatemala, while population-level HIV prevalence among adults is estimated to be less than 1%, HIV prevalence among MSM is 10.5% (Guardado Escobar et al., 2017; Miller et al., 2010). Research in Guatemala has found that fear of discrimination due to sexual identity and fear of HIV stigma prevent GBMSM from using sexual health services (Boyce et al., 2012). From January 2017 to June 2018 we conducted an implementation science study to pilot a multicomponent intervention to promote viral suppression, ART adherence and retention in care among GBMSM living with HIV in Guatemala City. This paper focuses on one intervention component, emotional well-being (EW). Participants also received health navigation and mHealth messages.

The EW component included four individual health education and counseling sessions lasting approximately one-hour long and delivered by a psychologist (Y.P.R.). The intervention occurred during the first 6 months of the 12-month study window (described below). The curriculum for the study was informed by findings from formative research with GBMSM living with HIV and HIV care providers (Barrington et al., 2016) and adapted content from two interventions (Carcaño et al., 2015; Donastorg et al., 2014). In order to further tailor the content for this study setting and population, we also conducted additional formative research in Guatemala City as part of the first aim of the current study (Barrington et al., 2020). The insights from the adaptation and formative research processes were used to develop an intervention manual to guide the implementation of the EW intervention. Each of the four sessions had a specific objective and topical focus including: Session (1) social support and discrimination; Session (2) adherence, addictions, and HIV knowledge; Session (3) sexual health, diagnosis disclosure, partner relationships; and Session (4) developing a life plan. Content was guided by the intervention manual but was also flexible in response to participants' needs and was not necessarily delivered in the same order for each participant. ART adherence was a crosscutting theme addressed during each session. The psychologist tracked and recorded the number of sessions attended by each participant.

RECRUITMENT AND DATA COLLECTION

Inclusion criteria for the study were: male, at least 18 years old, ever had sex with another man, diagnosed with HIV or re-engaged in care in the 12 months before the study, and spoke Spanish. In total, 113 participants were recruited and consented to participate in the study. At baseline and endline, participants had a blood draw to assess their viral load, the primary biological outcome. An embedded sample of 10 participants were recruited from this larger sample to participate in longitudinal qualitative interviews at baseline (which occurred upon recruitment into the study), 6 months after baseline, and 12 months after baseline. Nine of the participants completed all three interviews, while one participant only completed two (baseline and 6 months), for a total of 29 interviews. Interviews were conducted between February 2017 and June 2018 and lasted between one and two hours. A Guatemalan woman with a background in anthropology, who had expertise in both HIV research and qualitative interviewing (K.G.) conducted the interviews in a private office at the HIV clinic where participants received care using a semistructured interview guide. The baseline interview

guide was focused on establishing rapport and eliciting the participant's HIV story from diagnosis to their current experiences managing life with HIV, including care and treatment as well as employment, social networks, and intimate partnerships, among other topics. The guides for the follow-up interviews at 6 and 12 months probed on intervention experiences as well as ongoing experiences with HIV care and treatment adherence and included tailored probes based on past interviews. To understand the unique impact of the EW intervention, beyond the effects of the other components of the intervention, the interview guide specifically asked about participants' perceptions of the EW intervention and its impact on their lives. The interviewer wrote field notes after each interview. Throughout the data collection process, a research assistant, who was not present during the interviews, used the interview transcripts and audios to rapidly create narrative summaries to facilitate the tracking of changes over time and to inform subsequent interviews.

PARTICIPANT CHARACTERISTICS

Average participant age was 29 years old (age range = 19–45). All but one participant (who identified as bisexual) identified as gay. Half of the participants were in a relationship at the time of their first interview. Two participants had completed middle school, two had completed high school, and six were in university or had a university degree. Half of the sample worked full-time ($n = 5$), while about half were unemployed ($n = 4$), and one did seasonal work. While participants were offered a maximum of four EW sessions, most ($n = 7$) completed at least three (range = 1–4). Participants had been diagnosed with HIV between 8 days and 5 years before their first interview (average = 1 year, median = 8.5 months). Only one participant (Carlos) was care re-engaged; the rest were newly diagnosed. See Table 1 for full participant demographics at baseline. All participant names presented in this article are pseudonyms.

DATA ANALYSIS

Interviews were audio-recorded and transcribed verbatim in Spanish. The lead author (S.M.B.), a PhD student from the United States who is fluent in English and Spanish and trained in qualitative research methods, used a multistage analytic process involving a combination of thematic and narrative techniques (Gibbs, 2007a; Maxwell & Miller, 2008; Riessman, 2008). Informed by thematic techniques, she first read all of the transcripts multiple times and wrote reflexive memos about her perceptions of the data and emergent themes (Gibbs, 2007a). She then developed a codebook based on those themes as well as content from the interview guide. Codes were created both to capture participants' experiences at each timepoint and change across interviews. NVivo 12 was used to code the data (NVivo Qualitative Data Analysis Software [NVivo 12], 1999). New codes that emerged during coding were iteratively applied to all interview transcripts.

Informed by narrative techniques, S.M.B. then created a longitudinal narrative summary to organize participants' narratives from the three interviews into chronological order (Barrington et al., 2021; Riessman, 2008). This restructuring of the data was important as participants might tell or elaborate on stories from the past during their follow-up interviews. This is a strength of longitudinal data, as it not only allows for an understanding of changes over time, but it can also provide more depth to participant stories (Barrington et al.,

2021). The lead author structured the narrative summaries into participants' experiences from the past (before the start of the study), participants' experiences between interviews, and participants' perceptions or experiences at the time of the interview (during the present moment).

S.M.B. then combined summaries and codes into two matrices (Barrington et al., 2021; Gibbs, 2007b; Miles & Huberman, 1994). The first matrix summarized different types of impacts of the EW intervention by participant and was based largely on the code outputs (see Table 2), and the second was created from the narrative summaries to capture changes that occurred across time points by participant (see Table 3). The types of impacts, which were the column headers of the first matrix, came directly from the sub-categories of the change over time codes, and included mental and physical health, view of self, diagnosis perception, adherence regimen, and goals/fears. These matrices allowed for an analysis of both between participant themes and within participant changes across time, and for an understanding of how the EW intervention contributed to these changes. From the matrices, S.M.B. identified dominant narratives of change, changes that occurred over the course of the year that were shared by the majority of participants, and reflections on the impact of the intervention. CB was the study's principal investigator and supervised data collection and analysis.

ETHICAL APPROVAL

All participants consented to participate in the overall study and qualitative interviews. The study was reviewed and approved by the Guatemalan Ministry of Health and the Universidad del Valle de Guatemala's Ethics Committee for the Protection of Human Subjects and the University of North Carolina at Chapel Hill's Institutional Review Board.

RESULTS

We present the results as narratives of change over time across the baseline, 6-month, and 12-month interviews. These changes included: (1) view of self and diagnosis perceptions; (2) physical and mental health outcomes; (3) sex and relationships; and (4) life goals. Interwoven with each narrative is how participants reflected on the impact of the EW intervention on these four areas of change. Although all participants experienced significant changes over the course of the intervention period, two participants (Miguel and Carlos), only completed one and two sessions (respectively) and did not attribute any of these changes to the EW sessions, mostly due to the fact that they did not like psychologists.

VIEW OF SELF AND DIAGNOSIS PERCEPTIONS

One of the most significant changes that took place over time was in how newly diagnosed participants viewed their HIV diagnosis, and in turn, how changes in their perceptions of the diagnosis impacted how they viewed themselves or thought that others viewed them. At baseline, Juan feared that because of his diagnosis he was "branded," and worried that others would notice that he had become paler. Endorsing similar feelings of self-stigma, Luis and Miguel used words like *dirty* to describe themselves and expressed that their diagnosis had shaken their self-confidence. Additionally, many participants' view of their diagnosis

was characterized by fear of death and uncertainty. For participants, like Jose and Luis, their ultimate goal was to reach a place of “normality.”

Over time, these perceptions shifted from shock and fear to greater acceptance at the end of the intervention period. For example, at baseline Francisco described feeling like he was in an “atmosphere of death.” At endline, he described, “How does one look at HIV today? Let’s say it’s not one, it’s not a ... death sentence let’s say ... I don’t know, I always do the ..., the comparison that is made, sometimes, that HIV could be comparable to, living with a chronic disease, say.”

While Francisco did not directly tie this change to the EW intervention, the intervention directly addressed the myth of HIV as a death sentence, specifically how someone who is diagnosed with HIV can live a long and healthy life. This language was reflected in Francisco’s changing perceptions.

Other participants explicitly connected achieving acceptance of their diagnosis to the EW intervention, which helped them to overcome the guilt that they felt for having contracted HIV. Juan, who expressed significant guilt and fear related to his diagnosis at baseline, used a metaphor to describe how at 6 months he perceived his diagnosis as “a wound that is closing ... in the soul.” At his 12-month interview, he said the EW intervention had helped the wound to heal: “With [the psychologist], then, with what she helped me with was, to ... maybe heal some wounds, to be able to go through, the process, of acceptance ... to know that, that it is possible, to move forward....”

PHYSICAL AND MENTAL HEALTH OUTCOMES

A second change that occurred over the intervention period was in participants’ physical and mental health. At baseline, some participants, specifically those that had been diagnosed and engaged with care for less than 5 months, had high viral loads (4/10 were not virally suppressed), reported low CD4 counts, and feelings that their mental health had deteriorated, both in the form of depression as well as newly emerging anxieties related to their diagnosis and uncertainties about the future (which overlapped with their diagnosis perceptions and journey towards diagnosis acceptance described above). In an effort to improve their immune systems and health, almost all of the participants described making adaptations to their lifestyles. These changes included reducing alcohol consumption, eating healthier, and sleeping and working out more. While participants recognized that ART was important to improving their physical health, a few described struggling with taking their medications daily and incorporating them into their schedules.

By their 6-month visit, the dominant narrative was that participants’ mental and physical health had improved or they had begun receiving treatment for mental health conditions. One participant, Santos, shared that the clinic’s psychologist prescribed him antidepressants between his first and second interview due to worsening mental health related to the uncertainty of his diagnosis, including not knowing when he might get sick. In regard to their physical health, participants reported that they had continued reducing the behaviors from baseline that they viewed as unhealthy, including cutting down on cigarette and alcohol consumption, a change that some participants, like Pedro, attributed to the EW intervention.

In response to a question about if his life had changed since the intervention, Pedro stated: “Yes, now I almost don’t smoke ... before [the intervention] I smoked like five or six cigarettes daily ... [now it’s] like two or one.”

An example of additional positive physical and behavioral changes was recounted by Miguel at his 6-month interview:

Thank god I’ve been good ... surprisingly because before I was always sick with a cold ... now I have not been sick with anything ... the only thing that I have not achieved is to quit smoking ... but I’ve already reduced the amount, because before I smoked two packs and now I only smoke half.

Participants also shared how their improved physical health, specifically reaching viral suppression, improved their mental health, as exemplified by Luis:

Well, for the moment, I feel that maybe since my last appointment, my spirits went up, because, well, in the first months of the appointments I was kind of worried because my viral load was like very high eh, my defenses were very low.... In my last appointment, well, they gave me the news that my, my viral load was 119, so it was like, well, almost undetectable.... Then it was like wow! I mean, maybe that raised my spirits

Participants reported that these positive mental health changes were often closely tied to the EW intervention. Specifically, they described how the intervention and the emotional support they received in the sessions helped to calm their fears. At the final interview, Francisco described how the intervention had helped him with his thinking process: “It taught me about how to uninstall, to try to uninstall negative thoughts that I had lodged in my head, some I have not been able to remove.... And, and also, uh, to manage to place positive thoughts in my head.”

Francisco described how during bad mental health moments he draws upon the affirming positive thoughts exercise that he did during the EW intervention. For another participant, Manuel, who at the beginning of the study had significant anxiety about being rejected from work or by his family if they found out about his diagnosis, by the 12-month interview he reported that the EW intervention helped him to overcome some of this anxiety: “Yes, change, because I felt very sad, I felt as if I could never get out of that hole, let’s say.... And now, thank God, yes, I have been able to get out, right? ... I don’t feel very nervous ... as a result of the fact that [the psychologist] provides support.”

For Manuel, the EW intervention, specifically feeling supported by the study’s psychologist, helped to address some of his anxiety, which improved his overall mental health and well-being. Finally, the intervention was useful for one participant, Jorge, in connecting him to mental health care. Although at baseline Jorge shared that his diagnosis did not make him feel “sad,” at his 12-month interview he shared that he had been depressed since his diagnosis, and that he had not known what to do. However, he reported that the intervention had helped him to feel better and that he had learned from the psychologist about where to seek professional help for his depression.

By 12 months, all participants had reached viral suppression (<400 copies/mL), leading them to switch their health goals from achieving viral suppression to generally staying healthy. At this point, participants talked less about their changed health behaviors, as they had become an entrenched component of their new lives with HIV. Although participants continued to attribute the positive changes in their physical health to their ART, some participants shared that they were growing tired of having to take a medication every day. In contrast, for others, taking ART had become a routine part of their lives, they had family or partners who reminded them to take their medications, even when some of these individuals did not know why the participant was taking a daily pill, or they felt that the EW intervention had helped them to improve their management of their HIV care and treatment adherence. Although few participants specifically mentioned how the intervention improved their adherence, for Manuel, the intervention taught him about the medical importance of adherence, which he had not learned about from his clinicians.

SEX AND RELATIONSHIPS

Participants also reported significant changes in their sex lives, relationships, and comfort with disclosure to partners, family, and friends. Over the course of the year, multiple participants shifted from not wanting to have any sexual relationships, to starting to be open to sex and/or a relationship at 6 months, to being in a new relationship and/or feeling interested in having sex again by the end of the year. At baseline, decisions to not have sex were driven by fears of infecting others, rejection, and of having to disclose their HIV diagnosis. However, by 12 months, having reached viral suppression helped participants feel more comfortable with sexual encounters. Multiple participants attributed these changes in their comfort and interest in having sex and/or relationships to the EW intervention. They reported that the intervention helped them overcome fears of rejection and gain the confidence necessary to start a relationship. Luis described how the EW intervention helped him start a relationship by the third interview:

I felt afraid of meeting someone, perhaps [the intervention] was also what helped me, as well as encouraging me to meet someone else, right? Because I was [emotionally] shut away. And I have told my boyfriend, that I was shut away in my circle, since I was diagnosed, I no longer wanted to meet anyone ... but in the end [the psychologist] told me no, well, that is, to release all that, and well, yes it helped me a lot.

The intervention helped Luis to regain his self-worth and encouraged him to release negative perceptions of himself and fears that were keeping him from feeling worthy of a relationship.

Among participants with stable partners, the biggest change in their sex life was using condoms to prevent transmission or, if their partner had HIV, re-infection. Although some participants at baseline reported struggling with remembering to use condoms consistently or reported having trouble getting used to using them at midline (which led some partners to have less sex), participants reported that they and their partners understood the importance of condoms for protection. At their 12-month interview, most participants reported that they had adapted to using condoms. While participants did not directly attribute this change in

condom use to the EW intervention, condoms use was highlighted during the session about sex and relationships.

For participants who already had a partner at the time of their diagnosis, the diagnosis also encouraged them to reflect on their relationships. For some, they perceived the diagnosis as leading to a maturing of their relationship in areas like conflict management and support. For others, their diagnosis encouraged them to end relationships that they viewed as unhealthy; Manuel broke off a relationship where his partner was cheating on him, and Francisco broke up with a partner who was using him financially. Participants reported that the EW intervention helped them to make these changes in their relationship through a focus on relationship evaluation and self-esteem. For Santos, the intervention encouraged him to stand up to his partner and ask for more respect; it also connected him to couples' therapy. For Luis, the intervention gave him tools to overcome guilt and fear of infecting his HIV negative partner:

It helped me a lot like, eh, to be able to get rid of that anger that maybe I had against myself, eh, to feel angry, because of my diagnosis and because it was an oversight of mine and [the psychologist] said, no, it's not your fault then, then take the blame and throw it away because it is not your fault.

For these participants, the intervention was key to encouraging them to assess their relationships, strengthening those that provided them with positive support and cutting ties with those that acted as negative forces in their lives.

For participants who were avoiding sex due to disclosure fears, the EW intervention helped them to feel more in control of their disclosure decision-making. At baseline, Luis shared his view of sex and disclosure as a potentially dangerous activity for himself and others: "I had a long time not of not having, sexual relations ... first because it scares me, eh, because I don't want to, harm another person, I don't want to be like disclosing my diagnosis to many people and say to someone look, before having sex, look, I'm HIV [positive]."

At 6 months in the intervention, Luis realized that sex and disclosure did not need to be as fear-inducing as he had previously believed:

[The psychologist] said, she told me that it was not my obligation to tell the person who was with me ... until I feel comfortable telling him look, I'm going through this ... so that helped me, because it made me see how more, to open my eyes more and stop telling myself, yes, I am the guilty [one].

The EW sessions helped Luis realize that as long as he was protecting his sexual partners, he did not need to disclose to them until he felt comfortable. By the final interview, Luis shared that he had a new partner, and had a positive experience disclosing to him.

The EW intervention also impacted participants' views of disclosure to their family and friends. Although at 12 months the majority of participants still had not disclosed to their family and friends, participants felt that the intervention gave them tools (including analyzing the risks and benefits of disclosure and practicing the disclosure steps) to do so when they were ready for this step. Additionally, learning from the EW sessions about their

legal disclosure rights, including their right to confidentiality, empowered participants in their disclosure decision-making and in creating supportive social networks.

LIFE GOALS

The final change that participants reported over the course of the intervention period was in their life goals. The dominant narrative across participants was that by their final interview, their HIV diagnosis, combined with the EW intervention, helped to clarify their goals, and bring into focus what was most important to them. For example, at baseline, Francisco's main goal was to go back to school; by his final interview, he reported that his diagnosis made him want more stability in his life, which shifted his goals towards supporting his family, migrating to the United States to pay off his debts, saving money, and establishing himself permanently in a location.

However, for some participants, managing their goals while also managing their diagnosis was a challenge. Carlos, who was in school, reported that having to go to his HIV appointments impacted his ability to turn assignments in on time. During his 6-month interview, Carlos described the consequences of missing classes because of his monthly appointments: "Things have gotten complicated for me ... the teachers have already given me an ultimatum, 'If you continue missing [class], forget it here.' ... I prefer to come to my appointments and skip University."

By his 12-month interview, Carlos reported being better able to manage this challenge through conversations with his professors, although he was still working with the clinic providers to get a doctor's note for one stricter professor. Additionally, as Carlos improved his diagnosis management, he also started performing better in school.

For other participants who were struggling to restart or re-imagine their futures, the life plan component of the EW intervention helped them to develop confidence that they could achieve longer-term work and school-related goals that they put on hold while they were still learning to manage their diagnosis. As Manuel, a participant who at baseline was unemployed and battling with fears of rejection from employers due to his diagnosis, shared about his experience with the intervention during his 12-month interview, "I still remember that [the psychologist] told me, um, that I was special ... and that I had to continue forward, so because of that, *I wanted* to continue forward ... it motivated me a lot.

Between baseline and his 6-month interview, Manuel found part-time work, and at his 12-month interview, his goal was to find a full-time job.

Particularly for the nearly half of the sample ($n = 4$) who were unemployed at baseline, the EW intervention both motivated them to think about the future and helped to reduce their fears of rejection and finding a job that would let them take time off for their HIV appointments. By their 12-month interviews, three of these four participants had found a job, which improved their self-esteem and distracted them from their diagnosis. The one participant who had not found a job, Santos, was actively job searching with the support of the EW intervention, which helped him to understand his disclosure rights and overcome his fears of experiencing HIV-related discrimination during the job search.

DISCUSSION

During the year following a recent HIV diagnosis or re-engagement with HIV care, participants experienced varying degrees of changes in their views of themselves and their HIV diagnosis, physical and mental health, sex and relationships, and goals, work, and school. One of the strengths of the longitudinal qualitative approach is that it allowed for an in-depth assessment of the changes that participants experienced during the year and the ways in which the EW intervention impacted these changes. The dominant narratives across participants were shifts in their view of the diagnosis as a death sentence to a place of acceptance, an improvement in physical and mental health, a re-development of interest in sex or relationships, and a clarification of goals. For many, the EW intervention was a catalyst or contributor to these changes. Across the four categories of change, the EW intervention acted through three main channels by helping participants: (1) reach diagnosis acceptance, (2) improve their self-esteem, and (3) gain self-efficacy for managing life with HIV.

A significant amount of the research focused on adapting to a diagnosis of HIV has centered around the idea of coping, using the Stress and Coping Theory to explain how an individual's appraisal (perception of) HIV impacts their coping process (Folkman, 2013). Research has categorized newly HIV-diagnosed individuals into appraisal categories, or thematic groupings of how the ways in which individuals perceive their diagnosis impacts their emotional response to it. Example categories include HIV as a chronic illness, concern about dying, and stigmatization (Moskowitz & Wrubel, 2005; Moskowitz et al., 2013). Our participants endorsed similar initial appraisal categories, but we also found that their perceptions of HIV changed dramatically over the course of a year, and were greatly impacted by the EW intervention. During their first interview, participants expressed significant fear that their diagnosis meant an end of their ambitions, which impacted their goal-making and mental health. As time progressed and participants' physical health improved, the EW intervention changed participants' perceptions of the diagnosis and provided them with an opportunity to re-define their goals. The EW intervention, in combination with improvements in participants' physical health, also reduced their anxiety related to death and rumination on negative thoughts. The positive impact of the EW intervention on illness appraisal indicates the benefits of this type of intervention for helping participants manage stress and cope with a recent HIV diagnosis. Other studies have also identified the importance of psychosocial or counseling interventions, like ours, in helping GBMSM manage the emotional impact of HIV, develop coping skills and resilience, and become less agitated when they face challenges (Hussen et al., 2018; Millard et al., 2016; Yang et al., 2018).

Beyond changing participants' illness appraisal and helping them reach diagnosis acceptance, the EW intervention also improved their self-esteem. Initially, many participants had negative views of their self-worth tied to their diagnosis, which impacted their mental health, interest in relationships and sex, and ability to make long-term goals. The EW intervention created a space for participants to work through their self-blame and anger. Newly diagnosed individuals may face challenges in finding or navigating relationships, including issues of disclosure, self-confidence, and fears of rejection, which, in turn,

may negatively impact their mental health (Green & Smith, 2004). These challenges are particularly acute in Guatemala, where research has found that anti-gay discrimination and HIV stigma across Guatemalan society contribute to poor mental and physical health and reduces retention in HIV care and diagnosis acceptance among GBMSM (Barrington et al., 2016; Rhodes et al., 2015). However, through their work with the psychologist, who stressed that they deserved love and were not defined by their diagnosis, participants' improved self-image encouraged them to again seek intimacy and positive relationships and reduced their fears of rejection during job searches. Other research has found that creating a space for identity re-construction through developing de-stigmatizing narratives can help PLWH challenge oppressive norms and reach a space of freedom and empowerment (Carrasco et al., 2016).

Finally, the EW intervention improved participants' HIV and diagnosis-related knowledge, which increased their self-efficacy. Increasing self-efficacy for HIV management has been found to be positively correlated with physical and mental health outcomes, treatment adherence, and quality of life (Johnson et al., 2007; Sharma-Uppal & Chhabra, 2014). Specifically, the EW intervention's focus on the rights of HIV-positive individuals made participants more comfortable with HIV disclosure and empowered them during the job search process; for participants who avoided sex due to disclosure fears, practicing disclosures during the intervention helped them to feel comfortable having sex again. The intervention's ability to empower participants in the job search process is particularly important in the context of Guatemala, where previous research has found that HIV stigma may prevent GBMSM from applying to jobs, and that lack of employment is a major barrier for GBMSM for staying in HIV care and adhering to their treatment regimen (Barrington et al., 2016). Additionally, the intervention's focus on the medical implications of inconsistent adherence, diagnosis management, and lifestyle behaviors helped participants understand the importance of adherence and encouraged positive physical changes.

Particularly within low and middle-income countries (LMICs), there is a need for more interventions that address the holistic well-being of newly diagnosed PLWH (Sikkema et al., 2015). Although there is a large body of literature demonstrating that psychological and psychosocial interventions can improve the mental health of PLWH, the majority of these interventions have been conducted in high-income countries and are not tailored to GBMSM; a systematic review of intervention trials in LMICs between 2000 and 2014 addressing the mental health of PLWH identified only 22 unique interventions, with none tailored specifically to GBMSM and few demonstrating efficacy (Sikkema et al., 2015). A few more recently conducted well-being/adherence intervention studies (in Kenya and China) were targeted to GBMSM, but their preliminary nature, limited effect size, and small number indicate a need for more research in this area (Graham et al., 2020; Kunzweiler et al., 2018; Yang et al., 2018). This research is necessary given that our Guatemala-based study found that newly diagnosed or care re-engaged GBMSM may experience significant psychological and physical distress, and that the mental and physical health of these individuals are closely connected. Particularly for GBMSM, who disproportionately experience interrelated health problems tied to HIV, including stigmatization, psychological comorbidities, and sexual victimization (also known as syndemics), HIV treatment requires a holistic approach that takes into account how these mutually reinforcing conditions

impact their health and well-being (Halkitis et al., 2013). The flexible delivery of the EW intervention's sessions allowed the psychologist to further tailor the intervention to the participant's needs at the time, such as the overlapping challenges described above; while this flexibility may make it more difficult to tease out the intervention's effects, we believe that it increased the appropriateness of the intervention.

Finally, we found that while all participants experienced changes over the course of the intervention, two participants did not attribute any of the changes to the EW intervention. These participants attended only one or two sessions because they expressed that they did not like psychologists. The experiences of these two participants could reflect the overall high levels of stigma towards mental health disorders and seeking treatment from mental health professionals, like psychologists, in Latin America (Alonzo & Popescu, 2021; Mascayano et al., 2016). Research in Latin America has found that values like *machismo* and *familismo* may increase mental health stigma among men, who may associate having to seek treatment for a mental illness with weakness or an inability to fulfill one's role in the household (Mascayano et al., 2016). This may pose challenges for uptake of the EW intervention for some GBM in Guatemala, although overall this intervention was perceived as highly acceptable by the majority of participants interviewed.

This study had several limitations. First, because the interviews were conducted by a study team member, it is possible that results could have been influenced by social desirability bias. As a result, participants could have overstated the positive benefits of the EW intervention. Second, the results could have been influenced by selection bias. It is possible that participants who felt particularly excited by or in need of the intervention were those who chose to participate in the in-depth interviews. Finally, we can never completely control for factors, such as peer navigation, that may have led to the impacts that the participants attributed to the EW intervention; however, as discussed previously, our interpretations were made directly based on participants' perceptions of the EW intervention's impact, so we do not see this as a major limitation of this study.

CONCLUSION

The year following a recent HIV diagnosis or re-engagement with care can be both a particularly vulnerable and volatile time as well as a key opportunity for intervention to improve gay and bisexual men living with HIV's emotional well-being and ability to cope with their diagnosis. Emotional well-being interventions can positively impact the changes that PLWH experience during this time in their diagnosis perceptions, health, relationships, and goals, which may have long-term positive implications for their care trajectories and holistic health.

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TABLE 1.

Participant Demographics at Baseline

Name*	Age	Sexual Orientation	Completed Education	Relationship Status	Work	Time Since Diagnosis	# of EW Sessions Attended	Baseline Viral Suppression (<400 copies/mL)	Endline Viral Suppression (<400 copies/mL)
Jose	39	Gay	University	Single	Full-time	1 year	3	Suppressed	Suppressed
Juan	24	Gay	2nd semester of university	Partnered	Unemployed	1 month	3	Not suppressed	Suppressed
Carlos	28	Gay	University	Single	Seasonal	5 years	1	Suppressed	Suppressed
Luis	28	Gay	8th semester of university	Single	Full-time	5 months	2	Suppressed	Suppressed
Francisco	31	Gay	Technical university	Partnered	Full-time	1 month	4	Not suppressed	Suppressed
Pedro	23	Bisexual	High school	Partnered	Full-time	1 year	4	Suppressed	Suppressed
Santos	24	Gay	Bachelors	Partnered	Unemployed	1 year	4	Suppressed	Suppressed
Manuel	45	Gay	Middle school	Single	Unemployed	1 year	3	Suppressed	Suppressed
Jorge	19	Gay	Middle school	Partnered	Unemployed	8 days	4	Not suppressed	Suppressed
Miguel	32	Gay	University	Single	Full-time	3 months	2	Not suppressed	Suppressed

Note.

* All names are pseudonyms

TABLE 2.

EW Intervention Impacts Matrix Shell

Participant ID	Goals	Mental Health	Physical Health	Perceptions of Diagnosis	Relationships	View of Self	Other
1							
...							

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TABLE 3.

Change Over Time Matrix Shell

Participant ID	Baseline	6-Month Changes	12-Month Changes	Notes
1				
...				

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