

CHALLENGING DEPRESSION AND HIV

Part 1: Report on the Pilot Project
Part 2: A Manual for HIV-Service-Providers

Second Edition

The HIV/AIDS Interagency Coalition on Mental Health
Comprised of

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St. Michael's Hospital, HIV Psychiatry Program
The David Kelley HIV/AIDS Community Counseling Program, Family Service Association of
Toronto, Sunnybrook and Women's College Health Sciences Centre, HIV Outpatient Clinic,
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Preface

This report, the culmination of three years of work by The HIV/AIDS Interagency Coalition on Mental Health in Toronto, seeks to achieve two inter-related goals:

1. provide an overview of the Coalition's development, articulate the research literature related to HIV and depression, outline the theoretical foundations for the model selected for the pilot research and report on the pilot research outcomes;
2. provide practitioners who wish to use the approach researched with a practice-based description of how the theoretical model was applied by Coalition participants.

We hope that the report contributes to an understanding of why depression is a significant issue, how agencies can work together, and with the community, mount a response and what group methods are effective in the treatment of HIV/AIDS and depression.

It needs to be noted, however, that this represents our first step in exploring effective ways of treating HIV and depression. The outcomes of this pilot project were very encouraging, both from the point of view of clients and of the agencies and community members who participated. However, it is pilot research and, as such, it did not employ a control population or control for such contaminating variables as changes in anti-depressant medication. While the results suggest efficacy, causal relationships between the client outcomes and the method used cannot be unequivocally established. At the same time, however, we hope that this first effort will lead others to explore the model used and form the basis for on-going research.

Using the Report and Manual

Part 1 of the **report** addresses the first goal identified above. Section 1 outlines how the Coalition came to be, and in doing so, provides a roadmap other communities may choose to emulate in mounting responses to HIV-associated mental health issues. It should be read in conjunction with Section 6, which reviews the interagency experience and community outcomes of the project.

Section 2 provides a review of existing literature related to the incidence of HIV and depression as well as a summary of research-based treatment approaches. The section therefore speaks to the needs for treatment responses designed to address the incidence of depression specifically among those living with HIV/AIDS.

Section 3 explores the theoretical framework of and justification for pilot research which tests the efficacy of the social group work model. Core concepts (such as mutual aid, group as a whole, group structure, including norms, stages of group development and co-leadership) are reviewed. As such, this section addresses the 'why's' related to the choice of the model. Sections 5 and 6 are of greater interest to those wishing to consider mounting similar research as well as to those wishing more information about the research questions, the instruments used and the outcomes of the pilot.

For those wishing a glimpse of the ‘how to’s’ of the model, Part 2, the **manual**, (Section 8 in particular) provides more information about what the model looks like on the ground and is useful as a troubleshooting guide. Thus the tone of the two sections is significantly different; while the theoretical framework in Part 1 reflects a more academic approach and presentation, Part 2 reflects a practical approach to what is likely to happen in group on a stage-by-stage basis.

Finally, some tools the Coalition used in mounting the project are included in the appendices. Here are found samples of advertising used to recruit clients and the assessment tool used to screen potential clients.

PART 1: THE PROJECT – CHALLENGING DEPRESSION AND HIV

1. Development of the Project

1.1 Context of the Project

The Challenging Depression and HIV Project is the outcome of discussions that began in March 1999 among service providers and HIV community members in Toronto. These initial discussions resulted in the establishment of the HIV/AIDS Interagency Coalition on Mental Health Issues. It brought together individuals from community-based AIDS service organizations, HIV community members and hospital-based social workers working in both HIV medical and HIV mental health clinic settings. While members approached the discussions from different points of view, the group's discussions highlighted a number of common themes and concerns with respect to understanding the mental health issues that impact on the day-to-day lives of individuals living with HIV-infection.

It became apparent to members of the Coalition that depression is a major factor influencing the coping capacity of a significant percentage of individuals living with HIV-infection. The Coalition also came to understand the extent to which the psychosocial impact of illness, medication regimes, medication side effects, poverty, isolation and marginalization were all important determinants of coping and overall mental health.

What distinguished the Coalition from the very beginning was a commitment to do more than meet as a group to discuss our shared observations and experiences with respect to the mental health issues facing individuals living with HIV-disease. Coalition members clearly wanted to explore ways to address the issues that we came to understand impinged on the coping and mental health of people living with HIV-disease. In other words, there was a very strong commitment to **action** arising from our discussions as we all concurred that there was value in pooling the wealth of expertise within the group into a collaborative service delivery project. Coupled with this commitment to provide a service to individuals living with HIV disease was an equally strong commitment to explore new ways of providing care and an understanding of the importance of evaluating any service we would provide.

What developed was a unique collaboration involving community-based organizations, hospital-based HIV medical and mental health services and people living with HIV/AIDS. The volunteers interested in being members of the Coalition were affiliated with a community agency. This ensured that all members of the Coalition had accountability and liability for their actions through an agency or institution's policies, procedures and mandate. All members had equal participation and the Coalition utilized a consensus model of decision making.

Our objective was to develop a model of group therapy incorporating practice elements and expertise from these various domains. This overall objective was further refined into the following three areas:

- development and delivery of a rehabilitative group therapy model which seeks to enhance coping skills and strategies, addressing the experience of depression for people living with HIV/AIDS.
- building of a coalition of service providers delivering mental health and/or psychosocial programming from diverse sectors, in order to identify existing and emerging mental health issues of people living with HIV disease, and recommend or develop effective, relevant service responses.
- Research into and evaluation of therapy group and process, documenting our findings and specific programming details so that the program might be used by other organizations in Canada concerned with responding to the experience of depression in people living with HIV disease using a group therapy modality.

1.2 Development of the Project

Following the decision to develop a treatment model, two main issues arose that needed to be resolved: developing first a shared vision/framework for understanding what was meant by depression and secondly an understanding of group work. The initial plans of the Coalition did not include a research component; however, funding became available for projects of this type through the Canadian Working Group on HIV Rehabilitation and a proposal was submitted and accepted.

One of the project-funding criteria was the requirement for ethics approval of the research. Given that several Coalition members represented hospitals, separate ethics approval was required from each site so that the members could participate in the research. This was a particular challenge for the group. Ethics approval proved to be a time-consuming process, requiring additional time commitment by those coalition members at each institution who shepherded the projects through their respective sites.

The ethics approval process highlighted differences between community and institutional settings. Community agencies have typically not had to deal with ethics approval as research projects have generally been parachuted into the agencies by institutional researchers who receive ethics approval at their respective institutions, recruit research participants and complete the research in partnership with an agency. This has been changing as community-based agencies have been taking part in more research. There has been an increasing sophistication in research projects in community agencies and individuals with expertise in research are being hired.

In both institutional settings and community agencies, research and collaboration with other organizations have been valued and are often included in the organization's mandate. To advocate for their involvement in this project, Coalition members based their arguments on the value of research and collaboration. The support of management in members' organizations has been vital to this project, particularly given the time commitment of the members to the project.

Perhaps the main challenge for the group was the time commitment involved in this project, particularly for those individuals who also took on a facilitation role. The process of assessing individual participants to ensure that the group would be beneficial for them required a significant amount of time. The support of the various coordinators at each of the settings in which the Coalition members work was essential in maintaining the project's momentum. Essential elements for participation in the project for Coalition members were flexibility, manager/co-worker support of the project and dedicated time set aside to work on the project.

Another issue that arose was the matching of some of the Coalition members with a co-facilitator to facilitate the group work creating a delay in program implementation. As in any collaboration of this nature, co-facilitators required sufficient time to become comfortable with one another's style and to build up trust and mutual support.

There have been many benefits to working as a coalition on this type of project. It has allowed the group to capitalize on the strengths of the various partners to ensure that components of the project could be done as efficiently and effectively as possible. For example, one of the agencies was able to provide the training to Coalition members for the social group work model as well as an expert in this model to be part of the group on a consultative basis at no cost. Another of the agencies, having recently started an in-house research unit, provided statistical resources needed for the project at a greatly reduced cost. Finally, one of the agencies was able to take on the role of administration, allowing the group to manage the project in a very flexible manner. The inherent flexibility of a coalition also ensured that any issues that arose in the course of the program could be problem-solved and dealt with efficiently. Due to its very nature, a coalition has more expertise, experience, networks and insight to enhance this type of research project.

2. HIV/ AIDS & Depression Literature Review

The range of this literature review, updated for the second edition, is broader than the research questions posed in the pilot study as reported in this monograph. In particular, Section 2.2 offers a useful exploration of broader issues, which emerge out of considering the social impacts of depression among People Having AIDS (PHAs) while Sections 2.3.3 and 2.3.4 examine stigma and coping styles as variables associated with depression among PHAs

2.1 Prevalence

Research studies have often reported elevated rates of psychiatric problems and emotional distress among HIV-positive people compared to the general population (McDaniel, Fowlie et al. 1995; Katz, Douglas et al. 1996; Kelly, Raphael et al. 1998; Van Servellen, Sarna et al. 1998; Cohen, Hoffman et al. 2002). Throughout this literature, mood disorders and disturbances, and particularly depressive disorders, are identified as the most common psychological difficulties faced by people living with HIV/AIDS (PHAs). One study found depression rates of 41% among male PHAs and 54% of female PHAs (Belkin, Fleishman et al. 1992). A recent large-scale study of mental health and HIV found that almost one third of the HIV-positive sample met the screening criteria for major depression, and over one quarter met criteria for dysthymia (Bing, Burman et al. 2001). Another study found rates of current major depression to be four times higher in a sample of HIV-positive women than in a comparable HIV-negative sample (Morrison, Petitto et al. 2002). Whether depression rates for PHAs are elevated or unexpectedly low depends on interpretation: they are high compared to rates in the general community, and low compared to rates in other medically ill populations (Rabkin 1996). In any case, researchers have repeatedly reinforced what clinicians and community members have observed for themselves: depression continues to be a concern for a significant number of people living with HIV/AIDS.

2.2 Impact of Depression on PHAs

2.2.1 Medical Outcomes, Physical Health, and Depression

The connection between depression and physical health has been a source of ongoing interest and controversy in the HIV research literature. Burack et. al. found a correlation between depression and increased mortality in a male, HIV-positive sample (Burack, Barrett et al. 1993). More recent prospective research by Mayne et. al. supported a link between depressive affect and increased mortality risk (Mayne, Vittinghoff et al. 1996). Other researchers have directly challenged such findings and concluded that depressive symptoms are not predictive of medical outcomes among a male sample of PHAs (Lyketsos, Hoover et al. 1993).

Several more recent studies have continued this debate using female samples. One study of female PHAs found that depression was correlated with decreased immunological activity, and another longitudinal study connected depression with increased mortality in

female PHAs (Ickovics, Hamburger et al. 2001; Evans, Ten Have et al. 2002). On the other hand, a prospective study found no significant difference in disease progression between depressed and non-depressed HIV-positive women (Vedhara, Schifitto et al. 1999). Hence, the literature at this time offers no solid conclusions about the impact of depression on physical health, but there is at least some evidence suggesting that depression can have serious physical consequences.

Approaching physical health and depression from another angle, several studies have explored the impact of HIV-related physical symptomatology on mood. In a study with HIV-positive men, Griffin et al. found that physical limitations were correlated to rates of current depression, and that increased limitations were predictive of future depression (Griffin, Rabkin et al. 1998). Research on distress in HIV-positive women has also found that depressive symptoms increase as health functioning decreases (Van Servellen, Sarna et al. 1998).

The connection between physical symptomatology and depression cannot be reduced to a simple causal relationship, and many other factors need to be considered. For example, Hays et al. found that while HIV-related symptoms were predictive of depression, satisfaction with social support buffered the impact of physical symptoms on the subjects' moods (Hays, Turner et al. 1992). A recent study found that the depressive scores of PHAs varied in response to medical reports of their viral load, even when the researchers controlled for physical symptoms of HIV (Kalichman, DiFonzo et al. 2002). How depression is measured may also complicate any distinction between physical and mental health (Belkin, Fleishman et al. 1992; Kalichman, Rompa et al. 2000). For example, another recent study found that while fatigue was partly predicted by physiologic factors, depression was predicted only by psychological factors (Barroso, Preisser et al. 2002).

2.2.2 Service Use and Expense

The research literature suggests that many of the people who are HIV-positive and struggling with depression are not receiving the appropriate services. One study found that most of the depressed, HIV-positive men in their sample had not received recent mental health treatment (Katz, Douglas et al. 1996). A more recent, large-scale American study estimated that over 60% of PHAs used mental health or substance abuse treatment services in the preceding year. However, they found that socioeconomic status changed service use patterns, and those of lower socioeconomic status were less likely to access specialized mental health services (Burman, Bing et al. 2001). Another American study, based on 50 interviews, found that the use of services was linked to a combination of variables including gender, sexual identity, language requirements, and ethnicity (Takahashi and Rodriguez 2002).

Since the Canadian social context and health care system are distinctive from the American, Canadian investigations into service use and expenditure are essential. One Canadian study of 215 chronically ill patients (whose HIV status was not identified) found that psychosocial factors, rather than disease severity or prognosis, were most strongly correlated to health service use. Using a standardized scale to measure

adjustment to illness, these researchers also found that the average service expenditure for a patient in the “good” adjustment category was less than half of the cost for a patient in the “poor” adjustment category (Browne, Arpin et al. 1990). Further investigations of the expense of poor psychosocial adjustment to chronic illness have supported these findings (Browne, Roberts et al. 1994). This research suggests that psychosocial interventions with people who have a chronic illness could have significant financial implications. There is, however, a lack of research on factors contributing to service use and related expenses among PHAs in the Canadian context.

2.2.3 Medication Adherence and Depression

The medical landscape has shifted significantly in recent years, and highly-active anti-retroviral therapy (HAART) has increased survival rates for many PHAs. At the same time, PHAs on these complicated medical regimens often face new stressors and uncertain medical outcomes, including possible psychiatric side-effects from HAART medications (Brashers, Neidig et al. 1999; Balderson, Halman et al. 2000; Bogart, Catz et al. 2000).

The possibility of developing resistance to available medications makes adherence especially important for PHAs who are receiving HAART (Altice and Friedland 1998). Recent studies have found a significant connection between PHAs’ adherence to treatment and their depression scores, indicating that people who have more depressive symptoms are less likely to follow treatment regimens (Schuman, Ohmit et al. 2001; Spire, Duran et al. 2002; Van Servellen, Chang et al. 2002). Among those not receiving any conventional medical treatments such as HAART, Kalichman et. al. found higher rates of depression (Kalichman, Graham et al. 2002). HIV-positive intravenous drug users seem to have higher depression scores and lower treatment adherence, although there are many possible intervening factors that defy a causal interpretation without further research (Belkin, Fleishman et al. 1992; Gordillo, Amo et al. 1999).

2.2.4 Transmission Risk and Depression

While most of the research on HIV transmission has focused on the behavior of people who are not HIV-positive or are unsure of their HIV status, of late more research has been done on the decision-making of PHAs and its role in the HIV pandemic (Godin, Savard et al. 1996). Some of the findings in this area suggest that depression is connected to the behaviors that PHAs engage in, and may play a role in transmission risk. For example, Thompson et al found correlations between stress, depression, and unsafe sexual behaviors in a sample of 105 HIV-positive men (Thompson, Nanni et al. 1996). In a large sample of 1,109 HIV-positive women, Hogben et. al. found that both depression and potentially risky sexual behavior were predicted by women’s experiences of sexual and physical violence (Hogben, Grange et al. 2001). The relationship of depression in PHAs to HIV transmission risk represents an under-researched gap in the existing literature.

2.3 Co-variables associated with HIV and Depression

2.3.1 Social Support, HIV, and Depression

Social support is a frequently researched topic in the HIV literature. A number of studies have concluded that there is a correlation between lower social support and increased depression (Crystal and Kersting 1998; Hall 1999; Swindells, Mohr et al. 1999; Song and Ingram 2002). The importance of social support for the well-being of PHAs seems to hold true across ethnicities, genders, socioeconomic loci, sexual identities, and other demographic variables, although these differences can affect the availability of support (Metcalf, Langstaff et al. 1998; Greene, Frey et al. 2002; Lichtenstein, Laska et al. 2002).

Unsupportive interactions have also been shown to increase depressive symptoms. Ingram et. al., and Song and Ingram found that PHAs who had experienced higher levels of unsupportive responses experienced more depression and mood disturbance, even when positive social support was taken into account (Ingram, Jones et al. 1999; Song and Ingram 2002).

Support levels interact with depression and other factors. For example, Leserman et. al. found that social support satisfaction, stress level, cortisol levels, depression, and coping style interacted in predicting disease progression (Leserman, Petitto et al. 2000). In a study of 103 gay men with HIV, Johnson et. al. found that low social support did not predict depression when hopelessness was controlled for statistically (Johnson, Alloy et al. 2001). Social support can be unstable for many PHAs who lose multiple family members, friends, and even support group contacts to HIV/AIDS (Lichtenstein, Laska et al. 2002). Murphy et. al. found that social support did not moderate the relationship between stressful life events and depression in a sample of 230 HIV-positive adolescents (Murphy, Moscicki et al. 2000). While social support levels seem to be connected to mood in PHAs, researchers need to consider other factors that might affect this relationship.

2.3.2 Quality of Life and Depression

Both HIV and depression can affect many different areas of individuals' lives. In recognition of this diffuse impact, the recent HIV research literature includes some more holistic measures, such as quality of life scales. Some of this research has identified a connection between depressive symptoms and decreased quality of life scores (Sherbourne, Hays et al. 2000; Eller 2001). In addition, outcome studies indicate that decreases in depression are connected to improved scores on quality of life measures, suggesting that effective treatment of depression could have generalized benefits for PHAs (Elliott, Russo et al. 2002; Molassiotis, Callaghan et al. 2002).

2.3.3 Stigma

For many, stigma has been an unfortunate but undeniable aspect of living with HIV/AIDS. Qualitative findings from interviews with PHAs have indicated that many PHAs experience stigma as a problem in their lives. Goggin et. al. found that stigma and alienation were common themes in interviews with 55 HIV-positive women (Goggin, Catley et al. 2001). Other qualitative research with female PHAs confirms the prevalence of stigma and marginalization for this population (Hackl, Somlai et al. 1997). Research suggests that gay male PHAs may be protected from some of the effects of stigma through involvement in the gay community and in HIV activist groups (Brashers, Haas et al. 2002; Lichtenstein, Laska et al. 2002). Studies have found that unsupportive HIV-related interactions are connected to depression for some PHAs (Song and Ingram 2002). Negative messages about PHAs in the media have also been found to negatively affect HIV-positive individuals' self-concept (Chapman 2002).

The quantification of stigma is a daunting task, but some researchers have developed measures to meet the challenge. Fife and Wright used survey questionnaires to compare the impact of stigma on PHAs to the impact of stigma on people living with cancer. They concluded that stigma was a multidimensional construct, and that its effects were felt more strongly by those living with HIV/AIDS than by those living with cancer (Fife and Wright 2000). Berger et. al. developed a measure for stigma in PHAs, which they found to be valid and reliable with a sample of 318 adult PHAs (Berger, Ferrans et al. 2001). Regardless of methodological approach, researchers and service providers should take into account that definitions and mechanisms of stigma are complex and that these occur within a cultural framework of assumptions, prejudices, and perspectives (Herdt 2001).

2.3.4 Coping styles, Stress, and Depression

Many researchers have investigated how different coping styles affect the experiences and health of PHAs. Leserman et. al. found that coping through denial was correlated to faster disease progression (Leserman, Petitto et al. 2000). Several studies concluded that problem-focused coping styles predict improved psychosocial functioning, and emotion-focused styles have adverse effects on functioning (Swindells, Mohr et al. 1999; Ball, Tannenbaum et al. 2002; Brashers, Haas et al. 2002). Surprisingly, another study concluded that interventions that increase emotion-focused coping are most effective for PHAs experiencing depression (Kelly, Murphy et al. 1993). Beliefs about HIV and personal control also seem to be connected to depression. Research with a military sample of 588 PHAs found that subjects endorsing internal control or control by powerful others had increased rates of depression (Jenkins and Patterson 1998).

Stress has been correlated to depression and to poorer overall functioning in PHAs. In a sample of 105 HIV-positive men, Thompson et. al. found that those who had more stressors in their lives had higher depression scores (Thompson, Nanni et al. 1996). A study of 82 gay male PHAs also showed a connection between more stressful life events

and more rapid disease progression, although the role of depression in this interaction remains to be determined (Leserman, Petitto et al. 2000).

2.4 HIV and Treatment of Depression

Since elevated depression rates have been found amongst people living with HIV/AIDS, a number of research studies have investigated the efficacy of different treatment approaches with samples of depressed PHAs. Reviews of the literature conclude that antidepressants, supportive, and psychotherapeutic interventions (including cognitive, cognitive-behavioral, interpersonal, and psychoeducational models) are all effective in reducing depression in PHAs (Valente and Saunders 1997; Levine 2001). In an overwhelmingly male sample of PHAs, Wagner et. al. found very high efficacy rates of 70% or greater for several standard and alternative antidepressant therapies, including testosterone replacement therapy (Wagner, Rabkin et al. 1996). Levine's review also cites studies that found less traditional interventions, including pet ownership and exercise, to be effective treatments for depression in certain samples of PHAs (Levine 2001).

Group outcome studies with PHAs who do not necessarily show signs of depression also indicate potentially beneficial interventions. For example, in a sample of 39 HIV-positive gay men (of whom 12% scored as depressed on the Beck depression inventory), Mulder et. al. found that people assigned to either a cognitive-behavioral group intervention or an experiential group intervention showed greater decreases in distress than those in a control sample (Mulder, Emmelkamp et al. 1994). Interventions based on relaxation and stress-reduction models have also been found to benefit the psychological and physical well-being of PHAs (Ironson, Antoni et al. 2002). Other research has concluded that couple groups and bereavement groups reduced participants' depression scores (Goodkin, Blaney et al. 1999; Pomeroy and Van Laningham 2002).

The relative efficacy of specific psychotherapeutic interventions can be complicated by the influence of psychiatric medications. For example, Markowitz et. al. compared several individual treatment models in a sample of 101 depressed PHAs. They evaluated interpersonal psychotherapy without the antidepressant imipramine, supportive psychotherapy with imipramine, supportive psychotherapy without imipramine, and cognitive-behavioral psychotherapy without imipramine. These researchers found that both interpersonal psychotherapy without imipramine and supportive psychotherapy with the antidepressant were more effective than either supportive psychotherapy or cognitive behavioral therapy without imipramine (Markowitz, Kocsis et al. 1998).

2.4.1 Group interventions addressing depression with PHAs

Groups have been a central part of the response to HIV/AIDS throughout the disease's history in North America. There is extensive research literature on groups for PHAs, and strong evidence that groups can help reduce depression and improve quality of life. For a recent review of group work research with PHAs experiencing symptoms of depression, see research by Kelly, by Bower et. al., and by this research coalition (Kelly 1998; Coalition 2001; Bower, Kemeny et al. 2002).

Several research studies have evaluated the relative efficacy of various group approaches to working with depressed PHAs. Many of these studies have small sample sizes and no control or comparison groups. Blanch and colleagues found that a 16-week cognitive-behavioral group was followed by reduced anxiety and depression scores in a sample of HIV-positive people who had been referred to a consulting psychiatry department. The researchers also found an association between intravenous drug use and less improvement in Beck Depression Inventory scores. While the sample in this study was strong in its almost equal numbers of men and women, there was no comparison or control sample (Blanch, Rousaud et al. 2002).

Lee et. al. also found that 13 gay men living with HIV/AIDS and depression or dysthymia had decreased depression scores after participating in a cognitive-behavioral group (Lee, Cohen et al. 1999). Similarly, a Canadian study of a psychoeducational group model found that group participants (11 men and 1 woman) had decreased post-test scores for depression and negative affect (Balfour, Hamel et al. unpublished). Both studies' findings have limited applicability as a result of small, non-representative samples and the absence of control or comparison groups.

Several group outcome evaluation studies have included control or comparison groups in their design. Zisook et. al. compared supportive group therapy combined with fluoxetine antidepressant treatment to supportive group therapy with a placebo in a sample of 47 HIV-positive men who were diagnosed with major depression. They found that the improvements in depression were significantly greater in the group also receiving the antidepressant treatment (Zisook, Peterkin et al. 1998). These findings contradicted earlier research by Targ et. al. who used similar measures and found no significant differences between structured group therapy plus fluoxetine and the same group therapy with a placebo in a sample of 20 gay male PHAs (Targ, Karasic et al. 1994). The differences between the studies' sample sizes and group therapy models may have contributed to their contrasting conclusions. The two research groups also used different dosing systems of fluoxetine, and some participants in the Zisook et. al. study received up to three times the standardized dose given to participants in the earlier study. In another randomized trial, Kelly et. al. concluded that a social support model focused on emotional coping was more effective than a cognitive-behavioral group intervention with a sample of depressed, male PHAs. In addition, there were greater reductions in depression for participants in either group intervention than for those in the control sample (Kelly, Murphy et al. 1993).

2.4.2 Social Group Work Model and Support Group Model with PHAs

In addition to the relative dearth of randomized control and comparison studies on groups for depressed PHAs, there is a near absence of research using the social group work model with depressed HIV-positive people. Tolman and Molitor noted in their 1994 review of the social group work literature that cognitive-behavioral models have

dominated, and most studies have been nonexperimental or quasiexperimental in design (Tolman and Molidor 1994).

This coalition's pilot project is the only known outcome study using the social group work model with depressed PHAs (Coalition 2001). There are a few other studies that discuss social group work with PHAs, but these are not outcome evaluations (Gambe and Getzel 1989; Getzel 1991; Edell 1998). Nevertheless, what research exists suggests that the social group work model, which combines supportive, cognitive-behavioral, psychoeducational, and interpersonal elements, could be beneficial with this population.

Several studies have evaluated the efficacy of support groups in reducing depressive symptoms and distress in PHAs. A pilot study by Molassiotis et al. concluded that both a cognitive-behavioral group and a peer support group led to greater psychological functioning and higher quality of life scores than the control condition of no group intervention (Molassiotis, Callaghan et al. 2002). Kalichman et al. found that people who had not attended support groups had higher levels of depression than those who had attended groups, however there were other significant differences between the two samples that complicate comparison (Kalichman, Sikkema et al. 1996). Other researchers have found support groups to be effective in reducing distress and depression among PHAs, including Kelly and Zisook et al., whose studies are described above (Kelly, Murphy et al. 1993; Zisook, Peterkin et al. 1998).

2.5 Qualitative Research on HIV

Qualitative research has been gaining recognition within the research community, but it is still limited in its influence and scope. In spite of these restrictions, qualitative research that has focused on issues surrounding HIV has indicated the potential usefulness of this approach. Qualitative investigation, when pursued rigorously and ethically, provides insight into complex and highly personal topics, such as meaning-making and phenomenological experience. Usually, such topics cannot be quantified without significantly reducing the complexity and the richness of the participants' perspectives. Ideally, qualitative and quantitative methods can be integrated. For example, researchers' initial explorations can gain direction and community input from qualitative interviews or focus groups, and use the themes that emerge as springboards for more focused quantitative investigations.

In the HIV literature, the vast majority of qualitative work has been published within the HIV education and prevention field (Parker and Carballo 1990; Carey, Gordon et al. 1997; Bockting, Robinson et al. 1998; Stevens and Hall 1998). Some qualitative investigations have combined the prevention/education objectives with investigations of the lives of PHAs (Jackson, Millson et al. 1998-1999; Semple, Patterson et al. 2002). There also seems to be a greater emphasis on qualitative methods in research on HIV-positive women than on male PHAs or on mixed-gender groups. This gendered trend in qualitative research may stem from the earlier acceptance of qualitative methods within the feminist research community, from a more exploratory objective of this research, or

from numerous other factors. See the reference list for examples of qualitative investigations of the experiences of HIV-positive women (Hackl, Somlai et al. 1997; Metcalfe, Langstaff et al. 1998; Jackson, Millson et al. 1998-1999; Goggin, Catley et al. 2001). For examples of qualitative studies with mixed gender or more male samples, see Brashers et. al., Demas et. al., or Pugatch et. al. (Demas, Schoenbaum et al. 1995; Brashers, Neidig et al. 1999; Pugatch, Bennett et al. 2002).

Qualitative measures offer means to uncover potential barriers from the perspective of the people accessing services. Through interviews with eight HIV-positive women in a Canadian city, Metcalfe and colleagues found that the women were uncomfortable with or unaware of existing services, and that they felt women had different support needs than men (Metcalfe, Langstaff et al. 1998). Stigma, a significant consideration for any researcher in the HIV/AIDS field, has also been a particularly appropriate concept to explore through qualitative means because of its many layers of meaning and impact (Chapman 2002). Takahashi et. al. used qualitative interviews to explore the impact of stigma on access and service use for different groups of PHAs (Takahashi and Rodriguez 2002).

In exploring different factors connected to depression, qualitative research also underscores the complexity and range of experiences of PHAs. Bogart et. al. used qualitative interviews to explore the impact of the HAART era on individuals' experiences, and found a rich range of responses and beliefs that would be difficult to access in a quantitative study (Bogart, Catz et al. 2000). In addition, qualitative research promises to enrich considerations of medication adherence and other treatment choices made by PHAs (Demas, Schoenbaum et al. 1995; Bogart, Catz et al. 2000; Cooper, Buick et al. 2002; Jones 2002; Marelich, Roberts et al. 2002; Pugatch, Bennett et al. 2002).

There has been some limited qualitative research on PHAs and group work experiences, and this has often been combined with quantitative methodologies. Balmer used quantitative and qualitative measures to study the outcome of a six-month group counseling program in Kenya (Balmer 1994). Kalichman and colleagues used a combination of qualitative and quantitative methods in their pilot study of PHAs who have or have not attended support groups (Kalichman, Sikkema et al. 1996). Outside of the HIV literature, other group evaluation research has also used qualitative methods, often in combination with quantitative means (Saulnier 1997; Sullivan 1997; Perry 2000).

2.6 Collaboration in Research and Service Delivery

While many articles and books suggest that “collaboration” is necessary or beneficial to meet the challenges posed by HIV, the specifics of this proposed collaboration are often vague. Researchers and practitioners urge collaboration between professionals in treatment planning and implementation, and some emphasize collaboration between individual service providers and service recipients. This study, however, has an unusual degree of collaboration on a number of levels, including and surpassing these first two definitions of collaboration. Researchers, service providers, and members of

communities who receive HIV-related services are all represented in the research coalition, with considerable and continual overlap between these identities.

The HIV literature discusses the benefits and challenges of such collaborative efforts in research practice. Several authors have discussed the importance of ethical community collaboration and empowerment in HIV research in light of the marginalized and vulnerable history of affected communities (Garnets and D'Augelli 1994; Sanstad, Stall et al. 1999). Sterk, and Reed and Collins developed two models of community involvement in HIV research that advocated for the input of traditionally marginalized perspectives throughout the research process (Collins and Reed 1994; Reed and Collins 1994; Sterk 1999). Harris and Harris argue for collaboration between AIDS service organizations in producing research that promotes change to benefit service users (Harris and Harris 2002). In a discussion of an often neglected stage of the research process, Roberts et. al. describe a Canadian project which involved research participants in research dissemination through the development of literature for similarly affected community members (Roberts, Dematteo et al. 2002). For a more general discussion of the principles of community partnerships in public health research, see work by Israel and colleagues (Israel, Schulz et al. 1998).

Few contributors to the HIV literature have focused on collaborative service delivery to PHAs on an interagency level (Kmita, Baranska et al. 2002). Cain's 1997 trans-Canadian study of ASOs found that agencies needed to coordinate and focus their services and mandates more effectively (Cain 1997).

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3. The Theoretical Framework

3.1 Introduction

Social group work has a long history of application to work with the socially disadvantaged and with at-risk populations. Social group work's core assumption is that the development of a mutual aid system facilitates individuals in their collective attempts to realize common goals (Schwartz, 1961). Glassman and Kates further suggest that the group (with its characteristic norms or unwritten rules of behaviour (Yalom, 1995) regarding the equality of all members, the equal right of access to the group, an open role system, mutual aid and democratic process) provides the means for enacting the group's purpose (Glassman and Kates, 1986).

Through the enactment of these norms under the guidance of an ascribed (i.e. designated) leadership, the group becomes a micro-society (Klein, 1972) within which members can experience the safety and support essential for the emergence of mutual aid and individual change. Members can begin to experiment with practising the norms or behavioural rules which guide the group, and develop more flexible roles or ways of being in the world.

Within this framework, group leadership focuses on engaging the group as a whole (Glassman and Kates, 1986) in order to foster the group's collective ownership of its purpose and the norms that foster mutual aid and encourage client change in relation to the purpose of the group. In fact, the leadership system views the group as the client rather than the individuals within it. All interventions or actions taken by the leaders are therefore focused on their usefulness in moving a collection of individuals with divergent perspectives and experiences into a cohesive entity or group. The eventual development of such cohesion, so essential to realizing the purpose of the group, occurs over time as members resolve internal conflicts relating to the desirability of group membership. By deciding that indeed this is a group to which they want to belong because it offers safety and support, members are able to experiment with other ways of being in the world. When this stage is reached, members finally identify with and internalize the group norms which support safety and facilitate change. |

This process of internalizing and owning group norms is staged. As Garland, Jones and Kolodny (Garland, Jones et al., 1973) note, norms and roles at the beginning stages of a group are differentiated as members bring to one another fixed views of how they operate in the world. Conflict will emerge as members explore and test the operational values or norms of the group (i.e. equal access, equality, tolerance for others) (Northen, 1988) which may differ from those imbedded in their life experience. Similarly, they will test and experiment with the group's open role system (Northen, 1988) which requires them to engage in flexible interpersonal strategies. For example, those who assume a role of pleasing others by conforming to expectations are able to learn how to express their own needs in relation to others. Resolution of the conflict over norms and roles gives way to the establishment of patterns of interaction, which allow mutual aid to emerge in pursuit of the group's purpose (Garvin, 1977). The final stage of group development involves the summarization and celebration of group accomplishments (Garvin, 1977).

The social group work model as outlined above has been used both in relation to gay populations in general and those infected and affected by HIV/AIDS (Ball and Lipton, 1997; Getzel, 1991a; Getzel, 1991b; Getzel, 1994; Getzel, 1997; Getzel and Mahoney, 1990). This model is particularly useful in helping at-risk or marginal populations. This pilot project assumes that HIV has a marginalizing effect on those who are infected, and that this effect is amplified and reinforced when it exists in association with depression. The more those who are HIV-infected are marginalized, the more depressed they are likely to become. And, the more depressed individuals are, the more likely they are to be marginalized. Because of its mutual aid focus, the group activates Yalom's (Yalom, 1995) therapeutic factors of: universality ("I'm not alone."), altruism ("Helping others makes me feel better."), group cohesiveness ("I belong somewhere."), interpersonal learning ("I know what I do to get the reactions I do from other people and I know what I can do about it."), guidance ("I can get suggestions from other people which can help me figure out what to do."), catharsis ("I can express my feelings; I don't have to censor myself all the time."), identification ("Someone else is like me."), family re-enactment ("I can see how my family affected the way I handle myself."), self-understanding ("I think I know why I am who I am."), instillation of hope ("There is a way out of this.") and existential factors ("I can accept that life is unfair and that I have to look death in the face. It's not a failure on my part."). The ability of the social group work approach to activate these factors makes it particularly appropriate to those who are both HIV-infected and depressed.

In addition to drawing on social group work theory, the model being piloted exploited the established strategies of cognitive therapy. As Yalom pointed out in his classic, The Theory and Practice of Group Psychotherapy:

"Cognitive learning or restructuring (much of which is provided by the therapist) seems necessary for the patient to be able to generalize group experiences to outside life; without this transfer or carryover, we have succeeded only in creating better, more gracious therapy group members. Without the acquisition of some knowledge about general patterns in interpersonal relationships, the patient may,

in effect, have to rediscover the wheel in each subsequent interpersonal interaction.” (Yalom, 1995, 216)

As a result, the model, in the early sessions of the groups, incorporated teaching about the cognitive distortions accompanying depression (e.g. over-generalizing, catastrophic thinking, setting unrealistic goals, expecting the worst, all or nothing thinking) as well as teaching about methods of cognitive restructuring. For example, each group incorporated an exploration of what depression is within a cognitive framework and followed this discussion up with teaching about how to recognize the cognitive distortions brought by depression and ways of dealing with them by using self-talk techniques (e.g. monitoring thinking processes, identifying activating events which trigger cognitive distortions, identifying and challenging distortions in thinking and identifying ways of providing positive reinforcement for changes made in thinking processes). Various cognitive therapy exercises can be obtained from Monti *et al.* (Monti, Abrams *et al.*, 1989). While the exercises are presented in relation to alcohol dependence treatment, they are easily transferable for other treatment goals.

Because the cognitive strategies were incorporated into a social group work framework, teaching was interactive and where possible, was punctuated by reflecting on what was happening in the here-and-now process of group interaction. For example, rather than simply instruct members about the nature of depression, the group leaders introduced the framework while depending on members to fill in its contents. At the same time, the leaders bridged between members and supported the development of cohesion, or a sense of common ‘we-ness’ by pointing out similarities between members. Recognizing the inevitable differences in group members helped to establish the norm that it was acceptable for members to be different from one another because they were bound by the goal of mastering depression as a force in their lives. Similarly, recognizing depressive thinking processes or distortions and linking them to the here-and-now helped the group to acknowledge ways in which group discussion reinforced or relieved depressive thinking. For example, after exploring and challenging the depressive thinking of a member, the leadership might pose a question to the group which punctuates a cognitive skill:

Leader 1: As members have challenged John’s way of looking at his life, I’m observing more lightness in the room. People seem more animated and the body language seems more open. I’d like us to imagine, for a moment, that the group represents the different ‘voices’ in one person’s head. What just happened in terms of self-talk in the group as a whole?

3. 2 Co-leadership

The model used in our project assumed that co-leadership of groups was the ideal form of leadership. This assumption arose out of an appreciation of systems theory. First, it recognized the principle of isomorphy, meaning that all systems share identical structures (i.e. boundaries between subsystems and adjacent systems) and organizing processes (i.e.

complex, non-linear interactions) (Durkin, 1981; Durkin, 1981a). Change in one system therefore automatically generates change in associated systems or subsystems. As Nosko and Wallace note:

“If the co-leadership team is viewed as a sub-group within a larger group...structures and processes within the co-leadership team will be paralleled within the larger group as a whole. This means that the developmental stage of the co-leadership team and stages of group development will be dynamically linked (Nosko and Wallace, 1997, p. 3).”

Thus, interactions within the co-leadership subsystem become, themselves, powerful tools for generating changes in the group as a whole. For example, if the group leaders are able to demonstrate mutual respect, an equal distribution of power, equality of access and democratic process, this dynamic will model for group members the norms and values governing group operations. This touches one of Yalom’s therapeutic factors of group (interpersonal learning) which helps members learn new ways of interacting through observing others and modeling (Yalom, 1995).

Secondly, systems theory posits that all living systems have a capacity for growth and that this growth occurs through the selective opening and closing of boundaries, by selecting from external stimuli that which is and is not allowed to influence the system. The permeability of boundaries or the flexibility of the members to change what is allowed to influence them is moderated by the co-leadership’s transmission of new information, such as the group’s values and norms, which members internalize through the treatment process (Durkin, 1981; Durkin, 1981a), and information regarding the skills of cognitive restructuring. Again, as Nosko and Wallace note:

“In practice terms, this means that how the leadership presents new models of interaction will influence the members’ willingness to internalize and operationalize these values within the group as a whole. This exemplifies how the opening and closing of boundaries between the individual and the co-leadership structures is the means through which new information is introduced and change is effected” (Nosko and Wallace, 1997, 5).

In summary, systems theory provides a critical piece of the puzzle in identifying the roles and potential impact of the co-leadership system on the group as a whole. What goes on within its boundaries will critically impact on how the group progresses through its stages of development. For this reason, the preliminary training provided to potential leaders in the program identified five critical questions which they had to address in their selection of co-leadership partners:

- To what extent is a particular potential team able to resolve conflict between themselves, particularly while the group struggles with Power and Control issues (Nosko and Wallace, 1997)?
- To what extent have the potential teams worked through their own issues regarding equal status (Nosko and Wallace, 1997)?

- To what extent are theoretical frameworks compatible (Paulson, Burroughs et al., 1976)?
- To what extent do potential co-leaders concur about the appropriate amount of intervention (Paulson, Burroughs et al., 1976)?
- To what extent are teams able to develop comfort levels about potential disparities in knowledge and experience?

For teams to be successful in working with clients, it was advised that these issues had to be addressed in constructive and honest ways in order to avoid dysfunctional interactions. Addressing these issues increased the group's ability to learn and practise interpersonal strategies enabling the group to proceed towards the desired state of cohesion.

Other advantages of co-leadership were also identified in the development of a co-leadership model. Following Yalom, the Coalition acknowledged that co-leadership increased what Yalom called the 'cognitive and observational range' of the leadership: "their two points of view generate more hunches and strategies" (Yalom, 1995, 414). In other words, two sets of eyes were considered better than one in understanding what was going on within the group. Finally, the use of co-leadership teams, each of which drew upon more than one organization, supported the Coalition's broader systemic goal of building inter-agency and community cooperation in responding to the problem of depression and HIV.

3.3 Stages of Group Development

As noted earlier in 3.1, the movement of the group from a collection of disparate individuals to a cohesive entity is a staged process. However, before defining the nature of the specific stages and the interventions designed to further them, it is important to note that group development is rarely linear. Although there are clearly identifiable signs that the group is moving forward, there are also times when gains that are made seem lost as the group falls back into an earlier stage of development. This is particularly true of HIV and depression groups, in part because health crises may well interrupt cohesion and cause members to resume previous maladaptive ways of coping with distress. For example, if a member is diagnosed with a lymphoma as the group approaches cohesion, the group will undoubtedly revert to an earlier stage. The role of the leadership is to monitor for signs of such shifts and intervene in ways which will recapture lost ground. This requires focusing on here-and-now processes within the group and exploring with the group what their collective behaviour represents in terms of group process and what will move them forward.

Another complication with these groups results from the uneven attendance that frequently accompanies medical crises. In any given session, up to half the group may be away because of health problems. When these members return, those who were present for prior sessions may have moved to a different stage, while those returning may pull the group back in a process of catch-up. The leadership's goal then becomes one of activating the strengths of the core group and helping them draw the returning members into the newly emerging stage of group formation.

We based this present project on two social group work approaches: the model utilized by Garvin (Garvin, 1981) and Toseland and Rivas (Toseland and Rivas, 1984) to understand the preparatory or assessment phase and the model developed by Garland, Jones and Kolodny (Garland, Jones et al., 1993) to understand the later stages of group development.

3.3.1 Preparation for the Group

The pre-group phase attends primarily to recruiting and selecting suitable members for the group and preparing potential clients for the group experience. First, the program needs to be clear about its purpose and its anticipated outcome goals. In terms of this pilot, this meant clarifying, across different participating sectors, what was meant by depression, determining how to target client recruitment and determining that the program would rely on self-referral based on client identification with a checklist of symptoms incorporated into the advertising (Appendix 1). It also included specifying exclusion criteria, which were made known to potential referral sources. Clients who self-referred on the basis of general advertising in the community were screened again with the criteria at the assessment interview.

Once potential clients expressed an interest in group participation, a standardized assessment framework was used to determine whether clients met the criteria for membership (Appendix 3).

A critical function of the preparation phase is ‘role induction.’ This involves describing for members what they might expect in group sessions and introducing clients to the norms. For example, clients are advised that all members are considered equal, with equal rights to participate: that the group operates democratically and that clients can expect to receive feedback from and are expected to give feedback to other members.

3.3.2 Pre-affiliation

Pre-affiliation (5), the first stage of group process, focuses on establishing the norms that distinguish the operating values of the micro-society (4) from those of the clients’ external world. Building safety occurs through focusing group activity on what they see as rules needed to ensure that they feel safe (democratic process). In addition to these negotiated rules, which are part of the group’s structure, the leadership engineers member-to-member interaction in such a way that members begin to address one another in ways which act out the norms of the social group work model identified above. This may mean, for example, identifying commonalities between members, asking others to react to content put out by particular members and directing members to respond directly to each other rather than through the leadership. This facilitates the beginning process of building cohesion. It may also involve containing members who are highly active while inviting those who are silent into the process to ensure equality and equal access.

In this stage, the interplay between the leaders is critical because it models for the members the norms at the heart of the group process. Thus, for example, the leaders ensure that they are equally active and may negotiate where they will go with group discussion by negotiating in front of the group. This may look as follows:

Leader 1: I'm thinking it's time we left this topic and moved on. Do members agree or do you think there is more to be said here?

Leader 2: Leader 1, I'd like to stay with this a bit. How about we spend five more minutes before leaving the topic?

Again, it is assumed that through observing the enactment of the norms within the leadership sub-system, members will be impacted isomorphically and the group will eventually follow the lead of the facilitators. In other words, by modeling effective communications and relationship skills, the leadership has a modeling effect on group members who will then mimic what they see.

The group's agenda, at this pre-affiliation stage (2-3 sessions), includes group goal setting in relation to the group's purpose, the introduction of a cognitive-behavioural framework for understanding depression and the group norms modeled by the leadership. The latter is introduced here because there is safety in going into a learning mode: clients can better pace themselves in breaking the silence of being infected and test out the waters of intimacy at a slower pace. It is important to note, however, that teaching is highly interactive at this stage. Rather than be leader-focused, the leaders provide a framework and engineer the group through a discussion with one another about what that looks like for them.

3.3.3 Power and Control

During this stage of group development, group members test the leadership around the group norms. This reflects the tension between their native ways of being in the world and the norms governing group interaction. It also reflects their attempts to resolve the relationship questions posed by beginning to encounter one another in more intimate ways. It is generally a turbulent period involving challenges to the group leadership (Garland, Jones et al, 1973). It may manifest as rebellion (e.g. "I'm here to learn not listen to this boring stuff."); splitting the group leaders (e.g. a member who always talks to one group leader says to the other, "Why aren't you kinder, the way Leader 1 is?"); or passivity marked by extended group silences in response to leadership prompts.

During this Power and Control stage, conflict is often experienced within the leadership as members struggle to maintain **their** status quo. It is critical, therefore, that the leaders are able to identify that any conflict between them may be mirroring group anxiety about moving forward and internalizing the norms of the group. Open communication between the leaders is critical. If it does not happen, the group will not progress. One of the functions of the leaders' consultation process is therefore to ensure that conflict can be addressed in terms of what the group as a whole is doing.

What feels and often looks like a power struggle between the leaders and the group is, at core, a reflection of the struggle each member has around forsaking dysfunctional ways of being in relation to others and the more functional ways demanded by the group norms. This perspective must direct every intervention made by the leadership. Consider, for example, the following fictional scenario:

Group member 'a' has been talking about her belief that AIDS is her punishment for being sexual. When she begins to cry, group member 'b' turns to leader 1 and says, "What are you doing? We didn't come here to get into all this stuff."

Leader 2: Is that how others are feeling?

Group member c: Yeah. You're pushing us too much.

Leader 1: Leader 2, I'm wondering what is happening to the group right now?

Leader 2: I'm wondering if the group isn't hitting on some hard stuff that is painful to experience.

Leader 1 (to the group): What is it like for others to see such distress come into the room?

Group member d: It's pretty jolting. I don't like it.

Leader 2 (to the group): How does that compare with what others are experiencing? Is this pretty jolting for you too?

Several members mumble assent.

Leader 2: I'm wondering if this is what happens in your lives outside this room. What would the group need right now to feel safe in expressing strong feelings?

In this vignette, the leadership does not enter into a direct power struggle with particular challenges but engages the group in a here-and-now exploration of the group process. It is critical that challenges be viewed in terms of the membership's struggle to engage in a different way of interpersonal encounter and to feel safe in such an engagement. The leadership's goal is therefore to use group norms to activate mutual aid, engender a mutually supportive group culture and encourage members to use different parts of themselves to make different choices about their lives.

Until the group as a whole resolves the issues inherent in the Power and Control stage, it cannot move forward (Garland, Jones et al., 1973) because the group has not yet established the safety required to move forward to more intimate encounters.

3.3.4 Intimacy

Achievement of this stage is marked by greater risk-taking, more emotional expression and more frequent references to the sense of 'we-ness' engendered by the group. At this stage, then, safety has been achieved and ownership of the group has passed to the group members. Because of the greater sense of group ownership and safety, agenda setting is transferred to the members themselves. Interactive methods of teaching information about cognitive coping strategies may continue to be used in this phase but the quality of discussion is different as members risk exploring their application to all aspects of their lives.

During this stage, the leadership becomes less active since member-to-member interaction is more spontaneous. It also embodies the norms. The function of the leadership is more geared to shepherding members when regression occurs and focusing on what is happening in the here-and-now. For example, if a charged issue like barebacking were to emerge, the group may revert to earlier forms of defense. The role of the leadership is to identify, through observation, what appears to be happening and put it out for group discussion:

Leader 1: I noticed that when Juan said he was having unsafe sex, a number of you seemed to freeze. For example, there were a number of frowns and crossed arms. I'm wondering what is happening in the group right now. Any ideas?

3.3.5 Differentiation

At this point in group process, the group's members enact the norms without the direction of the leadership and activities become self-directed (Lang 1979). Defensive strategies aimed at avoiding change give way to enactment of a broader repertoire of interactions among members, and the role of the leadership is to act as a resource for the group. Thus, the group as a whole takes ownership of its agenda as it relates to group purpose.

3.3.6 Termination

Between three to four weeks prior to termination, the leadership acknowledges the fact that termination is pending. Because the group's ending represents loss, it is a particularly important issue for those who are HIV-positive. Most, if not all, members will have experienced multiple losses in their lives related to deaths in their networks as well as losses related to positioning in the world (e.g. work roles, occupational status). When introducing the issue of termination, the leadership therefore needs to anticipate regression to earlier forms of interaction and be prepared to address them on a group level. What this will look like will be influenced by the pre-treatment interpersonal styles of the members. For example, members may become more withdrawn and less engaged with one another, reverting to one of the core symptoms of depression. At this point, the leadership becomes more active again. For example, if withdrawal occurs, the leadership will punctuate the process:

Leader 2: I notice that when the issue of ending came up, there was a great deal of silence. I'm wondering if it relates to your feelings about all the other losses you have experienced in your lives.

Member a: It's kind of overwhelming to go there.

Leader 1: Maybe this would be a good time to look at loss and how this one might be different.

As this scenario illustrates, it is important to work in the here-and-now while working with the group around how they can consolidate what they have gained by making this experience of ending different. For example, it is important at this stage to reinforce the gains members have made, to address how they have used them to restructure their lives and regain a sense of personal efficacy and to explore ways they can continue in relation to one another.

3.4 Consultation Process

Once the clinical members of the Coalition had developed the framework and agreed upon core interventions for the first eight sessions, members who agreed to deliver services received training in social group work. The trainers, both of whom had extensive clinical experience in using and teaching the method, provided two initial days of training using the social group work method in the training process.

Concepts introduced to participants included:

1. systems theory concepts as they relate to social group work (Durkin, 1981; Durkin, 1981a; Wallace and Nosko, 1993);
2. the concept of group as a whole, including group as micro-society (Klein, 1972) and the enactment of mutual aid group norms (Schwartz, 1961);
3. stages of group development in relation to group norms (Garland, Jones et al., 1973);
4. Yalom's therapeutic factors (Yalom, 1995) in relation to social group work theory;
5. issues related to co-leadership of groups (Nosko and Wallace, 1977).

Just as social group work is rooted in an understanding of systems theory, the method of training mirrored the methods used in group delivery, recognizing that the purpose of the training was to entrench an understanding of the theory and skills of the method. Thus, the trainers employed a highly interactive approach facilitating the training group through the stages of group formation, and grounding theory and skills development in the teachable moments offered by a here-and-now focus.

Because of the time lag between the development of the project and its delivery, participants completed a one-day refresher training prior to the actual delivery of the group.

In order to ensure consistent application of the model and track changes made in the initial outline by the three co-leadership teams, all participants agreed to participate in a consultation process which required attendance at team consultation meetings every two weeks for the project's duration. The two clinicians who provided the training facilitated the consultation process. Each team was also required to complete written sessional summaries, which tracked what they actually did versus the preliminary outline for the first eight sessions. The summaries also tracked external events which impacted on group process (e.g. low attendance due to holidays such as Christmas, snowstorms).

A goal of the consultation process was to model the application of social group work theory, again recognizing that group delivery would benefit by using the same method in service delivery, training and consultation. To reiterate, it was hypothesized that what happened in one system would impact on the performance of all adjacent systems. Thus, how the consultation group operated would impact on how the group leaders conducted their own groups.

The consultation process was complicated by the fact that groups were offered sequentially, with a gap of one to two months before the next group commenced. As a result, it was difficult to fully enact the principles of mutual aid; each team was at a different stage with its group and was therefore experiencing a different learning curve. Thus, leadership teams applied the skills at different points in time. The role of the facilitators was therefore very active until the first team had applied the skills needed and could act as resources to subsequent leadership teams.

Another important variable affecting the consultation process was the fact that the group was made up of peers. There was therefore no power differential between any team members. Moreover, it was clearly agreed by all parties, including the participating institutions, that the role of consultation was not supervisory. In other words, the consultants were responsible for providing a learning environment and for teaching practice and theory; they had no administrative power over the participants. That responsibility was carried by the AIDS Committee of Toronto (ACT) and their protocols for supervision. For example, leaders were required by ACT to report any critical incidents (e.g. suicidality) to the agency, not to the consultants. This freed up the consultants to create a team culture which reflected the safety-producing norms of social group work (e.g. tolerance for difference, open roles, democratic process).

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4. The Pilot Research Project

4.1 Purpose

This pilot project was designed to test the effectiveness of the social group work model on groups of depressed HIV-positive individuals. As this was a preliminary step, the Coalition was not interested in whether or not this model outperformed another type of therapy or medication. Rather, we were concerned with analyzing whether or not the model was effective in and of itself.

Within the context of the overall program goals of developing a therapeutic response to depression, addressing the relationship between the psychosocial context of individuals with both HIV/AIDS and depression and enhancing the ability of these individuals to engage meaningfully with the world, the following were three goals of the pilot project itself:

- development of a pilot program which incorporates the determinants of health into treatment for depression;
- delivery of three co-facilitated groups over a one-year period;
- evaluation of the efficacy of the treatment model through the use of pre-test and post-test measures of depression and social functioning.

The following two research questions were addressed by the pilot project:

- Does a social group work model utilizing cognitive interventions effectively treat depression among those with HIV/AIDS?
- Is change sustained over time, following treatment?

4.2 Methods

Three groups of up to thirteen individuals each were recruited. Advertisements were placed in the current event section of local newspapers (Appendix 1). The advertisements highlighted various depressive symptoms to ensure that self-referred individuals really were experiencing the core symptoms of depression. An actual diagnosis of depression was unnecessary. Information on the groups was provided to local physicians, counselors, therapists and psychologists who had an interest or specialty in HIV/AIDS. This recruitment process took several months.

As this was a research study, all individuals assigned to a group filled out a research consent form upon acceptance in a group. Sessions ran for 20 consecutive weeks, the exception being the December holiday season. Each session was two hours long.

At the beginning and the end of the 20 week sessions, the group members filled out three separate questionnaires, as described below. Demographic information was also collected

at the beginning of the study. Qualitative information was collected at the end of the study to ascertain strengths and weaknesses of the program as perceived by the participants and their suggestions for change. The group members gathered one final time three months after their last session and repeated the three questionnaires (for a total of three times) to allow for longer-term follow-up.

4.3 Measures

The researchers wished to use measures that were sufficient yet not intrusive on the experience. They chose three different measures to explore several facets of the issues facing HIV-positive, depressed individuals.

For a depression measure, the Beck Depression Inventory (BDI) was chosen (Beck, 1993). This measure is one of the most widely used scales to assess depression. The BDI is considered a sensitive measure of treatment effect and has good construct validity (Richter, Werner et al., 1997). Well over 25 years of experience with this scale provides extensive evidence of sound reliability and validity (Beck, Steer et al., 1988). This measure is appropriate to assess change in depression in a time interval of at least several weeks. There is some concern that the Beck Scale contains somatic items that are analogous with HIV symptoms, thus artificially inflating the scores (Savard, Laberge et al., 1999; Kalichman, Rompa et al., 2000). These would include weight loss, appetite loss, insomnia and fatigue. Our concern in this pilot was not with the actual score per se but rather with the change in scores over time.

As a general health survey measure we utilized the MOS-HIV measure (Wu, 1996). This scale is an adaptation of the longer Medical Outcome Study General Health Survey (Steward, Hays et al., 1988). The MOS-HIV demonstrates good reliability and validity (Wu, Rubin et al., 1991; Revicki, Sorenson, 1998; Hughes, Kaplan et al., 1997). In our case, scores were segmented into two separate parameters: a physical health scale and a mental health scale for which good evidence of reliability and validity exists (Revicki, Sorenson et al., 1998).

The third measure used was the Social Support Questionnaire, using the adaptation by Hays (Hayes, Turner et al., 1992) for the HIV population from the original Social Support Questionnaire developed by Saran and colleagues (Saranson, Levine, 1983). The Hays version involves 12 questions versus the longer original 27 question scale and demonstrates good validity and reliability (Hayes, Turner et al., 1992).

The hypothesis was that there would be an improvement in self-reported depression over the course of the sessions, which would be maintained in the longer-term follow-up as monitored through the Beck Depression Inventory and the Mental Health scale of the MOS-HIV. At the same time, researchers wished to see if participants' sense of social support improved over the course of the 20 weeks. Although we were measuring changes

in physical health through the MOS-HIV measure, we did not expect to see a change in physical health of participants over the course of the pilot project.

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5. Outcomes of the Pilot Project

5.1 Group Composition

At the start of the study there were 31 participants. 90% of the participants were male despite activities targeted to recruit women. All but two participants completed high school and over 30% also had some form of university education. Two-thirds were not employed at the time of entry into the study. 60% of participants lived alone; the remainder lived with roommates, partners or family. 75% of the subjects indicated that they were homosexual, 13% were heterosexual and 10% were bisexual. 80% of subjects were white, the remainder being Asian, Black, Hispanic and East Indian. We did not have a large enough group size to conduct factor analysis to ascertain if any of these components were statistically related to depression (Appendix 2).

Subjects were asked about their psychiatric/psychological history. 50% were currently receiving some form of counseling for a mental health concern. Nine participants were taking anti-depressive medications at the start of the sessions.

60% of subjects indicated that they were currently suffering from physical health concerns related to their HIV status. Over and above HIV-related health concerns, 40% of the participants indicated that they were currently suffering from other health concerns.

One subject identified himself as having a problem with alcohol use. A full 40% of participants indicated that they considered themselves to have had alcohol problems in the past. 70% now considered themselves social drinkers; the remainder did not drink at all. Half of the participants consumed fewer than 2.5 drinks per week.

Three subjects felt they had a current problem with drugs and eight (or 28%) felt that they had drug problems in the past.

Over the course of the 20 week sessions a number of participants dropped out. By the end of the sessions, 20 participants were available to complete the post-test set of questionnaires; however, average combined attendance among the groups was generally higher than 20.

The dropouts did not seem to differ in any discernible way from those who remained until the end of the process in terms of gender, sexual orientation, race or living arrangements. However, they differed in terms of employment, where 91% (10 of 11 people) of those not completing the full 20 sessions were unemployed. We had an even split between employment/unemployment among those who remained for the full 20 sessions. 50% of the dropouts considered themselves to have had a past drinking problem, where only a third of those remaining felt this way. Additionally, the one individual who had indicated that he was currently suffering from a problem with alcohol

dropped out of the sessions. Finally, those individuals remaining for the full 20 weeks were more likely to have had a university education than those who dropped out.

5. 2 Participants' Feedback on the Sessions

According to the participants the groups were highly successful. Of the 19 responses we received, 18 felt that the discussions within the groups and methods of interacting reinforced during the sessions helped them manage their depression. In fact, verbal feedback was excellent and some group members continued to meet months after their groups had formally ended.

What was mentioned most often as beneficial was the provision of coping skills. Participants were taught to recognize triggers (such as negative self-talk), allowing them to develop solutions such as stress management and problem solving.

The second most helpful aspect was the basic recognition that each participant was not alone in feeling the way he or she did. Listening to others describe similar feelings and their mechanisms to solve problems made participants realize that they too could deal with a depressive episode.

Group members felt the supportive and encouraging environment was a key component to the success of the program. One member noted that "it forced me to confront, empathize, encourage, acknowledge and generally deal with others."

The one participant for whom the sessions were not helpful indicated that he liked the group sessions and did not suggest any changes to structure or content.

Group members felt there were two components of the group experience that made it particularly successful. First, the climate of openness and honesty within the groups ensured that the members could speak freely and feel safe. There was no sense of being judged and the knowledge that the discussion within each group was confidential led to enhanced feelings of safety.

The second component of the group that was identified as being helpful was the facilitation. Members credited the facilitators with creating the safe environment for discussion and highlighted their ability to elicit discussion from all members.

We asked participants what they didn't like about the groups. Most indicated they had no dislikes; however, the next most cited element was the discomfort they felt with the concept of the group self-directing. As one member indicated, "I didn't like the sensation of the group being set free to progress along its own path at its own pace so freely, despite understanding the rationale behind it." This facet of the group experience was mentioned anecdotally during the course of the sessions. Some group members preferred stronger direction.

We asked group members what they would have liked more of during the sessions. Many respondents did not provide any feedback. Of those who did, the most frequent response was a request for a greater number of sessions (more than 20). Additionally, several participants felt that the sessions could have been longer than two hours.

When asked about topics they would like to have covered, participants indicated: dealing with death, suicide, sexual ethics, more coping skills and information from other professionals in the field. It should be noted that these topics were discussed in each of the groups; however, it indicates that either the clients had missed that particular session or that the discussion did not feel closed or finished to them.

5.3 Quantitative Outcomes

Three quantitative measures were used in the pre-testing and post-testing: the Beck Depression Inventory, the MOS-HIV Survey and the Social Support Questionnaire. Participants completed the scales at baseline, at week 20 and finally three months after the sessions ended.

Analysis of the data from the 20 week sessions was conducted using SPSS™. The Beck Depression Inventory is scored out of 63 points with 0 indicating no discernible depression. For this scale, we had normal distribution of the data at both week 1 and again at week 20. Average scores for the groups ranged from 18 to 28 in week 1 and from 11 to 17 at week 20. Using ANOVA we found no significant differences between the groups at either date. Data for all three groups were then combined and a paired T-test was used to analyze the data. We found an average drop of 8.53 points over the 20 weeks. This was considered a significant change in the Beck scores ($p = 0.029$).

The MOS-HIV Scale is comprised of two parameters: the physical health summary score and the mental health summary score. Each is scored separately on five parameters and aggregated on a 0 to 100-point scale with 100 indicating excellent physical or mental health. On the physical health parameter, the data for each group were normally distributed and there were no significant differences between the groups. Average group scores at baseline ranged from 42 to 68 points. Using ANOVA we found that there were no significant differences between the groups. Scores from the groups were then combined for week 1 and again for week 20 and a paired T-test conducted. We found an average increase of 4.88 points in the scores over the 20 weeks. However, this was not a significant result.

For the MOS-HIV Mental Health Survey, the data were not normally distributed. There were no significant differences between the groups. Data were subsequently log transformed, which corrected the distribution. A paired T-test was performed on the transformed data that showed an average increase of 9.88 points over the course of the sessions. This was considered a significant increase in scores ($p = 0.014$). This agrees with the Beck Depression Inventory findings.

Our final scale was the Social Support Questionnaire as modified by Hays. This scale is also measured on two parameters: a numbers scale and a satisfaction scale. On the numbers scale one simply takes an average of the total number of people who a respondent feels would be supportive of him or her in 12 different situations. On the satisfaction scale one takes an average of the level of satisfaction the respondents feel with the numbers of supportive individuals they have in their lives. This latter score runs from 1 to 4, with 1 being very satisfied.

On the numbers portion of the Social Support Questionnaire, we did not have normal distribution of the data. In addition, there were significant differences between the groups. Consequently we could not aggregate the data from the three groups. We analyzed this data by group using the Wilcoxon Signed Rank Test. The numbers in the groups were very small and consequently not very valuable; however, we found no significant change in the numbers scale over the 20 weeks for any group.

For the satisfaction portion of the Social Support Questionnaire we did have normally distributed data and there were no significant differences between the groups. Scores ranged from 1.8 to 2 between the groups at week 1 and actually decreased over the course of the 20 weeks (respondents felt less satisfied). We combined scores for all groups and conducted a paired T-test. However, changes were not significant ($p=0.214$).

Overall our findings agreed with our original hypothesis. The respondents had a change in their mental health over the course of the sessions as supported by significant changes in both the Beck Depression Inventory and the mental health summary score of the MOS-HIV. We did not expect to see a change in physical health. We might have expected the groups to feel more social support over the course of the sessions; however, it is likely that the sessions highlighted the absence of good social support in the lives of the respondents, which may have accounted for the scores. At any rate, the social support findings were not significant.

Our results are in no way definitive. We cannot say that it was our sessions that caused the change in scores because we did not strictly control for factors such as taking antidepressant medications or the use of individual counseling. Notwithstanding these factors, we were conducting pilot research and these results give us confidence to go forward with more rigorous research.

6. Community Outcomes

6.1 Overall Benefits of the Collaboration Process

Our team was unanimous in its belief that a collaborative process brought many rewards. The increased knowledge gained through sharing and training and the honing of community-based research skills were professionally enriching experiences.

This collaborative process allowed for the development of an expanded peer support system and enhanced networking possibilities. The strong sense of commitment to the project and the presence of both institutions and agencies allowed for increased motivation for members, despite the initial delays in project start-up.

Common linkages developed that will be valuable beyond this one project. Perceived gaps in the system can, as we discovered, be filled in an innovative and rewarding manner.

As one member most aptly put it, “a coalition breaks down the sense of isolation that can occur in individual agencies.” Despite the extra time required for taking part in a consultative process, the impact of working in a coalition both broadens and deepens the impact of services to the community.

6.2 Lessons Learned Through the Process

Our group required the time that any group requires to coalesce and build trust (particularly if members have not worked together in the past). The lengthy initial delay due to the research process attached to the program gave our Coalition ample time to meld into a productive and cohesive unit.

Our Coalition members felt the funding delay and especially the ethics approval delay (compounded in our case by the fact that two teaching hospitals were involved, necessitating two separate ethics approvals) created the predominant weakness in our collaboration process. While community-based research is in its infancy, this will be a continuing challenge. Eventually, protocols may be put into place that will streamline the approval process for such ventures. In the meantime much patience is required.

Given the nature of our project, there was a significant time commitment required from members – with the planning, recruiting, ongoing consultation and actual group facilitation. Strong commitment by both Coalition members and agencies/institutions is necessary for successful implementation of such a project.

Our Coalition chose to approach the project in a collaborative decision-making fashion, with no designated principal/leader. This meant that discussion could be lengthy and decisions were often reached slowly. Our group felt by the end of the project that choosing a chair or co-chairs might have been beneficial. At least one Coalition member agency had some success with this type of model in the past. Having a designated chair-

person would not supplant the collaboration but rather assist in maintaining momentum of the project.

We also found that, despite the wealth of contacts and resources inherent in a multi-group project, there was still difficulty in reaching out to all communities affected by HIV/AIDS who might have benefited by our program. Care should be taken in the design phase to address this issue.

Finally, a project of this type requires a lengthy commitment by group facilitators. For our Coalition, the protracted timelines meant that we had to seek new facilitators mid-project. Care should be taken at the inception of a project to identify additional human resources should they be required and perhaps facilitators should be matched with a designated spare in mind at the beginning.

6.3 Our Experience With the Process Through the Project Stages

6.3.1 Development al Phase

While the idea for group counseling on depression was formulated at one agency long before the interagency Coalition was developed, the group process expanded the expertise available and fostered the development of strong linkages between institutions and agencies within the Toronto area. These linkages will be helpful beyond the time frames of this project and will allow these groups to provide augmented services to the HIV-positive community.

While conducting of formal research on the efficacy of the group work model was not an original goal of the project, it allowed all participants to gain valuable experience in community-based research. Groups seeking to conduct community-based research would be well-advised to plan sufficient time for planning the project, applying for funding and obtaining ethics approval. It is wise to check with your institution to see if you have a policy on research.

The Coalition spent a great deal of time developing a comprehensive plan for sessions. In the end, these plans were not followed with any degree of specificity as the groups had their individual rhythms and needs.

Coalition members uniformly felt collaboration was of benefit in the development stage. It allowed for a common understanding of depression as it relates to HIV/AIDS and the group work model. Members were provided with extensive training in the model, which is outlined in section 4.

6.3.2 Implementation Phase

Two elements were key to the smooth implementation and operation of the counseling groups: having a process for recruiting (which can be time-consuming) and carving out

time to meet (and a place to meet) on a regular basis for Coalition members while the program was underway.

Once the groups were up and running, the process of collaboration was seen as nothing but positive. Coalition members met bimonthly for two hours. These sessions ensured that there would be consistency between groups in applying the model, support for facilitators and an enhanced ability to solve problems. This process forged an even-stronger coalition so that the focus was on the group and not on any single institution.

6.3.3 Evaluation Phase

A coalition is also particularly useful during the program evaluation stage. Our members felt that the diverse perspectives helped to challenge perceptions and enhanced the overall learning experience.

6.4 Challenges

Our Coalition group reviewed the entire process of developing and implementing this project partly in order to ascertain what areas represented particular challenges. The biggest challenge for the group was to integrate the institutional with the community perspective. The delay in project implementation necessitated by the ethics process provided sufficient time for group members to gain trust and function optimally in a group environment. This carried over to the peer consultation process, where there was a secure environment which allowed for challenging and examining the clinical work.

Another area which posed some challenges was the pairing up of facilitators. Given a 20-week session format, it was imperative that facilitators be comfortable with each other. Some time must be built into program planning to promote the search for compatible co-facilitators who can commit time to the lengthy treatment process.

In addition, for our purposes, we were unsure whether we could possibly run three to four groups within the time frame imposed by the research component. Ultimately, due to a longer recruitment process than anticipated, we could only run three groups. This meant that not every coalition member was able to facilitate a group. Fortunately, the Coalition was sufficiently cohesive to deal with this

Not everyone who wishes to take part in a group counseling process is suitable for a group. Some would be better served by individual service. Information on alternate sources of therapy should be available at the time of recruitment for clients in order to deal with this challenge.

Our coalition found that, as new groups started into the counseling process, there was some discussion around the degree to which the groups should/could differ. For example, one group wanted to provide snacks for the members. Two previous groups had not done

so. In retrospect, a relatively simple issue of this type might have been discussed up front with some administrative guidelines for standardization of groups developed at the outset.

**END OF PART ONE: REPORT ON THE PILOT PROJECT –
CHALLENGING DEPRESSION AND HIV**

PART TWO: DEVELOPING A SIMILAR PROJECT

This section represents the collective practice experience of the leaders actually delivering the model. Its goal is to help those wishing to start a similar program by **identifying challenges** facing group leadership throughout the life cycle of the group and by **suggesting interventions** which will help in moving the group through all its stages.

7. Choosing Group Members

A challenge for anyone beginning a group is finding clients who will benefit from the intervention and be able to participate in a therapeutic group. While there are no hard and fast criteria to indicate the 'perfect' group member, the intake interview can help determine an individual's match with the group treatment model.

In order to determine whether or not the intervention was appropriate for a client, a formal list of questions was developed (see Appendix 3). The assessment tool had **two primary goals**: to determine the severity of depression that the individual experienced and to assess the individual's capacity to participate in a group intervention. We also wished to explore with the clients the relationship between HIV and depression, as well as gain information on their experience with HIV. A number of **exclusion criteria** were determined which were felt to affect whether an individual would benefit from the group intervention. These included active suicidal or homicidal behaviour or ideation, psychosis, substance use as the primary presenting issue and cognitive impairment or dementia. In addition, individuals were required to have a diagnosis of HIV for greater than one year prior to the intake interview. This was to ensure that the experience of depression was not solely linked to a recent diagnosis. The use of the assessment tool allowed therapists to determine whether an individual should be excluded based on any of these criteria. The interview also allowed therapists to determine whether or not the individual had adequate social skills to participate in the group and determine whether the client had the capacity to engage with the therapist.

Every attempt was made for the interview to be conducted by both of the therapists who would be facilitating the group. This provided the client with an opportunity to meet each therapist and allowed both therapists to assess the client's suitability as a group member. One therapist acted as the **primary interviewer** while the second therapist took notes. While the assessment tool provided a formal list of questions to elicit information from the client, interviews were conducted informally. This allowed the clients to provide information they felt was important and the primary interviewer prompted with specific questions relevant to the assessment tool. Since the **second therapist** was transcribing the information, the primary interviewer was able to maintain the flow of the interview without the interruption of recording responses. The role of the primary interviewer alternated between the two therapists with each interview. This ensured that one particular therapist would not be perceived as the 'leader' by all group members.

Interviews typically lasted one hour. Sometimes, the therapists, uncertain whether the client would benefit from the intervention or be able to participate in the group, scheduled a second interview for further assessment. If the client was deemed appropriate for the group and agreed to participate, he or she was asked to meet with the **research coordinator** who obtained consent for the research study and administered the research questionnaires. The research coordinator also provided an overview of the study and explained both the purpose of conducting the research and the commitment that was expected from the participant. If the client chose not to participate in the group or was deemed by the therapists not to be suitable for group therapy, alternative services were suggested. In one instance, a client was deemed not appropriate for the group based on member composition. He was then referred to a subsequent group where it was hoped a better match would occur, which was indeed the case. Individuals were typically informed of their acceptance immediately following the intake interview and met with the research coordinator to complete the process. Once the appropriate number of individuals was found, the research coordinator contacted each individual and informed him or her of the startup date.

8. Making a Group Happen: A View From the Ground

8.1 Stage 1: Pre-affiliation

This is the first stage in the group's development. What follows conveys an idea of how the first three sessions progressed in our program. Use this as a general guide for anticipating and dealing with some of the tasks and challenges presented in the Pre-affiliation stage.

From the perspective of a **facilitator**, the first session is by far the most intimidating. All of the work that has gone into making the group possible is finally coming to fruition. It is important to remember that you have the support of a **co-facilitator**.

Because tension between you and your colleague will immediately impact on the group, it is essential that you have had thorough **discussions beforehand** about how you understand the model, how you will deal with conflict between yourselves, how your styles will mesh and how you will deal with conflict within the group. These are essential elements of a competent co-leadership relationship and will impact significantly on your degree of comfort going into the first session. It is also important because in the first session the participants will be looking for guidance, support, trust, safety and other modeling behaviours they can emulate over the next five months.

8.1.1 The Beginning

The **set-up** of the room is important. The chairs need to be arranged in a circular formation so that everyone is visible and so that there is no position of power created by the seating arrangement. The facilitators sit across from one another so that they are able to make eye contact during the course of the group. There should be no table to sit around, since this separates group members and also has connotations of a business meeting. Once everyone is settled in position the facilitators introduce themselves, explain the purpose of the group, and clarify the facilitators' role within the group itself. You will have already explained these things in the interview phase, but it is important to **repeat** this process **with the group** to ensure that everyone understands the collective process. One of the most important aspects of this initial meeting is to impress upon members the fact that the individuals **must** function as a group; this means that there is no hierarchy among group members. The role of the facilitators is identified in terms of their responsibility to direct the flow of conversation, to ensure that group norms or rules are adhered to, to help the group deal with difficulties which emerge and to resource the group when needed. The group is now set to begin.

8.1.2 Introductions and Check-in

At the beginning of the first group meeting, group members introduce themselves. **Icebreaking exercises** may be used to assist in this often-awkward phase. Some

facilitators asked all members just to give their names and any information that they wanted the group to know. Another co-leadership team asked the members to give their names and the name of their favorite desserts. The method of introduction is not as important as getting each person to speak in a group atmosphere.

In subsequent meetings, a variant of this approach can be used at the beginning of every group meeting. This is called '**check-in**' and can provide a way of encouraging every group member to speak at the beginning of each session. Often this is the time when members touch on a burning issue that has been weighing on their minds. It is important, however, for the facilitators to ensure that the members do not speak for too long during check-in. This way everyone can get a chance to speak. If a member is speaking for what you have determined is too long, ask him or her if he or she could wait until after check-in to further discuss his or her issue. There is no one prescribed way for a check-in to occur. Some groups like to take turns speaking in a circle; others prefer the random approach. Any way that it occurs is fine, providing that the process meets its goal.

8.1.3 Establishing Norms

Establishment of what are called **group norms** is crucial in the first session. These are the explicit and implicit behavioural rules that guide how the group members interact and determine whether the group is a safe environment for members. Safety is the most important aspect of a well-functioning group. If group members feel they are in an environment where it is safe to speak honestly, a successful therapy group results. If an unsafe environment is perceived, no members will feel comfortable raising significant issues.

The paramount question is: **how can a facilitator create a safe environment?** The facilitators establish several norms immediately as the group begins which are central to creating safety. For example, it is important that every group member feels that he or she has a voice that is not only heard, but also respected. One of the characteristics of depression is low self-esteem, so it is vital that the members feel that speaking within the group parameters is encouraged and also ultimately rewarding. Active listening by each facilitator is key. Nodding, maintaining eye contact and mirroring what a member has said are all good methods to actively maintain a **stable rapport** with members as they share with the group. Remember to always ask the rest of the group to respond to issues that are raised. "What do other people think about that?" and "That sounds similar to what Bob touched on. Can anyone else think of an example of this?" are useful phrases to bring to the group. The goal is to show people that they are all in a similar situation, that everyone's input is important and that the group is a tool that can help them deal with their problems.

By so guiding member-to-member interactions and by modeling the norms of the model, the leaders are establishing the universal norms of the social group work method. These may or may not be made explicit in the first session and include:

- **mutual respect.** All members must respect each other's opinions, space and privacy within the environment of the group process.
- **non-judgemental attitude.** Because there is an overwhelming stigma towards HIV-positive people and those who suffer from depression, the members of the group have all experienced a great deal of judgemental attitude in their daily lives.
- **openness.** Members must be encouraged to help one another in the group process by sharing and understanding different experiences and perspectives.
- **honesty.** Members must strive at all times to express themselves honestly. Honesty is imperative to enable each group member to grow and thrive in a manner that only sincerity can provide.
- **equal access.** Everyone has equal entitlement to access the group.
- **open role system.** No member is fixed in one characteristic way of behaving in relation to others (e.g. the caregiver is encouraged to experiment with asking for support).
- **democratic process.** No member's opinion or value is more important than any other member's.

In the first session, it is also important for the facilitators to help the group establish and identify **other ground rules** that are needed to help members feel safe. This is done simply by asking, after the introductions, what rules members think necessary for them to feel safe. Some invariably emerge and may include:

- **confidentiality.** The group members and facilitators need to discuss and agree that what is said in the room stays in the room. A group member's name is not to be used outside of the group environment. Rules should be established to explore how group members greet each other if they see each other accidentally during the week. Privacy must be respected regarding other members' HIV-status.
- **alcohol/drug use.** It should also be agreed that no member of the group is permitted to attend if he or she is impaired. This compromises the integrity of the group atmosphere. Instead, the member must contact a facilitator who will inform the group that the member will not be attending that session.
- **attendance.** Because this is a structured group with a finite number of sessions, each group member must commit to attending as many sessions as possible. Members are asked to call one of the facilitators if unable to attend so that the rest of the group can be informed of their absence.

If the facilitators believe there are **other rules** which need to be established, their job is to prompt the group into considering them. For example, the group members might be asked how they, as a group, want to deal with conflicts which develop between members outside of the group or they might be asked about whether or not they want breaks. The facilitators' role here is to help the group identify potential problems or unanticipated questions about how it operates.

If a group were to decide on rules that contravene the universal norms outlined above, the facilitators need to challenge the group about the effect such rules might have, leading them to a realization of potential negative effects. If that doesn't work, the leaders need

to be direct about the fact that their knowledge and experience make it clear that groups can't operate with dysfunctional rules and still be effective.

8.1.4 Establishing Goals

Establishing the norms will take at least one or two sessions. At the same time, it is necessary to review within the group both **individual and group goals**. By doing this, the facilitators emphasize the purpose of the group and build a community among members. The facilitators do this by canvassing members about their goals and by writing this information on a flip chart for all members to review. As each member identifies what he or she hopes to change, other group members are invited to reflect on how their own goals are similar to or different from those of others. A separate listing may be made for answers to the question: "How will you know if your goals are reached?"

Besides creating a community of purpose, goal setting serves another function. Asking members to think about what they want to change encourages them to imagine a different future. This is the **instillation of hope** Yalom talks about which is discussed in Section 3.1 entitled "The Theoretical Framework." Are all of the goals stated achievable? Most likely they are, but there is only one way to find out and the promise of change is what led these people to the group in the first place.

Possible **individual goals** might be:

- Learn that mistakes are okay.
- Try to keep my temper under control.
- Try to think of myself as anything other than a loser.
- Learn to get a good night's sleep.
- Learn to sleep a little less.
- Find my self-worth again.
- Go out on a date again.
- Answer the phone when it rings.
- Be unafraid to walk alone.
- Feel great like I used to.
- Re-connect with old friends.

These are merely a sampling of the possible individual goals. You will receive hundreds of goals, ranging from very specific (“I want to be able to go to family dinners every Tuesday.”) to very general (“I don’t want to be angry all of the time”).

The importance of establishing **group goals** is to try to have all of the members think of themselves as part of a collective. This will encourage them to think in a more open-minded, inclusive fashion. This will ultimately lead to the group feeling confident as a whole, in other words, like a community. Possible group goals can include:

- mutual support,
- learning new coping skills,
- education about depression and HIV,
- learning about resources.

8.1.5 Managing Group Conflict

In this stage of group development, members rarely challenge one another or the facilitators. Members tend to be on their best social behaviour. There are times in the first sessions, however, when a group member or members may begin to **challenge** what is going on. When this happens, it signals that the group is anticipating the next stage of development. More will be said about that later, but for the moment, let it be said that the role of the facilitator is to deal with such challenges in the context of the group as a whole.

For example, during the norm-setting discussion, one member may say something like: “This is a complete waste of time.” In an instance such as this, it is imperative that the issue always be brought back to the group. One of the facilitators might say, “Do others agree with this comment?” or “Do others have an idea of why this is important?” In other words, the facilitators are beginning to encourage the group to **reflect** on its own process and to **take responsibility** for what happens. How the facilitators respond will set the stage for managing the conflict that will invariably emerge as the next step of group formation. This will increase the sense of safety needed for members to enter and resolve the Power and Control stage.

8.1.6 Teaching

Education, one of most important elements throughout the life of the group, is first introduced during this stage. It is up to the facilitators to educate members about the various dimensions of depression and to teach coping skills. Keep in mind that the participants have been living with both HIV and depression for a significant amount of time, and therefore are personal experts on both topics. They may not, however, be able to understand objectively or explain how depression works and progresses in their lives. By explaining the process, the facilitator not only **educates the group**, but also establishes himself or herself as a resource for change and improvement. It is beneficial to do your teaching on a flip chart so people are free to contribute, drawing on examples from their own situations. We agreed upon a conceptual framework to provide group members with a common frame of reference for talking about and understanding depression. Facilitators explained each of the following **four categories**, engaged the group members in providing examples from their own experiences and highlighted commonalities of experience.

- Cognitive/Thinking
- Emotions/Feelings
- Behaviours/Doing
- Physical

For example, if one member identifies getting out of bed in the morning as a difficulty, the leaders might ask the group, “Does anyone else have a similar experience?” This will not only build a clear understanding of the symptoms of depression and allow each member to integrate learning into his or her life, but it will also begin to foster the development of group cohesion, or a sense of ‘we-ness’. To this end, it is important that teaching be as **interactive** as possible; a lecture format must be avoided. Furthermore, teaching the participants about depression allows the group to open itself up to an atmosphere of teaching and learning, therefore enriching the experience.

Interactive teaching methods as described above were used for all teaching moments in the groups. For further discussion and a suggested resource, refer to Section 3.1, “The Theoretical Framework.”

8.2 Stage 2: Power and Control

In this stage the members are observing each other as individuals and as a group. They are exploring whether they can **risk** expressing thoughts and feelings that they tend to keep to themselves or whether they can risk initiating interchanges and conversation

when the outcomes are not known. They are checking out whether the leaders and the structure or the norms of the group are sufficient to give them the **protection** they need to take the above risks. Finally, they are sorting out for themselves whether or not this is a group to which they wish to belong.

This is, therefore, a stage in which members test others in the group and the leaders as to their **feelings of safety**. Trying to ward off unfamiliar ways of interacting, as embodied by the norms, the group members often seem to be in a high state of conflict both with the facilitators and with one another. What seems to be challenging behaviour can actually be a request that the facilitators reiterate and define again the rules or norms of the group so that members feel safe. Thus, almost all of the difficult moments in this stage are really about **reassurance**. These moments, many of them unpredictable, often appear to be a direct challenge to the facilitators.

Because the Power and Control issue manifests itself as resistance to risk-taking, it often first surfaces when **emotion** begins to be expressed, even in a tentative and subtle way. The facilitators need to be willing to abandon, for the time being, predetermined lessons or other content to deal with any resistance to the expression of emotions by the group. For example, when a member conveys emotion, the leaders may ask the group to reflect on how this is experienced. If for instance a member introduces emotion into a story, the leaders need to be willing to acknowledge the emotion, ask others what it is like for them when visible emotion comes into the room and explore with the group what it is about that emotion that makes them either comfortable or uncomfortable. This moves the group towards a norm which values **appropriate risk-taking** around emotional expression and facilitates connection between members, a central value for the group. It increases the sense of what is 'allowed' in the group, builds contact and fellow-feeling among members, allows for the possibility of members giving understanding to each other and tells the narrator something about himself or herself that he or she may not have been aware of before – e.g. that he or she was brave or strong in the opinion of others in the group.

Resistance to risk-taking may emerge in apparently hostile reactions to the expression of emotion. For example, a member might say, in response to someone's emotionally told story, "I don't want to get into this touchy-feely stuff." The goal then becomes exploring the meaning of this reaction with the group members and moving them to a point where emotions are tolerated.

Alternatively, resistance may manifest as a denial of emotion. A story, in which emotion would be appropriate, may be told in a completely dispassionate way. In this case, the facilitators can ask other members what they imagine it would be like to have a similar experience, checking out whether the responses of other members echo the narrator's experience.

Leaders can use themselves and their relationship to help the group deal with resistance to connection triggered by emotional expression. For example, if a member begins to cry and others respond with silence, the leaders can use their own connection to help the

group move past a feeling of being unsafe. One leader can make an observation to another in front of the group and ask for an opinion. In this instance, one leader may say to the other, “ I notice that when John began crying, there was a lot of silence. There were quite a few sighs and some fidgeting on the part of a few of you. What do you think the group might be experiencing right now?” The advantage of this approach is that neither leader feels alone, while at the same time, the leaders are modeling for members an ability to reflect on what is going on and an ability to tolerate emotion.

8.2.1 Other Examples of Power and Control

It is helpful here to give some **other examples** of what forms Power and Control might take in the group. Imagine that member (Bill) responds to another member’s (Fred) story, by saying, “That was a really dumb thing to do.” In order to establish safety about telling a story, it is up to the facilitators to respond to the group with a question such as: “How do others react when you hear someone’s behaviour described as dumb?” It is also a good idea to ask Bill, “Could you reword your comment in a way which Fred might hear?” It is imperative that the facilitators bring all conflicts to the group and support the value of non-judgement. Facilitators must also help people recognize potentially dysfunctional ways of communicating with others. This empowers the group as a collective and provides a sense of safety for confrontation and dispute resolution.

It is also quite likely that certain members will **challenge the facilitators’ control** of the group in the Power and Control stage of group development. A group member might complain of being bored during the group, particularly after another member shared a painful story. In such an instance, the facilitators need to check out how the rest of the group is reacting and ask what might be causing such a reaction. One way of doing this would be to say to the other group leader, “Joe’s story was pretty intense. I have a hunch that it may have to do with the reaction some expressed of boredom. Do you think there is anything in that?” Such a prompt can then lead to a question posed to the group as a whole: “What are some of the reactions you have at other times when someone tells you a distressing story?” When responding to such questions, members, as always, are encouraged to address each other and the group, not the facilitators. By **asking the group** for its thoughts, you reinforce the norms of democratic process, mutual aid, equality, respect, tolerance of difference, open roles and non-judgement. You also ensure that you are not missing any unspoken demand for restating the group’s safety parameters.

Because interpersonal encounter is one of the primary agents of change in a psychotherapy group, Power and Control is also likely to emerge when the facilitators prompt the group **to challenge the dysfunctional behaviours of some group members**. Examples may be:

- the member who finds it difficult to be part of the give-and-take of conversation;
- the member who always distracts from topics that are emotionally risky;
- the member who is unable to listen to other members;
- the member who wants to monopolize the group.

In these cases, the facilitators need to be prepared to use the group to challenge the inappropriate behaviours and be prepared to deal with members' anger for doing so. A leader may interrupt a client who is engaging in a monologue by saying something like: "Bob, I'd like to interrupt a moment and check out how the group is reacting to what you are saying." (To the group): "I've noticed that as Bob is talking, some of you are glazing over; others are fidgeting. I'm wondering if you can give Bob some feedback about why this is happening." That feedback may be given bluntly and critically (e.g. You're so boring!"). In this case the leaders need to work with the group about how to give non-judgemental feedback. Alternatively, while the feedback may be given appropriately, Bob reacts with anger. He might say, "Why are you picking on me?" Responding to this challenge, the facilitator directs the situation to the group and might say, "Is that what others think I'm doing?" The facilitator's failure to do this would undermine two group norms: all members have an equal right to participate and participation is a mutual process.

During Power and Control, some members may also divulge important information at the worst time imaginable. A member might say, with five minutes left in a meeting, "I've been thinking about going off my meds." It is at these moments that your skill at facilitating will most likely be challenged. You must remember to always provide boundaries for group safety. In this instance it would be useful to say, "That certainly is quite a statement. Maybe next week we can discuss that as a topic. Please try to raise this issue at the beginning of the session, so people can respond with an adequate amount of time, as opposed to feeling overwhelmed at the end of a session." This response will send a message that important issues need to be identified at the beginning of a session.

For facilitators, this second stage is, in some ways, the one in which they need to be most alert to what is happening in the group. Is a conversation (especially a challenging one) about content or about testing out the boundaries for feeling safe? A lot of interchange with one's co-facilitator goes on, to ensure both content and process are being addressed. These interchanges can be very simple: "Where do you think we should go from here? What are your thoughts?" Or, as in some of the above examples, the group may be asked about what has been going on in the past few minutes. If no one mentions any process elements, a facilitator can prompt the group by asking if anything about the norms has been touched on in the past few minutes.

The facilitators are **active** here. Interventions always link members' comments. For example, a facilitator will ask if a member's comments are a response to something someone else has said, encouraging them to talk directly to that person. Facilitators ask about similarities and differences in ideas about an issue that has come up, subtly reinforcing the norm that difference is acceptable.

8.2.2 Dealing With Client Topics

In stage 2 members also begin to bring up **topics and issues on their own**, related to their lives as people with HIV/AIDS and depression. The topics are often not on the facilitators' or group's intended 'agenda' or are being discussed earlier than anticipated

by the facilitators and the group, whether the agenda is formal or informal. It is important that members be given the opportunity to pursue these topics if they wish. It is the facilitators' role to negotiate with the group about the directions it wishes to take and, in so doing, empower the group as a whole. For example, if a member raises an important issue in the context of the leadership's teaching about depression, the leaders can ask the group what it would like to do with the material the member has introduced: "The issue John raised as we were discussing self-talk seems to be triggering a lot of interest. Would you like to talk about it now or put it down for later discussion?"

8.2.3 Addressing Client Roles

The possibility of addressing fixed client roles also emerges in this second stage. Sometimes a member will notice that a particular member always gets the discussion going or gives support. This is a chance for facilitators to talk about roles, to point out that individuals repeatedly taking on the same tasks have strengths beneficial to the group and note that always taking on the same job also limits the type of participation individuals have within the group. If members don't identify **fixed roles** assumed by others or by themselves, it is the leadership's task to address this by making observations. A leader may say, "I've noticed that Mary is always the one who expresses emotion first. I'm wondering how this helps out other members? What would happen if someone else took on this job from time to time?" The facilitators can encourage all members to try on behaviours and roles they see others fulfilling. In doing so, the norm of an open role system is enacted.

8.2.4 Dealing With the Intractable Client

Sometimes, when a member cannot adapt to a free flow of talk and emotion, he or she will drop out. Less often, the member stays even though he or she finds it difficult to adapt and continues to ask for a high level of control by the facilitators. These requests make progression to the next stages difficult. The facilitators might have to discuss with that member, **outside the group meeting**, whether the model is the right one for him or her. They also must clarify that this is a fairly open model that requires interaction, often at a deep level, with other group members. The facilitators can reflect that the member consistently appears to want a more structured format. A different approach to counseling or therapy could be offered to that member, whether group or one-on-one. Often the member who wants structure will share his or her own frustration with the group purpose, agree that it does not fit and choose another option.

8.2.5 Summary

The struggle evident in Power and Control reflects the members' internal struggle to incorporate the norms into their interpersonal relations. Helping members do this requires a clear and repeated talking about and demonstration of roles, with the facilitators ensuring that the norms are followed by directing the group to reflect on its process.

In general, in stage 2, members learn the extent of the flexibility allowed by the group and begin to try out the freedom this permits in expression of issues and emotions. One of the main focuses of the facilitators is to teach and to demonstrate this **openness** to members, through both their interactions with each other and their interventions with the group as a whole. Some members will respond quickly to the opportunity to express themselves and can model such behaviours for other group members.

Finally, in this stage, members begin to learn to talk about fear-laden issues and the emotions and thoughts associated with living with HIV and depression. Members are, to varying degrees, fearful at this stage of many of the issues that come with HIV. Even when the discussions have been good, members report that the fear remains. Knowing that the facilitators will provide safety, through ensuring respect for norms, provides a sense of safety for members, so they can be open in their expressions of issues and emotions with each other, even when fear remains.

8.3 Stage 3: Intimacy

Stage 3, generally, requires fewer interventions for facilitators and seems like much less work than the two previous stages. In reality, the stages are not clearly demarcated one from another. They overlap and members go from one stage to another, particularly at the junctures, before a more or less 'pure' stage is reached. Some members might anticipate the next stage and thereby introduce it and initiate it for the rest of the group.

When variations from the usual conditions in a group occur (for instance when there is a session or two in which only a few members attend or when a member has a serious illness), discussion can fall back to a previous stage while members get their bearings. It is suggested that facilitators ask those who were present the week before to tell those who missed what had happened. When someone is ill, whether he or she is in attendance or not, members can be asked for their feedback on the experience of illness in the group and its effect on the interaction within the group.

By this stage, as a continued part of the effort to turn over **responsibility to group members** themselves, facilitators can ask members for volunteers (maybe more than one or two) to call members who have not attended to see how they are. This will mean an exchange of contact information (with everyone's consent needed) which in itself can provoke interesting reactions from members about closeness to others in the group. Some members will set parameters around what might happen if they are called. A member might like to be called but reveals that he or she doesn't often return phone calls. This gives the group an opportunity to reinforce that there are differences in the group and that this is acceptable.

Members express **deeper emotions** more often in this stage. Before this, members might state they feel an emotion but would not show much of it in tone or body language. Here their behaviour is more consistent with the emotion they say they are feeling. Members may look down or away when talking while emotionally aroused; there may be tears or

laughter comes more readily. Facilitators can reinforce this expression by asking individuals what it was like to express so clearly what they were feeling. The answers can be both positive (relief or being understood) and negative (embarrassment or a concern about being judged).

As with the previous stage, a facilitator asks other members what it is like to see a member expressing an emotion so openly and asks if there have been times when they have felt the same way. Again, the facilitators encourage members to give their responses to each other using 'I'-statements and to talk less philosophically or generally.

In this third stage, members will increase their support for each other, on their own initiative, often in ways that are quite profound. Members have come to realize that they **share deep similarities** and their feelings of camaraderie show often. Topics that were previously discussed (like family relationships, jobs or lack of jobs, loneliness and sex) are brought up again. This time they are discussed on a more thorough level, with members often exploring how these issues hurt them, isolate them or make them feel useless. Again, similarities and differences will be expressed by other group members. Facilitators might have to encourage the expression of differences more than they need to for expression of similarities, as members with different experiences or reactions might feel these don't fit or that they need to go along with what they perceive the others all feel. Facilitators intervene to bring out **differences** and to probe for any belief that all of the individuals in the group need to express the same feelings. If such a belief is present, the leaders need to address it by asking, for example, what would happen if everyone did not agree. This could then lead to a discussion about fear of conflict, fear of being different and the value of difference within a group.

New topics will come up that might have been too distressing for members to talk about before: death, debilitating illness. At this point, the group members might still experience fear when talking about these issues but now they feel they have the resources and confidence in each other, and in the group norms, to face these conversations. As in the previous stage, the group will move through such topics to a point of at least temporary resolution, in surprising ways. Conversations that initially bring fear can end up in laughter or in the telling of comforting stories. Here the facilitators can point out or ask about this progression in response.

During this stage, members increasingly share **ideas and beliefs about the world and about themselves**. Once they are comfortable with this level of intimacy, facilitators can encourage members to examine the validity of these beliefs, either those they have expressed about themselves, or those expressed by another member. So, cognitive work moves from homework to here-and-now interactions in the group. The leadership punctuates the use of cognitive behavioural skills as they are actually happening. For example, if the group's collective talk leads to a mood change, a leader might say, "I've noticed the mood in the room. I wonder if others have noticed this and if anyone has some thoughts on what it means?"

There are many opportunities here for interventions by the facilitators. However, not all interventions will need to be made and the facilitators can sit back and be silent more often than they would have before this third stage. **Group members** will now often **intervene** in the same way facilitators had done before. They will respond to each other in ways facilitators might not think of. More and more, facilitator intervention is about reinforcing or restating the norms and even this happens less frequently. Even here members take on the tasks facilitators had done before. For instance, they might ask more silent members for their input.

However, facilitators still underline similarities and differences of experience, note the expression of strong emotion, recognize the depth of what happens in the group and note how members facilitate themselves as needed.

As this stage progresses, each member takes on a **greater range of roles** than he or she did before. Someone who always was the first to initiate a topic sits back; someone who participated by being sympathetic to another's difficulties talks about his or her own concerns. The facilitators build awareness of this change and ask how it can be replicated in members' day-to-day lives.

More and more, the **members set the agenda**. Sometimes topics or situations brought up by a member spark a long conversation and sometimes conversation is wound up fairly quickly; other members will feel freer than before to talk about something else. Facilitators do not orchestrate as they did before.

To underline what is developing within the group, facilitators can ask members to discuss what changes they have noticed in the group since its beginning and what has changed in them to bring this about. This builds awareness of new experiences they have had and of moments when they have not been depressed.

8.4 Stage 4: Differentiation

During this stage the group is fully enacting the norms. The leadership is often limited to opening and closing the session. Occasionally the leadership needs to be activated if a norm is at risk but this occurs rarely. The group has gained confidence and feels secure enough to be **self-guided**. In other words, the group as a whole takes ownership of the agenda as it is related to the group purpose.

For example, the participants may decide to begin the session using the check-in to identify issues they want to talk about. After this, some of the participants generally bring to the session issues that are more significant to the group. But whatever the members decide to do, the group handles the situation according to the skills that have learned through previous sessions. Through enacting the norms, performing spontaneously, being creative, validating one another and keeping the group in a constant exchange of information, the group finds new ways of coping. This serves to boost **individual and group self-esteem**. Such activity is not a rigid group-performance. It flows and

responds according to the group's own characteristics, style and personality. The group itself is performing.

In situations like these, the facilitators encourage the participants to make **decisions as a group**. They also encourage them to 'brainstorm' ideas that will help them to make the decisions. This is done through an atmosphere of safety and by strengthening the norms that have been learned in the previous weeks. Facilitators might ask, "What topics would you like to talk about today? Does topic X sound interesting to the rest of the group or would the group like to talk about another topic?"

The facilitators must keep in mind the group's democratic process, its mutual aid system and the equal status of its members. They must also make sure that the interaction of the group participants is respectful and non-judgmental. That is to say, facilitators must **apply the norms every time** the group is being addressed.

Indicators that the group has moved into differentiation become evident: the transition from the 'I-statements' to the 'we-statements', the feeling of a group as 'us', the 'we-ness'. Further indicators are the intensity of the challenges or risk that the group is taking and the way that the group is starting to self-regulate.

Throughout the fourth stage, group members help each other. They offer support, suggestions, reassurance and insights or share similar problems with group members. They discuss the strengths and assets of each other. They gain self-esteem as they are able to unfold their **newfound ability to help others**. By pointing things out to others, they boost their own sense of value, as illustrated in the following example.

The group focuses on the participant's issue but also works on a specific theme: confrontation. While the participants help this particular individual, they also benefit by exploring this theme.

Anthony I did not have a good weekend. I'm still having problems with my roommate.

Ben What happened between you and your roommate this past weekend?

Anthony Every time he uses the kitchen, he leaves a complete mess.

Charles Does he do that on purpose or does he not know how to cook? (The group laughs in a friendly way.)

Anthony I don't know why he does it. I haven't been able to talk to him about it. I'm afraid to have a confrontation.

Dorothy How do you deal with it when he gets mad?

- Ernest What happens to you when you have a confrontation or an argument with someone?
- Anthony I tend to back off. I always feel that it is my fault if there is a problem.
- Fernando But it's not your fault. You're not leaving the mess, right?
- Anthony Yes, but I'm afraid if I confront him he'll think I don't appreciate the other things he does. I'll just end up feeling guilty.
- Ben I also tend to feel guilty or back off when there is a confrontation or an argument. However, I have been learning over time that I can stand up for myself and express the way I feel or think, without offending or harming anyone.
- Fernando I try to say what I feel, but it is not so easy at times.
- Dorothy It is true it's not easy at times but... because we keep things inside, because we don't say what we feel or think, we get depressed, don't we?
- Anthony Yes, but... what if trying to talk about it with my roommate doesn't work?
- Dorothy Try another avenue. You are trying to fix a problem, not have a fight.
- Ernest Standing up for ourselves and expressing what we feel or think makes us feel better afterwards.
- Leader I've noticed that you were all very engaged with each other the last few minutes. There was a lot of interaction and openness. What does it mean to each of you that the group was able to do this so impressively?

Once the group has reached this level of functioning, the facilitators need to participate only to reflect on the individual and group successes obtained through the mutual help. As well, facilitators can point out the non-depressive behaviours the group is exhibiting. Facilitators can also serve as a resource for the group by, for example, providing information. They focus on guiding participants when regression occurs, zeroing in on what is happening in the here-and-now.

Teaching cognitive coping strategies may continue in this phase but the quality of discussion is different as the members risk application of the strategies to all aspects of their lives.

Once group safety is reached, the participants tend to **take ownership of the group** itself. It is then that the agenda setting is successfully transferred to the group.

8.5. Stage 5 Termination

The group participants have been creating links, supporting one another and slowly reducing fears they may have had at the beginning. They have acquired a set of new skills and coping mechanisms. The members of the group have created a secure environment. Around week 17 or 18, they confront the reality that the group will come to an end in two or three more sessions.

The leaders must be aware of the possible **risks and the challenge** that this stage presents. Occasionally members of the group react to the phase in a way that might jeopardize some of the work they have done as a group over the previous five months. As an example, the group members may respond to termination or closing topics with the following statements: “I'm experiencing depression less frequently, but it's more intense.” or “I don't know if there has been a change or not. I'm not feeling good and I'm not feeling down... just flat.”

There can also be reactions geared to maintaining the group as an entity, thereby avoiding the separation or the ending. Questions and comments focused on generating a friendship with the leaders may become evident during this phase. Such efforts to socially engage the leaders should be reflected back to members in terms of their desire to avoid loss.

These are examples of the responses from the group as a result of the possibility of **separation or loss** of an environment that has given them confidence and the opportunity to explore their potential. For some of the members, the closing or ending phase seems to trigger their worries or insecurities related to loss, abandonment, loneliness and/or protection needs.

This is why activation of the leadership in this fifth stage becomes a key element in guiding the group to an ending. With this guidance, the members are able to visualize all the work they have done throughout the sessions, the abilities they have acquired as well as the way that these abilities can be applied to everyday life. The leaders encourage the group participants to **recognize their achievements**. As well, leaders can reinforce non-depressive behaviours.

Towards the final part of this stage the facilitators, along with the group, analyze all the work they have done for the last five months: the processes they have undergone and the information they have learned. In this way, an evaluation of their achievements occurs as well as an exploration of ways to apply their achievements to their every day lives. A concrete way of accomplishing this is to review the initial goal statements with the group members.

This process of analysis and evaluation is important for the group. Through these two components, members **reinforce** all of the information they have learned. This is just as important for the facilitators because it allows them to see all the achievements that occurred during the whole process. It allows the facilitators to take note of their mistakes

or omissions. This latter information allows for a better understanding of the group process and is extremely beneficial for facilitating future groups.

After this wrapping-up activity, the group is ready to end. What the ending looks like depends on the style and the personality of the group. Once again the **group** enacts the norms for decision-making in regard to the way that the group will handle the closing. In the last session the group gathers in the way in which it has agreed to close the cycle.

9. Conclusion

The Challenging Depression and HIV Project arose out of the shared commitment of members of the Interagency Coalition on HIV and Mental Health to explore innovative ways of responding to the mental health concerns of individuals living with HIV-disease in Toronto. From our initial information-sharing meeting in March 1999, the Coalition very quickly determined to take the bold step of working toward the development of a collaborative group therapy intervention that would draw upon the expertise of community members, hospital and community-based agency service-providers. This manual records the experience of providing a group therapy intervention, using the social group work model, as well as the findings from our pilot project.

Our initial findings indicate a positive impact of this group intervention on the experience of depressive symptoms for individuals who participated in the 20-week groups. Additionally, Coalition members found the experience of working in a collaborative manner to provide a clinical service to be extremely positive. As service-providers we witnessed the positive outcome of the enactment of group norms of respect, honesty and mutual aid on individuals' coping abilities in the face of HIV-disease and depression. Participants in the 20-week groups recognized the benefit of learning from the differences contained within the group. Coalition members have equally benefited from different perspectives that have flourished within a collaborative service-delivery project.

This pilot research project has generated a number of further research questions that we plan to investigate in the future. One possible area of future research involves a more systematic study of confounding variables such as the use of antidepressant medications. Exploring how to control for such variables in our research design might be another focus of future research.

Our hope is that this manual will encourage you to think of innovative ways to respond to the challenges you face in providing services to individuals with HIV-disease and mental health concerns. As a coalition of service-providers we have found the social group work model and the collaborative way in which we have worked to be extremely powerful. We are aware that not all communities possess the wealth of services that we currently have in a large urban community such as Toronto. However, the spirit of respect, democratic process, tolerance of difference and mutual aid that are foundations of the social group work model can serve as a guide in directing the services you offer.

We conclude by thanking the participants in the three 'Challenging Depression and HIV' groups. We are truly indebted to these individuals who, despite feelings of isolation and despair, took part in this research project and, in the process, taught us so much about the resilience of the human spirit.

Appendix 1

Advertisement

The AIDS Committee of Toronto, The David Kelley Counseling Program of the Family Services Association, Sunnybrook and Women's College Health Sciences Centre HIV Outpatient Clinic and St. Michael's Hospital HIV Psychiatry Program

are looking for interested individuals to join a therapy/research project

Challenging Depression and HIV Groups

If any of the following describe you or someone you know....

**Feeling Blue?
Not feeling motivated?
Feeling lonely and isolated?
Not enjoying the things you used to?
Avoiding thinking about the future?**

The groups run for 20 weeks. Several groups are up and running but we would like to fill at least one more group.

We welcome HIV-positive men and women who are dealing with depression as part of the long-term impact of HIV in their lives.

For more information or to join a group, please phone ACT at 416 340-8484 Ext. 420.

Appendix 2

Results Tables

Characteristics of Participants

Variable	%	%
Gender	Males 90	Females 10
Sexual Orientation	Homosexual 75% Bisexual 13%	Heterosexual 12%
Employed	Yes 47	No 53
Living Arrangements	Alone 60	With others 40
Current Psych. Treatment	Yes 45	No 55
Ever Psych. Treatment	Yes 53	No 47
Current HIV health concern	Yes 60	No 40
Current non-HIV health concern	Yes 40	No 60
Current Alcohol Problem	Yes 0	No 100
Previous Alcohol Problem	Yes 35	No 65
Current Drug Problem	Yes 10	No 90
Previous Drug Problem	Yes 25	No 75
Race	Caucasian 80 E.Indian 10 Asian 5 Hispanic 5	

Analytic Results

Questionnaire	Mean Pre-score	Mean Post-score	Mean change	P Value
Beck Depression Inventory	23.59	15.06	8.53	P = 0.029 **
MOS-HIV Scale				
Physical health score	54.71	59.60	4.89	P= 0.217
Mental health score	39.61	52.33	12.72	P= 0.018 **

Social Support Questionnaire

Wilcoxon Signed Rank Test

Group 1 p = 0.499

Group 2 p = 0.500

Group 3 p = 0.752

Appendix 3

Depression and HIV Group Assessment Tool

Note: The following areas need to be covered during the assessment interview. This document is intended as a checklist rather than a prescribed format for the interview itself.

Goals of Assessment:

- a. determine severity of depression
- b. determine etiology, including pre-disposing factors and relationship to HIV
- c. determine appropriateness of group intervention

1. Reason for requesting the group:

- a. previous group experiences and type of groups (e.g.therapeutic/support)
- b. comfort and interest in talking in front of other people

2. Symptoms of depression:

- a. overwhelming feelings of sadness and/or guilt
- b. belief that client is being or should be punished
- c. weight changes that can't be accounted for by medication/disease
- d. lack of motivation/difficulty getting out of bed
- e. social withdrawal
- f. anhedonia
- g. irritability
- h. loss or increase in libido
- i. suicidal
- j. history of hospitalization(s) for depression or other mental illness
- k. number of hospitalizations within the last six months

3. Receiving medication and/or psychiatric or other therapeutic support:

- a. psychotropic medications if any
- b. name of physician and/or psychiatrist and/or therapist

4. History of depression:

- a. length of depression
- b. onset of depression
- c. onset pre-HIV/AIDS diagnosis or post-HIV/AIDS diagnosis

5. Predisposing historical and current factors:

- a. history of physical abuse
- b. history of sexual abuse
- c. early loss
- d. recent bereavement (HIV related or other)
- e. HIV or other medications known to induce depression (e.g. Sustiva)

6. Coping Strategies:
 - a. alcohol and drug use

7. Social Supports:
 - a. family and/or social supports for the client (including relationship status)
 - b. regularity of contact (e.g. through regular or structured activities, work paid or volunteer)

8. History of HIV:
 - a. date of diagnosis? It must be more than one year.
 - b. hospitalizations and/or opportunistic infections
 - c. medications

9. Expectations of therapy and of group:
 - a. facilitator to explain group (goals, duration, times, location) and outline group norms
 - b. solicit client's response to interview process

Accept a client into the group if he or she is:

- not actively suicidal
- not homicidal
- not presenting evidence of psychosis
- not presenting alcohol/drug abuse as primary issue
- not presenting evidence of cognitive impairment or dementia (e.g. able to follow content of interview; does not demonstrate memory deficits)
- diagnosed HIV-positive more than one year prior to intake
- able to engage with the counselor and appears to have social skills needed to participate in group