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The Relationship of Support Groups and Isolation in HIV Positive Clients

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### Abstract

The purpose of this study is to explore the relationship between support groups and the minimizing of depression and isolation in HIV or AIDS diagnosed individuals. The population of this study was a convenience sample of persons with HIV or AIDS who received services from an AIDS Service Organization (ASO). The research is quantitative and exploratory. Clients on the mailing list received a confidential questionnaire. Review of the literature indicated that support groups assist this population in dealing with many issues. Results agree with previously done research that within this population physical and mental fatigue as well as feelings of sadness and isolation is quite common. The clients surveyed indicate that they would attend a support group if available and indicated they felt it would lessen feelings of depression and isolation.

### The Relationship of Support Groups and Isolation in HIV Positive Clients

The Center for Disease Control (CDC) statistics indicate that there are a million people that are living with the Human Immunodeficiency Virus (HIV) virus in the United States. The unfortunate aspect to this fact is that one-fourth of those with HIV are not yet diagnosed. There are approximately 40,000 new cases reported per year in the United States (CDC Media Facts, 2006).

The statistics indicate of those affected 47% are African Americans and 34% Caucasian. In 2002, for African American women ages 25-34, HIV/AIDS was the number one cause of death. As of 2004, 34% of all the cases reported were from heterosexual contact and 43% were from male to male sexual contact. Diagnosis from heterosexual contact increased in percentage from 27% in 2003. The remaining ethnic groups of American Indians (“First Peoples”), Asian, and Pacific Islanders each account for one percent. One important note is that statistics from the CDC are based on 33 reporting states with California, Oregon and Washington not being reporting states (CDC HIV Topics, 2006; CDC Media Facts, 2006; CDC Morbidity and Mortality Weekly, 2006).

Despite the fact that AIDS has been around now for over 25 years, discrimination and stigma of the disease still exist in the workplace, in the medical field, and in the personal lives of those that fight this disease on a daily basis (Seidenberg, 2006). AIDS itself is contagious, sexually transmitted and can bring about an early end to a life. This increases stigmatization factors and can affect not only the patient, but those caregivers that take care of people with AIDS (Ciambrone, 2003). Even after the attacks of September 11, a Georgetown University student who was fluent in three languages was denied a job with the United States State Department based solely on the fact that he was HIV positive (Seidenberg, 2006). There is still

fear among many individuals that one can acquire AIDS by being close to an HIV positive person. Students and tourists in many countries have been deported once it was discovered that they were HIV positive. Countries have denied residence to HIV infected persons even though it is contrary to the Universal Declaration of Human Rights. This discrimination and stigmatization may have an effect on the research, treatment and care of this disease. (Malcolm et al., 1998).

Women who are affected by HIV find they are often more isolated than men due to the stigma of the disease. Those affected with HIV may not have the support that people affected with other illnesses receive from their families and friends. This could be related to the family's reaction to homosexuality or if HIV was acquired through drug use (Aronstein, 1998). Newly diagnosed cases worldwide occur for 80 percent of the women while they are married or in relationships they regarded as monogamous. Many of these women discover their status after their partner has entered into the final stages of AIDS or has passed away which leaves them with feelings of betrayal (Frederick & Swofford, 2006).

Assumptions about HIV and AIDS within the heterosexual community create a stigma for women as HIV and AIDS is often related to promiscuity or drug use. Consequently these women often lose their significant other or partner, but are often outsiders in the community of support. When identifying themselves as HIV positive, women lost their support system. Women have the additional concern about their children and what will happen to them once they are gone (Lichtenstein, Laska & Clair, 2002).

African American women constitute one-half of the cases of AIDS reported among women. They typically are caretakers of others in the family who have HIV/AIDS and although it was indicated that they felt families to be the most supportive, it was also indicated that they

are also a source of stress. Denial by the same supportive family members is something that they indicate occurs when those diagnosed want to discuss the future of their disease. Lack of education on the HIV virus as well as the women's past behaviors presented obstacles for support. (Owens, 2003).

Heterosexual men who are diagnosed with HIV face issues such as being perceived as gay or as a drug user. The potential for future plans is eliminated as they find themselves anxious about their financial future and family plans ever becoming reality (Hoffman, 1996). Gay men who are affected and who associate within the gay community have a larger support system than heterosexual men or women whose support system is typically limited to family and friends (Lichtenstein et al., 2002). Having no contact or minimal contact with family was found to be common with gay men and a majority lived alone. Adolescents who acquire HIV have to address fears of being disowned by family, discrimination once they disclose their status, and not having a social network of other HIV affected adolescents (Hoffman, 1996).

A growing population to consider when discussing HIV/AIDS are those who fall into the aging population, ages 45 and older. In New York, 25% of those diagnosed are 50 years of age or older. There is a lack of specialized services for those facing not only the virus, but specific age-related needs. Stigma is often a result from having HIV/AIDS. Reaching out to others for help by this population is difficult as they usually deal with a very vital but arduous medicine regimen as well as their many medical appointments. One of the difficulties in diagnosing HIV in this age group is that symptoms can be the same found in other diseases that may be typical of other age-related diseases. The longevity of those diagnosed in this age group is shorter compared with other age groups because of the late diagnosis (Heckman, et al., 2002; Shippy & Karpiak, 2005).

Disclosing their status to family and friends is not typical in this population due to the fear of stigma of HIV/AIDS. Support for this group is not only limited due to the stigmatization of HIV/AIDS, but they also are affected by life events which even further limit their socialization and support. These events may include retirement, becoming widowed, or other health issues that may limit their ability to reach out. Informal support may come from their family if they are close to their family emotionally or physically. If no family is available friends or others diagnosed with HIV within their age range for are sought for support. When this support level is affected by attrition or death, then the more formal support is needed from service agencies and/or hospitals. Results indicated that this population is typically not able to rely on informal family and friends for support. (Shippy & Karpiak, 2005).

Those who are age 50 and over and HIV affected have to learn to cope with declining cognition and physical abilities. These declining conditions are not caused solely by HIV but also by medical conditions due to the normal aging process. In December 1999 there were approximately 78,000 who were over the age of 50 and living with AIDS at the time of the diagnosis. They further state that there were more symptoms of depression in this age group than those who were younger and HIV positive (Heckman et al., 2002).

Discrimination and stigma have many faces and show in our policy, in our indifference as a society, and may affect an individual to such a degree that the result may be a person choosing not to acquire treatment or care. Possible rejection and fear of the burden on the families of HIV persons can keep them from telling their families or seeking care at a time when it is most crucial. Health care providers who should best understand this disease are included in those who show irrational response to interactions with HIV/AIDS clients. (Malcolm, et al.,1998).

AIDS is connected to many unplanned hospital visits and time frames in which one is unable to take care of the basic needs such as shopping, housekeeping, getting to and from the doctor or to the pharmacy (Ciambrone, 2003). Although there are medical treatments that have decreased the mortality rates for this disease the daily regimen for medicines may include several doses at various times of the day. In itself this type of regimen can be cumbersome but there also may be side effects to cope with such as diarrhea, exhaustion, being lethargic and forgetfulness (Davies, et al., 2006).

Keeping on the medical regimen for HIV can be affected by stigma and discrimination associated with this disease. It is important for the HIV individual to adhere to the medical regimen for them to have an opportunity for a longer life span. Social support was found to be an important part in the adherence to the drug regimen (Davies, et al., 2006). Caregivers or the social network that this population relies upon may have difficulty giving positive or nurturing support due to their own perception of peril by being exposed to an HIV individual or because they may feel that their assistance is ineffectual (Ingram, Jones, Fass, Neidig & Song, 1999).

Immunity is jeopardized when there is a constant exposure to stressful events which contributes to increased symptomatology and can precipitate progression to AIDS. Stress can be caused by how a person views the event rather than the event itself actually being stressful. A common complaint among HIV individuals is the feeling of fatigue which can be a symptom of perceived stress. The reduction of stress is important to help alleviate the symptom of fatigue. The HIV virus itself though can cause physical fatigue which is correlated to anxiety and depression (Hand, Phillips & Dudgeon, 2006).

Depression is common among those diagnosed with HIV/AIDS, and can increase when individuals are diagnosed with other conditions associated with HIV such as dementia. One

study indicates that depression can become severe due to the association of death and isolation from this disease (Lichtenstein, et al., 2002). Hedge (1990) found a relationship between depression and the lowering of the CD4 count. CD4 cells are also called T4 cells or Helper cells that tell all the other immune cells when to go to work. Without these CD4 cells, the others do not know when to start working and the body is unable to fight off infections or cancers. When the CD4 count is above 200 the patient typically is not on any medications, but when the CD4 count reaches 200, most HIV patients will then start HIV medication. (Milano, 2006).

Depression followed loss of health, work, family and friends with African American women scoring highest in depression from the Center of Epidemiological Studies on Depression Scale (CES-D) (Lichtenstein, et al., 2002). Heckman et al. (2002) found with younger adults and older HIV diagnosed adults, that although there was a somewhat higher level of isolation felt by the older adult, the level of depression was the same between the two groups. HIV and AIDS patients can receive unsettling responses from people that can affect their level of depression. Some of the reactions that they might receive are insensitivity, forced optimism about the disease or an attitude of blame (Ingram, et al. 1999).

Discrimination, depression, stigma, and isolation are the daily issues with which those affected with HIV/AIDS have to cope (Aronstein, 1998; Lichtenstein, Laska & Clair, 2002; Shippy & Karpiak, 2005). Being disowned by one's family, discriminated against by medical providers, fellow employees, and employers, as well as in housing (rent or own) is prevalent within this community (Vaughan & Kinnier, 1996). Protecting your family and friends from stigma and discrimination was one reason to not disclose one's HIV status (Petrack, Doyle, Smith, Skinner & Hedge, 2001). Over half of the older adults reported having unmet emotional support needs (Shippy & Karpiak, 2005). HIV does not simply affect the individual at the

physical level it affects how they perceive themselves, how they mentally process changes that occur in their life, and what their plans will now be for the remainder of their life (Hoffman, 1996).

In their research, Anderson and Shaw (1994) found that, “fear of ostracism is a powerful social control...disclosure of HIV infection or an AIDS diagnosis is potentially terrifying and isolating.” (p.1)

Feelings of isolation, being depressed or feeling stigmatized could be learned by this population through their interactions with society which determines how we perceive or think about ourselves. From the Social Learning Theory standpoint, being a target of discrimination in society may bring about a negative view of ones self and affect our emotions and behaviors.

Earlier on in the epidemic, Coleman and Harris (1989) noted that educational and supportive groups were needed to those newly diagnosed. The review of the literature in this present study indicates that the supportive needs for HIV/AIDS patients have not yet been addressed (Heckman, et al., 2002; Lichtenstein, Laska & Clair, 2002; and Shippy & Karpiak, 2005).

Support groups either educational, supportive or therapy are the most commonly used for those affected with HIV/AIDS. Social support groups were a way to deal with having HIV/AIDS, and those who attended support groups had less distress (Kalichman & Sikkema, 1996). Participants of support groups receive mutual support and empathy from other members when they are sharing within the group setting. These social support groups allow the members to communicate the daily difficulties they face and educate others to be better prepared for similar situations that they may face as well. Support groups were a way for the HIV/AIDS affected population to vent their anger and frustration about reactions they received from society

and family (Cawyer & Dupres, 1995). Fontaine, McKenna and Cheskin (1997) suggest that being part of a support group may assist individuals to feel they have more control over their health outcomes which in turn helps them in adapting to this disease. The feeling of having more self-empowerment due to the networking, sharing of knowledge and increase of education from attending a support group was also found by Hoffman (2003).

Support groups are typically available and are the most used interventions within the HIV community and have shown to be effective (Walch, Roetzer, & Minnet, 2006). Support groups have been useful for replacing support that has been lost, as well as the ability to share and receive support from those who are going through the same things (Aronstein, 1998). Communication in and of itself is very supportive, particularly in a support group situation. Support from other members can give encouragement and assist in emotional healing from the frustrations of this disease (Cawyer & Dupre, 1995). Older persons that were able to share their feelings and experiences in dealing with this disease were able to feel connected with others in the group (Nokes, Chew & Altman, 2003).

The conceptual definition of stigma for this research will be that used by the National Association of People with Aids (NAPWA, 2006) which states, “Stigma is a discrediting mark or attribute of shame. It is a feeling of undesirability that an individual possesses, thus reducing that individual’s self-esteem and status both in their own eyes and those of society” (np). The conceptual definition of discrimination is borrowed from NAPWA (2006) states, “Discrimination is a prejudicial act that is fastidiously selective based on a distinct stigmatizing mark, theory, fear or perception” (np). NAPWA (2006) states that without stigma there would not be discrimination. The conceptual definition of isolation will be the separation of a person suffering from contagious or infectious disease to a great extent from others.

This study will not address what other aspects of an HIV/AIDS client's life could be assisted with support groups or address the co-morbidity issues that may affect the outcome of this research. This research is being done to specifically address the question of whether the clients of an HIV/AIDS service provider in the Northwest would agree that they are exhibiting symptoms of isolation and would benefit from the establishment of a support group.

### Methodology

The present study is quantitative and exploratory. This study plans to explore the relationship between support groups and the minimizing of depression and isolation in HIV or AIDS diagnosed individuals. This study will also help to determine if the needs of the HIV clients are being met through the services currently available. The stigma that still remains due to HIV/AIDS is paramount in the lives of those affected. Medical advances have allowed the lives of those with HIV/AIDS to be extended; however, the physical reactions caused by the medications as well as the medicine regimen required often prevent people from being able to maintain a career or normal social life. Stigma and discrimination from employers, friends and family alter the socialization of HIV/AIDS patients.

The population of this study is a convenience sample of persons with HIV or AIDS who currently receive services from a rural Northwest AIDS Service Organization (ASO) and are currently not attending a support group. The current client list consists of thirty-four men and nine women. Clients on the mailing list will receive a consent form and questionnaire of eleven closed questions which will take them approximately 15 minutes to complete. A return self-addressed stamped envelope will be included.

The envelope will have no name identification of the client for confidentiality purposes. One phone call will be placed as a reminder approximately ten days after the questionnaires are

mailed. All persons on the initial mailing list will be called as it will not be known who has returned the questionnaire.

The questionnaire created by this researcher had one question asking the year of diagnosis. Following are six questions related to the DSM IV. There was a prerequisite question that asked if any of the following conditions had lasted for more than a period of two weeks, to circle a number that best describes the condition from one (*not at all*) to ten (*all of the time*). The conditions listed were as follows:

A. Feelings of Sadness, B. Mental Fatigue, C. Physical Fatigue, D. Change in appetite that resulted in weight gain/loss, E. Not being able to sleep or sleeping too much, and F. Feeling isolated. The following five questions were to be answered with yes or no; G. Have you been diagnosed as depressed? H. Do you feel you have emotional support from family and friends? I. Have you ever participated in a support group for HIV/AIDS? J. If there were one available in your area would you attend? K. Do you feel a group would lessen feelings of isolation or depression?

For the purpose of the study we are under the assumption that the answers are truthful and that the participants feel somewhat stigmatized.

The participants were advised that there did not appear to be any risks in responding to the survey. The Care Case Manager was available during normal business hours to discuss any concerns and that there would be no consequences should they chose not to participate in the study or withdraw from the study at any time.

Limitations in the present study are with using a convenience sample we cannot assume that they accurately represent clients with HIV/AIDS in generalizing to a larger population. This study is not including ethnicity, marital status or economic status on variables which could

influence the results. This study does not include those patients who are currently being treated under private insurance companies. This limitation is partially due to the population available in a northern Idaho rural community.

Frequencies of the values of each variable as well as correlative tests and ANOVA will be run on the results. This research has been approved by an IRB Board of Lewis Clark State College.

### Findings

This study was conducted to explore the relationship between support groups and the minimizing of depression and isolation in HIV or AIDS diagnosed individuals. This study will also help to determine if the needs of the HIV clients are being met through the services currently available. SPSS was used to analyze the data.

Of the forty-three participants who were on the mailing list, thirty-four returned the survey. Two of the thirty-four did not indicate the year of diagnosis on the returned questionnaire.

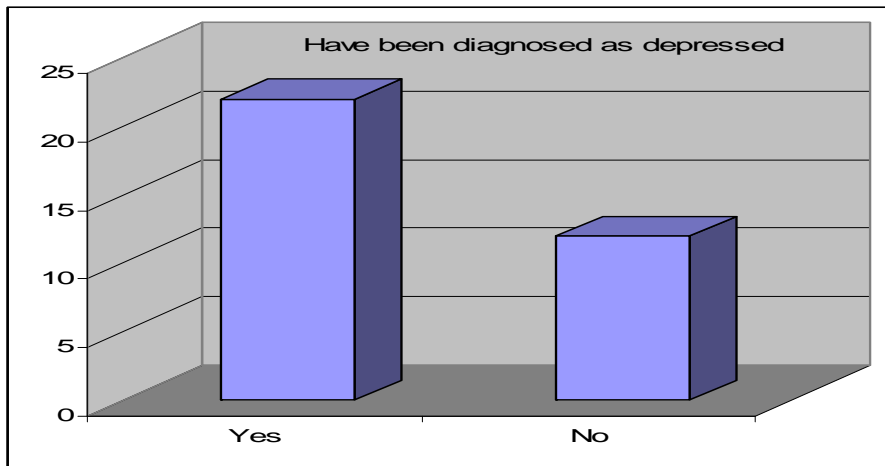
Table 1 presents the mean scores for questions 1 through 6 of the survey mailed to participants. Questions were based on the conditions having lasted for more than two weeks with 1 representing “Not at all” and 10 representing “All of the time”. The three highest means represented were physical fatigue (6.3), sleeping (5.9), and mental fatigue (5.6).

Table 1 – Frequencies of conditions

<b>CONDITIONS</b>	<b>MEAN</b>	<b>RANGE</b>
Feelings of sadness	4.9	1-9
Mental fatigue	5.6	1-10
Physical fatigue	6.3	2-10
Appetite change resulting in weight loss or gain	4.7	1-10
Sleeping	5.9	1-10
Feelings of isolation	5.0	1-10

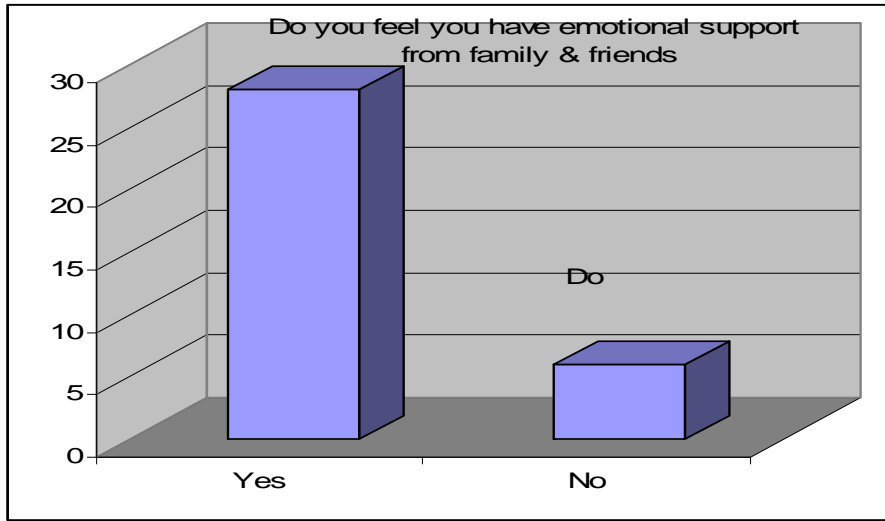
The five graphs below are the results of t-tests on questions G through K of the survey of which the answers were indicated with a “Yes” or “No” answer. To the question “Have you been diagnosed as depressed? Those who have been diagnosed with depression were 64.7 percent and 35.3 percent have not been (graph 1).

Graph 1



In response to the question “Do you feel you have emotional support from family and friends?” Of the 34 respondents 82.4 percent responded ‘yes’ and 17.6 percent responded ‘no’. (Graph 2)

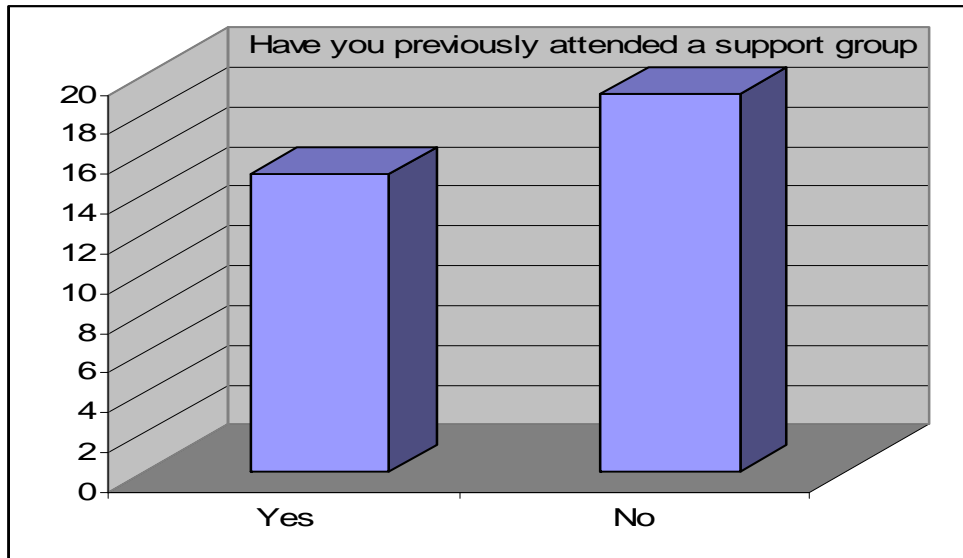
Graph 2



To the question of whether they had ever participated in a support group for HIV/AIDS, 44.1 percent responded with a 'yes' and 55.9 percent responded with a 'no'.

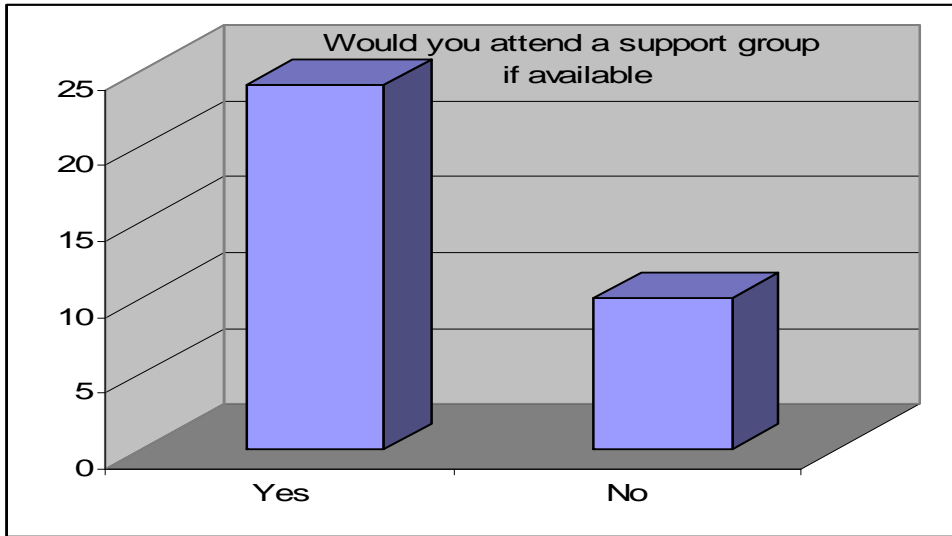
(Graph 3)

Graph 3



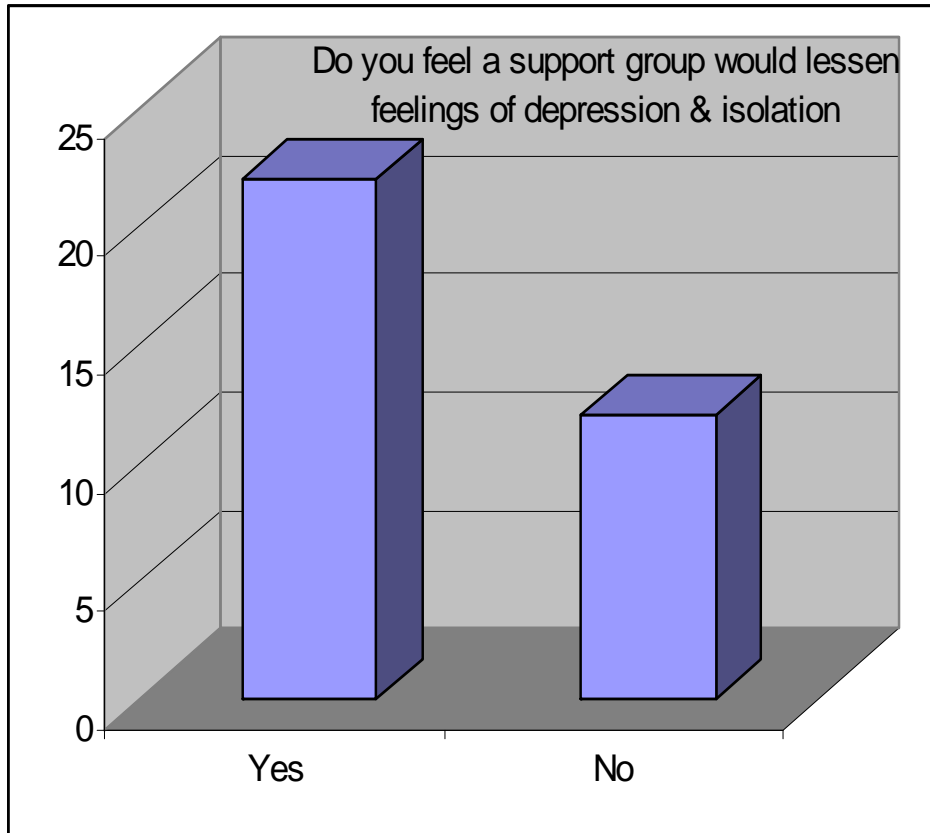
Of the question whether or not they would attend a support group in your area, 70.6 percent of the response was 'yes' and 29.4 percent was 'no'. (Graph 4)

Graph 4



In reference to the last question as to whether they felt it would lesson feelings of isolation or depression, 64.7 percent felt that it would and 35.3 percent felt that it would not. (Graph 5)

Graph 5



The correlation between sadness and mental fatigue, as well as sadness and isolation is strong and statistically significant. The correlation between mental fatigue in relation to physical fatigue, sleeping too much/too little, and feelings of isolation is strong and statistically significant. There was a very weak correlation between weight gain/loss and sleeping too much/too little as well as with feelings of isolation. Table 2 below presents the results of the correlations.

Table 2 – Correlations of conditions

<b>Correlated Conditions</b>	<b>Correlation Coefficient</b>	<b>Level of Significance</b>
Feelings of sadness & physical fatigue	.341	.024*
Feelings of sadness & mental fatigue	.652	.000**
Feelings of sadness & weight gain/loss	.332	.027*
Feelings of sadness & sleeping too much/too little	.386	.012*
Feelings of sadness & feelings of isolation	.602	.000**
Physical fatigue & mental fatigue	.514	.001**
Physical fatigue & weight gain/loss	.309	.038*
Physical fatigue & sleeping too much/too little	.319	.033*
Physical fatigue & feelings of isolation	.324	.031*
Mental fatigue & weight gain/loss	.310	.037*
Mental fatigue & sleeping too much/too little	.517	.001**
Mental fatigue & feelings of isolation	.574	.000**
Weight gain/loss & sleeping too much/too little	.247	.080
Weight gain/loss & feelings of isolation	.062	.364
Sleeping too much/too little & feelings of isolation	.409	.008**

\*Correlation is significant at the 0.05 level

\*\*Correlation is significant at the 0.01 level

Twenty-two of the thirty-four respondents indicated they were diagnosed as depressed. Of the twenty-two who were diagnosed as depressed had feelings of sadness with a mean of 5.5; mental fatigue with a mean of 6.4; physical fatigue with a mean of 6.9; weight gain or loss with a mean of 5.3; sleeping too much or too little with a mean of 6.4; and feelings of isolation with a mean of 5.9. Of the twelve who indicated they were not diagnosed with depression showed feelings of sadness with a mean of 3.9; mental fatigue with a mean of 3.9; physical fatigue with a mean of 5.0; weight gain or loss with a mean of 3.6; having difficulty with sleep either too much or too little with a mean of 4.9; and feelings of isolation with a mean of 3.4. Table 3 below represents these results.

Table 3 – Diagnosed with Depression

Depression with;	Diagnosed	Mean	Sig. (2-tailed)
Feelings of sadness	Yes	5.5	.075
	No	3.9	.090
Mental fatigue	Yes	6.4	.005**
	No	3.9	.014
Physical fatigue	Yes	6.9	.017*
	No	5.1	.021
Weight loss/gain	Yes	5.3	.059
	No	3.6	.083
Sleeping too much/too little	Yes	6.4	.051
	No	4.9	.038
Feelings of isolation	Yes	5.9	.011*
	No	3.4	.011

\*Correlation is significant at the 0.05 level

\*\*Correlation is significant at the 0.01 level

Independent sample two-tailed t-test showed that for those diagnosed with depression, that mental fatigue (.005), physical fatigue (.017) and feelings of isolation (.011) are significant. There is a trend with weight loss or weight gain (.059) and with sleeping too much or too little (.051).

Table 4 below indicates results for question H of the survey whether or not they felt they had emotional support from family and friends, 28 out of the 34 indicated they felt they did have support from family and friends. In relation to feelings of sadness the 28 had a mean of 4.3. The remaining 6 who did not feel they had emotional support had a mean of 7.5 with feelings of sadness. In relation to emotional support and mental fatigue those who had support had a mean of 5.0, where those who were without support had a mean of 7.8. Those who felt they had no emotional support had a mean of 7.8 with feelings of isolation compared to a mean of 4.7 for those who had support and felt isolation.

Table 4 – Feelings of Emotional Support

Emotional Support with;	Response	Mean	Sig. (2-tailed)
Feelings of sadness	Yes	4.4	.004**
	No	7.5	.001
Mental fatigue	Yes	5.1	.017*
	No	7.8	.000
Physical fatigue	Yes	6.2	.524
	No	6.8	.471
Weight loss/gain	Yes	4.7	.992
	No	4.7	.986
Sleeping too much/too little	Yes	5.7	.266
	No	6.8	.207
Feelings of isolation	Yes	4.5	.007**
	No	7.8	.004

\*Correlation is significant at the 0.05 level

\*\*Correlation is significant at the 0.01 level

Independent two-tailed t-tests showed that for those who felt they had emotional support had feelings of sadness (.004) and feelings of isolation (.007) are very significant. Also indicated is significance in the area of mental fatigue (.017) with this population.

For this research the important findings that we expected are that physical and mental fatigue and sleeping are symptoms that are very characteristic of this population. Findings that were also expected were that feelings of sadness and isolation are still prevalent within this population even when they indicated they felt they had emotional support. What we confirmed is that the majority of this population would attend a support group if available believe it would help to lessen feelings of depression and isolation.

### Discussion

The research confirmed that the clients in this study who responded would attend a support group if one were available. They also indicated that they believe that it would help alleviate symptoms of depression and isolation. The findings support the research that was previously done on this population. In this study, those who are diagnosed with HIV/AIDS have

symptoms of physical and mental fatigue which the participants indicated as being a normal part of their lives. Davies (2006) has previously shown that although medicines have prolonged their lives that the daily regimen as well as the side effects which include exhaustion and lethargic support these findings. Taking care of basic needs such as shopping or getting to and from the doctor could also be affected by the side effects of this disease and the medications that are required (Ciambrone, 2003). Perceived stress can hasten progression of this disease to AIDS. It is important for this population to reduce stress in their lives (Hand, 2006). As Hand, Phillips and Dudgeon (2006) pointed out that HIV itself can cause physical fatigue which is correlated to anxiety and depression.

Depression ran very high with this group which was found to be common with those diagnosed with HIV/AIDS. This depression can also become severe due to the association of death and isolation (Lichtenstein, Laska & Clair, 2002). Other factors may correlate to depression within this population. If we extrapolate that those who were not diagnosed had depression at some level, shown the by the relationship between feelings of sadness and mental fatigue, as well as sleeping too much or too little and feelings of isolation, it appears that finding ways to alleviate stress would be a paramount issue within the population. One finding which was not expected with the high percentage of diagnosed depression was that 82% felt that they have emotional support from family and friends. With such a high percentage feeling they have emotional support, there remains a question as to why the higher level of depression within this population still exists.

We also found in this population that there was a strong relationship between feelings of sadness and feeling isolated. Isolation can be caused from fear of or being disowned by one's family, or discriminated against from medical providers, employers or housing (Vaughan &

Kinnier, 1996). Not disclosing one's status was a way to protect family and friends (Pettrack, Doyle, Smith, Skinner & Hedge, 2001) and may be correlated to feelings of isolation felt by this population.

This study was limited due to it being a convenience sample and may not apply to the general population. Another limitation was not including HIV/AIDS patients who are seen by private practitioners and are covered by private medical insurance in the area. The level of depression felt by those that had not been diagnosed as depressed was not clear in the results. The study also did not indicate who had roommates or partners which may have affected the results of those who felt isolated and those who felt they had emotional support. The study did not ask sex or sexual orientation or whether they felt they received support from their community.

Implications of this research for practice indicate that a support group should be offered for the clients who receive services from the ASO. This could benefit the clients in alleviating feelings of depression and isolation. Support groups could be useful in alleviating stress and a way for the members to share daily difficulties they face. Support groups have been found to be a safe place where one can vent feelings of frustration or anger (Cawyer & Dupres, 1995). Funding for this group which should be available through the Ryan White Act (U.S. Department of Health and Human Services, 2006) is not sufficient to cover costs for support groups through the ASO. Other grants should be applied for and could include costs of a room, financial means for competent group leaders, and transportation for clients to and from the facility, as well as child care.

Approaching various clinical social workers and or psychologists in the area with knowledge and experience of HIV or AIDS to donate their time may be another approach to

starting a support group. Due to the Health Insurance Portability and Accountability Act (HIPAA) security and privacy, direct contact with other providers may be the way to discover other HIV/AIDS diagnosed individuals who are seeking the possibility of a support group. Due to their involvement with HIV reporting within the state, contacting the local Health District to determine if their budget would have room for a support group at their facility would be another option.

Although the Ryan White Act has listed in its policy many items that are to be covered by the funds available such as groups and transportation costs, the funding available for the ASO covers minimal case management for their clientele. Items that should be available to these clients include transportation, support groups and day care for children so that they may keep scheduled medical appointments. Agencies should be proactive in their research and writings to the government in regard to services that should be available and those that are actually provided due to budgetary limitations.

Implications are that although this was a limited study due to the population, future research should seek to discover if other ASO's or medical facilities that work with the funding from the Ryan White Act suffer the same limitations in offering services. Research into the limitations funding received by organizations would be important in determining if the structure of funding could be reorganized to better service this population. Future research should seek to determine why this population feels isolated and stigmatized even when they feel they have support from family and friends. If correlated to perceptions felt by this population from society, this research could help to address issues of public education and determine what information needs to be addressed to end the discrimination and stigma that still exist about HIV and AIDS.

Living arrangements or partner status was not addressed which could affect the feelings of sadness, isolation and depression and should be considered.

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