

AIDS Education and Prevention, 17, Supplement A, 53-65, 2005  
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## **Group-Level Interventions for Persons Living With HIV: A Catalyst for Individual Change**

Justeen Hyde, Paul Robert Appleby, George Weiss,  
Jeff Bailey, and Ximena Morgan

This study describes the perceived influence of group-level HIV interventions on persons living with HIV in Los Angeles, California. Funded by the Centers for Disease Control and Prevention and developed by a broad range of community organizations, group-level interventions ranged from small skills-building workshops to large educational forums and to intensive weekend gatherings. Recognizing the relationship between psychosocial factors and HIV-related risk taking, these interventions were designed not only to provide HIV prevention education and develop risk reduction skills but also to bring people together to facilitate the formation of supportive relationships. The formative data presented here are based on 35 qualitative interviews conducted with a sample of intervention participants. Interviews highlight the experiential opportunities that group interventions offer with respect to HIV knowledge, social support, HIV disclosure skills, and HIV risk reductions. Participants talked highly of their experiences in group-level interventions, suggesting that they should be considered an important prevention strategy for people living with HIV.

Advances in medical research over the last decade have helped persons who are infected with HIV to live longer and healthier lives. The efficacy of more recent treatment regimens has prompted new realizations about prevention strategies that are needed to help positive individuals maintain protective behaviors that prevent transmission to uninfected persons (Kalichman, 2000). Many people who learn that they are HIV-positive change their sexual and drug-use behaviors shortly following diagnosis (Centers for Disease Control and Prevention [CDC], 2003; Marks, Burris, & Peterman, 1999). However, many people also report challenges in maintaining safe sex and drug use over time (Colfax et al., 2002; Crepez & Marks, 2002; Posner &

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Justeen Hyde, Paul Robert Appleby, George Weiss are with the Health Services and Community Health Research Program of Saban Research Institute, Childrens Hospital Los Angeles. Jeff Bailey is with the Los Angeles Gay and Lesbian Center. Ximena Morgan is with the Los Angeles Shanti

Funding for this research was provided by the Centers for Disease Control and Prevention. The Los Angeles County Office of AIDS Programs and Policy (OAPP) was the recipient of this grant. The authors acknowledge Maggie Esquivel, who was the program manager at OAPP. They also thank Cecilia Mejia for assisting in the collection and coding of qualitative interviews and Jackie Porcel for managing the quantitative data. Finally, a special thanks goes to all PHIP intervention staff from AIDS Healthcare Foundation, AIDS Project Los Angeles, LA Shanti, Tarzana Treatment Center, and the Los Angeles Gay and Lesbian and their Positive Images Consortia members, including Antelope Valley Hope Foundation, Asian Pacific Islander AIDS Intervention Team, Being Alive Los Angeles, Being Alive Long Beach, Bienestar, Common Ground, Minority AIDS Project, Sunrise Community Clinic, and Women Alive.

Address correspondence to Justeen Hyde, PhD, Institute for Community Health, 119 Windsor St., Ground Floor, Cambridge, MA 02139; e-mail: jhyde@challiance.org.

Marks, 1996). As the epidemic continues to shift with respect to gender, ethnicity, and behavioral risks, innovative interventions that support HIV-positive individuals in preventing HIV transmission are needed.

A growing body of sociobehavioral research conducted with HIV-positive individuals suggests that HIV-related risk behavior is associated with a number of complex factors. Inadequate or inaccurate knowledge about HIV continues to be significant predictor of sexual risk taking among HIV-positive individuals (McCown, 1993; Müller, Sarangbin, Ruxrungtham, Sittitrai, & Phanuphak, 1995). A perceived lack of social support and feelings of loneliness and isolation have also been associated with risk behavior (Clement, 1992; El Bassel, Ivanoff, Schilling, Borne & Gilbert, 1997; Nyamanthi, Wayment, & Dunkel-Schetter, 1993; Semple, Patterson, and Grant, 2000). Conversely, HIV-positive gay men who perceive greater family support have been found to engage in less risky behavior (Kimberly & Serovich, 1999). Other research has highlighted the difficulty that many positive individuals face in self-disclosing their serostatus. In several studies, nondisclosure of one's positive serostatus has also been associated with greater sexual risk taking among both men and women (de Rosa & Marks, 1998; Niccolai, Dorst, Myers, & Kissinger, 1998).

These studies and numerous others have been useful in informing the development of HIV prevention services for people living with HIV. Given the complex psychosocial factors associated with HIV-related risk taking, a wide range of programs and services have been developed to support positive individuals in reducing HIV-related risk behaviors. In the United States, interventions range from group-level interventions (GLIs), such as skills-building workshops and support groups (Kalichman et al., 2001; Rotheram-Borus et al., 2001) to intensive individual-level interventions (ILIs), such as prevention case management or couples counseling (Gardner et al., 2003; Margolin, Avants, Warburton, Hawkins, & Shi, 2003; Purcell, DeGroot, & Wolitski, 1998). Recognizing the diverse backgrounds and life circumstances of individuals living with HIV, the CDC and other intervention specialists have recommended a combination of individual and group-level services as the best strategy for supporting individuals over time (CDC, 2003; Purcell, 2003).

Although the recommendation to offer a combination of HIV prevention services makes intuitive sense, many community-based agencies are struggling to meet what they believe to be the prevention needs of HIV-positive individuals in their communities while simultaneously meeting the demands of organizations that fund prevention services. With decreasing funds for HIV prevention services at national, state, and local levels, community agencies are increasingly required to evaluate their services and demonstrate that their interventions are effective in changing HIV-related risk behavior. Although perhaps a reasonable request, there are a number of challenges in designing and implementing evaluation studies that are able to demonstrate the efficacy of prevention services. One of the biggest challenges is the cost of carrying out a well-designed evaluation study; quasi-experimental longitudinal studies are expensive and resource intensive, and few funding agencies are willing or able to fund such studies in addition to prevention services. The limited funds available for prevention services also presents a dilemma of competing priorities, with service delivery taking precedence over evaluation efforts. Evaluation of interventions can also be limited by the timing at which an evaluator is identified; evaluators are often brought in after interventions have been developed and implemented. When studies begin after interventions are implemented, evaluators often encounter challenges with balancing the

structure and methods that comprise a well-designed evaluation study with the realities of service provision and funding.

Given the variety of conditions under which many evaluation studies of HIV prevention services are conducted, evaluation researchers are often challenged to think creatively about their study designs by identifying methods that are feasible to employ and that will generate useful data. In this article we present findings from a formative evaluation of GLIs that were implemented in Los Angeles as part of the CDC's Prevention with HIV-Infected Persons (PHIP) initiative. The evaluation was funded in the final year of the local initiative and is thereby limited in scope. Our study aims and objectives corresponded with data that were feasible to attain after intervention activities had been implemented. In particular, we were interested in eliciting feedback from intervention specialists and participants about the unique characteristics of various GLIs that were developed as part of the initiative and the perceived impact of participating in these interventions on HIV-positive participants.

Our intent in presenting these findings is two fold: First, we believe that feedback from program participants is important to share with other service providers, researchers, and advocates interested in prevention efforts targeting HIV-positive individuals; second, the qualitative methodology employed in the evaluation helps shed light on how and why GLIs can be effective forums for supporting individuals in preventing HIV transmission. We also believe that the feedback provided by participants is useful for thinking about additional questions that may be included in more structured evaluations of HIV prevention services.

### INTERVENTION DESCRIPTION

Los Angeles County represents about 3.5% of the total population of the United States yet is home to 5.5% of all reported cases of AIDS nationally. Unprotected sexual intercourse between men is attributed to the majority (58%) of reported cases of AIDS (Los Angeles Department of Health Services, 2004a). In recent years, the local epidemic has shifted, with new reported cases of AIDS increasingly found among individuals of color, particularly Latinos and African Americans (Los Angeles Department of Health Services, 2004a). Transgendered persons are also disproportionately represented in reported cases of AIDS (Los Angeles Department of Health Services, 2004b). In response to local shifts in the epidemic, funding for the interventions was granted to agencies with particular expertise in working with these communities.

In 2000, five local providers in Los Angeles County were awarded funds under the CDC's PHIP initiative to develop and implement a variety of HIV prevention interventions for people living with HIV, including HIV testing and counseling in non-traditional settings, partner testing, prevention case management, risk reduction counseling and small and large GLIs. Most agencies funded under this initiative provided a combination of individual- and group-level interventions. As stated above, our discussion here is focused on GLIs. Among the five funded agencies, four received funding to develop and implement GLIs: AIDS Project Los Angeles, Los Angeles Shanti, Tarzana Treatment Center, and the Los Angeles Gay and Lesbian Center, the last of which worked through the Positive Images Consortium comprising 11 agencies.

GLIs consisted primarily of single session educational forums and topic driven multisession psychoeducational small-group workshops. Although the GLIs developed by each agency differed in structure, the content of the workshops were often similar. For example, AIDS Project Los Angeles targeted services to HIV-positive in-

dividuals who were diagnosed for longer than 2 years through the POWER program. They offered both educational forums and multisession small-group workshops. Likewise, Los Angeles Gay and Lesbian Center's Positive Images Consortia and Tarzana Treatment Center offered forums and multisession small-group workshops to both newly diagnosed and HIV-positive individuals who were diagnosed longer than 2 years. Los Angeles Shanti partnered with four HIV community clinics within specific areas of the county to target HIV-positive individuals, regardless of length of diagnosis. This provider developed the LOVE Positive seminars, multisession small-group workshops conducted across one weekend with a series of nine weekly follow-up support groups. Our focus here is not on any one agency's GLI strategy but rather on the group format as a whole for delivering HIV prevention interventions.

The majority of workshops and forums were developed and facilitated by HIV-positive peers. Providers relied heavily on consumer input in the design of their interventions. Commonalities across providers included a harm reduction approach to substance use/abuse, a risk reduction approach to HIV prevention, and reinforcement of healthy behaviors through social networking and social support with peers. Key topics covered across the GLIs included HIV and STI education, relationship and communication skills, strategies for self-disclosure of HIV status, maintaining positive physical and mental health, accessing and adhering to HIV treatment, and addressing common psychosocial issues, such as social isolation, substance use and abuse, among others. Although most providers were able to receive general trainings on group facilitation and HIV prevention counseling through the Los Angeles County Office of AIDS, more specific training on the interventions was provided by each lead agency.

## EVALUATION METHODS

Semistructured qualitative interviews were used to explore what agency directors, intervention specialists, and HIV-positive participants believed to be the strengths and challenges of the different interventions, and the perceived impact of the interventions on participants' overall health and HIV-related risk behaviors. Given the limited published data describing feedback from HIV-positive individuals who participate in interventions, we focus our discussion here on key themes that emerged from qualitative interviews conducted with intervention participants. These interviews explored participants' experiences in the GLIs and their perceptions of how the interventions influenced different aspects of their lives, such as physical health, social support, self-disclosure of HIV serostatus and HIV-related risk taking. Feedback on the interventions and recommendations for future prevention efforts were also elicited.

Interviews were most often conducted in a private room at the agency from which participants were recruited. The majority of interviews were conducted in English. However, roughly one third were conducted in Spanish by a bilingual interviewer and one interview was conducted in Cantonese with the assistance of a translator. Interviews lasted between 45 minutes and 2 hours. Participants were compensated \$20 for their time. The institutional review boards of the Los Angeles County Department of Public Health and Childrens Hospital Los Angeles approved the evaluation design and research protocols before research activities began.

## SETTING AND RECRUITMENT

Recruitment of individuals to participate in qualitative interviews occurred between October 2003 and April 2004. HIV-positive participants across the various

GLIs were eligible to participate in an open-ended interview if they had participated in at least one large group educational forum and one skills-building workshop. In the two agencies that did not sponsor large educational forums, the criterion was that they participate in at least two skills-building workshops. To protect the rights and confidentiality of intervention participants, intervention specialists assisted in the identification and recruitment of eligible participants. Introductions to the evaluation were most often made at the conclusion of an intervention. If any participant was interested in learning more about the study, intervention specialists facilitated an introduction with a member of the evaluation team. Interviews were conducted with all individuals after review of the study protocol informed consent procedures.

### ANALYSIS OF QUALITATIVE INTERVIEWS

All qualitative interviews were audio-recorded and professionally transcribed. Members of the evaluation team reviewed an initial sample of interviews to identify key themes, which formed the basis of project codebooks. The code book was modified as needed during the initial stages of coding. Once the code book was finalized, three members of the evaluation team were responsible for coding the interviews. Approximately 15% of the interviews were double-coded to assess coder reliability. In addition, the project coordinator reviewed all coded interviews to check for consistency in coding patterns. Disputes in coding were discussed and resolved by the team. Once the coding process was complete, transcripts were imported into N6, a software program designed to assist in the management and analysis of data. Text segments were electronically assigned codes. Data analysis consisted of reviewing reports generated for themes of interest, including personal outcomes, challenges of living with HIV, and reflections on PHIP interventions.

## QUALITATIVE FINDINGS

### DESCRIPTION OF STUDY SAMPLE

In 2003 a total of 1,844 encounters with persons living with HIV occurred across all GLIs. According to aggregate data reported by each agency to the Los Angeles Office of AIDS Programs and Policy, the majority of participants were Latino (41%), followed by African American (24%), White (20%), and Asian/Pacific Islander (10%). A total of 36 individuals who participated in the GLIs in Los Angeles were recruited to complete qualitative interviews. The mean age of the sample was 35 (range 18–63). The majority of participants were men (67%), followed by women (23%) and transgendered persons (9%). The sample was ethnically diverse and closely represented the overall population of program participants; 23% African American, 43% Latino/Hispanic, 14% White, 11% Asian/Pacific Islander, and 9% of mixed ethnicities. Self-reported sexual orientation also varied, with 33% self-identifying as heterosexual, 51% homosexual, and 16% bisexual. Just over three quarters (77%) of the sample reported being single.

The majority of participants lived in their own house or apartment (80%), whereas 14% had transitional housing and 6% lived with a relative. Although all participants were currently housed, 34% had a previous history of homelessness. Nearly two thirds of the sample lived on less than \$15,000 a year.

## PERCEIVED IMPACT OF PARTICIPATING IN GROUP-LEVEL INTERVENTIONS

Despite variations in the structure and content of the interventions, participants in the GLIs provided remarkably similar feedback on the perceived impact of participating in these interventions. In general, we found that the most consistent and important benefit reported by participants was the opportunity to interact with and learn from other HIV-positive individuals. These interactions provided unique experiences that participants benefited from in a number of ways, including (a) access to a diverse array of information about living with and managing HIV disease (b) an increase in skills that help facilitate self-disclosure of HIV to intimate partners, friends, and family members, and (c) an increase in positive social networks that support reductions in risk behavior. Although these benefits are self-reported and not empirically assessed over time, they are constructs that have been associated with a reduction in HIV-related risk behavior in previous studies. Below we describe these reported benefits in more detail by utilizing participants' own words to highlight some of the many ways in which group interventions can facilitate change with respect to key factors associated with HIV risk behavior.

### ACCESS TO INFORMATION AND EDUCATION

Although HIV education has been at the heart of prevention efforts since the beginning of the epidemic in the United States, there are many individuals who are uninformed or misinformed about HIV and related risk behaviors. This is especially true in communities of color where mainstream educational campaigns have not, until recently, been sensitive to cultural variations in educational preferences, including language, composition, and message framing. Most of the GLIs in Los Angeles were tailored to specific cultural groups, as well as participants' gender and sexual orientation. For example, agencies serving predominately Latino populations conducted groups in Spanish. One agency that served predominately Asian/Pacific Islander populations had translators available to translate information shared in groups into a variety of languages (e.g., Korean, Thai, Tagalog).

Individuals with limited English proficiency talked at length about a variety of ways in which the GLIs offered opportunities to dialogue with other HIV-positive individuals in a language they could understand. This was very important to a couple of participants who, for example, did not understand how they contracted HIV until they began participating in the workshops and had an opportunity to ask questions and receive answers in their native language about the modes of transmission.

*(Speaking through a translator)* When I don't understand something, I will ask the people at the workshops who understand the English better, and so, I'll ask the people who are participating in the workshops of what was being said. Sometimes the translators are brought in, but when they are not, I'll ask the people that are there what is being said because I understand Chinese and I also understand Vietnamese. (Cambodian male, aged 57)

Most workshops included an educational component about HIV and sexually transmitted infections, including how they are transmitted and the health consequences of becoming infected. Although there are concerns among prevention specialists that people living with HIV are saturated with information about the disease, the majority of participants in the evaluation described educational workshops and forums as having a major impact on their risk behavior. For example, many noted that they had little

knowledge of sexually transmitted infections prior to the workshops and were unaware of the risks of HIV reinfection.

I thought you can just have sex with other HIV people without, you know protection. I didn't know you have different strains. So you have to protect, you still have to use protection. I didn't know that. And I learned about so much about diseases, sex[ually] transmitted. They have a lot of good things. (Latino male, aged 48)

In addition to HIV education and risk reduction strategies, participants also noted that interacting with other HIV-positive individuals in a group setting provided opportunities to learn more about health-related issues, such as secondary infections, HIV medications, and nutrition.

Sharing and discussing ideas with peers who are also HIV-positive in an emotionally safe forum was critical to participants' own growth and development.

It's one thing to have one-on-one case management, but you're dealing with a case manager and that's it. You talk to them and they give you things and they refer you to places. But when I am in a group with other HIV-positive people, I get to see them and be around them. You see, I'm young and I get to learn from them . . . Because you can learn from people and people can learn from you, regardless of how far along you are. So the people part is a big thing. (Caucasian male, aged 23)

Finally, participants talked about the process of becoming educated. Many described this process as being fundamentally linked to a group dynamic.

Well, it feels good because it allows me not only to express my own opinions and possibly get them validated or questioned, but it allows me to hear how other people are reacting to the information, how other people view things, which is always a good, like, "safety check" on your own thought process. You don't have to agree with everybody, but some things resonate, and therefore it kind of fills out your own philosophies and feelings about things. (Caucasian male, aged 60)

For many, it was the process of hearing new ideas and discussing them that allowed individuals to formulate new understandings of themselves and their behavior. Rather than being told what to do and how to think, participants felt a sense of ownership over their educational process.

#### INCREASE IN SKILLS THAT HELP FACILITATE DISCLOSURE OF HIV TO SEX PARTNERS, FRIENDS, AND FAMILY

For many participants, self-disclosure of a HIV-positive status to sex partners, friends, and family members was among the greatest challenges they faced in their intimate and personal lives. Workshops on disclosure were highly regarded by workshop participants and often considered to be the most valuable among all the workshops offered. Most participants were afraid to disclose their status to people in their lives out of fear of rejection. Individuals living in communities of color often reported a lack of understanding about the disease in their communities, which many believed to underlie the stigma associated with the disease. A fear of rejection was often linked to feelings of isolation and depression.

In my circle of friends, I am the only one that is positive . . . I feel like I have to surround myself with people who I know are positive and people who know that I am positive in order for us to have a dialogue. Because I feel like I really can't talk to my friends about it or they really don't want to talk to me about it. (African American male, aged 39)

Disclosure workshops provided individuals with opportunities not only to discuss the pros and cons of disclosing their serostatus to the people in their lives but also to practice disclosure skills.

Being in that safe environment and being able to basically reveal my status to that group and discussing these things in that environment made it a whole lot easier to go to my best friend and say, "I need to talk to you". . . These relationships build over a very long time. And to fear having any kind of rejection is threatening. These people are a part of your social support network. So I felt really wonderful about how my best friend reacted when I told him. [This] has had a positive effect on my health . . . I reduced my stress in a sense that I'm not having to withhold information from him. (Caucasian male, aged 39)

For many, but not all, learning how to disclose to friends and family members opened up new sources of social support for them. The few individuals who had negative disclosure experiences were able to draw on the support they had from workshop participants to deal with these experiences. Some individuals had not disclosed yet to family and friends but identified this process as a personal goal.

I really haven't disclosed yet to my family, but I feel like I'm making progress. Without MAP [PHIP provider], I really don't think I would have that feeling . . . I really didn't talk about it at all until I started coming to MAP. If I had met you a year ago and you asked me for an interview, I would have thought you were crazy. (African American male, aged 43)

Participants identified small-group forums as ideal for building disclosure skills. Participants responded favorably to facilitators who did not simply tell them that they needed to disclose but rather opened up dialogue about what disclosure means, participants' fears of disclosure, and strategies for disclosing to different types of people (e.g., intimate partners, family members, friends).

I wanted to know as an HIV-positive man where I was with dating and relationships and what I needed to look out for and consider. One of the issues that was touched on was disclosure. And as a result of what I've learned from LA Shanti [PHIP provider], I have a firm commitment to not have an intimate relationship with anyone without full disclosure. (Caucasian male, aged 60)

Comments such as these were common in the interviews we conducted and spanned discussions about different types of GLIs. Participants appreciated the experiential process of learning that they were afforded through group discussions. Facilitators played a key role in providing a base of information about disclosure but also in encouraging participants to discuss and debate the information and ultimately develop their own commitments to disclosure.

### INCREASE IN SOCIAL SUPPORT

Previous studies found positive social support to be associated with a decrease in HIV risk behavior among both HIV-positive and negative populations. During this evaluation, participants described a variety of ways in which GLIs were associated with an increase in social support. Discussions about changes in perceptions of social support were both directly and indirectly linked to changes in health-seeking behaviors and risk reduction efforts.

Receiving a positive HIV test was a major turning point in many participants' lives. Intense feelings of shame and loneliness often accompanied a new diagnosis.



Some used drugs and alcohol to cope with these feelings, while others isolated themselves from friends and family.

Before my coming here, I was really very depressed—very depressed, because of the man who infected me. I never knew he was infected until he told my doctor when he went for an exam . . . I thought we were going to die of AIDS . . . I wanted to commit suicide. Everything bothered me, everything upset me, people annoyed me, I didn't want people to talk with me on the phone. It was a difficult battle. (Latino, female, aged 53)

Feelings of shame and loneliness were particularly salient among women and gay men of color, who felt their families and communities were largely uneducated about HIV and held negative stereotypes about people who had contracted the virus. For some participants, small-group workshops and forums provided an opportunity for them to learn that there are other people who share similar backgrounds and experiences. Comments like "I realized I wasn't the only person with HIV" were common across all interviews.

There was one individual who spoke [at a workshop] that I mostly connected with. He said he grew up basically dating women and then transferred over to dating men. He had the persona of being in the hood, and of having to live a double life. That's what I closely connected with because that's the way I basically grew up . . . Those are the type of people and . . . things that I want to hear about to let me know that I'm not the only one. That is what's most scary for me, to think that I am the only one to travel down this road . . . I'm not to feel ashamed about it or any less than—that's why it is important to me to be in the workshops. (African American male, aged 39)

Participants also talked about the influence of participating in the workshops on their ability to cope with their illness. When group dynamics were perceived as positive, individuals reported feeling supported in their efforts to deal with the everyday struggles of the disease and develop strategies for coping in a positive manner.

I can easily move and relocate myself and hang out with my old friends and just ignore this whole HIV thing. But you know, I'm glad that I am not . . . I'm positive and I can easily just forget things and just kind of, like, block that idea and engage in risky stuff. But this program helps me see it and deal with it. The workshops help me deal with it, and I won't forget it now. (Caucasian male, aged 23)

Across the different GLIs, individuals highlighted the importance of being able to come together with other HIV-positive individuals to discuss issues that are important to them, such as disclosure, sex, relationships, emotions, medications, and health care. Many maintained relationships with group participants outside of the group forums. These relationships provided not only a constant source of social support for participants but also an opportunity for them to give back to others in times of need. Opportunities to give back to others and share their experiences further strengthened support networks for individuals who were previously disenfranchised and helped improve their sense of emotional well-being and self-efficacy.

### SUPPORTING RISK REDUCTION

Although it was not possible to systematically assess changes in HIV-related risk behavior associated with participation in GLIs, many participants talked openly about a variety of ways in which these interventions influenced changes in their risk behavior. A combination of education, skills-building exercises, and social support from peers were most often attributed to reported changes. In a group format, partici-

pants have an opportunity to share with others the strategies they use to prevent transmission. Those who described the greatest benefits from the group discussions were those who faced challenges in negotiating condom use with sex partners.

At the workshop, I learned something new from one of the other guys—using the female condom. Insert it in myself so he doesn't have to have the uncomfortableness or the unease of putting one on. I'm already protected . . . You just gotta take out that little ring. That hurts. Not so cute! But if you take the ring out, it's cool 'cause it goes in easily . . . I learned that at the workshop. Yeah. There are alternatives. 'Cause there are men out there who do *not* want to use a rubber. And you should have alternative ways to enjoy safe sex without getting beat up! (mixed-ethnicity male, aged 53)

As this quote alludes to, violence is a reality for some men and women. Like this man, several participants described the fear of violence as a major barrier to the negotiation of condom use. Rather than not use any protection at all, some participants noted that the group format was important for them because it provided an opportunity to learn about a variety of risk reduction strategies that they otherwise would not have been exposed to. These participants discussed feeling more in control of their sexual behavior and, in turn, better about themselves.

Although education was an important first step, it was often not education alone that inspired changes in HIV risk behavior. Individuals who participated in GLIs often discussed a change in themselves while active in the groups. For many, it was the first time that they had tapped into a network of other HIV-positive individuals in an environment that was not sexually or emotionally charged. As people began to feel changes in their emotional well-being, they also began caring more about their risk behavior. In part, many described feeling like they did have something to lose if they died and began taking more precautions to protect themselves from other infections. Others began thinking and caring more about others, particularly about transmitting the virus to individuals who are uninfected.

I've learned that if you are safe, you won't be sorry later. I don't really want anyone to have what I have. But before I came in to the [workshops], I didn't care. You can give it to me, I will give it to somebody else. I just didn't care . . . , but now I think I have more respect for myself and for other people. Now I say, "No, it's not the right thing" [not to use condoms]. (Caucasian male, aged 43)

One of the sessions was on condom use. There was something about the questions that were asked during the group that just stuck with me. I don't know, but when I'm intimate now, I am sure to mention the condom thing with the person I'm with, whereas before I never even cared. It just made me more conscious of the fact that—it just opened my eyes up to what's around me. (Latino male, aged 33)

Finally, we believe that one of the most important reported benefits of the interventions is the social support that is fostered to help individuals maintain healthy behaviors. GLIs provided positive individuals with an opportunity to interact with other positive individuals who were also interested in improving their physical and emotional well-being.

I made friends here . . . We'll have issues that are about the same, and it's good to have a friend that you can call and say, "Girl, I tried that. It didn't work. Now what should I do?" And he might have something that he did that could help you . . . I have three friends right now and we all made a pact that we're not fuckin' without a rubber. We're all HIV-positive, we all have a good T-cell count, and we want to stay like that. We made a pact between ourselves. (mixed-ethnicity male, aged 53)

The relationships developed in these contexts were often powerful sources of support to maintain healthy behaviors. If developed and implemented well, GLIs can help nurture the development of peer-to-peer support networks that can continue beyond the life of an intervention.

## DISCUSSION

In this article, we have highlighted a variety of ways in which GLIs in Los Angeles supported persons living with HIV to become active participants in efforts to prevent transmission of the disease. A primary strength of GLIs is that they provide education and social support from a variety of sources, including group facilitators and peer participants. Participants repeatedly noted that they appreciated the experiential process of learning that group interventions encourage. The combined knowledge and experiences of peers can provide individuals with unique opportunities to listen, discuss, debate, practice, and ultimately transform what they learn into information that is meaningful and useful. The positive support provided during the intervention sessions often extended beyond the groups. "Out in the real world," these support networks helped individuals overcome feelings of social isolation and depression and to maintain positive health behaviors over time.

Like many evaluation studies conducted for prevention services, this study has a number of limitations that need to be acknowledged. First, the evaluation did not begin until the final year of funding, which limited the types of methods and data that could be used in the study. Thus, the findings are largely descriptive. Second, the sample size is small, and the information provided by participants may not be generalized to all participants in GLIs in Los Angeles. Third, individuals who agreed to participate in the evaluation were not randomly selected. Rather, they were selected based on their current participation in the interventions and with the assistance of intervention specialists. It is possible that intervention specialists informed only individuals with more positive experiences in the GLIs about the evaluation. Thus, this study does not include feedback from individuals who dropped out of the interventions and may not include individuals with negative experiences in the groups. Given the small sample size and the qualitative nature of the evaluation, we are not able to systematically assess the overall impact of the GLIs on individual participants. Despite these limitations, this evaluation has provided us with a wealth of valuable information for planning the evaluation of future HIV prevention with positive persons initiatives.

The use of qualitative methods in this evaluation helped shed light on some of the ways in which GLIs help support HIV-positive individuals in making positive health choices. Quantitative assessments, which can systematically assess changes across large samples, are typically the standard for systematic program evaluations. Although changes in knowledge about HIV and behavioral intentions are relatively easy to evaluate, gradual shifts in feelings of isolation, depression, social support, and control over health-related issues are more difficult to assess using quantitative measures. Given the variability in time that it takes for individuals to adopt safer practices, we believe that evaluations that focus only on primary outcomes are likely to miss some of the most important positive changes that are occurring among participants. Evaluators need to work with intervention specialists to identify ways of assessing changes in factors associated with behavioral change, such as perceptions of social support, isolation, and comfort with living with HIV. It may also be of interest to better understand what aspects of the interventions participants believe to be most valuable for them in their efforts to maintain healthy behaviors.

Finally, the importance participants attributed to the experiential process of learning and connecting with other HIV-positive individuals cannot be overstated. We were surprised to find such similar and consistent findings across the interviews we conducted. It may be that one of the greatest strengths of GLIs lies not in their content, but in the form itself. GLIs are unique, dynamic approaches to prevention for people living with HIV that may serve as an important catalyst for behavioral change beyond the life of the intervention.

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