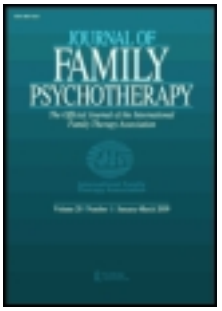

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Solution-Focused Group Work: Collaborating with Clients Diagnosed with HIV/AIDS

Adam S. Froerer [a], Sara A. Smock [a] & Ryan B. Seedall [b]

[a] Marriage and Family Therapy Program, Texas Tech University, Lubbock, Texas, USA

[b] Marriage and Family Therapy Program, Michigan State University, East Lansing, Michigan, USA

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Solution-Focused Group Work: Collaborating with Clients Diagnosed with HIV/AIDS

ADAM S. FROERER and SARA A. SMOCK
Marriage and Family Therapy Program, Texas Tech University, Lubbock, Texas, USA

RYAN B. SEEDALL
Marriage and Family Therapy Program, Michigan State University, East Lansing, Michigan, USA

This article looks at the current trends and challenges faced by persons diagnosed with human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS). Given the lack of resources available to persons living with HIV/AIDS, a rationale for using solution-focused brief group therapy (SFBGT) is presented. The solution-focused approach builds on client resources to move them closer to their desired life despite having a life-threatening illness. SFBT is uniquely suited to facilitating positive outcomes with individuals living with HIV/AIDS. The overall aim of this article is to provide a theoretical explanation and justification of how SFBGT can effectively aid those diagnosed with HIV/AIDS to combat the obstacles they encounter. An example of a group format is also offered as a template for clinicians and practitioners.

KEYWORDS human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), solution-focused brief therapy, solution-focused group therapy

INTRODUCTION

In over 2 decades, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) has affected and taken the lives of so many. Despite medicine's attempt at treating this epidemic, HIV/AIDS continues to infect men, women, and children worldwide. Those infected with HIV/AIDS

Address correspondence to Adam S. Froerer, Marriage and Family Therapy Program, Box 41162, Texas Tech University, Lubbock, TX 79409-1162, USA. E-mail: adam.froerer@ttu.edu

face a unique struggle, with a variety of difficult obstacles facing them. Although some of these are related to physical symptoms associated with the illness, still others affect their emotional well-being (Smiley, 2004). These issues necessitate that more mental health treatments be adapted to salient problems that individuals with HIV/AIDS encounter. Given that solution-focused brief therapy (SFBT) is strength-based, emphasizes resources, and focuses on solutions despite the presence of a problem, SFBT groups may be one unique resource available to combat the challenges encountered by persons living with HIV/AIDS. This article aims to set forth the value of adapting SFBT principles within the context of group therapy to best serve the mental health needs of the HIV/AIDS population.

HIV/AIDS

Since its discovery in 1981, AIDS has become one of the most complex and far-reaching diseases in history. Since the early 1980s HIV/AIDS has drastically increased in prevalence. By the end of 2003, it was estimated that between 1,039,000 and 1,185,000 individuals in the United States were living with HIV/AIDS and that between 24% and 27% of infected persons were either unaware or undiagnosed (www.cdc.gov/hiv/resources/factsheets/us.htm, 2006). Through 2004 it was estimated that 944,305 individuals had been diagnosed with AIDS and that 10% of infected persons were children (www.cdc.gov, 2006). The Centers for Disease Control (CDC, 2006) also estimated that, by the end of 2005, an estimated 550,394 people in the United States died as a result of AIDS.

HIV/AIDS is a concern worldwide and not just within the United States. In a recent report provided by the World Health Organization (WHO, 2007) it is stated that about 33.2 million individuals are living with HIV/AIDS worldwide. The WHO also reports that there have been 2.5 million newly infected persons in 2007 alone. Additionally, there have been approximately 2.1 million deaths due to AIDS in 2007. The WHO also report that sub-Saharan Africa is the region of the world that is most seriously affected by the AIDS epidemic. In fact, AIDS is the leading cause of death within this region of the world. It is evident that HIV/AIDS is an international and global concern demanding attention (http://data.unaids.org).

UNIQUE CHALLENGES ENCOUNTERED BY THOSE WITH HIV/AIDS

A number of severe effects often accompany HIV/AIDS, including “rapid weight loss; dry cough; recurring fever or profuse night sweats; profound and unexpected fatigue; swollen lymph glands in the armpits, groin, or neck; diarrhea that lasts more than a week; . . . pneumonia; . . . or memory loss,

depression, and other neurological disorders" (www.cdc.gov, 2006). The social and emotional challenges accompanying HIV/AIDS affect individuals to varying degrees and are equally stressful and debilitating. Some of these potential challenges that will be outlined in this section include (a) managing ongoing symptoms, daily life functions, and difficult life decisions; (b) stigmatization and marginalization; (c) feelings of guilt and shame; and (d) significant loss, grief, and hopelessness.

Managing Ongoing Symptoms, Daily Life Functions, and Life Decisions

Everyday challenges accompany a diagnosis of HIV/AIDS. Infected persons must learn to adapt to their changing physical appearance and bodily functions while also compensating for the effects of the illness symptoms (Smiley, 2004). This learning and adaptation may be an ongoing experience for those with HIV/AIDS (Mayers & Spiegel, 1992). Individuals with HIV/AIDS also face the challenge of making difficult life decisions due to the infection. Infected individuals must face the reality of chronic/terminal illness and the continual deterioration of health and well-being that accompanies the shortened life expectancy for themselves and others within their social sphere (Mayers & Spiegel, 1992; Smiley, 2004). Decisions about health care coverage, disease treatments, and priorities of a daily routine must be reevaluated as health care concerns become more prevalent. Choices about disclosure surrounding HIV status must also be considered and weighed regularly by infected persons (Mayers & Spiegel, 1992).

Stigmatization and Marginalization

Not only do individuals diagnosed with HIV/AIDS have to learn to work and maximize daily life functioning but they are often stigmatized and marginalized by others in society who may send messages that HIV/AIDS is a curse or punishment for improper activity (Molassiotis et al., 2002). Marginalization and stigmatization are also heightened due to prejudice toward certain minority ethnic groups; members of the lesbian, gay, bisexual, transsexual, queer (LGBTQ) community;, drug users; and sex workers, all of whom are at increased risk of contracting HIV (Bacha, Pomeroy, & Gilbert, 1999; Greenwood, Szapocznik, & McIntosh, 1996; Molassiotis et al., 2002). Unfortunately, the marginalization of these groups is often increased or compounded upon contraction of HIV/AIDS. Individuals infected with HIV/AIDS must also face the reality of challenges within their families of origin and families of choice. HIV/AIDS does not affect the individual in isolation, but the effects reverberate into their family systems (Greenwood et al., 1996). Thus, individuals previously marginalized by their families due to risky behaviors may be further ostracized upon contraction of the infection.

Internalized Shame

Simultaneous to stigmatization by outside communities, gay males face the challenge of internal homophobia, characterized by shame, self-stigmatization, and self-hatred (Smiley, 2004). Shame has been referred to as global, internalized self-attribution of one's "badness" (Baldwin, Baldwin, & Ewald, 2006; Harper & Hoopes, 1990). Shame may result for a variety of reasons, including past risky behavior such as drug use or unprotected sexual activity that may have contributed to the contraction of the virus (Molassiotis et al., 2002). Upon infection gay men must face their self-loathing due to their homosexuality and reevaluate their sexual orientation and sexual practice again (Smiley, 2004). Another potential source of shame is the strong possibility of passing the infection on to others, particularly when considering mother–child or partner–partner transmission (Bacha et al., 1999). Survival guilt, or feelings of undeserved life or happiness after the passing or loss of a loved one, is another common source of shame for those with HIV/AIDS (Bor, Elford, & Perry, 1988). Ultimately, the self-loathing and anticipated rejection that often accompany internalized shame are likely to precipitate withdrawal and detachment from mainstream culture (Blaisdell, 1994).

Loss, Grief, and Hopelessness

Finally, a further challenge persons with HIV/AIDS may encounter is the loss of a future orientation, or hope for the future, due to the contraction of the virus (Bor & Miller, 1988). Individuals not only have to deal with their own physical symptoms and the stigmatization that accompanies an HIV/AIDS diagnosis but also are faced with the imminent but unpredictable mortality of many of their support group who also have the virus. This sobering realization likely activates intense grief-related emotions that are extremely complex and difficult to understand (Bacha et al., 1999). As others from their community lose their lives due to HIV/AIDS or other related infections, individuals also encounter the reality of their own premature death due to HIV/AIDS infections. With so much that can happen unexpectedly and the potential for relatively little elapsed time between losses to cope and adjust, it is extremely difficult to adopt a future, hopeful orientation that could greatly enhance life satisfaction.

SOLUTION-FOCUSED BRIEF THERAPY

SFBT is a social constructionist approach established primarily by de Shazer (1985) and Berg (1994) in an effort to facilitate change for clients by minimizing the focus on problems, previous challenges, and failures while highlighting the clients' goals, strengths, resources, and exceptions to the problem

(T. S. Nelson & Kelley, 2001). de Shazer (1985) emphasizes that SFBT is able to get results by asking purposeful questions, focusing on solutions rather than on problems, and identifying what individuals are already doing well. It is this process of focusing on what works that facilitates increased hope for future change while mobilizing and expanding client resources for change. Some common SFBT interventions designed to accomplish these tasks include the following: establishing goals, the formula first session task, difference questions, compliments, relationship questions, the miracle question, scaling questions, taking a break during the session, and experiments or assigning homework (Berg, 1994; Berg & Miller, 1992; de Shazer, 1985, 1994; T. S. Nelson & Kelley, 2001).

Listening to the clients' questions is a way for therapists to validate clients and helps clients to discover their own solutions. SFBT therapists take minimal responsibility for providing answers to the clients' questions. Rather, therapists aid clients in coconstructing new realities by using solution-oriented questions (Bor & Miller, 1988). The role of the therapist from a SFBT perspective is to provide a safe environment, assist the clients in identifying what would be different about life without the problem, highlight steps the clients have taken toward the solution, and empower the clients to continue to move in the direction of achieving their ideal or goals (Pichot & Dolan, 2003).

Value Added by SFBT to Treatment of Persons with HIV/AIDS

The assumptions and techniques of SFBT are effective at addressing and countering the regular challenges encountered by persons diagnosed with HIV/AIDS, given that emphasis is on what the client would like to be different not on what has gone wrong (Berg, 1994). The SFBT treatment manual (Trepper et al., 2006) asserts that "the therapeutic focus should be on the client's desired future rather than on past problems or current conflicts" (p. 1). This focus on the future sends a message to those with HIV/AIDS that what has happened in the past cannot be changed and that the infection status is not going to change. Simultaneously, this assumption sends a clear message that working toward goals and a desired future is what is needed to establish change and increase success and satisfaction despite the infection. This message helps to instill hope that life can have positive aspects regardless of HIV status.

The SFBT assumption that clients have all the resources they need to create a better life is an empowering approach for individuals who may feel powerless due to symptoms and illnesses. This perspective validates that problems and challenges exist but shifts the focus to the strengths the group member has and the ability to do something different. Connected to this idea is the notion that the solution may have nothing to do with the problem (de Shazer, 1985). This approach is particularly applicable to those with HIV/AIDS because although their HIV status will not change or be

solved, therapy focuses on how they want their life to be despite their HIV/AIDS status. SFBT clients are encouraged to make small changes, and these changes will often lead to larger changes (Berg, 1994; Trepper et al., 2006).

Thus, the ideas, perceptions, and techniques related to SFBT can create a solution-oriented, strength-based environment conducive for individuals to make lasting changes in their lives and perceptions. In this manner, SFBT shows additional promise to be applicable for individuals diagnosed with HIV/AIDS. In placing primary emphasis on past successes as well as existing resources, strengths, and competency, SFBT has the potential to engender feelings of hope and empowerment within clients, even in the midst of major obstacles and stressors.

GROUP WORK AMONG PEOPLE WITH HIV/AIDS

Group work is one of the most common formats for therapy with clients infected by HIV/AIDS (Siebert & Dorfman, 1995). Many different types of groups have been used with the HIV/AIDS population, with substantial benefit for clients. These include cognitive-behavioral groups (Lee, Cohen, & Hadley, 1999; Molassiotis et al., 2002), psychoeducational groups (Bacha et al., 1999; M. K. Nelson, 1997; Pomeroy, Rubin, & Walker, 1996), support groups (Gossart-Walker & Moss, 1998; Mayers & Spiegel, 1992), art and play groups for children affected and infected with HIV/AIDS (Antle, 2001; Willemsen & Anscombe, 2001), bereavement groups (Dane, 2002), harm reduction or risk management groups (Avents, Margoli, & Usubiaga, 2004; Henry, 1996), and sensory awareness groups (McLaughlin, 2002).

Group therapy has been found to decrease psychological symptoms associated with HIV/AIDS and has been shown to be a valuable source of support for persons with HIV/AIDS (Kelly, 1998; Siebert & Dorfman, 1995). Yalom (1995) establishes that group work is helpful in providing an arena for socialization, feelings of inclusion, an atmosphere for emotional experiences, and a realistic microcosm of the world. Each of these features adds to the power and effectiveness of group therapy and directly facilitates the overcoming of the unique challenges encountered by those living with HIV/AIDS.

Solution-Focused Group Work with Persons Living with HIV/AIDS

Group work within an SFBT framework creates a synergistic effect as the benefits of group therapy are merged with the most effective elements of SFBT. Clients are encouraged to identify areas of their lives that are going well or that are fulfilling and satisfying and then use those competencies to create customized solutions (O'Hanlon & Hudson, 1995). Not only are resources and strengths explicitly identified for possible utilization but group

members are able to work together to uncover and highlight additional exceptions to problems encountered by individual group members (T. S. Nelson & Kelley, 2001).

In addition, working in groups is consistent with SFBT because it reduces the therapist's role of being the expert (T. S. Nelson & Kelley, 2001). In a group format, clients are inclined to help one another and offer suggestions and insights about what has been helpful for them in the past. This reliance on the other group members and the generating of ideas elevates the group members to the role of expert for their own situations and encourages clients to develop their own goals and solutions to their problems.

SFBT groups also provide a sense of family or a community where persons can feel welcomed and feel like they belong to something bigger than themselves (Smiley, 2004). This sense of community or network is invaluable to persons infected with HIV who continually face the reality of isolation and loss of their peers and loved ones (Bacha et al., 1999). Being in a group with other individuals who are facing the same challenges and struggles helps to counter feelings of isolation and marginalization. Working together to develop solutions and being supported reduces the negative feelings associated with not belonging (Berg, 1994; Berg & Miller, 1992; de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989). Thus, group work anchored within the assumptions and techniques of SFBT can be of particular utility to those individuals diagnosed with HIV/AIDS.

Given the specific challenges encountered by individuals from this population, attending therapy and countering the effects of these challenges may facilitate change and growth while restoring hope and a future orientation. Although group work has been shown to decrease some symptoms with this population, no group work has been conducted and reported from a solution-focused perspective with this population. SFBT is one potentially effective method that sufficiently addresses the challenges and obstacles encountered by persons with HIV/AIDS.

SOLUTION-FOCUSED GROUP FORMAT AND OUTLINE

Prior to outlining the general format for SFBT groups with individuals diagnosed with HIV/AIDS, it may be helpful and ultimately maximize effectiveness to conceptualize SFBT groups within a developmental group framework (LaFountain & Garner, 1996). Yalom (1995) outlined a developmental framework consisting of four stages: orientation, conflict, harmony/cohesiveness, and maturity. During the initial orientation stage, group members continue to develop and build upon the goals and expectations they discussed in their individual prescreening sessions. Another important element of the initial stage of group process is the establishment of group boundaries and rules. From an SFBT perspective, these group goals and boundaries can be

developed using the miracle question, scaling questions, and exceptions (T. S. Nelson & Kelley, 2001).

During the conflict stage of group development, group members tend to notice and highlight the differences among group members, making conflict a possibility (Yalom, 1995). SFBT interventions and procedures can help group members work through any conflict that may arise. For example, the therapist could ask group members what is going well in the group, what has enabled those positive things to occur, and what group members would like to see more of in the group. Therapists could also ask the miracle question to determine what would be different if the group conflict was miraculously eliminated. Effort should be given to encouraging group members to develop their own solutions to the group dynamics.

After successfully navigating through potential conflict, the next stage is characterized by group members striving for group harmony and cohesiveness. This stage of group work is particularly helpful for clients in overcoming the challenges faced due to infection, as it helps to increase the social support and network of possible resources available to those living with HIV/AIDS. Having a place where cohesiveness is abundant may serve to reduce the feelings of isolation, stigmatization, marginalization, or self-loathing commonly experienced by members of this population. Being part of a group that is accepting may also help to restore a sense of safety and belonging, previously lost due to risky behavior or the contraction of HIV/AIDS.

During the maturity stage of group development, members are fully engaged and are working to fulfill the goals of the group. This stage builds on the previous stages of acceptance for isolated individuals. Changes and successes that have occurred throughout the group are regularly highlighted by the SFBT therapist, and clients should be encouraged to continue doing what works (Berg, 1994). Overall, the group development process may serve to revitalize a future orientation and instill hope for the future, while providing a network of support to previously isolated and stigmatized individuals.

Group Composition, Length, and Duration

Yalom (1995) specifies three important considerations for interactive therapy groups such as an SFBT group. In terms of group composition, interactive therapy groups ideally consist of between 7 and 8 participants, with a possible range of 5 to 10 group members. In addition, existing literature recommends that each group session last approximately an hour and a half. One hour is often too short to allow a warm-up time and to address the issues, while 2-hour groups often become repetitious and ineffective (Yalom, 1995). Finally, it is suggested that the group meet in a closed group format, weekly for between 6 and 8 weeks (Yalom, 1995). A closed group format can be especially effective with at-risk individuals because it provides protection and privacy and reduces the possibility of restigmatization and marginalization by constantly

introducing new group members. In addition, a closed group can also provide stability to those whose lives may typically lack predictability and constancy in other areas of their lives.

Prescreening

Individual prescreening is an important component of all groups, as group work may not be the ideal fit for everyone. "Patients improperly assigned to a therapy group are unlikely to benefit from their therapy experience" (Yalom, 1995, p. 217). Prescreening is useful in determining if clients are able to effectively work with others, if they will meet the attendance requirements, and if their needs will be met by the group (Yalom, 1995). When done from a solution-focused perspective, it has been recommended that prescreening include the following question: "What would you like to change?" (LaFountain & Garner, 1996, p. 128). However, from an SFBT perspective, prescreening need not be used to gain an extensive background on individuals in order to help them; the solution may have nothing to do with the problem (de Shazer, 1985).

The prescreening process also introduces and utilizes the following SFBT interventions: the miracle question, scaling questions, and the formula first session task (de Shazer, 1985) may also be used to begin accessing individual goals that can then develop into group goals and expectations (Zimmerman, Jacobsen, & MacIntyre, 1996; Zimmerman, Prest, & Wetzel, 1997). Group facilitators should look for and encourage group members to be interested in changing themselves and articulate goals that are attainable (LaFountain & Garner, 1996). Goals should be specific, emphasize what the client will be doing behaviorally when the goal is achieved (LaFountain & Garner, 1996), and be realistic and attainable (de Shazer, 1985; T. S. Nelson & Kelley, 2001). For example, because HIV/AIDS cannot currently be cured, the client's goal cannot be to live HIV/AIDS free. Thus, goals should include things that will be happening when the client is able to cope with HIV/AIDS better. In all, one of the primary goals of prescreening is to encourage potential clients to begin adopting a solution-focused lens by identifying specific goals as well as exceptions (LaFountain & Garner, 1996).

Session Outline

The following session outline represents an integration and expansion of the solution-focused group formats described by T. S. Nelson and Kelley (2001), Zimmerman et al. (1996, 1997), and Pichot and Dolan (2003). Each of the sessions follows basically the same outline, with the exception that the first session includes an introduction of group members, the sharing of one thing group members value about themselves, and a brief discussion of group rules and expectations. Sessions two through six begin by reviewing

and discussing the completion of the previous week's self assigned homework, member successes and progress made during the week, and how they were able to make progress happen (Zimmerman et al., 1996, 1997).

Opening question

Following the introductory material of each session, the opening question is asked. Opening questions are designed to continually enhance group cohesion while also helping to develop the primary theme for each session. They also are intended to be a gateway to the solution building that will occur during the remainder of each session. As such, it is recommended that they be asked without follow-up questions. Following are potential questions for each session (see Pichot & Dolan, 2003):

Session 1. If you could have one quality that you currently do not have, what would it be?
Session 2. What has been your most important accomplishment in your life?
Session 3. What is one thing of which you are proud that no one else knows about you?
Session 4. What is one thing that you have done between now and last time you were here that has helped you get closer to your goal?
Session 5. Who do you most admire and why?
Session 6. What has been better in the past week?

Establishment of the session theme

While the group members are discussing the opening question, the team behind the mirror listens for themes in the group members' responses. If a team is not present, the therapists listen and write down theme ideas. The theme is intended to be a concept, behavior, or thought that displays hope, goals, and/or aspirations of group members and represents a common thread among all of their answers. The possible group theme is then shared with the clients, who then are invited to address the identified theme, unless another emergency issue needs to be addressed. If one or more individuals do not feel that the theme fits, the therapists and clients discuss a way to adjust the theme to make it more inclusive and representative of everyone's experiences.

Future-oriented question related to each person's miracle

After establishing a representative group theme for the session, the therapists ask either the miracle question or another future-oriented question in order to encourage group members to reflect on how the session theme relates to their hopes, goals, and aspirations. Goals for each individual client

should be active, have a future focus, be in the client's language, and be within the client's control (LaFountain & Garner, 1996). Whereas follow-up questions are discouraged following the opening question, they are an integral part of gathering and developing as many details as possible about exceptions as they relate to the session's theme. The session format outlined in the following alternates the miracle question with another future-oriented question each week. It is important to note that although therapists may view it unnecessary to restate the miracle question every 2 weeks, it is crucial that they regularly ask clients how session themes will affect and contribute to their miracles:

Session 1. If you have more [theme] 1 year from now, how will that contribute to achieving your miracle?
Session 2. Ask the miracle question in the context of the theme (Berg & Reuss, 1998).
Session 3. It is 1 year from now, and [tie in theme]. What difference does that make?
Session 4. Ask the miracle question in the context of the theme (Berg & Reuss, 1998).
Session 5. It is 1 year from now and you now have [theme], what difference does that make for you and your loved ones?
Session 6. Ask the miracle question in the context of the theme (Berg & Reuss, 1998).

Scaling questions and assessment of progress

Another goal of each session is to assess the baseline or current level of behavior in relation to the goal (T. S. Nelson & Kelley, 2001). This can be done by employing a scaling question to assess the current level of performance, and specific follow-up questions can clarify precisely how clients view their current position (de Shazer, 1988). After each group member has responded, it is important to highlight and celebrate specific efforts clients have made to reach and maintain their current level of progress. Relationship-oriented questions that involve asking group members how others would rate them on the scale or what changes others have noticed may also be helpful. During this part of the group, therapists can continue to tie in the session theme to each person's goals, expectations, and exceptions.

Session break, compliments, and homework

All SFBT session should include a break (Berg, 1984; de Shazer, 1985). This break can be used to formulate compliments and conclusions and to consult with a team behind the mirror. Each SFBT session should end with the therapist, team members, and other group members giving genuine compliments

and encouragement to each individual (de Shazer, 1998). In addition, because "the most important work takes place outside of the group" (Pichot & Dolan, 2003, p. 48), a task or homework assignment should be given at the end of each session (de Shazer, 1985; T. S. Nelson & Kelley, 2001; Pichot & Dolan, 2003). For example, clients can assign themselves tasks for the upcoming week based upon their specific goals and session theme. Following are several questions designed to encourage solution-focused reflection and homework:

Question 1. What did you do between now and last time you came here to work on what is important to you?
Question 2. What will you need to do to reach your goal/miracle and to get what you want from coming to this group?
Question 3. What are you willing to do between now and next time you come to group to work toward achieving your goal/miracle?

LIMITATIONS AND CAUTIONS

There are some concerns that should be considered when conducting a group with persons diagnosed with HIV/AIDS. Confidentiality is a major concern, and every action necessary should be taken to ensure the confidentiality of group members, their HIV status, issues discussed during group, and other related issues. Group members should be encouraged to maintain confidentiality for the other individuals in the group. This population has already experienced much stigmatization and marginalization, and the group facilitators should work to ensure that no harm comes from group participation.

There is also potential that further grief and loss may result due to group participation. Becoming involved in the group includes getting to know other at-risk individuals. Watching peers in their newly found support group deal with the inevitable complications and symptoms of the illness may be challenging for group members. During the prescreening process this should be discussed with each potential participant and a personal care plan should be in place for each individual. In addition, group time may need to be used to discuss these developments; specifically, the possibility of people in the group dying and how the group would like to address the challenge if it arises.

Also, SFBT groups may not fit everyone. Although SFBT is effective and works for many people (Trepper & McCollum, 2006), group therapy within an SFBT context may not be the best treatment for each individual. Care should be given to aiding each individual find the treatment that will work best for him or her. If group participation is not helpful, SFBT asserts that a client should do something else (T. S. Nelson & Kelley, 2001). The group facilitator should aid clients in getting their needs met, even if that means referring them to another form of treatment.

IMPLICATIONS

Solution-focused brief group therapy (SFBGT) provides a unique and effective fit as a treatment option for working with individuals who have been diagnoses with HIV/AIDS globally. Given that HIV/AIDS is an international concern, specific and effective treatment options are needed that can assist individuals worldwide to cope with and counter the psychological, emotional, and social impacts of this disease. As mentioned, SFBT is such a treatment. Given that SFBT is strength-based and directed by the clients, clinicians can assist their clients to voice what is going to be most helpful despite the presence of HIV/AIDS. SFBGT provides attention on what will help each group member individually while receiving support from group members. Additionally, this client-directed treatment allows individuals to adapt treatment so that it is culturally congruent with their needs.

CONCLUSION

Although much work has been done in helping persons infected with HIV/AIDS, no scholarly work has addressed working with this population within the context of SFBT groups. Groups provided in this manner combine the support-building benefits of group therapy with the strengths-focus of SFBT. SFBT does not encourage individuals to ignore HIV/AIDS or pretend that the diagnosis does not exist for them. Rather, it promotes that clients access and utilize existing competencies, resources, and solutions they possess or have experienced in the past to cope more effectively with their illness and enhance their life satisfaction. In this manner, SFBT groups are a particularly valuable option for therapists wishing to empower clients dealing with debilitating struggles such as HIV/AIDS. This article has set forth the potential value of SFBT groups for individuals diagnosed with HIV/AIDS while also providing a sample group outline and framework. It is recommended that future empirical research seek to understand how clients' with HIV/AIDS view SFBT groups and also compare their effectiveness with other established group approaches for this population.

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