• **PROFESSIONAL FORUM**

Lazarus and Group Psychotherapy:
AIDS in the Era of Protease Inhibitors

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A new class of medications, protease inhibitors, has dramatically improved the health of many people with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). This development has had a major impact on the lives of those affected by HIV/AIDS. This article considers how a group is affected by the larger systems of which it is a part. The article examines changes in the content, process, and salient leadership tasks of an ongoing therapy group for people with HIV and AIDS before and following the initial introduction of new medical treatments. It also considers how the group process continues to be affected by the more recent failure of these medications for many patients. Implications for research, practice, and training are discussed.

Twenty years have passed since the reports of a sudden and mysterious illness afflicting five "previously healthy" young men from Los Angeles appeared in the medical literature (Centers for Disease Control and Prevention [CDC], 1981). These were among the first recorded fatalities due to the syndrome now known as AIDS. Since that time, AIDS has claimed the lives of more than 457,667 people in the United States and 21.8 million individuals worldwide (CDC, 2001; Kaiser Family Foundation, 2001). The epidemiology of AIDS, like the virus itself, has been a chronicle of constant mutation. AIDS was first perceived as a death sentence because no treatments seemed to work. As newer, more effective treatments became available, AIDS was depicted as a treatable, if not curable, illness. Still more recently, the limitations of even newer treatment regimens have been noted. In addition, in a way

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different from other chronic or terminal illnesses, AIDS has carried with it a social stigma (Tunnell, 1991). Many in society report ambivalent feelings toward those infected with HIV, feeling that they "brought it on themselves." Thus, the constantly changing nature of the illness itself, the evolving medical standards of care, and the psychological impact of the stigma attached to HIV infection all present important implications for the work lives, relationships, ongoing adjustment to medical management, and overall psychological health of those who are sero-positive. Finally, HIV/AIDS has been a disease associated with marginalized populations in the United States (see Kaiser Family Foundation, 2000, 2002a; CDC, 2002). Because of this, great emphasis has been placed on the need for a multicultural approach to treatment and prevention (e.g., McQuiston, Choi-Hevel, & Clawson, 2001; Murray-Johnson et al., 2001; Paniagua, 2000; Raj, Amaro, & Reed, 2001; Winiarski, 1997b).

Several particularly salient issues for those with HIV/AIDS relate to areas in which counseling psychologists are well versed. First, counseling psychology has a long tradition of addressing the psychological impact of work (and unemployment) in people's lives (e.g., Richardson, 1993). For many, a diagnosis of HIV will represent, at some point, a disruption in their work lives. Decisions about leaving or returning to work and understanding the meaning that such decisions have for one's life are among the central concerns of counseling psychology. Second, in recent years, counseling psychology has come to regard a multicultural perspective as central to its self-understanding. Counseling psychologists have been instrumental in articulating multicultural perspectives to mental health treatment and in designing culturally appropriate treatment strategies (e.g., Ponterotto, Casas, Suzuki, & Alexander, 2001; Sue et al., 1998; Sue & Sue, 1999). Both because of the social stigma attached to HIV/AIDS and because the virus has disproportionately affected marginalized populations (i.e., gay men first and more recently people of color, intravenous drug users, and women), a multicultural counseling approach seems imperative (CDC, 2002; Croteau, Nero, & Prosser, 1993; Hoffman, 1993; Kaiser Family Foundation, 2000, 2002a). Third, counseling psychology's traditional emphases on normal development, the psychological health and strengths of clients, alleviation of distress and maladjustment, crisis resolution, skill enhancement, and prevention (American Psychological Association, 1999) are particularly well suited to the unique stressors of those seeking to adjust to life-threatening illnesses or chronic medical conditions. Not infrequently, clients seen in a medical setting have a prior history of adaptive psychological functioning that has been thrown into disarray by their diagnosis and treatment. Hoffman (1991a, 1996) observed that just such a focus on adjustment and prevention is essential in work with people living with HIV/AIDS. The promotion of health and the facilitation of psychological adjustment to radically altered circumstances is central to what counseling psychologists do.

The counseling psychology literature over the past 20 years reflects efforts to respond to the AIDS epidemic. Adding to important work in related disciplines (e.g., Farber & McDaniel, 1999; Kalichman, 1998; Rabkin & Ferrando, 1997; Rabkin, Remien, & Wilson, 1994; Wicks, 1997; Winiarski, 1991, 1997c), counseling psychologists have sought to explicate the psychological impact of HIV/AIDS. While the counseling psychology literature on HIV/AIDS has been wide ranging, special emphasis has been given to several general (at times overlapping) domains. A primary focus has been the unique psychosocial issues posed by HIV/AIDS. This broad emphasis includes both comprehensive models (e.g., Allers & Katrin, 1988; Hoffman, 1991a, 1996) and specific psychological implications for clients, caregivers, and counselors (e.g., Dworkin & Pincu, 1993; Hayes, 1991; Hayes & Erkis, 2000; Holt, Houg, & Romano, 1999; Keeling, 1993; Springer & Lease, 2000; Vinney, Allwood, Stillson, & Walmsley, 1992). Based in part on these psychosocial factors, treatment interventions geared to people with HIV/AIDS have also been proposed (e.g., Hovell et al., 2001; Vaughan & Kinnier, 1996). Another theme in the counseling literature has been the importance of culture- or context-specific responses to people diagnosed with HIV/AIDS (e.g., Carballo-Dieguez, 1989; Cochran & Mays, 1992; Croteau et al., 1993; Hayes & Gelso, 1993; Hoffman, 1993; Newcomb et al., 1998; Organista & Organista, 1997; Spigner, 1993; Ybarra, 1991). Yet another area that has received considerable attention is HIV/AIDS education and training for students or practitioners (e.g., Britton, Cimini, & Rak, 1999; Britton, Rak, Cimini, & Sheperd, 1999; Hoffman, 1991b; Morran, Kurpius, Brack, & Brack, 1995; Ullery & Carney, 2000; Werth, 1993). A number of journal articles have underscored ethical and legal issues, particularly confidentiality and rational suicide (e.g., Cohen, 1997; Driscoll, 1992; Erickson, 1993; Friedman & Hughs, 1994; Harding, Gray, & Neal, 1993; Hughs & Friedman, 1994; Melton, 1991; Posey, 1988; Rogers & Britton, 1994). Finally, the impact of HIV/AIDS on work and career has also been discussed (e.g., Chung, 1995; Hoffman, 1997; Lightfoot & Healy, 2001).

Group therapy has been a mental health treatment modality of choice since the earliest days of the AIDS pandemic (Greene, McVinney, & Adams, 1993; Hoffman, 1991a, 1996). Yet to the authors' knowledge, only one article in the counseling psychology literature has focused on group treatment for people with HIV/AIDS. In that article, Stewart and Gregory (1996) noted the adoption and adaptation of the group modality for people with HIV/AIDS and gave particular attention to six content themes that emerged in an ongoing support group for people living with AIDS over the course of 5 years: marginality, making choices, coping with the emotional roller coaster, premature confrontation of life issues, living with a chronic illness versus dying with a terminal disease, and death and dying.

Groups for people diagnosed with HIV/AIDS are similar in some ways to any support or therapy group for people living with a chronic or terminal illness. Issues of deteriorating health; debilitation, helplessness in the face of advancing disease; confusion over diagnoses, treatments, and prognoses; mortality; death; grief; and bereavement are just as relevant in groups for people with cancer, for example, as they are in HIV/AIDS groups. Yet there are also important differences. Various authors have commented on the unique dynamics of groups for people living with HIV or AIDS and the particular challenges they present for those who lead them (D. Anderson & Shaw, 1994; Brazaitis & Gushue, in press; Field & Shore, 1992; Frost, 1993; Gabriel, 1993, 1994, 1996; Gambe & Getzel, 1989; Greene et al., 1993; Guthrie, 1997; Kelly, 1998; Rabkin et al., 1994; Sageman, 1989; Tunnell, 1991, 1994). Frequent topics in HIV/AIDS groups include the stigma and shame often attached to the diagnosis; thoughts and feelings related to how the virus was transmitted, including guilt over not practicing safe sex or using intravenous drugs; and, in some communities, coping with the loss of family or friends to AIDS in addition to facing one’s own diagnosis. By extension, leaders of these groups must be prepared not only to cope with the pain and frustration involved in watching one’s clients deteriorate and die but also to bear witness to their daily struggles against the social stigma and its resulting marginalization.

Like the individuals who compose them, groups are a part of larger systems. An AIDS therapy group, in particular, is embedded in a larger system of HIV/AIDS research, treatment, and society’s attitudes toward the virus and those infected with or affected by it. This article discusses the impact of one dramatic shift in the larger system of medical treatment on an AIDS therapy group co-led by the authors over the past 9 years. Six years ago, the introduction of a powerful class of medications known as protease inhibitors represented a sea change for the health of many people living with HIV and AIDS, the public perception of HIV/AIDS, and how people with the virus viewed themselves. Many people with AIDS began to thrive on these new medications, including those who had been told they had only a short time left to live. This phenomenon among people with AIDS has been referred to in the popular literature as the “Lazarus Syndrome” (France, 1998; see also Leland, 1996), in reference to the biblical figure whom Jesus Christ was said to have raised from the dead. For many people with HIV and AIDS, this radical change in health status has demanded a fundamental shift in their psychological perspective (e.g., Farber & McDaniel, 1999; Kalichman, Ostrow, & Ramachandran, 1998; Rabkin & Ferrando, 1997; Winiarski, 1997a). People who had been living with the expectation that they did not have much longer to live were confronted with the idea that they now might have an extended future. This dramatic news forced a reevaluation of the status quo in many areas of life, especially health, relationships, and career. However, these new treatments did not work for everyone. Moreover, medical researchers and clinicians have begun to chronicle the diminished effectiveness of the new treatments over time (e.g., Beale & Robinson, 2000; Miller, 2001; Rinaldo et al., 2000). Some of those for whom the newer treatments provided a new lease on life have discovered that the lease was short-term as, once again, they faced deteriorating health and the threat of death.

What follows is the case of one group affected by these dramatic changes. After offering a brief description of the group itself, the authors examine the impact on the group of significant changes in the larger systems in which it was embedded. Specifically, the authors explore how a marked shift in the standard of care in medical treatment influenced three dimensions of the group's functioning: (a) content—the themes discussed, (b) process—the group's dynamics, and (c) co-leading roles and tasks. Characteristics of these three dimensions before and after the introduction of protease inhibitors are noted. Finally, the authors comment on the next wave of change and the implications of these new developments for research, training, and practice in counseling psychology.

THE GROUP

For the past 9 years, the authors have co-led a weekly psychotherapy group for people with AIDS sponsored by a large urban HIV/AIDS service and advocacy organization. The authors are now both licensed counseling psychologists, although they began leading the group during graduate school. Almost all of the agency's groups, including this one, are led by volunteer clinicians in various disciplines including psychology, social work, psychiatric nursing, and psychiatry. The group has been in existence for roughly 11 years and had at least three leaders before the authors. All the members have been diagnosed with AIDS.

The leaders specifically identify their group as a psychotherapy group versus a support group and utilize a group-as-a-whole (Wells, 1990) or group-centered perspective (Ettin, 1992) as part of their psychotherapeutic framework (for a more detailed rationale regarding the use of this therapeutic stance in an AIDS group, see Brazaitis & Gushue, in press). The primary task of the group is to promote members' insight, encourage the integration of thoughts and feelings, facilitate positive behavioral changes, and enhance and broaden coping skills. The leaders see themselves as facilitators, intervening when the group is stuck or off-task. The leaders do not focus primarily on consulting on issues surrounding the virus per se but rather on the members' shared thoughts, feelings, and behaviors demonstrated in the group. As heterosexual (one male, one female), HIV-negative clinicians, the coleaders bring expertise in group dynamics and group psychotherapy to the task, while the members, gay men living with AIDS, bring their own expertise of their lived experiences of having the virus. This is not to say that the leaders do not have their own experiences of HIV and AIDS. Indeed, after nearly a decade of working with people and communities infected with and affected by HIV and AIDS, both in the group and in their paid positions, the coleaders have become knowledgeable about the symptoms, pathologies, treatments, and experimental trials as well as the legal, social, familial, and existential dilemmas related to HIV and AIDS. They have developed their own experiential base in the world of HIV/AIDS, one that is different from that of the group members yet from which they can intervene with genuineness and integrity. At times and to some degree, however, the leaders also represent the world outside HIV and AIDS, a world in which many members have experienced misunderstanding, ignorance, prejudice, and hostility. Just as any counselor must be attuned to his or her social identities and their effects on clients, the coleaders of this group have had to remain cognizant of the bidirectional impact of their heterosexuality and HIV-negative status in working with a population of HIV-positive gay men.

Over the years, group membership has fluctuated between 6 and 10 members. Currently, there are 9 members: gay men whose ages range from 32 to 57. Six are White, 2 are Black, and 1 is Asian American. Seven were born in the United States. Half the members are working, while the others are on disability. There is a range of health statuses: Some members appear asymptomatic and are able to keep up with numerous work and social obligations, while others are dealing with multiple diagnoses (e.g., HIV and Hepatitis C) and cannot walk unassisted. Three are in long-term, committed relationships. Most are college graduates; several are also in individual psychotherapy. Two have been in the group for more than 8 years, 3 for less than 6 months, and the others between 2 and 4 years. Three members of the group have died within the past year.

During the 9 years that the authors have been with this group, there have been about 40 members in total. During that time, members have left the group for many reasons including death, debilitating illness, moving away, dissatisfaction, and accomplishing the goals that originally brought them to the group. Approximately 8 have died while still attending group. More often, members (approximately 20) have terminated their relationship with the group when they became no longer physically able to travel to the agency. Of those making up this last cohort, the authors have no way of knowing who is alive and who is dead.

BEFORE PROTEASE INHIBITORS

Content

Common themes of traditional (pre-protease) AIDS psychotherapy groups are well documented (see Stewart & Gregory, 1996, for a depiction of a group similar to the one described here, written on the cusp of the introduction of protease inhibitors). Dealing with anger, loss, shame, and guilt and coping with physical decline and impending death are among the issues frequently cited in the literature (e.g., Stewart & Gregory, 1996; Tunnell, 1991, 1994). These topics also characterized many of the discussions of the authors' group during that time period. In general, the themes that were salient in treatment for our group were related to a person's place vis-à-vis the progression of the illness. For instance, those recently diagnosed might be coping with disbelief, anger at the person who infected them, or when and to whom to disclose the bad news. People at this stage of the illness frequently used the group to contain the powerful feelings that at times threatened to overwhelm them. Often, the group served as a place where newly diagnosed clients experiencing upheaval and chaos could feel grounded. For some, the group became perhaps the only place where they felt safe enough to talk about a diagnosis they had not yet disclosed to family or friends. Older members socialized newer members into the world of AIDS, deciphering a whole new language (e.g., references to syndromes and medications and their side effects), helping them advocate for themselves with physicians, or assisting them in exploring their feelings about participating in a particular clinical trial.

Members whose illness had progressed, on the other hand, tended to present different themes such as dealing with the impact of a decline in physical functioning or fears that the next hospitalization would be the last. For instance, longer term members used the group to explore the emotional upheaval from a decision to stop working and go on disability. These members often sought ways of coping with a gradual or sudden loss of control—the helplessness experienced during repeated hospitalizations, the horror of developing a new AIDS-related symptom, or the relentless cycle of elation and betrayal following the failure of some new medication. Some members used the group to talk about final plans. For some, this meant talking about preparations for funerals or hopes for a reconciliation with estranged friends or family members. For others, it meant accepting the fact that such reconciliations were unlikely. For both newer and older members, these sessions addressed AIDS-related crises in the members' lives. The group's content frequently had a sense of urgency. Group counseling served to facilitate both older and newer members' efforts to tolerate a radical uncertainty about the future as well as their attempts to integrate feelings of hope and despair (Gushue, 1997; Rabkin et al., 1994; Winiarski, 1991).

Process

During a time when the only ultimate certainty seemed to be the inevitability of death, the process of the group was marked by cohesion (e.g., Stewart & Gregory, 1996). Group members experienced themselves as bound inextricably by their status as people sharing a common struggle to live in the face of death. Although many other groups were distinguished by social identities or mode of transmission (e.g., gay men, straight women, substance abusers), the major differences within groups were often related to one's place in the course of the illness (e.g., first opportunistic infection vs. end stage). However, members of our group understood these differences as points along a continuum that connected them. The only factor separating those newly diagnosed from those frequently hospitalized was time. Members clung to each other and were reluctant to let anyone leave the group except "feet first." Indeed, during this time, the group argued vehemently against anyone's leaving, even if his reasons were sound or if he was highly irritating, defensive, or ill matched. In a group where people had experienced so much loss, both within and outside the group, the members seemed unable to bear "losing" anyone else, no matter what the reasons or circumstances.

Coleading Roles/Tasks

Early in their work, the therapists found themselves in a role best described, perhaps, as one of "bearing witness" to the multiple losses, repeated trauma, despondency, fear, helplessness, rage, courage, tenderness, humor, magnanimity of spirit, and fierce determination to fight to the end that characterized an era when an AIDS diagnosis was linked to death with such immediacy. At this time, one of the principal roles of the group leaders was to ask about, listen to, and often just tolerate thoughts and feelings that were intolerable to the group members' loved ones, family, and friends. For instance, many group members appreciated the therapists' inquiries about how a recent death might be influencing the group's conversation on a particular evening. Others were relieved by the group leaders' readiness to listen to fears about physical deterioration without offering reassurances. The leaders frequently served as containers for fear and despair, allowing group members to express these feelings with less internally imposed restraint.

Although the leaders encouraged the work of uncovering and promoting insight, the group's tenor was often very supportive, largely, it seemed, due to the tremendous commonalities in the members' experiences. The therapeutic focus was frequently on the intrapersonal versus the interpersonal dimension. The coleaders' primary task during this period was to facilitate members' ability to live with uncertainty and to support their efforts to integrate feelings of hope and despair (Gushue, 1997).

THE PROTEASE ERA

Content

Dramatic changes occurred following the Food and Drug Administration (FDA) approval of protease inhibitors in 1996. These medications represented an integral part of a new biochemical approach to combating the virus (i.e., highly active antiretroviral therapy [HAART]) and proved far more effective at halting its progression than any medicine available during the first 15 years of the epidemic. Many group members enjoyed improving health. One member who had formerly joked about giving names to each of the six remaining helper T-cells supporting his immune system decided to sell his life insurance policy for cash. It was noted in the group that while the viatical company that bought the policy was betting the man would die soon, he was betting he would live. This was a critical moment in the group, as it was the first time any member planned on living. Members began to talk about the future. New themes emerged; old themes were discussed in new ways.

Although certain core issues remained the same, the changes in health care affected the ways some of these themes were discussed. For instance, although many of the newly diagnosed members still expressed feelings of anger, shame, and guilt, they now did so in a context of increased medical optimism. As one member of the group noted ironically, "There has never been a better time to be diagnosed HIV+." Talking about one's physical decline took on new poignancy in a group where the health of many was actually improving. Members continued to grapple with uncertainty. For some, this uncertainty focused, as before, on issues such as, "Will I be able to get out of bed today?" or "Will I live to my next birthday?" For others, uncertainty now included attempts to make choices about a dizzying array of new treatment options and protocols. As before, the leaders continued to support members' attempts to integrate optimism and pessimism, feelings of hope and despair. However, now the optimism seemed better founded, and the despair following the failure to tolerate the side effects of a "miracle drug" was all the more wrenching. Moreover, now that there were more options, the cycles of hope and despair seemed to accelerate as members moved from one combination treatment to another. For the group described in this article, four content areas either changed or gained prominence in response to the advances in treatment: health, work, relationships, and living in a climate of diminishing support.

First, although discussions of health-related concerns had always been part of the content of the group's meetings, new issues around health came to the fore at this time. Although the new medications gave many a new lease on life, they often did so at a terrible cost (see Dilley, 1998; Kalichman, 1998; Kelly & Kalichman, 2002; Rabkin & Ferrando, 1997). For some, constant nausea or unremitting diarrhea was the price to be paid for stopping the virus. One member wondered aloud whether he would ever be able to leave his house again without an extra pair of underwear in case he soiled himself. Other side effects were potentially more serious. Some medications caused neuropathy, a painful nerve disorder. Other medications were reported to cause permanent liver damage in some patients. Members used the group to talk about increasingly difficult decisions regarding the compromises between quantity and quality of life. Related to this, the group now served as a place where members could talk about the dissonance between their subjective experience of health and the objective reports gleaned from their blood work. A rise in a patient's CD4 cells (a white blood cell responsible for coordinating much of the body's immune response and a good predictor of immune health) and a lowering of his or her viral load (the amount of virus in the body) to undetectable levels were understandable causes for jubilation for infectious disease physicians, many of whom had spent years feeling as though they were little more than gatekeepers to the hospital's morgue. Yet many of these same patients felt sicker than they ever had despite the "good numbers." Group became a place where members' subjective experiences of being ill could be explored and validated in spite of the medical data to the contrary.

Another health-related theme that surfaced was the disparity between members who responded to the newer treatments and those who did not. Although many members' health improved dramatically, this was not the case for all. For some members, adherence to the newer regimens brought little or no improvement (see Kalichman, 1998; Kalichman et al., 1998; Kelly & Kalichman, 2002). A new task for the coleaders became how to help these members talk about feelings of frustration, anger, and shame at not responding to treatments many regarded as medical breakthroughs (e.g., Rabkin & Ferrando, 1997). Indeed, the common medical jargon of "failing a medication" reinforced such guilt. Some members felt that they must be in some way culpable if the medications did not work for them. Some wondered aloud what they had done to deserve it. Healthier members said they felt guilty about feeling better in the presence of those who were not. This pronounced and distressing differentiation between responders and nonresponders had important consequences for the group's process.

A second major area that became more salient in the group's discussions was work (see Hoffman, 1997, for an extensive overview; Rabkin & Ferrando, 1997). A number of members on long-term disability found that their health had improved to the point that they could consider returning to work. Some of these members commented that before they had become ill, work had defined their identities and provided a foundation for their sense of self-worth. For them, the thought of returning to work represented a return to normalcy: getting on with their lives and possibly leaving the nightmare of HIV/AIDS behind. However, for some, it soon became apparent that feeling better than one had in years was not the same as being able to work an 8-hour day, much less take on extra projects or compete for promotions. What had begun as the dream of resuming a career became the challenge of finding a job one could tolerate. Some members found themselves locked into jobs they no longer enjoyed because the company's insurance plan was one their doctor accepted or that paid for their medications. Others discovered that after a 5- or 10-year hiatus, their careers had simply passed them by. One who put plans for law school on hold when he was first diagnosed HIV+ felt unable to begin or commit to such a long-term project a decade later. Another member was not able to concentrate sufficiently to resume writing his doctoral dissertation. Thus, the advent of the combination therapies represented a paradox in the career lives of a number of members. On one hand, as their health improved, they began to feel bored and restless. The sedentary life of an "ill person" was no longer a good match for their renewed physical capacities or their self-perceptions. However, for many, the type of work that had once been the source of satisfaction, the object of aspiration, or the foundation for feelings of self-worth no longer seemed plausible. In group meetings, members talked about how these changes affected their understanding of themselves; they struggled to let go of cherished dreams and to begin to imagine their vocational identities in new ways.

A third content area affected by the introduction of protease inhibitors was members' relationships with significant people in their lives (Farber & McDaniel, 1999; Winiarski 1997a). For some, this meant contemplating the costs and the benefits of reconnecting with previously estranged family and friends. Illness and the effects of illness had caused some members of the group to withdraw from or to sharply reduce their circle of friends, sometimes gracefully, other times less so. Now that they had the energy to return phone calls, they faced the anger or, perhaps, indifference of old friends they had pushed away or dropped. This was also true of relationships with family members, especially where relationships had been somewhat conflicted. When facing death, a group member may have felt he did not have the energy to engage with relatives whose support had been ambivalent at best. However, now that it appeared that life might extend considerably into the future, the same member was reluctant to accept a permanent disengagement from people with whom he had significant shared history.

Similar dynamics also occurred in members' primary relationships. Sometimes important rifts in relationships were put on hold due to the ill member's health crisis. Frequently, the healthy partner would be reluctant to confront the ill partner, much less abandon him as he was dying. The thinking went along the lines of "I no longer love him, but I'll take care of him until he dies, then I'll move on with my life." Often these doubts were not stated explicitly because the ill partner was thought to be suffering enough. Other couples entered into a tacit agreement that the healthy member could seek sexual satisfaction outside the relationship. These states of affairs changed dramatically once the ill partner regained his health. Dissatisfied partners realized that death was not going to provide a convenient solution to a troubled relationship about which they had never spoken. Conversely, some ill members had also come to realize that they no longer wished to remain in their relationships. However, in cases where the feeling was not shared, how was it possible to tell someone who had cared for you, cooked for you, taken you to the doctor, and emptied your bedpan that you no longer wanted to be with him? Was it better to say nothing and pretend?

Even for couples for whom the return to health of one partner did not presage the dissolution of the relationship, there were major adjustments to be made. Not infrequently during the long illness, the partners had assumed and settled into roles of patient and caretaker. As the ill partner grew stronger, the caretaker found that some of his decisions were now challenged and that some of the care he was used to providing was no longer wanted. Partners who were now feeling better struggled to recover a sense of independence and autonomy. Fundamental issues in any relationship, such as "Who's in charge?" and "How is love expressed?" needed to be renegotiated. Members used the group as a place to discuss and get feedback about the unexpected havoc that their improved health seemed to be wreaking in their relationships.

One other effect of the introduction of combination therapies was a vastly changed social context regarding AIDS. This shift caused a fourth content area to gain salience in the group: members' experiences of diminished support. The fact that the newer treatments were far more effective than previous regimens in slowing the progression of the illness and even, in many cases, lowering the number of copies of the virus in the bloodstream to undetectable levels, led some to begin speaking of AIDS as a chronic (vs. terminal), treatable illness (see Leland, 1996; Sullivan, 1996). The good news about treatments seemed to lead to a popular perception that the AIDS epidemic was over or nearly over. One way that this perception was reflected on a social level—combined with the fact that the epidemic was becoming increasingly identified with the poor, women, and people of color and less with middle-class White men—was markedly decreased financial support (both public and private) for AIDS service organizations, which were then forced to compete more aggressively with each other for limited funds (e.g., K. Anderson, 2000; Leland, 1996; Murphy, 1999; Shatzkin, 2000). AIDS agencies, taskforces, and research programs had to eliminate some activities and severely curtail others. The agency that sponsored the group discussed in this article saw its group services program shrink from approximately 50 groups and four staff members to 20 groups and one staff member. On an individual level, this shift in social climate was mirrored in some members' experience that family and friends were now less likely to inquire about their health. One member reported that now that death was not imminent, friends had little patience for his complaints about side effects of medications. Instead, they would chastise him, "Hey, it's better than the alternative" (i.e., being dead). He said his friends were as good as telling him, "AIDS is over, you're doing better, quit whining!" Ironically, one result of improved health and better treatment options was increased isolation. For many members, group therapy became more important than ever as a unique place where feelings about ill health or debilitating effects of toxic medications could be validated. Oddly, for many, the price of doing better physically was feeling increasingly alone.

Process

As has been noted, the introduction of protease inhibitors represented a momentous shift in the social context of the group. The impact of that change had consequences not only for the content of the group's discussions but for its process as well. Three such changes in the group's dynamics were the increased salience of individual differences, renegotiation of members' commitment to the group, and the stigmatization of illness and wellness within the group. Following the initial improvements many members felt in response to combination therapies, individual differences became the figure focused on against the ground of AIDS. During the years when it seemed that death was waiting just outside the door of the meeting room, individual differences faded to the background against the overwhelming, shared, and immediate crisis the illness represented. However, as members' health began to improve, the sense of combat solidarity that had bonded together very different personalities was diminished. The result was diminished cohesion and increased conflict. Long-suppressed differences in personality now came to the fore. For example, group members who were more self-reflective and contemplative increasingly became frustrated with those who were more concrete or action oriented and vice versa. Members whose socioeconomic status was working class and who were struggling to make ends meet could not understand or empathize with those members who were middle class and who complained of being unfulfilled in their (high-paying) jobs. A White member of the group expressed his fear that he would be excluded from the friendly and supportive alliance formed in the subgroup of Black members. A Black member revealed that he felt the group oversexualized him based on racial stereotypes and this made him angry and uncomfortable. Another Black member decried some of the White members' easier access to good doctors and expensive medications, a fact he tied to White privilege. Another White member acknowledged his fear and dislike of "the changing face of AIDS," which he characterized as increasingly poor, Black, Latino\, or heterosexual substance abusers and decreasingly White, middle class, and gay.

During this period, differences in beliefs about sexual mores proved provocative for the first time. Group members fought bitterly about what constituted safer sex; whether to disclose one's HIV status to colleagues, parents, and/or sexual partners; and the pros and cons of anonymous sex, multiple partners, and monogamy. Group sessions were increasingly tension-filled as members tried to negotiate these differences. What had been, when everyone was dying, an overwhelmingly supportive and accepting group was a conflicted one now that people were living. Group members began to ask questions such as, "Who are these guys?" and "Would I be friends with these people if I met them outside of group?" The commonality of AIDS was no longer enough for group cohesion. Nor was the shared identity status of being gay enough to make members feel securely connected to one another.

The leaders intervened to understand, contain, and interpret these conflicts. They took the position that what was now occurring created the possibility of a different kind of intimacy, not necessarily forged only in the face of a common affliction. Rather, members were faced with the mundane yet important task of seeing in each other an identity beyond that of their shared HIV/AIDS status. The challenge for the group now was to abandon the easy intimacy afforded by a common dilemma and begin the more difficult task of acknowledging, tolerating, and accepting sometimes painful differences of personality, race, culture, class, and gay identity.

Another way the effects of combination therapies caused a change in the group's process was by sparking a reexamination of members' commitment to the group, a reexamination of their understanding of the group's primary task, and a renegotiation of the group's boundaries. This dramatic external shift in the group's context forced many members to revisit an earlier stage of their relationship to the group. Issues that members had raised and answered during the joining phase once again became salient. As death seemed less imminent and members experienced greater health and capacity to resume a variety of work or leisure activities, a number of members began to question whether the group was still what they needed. Now that coping with life took precedence over preparing for death, did members need an AIDS therapy group? Some members found themselves almost able to forget the disease. Did they want the weekly reminder that they were still infected with a virus that at some point could kill them?

The group also found that it needed to renegotiate its boundaries as members reengaged with life. Illness had always been seen as a legitimate reason to miss group. Now the members had to reexamine what they expected from each other. For most, it seemed clear that the occasional need to miss group because one was working late constituted a valid excuse. How about an opportunity for free opera tickets? Improved health provided some members with greater freedom to travel. Vacations became extended or more frequent. Could someone be away for months at a time and still come to group when he was in town? When most members were on disability, there were few conflicts with attendance. Now both the leaders and the group realized that the boundaries needed to become more flexible. However, at what point would they become so permeable as to threaten the group's sense of identity? Leaders and members struggled to maintain group boundaries that would acknowledge and even facilitate members' legitimate work and social needs and at the same time support the task of members' ongoing engagement with each other in a consistent and coherent way.

Another shift in the group's process following the introduction of the newer medications was evidenced in the emerging differentiation of members by health status and, relatedly, the stigmatization of extremes of illness and wellness within the group. As was noted above, the impact of response versus nonresponse to the combination therapies became part of the content of group discussions. In addition, these important differences also produced new alliances within the group as members identified with each other less on the basis of infection with the AIDS virus and more in terms of efficacy of response to medication. This change was subtle. There was no overt hostility between those for whom the medications were having their intended effect and those for whom they were not. Rather, the shift was manifest in who participated in which discussions and, perhaps more important, in who felt silenced. At differing times, members from one subgroup or the other would complain, usually at the end of a session, that they had felt "unable" to speak about something they had wanted to. For instance, members who were ill would allude to some urgent concern about their health status but say that they "did not want to bring the group down." Similarly, members whose health was good and who were returning to work would state that they felt their issues were unimportant compared to someone else's health crisis. These particular divisions and implicit rules about who could speak and when represented a new development in the group's process.

Coleading Roles/Tasks

In contrast to the pre-protease group leadership role, which could be described as “standing still,” the post-protease role emphasized activity. For instance, the coleaders found themselves working to help the group renegotiate its boundaries and intervening actively to help the group recognize and understand the processes of scapegoating and splitting. As the seemingly ever more differentiated members worked together in group, a more active facilitating style was required to help integrate members who represented very different aspects of the group’s life. If before the intrapersonal dimension had seemed salient as a focus of therapeutic attention, now, as members collided on a weekly basis, the interpersonal and group-centered dimensions gained prominence. The leaders worked to help members make sense of confrontations, both by exploring their possible meaning for the group as a whole and by helping individual members gain insight into recurring patterns of interpersonal behavior. If the pre-protease group members had seemed fused in a common identity, the now gaping differences between members created the possibility of both hatred and deeper intimacy. The coleaders needed to be active in helping members balance honesty and respect in feedback as they attempted to forge a new kind of relationship. While previously the coleaders served to contain the group’s despair, they now more often worked to contain the group’s anger. By making the group safe for conflict, the leaders provided the possibility of a new and differentiated kind of affiliation. If before the group’s supportive character had predominated, now the therapeutic dimension had come to the fore.

Parallel Process and Countertransference

To be sure, the momentous changes in the context of AIDS occasioned by the combination therapies profoundly affected the group’s members as well as the entire system in which the group was conducted. As the popular press flirted with the idea that AIDS might be one more chronic illness among many, there was a dramatic decrease in public interest and concern with the crisis (e.g., K. Anderson, 2000; Leland, 1996; Murphy, 1999; Shatzkin, 2000). This translated in turn to a precipitous reduction in donations to the agency that sponsored the group. As the agency struggled, each new round of budget cuts included some discussion of whether the group services program itself might be eliminated. Thus, the leaders felt increasingly isolated and irrelevant in a world that had seemingly moved “beyond AIDS,” an experience that paralleled that of the group members.

Like many others, the leaders were not immune to denial about the limitations of the new medications. After years spent watching members die, the leaders now watched in amazement and relief as the members began to get better. That the combination therapies were not a cure was clear to them—at least in theory—and they were always careful to qualify statements about the success of the treatments. However, the thought that "the old days" of utter helplessness, constant deterioration, and death might return was sometimes too much to bear. After a period of relative health in the group, it seemed the leaders were unconsciously willing to collude with the prevailing popular beliefs about the efficacy of the medications. This fantasy was shattered when the first group member was hospitalized after a period of approximately 2 years of relative health. The leaders found themselves totally unprepared for the news and responded with shock, disbelief, and depression. How could this be? Like the members, the leaders had to struggle to maintain a realistic assessment of the newer medications. More important, they needed to work to acknowledge and integrate their own disparate feelings: hope regarding the apparent clinical benefits of the combination therapies and terror related to their potential limitations. In some ways, it had been simpler to lead a group where death was the expected outcome. However bleak and painful, the future was known and the task was clear. Now, along with members, the leaders had to live with uncertainty. They too had to allow themselves to experience the alluring hope that some members might outlive the epidemic as well as the foreboding possibility that others would not. It was impossible to predict which feelings would be easier to acknowledge and which more difficult from one week to the next.

BEYOND PROTEASE: IS LAZARUS DYING?

As these words are written, members of the group are beginning to die again. After several years in which no deaths occurred, three members have died within the past 9 months. Two others have become progressively more ill. For some, the virus is becoming resistant to the newer medications (Beale & Robinson, 2000; Miller, 2001; Rinaldo et al., 2000). For others, death is related to toxic secondary effects from the treatments (Herman & Easterbrook, 2001; Reisler, 2001; White, 2001). Clearly, at this juncture, the medical context in which our group is embedded is changing once again.

How the group's content and process and the coleading tasks will change again remains to be seen. To be sure, aspects of present group discussions resemble those of the pre-protease era. While these issues were never absent from the group, they have again assumed prominence. For instance, illness and medication have come back to the fore. Again, it is not unusual to see some members hobble into group with effort. Illness, rather than theater tickets, has returned as a primary reason offered for missed sessions. There are more hollow faces in a room where the membership has not changed. Conversations that include feelings of helplessness and fear of death again are the norm.

Yet what this group is experiencing is not simply a return to a prior moment in its life. There are important differences. Although some members have died, others are thriving. Still others, however, seem consigned to a netherworld somewhere in between. They are not well enough to work yet not sick enough to be hospitalized. Their deaths do not seem immediate or inevitable, yet they report debilitating weakness, fatigue, and chronic pain. It seems that they could linger like this indefinitely. Many of the symptoms are related to their medical regimens. The present group is one that has lived through one more cycle of hype and crash, hope and disillusionment, surrounding a new class of medications. Yet unlike previous generations of HIV/AIDS medications, protease inhibitors continue to help many lead vibrant lives. Many others just survive. This has engendered a wary brand of optimism in the group. The potential promise of new medications is ever present. Other medications are helping members manage side effects that would have been unbearable a decade ago. The newer medications are undeniably better than those that went before, but there is still no cure. How many times can one gear up for the next great medical hope? How does one manage repeated disappointment? These are some of the issues the group is grappling with at present—in the era beyond protease. Members and coleaders alike must tolerate a great deal of uncertainty and again combine tempered optimism with realistic trepidation.

Perhaps these most recent changes have contributed to a group process that feels more cohesive but not uniform. Clearly, the members both are and are not in similar circumstances. Some are physically not well enough to come to meetings; others are leading active lives. All face the specter of an illness that has not gone away. The group remains quite differentiated around health status and appears to have grown more tolerant of members' differences. Members push each other to work in group and yet generally are kind in helping one another uncover painful insights or in giving constructive criticism. During many sessions the group is quite emotionally intimate—supportive, challenging, revealing, and painful all at the same time. Again, the intimacy is hard won and based not solely on the commonality of being gay men with AIDS but also on truly getting to know each other over time. For some group members, the new medications have provided a precious resource—time—that has enabled them to grow close to one another.

Having time to get to know the members has been a gift to the coleaders as well. Over the years, they have seen members grow in their ability to be insightful about themselves and each other. They have observed positive behavior changes and watched as members have "graduated" from group and moved on with their lives in beneficial ways. They have witnessed members' increasing ability to engage in and enjoy relationships inside the group and have heard of their gains outside. They have sometimes had the luxury of hearing members' accounts of passing through life's "normal" stages such as successes at work, death of parents, commitment ceremonies, and so on. Before protease, the coleaders worked to help members improve their lives and were grateful for whatever time they had in which to offer such help. Often it was brief, and one's experience of a group member was intense, meaningful but usually short-term and, of course, limited. Since protease inhibitors, the leaders find themselves doing long-term psychotherapy with a group of people who by and large do not take long-term anything for granted.

Yet for members and leaders alike, developing long-term, emotionally intimate relationships with people over time presents the risk of suffering when the same people become ill, become debilitated, or die. As a group leader, it is different to bury a member one has known for 6 months than a member with whom one has worked for 7 years. As coleaders, it is easy to empathize with members' resistance to growing closer to each other out of fear of being abandoned; the authors know something about this firsthand from their own resistance to coming to care for members only to watch them die. Support in these tasks and the feelings associated with them was vital to being able to continue with the group. The coleading relationship has provided invaluable emotional and intellectual sustenance over the past 9 years; it is hard to imagine being able to tolerate such emotional intensity as solo therapists over that period of time. A monthly supervision group has also been sustaining, as it has offered connection, insight, and support from others who have been doing this work for equally long periods (and in some cases, much longer). At this point, it is impossible to say if this account truly shows a trend due to a change in the efficacy of the medications. This past year feels like a new development in the group's life. But of course, the case described here reports only one group's experience. Considerably more data would be needed to determine if this shift is representative of a more global change in the profile of the epidemic.

IMPLICATIONS FOR COUNSELING PSYCHOLOGY

A number of the salient themes in the case just described emerge from areas well known to counseling psychologists. Specifically, the narrative has reflected a group counseling approach to issues related to work and unemployment; diversity and marginalization; and the adaptation, development, and growth of psychologically healthy people. In this section, we present several implications for research, training, and practice in counseling psychology.

In terms of research, group counseling has been cited as an efficacious treatment modality for people with AIDS. However, while there is some discussion in the literature about the preferred modality of group treatment (e.g., support groups versus therapy groups), there is a dearth of empirical data to support either side. In addition, the impact of group makeup for people with AIDS has not been examined. What is the influence of varying levels of heterogeneity or homogeneity on the effectiveness of groups for people with HIV/AIDS? Not infrequently, groups are organized by some membership commonality (newly diagnosed, women with HIV, individuals returning to work, longtime survivors, etc.). The group described here is homogeneous in terms of gender and sexual orientation, yet it includes members with vastly divergent health statuses; diverse racial, ethnic, religious, and social class backgrounds; and varied employment statuses. Some of our group members who are relatively healthy have noted that coming to group at times makes them "feel sick," yet these same members also say they appreciate having a forum to talk with others who have AIDS. Are AIDS groups an appropriate intervention for those who have few or no physical symptoms? Significant conflict has erupted at times in the group's history related to racial, cultural, and class differences. Would a more homogeneous group provide a safer environment, and would that be more therapeutic? Our experience is that while these differences have been challenging, ultimately they have been beneficial for the group. Is this the case empirically? Is heterogeneity of membership beneficial in some cases and not in others?

We noted above that having AIDS substantially impacts a person's career path and vocational identity. The psychological impact of employment, unemployment, underemployment, and the need to create a life when creating a career becomes impossible have all been frequent topics in our group. The shared experience of coping with these issues seems to be critical, which suggests that group treatment may be a useful intervention for helping people with AIDS address issues of vocational identity. Testing this hypothesis is a potentially fruitful area of research in counseling psychology. Moreover, the experience of our group may illustrate a different type of career pattern, one with multiple interruptions. Looking at the impact of repeated cycles of seeking disability and returning to work on variables such as career self-efficacy, outcome expectations, interests, and goals (see Lent, Brown, & Hackett, 1996) may be an important area of investigation. What changes in our thinking are needed to consider disability less as a trait that influences personality, learning experiences, and initial development of vocational identity and more as a state that exerts a variable influence on an identity that has already been formed? Research including the construct of "career realism" (i.e., the lowering of career aspirations; see Betz, 1994; O'Brien, Friedman, Tipton, & Linn, 2000), which has been studied in women's career development, may help to explicate the impact of HIV/AIDS on career decision making. In addition, are there variables that moderate the impact of changing health status on one's career development (e.g., perceived social support, optimism, particular coping mechanisms)? What factors may ease the psychological distress that often accompanies the involuntary lessening of the salience of the worker role? Also, what beliefs or attitudes might contribute to more or less self-efficacy in seeking disability accommodations in the workplace?

Finally, what is the psychological impact of other contextual factors on groups for people with HIV/AIDS? People living with HIV/AIDS must deal with the social stigma attached to their illness. How does this combine with other forms of social oppression or privilege that individuals experience in their lives, and what are the consequences for a group's dynamics? For instance, how do members' and leaders' levels of racial identity (Helms, 1995) or colorblindness (Neville, Lilly, Duran, Lee, & Brown, 2000) influence their interactions in groups? How do dimensions of gay or lesbian identity (McCarn & Fassinger, 1996) affect the dynamics? What is the psychological impact of the interaction of these social identities, and how might it affect members' abilities to sustain hope and treatment adherence over time?

The implications for training in counseling psychology relate to three mainstays in the field of counseling psychology—multiculturalism, adjustment, and work. In the United States, the rates of new HIV infections are highest among women and people of color (CDC, 2002; Kaiser Family Foundation 2000, 2002a). Therefore, future counseling psychologists will need to be conversant in the psychological aspects of HIV/AIDS if they hope to practice outside of society's centers of privilege. Training in how to help people cope with the psychosocial aspects of a chronic or terminal disease as well as how to improve their ongoing adjustment to disease management would be useful additions to counseling psychology curricula. Helping those with HIV/AIDS requires particular knowledge and skills on the part of the psychologist, particularly in the post-protease era. People with AIDS are often stigmatized, isolated, and marginalized; the fact that the virus is contagious often exacerbates the stigmatization and isolation. The medical advances in treating AIDS and the resulting changes in health status of AIDS patients have been precipitous and dramatic. Group treatment affords a buffer to the isolation and a community with which to share this chaos. As people with AIDS continue to have divergent experiences in living with the virus (versus the commonality of the death sentence that an AIDS diagnosis once provided), other differences such as social identities will likely continue to play a dominant role in AIDS therapy groups. Thus, the importance of training for multicultural competence in group counseling seems critical. Groups are living laboratories and, as such, issues of racial/cultural scapegoating, racism, and privilege emerge in the here and now of group processs. Training future counseling psychologists to provide multiculturally competent group treatment would contribute significantly to the field.

An AIDS diagnosis has far-reaching implications for a client's vocational identity. Counselors need to be trained with models of career development that can account for the multiple interruptions and career fluctuations occasioned by repeated cycles of illness and relative wellness. Much of the current training in career counseling emphasizes fostering exploration and making good initial and ongoing decisions about work. In short, the focus is often on those starting a career or considering changes in one that has been chosen. This case study suggests that greater attention may need to be given to decisions about suspending or ending work. Counselors need to be familiar with both the legal and psychological issues surrounding a decision to seek long-term or short-term disability. Clients with HIV/AIDS may need help in deciding when "enough is enough" and in coping with the enormous psychological and social fallout of such a decision. Future counselors could benefit from training that helps them anticipate seeing clients who need to redefine themselves once they are no longer working. Counselors need to be prepared to assist clients to discern just how much they can do, and want to do, as their health status changes for better or for worse. In short, counselors could benefit from training in issues related both to disengagement from and reengagement with the world of work. In addition, counselors should be conversant with the laws regarding disability and workplace accommodation (Hoffman, 1997).

This case study also suggests implications for practice. Our experience strongly suggests the need for a systemic approach to working with people with AIDS in group counseling. AIDS is more than just a medical illness; it is a medical illness that also has social and political meaning (see Sontag, 1990; Sullivan, 1996). Counselors must be aware of the larger social context of the group, not simply to keep up to date on the latest medical advances or problems but, more important, to be attuned to the possibility of important shifts in a group's psychological life. For example, particular members may serve to carry the group's hopes or fears about outside events related to AIDS. Dynamics between members may reflect more global concerns regarding the virus.

In general, counselors working in AIDS groups must be able to tolerate extreme uncertainty and constant flux. One task is to help clients cope with ongoing changes and disruptions in their lives. Clients engaged in multiple cycles of medical trials never finish adjusting. As a result, one goal is to help clients find the psychological strength to sustain successive periods of feeling well and feeling poorly, feeling the desire to engage in work and relationships and feeling the need to withdraw. The process is one of ongoing adjustment. In an AIDS group, this is true for the leaders as well. In light of the changes in the lives of the group members and the shifting dynamics of the group, we often needed to unlearn what we thought was true and reconsider and renegotiate the way we led the group. As our group moved through these phases, we often felt bewildered and sometimes incompetent. It appears this will continue, as the recent announcement of another new class of medications—integrase or fusion inhibitors—currently in advanced clinical trials, may signal yet another cycle of reprieve for some and disappointment for others (Altman, 2002; Kaiser Family Foundation, 2002b).

While any therapist might struggle with tolerating ambiguity in a particular client or group, the uncertainty of working with AIDS patients seems to be unique. We often felt we were leading a group with no roadmap and no recognizable landmarks (a feeling shared by other leaders in our supervision group). Tolerating the suspicion that we had no idea what we were doing was (and continues to be) a challenge. What we know about AIDS and how we treat those infected with the HIV virus has grown and changed exponentially over the past 20 years. The effects of those changes on our AIDS group have been astonishing. It seems clear that even the most experienced counselors working in AIDS groups will need to be prepared to learn as they go and, we believe, will need support throughout the process.

One last implication underscores the traditional roles of a counseling psychologist in fostering optimal psychological development, focusing on a client's strengths, and promoting growth. It is certainly true that some people with HIV/AIDS are in need of psychotherapeutic remediation of long-standing psychological pathology while others need intensive psychological support, specifically around aspects of the illness. However, although people living with HIV/AIDS are medically ill, many are psychologically quite healthy and can benefit from a group that has psychotherapy rather than support as its primary (though not exclusive) task. It is commonplace to say that people with AIDS are more than their medical diagnoses. Many seek to continue to foster their own psychological growth and development. Some approaches to mental health treatment are designed to alleviate psychological distress and promote comfort until the client's death. This may be appropriate in the final stages of an illness or when specifically requested by a client. However, one member of our group reported he felt tremendously helped by the intervention, "I don't care if you're dying, you still have to come to group." He said it made him feel accountable, taken seriously, and not like someone already written off. The implication is that many people living with HIV/AIDS are psychologically vibrant and seek more than the psychological equivalent of palliative care.

CONCLUSION

Due to the enormity of the AIDS epidemic, the number of populations it has affected, and the variations within those populations, not to mention individual differences, no single article can speak definitively about group psychotherapy with people affected by HIV/AIDS. Rather, it has been our intention simply to speak from our own limited perspective: to report some of what we have observed, describe how we have tried to think about it, and suggest some implications based on our work.

Our experience has been one of both continuity and change. On one hand, certain key tasks in counseling people who are HIV+ or living with AIDS (i.e., helping clients live in a climate of radical uncertainty and integrate feelings of hope and despair) have been counseling goals since the earliest days of the epidemic. On the other, we have noted shifts in what these tasks entail and how important changes in the medical context have had enormous impact on the dynamics of our group and, consequently, on us as coleaders.

We have noted what we believe is a particular affinity between the mission of counseling psychology and the perspective and skills needed to work effectively with people who are HIV+ or who have AIDS. We have suggested implications for counseling psychology research, training, and practice. Finally, we have noted the impact of this work on counselors in general and us in particular. In many ways, leading a group for people with AIDS is akin to white-water rafting in a swollen, sinuous, uncharted river. You know where you have been, but that helps little in preparing for the next twist or turn, which you cannot see and cannot even anticipate. It is exhilarating and terrifying, and often the best you can do is just hold on. While we do not know what is around the next bend, we are grateful to the clients who have allowed us to accompany them this far and who have taught us so much.

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