AN INVESTIGATION OF GAY MEN'S EXPERIENCES WITH HIV COUNSELLING AND PEER SUPPORT SERVICES

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ABSTRACT

Although the length and quality of life for people living with HIV/AIDS has improved dramatically in recent years because of antiretroviral medications, these individuals still need to make significant psychosocial adjustments in order to improve their quality of life and the HIV trajectory. Mental health professionals can play an important role in this process. The present study investigated the experiences of 12 gay men living with HIV or AIDS who received counselling and peer support services. The findings are drawn from a larger phenomenological study that explored participants' experiences of receiving counselling and peer support services. This paper offers a description of these services and the participants' reactions. The authors report several important considerations for mental health professionals in relation to counselling and peer support programs.

Thousands of people in Canada live with the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS); the numbers are increasing (Health Canada, 2003; Siushansian, Nguyen, & Archibald, 2000), and there is no cure. In particular, men who have sex with men are overrepresented within HIV prevalence statistics, with this group accounting for 51% of reported cases in 2005 (Boulos, Yan, Schanzer, Remis, & Archibald, 2006). In addition, gay men and men who have sex with men are often faced with several unique issues such as extra stigmatization, externalized and internalized homophobia, and identity issues associated with sexual orientation and HIV (Alderson, 2000; Cadwell, 1994). Recent pharmaceutical advances have created antiretroviral treatments, sometimes referred to as the "AIDS cocktail" (Wong-Staal, 1997). These new treatments have significantly improved the length and quality of life for people infected with HIV by delaying the onset of AIDS through inhibiting viral replication. The effectiveness of these new HIV treatments means that the work of therapists as well as other health and social service professionals has changed from helping people through the process of dying of AIDS-related complexes to helping people *live* with HIV.

With HIV infections increasing throughout the world and with the increased longevity resulting from medical advances, therapists and mental health professionals will continue to be called upon to

assist people diagnosed, and living with, HIV and AIDS. Although research demonstrates that counselling and peer support are both effective and important in treating people with HIV/AIDS, several gaps in this research exist. Specifically, the present paper addresses the paucity of available research on (a) the counselling relationship factors and the counsellor's stance when working with people living with HIV/AIDS, and (b) the processes and benefits of peer support programs for people living with HIV/AIDS. It is hoped that through this exploration, counsellors and peer support workers will gain a more advanced understanding of the perceptions of gay men living with HIV/AIDS in relation to the mental health services that they receive.

Counselling Services for People Living with HIV/AIDS

Numerous authors have reported that counselling is beneficial to people living with HIV/AIDS (e.g., Feldman, 1989; Grinstead & Van Der Straten, 2000; Milton, 1994; Sarwer & Crawford, 1994; Schaffner, 1994). Individual counselling can be defined as "activities between a therapist and a client which focus on the client's issues and dynamics through means of the therapeutic relationship" (Milton, p. 13). In the context of the present paper, individual counselling is counselling offered by a trained professional counsellor or therapist (i.e., usually someone with a graduate degree in counselling or psychology, and who is a member of a regulatory body such as the Canadian Counselling Association or a provincial psychologist licensing organization) who may not be living with HIV or AIDS. Research has suggested that counselling can be one of the most powerful ways to address the psychosocial aspects of HIV (Hoffman, 1996). Counselling with this population focuses on several important areas: (a) preventing suicide attempts, (b) reducing anxiety and depression, (c) promoting social support and community support, (d) exploring existential concerns, (e) reducing high-risk behaviours (e.g., abuse of drugs or alcohol), (f) exploring grief and loss, (g) fostering and exploring relationships, and (h) helping individuals develop coping skills to deal with thoughts and fears of stigmatization and death (Frierson & Lippmann, 1988; Goldblum & Moulton, 1986; McKusick, 1988; Muller & Sarangbin, 1995; Weinhardt & Carey, 1999). Although research exists on counselling people living with HIV/AIDS as well as with other chronic and potentially life-threatening illnesses (e.g., cancer), little research explores the therapeutic relationship and the counsellor's perspective toward people living with HIV/AIDS. This gap is especially apparent in terms of the perceptions of people actually living with HIV and AIDS in relation to these services.

Horvath (2000) reported that the therapeutic relationship (i.e., bond between client and helping professional) can predict counselling outcomes. Specifically, a positive therapeutic relationship developed within the first five sessions of counselling increases the chance of positive outcomes. Rogers (1951, 1986) identified what he believed were the three core conditions of counselling: empathy, congruence, and unconditional positive regard. Rogers placed much of the emphasis of therapy on the therapeutic alliance. Bachelor (1995), based on 66 qualitative descriptive accounts, reported three specific types of therapeutic alliances: (a) nurturant (i.e., the client desires a relationship where the counsellor is respectful, non-judgmental, empathetic, and attentive); (b) insight-oriented (i.e., the client desires a relationship that is conducive to greater self-understanding, including deeper understand-

ing of the causes of present issues); and (c) collaborative (i.e., the client desires a relationship in which he or she can be actively involved in the therapy process).

O'Dell (1997) reported a lack of research addressing the therapeutic alliance in relation to people living with HIV/AIDS who are receiving counselling. In her own study she reported that clients living with AIDS, and their counsellors, perceived the therapeutic alliance as important to the success of counselling. Cadwell's (1994) clinical observations indicated that the therapeutic relationship between clients living with HIV/AIDS and their counsellors is extremely important because of the clients' fears of stigmatization by the counsellor. As the relationship becomes increasingly positive, these fears can gradually be dispelled. Furthermore, Cadwell noted that as the therapeutic alliance develops, counselling of gay clients living with HIV/AIDS becomes increasingly effective. However, Bodnar (1997) reported that clients living with HIV/AIDS can experience difficulty in building a therapeutic alliance as they can be accustomed to having significant others avoid them. Thus, they can experience isolation and become accustomed to feeling isolated. Interestingly, Horvath (2000) reported that clients were better raters of the therapeutic alliance than both outside raters and therapists, lending support for the need to undertake research that specifically examines the perspective of clients with HIV/AIDS about the counselling relationship.

Peer Support Services for People Living with HIV/AIDS

Peer support is also very important in helping people cope with HIV. Researchers (e.g., Bastardo & Kimberlin, 2000; Greene, McVinney, & Adams, 1993; Hays, Turner, & Coates, 1992; Koopman et al., 2000; Leserman, Perkins, & Evans, 1992; Serovich, Brucker, & Kimberly, 2000; Zich & Temoshok, 1987) have reported physical benefits (e.g., reduced physical HIV symptoms), psychological benefits (e.g., reduced depression), and emotional benefits (e.g., reduced helplessness and increased "fighting spirit") of peer support for people living with HIV. Although peer support is clearly an important element of treatment for people living with HIV/AIDS, little research has been conducted on peer support programs.

These programs combine peer support and empowerment through making clients the key providers and users of the services. At several community-based HIV agencies in Alberta, Canada, these programs have trained facilitators—clients living with HIV or AIDS who have been trained to facilitate with the assistance of the program coordinator and support team. Peer support programs are a way of providing opportunities for capacity building for HIV-positive individuals. Assisting individuals to help themselves is a key component of programming. The main aim of peer support programs is often to address practical concerns (e.g., cooking, finances) rather than to provide counselling; however, peer support services do exist within community-based agencies that are also designed to offer counselling from trained peer support workers living with HIV or AIDS.

Peer support programs can be offered within a group context or one-to-one. The peer counsellors are typically volunteers, and the services are free to clients of community-based agencies. The research that has been conducted on peer support programs suggests that these services can be beneficial for people living with HIV/AIDS and those at risk for contracting HIV. For example, clients may

experience a greater sense of trust in a group facilitated by peer workers whose first-hand experiences of HIV lends increased credibility. Peer members are in a better position to identify target groups (e.g., more isolated groups) as they are more aware and connected to these groups. There can also be increased development of an informal peer group, and empowerment of peer support providers as well as peer support users or consumers (Hughes-d'Aeth, 2002; French, Power, & Mitchell, 2000).

HIV and AIDS as Chronic Conditions

Although HIV has become a chronic condition that shares similarities with other chronic diseases such as cancer (e.g., uncertainty, need for support), it remains a unique illness with its own issues. For example, people with HIV risk facing severe stigmatization and feelings of alienation (Bor, 1995). They may harbour fears of discrimination and persecution due to the perception of HIV as a "gay man's disease." Furthermore, they must strictly adhere to a rigorous medication schedule despite devastating side effects. HIV is a highly infectious disease and this leads to other issues that need to be addressed and explored (e.g., major lifestyle changes). All of these issues have resulted in the need for counselling and peer support strategies that are unique for people living with HIV/AIDS.

METHODOLOGY

Research Design

The current study followed a community-based research perspective (Harris, 2006; Health Canada, 2002), and was situated within the phenomenological research tradition (Patton, 2002). The study applied the principles of community-based research as outlined by Health Canada: (a) community member involvement and understanding of as much of the project as possible, (b) community relevance, (c) equality in project partnerships, (d) adherence to scientifically accepted research standards, and (e) ethical guidelines. Community members were involved in the design of the study, identifying the research questions to be addressed, structuring the interview format, and selecting research sites. They defined areas of research that were relevant and important to the community. The principle of equality was observed within community partnerships in which all stakeholders (e.g., community workers, participants, academic researchers) had opportunities to make suggestions on different aspects of the study. Finally, the study followed the guidelines of transcendental phenomenology, a scientifically accepted research methodology (Husserl, 1931, 1962; Moustakas, 1994), and the ethics component was approved by the ethics committee of the University of Calgary in Alberta, Canada.

Sample

The study was conducted with 12 gay men who had had experiences with individual counselling and peer support while living with HIV or AIDS. The age range of the participants was between 27 and 56 years old (mean = 43 years). The participants had received their HIV diagnosis from 4 to 15 years prior to the study (mean = 9.75 years). Five participants reported that they had been previously married to females.

Two participants reported being retired and 3 reported that they were presently not working. Five participants reported an annual income below $20,000, 3 reported between $30,000 and $49,999, 1 reported above $50,000, and 3 did not respond to this question. Regarding their educational attainment, 3 participants had completed some university or college education, 5 had completed high school, and 4 had some high school credits. All participants were involved in local community-based agencies, suggesting that this was an unusual sample. Most participants noted that they were following their prescribed antiretroviral medications.

Criterion sampling (Osborne, 1994) was used to select participants (i.e., participants needed to be living with HIV/AIDS and to have utilized both counselling and peer support services). Participants were recruited through four HIV/AIDS community-based agencies in a Western Canadian province. Each potential participant was given an information sheet and an informed consent form by staff at the different agencies. Interested participants notified a staff member, who then notified the primary researcher of potential times for the interview to occur.

The men reported using peer support programs and individual counselling at varied rates. Six participants indicated that they had received peer support programming once or twice a week for 8 years on average. Seven participants reported that they had received individual counselling 119 times, on average, over a 4-year period.

Interview Procedure

Interviews followed a semistructured format. Of the 12 interviews conducted, 11 were face-to-face interviews that occurred within a private location at a local community-based agency. The other interview was conducted during a telephone conversation as requested by the participant. Interviews ranged from 55 to 175 minutes (mean = 93 minutes), except for the telephone interview, which lasted 20 minutes. All of the interviews were audiotaped to obtain the entire interview verbatim. Participant pseudonyms were utilized during the study to protect confidentiality. Each participant received a small honorarium of $40 for his time and travel expenses.

Data Analysis

The interviews were transcribed and analyzed for common themes using standard data analysis procedures in transcendental phenomenology (Husserl, 1931, 1962; Moustakas, 1994; Patton, 2002). Transcendental phenomenology seeks to understand "the essential meanings of individual experience" (Patton, p. 104). It attempts to uncover the specific nature of a phenomenon (Van Manen, 1990). Analyses were accomplished through separating the interview content into consistent patterns across participants. These sections were further analyzed to identify underlying themes. Themes related to counselling and peer support services are reported in this paper. Triangulation was obtained by reaching consensus between the two researchers in the final organization of the categories and themes (Stake, 1994), and by presenting this structure of categories and themes to 7 of the study participants and to three other gay men living with HIV who had had similar experiences. Information about the researchers' subjective perspectives during the study was reported in field notes and through journalling.

RESULTS

Participants identified counselling and peer support as being beneficial in several ways in helping them to effectively deal with HIV/AIDS. They also noted specific aspects that they experienced as particularly helpful to them.

Individual Counselling

Benefits of counselling. Individual counselling was useful in reducing feelings of isolation. "Counselling was especially useful that first year because that's when the isolation is so intense" (Sean, age 32). Professional counselling was also perceived as being useful in working through the process of accepting responsibility for the diagnosis. Many of the men noted that they blamed others for their diagnosis. "I was totally blaming the person I felt infected me, but I was made to realize that it's a 50/50 road and you have to be responsible yourself for protecting yourself as well" (Andrew, age 27).

Participants identified that being able to explore, examine, and vent emotions in the context of a safe and respectful environment was important in dealing with emotional turmoil.

> I'm not going to fight or argue—I just, what I'm dealing with is very, very scary. It's very powerful and that's when, you know, once again that's when I was really isolated and that's when I can see that I needed someone inspirational or spiritual to speak to, to help me, just to guide me or listen to me, just to listen to me vent and rage without feeling judged. (Ben, age 38)

Counsellors were viewed as offering reassurance and support to participants. This support could be experienced directly from the counsellor or from others recommended by the counsellor (e.g., support groups). "It was an opportunity to just debrief, to vent and learn from another person" (Kyle, age 48).

Counselling was utilized to help solve problems. This problem-solving assistance was especially important in the early phases of counselling and during periods of crisis.

> You tend to withdraw and get into a house-bound situation and just keep rehashing all of your situation without being able to resolve it. They're [counsellors] able to usually give you some suggestions or a different perspective on the situation to make you understand things a bit better, and that was very helpful. (Peter, age 41)

The private and confidential nature of individual counselling helped participants to discuss sensitive and private issues, some of which were not appropriate within a group forum. "It was a one-on-one situation. . . . Plus the fact, there are things that you don't want any particular group to know because it's a small community" (Tom, age 49).

Counselling was also useful for obtaining information about referrals, medication information, and health strategies.

> I definitely needed someone to talk to me and just listen to my problems that I had besides the HIV and find out how long I had to live—that was the major issue. What was available in drugs because I had heard about AZT [antiretroviral therapies], I had also heard that that wasn't totally effective but that's about it. So I didn't know what was available. (Sean, age 32)

Counsellor qualities. Participants identified nine attributes or qualities of professional counsellors that were important to them. They wanted counsellors to be non-judgmental, confident, knowledgeable about key areas (e.g., HIV, community resources), inspirational, empathetic, supportive, kind, respectful, and capable of providing perspective. The desire for confident and knowledgeable counsellors who "have a plan in the back of their minds" (Ned, age 47) was apparent in participants' responses about wanting counsellors to use their knowledge to partially direct discussions about crisis situations, sexual orientation, HIV/AIDS issues, and problem solving, as well as to engage the client in perspective-taking exercises. Participants also mentioned the importance of qualities related to the counsellor "being the expert" and conveying this expertise to the client in certain situations, such as times of crisis. However, even in these situations the participants reported the need to maintain an egalitarian relationship.

Therapeutic alliance within individual counselling. Participants reported five components as essential for the development of a therapeutic alliance: (a) the presence of specific counsellor qualities (e.g., effective listener, non-judgmental, empathetic), (b) client involvement in the process of counselling, (c) an egalitarian counselling relationship, (d) the need to accomplish goals during counselling, and (e) the need to feel comfortable and connected to the counsellor. These components were illustrated by the following participant quotations:

1. It was just that they [counsellors] were there to help. They were there and they were going to listen and a lot of times it was just the listening part that's a big part of it, to get me to talk on where I was at and what was going on, to drag it out of me and just be compassionate and non-judgmental. (Joey, age 56)

2. Not trying to fix my problems but to help me fix my problems, to give me the tools to fix my problems, or not to fix but to work towards. (Ted, age 53)

3. We each needed to have equal say in what was going on, in what was happening. (Ben, age 38)

4. I needed to feel like something was happening. We didn't seem to be accomplishing anything at all which led to the end of counselling [with that counsellor]. (Tom, age 49)

5. It makes a difference if you can really feel comfortable with the counsellor, you feel connected. (Tom, age 49)

Issues addressed in individual counselling. Participants identified ten main issues that they explored within individual counselling: anger, relaxation/reduction of stress, financial planning, revealing HIV to others, revealing sexual orientation to others, alcohol use, intense fear, prioritizing life, crisis/suicide, and relationship separation.

Peer Support Programs

Benefits of peer support. Peer support programs were helpful in reducing feelings of isolation for participants. "You can develop camaraderie and friendships and you see that you're not alone in a huge way" (Tom, age 49). These programs also helped participants to obtain physical resources, such

as food. "They get their meals at a reasonable rate, they get some better meals and they also connect with other people who are HIV and AIDS and it's a social thing as well as a financial help" (Sean, age 32).

Participants also learned and enhanced certain skills (e.g., social skills) through their involvement in peer support programs. "These programs were useful to get better at making friends" (Tom, age 49). Psychosocial support in the form of solution dialoguing, venting thoughts/feelings, gaining information/resources, and discussing other issues to temporarily forget about everyday problems were all reported to be useful aspects of peer support programs by participants. "It's nice to be able to share your questions with others who have had the experience, get their ideas on how they would handle it" (Kyle, age 48).

Through the support they received, participants found it easier to focus on other people as opposed to dwelling on their own problems. Focusing on others' problems can offer temporary relief from personal concerns.

> There are a lot of others like me, so I find if I chum around with the other ones, with the other people like me, then we can talk about our fears and that sort of thing, and you can concentrate on them rather than yourself, so you tend to forget about yourself and start worrying about others. (Randy, age 47)

In addition, these programs helped clients gain valuable information about available resources and others' first-hand experiences of how they dealt with psychosocial and health problems (e.g., dieting and stress reduction). "You can talk to them a little more freely about medications and STD situations, get their experiences" (Andy, age 51).

Relationships. Participants reported equal power in peer relationships. "You can take what they say with a grain of salt because it is a group as opposed to individual counselling, because like, they're not the boss (laughing)" (Ned, age 47). Participants found that having others to relate to who were similar to them resulted in increased openness and ability to communicate. "Well, they [peer support programs] have people that I know, for one thing (laughing), and they have people, also, who are in the same boat as I am in. And they don't judge you" (Ned, age 47).

> We're all HIV infected, so there's a sense of community there, already established before you even hook up because they're affected in similar ways. So that's a common denominator and so you didn't have to wade through all the identity stuff. You're HIV positive, and a lot of that stuff is out of the way and it makes for clear communication. (Joey, age 56)

Relationships with one another also made participants more aware and respectful of the diversity among them. "I am finding out that it's like I am learning about people too, like, there are groups that frankly I did not like to begin with, and now I am more accepting of them as well now" (Ted, age 53).

Role models. Participants recalled a number of benefits to connecting with other people who have experienced the same types of issues that they were experiencing. They often regarded the peer support worker as a role model. In the context of this study, role models are people who are more likely to truly understand, and who can offer information and advice—based on first-hand experience—on HIV side effects, resources, parenting issues, relationship issues, and medication benefits/side effects.

> I mean, I like talking about it, but it's got to be with people that are like me, or in the same boat as me, so they can truly understand me. (John, age 28)

You know it was another person who has been there, done that kind of thing, because a doctor hasn't and doctors aren't gods. (Ben, age 38)

They help you because you don't know, you can talk to friends but they don't have the same experience and that's definitely the most important. (Sean, age 32)

They can send you to resources, give you resources, and tell you how they went through it. You can pick and choose from there, what would best suit you, you know. I found that aspect very helpful as well. (Peter, age 41)

Been there, done that, you know I'm positive, too. I can understand when a person says, "How am I going to tell my wife, or my ex-girlfriend, or my child," you know? I can understand that fear where you can maybe empathize with it but you can't feel it because you haven't been there. So that's why I said "Been there, done that." (Ben, age 38)

DISCUSSION

Participants in the present study found counselling and peer support programs beneficial. Importantly, participants identified several different components of support that helped them to deal with HIV/AIDS.

Benefits of Counselling Services

Participants noted that counsellors were able to help them reduce their experience of isolation. Cadwell (1994) reported that gay men living with HIV/AIDS may have few social supports. This isolation is problematic as it may have negative effects such as illness and depression. The results of this study suggest that although isolation can be a common experience for people living with HIV, mental health professionals can help to reduce this experience. Counsellors offer direct, one-on-one support to people with HIV/AIDS, and also facilitate support by connecting clients to programs such as peer support groups.

Working through blame was another focus of professional counselling for the participants. Counsellors helped gently challenge their clients to begin the process of accepting partial responsibility for the diagnosis. Participants suggested that the counsellor's perspective and ability to show them others' perspectives were important in helping them to accept partial responsibility. Through accepting partial responsibility, and learning to move away from blame and anger, feelings of empowerment and acceptance were facilitated. Having said that, helping clients to accept responsibility for their diagnosis is a delicate process because HIV and AIDS can breed destructive self-blame. This is a dangerous experience that can impede therapeutic progress and prevention measures, as people who are focused on external blame or self-blame can become isolated—left to deal with HIV and their anger on their own without the support of others or the benefit of sufficient knowledge and treatment. Given the results of the present study, it seems clear that counsellors can play an integral role in helping clients reduce external and self-blame, which can facilitate acceptance and empowerment.

Another important finding of the study was that counsellors can deliver accurate information and education to clients. Information on HIV seems to be a central intervention for increasing empowerment and hope for people living with HIV or AIDS. Providing facts, and dispelling myths, are key to empowerment and effective treatment/prevention.

Counsellor Qualities

Participants identified several attributes or qualities of counsellors that they saw as important. Interestingly, many of these qualities are highly consistent with a person-centred approach to counselling. Rogers (1951, 1986), the founder of person-centred therapy, believed that the three core conditions of counselling were empathy, congruence, and unconditional positive regard. These core conditions were said to facilitate the development of a therapeutic alliance and lead to client change. Participants in this study highlighted these qualities, illustrating the importance of counsellors' responding with empathy, maintaining congruence, and demonstrating unconditional positive regard. Given the lack of research on the qualities of counsellors working with people living with HIV/AIDS, further research could explore specific counsellor qualities that translate into effective therapeutic alliances as well as productive counselling outcomes.

As mentioned previously, Bachelor (1995) described three specific types of therapeutic alliances: nurturant, insight-oriented, and collaborative. Participants in the present study mainly identified aspects of the nurturant (e.g., counsellor being non-judgmental) and collaborative (e.g., client involvement in the process of counselling) styles of therapeutic alliances as being important to them, although some did suggest that obtaining insight was important. The nurturant and collaborative alliances seem to fit well with a person-centred approach to counselling.

Similarly, four of the five components identified by participants as essential for the development of a therapeutic alliance—specific counsellor qualities such as being non-judgmental and empathetic, client involvement in the counselling process, an egalitarian counselling relationship, and feeling comfortable and connected to the counsellor—have been suggested as important in the person-centred approach to counselling. Again, this provides evidence of the importance of the therapeutic alliance and the need to pay attention to specific tenets of person-centred counselling when working with this population.

Participants identified counsellor qualities associated with "being the expert" and conveying this expertise to the client in certain situations; however, even in these situations the participants noted the need to maintain an egalitarian relationship consistent with a person-centred or feminist approach to counselling (Corey, 2001). Participants saw the counsellor as the expert on the process of counselling and the client as the expert on himself (Rogers, 1951, 1986). This egalitarian relationship suggests that counsellors need to be able to offer multiple qualities to their clients, depending on personal (e.g., personality of the client) and contextual (e.g., nature of the session) factors.

Importantly, many clients living with HIV/AIDS receive counselling in hospital or medical settings. Given the heavy focus on the medical model and managed care in these settings, it may be challenging for counsellors to offer services consistent with the principles of a person-centred approach. The medical model and managed care typically focus on the clinician as an expert and resist egalitarian relationships with clients. Clinician involvement with clients in these models is often short-term and highly structured/directive. Counsellors working in these settings can be reminded of the importance of developing a therapeutic alliance with people living with HIV and AIDS.

Another important finding was the value of inspiration in the counselling process. Inspiration is likely an implicit component of almost all counselling endeavours, and this is no exception when working with clients living with HIV. For participants in this study, becoming inspired meant becoming motivated and empowered. It involved not only being heard, but also listening to inspirational stories, information, and perspectives. The published research to date on counselling persons living with HIV/AIDS has not explicitly addressed the need for inspiration. Thus, counsellors need to be aware of the importance of inspiration when working with this population. Research could continue to explore the processes involved in the counselling relationship that give inspiration to individuals living with HIV/AIDS.

Peer Support Programs

Numerous researchers have demonstrated the positive influences of peer and social support on gay men living with HIV/AIDS in terms of their physical, psychological, and emotional well-being (Bastardo & Kimberlin, 2000; Hays et al., 1992; Koopman et al., 2000; Leserman et al., 1992; Serovich et al., 2000; Zich & Temoshok, 1987). However, little research has been conducted on peer support programs and their impacts on people living with HIV/AIDS. This study lends support to the notion that gay men living with HIV/AIDS need peer and social support opportunities and, according to the participants, one way that these opportunities can occur is through peer support programs at the community level.

Gay men living with HIV/AIDS typically experience losses in their relationships with family and friends, resulting in varying degrees of isolation (Cadwell, 1994; Tegusi & Ahmed, 1992). Thus, programs designed to foster the development of relationships need to be a key component of treatment. Helping persons living with HIV/AIDS to develop survival skills (e.g., social skills) is also necessary. Peer support programs offer these types of opportunities.

Participants reported that equal power in peer support relationships and similarities among peer support group members resulted in increased openness, ability to communicate, and opportunities to learn within the relationships. French et al. (2000) reported that peer support programs increase the level of trust, which can facilitate openness and communication. The recurring theme of egalitarianism suggests that gay men living with HIV/AIDS need therapeutic relationships that are equal, non-judgmental, and respectful, regardless of the context (e.g., individual counselling, peer support). This need is possibly due to the isolation and stigmatization often experienced by gay men living with HIV/AIDS.

Participants noted a number of benefits to connecting with other people who have experienced the same types of issues that they were experiencing, and they often referred to their peer support workers as role models. This study suggests that peer support workers are important role models because they provide first-hand knowledge, support, and information to clients. It is also likely that peer support workers help to inspire their clients/peers. Research suggests a number of benefits of peer support such as greater trust, credibility, and acceptability (Hughes-d'Aeth, 2002; French et al., 2000); however,

research has been limited on the benefits of role modelling in peer support programs. This study offers evidence for the benefits of peer support workers as role models.

Counselling Versus Peer Support Programs

It needs to be stated that participants found both counselling and peer support services highly beneficial. Each encompassed important therapeutic benefits that helped participants to improve their quality of life while living with HIV or AIDS. According to participants, however, there were some important differences between professional counselling and peer support that should be considered during the referral process. For example, many participants suggested that sensitive and personal issues were best explored with a professional counsellor in a one-to-one context, rather than with peer support workers or in a group context. Additionally, some participants suggested that peer support workers were able to offer a deeper sense of empathy and understanding than professional counsellors not living with HIV. Thus, clients experiencing intense isolation and who desire a connection with someone similar to themselves would potentially benefit from peer support services. Ideally, these two services would be offered in conjunction with each other.

STUDY LIMITATIONS AND SUMMARY

The small sample size ($n = 12$) used to derive the results can be considered a limitation of the present study. Qualitative research is primarily concerned with description and exploration, as opposed to generalization to other groups (Goetz & LeCompte, 1984; Morgan, 1986). The sample consisted of participants who were connected with a community-based agency. In addition, the participants were all gay men, suggesting that the results may not apply to other groups. With that being said, the participants in the study were highly insightful and possessed a community perspective, which led to a rich source of data.

Counselling and peer support programs can be highly effective in helping gay men to *live* with HIV and AIDS. In this study, the authors have elucidated key considerations in offering effective and satisfactory mental health services to gay men dealing with this infection. Through awareness and proper training, mental health professionals can be an asset to gay men living with HIV or AIDS.

RÉSUMÉ

Ces dernières années, grâce aux médicaments antirétroviraux, la qualité de vie des personnes séropositives ou atteintes du sida a augmenté de façon très significative. Toutefois, ces personnes doivent vivre de nombreuses adaptations, sur le plan psychosocial, afin d'améliorer leur qualité de vie et de freiner la progression du VIH. Les professionnels de la santé mentale peuvent jouer un rôle important dans ce processus. Cette étude examine les cas de 12 hommes homosexuels séropositifs ou atteints du sida et ayant reçu des services de consultation et de soutien par les pairs. Nos constatations sont tirées d'une étude phénoménologique plus vaste qui a permis d'analyser le cas de personnes ayant accès à ce type de services. Dans cet article, nous présentons ces services, et les réactions des participants. Nous en déduisons plusieurs considérations importantes qui pourraient être utiles aux

professionnels de la santé mentale qui s'intéressent aux programmes de services de consultation et de soutien par les pairs.

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