OVERCOMING DEPRESSED MOODS AFTER AN HIV+ DIAGNOSIS:
A CRITICAL INCIDENT ANALYSIS

by

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Date **June 24, 1997**
The experience of being diagnosed with HIV/AIDS is extremely stressful and often depressing. Presently there is a trend to study the psychological implications of HIV/AIDS. A majority of these investigations have consisted of quantitative studies that excluded people’s “voice” from within. The present study attempts to bridge this gap. Flanagan’s (1954) Critical Incident Analysis methodology was used in this study to investigate what facilitates the process of dealing with depressed moods after an HIV+ diagnosis. Resiliency was also analyzed. A total of 246 critical incidents were collected. Thirteen categories emerged from an inductive study of the incidents reported by the 11 co-researchers. The results indicate that the facilitative categories of personal strategies employed by the participants are the following: (a) physical exercise, (b) participation in activities, (c) commitment to life, (d) career/work, (e) alcohol/drugs, (f) connection with self, (g) looking for meaning, (h) helping others, (i) gaining understanding of the problem, (j) sharing the news, (k) learning from a role model, (l) spiritual connection, and (m) establishing social connection. A strong thematic similarity was found
between the categories that emerged from this study and the self-reported resilient aspects of the co-researchers. The validity of the categories was confirmed by: independent rater, expert rater, co-researchers' cross-checking, exhaustiveness participation rate, and theoretical agreement. Resiliency emerged as a viable psychological construct in the analysis of the data. Counselling implications are discussed, and practical ways of applying a model of resiliency are suggested.
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Thanks are owing to my mom and dad -models of resiliency- for their long-distance encouragement and support. Aunque lejos, siempre cerca!

To my husband Jess and my sons Marc and Victor: We have always been a team! Sense la vostra dedicació, paciencia, ajuda, I carinyo no haguessim pogut conseguir el rovello. Os estimo!
What is AIDS/HIV?

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease that renders the body's immune system unable to resist the invasion by microorganisms that cause serious infections leading to death. AIDS is a killer different to cancer or heart disease because it permeates societal stigma, it is lethal, it has contagion risk, and -in some cases- one imprudent act is enough for individuals to become infected.

The Human Immunodeficiency virus (HIV) causes AIDS. Among the variety of body cells infected by HIV, the most important is a type of white blood cell called CD4 lymphocyte (also known as T-cell). This T-cell is a major component of the immune system that keeps people free from infections. HIV destroys T-cells throughout the course of HIV disease by reproducing at a steady rate. The body reacts to the invasion by attempting to replace lost T-cells, but, over the course of the years, it becomes unable to produce a sufficient number of new cells to counteract the destruction and keep the CD4 count at a safe level.
HIV infection results in a spectrum of disease, ranging from the absence of symptoms, to mild nonspecific symptoms to severe infections, cancers, wasting, and neurologic conditions. The earliest symptoms of HIV infection are known as the "primary HIV syndrome". They occur soon after becoming infected and include fever, rash, muscle and joint aches, and swollen lymph glands. Other symptoms such as seizures, hepatitis, and diarrhea can also be present, although they are less frequent. The HIV antibody blood test can be negative during the primary HIV syndrome, but becomes positive within the following three to six months. After these primary symptoms, the HIV infected person usually remains without symptoms for a period of time. This is described as "latency period". For men who contract HIV infection from unprotected sex with other men (as is the case of the participants in this study), this latency period is, on average, ten to twelve years.

During the latency years, the T-cell count usually declines from its normal value of 500-2000. When the count drops below 500, the person may be at risk for shingles, herpes simplex infection, and Kaposi's sarcoma, globally known as opportunistic diseases. When the T-cell count drops below 200, the individual is considered to have advanced
HIV disease or AIDS.

AIDS is spreading aggressively. Data presented at the XI International Conference on AIDS in Vancouver in July 1996 showed that an estimated 21.8 million adults and children worldwide were living with HIV/AIDS, of whom 20.4 million (94%) were in the developing world. Populations affected vary across the world. In Sub-Saharan Africa transmission occurs essentially through heterosexual contact, with the highest number of infections occurring in the 15-24 year old group among both males and females. The epidemic in Asia is predominantly spreading through heterosexual contact, with infected men outnumbering infected women by a factor of 3 to 1. This male/female ratio is expected to drop as the epidemic spreads into the general population through spread of HIV from clients of sex workers to their regular partners and spouses. In Asia, the epidemics have been strongly influenced by gender inequality and the frequent practice of men visiting sex workers. In Latin America, sexual transmission accounts for 80% of overall transmission, with the predominant mode of transmission being heterosexual contact. The epidemiological evidence signals a rapid shift of new infections to people between 15 to 24 years old.
Even though the growth of the AIDS epidemic in America has slowed in recent years, largely due to the decline in sexual transmissions between men, HIV has been one of the major causes of death for individuals between the ages of 25-44. In 1994, HIV infection was the second leading cause of death among Canadian men. Incidence among men who have sex with men (MSM) has dropped from about 5-10% per year in the early 1980's to an estimated 1-2% per year in the 1990's. However, the prevalence of HIV infection among MSM remains high in North America. In Canada, HIV infection among intravenous drug users (IDUs) is a major concern, while heterosexual contact has doubled as a proportion of female AIDS cases in Canada since 1991.

By July 1996, 21.8 million people had been infected and 2 million had been killed worldwide (XI International Conference on AIDS, 1996). The number of cases transmitted among drug users has increased from an 18% of the total in 1985 to 28% in 1993, while cases contracted homosexually dropped from 50% to 47% (XI International Conference on AIDS, 1996). Since the early 1990's more women have become infected with HIV. In 45% of these cases the women had sexual relations with male IV drug users. The Center for Disease Control reports that the
increase of AIDS among heterosexuals is mainly because adolescents and adults continue to fail to adopt safe sexual behaviours. Alcohol abuse seems to mediate AIDS infection among adolescents and young adults, as safe sexual behaviours are not always practised when intoxicated (Montaner, 1994).

According to the latest statistics from Health Canada-Division of HIV/AIDS Epidemiology at the Laboratory Centre for Disease Control (March 1996), the total number of AIDS cases reported in this country (adults and pediatric) is 13,291. These include 13,160 adults (12,437 males and 854 females) and 131 pediatric (<15 years old) cases. A total of 9,552 deaths have been reported; (see Table 1). The highest number of cases reported are in the 30-39 years old range for both males (44.4%) and females (35.6%), while for children the highest incidence is for the less than 1 years old group (26 males, or .02%, and 33 females, or 3.9%). Men who have sex with men (MSM) constitute 79.6% (9,846) of all reported cases. The highest exposure category for women is heterosexual contact with a person at risk (287 women or 36.1%). Ontario has the highest total number of AIDS cases reported to date (5,298 or 39.9%), followed by Quebec (4,299 or 32.3%), British Columbia (2,239 or
16.8%), Alberta (814 or 6.1%), the Atlantic provinces (385 or 2.9%), and the Prairies and Territories (256 or 1.9%).

Insert Table 1 about here

Considering the pandemic we are facing, and the severity and high fatality of the disease, it seems appropriate to conceptualize and assess responses to HIV infection as highly stressful situations. Normal responses to such diagnosis are anger, anxiety, depression, fear, guilt, low self-esteem, suicidal ideation, substance abuse, and somatic preoccupation (Ishiyama, 1995a; Kelly, Murphy, Bahr, Koob, Morgan, Kalichman, Stevenson, Brasfield, Bernstein, & St. Lawrence, 1993; Kuhl, 1995; Montaner, 1994; Nichols, 1985; Ostrow, Monjan, Joseph, Van Raden, Fox, Kingsley, Dudley, & Phair, 1988; Salisbury, 1986).

After the initial focus on studying the physiological aspects of the disease, there is now a trend to study the psychological implications of AIDS/HIV. Presently, there is some controversy regarding how depression affects HIV and vice versa. Some researchers (Burack, Barrett, Stall, Chesney, Ekstrand, & Coates, 1993) contend that depressive symptoms
**Table 1: Number of AIDS cases in Canada**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Cases</th>
<th>% of Total</th>
<th>Reported Deaths</th>
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<tbody>
<tr>
<td>Adult males</td>
<td>12,366</td>
<td>93.4</td>
<td>8,940</td>
</tr>
<tr>
<td>Adult females</td>
<td>794</td>
<td>6.0</td>
<td>525</td>
</tr>
<tr>
<td>Pediatric males (&lt;15 yrs)</td>
<td>71</td>
<td>0.5</td>
<td>46</td>
</tr>
<tr>
<td>Pediatric females</td>
<td>60</td>
<td>0.5</td>
<td>41</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13,291</strong></td>
<td><strong>100.0</strong></td>
<td><strong>9,552</strong></td>
</tr>
</tbody>
</table>

ADAPTED FROM HEALTH AND WELFARE CANADA - DIVISION OF HIV/AIDS April 1996
predict immune system cells decline, which makes it easier to prompt an AIDS diagnosis. Others (Lyketsos, Hoover, Guccione, Perry & Fishman, 1993) did not find a significant difference and argue that no study has shown that depression predicts the onset of the HIV-related physical symptoms, AIDS, or death.

Even though the mechanism of depression contributing to immunologic deterioration remains unexplained, one of the implications of this controversy is the need to investigate whether treating depression can enhance individuals' effectiveness in maintaining an appropriate quality of life. This study represents an effort in this direction, as it investigates what facilitates people to overcome the depressive moods that usually accompany an HIV+ diagnosis.

Purpose of the study

The purpose of the present study is to develop a set of categories that describe what facilitates people diagnosed with HIV+ to deal with the depressive moods that usually ensue after receiving the news of their diagnosis. Resiliency was also studied, in order to come up with a map of personal resources that enable people to bounce back after a stressful critical event. This kind of inquiry is intended to contribute to the field of
counselling psychology by: (a) providing information on what helps people
with HIV+ overcome depressed moods; (b) supplying a structured channel
for HIV+ individuals to contribute their expertise toward the compilation of
facilitative processes in the battle of overcoming depressed moods; and
(c) dispensing the kind of information necessary in developing preventive
measures in dealing with depressed moods.

Assumptions

There are three underlying assumptions in this study: (a) the
tendency to depressed moods as a reaction to the news of an HIV+
diagnosis; (b) the notion of "exception" to the problem of depressed
moods; and (c) resiliency.

Depressed moods. One of the assumptions of this researcher is
that people who have been diagnosed with the HIV virus tend to exhibit
depressive symptomatology. This assumption is corroborated by the
literature and also by people with AIDS and/or HIV and their doctors, in
general (Brown, Rundell, McManis, Kendall, Zachary & Temoshok, 1992;
Chesney & Folman, 1994; Faulstich, 1987; Ishiyama, 1995; Holland &
Tross, 1985; Montaner, 1994; Tross & Hirsch, 1988). For example, Brown
et al., (1992) concluded that early in the course of HIV infection men are
at risk for developing major depression, anxiety disorders, and disorders of sexual desire. Belkin, Fleishman, Stein, Piette, and Mor (1992) report that 373 out of 881 respondents (42.3%) scored above the cutoff on the depression screener. In Fleishman and Fogel’s study (1994) 43% of the analytic sample scored above the cutoff for depression. Studies using self-report measures of depressive symptoms consistently report elevated depression scores for HIV-infected individuals (Atkinson, Grant, & Kennedy, 1988; Dew, Ragni, & Nimorvicz, 1990; Ostrow et al., 1989). Cavallari (1996) concluded that the HIV+ diagnosis was traumatic in 83% of the patients studied. Kennedy, Jacobsen, VanDevanter, Skurnick, & Louria (1996) discussed the results of their study on depressive symptoms in HIV serodiscordant and HIV seroconcordant heterosexual couples. They found that more than 40% of individuals had clinically important depressive symptoms defined as a CES-D score of 16 or greater (HIV+=50%; HIV-=38%). They concluded that depressive symptoms are common in the studied cohort. Furthermore, depression can have broad implications for increased morbidity, additional disability, and diminished quality of life in those affected.

These results are similar to findings from other chronically ill
populations, particularly cancer patients, for whom the rate of depression ranges from 6% to 74% depending on the use of the term "depression" (Bukberg & Penman, 1984; Peck, 1972). This researcher will not attempt to study people who have a diagnosis of major depression, or of a depressive disorder meeting full DSM-IV criteria. The Center for Epidemiologic Studies Depression Scale (CES-D Scale) will be used as an indicator of depressed mood in the past (Radloff & Locke, 1986) instead of other depression inventories that contain confounding factors such as illness-related symptoms (i.e., fatigue, physical complaints, and weight loss) or neuropsychological symptoms (i.e., forgetfulness), as is the case of the Hamilton Depression scale and the Beck Depression inventory (Drebing, Van Gorp, Hinkin, Miller, Satz, Kim, Holston, & D'Elia, 1994).

Recent researchers and theorists have begun to consider the role of social and interpersonal factors in the maintenance and exacerbation of depressive episodes (Coyne, cited in McCann & Endler, 1990). Social learning theory emphasizes the importance of quality and quantity of person-environment interactions as determinants for depressive moods. The researcher's understanding of depressed moods derives
mainly from Social learning theory (Bandura, 1992) and Solution-Oriented/Possibilities theory (deShazer, 1985; O’Hanlon, 1995).

According to Bandura (1992) normal and abnormal behaviours are learned and are influenced by (and they also influence) person-environment interactions. Depression is associated with an increase in unpleasant person-environment interactions. Depressive behaviours are those associated with unpleasant outcomes. Non-depressive behaviours are those associated with positive outcomes. The depressive cycle may be described as follows: when we feel bad we are less likely to initiate behaviours, and we also may doubt ourselves and our ability to engage in preferred behaviours successfully. As we become less active, we feel even more depressed, and we do even less. The cycle perpetuates itself until broken. Treatment of depressive moods should increase the quality and quantity of the positively reinforcing person-environment interactions, and decrease those of punishing person-environment interactions. Therapists need to help clients notice the differences between the times they feel less depressed, and the times they feel more depressed, by asking questions such as follows: What is happening around those times? What are you feeling, thinking, doing that may perpetuate your depressed
moods? How do you catch yourself spiralling down the depression cycle? How have you broken that cycle in the past? The aim of these types of questions is to bring out people's resilient characteristics that enable them to successfully reach their goals.

"Exception" to the problem of depressed moods. A second underlying assumption of this research is that there is always an "exception" to the problem (de Shazer, 1985; O'Hanlon, 1990). In other words, depressive moods do not happen all the time, nor do they happen the same way. Such times can become gateways to longer periods of time when people are free of their concern. This assumption entails the notion of resilience (Flach, 1988; Kadner, 1989; Rutter, 1987).

Resilience. Resilience can be understood as an ability to recover from or adjust easily to misfortune or chance (Kadner, 1989). According to Kadner (1989) it implies a less adversarial stance towards the environment. Thus, instead of fighting a presumed hostile outer environment (i.e., HIV+) the individual focuses on summoning inner and familiar resources. Rutter (1981) conceptualized resilience as young people coping effectively despite experiencing a form of stress that in the general population carried a substantial risk of an adverse outcome. He
suggested that a lack of intimate relationships, and negative experiences increase the adverse effects of stressors.

Flach (1988) proposes the following resilient traits -while emphasizing that not one particular attribute is a static ingredient of our personalities: creativity, ability to tolerate pain, insight into ourselves, self-respect, independence of spirit, capacity for learning, ability to make friends, freedom to depend on others and be able to set the limits to that dependency, ability to restore self-esteem, tolerance of distress, and the ability to interpret experiences with meaning and hope.

The working definition of resilience or psycho elasticity adopted by this researcher is, "an individual's innate and learned ability to muster those strengths or resources that enable him/her to deal with personal challenges, and to return to no less than his/her previous psychological state or -in some cases- to a higher level thereof". This definition encompasses two important elements of resiliency: nature and environment, that had not been included in previous definitions. In the context of the current study the thirteen categories embody facilitative coping mechanisms, while resiliency can be defined as the process that enables people to bring up resources to overcome depressed moods.
The construct of resiliency is congruent with the researcher's theoretical orientation, based on the need for counsellors to bring up to the foreground clients' resilient and familiar resources in order to open up possibilities for meaningful change. Similar to Flach's (1988) and Warschaw & Barlow's (1995) concept of resilience, this researcher believes that people have been created with a gift that allows them to change. Some are able to put it to use, and others are not always successful. When a person is diagnosed with HIV he/she may enter a state of confusion and emotional anguish. She/he can look at it as an opportunity to discover new ways to deal with life, or remain in a chronic state of dysfunction and helplessness.

Resilient or psycho elastic people are engaged in the process of living life and, although not invulnerable to stressful events, they do not succumb to the effects of stress. When facing stressful situations, resilient people engage in a creative process of calling upon their flexibility, adaptation, support, guidance from others, independence of spirit, self-awareness, and their ability to interpret experiences with a sense of meaning and hope (Warschaw & Barlow, 1995). Some people may develop their inborn psycho elasticity in infancy due to a good bonding
experience with a parent or a caregiver. As they grow older, they may be
diligent in using their resiliency to grow stronger and more resilient. Flach
(1988) and Warschaw & Barlow (1995) agree that less resilient people
can also learn how to become more resilient by becoming aware of their
personal strengths, using them adequately and flexibly, and renewing
their commitment to life and change. Resilient people respond
emotionally, cognitively, and behaviourally to a stressful event. Not only
may people react to different critical situations by using different
responses, and by being more or less resilient some times, but their level
of resilience may also fluctuate over time, and change according to the
circumstances.

Resiliency is not coping, but the readiness to cope. It is not
survival, reckless behaviour, or invulnerability to the effects of stress
(Warschaw & Barlow, 1995). It is flexibility, adaptation, creativity, and an
adequate range of strategies that can change depending on the
circumstances. It is a preparedness that is mobilized when a stressful
situation occurs. The concept of resiliency is different from the
psychological concepts of hardiness and self-efficacy. Hardiness has
been described as a personality trait that fosters cognitive reappraisals
and that enhances adjustment under stressful circumstances (Blaney, 1991). According to Kobasa, Maddi, & Kahn (1983) persons high in hardiness commit themselves to what they are doing (rather than feeling alienated from it); generally believe that they can at least partially control events, without manipulating them (rather than feeling powerless); and regard change to be a normal challenge or impetus to development (rather than a threat).

Self-efficacy is defined by Bandura as an individual's belief that he/she can successfully execute a given behaviour. This belief is based on an assessment of people's capabilities, and it influences how they think, feel, and/or act. Self-efficacy is different from resilience because the former is considered to be a basic expectancy that guides human behaviour, and it derives from (a) performance accomplishments, (b) physiological states, (c) vicarious experience, and (d) verbal persuasion.

Regarding individuals diagnosed HIV/AIDS, one can hypothesize that those who cope well may possess some of the characteristics of hardy people, as well as an adequate level of self-efficacy. However, for this population, the above constructs seem less appropriate than
resiliency. AIDS/HIV is permeated by societal stigma, thus the possibility of carrying feelings of alienation. Also, when considering seropositive individuals, physiological states may be diminished due to primary HIV syndrome or opportunistic diseases. Moreover, vicarious experience may not always be helpful as it might originate anxiety and fear in those individuals at earlier stages of the illness.

Psycho elasticity is necessary in life because it is essential for people to bounce back and face the daily challenges that life brings. Therapists can help clients notice their resilient potential by bringing up familiar resources that clients have used in the past to help themselves in difficult situations. Moreover, the type of questions asked in therapy can bring up the awareness of strengths that contribute to the resilience of a particular individual. These questions can tap into conscious and unconscious processes in order to mobilize people's resources and strengths, and eventually lead to a build-up of self-esteem and empowerment. Resilience is crucial for people with HIV/AIDS, many of whom suddenly experience significant loss of control. The realization that they possess personal strengths and resources that can be used to deal with this challenge in their lives, can restore a measure of control, thus
making the concept of resiliency valuable.

Rationale for the study

There were several reasons for conducting a study of depressive moods among HIV+ persons. First, there seems to be a high incidence of depression among the HIV+ population, with a reported range of 27% to 80% of the HIV/AIDS population (Atkinson, et al., 1988; Brown et al., 1992; Chesney & Folkman, 1994; Dew et al., 1990; Faulstich, 1987; Holland & Tross, 1985; Kennedy et al., 1996; Kuhl, 1995; Montaner, 1995; Ostrow et al., 1988; Tross & Hirsch, 1988). Baum & Temoshok (1990) speak to the need for empirical studies “to assess what is effective in reducing psychological distress and promoting adaptive coping to the social stressors associated with HIV-spectrum disorders” (p. 7). Brown et al. (1992) state that the availability or appropriate support is a must for the assessment and treatment of suicidality, depression, and anxiety, in order to limit psychosocial morbidity. Therefore, it is critical that more research be undertaken in the field of counselling psychology, so that therapists can design appropriate interventions for effectively helping clients facing episodes of depressive moods, as well as trying to prevent them.
Second, researchers seem to have paid little attention to investigating how people enable themselves to overcome depressive moods. The largest volume of literature on AIDS/HIV explores the epidemiology and physical manifestations of the disease. In comparison, a small percentage focuses on the psychosocial effects that accompany the individuals' experience of AIDS/HIV. These articles usually emphasize psychological problems such as depression, anxiety, guilt, social isolation, helplessness, and suicidal ideation. Most of the studies are quantitative in nature, and have excluded the investigation of people's "voice" from them. Among the literature on HIV/AIDS only few articles include the voice of those individuals who are faced with this devastating illness. It is imperative that we find out how people enable themselves to overcome depression, as a first step to develop, conceptualize, and plan interventions that will be aimed at helping others who are less successful in encountering their resiliency.

Third, the number of people diagnosed HIV+ is growing every day. It is imperative that we find ways of preventing people from becoming clinically depressed. This can be done by listening to their expertise, to their "solutions". Kadner (1989) states that "information about resilience
facilitates nursing's rehabilitative and consolatory roles" (p. 25). Thus, it is important that we listen to these people's expertise in enabling themselves to successfully deal with their depressive moods.

Fourth, counsellors need to identify triggers and warning signs to help clients reduce depression, anxiety, and/or fear, and mobilize themselves out of a depressed mood, deal with suicidal thoughts, and distinguish between the type of anxiety and fear that are preferably to be regarded as normal and acceptable considering their condition, and that which can be controlled (eg., what they choose to do or not to do in order to help themselves accept their new reality) (Ishiyama, 1987; Morita, 1928/1974). In the present study, questions were directed towards identifying the resources as well as the signs that hinder the process of dealing with depressive moods. Hindering incidents were not analysed. They served as a basis for validating facilitative incidents.

Fifth, there is some discussion and controversy among researchers about the notion that psychological interventions for HIV+ individuals may have beneficial effects on immune status (Antoni, Bagget, Ironson, LaPerriere, August, Kimas, Schneiderman, & Fletcher, 1991; Baum & Temoshok, 1990; Chesney & Folkman, 1994; Rabkin & Remien, 1995).
Nothing has been scientifically proven yet that points towards this fact. On the other hand, even considering this a small possibility, it would seem worthwhile to investigate what facilitates people deal with their depressive moods. Such a study was seen as a valuable step not only towards preventing depression, but also as a potential way to attempt to decrease CD4 levels and, ultimately, prolong life.

Sixth, Baum & Temoshok (1990) point out that "perceived control is also important. We know that a sense of control can reduce the consequences of stress, and if stress affects HIV disease, it should be important as well" (p. 7). Their point appears to validate the aim of the present investigation, as the objective was to study what people perceive is helping them diminish their depressive moods.

This study attempted to bridge the gap by utilizing the co-researchers “expertise” (i.e., personal experience, perceptions, ideas) to provide psychotherapists with an understanding of the processes that help people with HIV+ deal with their depressive moods. Practitioners can develop interventions to assist individuals at the time of the diagnosis, as well as helping them utilize their personal strengths and abilities to prevent future depressive episodes.
Approach to the study

It is valuable to understand from the co-researchers' perspective the nature of resilience in the context of dealing with depressive moods after an HIV+ diagnosis.

A research method that appeared to embrace the current research question as well as being congruent with the researcher's assumptions, is Flanagan's (1954) Critical Incident Technique. This method was considered most suitable for studying people's resilience, as well as exploring those times when the exception to the problem is present. This method engages participants in self-reflection and articulating the experience or instances of successfully dealing with their depressed moods.
CHAPTER II
REVIEW OF THE LITERATURE

The largest volume of literature on AIDS/HIV explores the epidemiology and physical manifestations of the disease. In comparison, a small percentage focuses on the psychosocial effects that accompany the individuals' experience of AIDS/HIV. These articles usually emphasize psychological problems such as depression, anxiety, guilt, social isolation, helplessness, and suicidal ideation.

The literature on AIDS/HIV and depression consists of a large number of quantitative research papers pointing out issues faced by seropositive individuals, and correlations of different factors that could potentially help them cope with their diagnosis. However, most of the studies come from the quantitative field, and have excluded people's "voice" from them. Little has been written from the point of view of the "real experts", that is, the people who are experiencing dealing with this disease and its psychological effects. The body of literature claims that HIV+ individuals can face issues such as despair, anxiety, guilt, fear, and depression. The same literature also claims that these people do not
seem to stay at the same emotional, cognitive and behavioural level all the time. This study bridges this gap by asking these individuals what enables them to move from depressive moods to non-depressive moods.

The articles covered in this chapter can be divided in four groups: (1) psychosocial implications for people with AIDS/HIV; (2) factors associated with depression; (3) assessment of depressive moods; and (4) resilience and HIV/AIDS.

**Psychosocial implications for people with AIDS/HIV**

Upon being informed of having tested positive for HIV antibodies, individuals confront the realization that they have contracted what is presently considered to be a terminal condition. According to the literature this realization can be accompanied by feelings of shock, disbelief, personal grief, anger, fear of death, fear of disclosure of seropositive status and sexual preference, loneliness, a sense of loss, and depression (Brown et al., 1992; Chesney & Folkman, 1994; Faulstich, 1987; Ferris, Flannery, McBeal, Morissette, Cameron, & Bally, 1995; Ishiyama, 1995a)

Illness progression is characterized by losses, such as declining health, loss of financial resources, ability to work, to make social connections, to care for loved pets, to feel in control, and to carry on with preferred daily
Nichols (1985) describes three phases of situational distress as a reaction to AIDS: (1) initial crisis; (2) transitional state, and (3) acceptance stage. The initial crisis is accompanied by periods of denial and intense anxiety, to the point where medical advice may be denied or not followed consistently. Some individuals may even engage in life-threatening behaviour such as disregard for one's safety, drinking binges, and total disregard for the partner's safety during sexual activity. Nichols (1985) points out the need for psychotherapy, and legal and financial assistance to begin as early as possible. The transitional state begins when alternating waves of denial, anger, anxiety, guilt, and/or self-pity supersede the denial experienced after receiving news of the diagnose. Finally, the acceptance stage is characterized by the "formation of a new, stable identity" (p. 766). People learn to accept the limitations imposed by the disease, while realizing that they can still manage their lives by making a conscious effort to live each day fully "using reason rather than emotion" (p. 766).

Nichols (1985) makes an invaluable distinction in his article. He distinguishes between the two problems that surround AIDS: one being
the disease itself, and the other being induced by societal stigma. It
seems that when dealing with this population both perspectives are
needed in order to attempt to understand what it means to have this
disease in a practical, emotional, and cognitive way.

Nichols' (1985) paper is one of a small number of descriptive
articles that addresses strategies that help people with AIDS achieve
quality of life and a sense of well-being. In the conclusion Nichols (1985)
opens possibilities for this population by noting that people with AIDS
"can serve as models of adjustment to a progressive and devastating
illness" (p. 767), as the majority of patients he dealt with took positive
steps to reassess their values, and took more responsibility for their
health once they reached the acceptance stage of their grieving process.

Salisbury (1986) reports that some individuals perceived their
experience with AIDS as an opportunity to appreciate their relationship
with others, and to deepen their understanding of themselves. In this
descriptive study, the author makes recommendations for psychosocial
care that are now made available for this population (i.e., support groups
for patients and their families; education around nutrition, stress reduction
techniques, and safe sexual practices). Salisbury (1986) points out how
people with HIV/AIDS experience a number of psychological adaptations to the illness: (1) number of symptoms experienced; (2) premorbid personality; (3) self-concept; (4) attitude toward health and illness; (5) previous experience with AIDS; (6) perceptions of the syndrome consequences; and (7) reactions of both the public and significant others. Her point is very valuable in getting a global picture of these individuals' experience, and it is often brought up in the literature.

Salisbury’s (1986) article focuses more on the health care worker, which allows the readers to realize even more the importance of working as a team with health care workers in order to help people with AIDS/HIV accept their diagnosis, and maintain as much control of their life as they possible can. The current investigation was an attempt to collaborate in this enterprise as it ventured to provide people who work with AIDS/HIV patients with an understanding of how this population dig into their resources to come up with those behaviours, thoughts, and emotions that help them overcome their depressive moods in a way that is meaningful to them.

Ishiyama’s (1995a) paper consists of a valuable review of the literature of psychosocial issues faced by persons with AIDS, such as
reactive depression, anxiety, stigma, anger, denial, and shame, among others. His self-validation model offers a practical way for counsellors to explore the implications of clients' experiences.

In summary, these authors coincide in the need for investigating what is effective in reducing psychological distress and promote movement towards adjustment. One way of doing so is by acquiring information -from HIV+ individuals' experience- about what facilitates their dealing with depressed moods.

Factors associated with depressed moods and coping with depressed moods

Depression is a major psychological reaction to HIV infection. Its recognition and treatment is of fundamental importance as it may alleviate the suffering for those facing a terminal illness, may increase coping, and may improve the quality of life. According to the literature (e.g., Sherr, Davey, & Strong, 1991) a number of individuals experience fluctuating moods during the course of their HIV illness. This can vary from mild to severe depression. The assessment of depression is considered to be essential, not only to enhance people's quality of life, but to facilitate them making meaningful and appropriate choices regarding their future
medical care. Fogel & Mor (1993) found that patients who are less depressed are more able to choose among a variety of care preferences (i.e., palliative ward, nursing home, use of respirator) than those who are more depressed. Thus, the need for studies that investigate what facilitates people overcoming depressive moods, and design interventions, -based on such qualitative data and information-, to help prevent future depressive episodes.

Elevated rates of clinical depression have been reported in samples of seropositive individuals (Atkinson et al., 1988). The prevalence of major depression has been reported as high as 27% whereas the combined incidence of all depression disorders has been noted as high as 80%, depending on the measurement scale employed (Chesney & Folkman, 1994; Dew et al., 1990).

Ostrow et al. (1989) administered the Center for Epidemiology Depression scale (CES-D) to 4,954 volunteer homosexual men who considered themselves at risk of developing AIDS. The uniqueness of this study is that participants were unaware of their HIV antibody status at the time of the study. These authors found that younger subjects had a higher mean score in the CES-D scale. These subjects had used
downers, opiates, and/or marijuana, had no confidants, reported more
than three possible HIV-related symptoms, and were uncertain if they had
ever been exposed to someone who later developed AIDS. These
findings are consistent with the psychosocial issues literature.

An interesting discovery of Ostrow et al.'s (1989) study is the fact
that bisexuals had a higher mean score in the CES-D scale than
“exclusively homosexuals.”

Fleishman & Fogel's (1994) study analysed coping behaviours of
people with AIDS. They used a large sample (N=736) that was
demographically and sociodemographically diverse, and employed factor
analysis of 16 coping behaviours that had been developed in prior
studies. No clear explanation of how this selection was made is provided
in the study. Coping was measured by having participants indicate how
they reacted in the month after they learned about their diagnosis. The
researchers read the participants a list of how people might react after
hearing the news. As the purpose of their study was “to examine coping
behaviours of people with AIDS” (p.156), it may have been helpful to have
the subjects confirm or modify the items in order to investigate if
participants could come up with different items.
There are three findings relevant to the present study: (1) 45.8% of the sample scored above the cutoff for depression using the CES-D Scale, which seems to confirm the fact that depression and/or depressive moods are an integral part of people's lives after learning about their diagnosis; (2) avoidance coping was associated with higher levels of psychological distress and was more prevalent among non-whites, IV drug abusers, women, and lower incomes. Furthermore, the greater the symptoms' intensity and the longer period of time since being informed of the diagnosis, the more avoidance coping; and (3) positive coping was inversely related to depressive symptoms, and it was negatively related to months since notification of HIV infection. These findings have been corroborated by studies reported by Nicholson & Long (1990), and Folkman, Chesney, Pollack & Coates (1993).

Fleishman & Fogel's (1994) study seems to be an in depth investigation of coping and depression. It has a large sample size which the researchers employed in cross-sectional and longitudinal analyses. This study was a replication of prior studies because they “feed the answers” to the participants by introducing coping skills employed by other studies done with the same population. The current research
attempted to take this study a step further by asking people "what"
facilitated them to overcome depression and "how" they kept helping
themselves in a meaningful way, instead of assuming certain coping
behaviours.

Brown et al. (1992) studied Air Force men on active duty. The
results of their study confirmed a high prevalence of mood disorders,
especially major depression. After being informed of their diagnosis, the
rates of depressive mood disorder and sexual dysfunction accelerated.
These authors endorse "the need for availability of appropriate support in
order to limit psychosocial morbidity" (p. 598).

Folkman et al. (1993) examined the relationship between stress,
appraised control, and coping and depressive mood in 425 HIV+ and HIV-
men in San Francisco. Results indicated that stress perceived as
controllable was associated with involvement coping, which in turn was
associated with diminished depressed mood. They found that individuals
who feel in control and cope actively with stressful situations may not
experience increases in depression, while those who do not perceive
themselves as being in control and use detachment coping strategies may
experience increases in depression. Their findings are consistent with
Namir, Wolcott, Fawzy, & Alumbaugh (1987), and Nicholson & Long (1990) among others. The major contribution of this study is their emphasis on the importance of taking into consideration how much seropositive individuals believe they are able to cope with the stress in their lives, and the kind of coping strategies they use to manage their stress and depression. These authors suggest that it might be helpful to develop cognitive behaviour interventions that help people identify daily stressful areas that are potentially controllable, and teach them problem solving, cognitive reframing, and how to seek social support.

A substantial volume of the research literature suggests that social support is associated with psychological and physical health and moreover may buffer the effects of stressful life events such as an HIV+ diagnosis or AIDS. These findings are corroborated in the cancer literature (Behen & Rodrigue, 1994; Priestman, 1986). It seems that people who suffer from cancer also benefit from having confidants.

Lackner, Joseph, Ostrow, & Eshleman (1993) found a strong association between depression and social support. They state that perceived social support appears to be protective of one important aspect
of mental health against depression. Furthermore, it is HIV+ men who seem to derive more benefit from such support. Their results demonstrate the constancy of social support as a buffer of depression. This finding does not come as a surprise. Garmezy (cited in Rutter, 1987) states three predictors of resilience: (1) personality features (e.g., self-esteem); (2) family cohesion and absence of discord, and (3) availability of external support systems. Rutter (1987) considers social support a protective factor, and states that, "It appears that good intimate relationships, even in adult life, can do much to bolster people's positive self-concepts about themselves and their worth in other people's eyes" (p. 348).

Wolf, Balson, Morse, Simon, Gaumer, Dralle, & Williams's (1991) study introduces a new concept about the relationship between social support and coping that was not mentioned by Ostrow et al. (1989), Dew et al. (1990), or Kessler, O'Brien, Joseph, Ostrow, Phair, Chmiel, Wortman, & Emmons (1989) in their studies of coping, social support and enhanced/diminished depressive mood. Wolf et al. (1991) suggest that the ability to cope effectively with an HIV+ diagnosis may influence the availability of quality of social support. In other words, those people may be viewed as attractive and more likely sought by others than "poor
copers." Also, they suggest that social support may directly affect immunological function or serve as buffer against stress by enhancing coping effectiveness, self-esteem, motivation, and or engagement in health-promoting behaviour. These suggestions seem to substantiate Lazarus & Folkman's (1984) view of stress, and Bandura's (1992) theory of reciprocity. Wolf et al. (1991) findings are corroborated by Belkin, Fleishman, Stein, Piette, & Mor's (1992) and Folkman et al. (1993).

Kelly, Murphy, Bahr, Koob, Morgan, Kalichman, Stevenson, Brasfield, Bernstein, & St. Lawrence (1993) investigated the relationship between social support, stage of illness, health, locus of control attributions, and substance abuse with levels of depression. They used the CES-D Scale as determinant of depressive moods. Their sample of 127 men and 15 women diagnosed with HIV infection was not as large as Fleishman & Fogel's (1993) 736 people. Precautions were taken not to confound physical with depressive symptomatology by asking participants to complete a 14 item checklist of common illnesses related to HIV. One of the limitations of any depression scale is to confound typical physical symptoms related to the illness with depressive symptoms, as it can inflate the depression score.
These researchers found that lower social support predicted higher levels of depression. They also found that higher health locus of control (external locus of control) attributions predicted higher depression. Both findings have clinical implications. The former speaks to the need for helping individuals diagnosed with HIV establish and/or re-establish supportive relationships with family, friends, and other support groups. The HIV/AIDS population is unique in the sense that some homosexual people cut off familial relationships in order to hide their sexual identity. Also, a few individuals have found that friends in the gay community abandon them once they learn of their diagnosis (Anonymous, 1995). The latter speaks to the importance of enhancing a personal sense of control in these people’s lives. One way of doing it is by providing counselling that focuses on empowering them by looking at their abilities and strengths, as well as those areas in their life where they can have control (i.e., types of medication, nutrition, social supports systems). This coincides with Kadner’s (1989) suggestion that nurses tend to work towards bringing up the resilient aspects of patients in order to help them problem solve.

In summary, the literature on depression and HIV/AIDS indicates
that depression is a major psychological reaction faced by a large number of seropositive individuals. Perception of adequate social support seems to have a high correlation with diminished depressive moods, and it has been reported as an effective coping mechanism, which was expected would form one of the major categories emerging from the data. 

Assessment of depressed moods

Among the list of criteria symptoms that are necessary to make a formal diagnosis of major depression are many physical complaints often voiced by people with AIDS/HIV, such as significant weight loss, sleep problems, and loss of energy. However, the diagnosis and measurement of depression in medically ill individuals appears to be a difficult task due to two factors. First, illness-related symptoms may exert confounding influence. Depression and physical illness (i.e., cancer, AIDS, HIV infection) share symptoms such as diminished appetite, weight loss, decreased sleep, and fatigue which, if interpreted as vegetative signs of depression, may inflate the assessment of depression. This difficulty seems particularly augmented in cases of advanced HIV infection or in cases of full-blown AIDS, when individuals experience many of the symptoms shared with a diagnosis of depression. Second,
neuropsychological symptoms such as forgetfulness and motor slowing are common in cases of severe depression and HIV-infected individuals.

The Center for Epidemiologic Studies Depression Scale (CES-D scale) has been used in a large number of studies as an indicator of depressed mood. Radloff & Locke (1986) report that this scale was developed by the Center for Epidemiologic Studies of the National Institute of Mental Health of the U.S.A. and tested as a measure of depressive symptomatology for use in studies of the general population. "The choice of items was based on published item validity data and on coverage of depressed mood, feelings of guilt and worthlessness, feelings of hopelessness and helplessness, psychomotor retardation, loss of appetite, and sleep disturbance" (p. 178). Investigators have reported data supporting its validity and reliability. The CES-D Scale is intended and expected to identify not only the presence but also the severity (number of symptoms weighted by frequency/duration) of depressive symptomatology. It is not intended to discriminate between subtypes of depression, nor to distinguish primary depressive disorders from secondary depression. Other advantages of the CES-D scale are: (1) its acceptable test-retest reliability (Burnam, Wells, Leake, & Landsverk,
1988; Radloff & Locke, 1986; Roberts & Vernon, 1983); (2) with only 20 items, it is short and easy to administer; (3) it has been consistently predictive of depression (Burnam et al., 1988; Myers & Weissman, 1980; Roberts & Vernon, 1983); (4) it is a sensitive indicator of mild forms of depression (Myers & Weissman, 1980; Roberts & Vernon, 1983).

A major criticism of self-report scales measuring depression is the modest relationship between self-reported symptoms and diagnosis of depression (Roberts & Vernon, 1983). According to the literature, it seems that 27% of all cases are diagnosed as major depression, while 80% may suffer some other form of depression. This study intended to stay away from psychiatric diagnosis by utilizing the notion of depressed mood as well as remain congruent with the researcher's theoretical background which acknowledges the importance of individuals' "perceptions" of their realities. Thus, the choice of a self-report measure of depressive moods.

**Resilience in people with AIDS/HIV**

Identifying essential psychological and social resources that enable coping is a current research focus (Blaney et al., 1991; Gloersen, Kendall, Gray, McConnell, Turner, & Lewkowicz, 1993; Kadner, 1989;
Rabkin, Williams, Neugebauer, Remien, & Goetz, 1990; Remien, Rabkin, Williams, & Katoff, 1992; Worden & Sobel, 1978). Although not often enough, two constructs appear in the AIDS/HIV literature: (1) hardiness; and (2) resilience. Blaney et al., 1991 define hardiness as, “a personality trait, a composite of commitment, challenge, and control, qualities which foster cognitive reappraisals that enhance adjustment under stressful circumstances” (p. 297). Resilience is the individual’s ability to call on those strengths and resources that are needed to meet personal challenges, and to return to his/her previous psychological state or -in some cases- to a higher level.

The notion of resilience was embedded in the current research question, as it addressed this study’s aim to identify those resources that enabled seropositive individuals deal with their depressed moods.

Remien et al. (1992) studied long-term (36 months or more) AIDS survivors using quantitative and qualitative measures. Their findings suggest that active coping is associated with decreased psychological distress. Those individuals who continued to do well after prolonged survival were those who continued to respond with active coping. The data supported other findings that active coping is associated with

Furthermore, these authors found that psychological resilience and self-reported satisfaction with one’s life in long-term survivors is associated with (1) an absence of denial, (2) appropriate vigilance regarding physical symptoms, (3) pragmatism, and (4) adaptation of active and multiple cognitive and behavioural coping strategies. This finding is particularly interesting as it appears to substantiate the importance of people’s resilience in the process of dealing with depressive moods, and it supports the association between active coping and psychological distress - depression. Their qualitative data are particularly interesting. Unlike other researchers, Remien et al. (1992) collected data which were based on the participants’ perspectives. Their coping strategies, beliefs about reasons for survival, advice to newly diagnosed individuals, and the process of facing the “hardest part” of the AIDS challenge, represent inestimable information about the participants’ cognitions, beliefs, and resilience.

Gloersen et al. (1993) two year qualitative study focused on the phenomenon of “doing well” in people with AIDS. One of the similarities
between this study and the current investigation is that both include the notion of resilience in an arena that is more than often clouded with despair, helplessness, and lack of hope. The authors chose grounded theory to generate an understanding of the concept of "doing well" because of its focus on exploring individuals' perceptions, rather than verifying and defining wellness through quantitative measures. Participants were selected based on their ability to articulate and provide explanations concerning their experience with the disease.

Data were analysed using the constant comparative method. The authors made sure that potential limitations regarding the data's trustworthiness were minimized by having team meetings for peer debriefing, presenting the data to half of the participants for confirmation or revision, and by having an inquiry audit. It is unclear how they selected which eight participants to employ for confirmation and revision purposes. Furthermore, the study did not seem to have taken into consideration other validity and reliability procedures such as independent raters, experts raters (i.e., doctors and/or nurses dealing with this population), participation rate, or theoretical agreement from the literature in the field. It would be interesting to know if and how this study's findings can be
transferred to similar populations in order to look for similarities and differences in patterns and personal meanings. The authors identified eight categories: accepting; being active; masterful living; relating mind and body; being positive; positive thinking, experiencing support, and participating in health care. These results are valuable, as this investigator suspected that similar categories would emerge in the current study as themes that enable people to overcome depression.

Gloersen’s et al. (1993) study seems congruent with the major assumption of grounded theory, which is that the answers lie among those who experience the phenomena. Using co-researcher’s expertise was also part of my research, clinical practice, and ethical beliefs and conduct. Moreover, Gloersen et al. (1993) also concluded that “it is crucial to maintain nursing’s ideal of individualized care with clients by assessing and promoting the individual’s personal strengths and past responses to crisis” (p. 53). Bringing up strengths and past solutions is also congruent with this researcher’s theory and with the notion of resiliency. Gloersen et al. (1993) study represents the kind of research that sends a ray of hope and opens up possibilities for those individuals who are trying to find a more meaningful life story.
In summary, there is a growing tendency in the research world towards identifying the psychological resources that enable people to cope. The construct of resilience is one way of understanding people’s ability to adjust easily to life events. It connotes flexibility and readiness to cope. Remien et al. (1992) and Gloersen et al. (1993) embody invaluable references utilized to validate the data from the current study.
CHAPTER III
METHODOLOGY

The major considerations in selecting a design for the present study were threefold. This researcher was interested in providing a comprehensive vision or map of what helps people with HIV deal with the depressive mood that usually accompanies the diagnosis (Brown et al., 1992; Chesney & Folkman, 1994; Faulstich, 1987; Gloersen, Kendall, Gray, McConnell, Turner & Lewkowicz, 1993; Holland & Tross, 1985; Kessler et al., 1988; Montaner, 1994; Ostrow et al., 1989; Tross & Hirsch, 1988). Second, the investigator was interested in giving these people a "voice" regarding what facilitates the process of dealing with depressive moods from their perspective. The third reason refers to prevention. AIDS is a new disease. Very little is known about what helps people deal with their HIV+ diagnosis. It seems that more efforts have to be made in the direction of prevention, be it education on how to prevent contracting the virus, or having the information necessary regarding how to help this population deal with their diagnosis in a productive way (O'Shaughnessy, 1994). The present study is intended to contribute to the field of
counselling and prevention by providing information about what helps people with HIV+ deal with their depressive moods.

In trying to identify a research method that was congruent with the current investigator's assumptions and theory, Flanagan's (1954) Critical Incident Technique was considered to be appropriate and compatible with the author's assumptions and theory regarding resilience, and the purpose of the study. It was also considered a suitable means of exploring those times when the "exception" to the problem is present, as it requires the participants to look inside themselves to identify and describe these exceptions or "unique outcomes" (White, 1989). Based on this study's theoretical assumptions and the type of interview questions proposed by Flanagan (1954) and Woolsey (1986), the current investigation endeavoured to empower co-researchers to distinguish those resources that enable them not only to adjust and cope, but to move forward in their resilient world.

This researcher is aware of the existence of other methods that can be employed in qualitative research, such as case studies or phenomenological analysis. One of the purposes of the present study was to provide a channel for HIV+ individuals to expose and contribute their
expertise towards the collection of specific facilitative processes in their battle to overcome depressed moods. In other words, to give these individuals a "voice". A case study did not seem the most appropriate method to successfully attain the above mentioned purpose.

The research question in phenomenological studies is directed to elicit an in-depth reflective description of the experience that is the focus of the analysis (e.g., What is the meaning of overcoming depressed moods?). However, as the current study intended to identify specific behaviours (i.e., what facilitates overcoming depressed moods) and was not open to all aspects of the experience, it was considered that the critical incident technique was more appropriate in addressing the current study's research question than a phenomenological analysis.

In this chapter, the general nature of this technique is presented first, followed by a description of the co-researchers, interview procedures, collection, and classification of data.
Critical Incident Technique

The Critical Incident Technique (Flanagan, 1954) is designed to generate descriptive and qualitative data of an experience that is still mostly uncharted in the literature. This method was chosen to investigate what facilitates dealing with depressive moods after an HIV+ diagnosis in this study.

The Critical Incident Method consists of a set of procedures for collecting information from people about their direct observations of their own or other people's behaviours. The emphasis is on incidents which are critical. That is, things that happened that were directly observed or experienced, which significantly affected the outcome (Woolsey, 1986). Selection of co-researchers is based on these people having been in a position to observe or experience facilitation or hindrance relevant to the study in question, and their ability to articulate their experiences. Once the interview process is completed, critical incidents are extracted from the accounts and grouped to form similar thematic categories that encompass the events. These categories provide a comprehensive list (i.e., conceptual map) of what hinders or facilitates a certain psychological condition which is being investigated. It is Flanagan's
Flanagan (1954) developed this technique from studies in the Aviation Psychology Program of the United States Army Air Forces in World War II. His procedure helped in establishing factors that were ineffective or effective in learning to fly, being a good leader, or accomplishing any other specific activity.

Since Flanagan’s original studies, this technique has been successfully used in a multitude of studies in a variety of fields. Herzberg, Manseur, and Snyderman (1959) studied work motivation. Cohen and Smith (1976) investigated group process and found that a group leader needs to choose an appropriate intervention when a critical situation arises in the group. Flanagan (1978) conducted a study aimed to define the critical features of the quality of life of people from the United States of America. Borgen and Amundson (1984) investigated the experience of unemployment. Weiner, Russell, and Lerman (1979) used this technique for theory development in their study of the connection between emotions and cognitions in achievement related contexts. Rimon (1979) studied nurses perception of their psychological role in treating rehabilitation...

Flanagan (1954) describes five steps to a critical incident study: (1) determining the aim of the activity to be studied, (2) setting plans and criteria for the information to be observed, (3) collecting data, (4) analysing the themes or categories induced from the data, and (5) reporting the findings. The first step is to identify the purpose of the study in a clear and simple way. According to Woolsey (1986) this is a difficult step, as it requires "a good deal of hard thinking to clarify and to focus the aim statement" (p. 244). She suggests consulting the theoretical and empirical literature, as well as experts in the specific field the researcher is trying to investigate. Setting plans refers to who will make the observations, which individuals or activities will be observed, and which specific experiences or behaviours will be investigated. The incidents are collected through the use of questionnaires or interviews. Woolsey
(1986), Cochran (1995), and Ishiyama (1995b) suggest writing a detailed interview guide before starting the data collection. The next step is transcribing the data making sure to add nonverbal cues. Woolsey (1986) prefers working directly with audio-tapes in order not to lose vocal nuances and additional nonverbals provided by co-researchers' voices that can clarify the incident.

Analyzing the data consists of inductively studying the thematic nature of the description of the identified incidents. This involves a subjective process with the aim of providing a detailed and valid description of the activity that is being studied. The categories are tentatively formed by sorting the incidents into clusters that appear to be similar, and labelling them with descriptive titles. According to Easton (1986) and Proulx (1991) a process of redefinition of categories, and reclassification of incidents needs to occur until all items are allocated.

Description of co-researchers

Potential volunteer co-researchers were made aware of the present study through posters at St. Paul's and through doctors involved with this group of patients in Vancouver. Doctors were informed of the inclusion and exclusion criteria. Based on these criteria, they asked some
of their patients if they would like to participate in a research project that was studying what helped people overcome depressed moods after an HIV+ diagnosis. When patients expressed their interest to participate, doctors directed them to the Infectious Disease Clinic secretary, who proceeded to give them a card describing the researcher's background (Appendix A), and a letter describing in detail the purpose of the study (Appendix B). The pre-selection interview was done over the phone to ensure confidentiality of potential participants in the study. During the pre-selection interview the researcher ensured that potential participants met all the inclusion criteria. Part of the screening process was to check with the potential volunteers if they could foresee having any problems (i.e., strong emotional reactions) answering the type of questions that pertained to the aim of the study. Co-researchers were chosen from a total number of 20 interested seropositive individuals. Eleven volunteers met the inclusion criteria.

The inclusion criteria were as follows:

(1) 20-49 years old
(2) male
(3) sexually acquired infection
(4) within 6-18 months of HIV+ diagnosis
(5) documented HIV+ infection
(6) admission of the experience of depressive symptoms such as sadness, associated with the HIV+ diagnosis, and their willingness to talk about it.
(7) ability and willingness to provide informed consent
(8) ability and willingness to conduct an interview in English or Spanish
(9) ability and willingness to comply with study procedures (i.e. 2 interviews of up to 90 minutes within 3 months)

The exclusion criteria were the following:
(1) substance abuse within the last 6 months (i.e. drugs, alcohol)
(2) prior psychiatric diagnosis
(3) any use of psychotropic medications in the last 18 months
(occasional use of minor tranquillizers as nighttime sedation were not considered an exclusion criteria)
(4) prior AIDS defining diagnosis or CD4 below 200
(5) dementia of any etiology

A total of 11 (n=11) volunteer co-researchers participated in this study. The age of the participants ranged from 24 to 49 years old. All 11
co-researchers reported having been sad since the diagnosis. Only four participants were employed at the time. Those who did not work reported a difficult to moderate financial situation; while the four co-researchers who worked reported a moderate to easy financial situation. CD4 count levels ranged from 230 to 520. Three of 11 had been in an HIV status for 9 years; 18% \( (n=2) \) for 8 years; 9% \( (n=1) \) for 7 years; 9% \( (n=1) \) for 6 years; 18% \( (n=2) \) for 3 years; and 18% \( (n=2) \) for over one year, but less than three years.

**Interview procedures**

The first interview was divided in two parts. The first portion consisted of an orientation. The following statement was used to orient participants to the purpose of the study:

*Hello, X. Thank you very much for coming today. As I mentioned to you on the phone, the purpose of this study is to find out what helps people with HIV deal with the depressed moods that sometimes ensue after receiving the diagnosis. My intention is to meet with individuals like you, so that you can tell me what has helped and/or hindered this process, and find out what enabled you to*
respond to different events in a helpful way. My goal is to come up with a comprehensive map of what helped you, so that other people can learn from your personal strategies and maybe prevent them from having to go through some rough times. In order to do that I need your help, and I really appreciate your being here today to give me a chance to talk to you about this study. I am looking forward to working with you.

In addition, researcher and co-researchers discussed the nature of the study, clarified the nature of events to be reported, and established rapport. The researcher was aware of the importance of making the aim statement very clear to all participants, in order to avoid the danger of collecting answers that were not based on the study's aim. During this interview the co-researchers were presented with a consent form explaining the purpose of the study, the type of question to be asked, confidentiality and their option to withdraw from the study at any given time. Upon reading this form the researcher offered to clarify any questions the co-researchers might have had. The form (Appendix D) was signed by both researcher and co-researcher when all the details had
been addressed and discussed to the benefit of the co-researcher.

Following Woolsey's (1986) suggestion and her statement that it is important to gather relevant descriptive biographical data about respondents, the co-researchers were asked to answer a demographic questionnaire (Appendix C) upon giving informed consent. Some of the questions were related to what the literature seems to have identified as coping mechanisms for people with HIV+ and/or AIDS, such as support from immediate family and friends, as a way of dealing with depressed moods (Belkin et al., 1992; Fleishman & Fogel, 1994; Lackner et al., 1993; Ostrow et al., 1989). Data from the demographic questionnaire were not analysed for the purposes of the present study, but might be used for further research with the co-researchers' consent. A summary table with basic demographic information, follows.

Insert table 2 about here
Table 2: **Summary of basic demographic data**

<table>
<thead>
<tr>
<th>Participant Code Number (All males)</th>
<th>Age</th>
<th>Year of HIV+ Diagnosis</th>
<th>Present Employment Status</th>
<th>Present Financial Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>24</td>
<td>1993</td>
<td>EMPLOYED</td>
<td>MODERATE</td>
</tr>
<tr>
<td>32</td>
<td>37</td>
<td>1987</td>
<td>UNEMPLOYED</td>
<td>DIFFICULT</td>
</tr>
<tr>
<td>33</td>
<td>41</td>
<td>1987</td>
<td>EMPLOYED</td>
<td>MODERATE</td>
</tr>
<tr>
<td>34</td>
<td>33</td>
<td>1987</td>
<td>EMPLOYED</td>
<td>EASY</td>
</tr>
<tr>
<td>35</td>
<td>37</td>
<td>1989</td>
<td>EMPLOYED</td>
<td>EASY</td>
</tr>
<tr>
<td>36</td>
<td>48</td>
<td>1988</td>
<td>UNEMPLOYED</td>
<td>DIFFICULT</td>
</tr>
<tr>
<td>37</td>
<td>31</td>
<td>1993</td>
<td>UNEMPLOYED</td>
<td>MODERATE</td>
</tr>
<tr>
<td>38</td>
<td>34</td>
<td>1995</td>
<td>UNEMPLOYED</td>
<td>MODERATE</td>
</tr>
<tr>
<td>39</td>
<td>43</td>
<td>1995</td>
<td>EMPLOYED</td>
<td>MODERATE</td>
</tr>
<tr>
<td>40</td>
<td>49</td>
<td>1990</td>
<td>UNEMPLOYED</td>
<td>DIFFICULT</td>
</tr>
<tr>
<td>41</td>
<td>37</td>
<td>1988</td>
<td>UNEMPLOYED</td>
<td>MODERATE</td>
</tr>
</tbody>
</table>
In addition, the participants were asked to complete the Center for Epidemiological Studies Depression scale (CES-D) in order to provide information on their depressed moods at two points in time (i.e., presently and at HIV+ diagnosis). The rationale for this procedure is that doctors in general seem to believe that because an HIV+ diagnosis can be considered a major life event participants will be able to remember how they felt at the time (Kuhl, 1995; Montaner, 1995).

The Center for Epidemiology Depression Scale (CES-D) was employed as an indicator of depressed mood (Appendix C-part II). The 20-item scale covers depressed mood, loss of appetite, sleep disturbance, and feelings of guilt, worthlessness, helplessness, and hopelessness. Four items (i.e., numbers 4, 8, 12, and 16) are worded in the positive direction to break tendencies toward response set, as well as to assess positive affect or its absence (Radloff & Locke, 1986). The possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology. The cut-off for depressed mood is 16. Each response was scored from zero to 3 on a scale of frequency of occurrence of the symptom during the previous week (i.e., presently) and at the time the participants received the news of their HIV+ diagnosis (i.e.,
According to the data collected on depressed moods at two points in time (presently and at diagnosis), all the participants showed reductions on the depression scores. As a whole group, the difference was statistically significant \( (F(1,10)=25.25, p<.01) \), indicating lowered depressed mood levels at the time of the interviews in the present study. Table 3 summarizes the CES-D data.

The second portion of the first interview consisted of eliciting critical events that pertain to the study. This part of the interview was approximately one hour in length and was tape-recorded with participants' consent. All interviews took place in an office at the St. Paul's Infectious Diseases Clinic. The last portion of the first interview began with the researcher asking the following question:

"Think back to a time since your HIV+ diagnosis when you were experiencing depressed moods. What helped the process of dealing with your depressed moods? What did
Table 3: Self-reported depressed mood scores at point 1

(HIV+ diagnosis) and at point 2 (presently)

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Point 1 (diagnosis)</th>
<th>Point 2 (presently)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>32</td>
<td>35</td>
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<td>40</td>
<td>50</td>
<td>21</td>
</tr>
<tr>
<td>41</td>
<td>56</td>
<td>25</td>
</tr>
</tbody>
</table>

n=11

M=39.7
SD=17.6

M=12.7
SD=7.3
not help? What would you say are the personal resources that enabled you (that you drew from) to deal with your depressed moods?

Once the above questions were asked in succession, the co-researchers took the time to recollect their memories. Although some co-researchers might still be experiencing some symptoms of depressed moods, this was not regarded as a problem in this particular study, because embedded in the research question is the theoretical assumption that there are usually exceptions to the problem (de Shazer, 1985). In other words, the level of depressed mood experienced by an individual may fluctuate depending on the individual's context, feelings, thoughts, and actions. It was hoped that if individuals were still depressed, the above questions might help them bring up their resilient aspects by looking into their familiar resources and coming up with helpful and meaningful strategies to deal with their depressed moods.

The questions asked to facilitate the interview process (Appendix E) were phrased in such a way that co-researchers could freely talk about what was pertinent and meaningful to their experience. The researcher elicited information about what facilitated and/or hindered dealing with
depression, and probed further to clarify responses with a question such as: “How did you know that it was helpful?” This process continued until the co-researchers were not able to think of any new incidents. At this point, they were also asked to think of what hindered dealing with depressed moods. From a theoretical point of view it was hoped that this question might, in addition, lead to provide information on “the difference that makes a difference” (deShazer, 1985). In other words, what facilitates the co-researchers’ change in their way of overcoming depressed moods. However, as this question does not refer to the aim of the study, the data was not analysed for the present study, but may be used for further research. When the co-researchers were not able to recall any new incidents, the researcher proceeded to ask them about their sources of resiliency. The question was: “What would you say are the personal resources that enabled you (that you drew from) to deal with your depressed moods?”

The interview ended after approximately 90 minutes, or when the co-researchers were not able to recall any new incidents. The participants left with an open invitation to recall more facilitative and hindering incidents to be shared with the researcher during the second interview.
The second interview can be considered as an innovation to the Critical Incident technique, as it introduced a phenomenological component to this study (e.g., participants ascribed meaning to the categories), and was used as a form of validation procedure (e.g., checking the categories with the co-researchers). The second interview occurred within three months of the first interview. In three cases, these interviews were conducted via telephone, for the convenience of the co-researchers. Data had been partly analysed by this time, according to the procedure that will be presented in the next section.

The protocol for the second interview was as follows. The researcher read from a protocol card:

As you know, the purpose of this second interview is to check the categories I have defined and find out if there are any more helpful and unhelpful critical incidents since we last talked. We will go over each recorded incident together. I will read them to you, and you will tell me if they fit with your experience, and if you agree with the category under which they have been classified. You can then modify, that is, add or subtract, any part that does not fit,
or add anything that is meaningful to that incident. After we have verified each incident, we will spend 15 to 20 minutes with any other new event that you may want to add regarding what helps or does not help you deal with your depressed moods. Do you have any questions?

Flanagan (1954) considers the size of the sample to be the number of critical incidents obtained from the interviews, rather than the number of people interviewed. Data were analysed after every three interviews, in order to recognize the emergence of repetitive patterns requiring no new categories. Repetitive patterns began to develop after the fourth interview. No new categories were formed after the ninth interview. When new categories stopped emerging, the researcher assumed that sufficient incidents had been collected.

**Analysis of the data**

The analysis of the incidents involved three parts. First, extraction of events from audio-tapes and keeping a record of each incident on a card. Second, grouping the incidents according to similarities to form categories. Third, examining the validity of the categories.
Extraction of the incidents

All interviews were tape-recorded, transcribed, and number-coded. Incidents were typed out in the words used by the co-researchers. Before the event was extracted, each transcript was carefully studied in order to understand the full meaning of the statements. Initially the researcher made a list of everything resembling a critical event. This list was later subjected to an examination based on the following criteria and corresponding questions: (a) Was the co-researcher's account stated in a complete way? (i.e., How and when did he notice symptoms of depressed moods?); (b) Was the event clearly identified? (i.e., What was helpful/hindering in overcoming depressed moods?); and (c) Was the outcome related to the purpose of the study? (i.e., What did the co-researcher do that helped/hindered the process of overcoming depressed moods?). Incidents that did not meet the above criteria were cast aside and re-checked and clarified with the co-researchers for validation purposes during the second interview.

Critical incidents were divided in three parts: the source, which indicated who was involved and the context of the event (e.g., “The Dr. told me that my CD4 count was at the lowest level ever”); the action
taken, which explained what happened (e.g., "I went to visit my mother in Ontario because I was depressed, scared, and I felt I needed to see her while I was still mobile"); and the outcome, which described the effect that followed the incident (e.g., "I felt very sad and guilty because I had made no effort to contact my mother and my sisters since I was diagnosed HIV+ two years back. When I saw her and told her about my condition face to face, I felt good about myself and I noticed that I had more energy to do things when I came back. We have kept in contact since my visit I feel quite supported by them all"). All incidents were divided into the above three components in order to facilitate sorting out the events into categories. The process of extracting incidents was straightforward after following the above mentioned guidelines.

**Forming the categories**

The purpose of this study is to provide a map of what helps people with HIV+ deal with the depressed moods that usually ensue after the diagnosis. The focus of sorting incidents into similar groups in order to produce categories was placed on the action taken (i.e., what happened). These groupings then became the basis of the evolving category systems, which emerged spontaneously.
Flanagan (1954) states that this process is "more subjective than objective", and that it requires "insight, experience and judgement" on the researcher's part (p.344). As it was expected, some incidents were clearer than others. The clearest incidents were categorized first and were used as prototypes for the corresponding categories. Less similar incidents were marked with a red flag and cross-checked by each specific co-researcher. The researcher had expected the possibility that some incidents could be categorized into several categories. Novotny (1993) categorized borderline incidents "on the basis to which extent they resembled the prototype of a particular category more than the other" (p. 54). Once a tentative facilitating category system had been established, and marked with a yellow flag, categorization was subjected to the co-researchers, who checked the fit between incident and category.

As this is an inductive process, it was expected that corrections would have to be made, and categories might have to be renamed in order to better represent their contents. Seventeen categories were formed after the first interview. Some of these categories were re-named, while others stayed the same. A few critical incidents were added or subtracted from a previously selected category, in order to accomplish a
more meaningful fit between category and critical incidents. This inductive process was jointly performed by researcher and co-researchers during the second interview. A table of the categories formed by the researcher, before (following the first interview) and after (during the second interview) validation from co-researchers had been performed will be presented in the following chapter.

In case of a strong emotional response on the co-researchers’ part, a list of counselling resources such as the Crisis Centre phone number, AIDS Vancouver, and some counselling agencies was to be provided to the co-researchers. The researcher prepared for a similar contingency by having an independent counsellor to process the emotional effects of the interviews and other counter transference issues. Neither the participants nor the researcher needed to pursue these alternatives.

Validation procedures

In a study published in 1964, Anderson and Nilsson concluded that the critical incident method was both valid and reliable. These authors utilized several methods to test the validity of the category system, and the reliability of the method. They found that the number and structure of the critical incidents were slightly affected by different interviewers, and
that the method of collecting data (e.g., questionnaires, interviews) did not affect the structure to any great extent. Flanagan (1954) suggested that the critical incident technique could be compared with relevant literature to provide a check of construct validity as well as an opportunity for discrepancies to be studied and illuminated.

The validity of this study was ensured through several procedures that addressed Maxwell's (1992) notions of validity. According to Maxwell (1992) qualitative researchers "rely on a variety of understanding and corresponding types of validity in the process of describing, interpreting, and explaining phenomena of interest" (p. 279). This author describes three types of validity commonly used in qualitative research: (a) descriptive validity; (b) interpretive validity; and (c) theoretical validity.

Descriptive validity refers to the accuracy of the account. In the current study tape-recorded interviews and transcripts were employed to faithfully utilize the participants' words. Unclear descriptions were constantly checked and clarified. The second interview was highly useful in ensuring validity. During this interview unclear incidents and emerging categories were cross-checked by the participants in order to avoid distortion of the co-researchers' account.
Interpretive validity is concerned with what the events and behaviours mean to the participants. This type of validity takes into consideration the co-researchers' perspective, their "voice", which was one of the purposes of the current study. According to Maxwell (1992) interpretive accounts are "grounded in the language of the people studied and rely as much as possible on their own words and concepts" (p. 289). Questions asked during the first and second interviews were directed towards obtaining a clear explanation and understanding of the critical events, and their effects on the individuals' depressed moods and psychological state. The outcomes section on the Discussion chapter is an example of interpretation constructed by the researcher on the basis of the co-researchers' accounts during the first and second interview.

Theoretical validity refers to the explanation of the phenomenon and it is related to the validity of the assumptions of the study. These assumptions (i.e., existence of depressed moods, "exception" to the depressed moods, and resiliency) are based on theory and previous research. The findings of the current study expand on the facilitative categories and the notion of resiliency.

To further ensure the validity of this study, several procedures
were selected to answer specific validation questions, such as consistency and comprehensiveness of the categories, agreement among independent individuals, relevance of the category system according to experts in the field, and compatibility with previous research. These procedures utilized: (1) independent rater; (2) co-researchers cross-checking; (3) exhaustiveness; (4) participation rate; (5) expert rater; and (6) theoretical agreement. These procedures are described in the following chapter.
CHAPTER IV

RESULTS

A total of 246 critical incidents were identified by eleven adult men diagnosed with HIV+, concerning what facilitates this sample of the population deal with depressive moods that may ensue after receiving the news of the diagnosis.

The 246 critical incidents were classified into 13 categories. In this chapter, these categories are first described, followed by validation procedures, and a description of the sources of resiliency of this sample.

Part 1: Description of Categories

In this section the 13 categories are described, and presented in order of higher frequency first. Categories sharing the same number of critical incidents are presented according to higher participation rate. Examples of incidents, and an indication of the sub-categories of critical incidents within each category are also provided. Co-researchers ID numbers were randomly selected and assigned. Table 4 represents a summary of the thirteen categories and their respective frequencies.
Category 1: Participation in activities (53 incidents - 100% participation rate.) Co-participants benefited from a pro-active attitude, which translated into a willingness to keep busy when feeling depressed, in order to deal with their depressed moods successfully. The outcome is a sense of balance, self-worth, of being in charge of their own life as much as possible, feeling more hopeful, empowered, competent, autonomous, and less depressed. Critical incidents themes in this category are: (a) pets; (b) connection with nature (e.g., gardening, looking at birds, and smelling the scent of flowers); (c) visualization (e.g., visualizing a memory that has special meaning); (d) reading; (e) writing; (f) house chores; and (g) art (e.g., listening to meaningful music, visiting museums, and looking at beautiful things).
Table 4: List of categories and respective frequencies

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (Total number of incidents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participation in Activities</td>
<td>53</td>
</tr>
<tr>
<td>2. Connection with Self</td>
<td>46</td>
</tr>
<tr>
<td>3. Establishing Social Connection</td>
<td>39</td>
</tr>
<tr>
<td>4. Sharing the News</td>
<td>14</td>
</tr>
<tr>
<td>5. Looking for Meaning</td>
<td>14</td>
</tr>
<tr>
<td>6. Commitment to Life</td>
<td>13</td>
</tr>
<tr>
<td>7. Spiritual Connection</td>
<td>12</td>
</tr>
<tr>
<td>8. Helping Others</td>
<td>11</td>
</tr>
<tr>
<td>9. Physical Exercise</td>
<td>11</td>
</tr>
<tr>
<td>10. Learning from a Role Model</td>
<td>11</td>
</tr>
<tr>
<td>11. Gaining Understanding of the Problem</td>
<td>11</td>
</tr>
<tr>
<td>12. Career/Work</td>
<td>6</td>
</tr>
<tr>
<td>13. Alcohol/Drugs</td>
<td>5</td>
</tr>
</tbody>
</table>
EXAMPLE 1
Co-researcher #41 (37 years old)
When I am feeling down I know it is because I am going to die. Then the feeling sky rockets. I get out of that mood by keeping busy. I'll do laundry, clean, take a walk, go for a drive. The bottom line is to get out of where I am, and then I feel less depressed.

EXAMPLE 2
Co-researcher #36 (48 years old)
I have found that listening to Native American music is an immense help when I am down. I get a better feeling overall. It's like, calmness comes over me, and it gives me peace and contentment, and I feel less down.

EXAMPLE 3
Co-researcher #41 (37 years old)
I like cross-stitching. It keeps me busy and keeping busy is very helpful to snap out of those depressing moods.
EXAMPLE 4

Co-researcher #40 (49 years old)

My dogs are very good therapy when I am depressed. Even though they can be a lot of work, and I sometimes do not feel like taking them for long walks, I love them very much. They are always happy to see me. They love me unconditionally, and when I have one of those depressed moods, just being with them, playing with them, helps me overcome these awful moods. It's amazing!

EXAMPLE 5

Co-researcher #33 (41 years old)

Looking at art is inspiring. I like to be surrounded by nice things. What I get out of it is a sense of relaxation, I feel better, more hopeful. I am happier, and less down in the dumps when I look at art.
EXAMPLE 6

Co-researcher #38 (34 years old)

I have a book where I write my thoughts. It's my gratitude list. A list of all the things that I have. When I'm depressed I read from it, and I remind myself of all the things I have and I should be thankful for. It helps put things in perspective, and my mood disappears.

EXAMPLE 7

Co-researcher #35 (37 years old)

My dog helps me a lot when I am down. I take it everywhere I go. I tend not to go to places where I can’t take my dog. It provides me with warm physical contact, because I can’t do it with a person. My dog gives me unconditional love, and it distract me from my sadness. When I am depressed, I take it for a walk or spend time with it.
EXAMPLE 8
(Added during the second interview)

Co-researcher #35 (37 years old)

Another example of what helps me overcome my depressed moods is this interview. Making the phone calls necessary to arrange our first and second meeting kept my mind busy. I was doing things for me, for something meaningful and important, and I had a good feeling. The side effect of this study is helpful to me. I get a sense of contributing positively to a better understanding of what is going on for me and others, and that makes me feel good about myself, fulfilled, and with a sense of self-worth.

EXAMPLE 9

Co-researcher #39 (43 years old)

Keeping a journal is a personal, important, and necessary experience. There are a lot of things I can share on paper that I have difficulty articulating. Actually, sometimes I have even surprised myself by writing things down that I had not been
aware they were important. Writing is very meaningful to me because I gain knowledge about myself, it calms me down, and I feel less depressed.

EXAMPLE 10

Co-researcher #36 (48 years old)
Sometimes when I have one of my low times I put on a video. A movie takes my mind off my down times, and I can escape for a while. I only need 5 or 10 minutes of watching it, and I have escaped! I know that a video is helpful because I stop dwelling on my problem and the sadness, and I feel less depressed, and I don't feel sorry for myself.

Category 2: Connection with self (46 incidents - 91% participation rate.) This category denotes self-understanding, and a sense of being in charge of their own life. Co-researchers are in tune with themselves in order to come up with the necessary resources to overcome their depressed moods. Participants are creative and imaginative in the way they use their internal resources. It is different from "Looking for Meaning"
because the co-researchers are tuned into their strengths/resources that will enable them to deal with their depressed moods. There is an internal search for what the participant knows might be helpful, whereas “Looking for Meaning” implies a search for a new improved self. This category includes sub-categories of preventive measures used by co-researchers such as: (a) not dwelling on negative feelings; (b) thinking what else they could do that might work; (c) having a helpful daily routine; (d) learning from the past; and (e) positive self-statements. Other critical incidents in this category are: (f) humour; (g) welcoming challenge; (h) individual space; (i) acceptance of self; and (j) being attentive to their moods and needs. The participants know themselves and what best works for them, can catch themselves getting into a depressed mood, and are good at knowing what to do to overcome it. The outcome is a sense of balance, control, competency, self-worth, and self-confidence.

EXAMPLE 1

Co-researcher # 38 (34 years old)

Some people pull away when I tell them that I am HIV+. That brings me down in my mood. But I do not let their behaviour
affect me. I choose not to take it personally. What I do is to remind myself that I am a good person, and I give myself some examples of why I think I am good. Like, I help others when I have a chance, and so on. Then I feel good about me, I feel more confident, and the depressed mood is gone.

EXAMPLE 2

Co-researcher #37 (31 years old)

I try not to dwell on negative feelings. I listen to what is going on for me. If I feel depression coming up, I change what I am doing, and do something that makes me happy, less sad. I am pretty good at knowing what might help me get out of my depressed mood.

EXAMPLE 3

Co-researcher #33 (41 years old)

When I am down I need to create my own space. I am kind of a loner, and I feel better, less depressed, when I can be by myself and put my thoughts together.
EXAMPLE 4

Co-researcher #33 (41 years old)

I think that having been depressed as a teenager has prepared me for this disease and the depressed moods that come with it sometimes. I know that I got out of depression once, and I can do it now again because I know what helps me. I can face it. What do I do? I tune in and try to come up with something that will help me get rid of my depression, and I have to say I am quite successful at it!

EXAMPLE 5

Co-researcher #35 (37 years old)

When I am sad, I ask myself: “Why do I feel this way?” Then I give myself permission to feel, not to worry, and not fight it. By doing that I put the feeling aside, I recognize it for what it is. This feeling is normal. Depression is normal. This insight lifts my spirits and I feel good about having solved one more question. By accepting the feeling, I get rid of it!
EXAMPLE 6

Co-researcher #34 (33 years old)

One of my favourites phrases is: "As long as I can, I will". I will work, I will sleep, I will be happy, etc. This is a statement I tell myself all the time. Someone needs to be positive in all this. I don’t take the whole world in my shoulders, but I try my very best. Repeating this statement to myself helps me feel better overall, more hopeful, less depressed.

EXAMPLE 7

Co-researcher #38 (34 years old)

When I am depressed, one of the things I try to do is use positive self-talk. I say to myself, “You are good looking.” That helps me when I am down. It may sound stupid, but it helps!

EXAMPLE 8

Co-researcher #34 (33 years old)

One of the things that really help me when I am hit by a depressed mood, is to rely on my strength to endure. I love the
challenge of every day life. I thrive on how tough it is, and I make it easy by just facing it and doing it. I say to myself, “Face the fear, and the fear is no more.” I know myself, and I know what helps me overcome those moods. And they don’t last.

EXAMPLE 9

Co-researcher #37 (31 years old)

If I feel depression coming up, I change what I am doing, and do something that makes me happy. I try not to dwell on negative feelings. I look inside myself, and I come up with something that I think will be effective in helping me overcome depression.

EXAMPLE 10

Co-researcher #31 (24 years old)

When I have a depressed mood, I need to have space. That’s why I have chosen not to tell my mom, or other people. I know myself and what works for me. Space is very important. I need
freedom, and I do not want pity. I know that not to create, or
have my own space would make me feel depressed.

Category 3: Establishing a social connection (39 incidents - 100% participation rate.) This category involves going beyond the individual's world and connecting with other people. By establishing a social connection, the individual is able to step out of his depressed mood and deal with his diagnosis in a more meaningful way. Critical incidents themes were: (a) reaching out to friends, co-workers, or family members; and (b) connecting with specialists or caregivers. The outcome is a sense of not being alone, being supported, loved, liked, and accepted by others. Establishing a Social Connection is often seen as a reason for living, a feeling of being in charge, being part of the world, which in turn facilitates dealing with depressed moods.

EXAMPLE 1

Co-researcher #41 (37 years old)

Talking to a friend who found me when I tried to commit suicide helps me a lot. I can be more honest with her than
with anybody else. So, I pick up the phone and call her when I am depressed. By talking to her almost every day, it helps me control my mood.

**EXAMPLE 2**

Co-researcher #32 (37 years old)

It helps me to know that I can talk to my brothers and sisters, and that they will not shy away. Talking to them, knowing that I can do that, is like a security blanket. I know it's there. It would hurt if I couldn't talk to my family. This is how I sometimes overcome my depressed moods. Talking to them helps a lot!

**EXAMPLE 3**

Co-researcher #38 (34 years old)

When I am down I ask my friends to give me a hug. It helps a lot. I know that I need to be touched, and I can ask for it. I need affection, attention, and hugs when I am depressed. So, I ask for it, and my depression gets lift off my shoulders.
EXAMPLE 4

Co-researcher #33 (41 years old)

I know that my family cares a lot about me. They have showed that many times. Their love, caring, acceptance, and support give me a reason for living, which helps me a lot when I am depressed because of my HIV.

EXAMPLE 5

Co-researcher #40 (49 years old)

I am quite introverted, but I have come to realize that opening up, talking to my best friend, really helps me deal with those depressed moods. It is not easy. I need to be prompted, and then I open up to a certain point. When I do, it definitely helps.

EXAMPLE 6

Co-researcher #37 (31 years old)

I get a lot of support from my gay friends and from my family. Their support is very helpful to me when I am depressed. It
makes me feel loved, supported, accepted, and I don't feel lonely any more. Their support helps me overcome my depressed moods.

EXAMPLE 7
Co-researcher #41 (37 years old)
When I am down I look at my three kids' pictures. That helps me get past the low point, and I know it makes tomorrow look a little bit better. I get strength from looking at their picture, and I feel hopeful that I am going to see them get older.

EXAMPLE 8
Co-researcher #32 (37 years old)
I come from a big family. My youngest brother is also gay. My brothers and sisters do not feel threatened by HIV, and they trust me with their kids. That's very important to me. It would really hurt if I could not talk to my family. Being honest and transparent with them is very helpful when I am down, and in general. I feel loved, and accepted, and I don't feel alone.
Category 4: Sharing the news (14 incidents - 91% participation rate.) Choosing to inform others of their HIV+ diagnosis can sometimes diminish the feeling of sadness and oppression brought by a depressive mood. It is different from the category "Establishing a Social Connection" in that its purpose is disclosing their HIV+ diagnosis to others. In general, the process of sharing the news involves premeditation (i.e., who to tell, when, and how). Sub-categories are: (a) telling friends; (b) telling family members; and (c) telling significant others and other meaningful people in their lives. The outcome of sharing the knowledge of their HIV+ status with other people, is a lifting of depressed moods, an expression of meaningful intimacy, valuing honesty and transparency, a sense of being in charge of their life, and the knowledge that they are not alone facing the challenge of the illness.

EXAMPLE 1

Co-researcher #38 (34 years old)

The day of the results I asked not to go alone. After I left the doctor's office, I told my friend, the one who had accompanied me. Then I shared the news with selected friends, so as to
keep control of my life. That helped.

EXAMPLE 2

Co-researcher #36 (48 years old)

I told my sister about being HIV+ and she understood. I feel very supported when I realize we can talk about anything, that there are no secrets. I always thought I had to be honest with my family. I felt much better, less down, relieved, after I told her.

EXAMPLE 3

Co-researcher #34 (33 years old)

I told my parents as soon as I was aware of the diagnosis. Telling them was a way to show them I loved them. They needed to prepare, like me, and deal with it. Telling is one of the keys to emotional survival.
EXAMPLE 4

Co-researcher #31 (24 years old)

I chose to tell a psychologist, who is also a friend of mine. When I did, I experienced a big sigh of relief. I felt totally supported. I could trust him, and I did not feel alone. What I got out of telling was a huge relief. I said to myself: "Now there is someone in my corner," and my mood lifted, I felt much better.

EXAMPLE 5

Co-researcher #34 (33 years old)

My grandparents had to know, and I had to tell them. One of the hardest things I have ever had to do in my life is to tell my grandparents that they might outlive their grandson. But I love them enough that if anything happened to me I did not want them to say, "Why didn't he tell us? Didn't he love us enough?" Even though it was hard to do, I felt much better afterwards. I felt relieved by the fact that I showed them my love and respect, and it helped me a lot. It was a feeling of being in charge, and it helped me feel less down.
EXAMPLE 6

Co-researcher #32 (37 years old)

When I was told of my diagnosis I felt very depressed. I was very afraid of telling others, so I decided to tell only my best friends. I froze HIV off completely for a while. It started hitting me when some of my friends died, especially one friend in particular. That's when I decided to do something about it, to face it. My friend's death motivated me to do things for myself, to take control again. One way of doing it is by telling my family. I told my brothers and sisters, but I have not told my mom. I'm not sure if I will tell her eventually. I know that right now, it would not help my mood if I told her, and that's why I have not done it yet. Telling others did help, because I felt more in control, more in charge, and less down.

Category 5: Looking for meaning (14 incidents - 73% participation rate.) This category implies the co-participants' search for improving themselves (self-actualization), and having a purpose in life, as well as a recognition of what is important in life and what is not. Critical incident
themes in this category include: (a) re-defining personal values; (b) acceptance of the diagnosis; (c) putting the diagnosis into perspective; (d) goal setting; (e) recognition of what is important in life; and (f) self improvement. The outcome is a sense of purpose which translates into hopeful views, an awareness of having a route, plan or purpose, and an overall sense of feeling less depressed.

**EXAMPLE 1**

*Co-researcher #35 (37 years old)*

Recognition of what is important in life helps me with my ups and downs. By reassessing what's important and what is not, I maintain my neutrality, and my mood is balanced.

**EXAMPLE 2**

*Co-researcher #34 (33 years old)*

When I lost my best friend I thought about my own mortality and I felt very down. Then I started doing things with a purpose, for a purpose, and felt much better having a route, a purpose in life, a plan. Knowing that I have a purpose helps
me feel less down, and I also feel more content, and more in control.

EXAMPLE 3

**Co-researcher #31 (24 years old)**

I was in a fog after the diagnosis, and very, very down. Then I started thinking about it all, and I asked myself: What do I really value? What do I enjoy? And I became aware of all those things, and did things according to my values. When I do that I feel better, less depressed. It helps.

EXAMPLE 4

**Co-researcher #38 (34 years old)**

Sometimes, when I am down or depressed, I remind myself that today is all I have. I can't change the past, and I do not know about tomorrow. By being accepting of the things I cannot change, I am finding a better sense of balance. Accepting what I cannot change helps me overcome those bad, depressing moments.
EXAMPLE 5

Co-researcher #39 (43 years old)

I set a goal for myself every day. This is my way of controlling depression, of preventing it as much as I can, of dealing with it even before it starts. I have found that by trying to do things, and setting goals for myself, I avoid depressed moods. Then I get a feeling of competency, of being in charge.

EXAMPLE 6

Co-researcher #38 (34 years old)

The HIV+ diagnosis has given me a new philosophy of life. I focus from death to life. Life is the train I want to be on. So, I look at things from a different perspective, and I don’t let depression overwhelm me. That’s how I feel I am doing something about it. I feel more in control, more balanced, and less depressed.
EXAMPLE 7

Co-researcher #35 (37 years old)

Sometimes when I am down I have nightmares and dreams. What I get from them are self-fulfilling signs, some kind of message or clarification. It's like a recognition, and support that I am in the right direction. I am happy to have dreams. I get some kind of physical vibration through the adrenalin that comes with them. When I look at the reason behind the dreams I get a comforting sense that I am on the right track, and I feel less down.

Category 6: Commitment to life (13 incidents - 82% participation rate.) This category denotes a belief, or attitude that speaks about the co-researchers' commitment to live. Participants talked about not wanting to waste time agonizing whether or not life is worth living. They know it is, and have the strength and courage to bounce back in spite of their illness. Critical incident themes are: (a) focusing on other aspects of life that are not HIV/AIDS related; (b) having the desire to grow older; (c) embracing every new day as a gift; and (d) not being caught in the despair of HIV.
The outcome is a willingness and commitment to make lifestyle changes, an overall feeling of empowerment, of being more in charge of their lives, a sense of competency, and a lifting of depressed moods.

**EXAMPLE 1**

**Co-researcher #31** (24 years old)

When I am depressed I think that HIV is something I have to deal with, and I have to fight it. It is ONE aspect of my life. It is not as huge, it is like any other disease. Then I feel more in control, able to deal with things as they come, and certainly less depressed.

**EXAMPLE 2**

**Co-researcher #41** (37 years old)

I used to be so depressed that I had suicidal tendencies for a while. I snapped out of that mood by thinking that I do not have a reason to kill myself, I have responsibilities, I have three kids, and I am financially OK, so I don't allow myself to act out those tendencies anymore.
EXAMPLE 3

Co-researcher #33 (41 years old)

When one of my friends dies from AIDS, I get depressed because I think of my own mortality. What I do then, is to remind myself that I also have friends who are not seropositive. What helps me is to try to grab to other aspects of life that have nothing to do with AIDS or HIV. Then I feel hopeful, more in control, and my depression is gone. Being caught in the despair of HIV can be very depressing. I have discovered that focusing on other aspects of life is very helpful to get out of those depressing moods that make me feel upset sometimes.

EXAMPLE 4

Co-researcher #34 (33 years old)

I am HIV+ and I also have cancer. I have always been an up sort of person, and I tend to look at things from different perspectives. I have embraced chemotherapy and HIV. The result is that I am facing the fear, and I am not afraid of dying
any more. That really helps me when I have a down moment.

EXAMPLE 5

Co-researcher #33 (41 years old)

When I am down I tell my body that I am not going to die of AIDS. I switch my thinking, and I remind myself that things are always changing in the medical world of AIDS. That helps. I am committed to fight this, and I will.

EXAMPLE 6

Co-researcher #32 (37 years old)

Sometimes I find it hard to look around and seeing other people dying of AIDS, and I wonder why I am still alive. I am aware that I have a gift, the gift of life, and I have to take advantage of it. Being aware of this gift helped me make some life-style changes. I stopped drinking and smoking. It also helps me get grounded when I am having a depressed mood.
Category 7: Spiritual connection (12 incidents - 55% participation rate.) This category encompasses prayer and other forms of connection with the Creator, God, or a spiritual self. As none of the co-researchers belonged to a specific religious group, this category does not include any form of participation in a specific religion, but focuses on spiritual connectedness. Some co-researchers pointed out that spirituality was an important source of balance in their lives. The outcome is a general sense of calmness, a hopeful attitude, a lifting of depressed moods, and a realization that death does not need to be feared. Included among other critical incidents were talking to their God and meditating.

EXAMPLE 1

Co-researcher #33 (41 years old)

Sometimes when I am depressed I pray and I ask for life. I don't know, it is something that seems to work, because afterwards I feel better, less depressed.
EXAMPLE 2

Co-researcher #36 (48 years old) Something that really helps my depression is meditating. What I get from meditating, or when I use my book of sayings, is a feeling of hopefulness. I feel immense help, more hope, and I end up less depressed.

EXAMPLE 3

Co-researcher #36 (48 years old)

When I am sad I remind myself that this is testing ground. I believe that we don’t go through this for nothing. To believe helps me. I feel secure within myself that even if I was to die, there would be something else out there. This is a big adventure, you know? When I think that I no longer feel sad, but I get a feeling of optimism and I realize that I’m not afraid of dying.

EXAMPLE 4

Co-researcher #40 (49 years old)

Reincarnation is in the back of my mind a lot. That is
something I think about when I am depressed. Life is a learning process. I am not afraid of dying. I believe in reincarnation. This belief helps me with depression sometimes. It gives me hope, and a feeling of being more in control of my life. Like, I can handle my life better.

EXAMPLE 5

Co-researcher #40 (49 years old)

Having faith helps me when I am being depressed. I believe there is a higher being, and that really puts things in perspective, so I can let go off those moods.

Category 8: Helping others (11 incidents - 73% participation rate.) In this category co-researchers paid attention to the world around them and found fulfillment and a relief from depressed moods in doing so. This category involves reaching out and doing something meaningful for others, which often results in mitigating depressed mood, a sense of self-worth, altruism, belonging, and fulfillment. Critical incidents included cooking for others, doing
volunteer work, and giving motivational speeches.

EXAMPLE 1

Co-researcher #34 (33 years old)

Sometimes I talk to other patients at the doctor's office. Just for five minutes. I have been told that I am inspirational to others, that I give hope. I do it any time I can and it makes me feel good about myself, less moody, less depressed, with a purpose.

EXAMPLE 2

Co-researcher #41 (37 years old)

After my suicide attempt I started working at People with Aids as a volunteer. It kept me busy and I felt good about myself. It helped me put things into perspective and it also helped me lift my depression.
EXAMPLE 3

Co-researcher #35 (37 years old)

When I was told that I could not give blood or be an organ donor I was devastated. So, I found out if some doctors would be interested in my organs after my death, and I was told, "yes". It makes me feel good to contribute to society somehow, to contribute to knowledge. Others have done it, and I have benefited from it. I want to do it, too. By helping others I feel more fulfilled, with a purpose, and my depressed mood diminishes in intensity.

EXAMPLE 4

Co-researcher #34 (33 years old)

Being a volunteer for HIV/AIDS drug studies is important for me. I feel good, worthwhile, less down, and more in charge. I have got nothing to lose, and I know that to volunteer blood and the kind of information they get from it, will help someone else one day. Others did it to help me now.
EXAMPLE 5

Co-researcher #38 (34 years old)

By helping others, I am also helping me. I am giving my life some meaning. This is the ultimate outcome of helping other people with little things that I can do for them. By doing it, I feel worthwhile, less down, fulfilled, and with a sense of purpose.

Category 9: Physical Exercise (11 incidents - 64% participation rate.) Co-researchers engaged in some form of physical exercise such as cycling, hiking, and walking. Exercise was frequently seen as a way of keeping active and alive. It helped these individuals feel better about themselves because this physical activity enhanced their self-worth and sense of competence, autonomy, and control. They were able to feel they were doing something positive, constructive, and meaningful, and they felt less depressed, and better about themselves overall.
EXAMPLE 1

Co-researcher #36 (48 years old)

Swimming helps me because I feel better afterwards. I know that if I am active, if I am out and doing something like swimming, it will take the depressed mood away. I know that for me it is important to keep physical. That's a very helpful way to overcome my depressed moods.

EXAMPLE 2

Co-researcher #32 (37 years old)

When I am down I sometimes go for a walk. What happens is that I stop dwelling, or pitying myself, and I feel better, less depressed.

EXAMPLE 3

Co-researcher #36 (48 years old)

I have found that biking helps a lot to get out of my depression. I can't do extreme biking like I used to any more, but I can still do some and it's a great feeling. I feel
independent, in charge, competent, and less depressed.

EXAMPLE 4

Co-researcher #31 (24 years old)

For me, doing exercise regularly helps me to overcome depression, and also to prevent it. I see it as part of taking action. When I take action, I feel better, more in control of my life, and far less helpless.

EXAMPLE 5

Co-researcher #36 (48 years old)

When I go hiking I get energized, I feel happier, and less depressed. I also get an overall sense of being competent at doing something that I like, and I feel independent. I can't go all out any more because I don't want to get overly tired, but I do as much as I can.

Category 10: Learning from a role model (11 incidents - 55% participation rate.) In some cases, the co-researchers obtained
example, guidance, or instruction from someone who was identified as a meaningful role model. A role model is someone who has made a meaningful impact on the co-researchers’ lives, which has enabled them to deal with their depressed moods positively. By evoking a role model, these individuals gained strength and wisdom from it, a sense of internal control, and they were able to cope with their depressed moods successfully. Sub-categories are: (a) talking to a mentor; (b) finding guidance from someone who said or did something that facilitated dealing with depressed moods; and (c) gaining strength from a role model.

EXAMPLE 1

Co-researcher #34 (33 years old)

Sometimes when I am sad or feeling sorry for myself I think about Rose Kennedy and what she once said about the Lord never giving us a cross that was too heavy for us to bear. It makes sense to me, so I end up not feeling so sorry for myself, and less depressed.
EXAMPLE 2

Co-researcher #31 (24 years old)

Magic Johnson is a role model. He keeps fighting. How he dealt with his diagnosis is similar to how I deal with it. Like him, I also have a positive attitude. When I think of him and how he is dealing with it, I feel less down, more positive about things, and I feel more competent about dealing with this.

EXAMPLE 3

Co-researcher #33 (41 years old)

I draw a lot of strength from my grandfather's experiences during WWII. It helps me to think of him as a role model. He found a way to survive, and he has given me a different perspective about HIV. I get guidance from him, and it helps me overcome my down moods.

EXAMPLE 4

Co-researcher #32 (37 years old)

When I am depressed and I hit bottom, I get tired of being
depressed. Then I say to myself: "Get up, go out!" I got that from my mom. She was a doer. She would get things done, and that was it. I am like her. When I am down I do something. Then I feel much better, because my depressed mood disappears. Thinking of my mom, being active and being in charge helps me!

EXAMPLE 5

Co-researcher #33 (41 years old)

My friend in San Francisco is a mentor, a role model. He was in Vietnam, and we talk about the similarities between Vietnam and HIV. Like, the not-knowing what is going to happen, or being close to people and watching them die. I feel supported and understood. I look up to him, and I don't feel alone. We have something in common, and I feel less down.
EXAMPLE 6
(Added during second interview)

Co-researcher #36 (48 years old)

I find hope and an immense help for my depressed moods when I read about First Nations culture, religion, and beliefs. I gain strength and wisdom from learning how they deal with illness and with problems in general.

EXAMPLE 7

Co-researcher #34 (33 years old)

Dr. "X" is my mentor. I admire him so much! I like it when he comes to my restaurant with his friends and family. I feel that I am not a number, I feel complimented and I know he sees my positivity. I want to be a good patient, and do well, so that it makes him look good, too.

Category 11: Gaining understanding of the problem (11 incidents - 55% participation rate.) In this category, participants obtained an understanding of their problem (i.e., the HIV+ diagnosis and ensuing
depressed mood) by learning to identify, clarify, and make sense of the problem. Individuals feel empowered to collaborate with medical doctors, in some way or another, to make decisions that can affect the progression of their illness. The outcome of understanding the problem is a sense of being in charge of their life, hope, competency, and a lifting of their depressed moods. This category is different from "Looking for Meaning" because it focuses on making sense of their diagnosis and ensuing depressed moods, and not other aspects of their lives. The co-researchers chose to actively seek out information in order to understand the problem. Thus, their stance was proactive, not reactive. Sub-themes in this category are: (a) being informed about the disease by word of mouth; (b) reading about the disease; (c) asking questions; (d) being part of a treatment program; and (e) taking part of the medical decision making process.

EXAMPLE 1

Co-researcher #32 (37 years old)

Being informed about the disease helps. I want to know my CD4 count before it becomes an illness. By understanding it
I realize options, I can see improvements, and it gives me hope. When I found out (CD4 count) I knew I wouldn't die as quickly. Because I knew, it took the mystery away. I know what to expect, and that is very helpful to keep a nice mood going.

EXAMPLE 2
Co-researcher #34 (33 years old)
I am constantly asking for information from caregivers (doctors, nurses, etc.). This is my way of feeling that I am part of the cure, by sharing ideas, and asking questions. My mood always spruces up after I do that, because I know I have done something about it (the disease).

EXAMPLE 3
Co-researcher #31 (24 years old)
Knowing that I am part of the cure by sharing ideas and information with my doctors, and by asking questions, makes me feel better about my moods because I know something,
and I have done something about it. It's kind of being in control, although realistically I know I am not.

EXAMPLE 4

Co-researcher #34 (33 years old)

Life and living is my goal. Taking active part in care giving practices and medical decisions are two of the things that allow me to stay within this path. Understanding about the illness allows me to being part of the decision making process, and it certainly helps me get rid of my depressed moods. I know that I am doing everything I can.

EXAMPLE 5

Co-researcher #41 (37 years old)

One of the ways I deal with my depressed moods is by getting as much information as I can about HIV. Having this knowledge allows me not to feel threatened every time I get a cold. By being hands on, I feel more in control, more competent, more in charge, and far less depressed.
Category 12: Career/Work (6 incidents - 37% participation rate.) 

Some co-researchers found turning into work/career a meaningful and helpful way to overcome depressed moods. They all concluded that work needs to be meaningful and fulfilling in order to help overcome depressed moods. Sub-themes in this category include working with other family members, and changing jobs in order to get fulfillment. The outcome is a sense of balance, self-validation, independence, fulfillment, competency, autonomy, and a lifting of depressed moods.

EXAMPLE 1

Co-researcher #31 (24 years old)

Work gives me balance. That balance has been great help for me. It helps me not to get depressed, and also to be less depressed when I concentrate on work. I guess that for me work is a preventive measure and also a solution!

EXAMPLE 2

Co-researcher #35 (37 years old)

I quit other jobs because the work environment was not sincere. Values at work have to match my personal values,
and honesty is a must. The satisfaction that I get from work is a sense of accomplishment to solve problems, or to help others with understanding. It helps me when I am down because I have to focus on what I do at work, and then I'm OK.

EXAMPLE 3

Co-researcher #33 (41 years old)

I really like my work. It has helped me a lot to focus on what is important, and it has also helped me with my depressed moods. I get a sense of accomplishment, of validation, of personal fulfillment. On my way to work I remind myself to be nice to people, to my co-workers. When I get to work I focus on what I am doing, and that helps me leave my other problems aside for a while. It really, really, helps.

Category 13: Alcohol/Drugs (5 incidents - 46% participation rate.)

In this category marijuana and alcohol (e.g., beer, wine, and hard liquor) are used as a release, as a way out of emotional pain (i.e., depressed moods). Co-researchers reported that neither was used daily, or abused
in any way. However, both were a quick way of getting in touch with their feelings, and a guaranteed escapism of their problems and subsequent depressed moods. Critical incidents included drinking alcohol, and smoking marijuana.

EXAMPLE 1
Co-researcher #34 (33 years old)
Marijuana has been a welcomed friend in a releasing way. It helps me accept reality more. Actually, I see marijuana as an anti-depressant that works for me.

EXAMPLE 2
Co-researcher #35 (37 years old)
Sometimes when I am down I have turned to alcohol. It helps me get in touch with my feelings. This loosening that happens helps me make a connection between other things, and when I make connections issues get solved and I feel better overall, less depressed somehow.
EXAMPLE 3

Co-researcher #32 (37 years old)

At the beginning, when I thought I was losing control, I saw alcohol as an easy way out of my depression. I enjoyed the feeling of not being in emotional pain any more. That is what I got from it: a pain killer. It killed my depression, and all my pain.
Independent rater

Following the suggestion offered by Anderson and Nilsson (1964), McCormick (1994), and Novotny (1993), this researcher asked two independent raters to sort the incidents in the categories provided. Anderson and Nilsson (1964) have indicated that the necessary level of agreement is between 75%-85% for the categories. If an agreement of 80% is reached, the categories may be considered valid.

Two independent raters participated in a one-to-one training session (45 min. long) with the researcher. Both are therapists with a Master's degree in counselling psychology. Definitions of the 13 categories had been printed in as many index cards. The researcher read each one of them to the independent rater, who was invited to ask for clarification when needed. Five random examples of critical incidents were given to enhance the rater's understanding of the categories, and the process by which these had been formed. Independent raters were then asked to place 39 randomly selected critical incidents (three for each original category) under the appropriate category. These incidents had also been printed in as many cards. No communication took place...
between the independent raters and the researcher while validation was taking place. The independent raters spent 30 and 40 minutes, respectively, sorting the 39 cards for appropriate categories. A 100% consensus was accomplished with the first independent rater (39/39), while a 97.4% agreement was accomplished with the second rater (38/39).

**Co-researchers cross-checking**

Fontana & Frey (1994) emphasize the following point: To learn about people we must remember to treat them as people. It seems important to treat participants as experts in their history and individual perspective of the world. This researcher believes that such expertise is needed for testing the validity of the categories. This belief is based on postmodern efforts to maintain the integrity of the phenomena that are being studied, and preserving the viewpoint of the people who participate in the study. Thus, participants were asked to check the categories for verification. As mentioned before, cross-checking took place during the second interview. Co-researchers and researcher jointly re-named categories, and talked about unclear critical incidents. As the purpose of this study was to give a voice to the real experts, the researcher shared
observations, facilitated clarification, and followed the co-researchers' lead in regards to placing unclear incidents and finding more meaningful names for the categories. It was during this interview that the 17 categories the researcher had formed were transformed into 13 categories. As shown on the following table, two categories were maintained (i.e., Career/Work and Sharing the News). Six categories were renamed (i.e., Role Model became Learning from a Role Model; Illegal Substances became Alcohol/Marijuana; Information about HIV/AIDS was named Understanding the Problem; Spirituality became Establishing Spiritual Connection; Meaning developed into Looking for Meaning; and Social Support became Establishing Social Connection. Sub-categories were maintained in the eight categories mentioned above. Absence of the Fear of Dying and Belief in Survival were included in Commitment to Life; Attitude, Life Preparedness, Control, Organization, and Privacy became sub-categories of Connection with Self. Activity was divided into Participation in Activities and Physical Exercise, to make a clearer distinction between the critical incidents. Volunteer Work was renamed Helping Others and included more sub-categories (e.g., giving motivational speeches).
Exhaustiveness

This test addresses the question of saturation and comprehensiveness. Anderson and Nilsson (1964) discovered that the category system became apparent after a relatively small number of incidents had been classified. Following McCormick (1994), approximately ten percent of the incidents (i.e., 20 incidents provided by participant number 11) were left unexamined until all the categories were formed. At this point, these incidents were examined and classified. It was expected that if the incidents could be placed within existing categories, the category system would be considered comprehensive. Although consideration had been given to the possibility of having to form new categories, this process was not necessary, as the remaining 20 incidents were placed within existing categories.
Table 5: A comparison between the categories corresponding to the first and second interviews

<table>
<thead>
<tr>
<th>First Interview</th>
<th>Second Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career/Work</td>
<td>Career/Work</td>
</tr>
<tr>
<td>Sharing the News</td>
<td>Sharing the News</td>
</tr>
<tr>
<td>Role Model</td>
<td>Learning from a Role Model</td>
</tr>
<tr>
<td>Illegal Substances</td>
<td>Alcohol/Marijuana</td>
</tr>
<tr>
<td>Information about HIV/AIDS</td>
<td>Understanding the Problem</td>
</tr>
<tr>
<td>Spirituality</td>
<td>Establishing Spiritual Connection</td>
</tr>
<tr>
<td>Absence of the fear of dying</td>
<td>Commitment to Life</td>
</tr>
<tr>
<td>Belief in Survival</td>
<td>Looking for Meaning</td>
</tr>
<tr>
<td>Meaning</td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td></td>
</tr>
<tr>
<td>Life Preparedness</td>
<td></td>
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<tr>
<td>Control</td>
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<tr>
<td>Organization</td>
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<tr>
<td>Privacy</td>
<td></td>
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<tr>
<td>Social Support</td>
<td></td>
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<tr>
<td>Volunteer Work</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td></td>
</tr>
<tr>
<td>Participation in Activities</td>
<td></td>
</tr>
<tr>
<td>Physical Exercise (i.e., physical activity)</td>
<td></td>
</tr>
</tbody>
</table>
Participation rate

This can be determined by adding the number of co-researchers that participated in each category and calculating a percentage of participation. According to Cochran (1995) and Flanagan (1954), the higher the participation rate, the more valid the category is. Borgen & Amundson (1984) suggested that a 25% participation rate could be considered sufficient in establishing validity of the categories. The participation rates ranged from a low 37% (Career/Work) to a high of 100% (Participation in activities and Establishing Social Connection). The thirteen categories are a manifestation of meaningfulness to the co-researchers, and as such the reason for retaining them. What follows is a table of the frequency and participation rate. Frequency corresponds to the total number of critical incidents in a category. Participation rate is the percentage of participants in a specific category.

Insert table 6 about here
### Table 6: Category, Frequency, and Participation Rate

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Total of incidents cited for each category and these categories) N=11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in Activities</td>
<td>53 (22%)</td>
<td>100%</td>
</tr>
<tr>
<td>Establishing Social Connection</td>
<td>39 (16%)</td>
<td>100%</td>
</tr>
<tr>
<td>Connection with Self</td>
<td>46 (19%)</td>
<td>91%</td>
</tr>
<tr>
<td>Sharing the News</td>
<td>14 (6%)</td>
<td>91%</td>
</tr>
<tr>
<td>Commitment to Life</td>
<td>13 (6%)</td>
<td>82%</td>
</tr>
<tr>
<td>Looking for Meaning</td>
<td>14 (6%)</td>
<td>73%</td>
</tr>
<tr>
<td>Helping Others</td>
<td>11 (4.5%)</td>
<td>73%</td>
</tr>
<tr>
<td>Physical Exercise</td>
<td>11 (4.5%)</td>
<td>64%</td>
</tr>
<tr>
<td>Gaining Understanding of the Problem</td>
<td>11 (4.5%)</td>
<td>55%</td>
</tr>
<tr>
<td>Learning from a Role Model</td>
<td>11 (4.5%)</td>
<td>55%</td>
</tr>
<tr>
<td>Spiritual Connection</td>
<td>12 (5%)</td>
<td>55%</td>
</tr>
<tr>
<td>Alcohol/Drugs</td>
<td>5 (2%)</td>
<td>46%</td>
</tr>
<tr>
<td>Career/Work</td>
<td>6 (2%)</td>
<td>37%</td>
</tr>
<tr>
<td>Total number of critical incidents</td>
<td>246 (100%)</td>
<td></td>
</tr>
</tbody>
</table>
Expert validation

One way of testing for soundness of the newly formed categories was expert validation. The researcher assessed the soundness of categories by asking other seropositive individuals, university professors, doctors, and psychologists who work with HIV+ patients to judge the relevance and usefulness of the categories for facilitating or hindering what the study is supposed to analyse. This could have been done in the form of questionnaires addressing the relevance of the categories according to their expert opinion and experience in the field. However, in order to reach a larger number of experts across the world, the researcher contacted a group of experts (i.e. medical doctors, psychologists, university professors, HIV/AIDS caregivers, and people living with HIV) in Spain, Canada, and the U.S.A. through the Internet. A total of 13 experts were contacted: seven medical doctors (four from Spain, and three from British Columbia); one psychologist and one university professor from Spain; and four seropositive males (three U.S. citizens and one from Barcelona, Spain). These experts were asked to determine whether or not the categories described to them were considered useful in overcoming depressed moods. Comments on usefulness were encouraged. For
example, a general practitioner from B.C. commented that Career/Work seemed to be critical for the majority of her HIV+ patients. In her opinion, work was an important source of validation, and a very helpful tool in maintaining non-depressed moods. An HIV+ individual from Portland, Oregon expressed his strong support for all 13 categories. He observed that he had not thought about volunteering for an AIDS organization, because he was afraid he would get depressed if he saw other people in a more advanced stage of the illness. Reading about this way of dealing with depression opened up a new possibility for him, and he was grateful for this new information. A Spanish psychologist who works with HIV/AIDS clients, confirmed the usefulness of the categories. She pointed out about how some of her HIV clients also seem to benefit from involving their immediate families in medical decisions.

This validation process confirmed that all 13 categories were useful in the experts' practices. Furthermore, comments made by the experts conveyed the message that these categories can lead to dealing with depressed moods. This analysis added further strength to the validity of the categories.
Theoretical agreement

The reliability and validity of the categories were also assessed through agreement with previous research done on depression and HIV+. It was decided that if such agreement was found, the researcher would consider the category to be sound. If no agreement was found, the category would not be dismissed automatically, but it would be marked with a "questionable" sign, and agreement from experts raters and co-researchers would be sought. The same opinions would be sought when testing any category that was neither confirmed nor disconfirmed by the literature. Theoretical agreement was found for 11 of the 13 categories, the two exceptions being "Career/Work" and "Learning from a Role Model". Since these two categories were agreed upon by co-researchers and expert raters, the researcher decided to retain them, in the hopes that they will be disconfirmed or confirmed by further research. These findings increased the confidence that the categories were well founded.

Reference to relevant research for the eleven supported categories are as follows:

Exercise. Lopez, Vega, Chuquiviguel, Rossell, Lira, Medina, Quezada, Alcoser, Anamaria, Cruz, & Ubilus (1996) mention exercise as
a helpful strategy in living with HIV+, as is considered one of the elements that facilitate reducing the psychological impact for HIV+ people.

**Participation in Activities.** In general, researchers seem to agree that proactive coping is negatively correlated to mood disturbance (i.e. anxiety, fear, and depressed moods). In a four year longitudinal study of quality of life, depressive reactions, and coping, Brieger, Leibrich, Schumacher, and Low (1996) found that goal-oriented active style was positively correlated with improved quality life, and lower psychological distress (i.e., depressed moods). Namir et al. (1987) found that active behavioural coping was related to lower mood disturbance. As well, one of the categories identified in Gloersen et al. (1993) study on “doing well” in people with AIDS was “keeping active”. Therefore, this category was confirmed by previous research.

**Alcohol/Drugs.** Drug consumption was seen as an evasive-regressive coping style in Brieger et al. (1996). Their findings coincide with statements by participants in the present study, regarding how alcohol and drugs can be facilitative, as well as hindering, in the process of dealing with depressed moods. Likewise, in a paper presented at the XI International Conference on AIDS, a Canadian male diagnosed in 1989
shares a personal account about how he tried to cope with his seropositive status by using drugs (Newby, 1996).

Establishing Social Connection. Social support has been found to act as a buffer against the impact of stress contributing to the individual's well being. Fleishman, Sherbourne, Crystal, Marshall, Kelly, Grant, Collins, & Hays (1996) found that perceived social support, contacts with friends, and contacts with relatives were three factors negatively related to distress (r's= -.27, -.30, -.18). When HIV related symptoms were controlled, distress remained negatively related to contact with friends. In Pedlow, Brown, Patterson, Song, Atkinson, & Grant (1996) study of coping strategies of HIV+ individuals in substance abuse recovery, social support was observed to be an effective coping strategy. DeVuyst, Fleerackers, Joosten, DeRoo, Pelgram, & Colebunders (1996) studied the emotional reactions to the diagnosis of HIV infection in Belgium. They found that heterosexuals found most support with family members (75%), while homosexuals found support with friends (64%). "Experiencing support" was one of the categories that emerged from Gloersen et al. (1993) study.

Looking for Meaning. Meaning can be derived through an
individual's efforts to understand adversity and human suffering. Perceptions of how one contracted HIV and beliefs about its implications can provide a sense of meaning. Engaging in personal growth activities was one of the six coping factors analysed by Fleishman et al. (1996) in their study on social support and coping factors associated with psychological distress. Positive interpretation, and a goal-oriented coping styles were two of the categories discerned by Brieger et al. (1996) after asking 43 people living with HIV/AIDS what they could do in order to achieve higher quality of life (i.e., less depressive symptomatology). These authors concluded that goal oriented active interventions were associated with lower psychological distress (i.e., depressed mood) and improved quality of life.

Commitment to Life. Sekar (1996) comments that being infected is not the end, but a new beginning. Brieger et al. (1996) found that people living with HIV/AIDS used positive interpretation as a way of improving their quality of life and depressive reactions.

Sharing the News. Bharat’s (1996) study on disclosure in the family concluded that disclosure in the case of men was perceived beneficial in most cases. Such disclosure to confidants of choice improved these men
emotional well being. In their grounded theory study, Lawless, Greet, & Vivienne (1996) examined the coping strategies utilised by a group of HIV+ women. One of the themes that emerged from the study was disclosure of seropositive status as a coping strategy. Miranda (1996) reported that disclosure was proved to contribute to the physical and psychological health of HIV+ people, because it can help improve prevention strategies, and it can enhance quality of life.

**Helping Others.** Thomas, Joseph, & Campbell (1996), three individuals affiliated with B.C. Persons with AIDS Society, reported that through volunteering persons living with HIV can enhance their self-esteem, and increase their quality of life, as well as improve their depressed moods.

**Connection with Self.** Fighting spirit was among the coping categories analysed in Brieger et al. (1996). The Southern Tier AIDS program in Johnson City, New York, came up with an empowerment program for people living with HIV and caregivers. First, caregivers are trained and led through a model of personal and professional empowerment which focuses on self-awareness, inner guidance, commitment, and self-responsibility. This model is also used with
individuals living with HIV/AIDS. People living with HIV/AIDS believed they had more control over their lives, and could deal with their psychological issues (e.g., depressed moods, anxiety, and fear) in a more constructive way. "Accepting" and "Positive Thinking" were two of the categories that emerged from Gloersen et al. (1993) study. Self-understanding, thinking positively, and accepting one's circumstances constitute part of this category.

Gaining Understanding of the Problem. Participating in decisions related to their health was one of the sub-themes in this category. Gloersen et al. (1993) identified "Participation in Health Care" as one of the eight categories formed in their grounded theory study on "doing well" in people with AIDS. Seeking information was one of the coping factors identified in Fleishman, et al.'s (1996) study on social support and coping and associations with psychological distress. Outside of the HIV/AIDS literature, the same category of Gaining Understanding of the Problem has been found as an important coping activity among individuals seeking information about the disease (Felton & Revenson, 1984), and those seeking medical advice and treatments (Feifel, Strack, & Nagy, 1987).

Spiritual Connection. The International Christian AIDS Network
was formed at the Eighth World Conference on AIDS in Amsterdam, as a response to the strongly voiced need of people living with HIV/AIDS for an increased recognition of the role of spiritual resources in HIV care and prevention. In a comparative study on the spirituality of men living with and without HIV/AIDS, Perreault & Perreault (1996) concluded that spirituality was an essential area in which individuals derive existential support, as they struggle to find meaning, and purpose in their lives. They further recognized the importance of spirituality in the care of individuals living with HIV/AIDS. Transcendental meditation was found to manage stress, reduce depressed moods, and enable a person to cope and adopt to the new living styles that are brought about by HIV (Kinara, 1996). In a study by Drew (1996) spirituality was found to be a key issue for HIV/AIDS programmes in Zimbabwe, as an essential part of holistic care.

The current data based on direct interviews and identification of categorical themes seems to include 6 out of the 16 coping items in Fleishman & Fogel’s (1994) study on coping and depressive symptoms among people with AIDS. These items had been developed in prior studies on the basis of their relevance to a sample of people with AIDS, but not in consultation with the individuals. Different themes not
previously covered by Fleishman & Fogel (1994) have emerged in the present study (e.g., learning from a role model.) One of the differences between Fleishman & Fogel's (1994) study and the present inquiry was that the former utilized an a priori list, and in this study the themes were identified and verified in collaboration with the participants. Table 7 shows the correspondence between Fleishman & Fogel's (1994) coping items and the present study's emergent categories.

Insert Table 7 about here

De Solla's (1995) book is a personal account of his life with HIV/AIDS, and his commitment to living positively. The title of his chapters (i.e., Helping Others and Letting Others Help you; The 8 Key points of Living Positively; Becoming your own Medical Expert) validate the following categories developed in the present study: Helping Others, Establishing Social Connection, Looking for Meaning, and Gaining an Understanding of the Problem.
<table>
<thead>
<tr>
<th>Coping items identified by Fleishman &amp; Fogel (1994)</th>
<th>Categories emerging from the present study</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Tell yourself to accept it&quot;</td>
<td>LOOKING FOR MEANING</td>
</tr>
<tr>
<td>&quot;Make plans for the future&quot;</td>
<td>PARTICIPATION IN ACTIVITIES</td>
</tr>
<tr>
<td>&quot;Try to learn more about AIDS&quot;</td>
<td>GAINING UNDERSTANDING</td>
</tr>
<tr>
<td>&quot;Look on the bright side&quot;</td>
<td>COMMITMENT TO LIFE</td>
</tr>
<tr>
<td>&quot;Ask friend and relatives for advice&quot;</td>
<td>SOCIAL SUPPORT</td>
</tr>
<tr>
<td>&quot;Make yourself better by drinking or taking drugs&quot;</td>
<td>ALCOHOL/DRUGS</td>
</tr>
</tbody>
</table>
In summary, the foregoing discussion attested to the validity of the category system developed in the present study. There was a high percentage of agreement obtained by independent raters, which supports the soundness and trustworthiness of the categories. Expert validation was obtained through 13 international experts on HIV/AIDS, who reported that all 13 categories would be useful and valid in their work with seropositive individuals. The categories were validated by the co-researchers through their meaningful feedback. Tests of exhaustiveness did not result in any new categories being formed, thus supporting the soundness of the category system. Participation rate was determined by checking for the agreement among the co-researchers in reporting the same type of event. A number of co-researchers reported the same type of event in all categories. Eleven categories showed a participation rate of 55% or higher. Theoretical agreement was demonstrated for 11 out of the 13 categories in examining related literature on HIV/AIDS. This agreement of previous literature supports the soundness and trustworthiness of the category system. Therefore it is possible to say that these categories can be employed confidently.
Part III: Sources of Resiliency

As mentioned in the methodology section, co-researchers responded to the question: What would you say are the personal resources that enabled you (that you drew from) to deal with your depressed moods? Self-reported sources of resilience and participation rate are presented in Table 8. Participation rate refers to the number of participants reporting specific sources of resiliency. The third column represents previous research identifying sources of resiliency that validate the data of the present study. The sources of resiliency as identified by the co-researchers of the present study are cross-validated by the existing literature on this subject, as shown in table 8. These results are discussed in the following chapter.

Insert Table 8 about here
Table 8: **Sources of Resiliency: Participation Rate**

and Theoretical Agreement

<table>
<thead>
<tr>
<th>Source of Resilience</th>
<th>Participation Rate</th>
<th>Theoretical Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-reliance</td>
<td>82%</td>
<td>Remien et al., 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine, 1991</td>
</tr>
<tr>
<td>2. Understanding self</td>
<td>64%</td>
<td>Remien et al., 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td>3. Flexibility</td>
<td>64%</td>
<td>Fine, 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kadner, 1987</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td>4. Self-esteem</td>
<td>64%</td>
<td>Rutter, 1987</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine, 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td>5. Accountability</td>
<td>64%</td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td>7. Positive attitude</td>
<td>37%</td>
<td>Gloersen et al., 1993</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine, 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remien et al., 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warschaw &amp; Barlow, 1995</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
Warschaw & Barlow, 1995 |
| 9. Acceptance of reality | 55% | Gloersen et al., 1993  
Blaney et al., 1991  
Remien et al., 1992  
Warschaw & Barlow, 1995 |
| 10. Making plans/organization | 55% | Warschaw & Barlow, 1995 |
| 11. Pro-activity | 100% | Gloersen et al., 1993  
Remien et al., 1992  
Warschaw & Barlow, 1995 |
| 12. Openness to information | 37% | Gloersen et al., 1993  
Remien et al., 1992  
Warschaw & Barlow, 1995 |
| 13. Survival instinct | 55% | Kadner, 1987  
Rutter, 1987  
Fine, 1991  
Warschaw & Barlow, 1995 |
14. Risk taking 37% Blaney et al., 1991
Kadner, 1987
Fine, 1991
Warschaw & Barlow, 1995

15. Being in tune with others/respectful 46% Rutter, 1987
Gloersen et al., 1993
Blaney et al., 1991
Remien et al., 1992
Kadner, 1987
Warschaw & Barlow, 1995

Warschaw & Barlow, 1995

17. Stubbornness 46%

18. Emotional strength 73% Blaney et al., 1991
Kadner, 1987

19. Looking at things from different angles 46% Fine, 1991
Of the 19 self-reported sources of resilience, fourteen types of resilience sources have also been identified by Warschaw & Barlow (1995); five by Kadner (1987); four by Blaney et al., (1991); ten by Fine (1991); three by Rutter (1987); five by Gloersen et al. (1993); and seven by Remien et al. (1992). This high degree of correspondence between the identified sources of resiliency in this study and those in the former studies seems to give additional validity to the present study. It appears that these 19 resiliency sources give a more comprehensive picture than other researchers have described.

Stubborness did not emerge as a theme in the former studies. However, 46% of the co-researchers reported stubborness as a source of resilience that enabled them to deal with depressed moods. Participants defined “stubborness” as being obstinate about not letting go of a helpful activity, value, positive self-talk, purpose, or goal.
Interviews with eleven co-researchers produced 246 critical incidents that were reported to facilitate dealing with depressed moods for HIV+ individuals. These critical incidents were placed into the following 13 categories that were found to be valid and reliable: (a) looking for meaning, (b) physical exercise, (c) establishing a social connection, (d) commitment to life, (e) spiritual connection, (f) participation in activities, (g) connection with self, (h) gaining understanding of the problem, (i) helping others, (j) sharing the news of the HIV+ diagnosis, (k) alcohol and drugs, (l) career/work, and (m) learning from a role model.

Outcomes of overcoming depressed moods

An examination of the facilitative outcomes that emerged from the 13 categories provided information that can further describe the process of overcoming depressed moods. The following themes were extrapolated from the facilitative outcomes reported by the co-researchers during the interviews: (a) pro-activity; (b) control; (c) empowerment; and
Pro-activity. When the overriding theme of these identified facilitative coping methods is considered, it appears that co-researchers were generally action-oriented. According to them, they attempted to meet challenges, and faced their fears with positive actions, rather than waiting until their depressed moods set in or being stopped by confusion, fear, or self-pity. They seemed to pay attention to the world around them, and to the voices inside themselves. This attentiveness might have enabled them to be creative about the kind of mechanisms that could facilitate overcoming depressed moods. It seems that their creativeness and flexibility in utilizing effective strategies, contributed to positive outcomes, and were an intrinsic part of their resiliency.

Participants did not seem to stand helplessly in the face of the illness. It appears that, in an attempt to exercise personal control, they took an active coping stance. Examples of such active stances are: being actively involved in the medical treatment; getting information about the illness; initiating an exercise program; and looking for different ways to overcome their depressed moods.

Meaning. Participants seemed to have learned to accept HIV as
part of their lives. At the same time, they appeared to refuse to let their illness detract them from being open to enjoying the gift of life. In general, they seemed to take one day at a time, and to put their physical and mental energy into those activities that could provide them with a sense of competency, purpose, autonomy, balance, and meaning.

In general, meaning appears to have been derived through the co-researchers' efforts to understand the adversity. In an attempt to answer the question, "Why me?" these individuals appeared to have discovered a new sense of self-knowledge, and a positive attitude toward life. Moreover, they seemed to have achieved increased self-awareness, inner strength, and resiliency, as well as a re-evaluation and consolidation of their core beliefs and values.

Empowerment. To summarize the general common attitude held among the participants, it seems that they re-organized and re-prioritized all those things that were important to them, such as: relationships, self-discovery, contributing to the lives of others, and a positive attitude towards life. Moreover, they appeared to share a conscious effort to live life each day to its fullest.

The HIV diagnosis appeared to have given them a new perspective
on life, on people, and on themselves. In general, they seemed to regard life as a precious gift. By taking an active role, they felt empowered to protect themselves from actions that could hinder their search for meaning and emotional balance.

Control. According to Lazarus & Folkman (1984) feelings of control over chronic illness seem necessary for psychological adjustment. Research has shown that perceptions of control over the course of disease correspond to psychological adjustment among women with breast cancer (Taylor, Lichtman, & Wood, 1984) and people with HIV infection (Remien et al., 1992). Personal control over the course of the illness is also associated with hope for longer survival (Rabkin, Williams, Remien, Goetz, Kertzner, & Gorman, 1991).

It appears that the need to be in control, to feel in charge of their lives, was a common thread among the eleven co-researchers. This personal control seems to join with strategies that facilitated coping, such as gaining an understanding of the problem of HIV+ and depressed moods, and getting involved in the medical treatment by being part of clinical trials. It seems that -in general- when the participants utilized their sources of resiliency to engage in the process of overcoming depressed
moods, they also attained a sense of perceived control. The notion of perceived control as a coping skill and an outcome of coping was previously suggested by Kalichman (1995) when he pointed out that "control and coping can appear similar to each other and often overlap" (p. 222).

Center for Epidemiology Depression scale (CES-D scale)

A self-report measure of depressed moods (CES-D scale) was administered. The results revealed a significant statistical difference between the participants' depressed moods at the time of their diagnosis when compared to their present mood. This finding is consistent with previous studies on depression and HIV/AIDS, and confirms the facilitative aspect of the categories that emerged from the study, as well as the co-researchers' sources of resiliency that enable them to deal with depressed moods.

Coping methods and sources of resiliency

A strong similarity between the 13 categories and the 19 self-reported sources of resiliency was found. These 19 sources of resilience were validated by the literature on resiliency, as shown in table 8. Table 9 represents the similarities between the sources of resiliency and the
categories that emerged from the study.

Insert table 9 about here

Eight categories were found to include sub-themes similar to the self-reported sources of resiliency in this study. They are: (a) connection with self, (b) spiritual connection, (c) looking for meaning, (d) participation in activities, (e) understanding the problem, (f) commitment to life, (g) helping others, and (h) establishing a social connection. Similarities were identified by comparing the definitions of the categories and range of critical incidents within them, with the self-reported sources of resiliency, and other researchers' components of resiliency as summarized in Table 8. It was found that: (a) except "stubbornness" all self reported sources of resiliency were present in these authors' elements of resiliency; and (b) embedded in the meaning abscribed to the categories by the co-researchers in the present study
Table 9: Similarities between categories of coping methods to overcome depressed moods and sources of resiliency

<table>
<thead>
<tr>
<th>Sources of Resiliency</th>
<th>Categories of coping methods to overcome depressed moods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-reliance</td>
<td>Connection with self</td>
</tr>
<tr>
<td>2. Understanding self</td>
<td></td>
</tr>
<tr>
<td>3. Flexibility</td>
<td></td>
</tr>
<tr>
<td>4. Self-esteem</td>
<td></td>
</tr>
<tr>
<td>5. Accountability</td>
<td></td>
</tr>
<tr>
<td>6. Spirituality</td>
<td>Spiritual connection</td>
</tr>
<tr>
<td>7. Positive attitude</td>
<td></td>
</tr>
<tr>
<td>8. Meaning making</td>
<td>Looking for Meaning</td>
</tr>
<tr>
<td>9. Acceptance of reality</td>
<td></td>
</tr>
<tr>
<td>10. Making plans/organization</td>
<td></td>
</tr>
<tr>
<td>11. Pro-activity</td>
<td>Participation in activities</td>
</tr>
<tr>
<td>12. Openness to information</td>
<td>Understanding the problem of HIV+</td>
</tr>
</tbody>
</table>
13. Survival instinct (will to survive) ___________ Commitment to Life

14. Risk taking __________________________ Connection with Self/Looking for Meaning

15. In tune with others/respectful ___________ Established a social connection/Helping others

16. Sense of humor _________________________ Connection with self

17. Stubbornness __________________________ Connection with self

18. Emotional strength ______________________ Connection with self/Looking for meaning

19. Looking at things from different angles _______ Looking for meaning
were Warschaw & Barlow's (1995) components of resiliency. Taking into consideration the fact that the researcher discovered Warschaw & Barlow's (1995) book after all the interviews had taken place, and the categories had been formed, the findings of the present study seem to expand the concept of resiliency, while identifying it as a viable psychological construct that can be employed to describe the processes that enable HIV+ individuals to help themselves deal with their depressed moods successfully. Of the ten components of resiliency identified by Warschaw & Barlow (1995), five can be identified as sub-themes of the same number of categories that emerged in the present study. Table 10 presents the correspondence between the categories and the sub-categories within, which concur with Warschaw & Barlow's (1995) components of resiliency.

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Insert table 10 about here

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According to Warschaw & Barlow (1995) an unambivalent commitment to life is the "core" of resilient people (p.3). Critical incidents demonstrating the participants' belief, attitude, or commitment to live life
at its fullest were included in this category. Being "open to new ideas" (Warschaw & Barlow, 1995 p.4) was part of this study's definition of the category "Understanding the problem" of depression and HIV+. Critical events demonstrating the participants' openness to identify, clarify, and make sense of the problem were included in this category. Warschaw & Barlow (1995) define resilient people as action-oriented. According to these authors, resilient individuals meet challenges with positive action. Co-researchers in this study benefited from a pro-active attitude, which translated into a willingness to keep busy when feeling depressed, in order to deal with it successfully. Acceptance, knowing what is important and what is not, and looking at things from a different perspective are sub-themes of the category "Looking for meaning". The ability to put things in perspective and recognizing what is important in life are also components of resiliency according to Warschaw & Barlow (1995). Furthermore, these authors define resilient people as creative in the way they use their resources to solve problems. Creativity, imagination, and self-knowledge are sub-themes of the category "Connection with self".
Table 10: Correspondence between the categories emerging from this study and Warschaw & Barlow's (1995) components of resiliency

<table>
<thead>
<tr>
<th>Present study categories</th>
<th>Warschaw &amp; Barlow (1995) components of resiliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to life</td>
<td>Unambivalent commitment to life</td>
</tr>
<tr>
<td>Understanding the problem</td>
<td>Openness to new ideas</td>
</tr>
<tr>
<td>Participation in activities</td>
<td>Willingness to be proactive</td>
</tr>
<tr>
<td>Looking for meaning</td>
<td>Perspective</td>
</tr>
<tr>
<td>Connection with self</td>
<td>Resourcefulness</td>
</tr>
</tbody>
</table>
Limitations of the study

This investigation is limited by a number of factors. First, one of the limitations that is often attributed to the Critical Incident methodology is that the amount of data produced can seem overwhelming. This study has provided us with rich information that could be interpreted in different ways. Some incidents could be placed in two different categories. For example, the facilitative action of "going hiking" could be placed under Exercise or Participation in Activities categories. This problem was addressed by asking for the co-researchers' opinions, and following through with their feedback. Critical events and categories that emerged from the data were the participants' way of expressing their "voice", thus the need to have the data remain closely meaningful to them.

Second, critical incidents were not observed, but self-reported. Events obtained by self-reported are only limited to those events that people can remember during the interview, and they were able to articulate. This fact may have excluded some events from being reported. Furthermore, the style of the interview may have prevented the participants from articulating and/or recollecting some critical events.

Flanagan (1954) addressed this limitation. He made a comparison
between reporting from memory and daily observations, and found that
recalled incidents could be relied on to provide adequate data. He
observed that the data was satisfactory when the critical incidents
reported were fairly recent, and when the participants were motivated—as
was the case among the co-researchers in the current study.

In an attempt to address these limitations, an invitation to think
about other events after the first interview, as well as further questions
(Appendix E) were employed to facilitate the co-researchers' recollection
and ability to articulate critical events. Also, part of the second interview
was used to modify, add, or subtract critical events. As it was expected,
several critical incidents were added during this interview. Their number
totalled 12. No substractions took place.

Unclear critical incidents that had been put aside by the researcher
after the first interview were addressed during the second interview. At
that time, co-researcher and researcher studied those events that related
to the participant in question, and were then placed in useful categories.
For example: "What helps me get out of depression is to assign myself a
daily reading and then meditate on the reading. I don't know how I choose
to do that, I just know that when I am down and I do it I feel less
depressed later.” It was initially unclear where this incident belonged to. From the point of view of the researcher it could belong under “Participation in Activities” or “Spiritual Connection.” After cross-checking it with the co-researcher, it was placed under “Spiritual Connection”, as it was the most meaningful category.

The process of cross-checking incidents and categories produced a number of 13 categories instead of the 17 categories tentatively proposed by the researcher after the first interview. Table 5 depicts the categories that emerged after the first interview, and the final categories once validation by the co-researchers had taken place. For future purposes, at the end of the second interview participants could be asked to provide a measure or rating (i.e., 1 to 10 analogue scale rating) for each category.

The protocol followed in the second interview was a highly useful tool, and an innovation of the Critical Incident technique. The follow-up interview introduced a phenomenological element to the current study, and it served the purposes of validation of the categories by the participant, which resulted in confirming their “voice”. Furthermore, the process successfully addressed some of the limitations of the study
pertaining to the methodology, as explained previously.

Data is based on 11 participants and may not be entirely
generalizable at this time. Qualitative studies are not designed to allow
systematic generalizations. The purpose of the current study was not to
extend the account of a particular situation or population to other persons
or settings. According to Maxwell (1992) generalizability is normally
based on the assumption that a theory may be useful in making sense of
similar persons or situations, rather than drawing conclusions about a
specified population through statistical inference. The validation
procedures utilized in the current study indicated a high percentage of
agreement from independent raters, and experts in the field.

This study was conducted with volunteer individuals who were also
part of clinical drug trials at St. Paul’s Hospital, therefore they may have a
psychological predisposition to “doing well” (Gloersen et al., 1993). The
population chosen for this study may not have been the most representive
of current trends of the pandemic. In Canada, heterosexual and injecting
drug user (IDU) infections have increased. HIV infection among IDUs is a
major concern. At the same time, the incidence of HIV/AIDS among men
who have sex with men (MSM) men has dropped from about 5-10 percent
per year in the early 1980s to an estimated 1-2 percent per year in the early 1990's. However, the prevalence of HIV infection among MSM remains high in almost all areas of North America. In British Columbia, this population amounts to approximately 80% of those infected with HIV/AIDS (Bureau of HIV/AIDS, Health Canada, 1996).

Caution must be exercised in interpreting the reduced depressed mood scores as reported by the co-researchers' completion of the CES-D scale, even though the retrospective ratings were only used for supplementary purposes. Participants were asked to recall the time when they were given the HIV+ diagnosis, and respond to the 20 items as they would have done at the time. For some, this represented approximately 8 years. This concern about proper recollection was shared with all participants, who reassured the researcher of their lack of difficulty transporting themselves back in time. In their opinion, the HIV+ diagnosis represented a major life stressor and, as such, it was not difficult to recall the circumstances surrounding that precise moment, or their emotional state at the time. Their opinions have been corroborated by Dr. Montaner (1995) and Dr. Kuhl (1995). However, it can be hypothesized that different results may have been attained had the CES-D scale been administered
shortly after the time of the diagnosis.

Implications for research and clinical practice

The results of this study expand the research concerning the facilitation of dealing with depressed moods and the sources of resiliency described in the review of the literature.

Most of the studies on depression and HIV/AIDS come from the quantitative field, and seem to have done little to include people's "voice" in them. In general, these studies analyze the issues faced by HIV+ individuals and point out different factors that could help them cope with their diagnosis. Some of these studies were addressed in the review of the literature (e.g., Fleishman & Fogel, 1994; Lackner et al., 1993; Wolf et al., 1991). The present analysis provided much richer information on the resources of coping with depressed moods than research methods using quantitative data on pre-constructed scales, such as Fleishman & Fogel (1994).

The basic implications of this study are fourfold. First, it represents the "voice" of a group of individuals. One of the purposes of this study was to provide a structured channel for people to expose and contribute their expertise towards the compilation of facilitative processes in their
battle to overcome depressed moods after an HIV+ diagnosis. The necessity for such a forum was shared by several presenters at the XI International Conference on HIV/AIDS in Vancouver. Issues raised at the conference were the need for action research with a strong participatory component (Mane, 1996) and the need to have the "expert" involved in the research (Cooper, 1996). This study is a step in this direction, as it attempted to bridge an existing gap in the research field by providing qualitative information that includes the reaction of the experts to the phenomena of HIV/AIDS, depressed moods, and sources of resilience. This researcher shares with others the hope that this "voice" is not lost, but becomes a welcomed addition to further research studies.

A second implication is that it provides a map of helpful categories that describe facilitative strategies to deal with depressed moods. Moreover, it delineates how people deal with depressed moods. A scale based on the present study could be developed that could be more inclusive than previous scales.

The current study confirms and expands on Gamezy (cited in Rutter, 1987) and Lackner et al. (1993) findings regarding social support as a buffer of depressed moods. It also expands on Folkman et al.'s
(1993) analysis on the relationship between stress, control, and coping with depressed moods. Their findings are consistent with the current study's findings of "control" as an outcome and also a way of overcoming depressed moods. Co-researchers seemed to try to prevent depressed moods as much as possible, as a way of dealing with them and feeling in charge of their lives.

Counsellors could utilize the findings of this study to develop interventions to help this client population. For example, by (a) encouraging clients to become active participants in their health care options; (b) suggesting sharing the news with meaningful people in their lives; (c) using psychoeducation to teach clients concrete ways of accessing other resources (i.e., friends, social activities, physical exercise). All categories can provide areas from which to obtain knowledge in order to help clients deal with depressed moods. At the same time, the categories also provide mental health workers with the kind of information necessary to develop preventive measures to help newly diagnosed individuals deal with potential depressive moods. Another way of benefiting from this research would be making this map of categories available to seropositive individuals interested in finding out
how others have fought against and successfully eluded depression. One of the categories that emerged from this study was learning from a role model. This category has yet to be validated by the research literature. One way of accomplishing it would be to share the findings of this study with people interested in learning from others’ experiences.

A third implication is that it identifies resiliency as a viable psychological construct for helping people come up with and become aware of the processes that facilitate recovery from depressed moods.

The current study expands on previous research findings. Nineteen sources of resiliency were reported by the participants, the largest number in any of the previous studies. For example, Remien et al. (1992) reported four elements: (a) absence of denial, (b) vigilance regarding symptoms, (c) pragmatism, and (d) adaptation of active cognitive behaviour coping strategies. Warschaw & Barlow (1995) suggested ten components of resiliency: (a) adaptability, (b) unambivalent commitment to life, (c) self-confidence, (d) perspective, (e) willingness to be proactive, (f) openness to new ideas, (g) acceptance of personal responsibility, (h) resourcefulness, (i) attentiveness, and (j) willingness to risk.

Resiliency is an important concept in clinical practice. Empowering
clients is a therapeutic goal. One of the findings that has important implications for practice is the issue of bringing up people's resources and strengths during therapy. Co-researchers pointed out the healing aspect of taking part in a one-to-one interview where their resources were brought up and pointed out, and meaningful differences in the way they dealt with their depressed moods were highlighted. The type of questions or interventions emphasized in counselling can help client achieve the sense of empowerment and control so much needed when facing life with HIV/AIDS.

A formal training program could be established that would: (1) use the 13 categories as a map of what facilitates negotiating depression successfully, and (2) ask the type of questions that can facilitate conscious and unconscious processes of paying attention to the resilient sources that enable these individuals to deal with depressed moods, and/or problematic situations in general.

Further research needs to be undertaken in the field of counselling psychology and HIV/AIDS, as the number of seropositive people is increasing. Additional research could be done to examine the effectiveness of the suggested programs to find out if the map of
categories could be refined, extended, or modified in a meaningful way. Subsequently, research to determine generalizability could be done by surveying a higher number of men who have sex with men (MSM), as well as including other populations such as IDU's, women, and heterosexual transmission. Future research could involve determining if new categories could emerge. Replication of this study might also help to refine the categories in order to expand present understanding of the process of dealing with depressed moods.

Future research could also utilize the present study to compare other cultures' way of dealing with depressed moods, and find out what are the meaningful differences according to cultural context. Such a test could provide international HIV/AIDS institutions with a working map of facilitative processes according to world zones.

Research on resiliency is so far limited. Most of the investigations come from the psychiatric and developmental psychology literature, and are interested in the mechanisms that allow some children bounce back in spite of stressful life situations. More research needs to be done in order to identify and clarify how people enable themselves to bounce back after a major life event. Following this study, further research could be done to
expand on the sources of resilience so far identified. Projects on
generalizing these sources to other terminally ill populations could also
enhance present knowledge on resiliency. These investigations would be
a major force in helping individuals facing the emotional pain of illness
utilize those mechanisms that allow them to live more meaningful and
comfortable lives.

The notion of resiliency could be further expanded by using
Ishiyama's (1989) self-validation model. This model provides "a holistic
framework for understanding the nature of struggles toward personal,
social, physical, and spiritual well being" (Ishiyama & Westwood, 1992,
p. 52). According to Ishiyama & Westwood (1992) the process of self-
validation consists of restoring or enhancing individuals' well-being
around five interrelated components (e.g., love, fulfillment, and meaning
in life; identity and belonging; security, comfort, and support; competence
and autonomy; and self-worth and self-acceptance). This model seems
appropriate for employing it with HIV+ individuals who may have
experienced "personal uprootedness" (Ishiyama & Westwood, 1992, p. 52)
attributed to their seropositive diagnosis (i.e., insecurity, abandonment,
identity loss, alienation from others, and helplessness).
The five themes seem conducive to bring up individuals' sources of resiliency during the interview process. Furthermore, this model could be employed to corroborate and expand the findings of the present study. Participants could be asked to appropriately place critical events in the model's diagram, as a first step to identify and clarify facilitative and hindering categories in the process of overcoming depressed moods.

A fourth implication relates to the Critical Incident methodology. This study introduced the idea of employing a second interview during which participants further expanded their descriptions of critical incidents, as well as cross-checking them for validation purposes. According to this researcher, the second interview was very valuable in terms of expanding the data, providing confirmation and clarification of critical incidents, ascribing meaning to the emergent categories, and giving a "voice" to the co-researchers by utilizing their feedback for validation purposes. Further research needs to be done employing the present innovation to the design to confirm its usefulness.

Conclusion

This study has addressed and met its purposes. Thirteen categories emerged from this investigation. They describe what facilitates
individuals diagnosed HIV+ deal with the depressed moods that usually ensue after the diagnosis. Several methods were employed to validate the categories. Resiliency emerged as a viable psychological construct to analyze data and as a valuable concept in the clinical arena.

The findings of this study contribute to the field of counselling psychology by providing several themes that describe, from the perspective of a group of seropositive men, what facilitates overcoming depressed moods. Emphasis is placed on the therapeutic need to enhance individuals' self-awarenesses in order to facilitate conscious and unconscious processes of paying attention to resilient sources that enhance the process of dealing with depressed moods.

This study can serve as a basis for expanding research in the areas of resiliency, prevention of depressed moods, categories that facilitate overcoming depression, and cross-cultural investigations.

From the researcher's perspective, I have learned that life is a precious gift and, as such, it should not be taken for granted. The 11 participants have given me the gift of appreciating myself, the people in my life, my work, and life in general. They have taught me that, instead of being driven by fear, despair, and anger, one can walk hand in hand with
fear, and focus on the desire to live constructively and meaningfully.
References


Dear Participant:

My name is Victoria Alfonso and I am investigating the facilitation of overcoming depressed moods after an HIV+ diagnosis. This research is part of my doctoral work in counselling psychology at the University of British Columbia. It is a study that will help begin to establish some criteria for assisting you and others in effectively dealing with the often ensuing depressive moods after receiving an HIV+ diagnosis.

Sincerely,

Victoria Alfonso
APPENDIX C - Part I

DEMOGRAPHIC QUESTIONNAIRE

PARTICIPANT NUMBER:_______

1. What is your age?

2. What is your occupation?

3. When were you diagnosed with HIV+?

4. How did you contract the virus?

5. Presently, how is your CD4 count?

6. Have you felt sad or down since your HIV+ diagnosis?

7. Are you experiencing sadness due to other reasons? (i.e. loss of partner or close friend?)

8. Are you working/studying now?

9. How would you describe your present financial situation? Difficult, moderate, easy?

10. Do you do any volunteer work?

11. What are your hobbies?

12. How often do you see friends and/or family?

Thank you for taking the time to complete this questionnaire.
APPENDIX C - Part II

CES-D Scale

Instructions for questions: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week/at HIV+ diagnosis.

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of time (3-4 days)
- Most or all of the time (5-7 days)

During the past week/When I was diagnosed HIV+

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
15. People were unfriendly
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people dislike me.
20. I could not get "going."

Note: The CES-D Scale was developed by the Center for Epidemiologic Studies of the U.S. National Institute of Mental Health. In this particular study the timing (i.e. "during the past week") was changed to fit with the aim of the study.
Potential benefits

No direct risks or benefits are anticipated from this research. However, through the interview you will become aware of the specific processes that have facilitated or hindered your ability to overcome or mitigate your depressed moods, and you may be able to apply this newly found awareness to potential future depressive episodes.

Monetary compensation

There will be no monetary compensation to participants.

Confidentiality

Any information resulting from this research will be kept strictly confidential. Upon signing the informed consent you will be given a code number to ensure the maintenance of confidentiality. Participants will not be identified by the use of names or initials.

If you have any questions or concerns at any time during the study, you may contact Dr. Ishiyama, Dr. Montaner, or Victoria Alfonso at the numbers listed above. You may also telephone Dr. R. D. Spratley, Director, Office of Research Services, at 822-8595 if you have any concerns about your treatment or rights as a research subject. You will be informed of any significant information that may concern you. Counselling services will be made available for any psychological fallout from participation in the study.

I have read the above information and I have had an opportunity to ask questions to help me understand what my participation would involve. I freely consent to participate in the study and acknowledge receipt of a copy of the consent form.

______________________________  _______________________
Signature of Participant Date

______________________________
Signature of Witness

Thank you for your willingness to participate in this study.
APPENDIX E

QUESTIONS

- "Think back to a time since your HIV+ diagnosis when you were experiencing depressive moods. What helped the process of dealing with your depressive moods? What did not help?"
- "How did a good day look like? And a bad day?"
- "I would like you to think of a specific time when you found yourself in a situation that helped/did not help you deal with your your depressive moods. Take your time to think of a specific incident in as much detail as you can. What were the general circumstances leading up to this event?"
- "What did you do or what happened to make you feel this way?"
- "What actually happened when this event took place?"
- "How important was this incident at the time?"
- "What made this incident so helpful/unhelpful?"
- "How did you know that it was so helpful/unhelpful?"
- "What was the outcome of what you did?"
- "What was meaningful about this incident?"
- "What did you learn about yourself from it?"
- "Was this incident so helpful/unhelpful that it changed your attitude towards other things, other people, your diagnosis, or yourself for a day, a week...?"
- "What would you say are the personal resources that enabled you (that you drew from) to deal with your depressive moods?"
- "What would others (i.e. friends, family, co-workers) say these resources are?"

Note: The interview focused on positive incidents first, followed by negative events. Questions were slightly modified accordingly.