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Cognitive-behavioral group program for Chinese heterosexual HIV-infected men in Hong Kong

Iris Chan [a,*], Paul Kong [b], Patrick Leung [b], Alma Au [a], Patrick Li [c], Rita Chung [c], Lee Man Po [c], Pansy Yu [c]

[a] *Clinical Psychology Service, Queen Elizabeth Hospital, 30, Gascoigne Road, Hong Kong, China*
[b] *Department of Psychology, The Chinese University of Hong Kong, Hong Kong, China*
[c] *Clinical AIDS Service, Queen Elizabeth Hospital, Hong Kong, China*

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Abstract

This study explored the effects of cognitive-behavioral program (CBP) using a wait-list control group in 16 Chinese heterosexual HIV-infected men. Participants in the treatment condition underwent a 7-week group based CBP, which addressed various HIV-related issues. Relevant cognitive and behavioral strategies were taught as well. The aim of treatment was to improve the quality of life and to reduce psychological distress in a sample of heterosexual symptomatic HIV-infected men. Prior to intervention, baseline measures showed that our sample had a lower quality of life in comparison with the local general population. They also experienced a significant level of psychological distress. Following intervention, men in the CBP group demonstrated significant improvement in the mental health dimension of quality of life and a significant reduction in depressed mood. These preliminary findings suggested that short-term cognitive-behavioral therapy can be effective in improving the quality of life and mood of Chinese heterosexual HIV-infected men.

Keywords: HIV/AIDS; Heterosexual; Men; Chinese; Cognitive-behavioral therapy

1. Introduction

Since the arrival of more effective antiretroviral medications for HIV infection, HIV-infected individuals have to cope not so much with death but with the complex psychosocial demands of a chronic life-threatening illness [1]. Subsequent to the first and the strongest impact of the initial news of seropositivity, infected persons have to experience lots of direct burdens and changes in lifestyle including overt signs of progressive physical deterioration [2], legal and societal stigmas [3,4], and possibly multiple bereavements [5]. Several studies found that adjustment disorder with depressed mood is very common among HIV-infected patients [6–9]. Although HIV-infected persons may not be afflicted with clinical affective disorder, many of them experience significant levels of distress. Therefore, emotional adjustment is a major dimension of quality of life that is relevant to them.

Previous research shows that apart from biological factors, various psychosocial variables contribute to individual differences in HIV disease progression [10,11]. The combination of unpredictable stressors and diminished social resources may lead to the use of maladaptive coping strategies, such as denial and avoidance [12]. The adoption of a fatalistic and pessimistic attitude was found to be associated with an accelerated disease course and a shortened survival period among men with AIDS [13–18].

Given the negative impact brought by HIV infection, psychological intervention may be beneficial to HIV-infected individuals [19]. Typically, these interventions involve groups of 6–8 participants which are led by two co-leaders. These groups usually meet weekly for 2–3 months. Studies that specifically recruited HIV-positive men who were experiencing ongoing mood problems found that group-based, stress-reduction interventions are successful in improving psychological functioning and reducing depressive symptoms [20–28].

Most of the past research has been focused on studying the efficacy of psychological intervention for the gay population [22–28]. Little is known about the generalizability of such intervention among heterosexual men. In Hong

* Corresponding author. Tel.: +86-852-2958-6308; fax: +86-852-2958-6665.
E-mail address: iriswschan@hotmail.com (I. Chan).

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Kong, heterosexual men made up a considerable proportion of HIV-infected patients. The purpose of the present study is to investigate whether group-based cognitive-behavioral intervention can help Chinese heterosexual HIV-infected men to relieve distress and to promote their quality of life.

2. Method

2.1. Participants

Participants were recruited from a pool of 62 HIV-seropositive heterosexual men, who attended the Clinical AIDS Service of Queen Elizabeth Hospital, a major general hospital in Hong Kong. Eligibility criteria included: (1) a diagnosis of HIV illness; (2) being in a symptomatic stage of infection (CDC stage B or C); (3) being heterosexual male and older than 18 years old; (4) able to comprehend and communicate in Chinese and (5) willing to participate in the study. Patients were excluded if they were hospitalized at the time of recruitment; having a highly infectious disease; have received psychotherapy before; or with cognitive deficits, mental retardation or psychotic symptoms at the time of the study.

Information was collected from nurse specialists and medical records to select patients who met the eligibility criteria. Eligible patients were contacted by phone to confirm their eligibility and interest in the study. Those consenting patients were scheduled to come to the clinic for further detailed assessment. During the assessment interview, the objectives of the study and content of the group were explained to the potential participants. Written informed consent was obtained subsequently. Consenting patients were asked to fill out a set of questionnaires for baseline assessment. Clinical interview was also conducted by a clinical psychologist in training.

Out of the 62 patients who met the inclusion criteria, 53 were successfully contacted. Twenty-four patients attended the screening interview. After the baseline assessment, 20 patients had signed consent to participate in the study. However, four patients were later found to be unsuitable candidates for the present study. Two of them were assessed to be unsuitable to place in a group environment, one indicated that he was bisexual at a later time, and one was found to be at the asymptomatic stage of HIV infection rather than symptomatic.

In total, 16 participants were recruited. Eight participants entered the CBP group and eight participants entered the waitlist control (WLC) group. However, two participants in the CBP group and one from the WLC group dropped out due to practical reasons. Data of these dropouts were excluded from the present analyses. Thus, the final sample that entered statistical analyses consisted of 13 participants. Six participants belonged to the CBP group and seven belonged to the WLC group.

2.2. Measures

2.2.1. Demographic characteristics

At the beginning of the study, we collected information on the participants' age, sex, employment status, relationship status, and years of education. Other biomedical information, including the time since diagnosis of HIV infection, stage of illness, and the latest CD4 count, was obtained from the medical records of the participants.

2.2.2. Psychosocial assessment

2.2.2.1. Health-related quality of life (HRQOL). Medical outcomes study short-form 36 (SF-36) [29] was used to measure HRQOL. It yields a profile of eight domains, which include physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health. Higher scores always indicate better HRQOL when raw scores are linearly transformed to a 0–100 scale. The SF-36 has been translated into Chinese and was validated on the local population in Hong Kong [30].

2.2.2.2. Mood state. The Center for Epidemiologic Studies-Depression Scale (CES-D) [31] was used to measure depressive mood. The scale includes 20 items related to depressive mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance. Participants reported the frequency of each of the symptoms during the past week on a four-point Likert scale ranging from 1 (rarely or none of the time) to 4 (most or all of the time). Higher scores indicate higher frequency of depressive symptoms.

2.3. Procedures

To ensure a satisfactory randomization, the 16 participants were grouped into eight matched pairs based on their demographic background including age, education level, employment status, marital status and the time since diagnosis. Participants within each matched pairs were randomized to either the CBP group or the WLC group respectively. The CBP group consisted of seven weekly sessions, with each session lasted for 2 hours. Immediately after the cognitive-behavioral program was completed, post-treatment data were collected from the CBP group. Comparison data were obtained from the WLC group at the mean time.

2.4. Cognitive-behavioral group therapy

The protocol of the CBP intervention was derived based on Beck's [32] theory of cognitive-behavioral therapy and the coping effectiveness training protocol developed by Chesney and her colleagues [33]. The aims of the program were to teach patients to identify and challenge their irrational beliefs related to various aspects of their illness, and to enhance their skills in coping with stressful situations