The cognitive behavioral therapy health and social care essay

Katz and Nevid (2005) assessed a sample of 102 women from the New York City metropolitan area and found that the total number of PTSD symptoms was significantly associated with a greater number of HIV physical symptoms, greater number of past traumatic events, less satisfaction with social support, greater negative life change, and greater degree of stigma. The strongest predictor of PTSD symptoms was higher level of perceived stigma. The authors further suggested that the reason stigma may be the strongest predictor is due to the trauma-related shame and guilt that the individual may also be experiencing as a result of having the illness. Research has theorized that an accumulation of traumatic experiences throughout life may be a risk factor for psychological distress in individuals who are HIV positive or have progressed to AIDS (Delany-Brumsey, Joseph, Myers & Ullman, 2011). Delany-Brumsey et al. (2011) examined the relationship between cumulative lifetime trauma and psychological distress in both an HIV positive and negative female sample. Results showed that greater cumulative trauma exposure was associated with greater distress and negatively related to psychosocial resources. Women with more traumatic events often had lower resources and experienced greater psychological distress. This study examined cumulative effects of trauma exposure, therefore avoiding the limitations noted in other studies (Safren et al., 2003). However, relative severity of trauma was not examined. Koopman et al. (2002) investigated a sample of 64 individuals with HIV or AIDS using PTSD and acute stress measures as well as a demographic questionnaire. After the baseline was measured, individuals were divided into two treatment conditions; group therapy versus psychoeducation. Three months later they were re-assessed for acute stress reactions. Results indicated that nearly one third of participants met criteria for the diagnosis of acute stress disorder after a recent life event. An interesting finding is that the life event did not have to be threatening to life or physical integrity to illicit a stress reaction. The authors also found that the acute stress reactions to recent life events were significantly and positively related to experiencing symptoms of PTSD prior to the event suggesting that those who react strongly to ongoing life stressors may be more likely to have developed PTSD after a previous traumatic life event. No differences were found between conditions. Delahanty, Bogart, and Figler (2004) suggested that the presence of traumatic stress or psychological distress related to trauma may be another factor which interferes with medication adherence. One hundred and ten participants in a Midwestern city completed self-report questionnaires which included information on socio-demographics, health status, symptoms, treatment adherence, and PTSD related to HIV diagnosis while also collecting salivary cortisol samples at bedtime and awakening. The researchers found that those who reported higher PTSD symptoms exhibited lower medication adherence. Individuals who had lower adherence were more likely to have a greater HIV viral load. Interestingly, PTSD symptoms were associated with lower salivary cortisol levels and both lower PTSD symptoms and lower salivary cortisol levels were associated with higher CD4 cell counts. Viral load appeared to be higher in participants experiencing PTSD due to the likelihood of non-adherence to medication regimen. However, lower cortisol levels appear to be a pseudo-protective factor against immunosuppression as CD4 counts tended to be higher in these individuals. The researchers were unable to report on the meaning of the negative correlation between PTSD symptoms and salivary cortisol levels. This is an interesting area for further research. Although receiving the diagnosis of HIV has been shown to be, in and of itself, traumatic, a study by Nightingale, Sher, and Hansen (2010) examined the concept of posttraumatic growth, or a positive psychological change, as a result of a challenging life circumstance such as chronic illness. One hundred and twelve participants were evaluated with a clinical interview and three scales measuring rumination, posttraumatic growth, and impact of events. Results indicate that there may be a small positive relationship between psychological distress and posttraumatic growth. In other words, individuals who experience distress after being diagnosed, may in fact be more likely to grow psychologically and emotionally. Symptoms of HIV often wax and wane over time (AIDS, 2012) creating a possible influx of PTSD symptoms when HIV symptoms are most distressful. Because of this, it may be difficult to identify any trauma issues resulting from the diagnosis while the individual is asymptomatic. This suggests that primary care physicians or specialists who are most closely working with the patient must be cognizant of less severe symptoms of PTSD in addition to the more obvious ones. Implications for clinical treatment based on this knowledge of include the initiation of long-term therapy to address issues as HIV stressors continue to accumulate overtime for the individual. Focus on death anxiety and managing issues of death and dying will also be important as it contributes to both symptoms of PTSD and general sense of well-being.

Treatment

It is clear that there are many areas of concern outlined above which could be impacted by appropriate treatment models. Issues of managing and coping with chronic illness, the impact of stigma, depression, anxiety, and trauma are only a few. Many different treatment modalities have been shown to be effective in working with these issues in other populations. Applying them to PLWHA appears to be a logical next step.

Cognitive Behavioral Therapy

The utility and impact of Cognitive Behavioral Therapy (CBT) on a wide variety of disorders has been well established (Roth & Fonagy, 2006). According to the theory of CBT, individuals acquire belief systems to explain their worlds (Beck, 1995). These beliefs are core to an individual’s value system and develop through life experiences or may be learned from others in the immediate environment. The core beliefs are fundamental to the individual and tend to be rigid, overgeneralized, and often not articulated. In addition to the core beliefs, there are intermediate beliefs that consist of personalized assumptions or rules that are more specific to individual situations and events. They include attitudes, rules, and assumptions related to the core beliefs that influence the individual’s point of view. Core and intermediate beliefs become a " part of the individual’s cognitive representations of the world and are reflected in a stream of self-talk or automatic thoughts" (Berman, 2010, p. 123). Automatic thoughts then develop from the individual’s cognitive representation or schemata, in turn influencing how he or he thinks, feels, and behaves (Berman, 2010). According to Beck (1995), during times of stress, an individual may develop maladaptive core beliefs, intermediate beliefs, and automatic thoughts, referred to as dysfunctional cognitions. These cognitions often present as distorted and self-defeating beliefs that the individual has integrated into his or her belief system (Berman, 2010). They may also have experiences that are contrary or reinforcing to already established beliefs (Beck, 1995). In either case, psychopathology may develop. Further issues arise when the individual's automatic thoughts begin to affect emotions, physiology, and behavior (Beck, 1995). Beck (1995) further states that as perception affects the way that beliefs are developed; developed beliefs can also influence an individual's perception of a situation and related automatic thoughts. This in turn can influence emotion, behavior, and even physiological response (Beck, 1995). With an inability to evaluate the thoughts, an individual is unable to dispute them and therefore experiences negative emotions and behaviors (Beck, 1995). While collaborating with the individual or group, the goal of CBT is to help facilitate recognition of cognitive thinking errors that have resulted in distress or mental disorder (Corey, 2009). Once the thinking errors have been identified cognitive reframing can be implemented in order to minimize negative automatic thoughts that will eventually help to reframe core beliefs (Corey, 2009). According to Roth and Fonagy (2006), cognitive behavioral therapy (CBT) is often studied for its efficacy in treatment of mental illness. In treating depression, CBT has been shown to be efficacious in three landmark studies (Elkin, 1994; Howard, Krause, & Orlinsky, 1986). Research has also identified the use of CBT and psychopharmacology as virtually equivalent as both were associated with significant change in depressive symptoms (Evans et al., 1992; Hollon et al., 1992). Thase et al. (1997) analyzed the existing literature and determined that there was a significant advantage to using psychotherapy in combination with medications, especially for severe depression. DeRubeis , Gelfand, Tang, and Simons (1999) compared medication and psychotherapy and found no difference in efficacy between treatment modalities. Similar research has corroborated these findings (Blackburn & Moore, 1997; Cuijpers, Van Straten, Hollon, & Andersson, 2009; Guidi, Fava, Fava, & Papakostas, 2011; Jarrett et al., 1999). CBT for depression in a primary care setting has also shown effectiveness compared to standard care (Holden, Sagovsky, & Cox, 1989; Scott, Tacchi, Jones, & Scott, 1997; Teasdale, Fennell, Hibbert, & Amies, 1984; Ward et al., 2000). Pyne et al. (2011) investigated the effectiveness of collaborative care for depression in Veterans Affairs (VA) HIV clinic settings and found that participants in the treatment group reported more depression-free days than the control group. Depression improved along with HIV symptom outcomes. This study was completed in a VA setting with a VA population which may not be generalizable to the general public. Crepaz and colleagues (2008) conducted a meta-analysis of cognitive-behavioral interventions for PLWHA. They analyzed data from 15 controlled trials between 1988 and 2005 to determine what main intervention effects on symptoms of depression anxiety, anger, stress, and CD4 cell counts were found. The studies included intervention characteristics such as thought appraisal/cognitive restricting techniques, coping skills training, stress management skills training, and social support. Delivery of interventions occurred in group or individual therapy and were delivered by professional psychologists, psychiatrists, or trained research staff. The researchers found significant intervention effects for improving depression, anxiety, and stress and concluded that cognitive-behavioral interventions are effective for improving psychological well-being in PLWHA. More specifically, they determined that when participants received training in how to assess and alter irrational thoughts and develop adaptive coping skills to manage and reduce stress they were more likely to show significant improvements in symptoms of depression, anxiety, anger, and stress when compared to controls. Further analysis did not show continued effectiveness long-term but the authors were unable to examine this closely due to insufficient data and suggested further investigation. While impressive in its findings on psychological improvements, this study was limited in its investigation of progression of the disease as measured by CD4 counts. It is clear that more longitudinal research in this area is needed. Stress management as a cognitive behavioral intervention has also been shown effective in treatment with PLWHA (Brown & Vanable, 2008; Scott-Sheldon, Kalichman, Carey, & Fielder, 2008). Studies have shown meditation exercises, cognitive restructuring techniques, relaxation techniques, adaptive coping training, emotional regulation training, and social support facilitation to be useful and effective in decreasing psychological distress and improving emotional well-being. When assessing stress management interventions, as noted above in other studies, a lack of evidence for improved immune functioning (CD4 cell count) was noted. This was also thought to be due to limited longitudinal data. In the HIV-positive population, Sambamoorthi, Walkup, Olfson, and Crystal (2000) found that antidepressant treatment increased appropriate HIV care for those who had depressive symptomatology. They also found that treating depression significantly lowered the monthly cost of medical care services. Both psychotherapeutic and pharmacological interventions for depression experienced by PLWHA have shown to be effective in decreasing depression, increasing utilization of services, improving overall health and HIV health care, adherence to medical regimens, and increased well-being and quality of life (Angelino & Treisman, 2001; Asch et al., 2003; Cabaj, 1996; Fernandez & Levy, 1991; Fernando & Wapenyi, 2002; Fulk, Kane, Phillips, Bopp, & Hand, 2004; Kemppainen et al., 2004; Lee, Cohen, Hadley, & Goodwin, 1999; Markowitz et al., 1995; Perdue, Hagan, Thiede, & Valleroy, 2003; Sambamoorthi et al., 2000; Starace et al., 2002; Wagner, Kanouse, Koegel, & Sullivan, 2003). Another common use for CBT is in the treatment of anxiety spectrum disorders. In treating anxiety disorders and generalized anxiety disorder specifically, CBT was found to show significant and consistent gains in 50-65% of participants (Roth and Fongay, 2006). Additionally, the use of relaxation techniques were found to be the second most efficacious treatment for anxiety (Roth and Fongay, 2006). Relaxation techniques are often considered behavioral techniques used in conjunction with cognitive reframing to increase positive coping and decrease stress (Hersen, 2002). The research was limited in its report on the effectiveness of relaxation training for PLWHA. Stress management in general has been found useful in this population (Mills, Wu, & Ernst, 2005; Sharoff, 2004). Common to many individuals living with HIV/AIDS is health related anxiety. Abramowitz and Braddock (2011) indicated that CBT can produce lasting effects for individuals with health related anxiety. While the specific intervention plan outlined focuses on issues of hypochondriasis and somatization, it may also be useful for individuals who are experiencing anxiety related to actual medical illnesses. The literature on evidence-based practice for anxiety related to chronic or terminal illness is vast and has also identified cognitive behavioral therapies as effective (Mannix et al., 2006; Sharoff, 2004; Sage, Sowden, Chorlton, and Edeleanu, 2008). More specifically, CBT is useful for developing strategies for managing life problems (Sharoff, 2004). As chronic or terminal illness creates the need for lifestyle change, CBT can be useful in decreasing anxiety related to life or role changes (Sharoff, 2004). As persons living with HIV/AIDS manages his or her chronic illness, many psychological challenges may arise. CBT has been investigated for use in managing chronic illness (Sage et al., 2008; White, 2001). Safren, Gonzalez, and Soroudi (2008) suggested that utilizing CBT can be helpful for treating chronic illness with regards to issues such as mental health symptoms, adherence, or symptom relapse rate all factors the authors suggested are associated with the management of a chronic illness. Similar studies with diabetes, breast and other cancers, chronic fatigue syndrome, chronic pain, and heart disease have also found CBT to be an effective treatment modality (Beatty & Koczwara, 2010; Epsie et al., 2008; Lett, Davidson, & Blumenthal, 2005; Lustman, Griffith, Freedland, Kissel, & Clouse, 1998; O'Dowd, Gladwell, Rogers, Hollinghurst, & Gregory, 2006; Vlaeyen & Morley, 2005). In treatment of HIV as a chronic illness, Olatunji, Mimiaga, O'Clereigh, and Safren (2006) found CBT to be effective in numerous studies with an HIV population. Mills, Wu, and Ernst (2005) investigated the use of complementary therapies for the treatment of HIV and found that stress management interventions were the effective in increasing quality of life compared to other complementary treatments.

Motivational Interviewing

Making change, whether it is behavioral, emotional, or cognitive, can be a difficult and sometimes distressing to any individual. The concept of Motivational Interviewing (MI) was first discussed by Miller in 1983 and later elaborated on by Miller and Rollnick in 1991. MI is a client-directed, goal-directed method of eliciting behavior change by helping the individual overcome ambivalence (Miller & Rollnick, 1991). This method assists clients in identifying and engaging intrinsic motivation to promote change. When using MI, a clinician first establishes rapport and focuses on reflective listening, using open-ended questions to explore motivations for change, affirming the client's change-related statements, and encouraging recognition of the gap between current behaviors and desired life goals (Miller & Rollnick, 1991). The clinician must also encourage the client's self-efficacy for change, ask permission before providing information or advice, and respond to resistance without direct confrontation. Miller and Rollnick (1991) suggested developing an action plan that the client can commit to. Traditionally, MI has been used for treatment of alcohol and substance abuse behaviors but more recently it has been adapted for use in health promotion, medical treatment adherence, and other mental health issues. MI has been included in The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP, 2007). There are numerous clinical trials of MI that have been published since the early 1990's suggesting efficacy for behavior change (Burke, Arkowitz, & Dunn, 2002; Dunn, Deroo, & Rivara, 2001; Noonan & Moyers, 1997). Hettema, Steele, and Miller (2005) suggested that MI is generally brief and sometimes used as a motivational prelude to other treatment interventions. In fact, in Hettema and colleague's meta-analysis, MI was rarely given alone. When combining MI to other interventions it is often referred to as adaptations of MI (AMIs). Burke, Arkowitz, and Menchola (2005) investigated the efficacy of AMIs in a meta-analysis and found that when compared to no treatment and/or placebo, AMIs showed significant clinical impact. Specifically, 51% of people who received an AMI for a targeted behavior change improved at follow-up compared to 37% of the control group. In managing chronic illness, Linden, Butterworth, and Prochaska (2010) applied MI techniques within a health coaching program. With a sample of 106 chronically ill participants, researchers compared the effects of the program intervention with 230 chronically ill persons receiving usual care. They found that when compared to the control, the intervention participants improved their perceptions of self-efficacy, demonstrated lifestyle change, and had an improvement in perceived health status. Safren et al. (2008) also used MI in their approach to coping with chronic illness and found the use of a discussion on both motivation and change to be helpful during the initial phases of coping with a chronic illness. There are specific research data investigating the use of MI with the HIV/AIDS population. Parson, Rosof, Punzalan, & Di Maria (2005) investigated the integration of MI with CBT in an HIV-positive population. They found that participants reported significantly high therapeutic alliances (reflected in increased comfort) after use of MI techniques. The sample size of this pilot study was small therefore, no statistically significant differences were found for other factors such a medication adherence. While a limitation of the study, the researchers suggested that with a larger sample, there is promise for efficacious findings. The literature is rife with articles outlining how MI may be useful for populations and treatment areas other than substance abuse however, it is limited in outcome studies for actual use. Despite this, MI is an effective evidence based practice for promoting change and when used in combination with other intervention strategies, appears to be helpful as a brief intervention for beginning the process of change, improving treatment engagement, and increasing outcome (Baer, Kivlahan, Blume, McKnight, &

Marlatt, 2001; Bernstein et al., 2005; Carroll et al., 2006; Senft, Plen, Freeborn, & Hollis, 1997; Vasilaki, Hosier, & Cox, 2006).

Positive Psychology

The theories of positive psychology date back to the 1950’s but were more recently summed up by Seligman and Csikszentmihalyi in 2000 with the concept that rather than treating only mental illness, positive psychologists seek to identify and focus on positive aspects and experiences to make normal life more fulfilling. By only focusing on the disorder or dysfunction in a person’s life, according to positive psychologists, one may only have a partial understanding of the person’s condition (Compton, 2005). Areas of the individual experience that are of interest for a positive psychologist are values, strengths, virtues, talents, and states of pleasure. Seligman (2011) proposed the acronym PERMA, positive emotions, engagement, relationships, meaning and purpose, and accomplishments, as the areas to investigate. When applying the concepts of positive psychology, the goal is to increase flourishing and encourage optimal functioning by assisting clients in identifying their own strengths for well-being (Gable & Haidt, 2005). Despite its popularity, the evidence-based research regarding the effectiveness of positive psychology is seriously lacking. There is limited to no available research on the use of positive psychology theory for chronic illness and/or HIV/AIDS. What is present in the literature is a general theme of promoting positive thinking, positive self-efficacy, positive relationships and communication, and a general sense of well-being for quality of life. Fredrickson (2003) suggested that the reason for this is that positive emotions produce longevity. Whether managing chronic illness or life circumstances, positive emotions can reduce physiological damage caused by stress and negativity. With the use of strength based language, positive characteristics, and value identification, along with the exploration of meaning and purpose, a clinician can utilize the theories of positive psychology in clinical practice.

Group Psychotherapy

One of the many modalities to deliver the afore mentioned therapeutic techniques is via the group therapy route. The Practice Guidelines for Group Psychotherapy were developed in 2007 by a task force for the American Group Psychotherapy Association (AGPA). The goal of the guidelines was to create successful therapy groups while also maintaining standards of practice and ensuring evidence-based practice. Within the framework established by the guidelines, group facilitators should follow certain principles for cohesion. For example, pre-group preparation including defining group rules and member roles, clinical judgment to balance individual group members and member interactions, and establishing and maintaining an emotional climate. According to the guidelines (Bernard et al., 2008) once group has begun, the goals of the facilitator are to establish a therapeutic alliance, reduce client anxiety, provide information, and reach a consensus on goals for group. As the group progresses, a five-stage model of development is proposed beginning with " forming," " storming," " norming," " performing," and lastly, " adjourning" (Tuckman, 1965). Within these stages, there are particular considerations for the facilitator to be aware of and manage. Further investigation into the stages of group development is encouraged for clinicians beginning a group intervention. The group process should consider group as a social system and be sure to address splits and subgroups while also acknowledging individual member and leader roles (Bernard et al., 2008). Additionally, therapist interventions should focus on caring, emotional stimulation, meaning-attribution, fostering client self-awareness, and establishing group norms while also being aware of therapist transparency and use of self-disclosure. In order to reduce adverse outcomes and maintain ethical practice of group psychotherapy, the authors (Bernard et al., 2008) suggested competence level awareness of professional ethics, group pressures, record keeping, confidentiality, boundaries, informed consent, and progress monitoring. In addition to the group psychotherapy, members may also be participating in other healthcare services, even other forms of psychotherapeutic services such as individual therapy, pharmacotherapy, or a 12-step program. Bernard and colleagues addressed the importance of collaborating care with concurrent treatments for the purpose of increasing effectiveness of the group intervention while also ensuring other forms of treatment are not contraindicated or possibly harmful in combination. When the group has come to an end and it is time to terminate, Bernard et al. (2008) indicated that the process of ending can be difficult for group members. They suggested that ending rituals that promote balance and continued learning and therapeutic gains, such as celebrating the accomplishment, may leave the group members with positive reinforcement for future leavings.

Efficacy

Pomeroy, Kiam, and Abel (1999) implemented a psychoeducational group for HIV-infected/affected, incarcerated women. This intervention provided group members with accurate information about the disease, social and emotional support, a safe confidential environment, and an outlet for stigma related distress. Additionally, the group consisted of cognitive-behavioral and task-centered (homework) approaches to help the members work on the emotional impact of HIV/AIDS. Anxiety, depression, and trauma symptom measures were given at the beginning and end of the group sessions. The researchers found that those women in the experimental group had significantly more positive outcomes than those in the comparison group. Similarly, the group intervention showed to be effective in decreasing the symptoms of depression, anxiety, and trauma in this population. While this is an impressive finding, women in the experimental and comparison groups were not randomly assigned and therefore the level of depression, anxiety, and trauma symptomatology was not equivalent between groups (Pomeroy et al., 1999). Due to self-selection it is possible that women who participated in the experimental group were either more motivated for change, experienced more distressing symptoms, or both. This could account for part of the change found at post-test. The authors suggested that despite this, improvements were most likely due to the intervention. Consideration should also be made to the setting in which this intervention took place as social desirability of the experimental group may have been a factor in reported change. The incarcerated women may have responded more positively due to possible sentencing outcomes (real or imagined) based on improvement. The authors also stated that a limitation of the study was the lack of follow-up to determine whether the benefits of the intervention carried on to life after release from jail or prison. A 2005 pilot study was conducted to determine whether a supportive-expressive group therapy in combination with an education intervention would show decreased viral load and increased CD4 counts than the education intervention alone in an HIV positive sample (Belanoff et al.). The group intervention consisted of 12 weekly 90 minute sessions exploring social support, expression of emotion, detoxifying dying, reordering life priorities, family support, effective communication with physicians, and symptom management. Group members were encouraged to create a new network of social support outside of the therapy setting while also working on coping and adjusting to life with a chronic illness. The education intervention consisted of a packet of materials provided for the patient in conjunction with medical care. When assessed post-treatment, the researchers found a statistically significant increase in CD4 cell count in the experimental group (z = -1. 8, n = 26, p = . 033; Belanoff et al., 2005). They also found significant decrease in viral load (z = 1. 63, n = 50, p = . 051). Belanoff and colleagues suggested that the addition of a supportive-expressive group psychotherapy intervention for HIV-seropositive individuals is beneficial for HIV CD4 cell count and viral load. This study is important to consider for future research as it suggested that there is some mechanism at work allowing increased feelings of support and well-being to decrease the progression of the disease. While the researchers used the term immunity to describe what was being enhanced by this intervention. Without explanation or working definition of " immunity" within the article, it was difficult to understand the meaning of this term as understood in the study. Suggesting that psychotherapy could create immunity for HIV is an inaccurate and dangerous statement regardless of intended meaning. In a sample of HIV-infected homosexual men, Mulder et al. (1994) investigated the effectiveness of cognitive-behavioral group psychotherapy (CBT) and an experiential group psychotherapy condition compared to a wait-list control group. Participants were recruited from a group already participating in a longitudinal study in the Netherlands. A screening battery was administered to measure pre-treatment depression, anxiety, fear of getting AIDS, active coping, and seeking social support. The goals for each of the two conditions were to reduce distress, improving coping, increase social support, and increase expression of emotions. A post-treatment battery was given to measure the effects of the interventions. The researchers found that both groups showed reduced psychological distress when compared to the wait-list group but did not find any significant change for the other factors of coping style, social support, and emotional expression. They did not find any difference between effectiveness of either experimental group intervention. While this study did not find significant change in many of the areas measured, there was a significant change in psychological distress suggesting that a psychotherapeutic group intervention, regardless of orientation, can improve well-being which may, in time, improve the other target areas discussed. This study was limited due to its use of participants from another study that may have been already " primied" for research. Rousaud and colleagues (2007) found similar results with their CBT group intervention and additionally stated that psychosocial adjustment was also improved. A study with a Chinese sample investigated the effects of cognitive-behavioral group therapy and peer support in decreasing psychological distress and improving quality of life (Molassiotis et al., 2002). This study used symptomatic participants and assessed mood states and quality of life before the intervention and at a 6-month follow up. The cognitive-behavioral intervention used was the same used by Mulder et al. (1994). The researchers found that quality of life significantly improved in the CBT group when compared to both the control and the peer support group. Additionally mood was improved in this group, especially with regards to anger, tension-anxiety, depression, confusion, and overall mood. Molassiotis et al. stated that while significant at the time of the study, improvements in anger-hostility were unfortunately not maintained at follow-up (2002). The peer support group seemed to have the opposite effect as it was not found to be significantly effective immediately post-intervention but at follow-up showed as much as a 34% improvement in quality of life. What is interesting about this study is that its participants were experiencing active HIV symptoms while participating, which is in contrast to most other similar studies. This suggests that group interventions may be effective even for more progressed HIV or possibly even AIDS. In addition to the specific areas of concern addressed in this project, group therapy has also been found effective for many related factors. For example, group interventions have been found effective for addressing AIDS-bereavement (Goodkin et al., 1999; Sikkema, Hansen, Kochman, Tate, & DiFranceisco, 2004; Sikkema, Hansen, Meade, Kochman, & Lee, 2005). Improved coping with grief also has a positive impact on health-related quality of life and psychological distress for PLWHA (Goodkin et al., 1999; Sikkema, Hansen, Meade, Kochman, & Lee, 2005). This is an important finding as the group intervention seemed to have a broad impact on both emotional and physical health. Additionally, research shows that a peer support group in an adolescent HIV population is associated with improvement in emotional well-being and can have a positive impact on medical outcomes (Funck-Brentano et al., 2005). Group interventions have been found effective in reducing traumatic stress in

PLWHA who have also experienced childhood sexual abuse (Sikkema et al., 2007). This was true for coping group interventions but not support group interventions in contrast to the previous study. Group therapy has also been found effective in specifically reducing depressive symptoms in HIV-infected individuals in a series of studies (Antoni et al., 2006; Chan, Kong, & Leung, 2005; Himelhoch, Medoff, & Oyeniyi, 2007; Kelly et al., 1993; Targ et al., 1994;). While noted as a limitation of many studies, it is interesting that the majority of the group members were male suggesting that in this case, the group was effective for male individuals living with HIV. Although there is limited literature available, group interventions for homeless individuals have also shown to be effective (Plasse, 2002; Washington, Moxley, & Taylor, 2009). Washington and colleagues (2009) used a life enhancement group intervention to enable older homeless minority women to overcome homelessness. Seventy-six women, who met the criteria for homelessness based on current housing status, were randomly split into a treatment group and control group after an interview and screening process. The intervention group received treatment using a cognitive-behavioral program to alter behavior by changing perceptions and thinking while also using systemic procedures. Participants had opportunities to learn strategies for coping with homelessness while also receiving emotional and informational support. The researchers found that when compared to the control group, women in the experimental group showed significantly greater levels of both self-confidence and personal control post-intervention. Washington et al. suggested that because of this, women were more likely to increase and sustain appropriate coping while overcoming homelessness as a result of their actions, efforts, and abilities (2009).

Discussion

HIV/AIDS has been considered a " defining medical and public health issue of our generation" (Fauci, 2003, p. 839). Currently, blood tests for HIV/AIDS help with diagnosis, antiretroviral therapies have shown some effectiveness, prevention strategies are widely implemented, continuous research for possible vaccination, and awareness of this condition has managed the crisis of the 1980’s and the necessities which followed in the 1990’s. The focus of the twenty-first century has been to continue with medical advancements and concentrate on well-being and the quality of life for individuals continuing to manage HIV infections and AIDS diagnoses. Many groups of people are still being infected with HIV and still dying of AIDS, at least in part, due to bigotry and fear that keeps them relegated to the bottom of the social hierarchy (Land & Linsk, 2013). Access to services, costs of treatments, and immense stigma remain issues for those most at risk. Targeted programs continue to be funded but the problem continues to grow. If HIV and AIDS is to one day be managed, society needs to address stigma. While the world to catches up with the ideas, concerns, and work of HIV and AIDS activists and experts, focus must be on providing quality services and programs to individuals who are currently living with the virus. Improving quality of life and focusing on living rather than dying is how HIV and AIDS should be treated in the 21st century. Based on the literature, an effictive intervention or treatment program should include the concepts of CBT for managing chronic illness, MI for assessing and promoting change, and positive psychology to focus not only on the disorder or disease but to focus on strengths and joy for greater quality of life.

Program Overview

This Practitioner Scholar Project is a program development to target common psychological dysfunction within a homeless HIV/AIDS adult population in an effort to contribute to already established medical and social services. Due to the availability of a thorough needs assessment conducted by the state of Arizona, it was determined that survey or interviews with current residents of such HIV housing programs was unnecessary. Consequently, no Institutional Review Board (IRB) submission was needed. Research for the literature review was accumulated through an online search using Midwestern University’s library search engine (EBSCO Host), Google, and Google Scholar. Only peer-reviewed resources were utilized. Articles were initially included based on a publication date within the past 10 years, however, due to limited research available, studies were later included that dated to the early 1980’s which were relevant to the current study. Studies referenced in this paper included homeless samples, male and female samples, African American samples, Hispanic samples, and both American and international studies and were chosen for inclusion due to their relation to the content material of this project. The " Simply Thrive" program will include eight-weekly modules formatted for persons living with an HIV infection or AIDS who have also recently experienced homelessness and are now receiving housing support services from a government contracted agency. Each module will have a theme that has been identified in the literature as salient to this population (i. e. chronic illness and coping, depression, anxiety, stigma, trauma, etc.). Additional topics with certain themes will include issues of advocacy, personal responsibility, productivity, meaning, self-esteem, and goals. As mentioned above, substance abuse treatment will not be specifically addressed in the " Simply Thrive" program. This program aims to use a combination of Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Positive Psychology to promote self-management for increased resiliency and improved general well-being. The group will be psycho-educational in nature with opportunity to process the emotional impact of HIV/AIDS and homelessness. Each session will include handouts to strengthen understanding of the topic and a group discussion allowing for some processing of the information within the group to occur. Some groups will include a homework component with varying levels of effort required. Coinciding handouts will be provided in a facilitator guide and handbook format for both facilitator and group member use in the group session as well as used outside of the group.

Hypothesis

The hypothesis of this project is that the addition of a psycho-educational and emotional processing group experience in a population of homeless HIV positive adults will increase resiliency and improve overall well-being. It is predicted that in combination with other services including housing, physical health, and income assistance (employment or social services), this program will provide greater support to PLWHA. Greater knowledge will allow for greater awareness and opportunity for psychological growth and well-being. Individuals who participate in the group will also be empowered to seek and receive additional individual services further promoting an increased quality of life. The goals of this project are to increase resiliency and improve well-being. This will be determined by a reduction in distress as evidenced by increased adherence to medical treatment, improved levels of social support, and improved coping skills. Participant outcome will be measured using the self-rated Outcome Rating Scale and Session Rating Scale described in more detail below. Program outcomes will be measured using the " Simply Thrive" feedback form.

Anticipated Impact of the Program

Initial anticipated impact of this program is limited to the residents of one HOPWA funded housing program within Maricopa county. The impact has the potential to be great for this population. The research and a relevant needs assessment completed by the state indicated that providing services that target mental health and psychosocial issues should be the standard of care. Adaptation for use in other similar organizations is also possibleIn sum, the current project will contribute to the existing literature involving mental health, HIV/AIDS, and homelessness. By understanding the relevant issues experienced by many in this population, appropriate interventions for such experiences can be encouraged. With fewer cases of adjustment and mental health dysfunction as the results of efficacious early interventions, housing programs will benefit from residents transitioning into independent living more rapidly allowing for more frequent availability of beds to new individuals. Early intervention is supported as a means to increase both quality of life for persons living with HIV and experiencing homelessness while also being cost and time effective for organizations providing housing. If this program is implemented and outcome data is consistent with the predictions above, it will provide support that the HIV/AIDS population can continue to be viewed through a lens of holistic approaches to their chronic illness, even when confounded by the significant stressors of homelessness.

Screening Measure

The Simply Thrive program was designed for adults living with HIV or AIDS who have recently experienced homelessness and are currently receiving government funded housing services. The setting will most likely be a community healthcare agency. The nature of this group intervention is to provide services to all incoming residents of a housing program that does not provide other psychological services. Group involvement will function as a requirement for residing in the program. Many common issues experienced by PLWHA are included in this group, however, not all issues can be addressed in a brief eight-week intervention and while the group is meant to be inclusive, some residents may bring experiences outside of the realms of this group that need to be addressed prior to beginning. Due to its complex nature, issues of substance abuse will not be formally addressed within this program. A screening measure is recommended to highlight possible areas of concern that can be better managed through use of other healthcare services such as alcohol or substance abuse. Typically, healthcare organizations use a form of screening for individuals just beginning services. It is recommended that such a screen be conducted prior to group participation. The screening measure will assist housing program staff and group facilitator to identify areas outside of the this group intervention that need to be addressed. One other area that was identified in the literature review section, is the experience of stigma as an area of dysfunction possibly causing distress. Berger and colleagues (2001) stated that identifying the extent of the stigma experience is particularly important and useful in treating this population. Consequently, it is also recommended that a stigma measures such as the Berger HIV Stigma Scale (Berger et al., 2001; see Appendix D) also be administered to screen for stigma related concerns.

Tracking Progress

Group members’ progress throughout the group sessions and at the end of the group intervention will be measured with the use of the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan & Johnson 2002) found in Appendix E. These two scales are ultra-brief outcome measures that have been designed for use by clinicians to assess change in clients following psychological intervention (Miller, Duncan, Brown, Spark, & Cloud, 2003). Both the ORS and SRS were found to have adequate validity, solid reliability, and high feasibility in an initial and a replication study (Miller et al., 2003; Bringhurst, Watson, Miller, & Duncan, 2006). At the beginning of each session group members will be instructed to fill out an ORS rating how he or she is doing in relation to when he or she first began the group intervention. This will provide both a measure of progress and, at discharge, a measure of outcome. These scores will also allow for facilitator/member collaboration in altering psychoeducation and emotional processing style if scores are not increasing or if new areas of concern are identified. At the end of each session group members will be instructed to fill out an SRS rating how he or she felt during the group session, this will function to identify any ruptures in the alliance or if something is not working for the group members. If the scores reveal an issue the facilitator and group members will discuss what is going on and determine a plan of action, be it a course correction or possible referral for additional services. Each ORS and SRS score may be graphed for a visual of progress. The ORS and SRS were developed as part of the Partners for Change Outcome Management System (PCOMS; Duncan, 2012). In March of 2013 PCOMS was included in SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP, 2013). SAMSHA suggested that the reliability and validity of the ORS are well supported in the literature with strong and dependable findings. Campbell and Hemsley (2009) investigated the validity and reliability of the ORS and SRS scales in a clinical setting against some already utilized longer measures. They found reliability and concurrent validity with the ORS and SRS when compared to longer measures. The authors suggested that this could provide a cost-effective method of measuring outcome. Additionally, the ORS was significantly correlated with measures of self-esteem, self-efficacy, and quality of life suggesting that although brief, it is able to identify areas of concern typically requiring more in-depth investigation. While the results are in favor of the use of brief measures for outcome and tracking change, the researchers suggested that because participants were recruited from a primary care setting rather than a psychiatric clinical population it was unclear whether an increase in psychiatric symptomatology will elicit similar results. Due to the parallel physical health and chronic illness components of the population targeted for this Program Development project and the population used in this study, this data suggests reliability and validity for use. Miller, Duncan, Brown, Sorrell, and Chalk (2006) found that utilizing the ORS and SRS as formal and ongoing feedback a clients’, and in this case, group members’ experience in treatment, with the alliance, and perceived progress improved both outcome and client retention. In fact, the authors found that when examining the 20% of the sample that did not complete an SRS at intake, these participants were three times less likely to attend any additional sessions than those who had completed an SRS at intake. This is an important finding for the group facilitator to consider as it emphasizes the importance of appropriate completion of the SRS at the end of the first session. Cross-culturally, Hafkenscheid, Duncan, and Miller (2010) found that the ORS and SRS measures were consistently useful in a Dutch sample as found in US studies, with considerations for typical translation and self-report concerns. Additionally, research shows that utilizing client feedback, in the form of the ORS and SRS, during supervision as a training tool can improve client outcomes and trainee self-efficacy (Reese et al., 2009). Improvements in supervisor supervisee alliance were not found, therefore, the authors suggested that utilizing client feedback may allow the trainee to develop more accurate self-assessment. For the purpose of this project, the ORS and SRS outcome measures may be beneficial tools for improving the effectiveness of supervision.

Ethical and Legal Concerns

Due to the sensitive nature of communicable diseases and the stigma attached to HIV/AIDS, the main legal consideration is the disclosure of HIV-related information. Risky behavior associated with HIV/AIDS such as intravenous substance use and unsafe sexual behaviors, may continue after an individual has been diagnosed with HIV/AIDS. This behavior may be a result of not understanding the consequences of such actions due to lack of education, addiction or difficult to break habits, or it may be intentional revenge seeking behavior after diagnosis. It may also be part of a subculture in which the transmission of HIV to others is pleasurable, a source of power, or sought after. While releasing such information risks harming the individual and damaging the therapeutic alliance, continued dangerous behavior puts others at risk. According to Arizona Revised Statute (A. R. S.) § 36-664, communicable disease related information, including HIV/AIDS status, obtained by a health care provider in the course of providing health care services shall be held confidential. The client, protected person, may sign an authorization to release information related to HIV/AIDS status to a specific individual or organization however, a general release of information is not authorization for the release of HIV-related information unless specified. Consequently, it is important for a clinician to be sure not to include HIV-related information in any release of records to third parties. As it relates to psychological practices, the statute further states that this information may be disclosed to the health care agency to provide health services or for billing and reimbursement, insurance agency or third party payors, anyone responsible for review of professional practices for quality purposes, or a private agency hired for services by the provider also required to protect confidentiality. Other exceptions include disclosing HIV/AIDS information when mandated by federal or state law, to government agencies authorized by law to receive the information, to any authorized employee or government agent that supervises or monitors the provider or facility in which the services are provided, or when ordered by a court or administrative body to do so. In addition, this information may be disclosed to secure legal advice or for purposes of research when conducted according to federal and state laws. A. R. S. § 36-664-B. explained that HIV-related information may also be disclosed to the department of economic security in the case of child placement in foster homes or adoption or for court-ordered placement. Information that has been disclosed to an excused source may not be further disclosed to any other source except pursuant to those previously outlined in the statute. Consequently, HIV/AIDS related information may not be included in records gathered from other providers unless specified in an authorized release document. A. R. S. § 36-664-I. further addressed the issue of risk to others. It stated that there must be a reasonable belief of risk and an identifiable third party in order to disclose and the information must be reported in writing to the local health department. The report must include the name and address of the identifiable third party as well as the name and address of the clinician making the report. The an individual with expertise in counseling persons who have been exposed to or tested positive for HIV or AIDS from the health department will contact the third party following policy. According to this statute, it is not the responsibility of the clinician to notify the identified third party or to notify the health department if there is not an identifiable third party. Lastly, the statute explained that except pursuant to this article or an order or search warrant to disclose communicable disease related information per A. R. S. § 36-664, HIV-related information received while providing a health service shall not be compelled by subpoena, order, search warrant, or any other judicial process. Arizona Revised Statute (A. R. S.) § 36-665-I. stated that baring any other law, no court or administrative body may order a county or local health department to release HIV-related information. This does not however, identify the responsibility of individual clinicians or organizations to release ordered information. A person, health facility, of health care provider may be immune to civil or criminal liability for releasing HIV-related information if it is found they have acted in good faith and without malice (A. R. S. § 36-666). Good faith and without malice are presumed unless clear and convincing evidence suggest the contrary. According to A. R. S. § 36-666, when in violation of HIV/AIDS related confidentiality, the individual is guilty of a class 3 misdemeanor. A civil penalty of not more than five thousand dollars may also be imposed for violation of confidentiality (A. R. S. § 36-667). In sum, according to relevant Arizona Revised Statutes (§ 36-664-§ 36-667) with a reasonable belief of risk and an identifiable third party a psychologist may disclose the information by reporting it in writing to the local health department and a health care provider may be immune to civil or criminal liability for releasing HIV-related information if it is found they have acted in good faith and without malice. According to relevant case law, Arizona is a Tarasoff state, suggesting that a reasonable degree of care must be taken in order to protect any intended victim or anyone foreseeably endangered by an individual’s conduct (Tarasoff v. Board of Regents the University of California, 1976). In 1980, Lipari v. Sears established that duty to warn be extended to the public at large and in 1983 Jablonski v. US further extended this to any foreseeable victim without the need for a specific threat. More recent case law has stated reasonable care must be taken to warn any foreseeable victims when there is foreseeable danger, or a zone of danger (Hamman v. County of Maricopa, 1989; Little v. All Phoenix South Community MH Center, 1996). Confidential information gathered while providing mental health services therefore must be disclosed in the case of danger to others. The available case law on duty to warn when a client is at risk of harming others does not specify any circumstance involving HIV/AIDS. It also does not specify what foreseeable danger constitutes. Smallwood v. State (1996) found that a man who knowingly infected his victims of rape with HIV was not guilty of attempted murder as death is not a probable consequence of exposing someone to HIV regardless of the defendants intent to kill. A Canadian case (R. v. Cuerrier, 1998) found that persons living with HIV/AIDS and knowingly participating in unprotected sexual activities without notifying the sexual partner are committing a fraudulent act and may be charged with aggravated assault. As all relevant case law regarding duty to warn was brought forth by a murder, it is unclear whether it is the intent to kill, actual threat of death, or some other form of harm that constitutes a duty. Canadian case law is also lacking in HIV-related duty to warn precedent for psychologists. In sum according to relevant case law, a psychologist has a duty to warn in the circumstances of an intended victim or anyone foreseeably endangered including the public at large in a zone of danger (Tarasoff, 1976; Lipari, 1980; Jablonski, 1983; Hamman, 1989; Little, 1996). Case law also finds that individuals may or may not be charged after intentionally infecting another individual however, case law is not present for HIV-related duty to warn. The American Psychological Association’s (APA) code of ethics (2002) indicates that a primary obligation of psychologists is to protect confidential information. This is especially true if the information could possibly cause harm to the client. The code of ethics further states that disclosure of information without the consent of the client must only be done when mandated by law or permitted by law to protect others from harm. The APA’s general principles outline the importance of safeguarding the welfare and rights of clients as well as other affected persons, establish trusting therapeutic alliances with clients, promote honesty, respect, dignity, and right to privacy of all individuals in the treatment relationship. Therefore, in the case that psychology ethics conflict with relevant law, psychologists may adhere to the law while also taking precautions to best limit harm to the client. According to the APA's 1991 resolution on Legal Liability Related to Confidentiality and the Prevention of HIV Transmission, psychologists should protect such sensitive information and avoid the potential for discrimination. Therefore, the APA believes that a legal duty to warn should not be imposed. The resolution further indicated that if an identifiable third party is at significant risk and is unaware of his or her risk and the client has refused to notify the third party at the urging of the psychologist, then disclosure should be permitted. While deciding to disclose or not disclose the psychologist is acting in good faith and should be immune from criminal and civil liability. The response to this resolution remains unclear in the case of HIV-related confidentiality. An article by Mills (1984). evaluates duty to warn based on the Tarasoff case, pre HIV epidemic. While seemingly outdated, this examination determines that at times potential victims may be unknown, potential for violence may be easily misperceived, and the value of warning potential victims is limited, all of which are continued issues with duty to warn laws. The author suggests that due to the unforeseeable nature of dangerousness in general, the courts should adopt more flexible strategies for determining liability or negligence. The implications for clinical practice when working with individuals with HIV/AIDS are plenty. This population is vulnerable to overt discrimination and more subtle bias because of the stigma attached to HIV/AIDS. It is often believed that an HIV infection resulted from some form of personal negligence. The reality is that knowledge of sexually transmitted disease or infection is limited within the general American public (Parker & Aggleton, 2003). Parts of society still hold the belief that HIV and AIDS affect gay men, prostitutes, or addicts and therefore the average citizen is safe. While more and more individuals are seeking mental health services as it becomes less taboo to do so, there are also increases in people living with HIV/AIDS seeking services. This provides practicing psychologists with a great opportunity for prevention work through psycho-education, behavioral modification, and support. Although much of the work may be beneficial, at times a client may present as dangerous and a risk to others. Research indicates that the therapeutic alliance is the single best predictor of outcome in psychotherapy, therefore it must be held at the highest importance to maintain trust and dignity (Martin, Garske, & Davis, 2000). It is difficult to imagine purposefully damaging this relationship for anything other than a serious risk of danger. In such situations the clinician must interpret the relevant information provided above and available within the literature by using clinical judgment and when necessary, legal counsel. In the context of this proposed group intervention, appropriate confidentiality and ethical decision-making is essential due to the vulnerability for discrimination, prejudice, and stigma associated with this population.

Program Description

The " Simply Thrive" program garnered its title from the concepts of the program that are essential for increasing resiliency and improving general well-being. It is a program which seeks to help PLWHA thrive in life despite circumstance and obstacles, which can be complex, through simple balance and change. This program is designed to be implemented by Clinical Psychology Doctoral students at the practicum stage of training under the supervision of a licensed Clinical Psychologist. To assist in the training of students, supervision tips have been placed throughout the facilitator manual to directly relate the material to the training process. Alternatively, this program could be implemented by other skilled masters and doctoral level therapists who work within community agencies serving homeless adults with HIV or AIDS. This program is not meant to be an all-inclusive clinical intervention, but rather group members are encouraged to seek additional services for managing concerns outside the scope of this intervention. This manual will provide a basic framework for the group but the facilitator, as a therapist, must use clinical judgment while considering individual and group perspectives (physical, emotional, cultural, environmental, etc.). This program will use a combination of cognitive behavior therapy, motivational interviewing, and positive psychology to increase resiliency and improve general well-being. Cognitive-behavioral interventions will be targeted at altering dysfunctional and helpful thinking and promoting more helpful and functional thinking when dealing with negative emotions, stress, worry, trauma, and management of HIV as a chronic illness. Behaviors as they relate to unhelpful thinking and resulting emotional experiences will also be addressed. Motivational interviewing strategies will be used in the first session to initially outline the process of change and begin to target ambivalence that may be present considering this group will be assigned rather than solicited. Positive psychology theories and concepts will be incorporated through a series of interventions centered on a combination of strength based, whole health, and self-management strategies to instill confidence and self-esteem. The Simply Thrive program consists of eight 1. 5 hour sessions over the course of consecutive eight weeks. This group is a closed group as the material is meant to follow the order it is provided in. Missed groups will need to be made up prior to attending the next group. It is suggested, based on availability, that the group member meet with the facilitator to go over the missed group's material. The group facilitator must use clinical judgment when determining the best course of action for missed groups. Group members will be instructed on the protocol and guidelines for missed groups during Session #1. The Facilitator Guide can be found in Appendix A and the Group Member Handouts can be found in Appendix B. The eight sessions are described below:

Session #1: Orientation & How to Make Change

This session is meant to orient the group members to the process of the Simply Thrive group intervention while also setting the tone for the remainder of the sessions. Group members will learn the guidelines and format of the group via handout and facilitator instruction. The second purpose of this session is to begin a discussion of personal responsibility and how to begin the process of making positive change. The facilitator's role in the Orientation and How to Make Change session is to provide a safe and supportive environment for continued participation in future sessions. The facilitator will use personal style to encourage participation. The use of humor, enthusiasm, and sincerity is recommended to begin forming a therapeutic alliance with each member and atmosphere for the group.

Session #2: Positivity

This session is meant to inform and educate the group members on the role thoughts play in relation to emotional well-being and resulting behaviors. Group members will learn some examples of negative self-talk versus positive statements, the role of gratitude, joy, and positive thinking, as well as what they can do to change unhelpful thinking into helpful thinking via handout out and facilitator instruction. This session is aimed at reinforcing the effect of positivity in everyday living. The facilitator’s role in the Positivity session is to provide an upbeat and positive atmosphere to allow group members to feel comfortable in making positive changes in their thinking. The facilitator will use personal style to encourage participation. The use of humor, enthusiasm, and sincerity is recommended.

Session #3: The View of Others

This session is meant to inform and educate the group members on the role the opinions and treatment of others plays in relation to emotional well-being. Group members will learn the definitions of prejudice, stereotypes, discrimination, and stigma. They will also have the opportunity to process personal and common experiences of stigmatization based on HIV status and mental illness via handout out and facilitator instruction. This session is aimed at processing the difficult emotions that can be experienced as a result of stigma. The facilitator’s role in the The Views of Others session is to provide a supportive and safe environment to allow group members to express themselves. The facilitator will use personal style to encourage participation. The use of understanding and unconditional positive regard is suggested.

Session #4: Coping With Stress & Worry

This session is meant to inform and educate the group members on the role stress, worry, and anxiety plays in relation to emotional well-being. Group members will learn the common causes and experiences of stress. They will also have the opportunity to identify some of their own personal stressors and learn ways to cope via handout out and facilitator instruction. This session is aimed at discussing the very common experience of stress while also allowing group members to understand how increased or prolonged stress can affect both body and mind. The facilitator's role in the Coping with Stress and Worry session is to provide psychoeducation and facilitate exploration into personal experiences of stress. The facilitator will use personal style to encourage participation. The use of humor and normalizing statements may be helpful.

Session #5: Coping with Chronic Illness

This session is meant to allow group members the chance to process the idea of living with a chronic illness while also informing and educating on the role chronic illness plays in relation to emotional well-being. They will also have the opportunity to identify some of their own personal fears and learn ways to cope via handout out and facilitator instruction. This session is aimed at learning some practical methods for managing parts of chronic illness such as maintaining a medication regimen and healthy lifestyle. The facilitator's role in the Living the Fullest Life session is to provide a safe and supportive environment for group members to process what it really means to them to have a life-long chronic illness. The facilitator will use personal style to encourage participation. The use of unconditional positive regard and normalizing statements may be helpful.

Session #6: Social Supports

This session is aimed at identifying positive social supports while outlining the role social support plays in relation to emotional well-being. Group members will learn about boundaries and the characteristics of healthy relationships via handout out and facilitator instruction. The facilitator’s role in the Social Supports session is to facilitate a discussion on healthy relationships while allowing the group members to safely assess the relationships they currently have in their lives. The facilitator will use personal style to encourage participation. The use of honesty and directness will be important to reinforce the difference between healthy and less healthy relationships and relationship styles.

Session #7: Living the Fullest Life

This session is aimed at providing psychoeducation on the role meaning, purpose, and being productive plays in relation to emotional well-being. Group members will learn about ways to feel productive and the difference between use and abuse for a healthy balance via handout out and facilitator instruction. Group members will have the opportunity to independently process what they have accomplished so far while participating in exercises aimed at identifying possible ways to develop meaning in the future. The facilitator’s role in the Living the Fullest Life session is to facilitate a discussion on what life is all about while allowing the group members to safely assess their lives thus far. The facilitator will use personal style to encourage participation. The use of supportive and encouraging language should create an atmosphere of unconditional positive regard. It may be difficult for some group members to think about what they have accomplished so far in life so the facilitator may wish to process this as a group.

Session #8: It’s Up to You!

This session is the culmination of the eight week program. It aimed at outlining the importance that developing a self-identity plays in relation to emotional well-being. Group members will learn about ways to have a healthy self-esteem and self-concept. Group members will have the opportunity to map out smaller goals to reach one larger goal for the future. The facilitator’s role in the It’s Up to You! session is to facilitate a discussion on the universal ways one defines oneself. The facilitator will use personal style to encourage participation. The facilitator should create an atmosphere of accomplishment and celebration while planning for the future.

Program Evaluation and Future Directions

To evaluate the usefulness of a program, it is recommended to collect feedback from participants or group members. Collecting feedback data helps to identify what was useful or not useful, provides information for improving the current program and designing future programs, while also showing participants that their opinions and feedback are valued (Taylor-Powell & Renner, 2009). Taylor-Powell and Renner suggested that the most common method of evaluation is an end-of-session questionnaire provided to participants that is aimed at answering specific questions. For the purposes of this program development and subsequent evaluation it will be important to know what the group members found helpful versus unhelpful, whether they feel they gained something from the experience, and where they see possible areas of improvement. The questions were developed using the suggestions and tips provided by Taylor-Powell and Renner’s Collecting Evaluation Data: End-of-Session Questionnaires (2009). Specifically, attention was paid to issues of ease, audience, culture, length, time, and anonymity. The " Simply Thrive" Feedback Form (see Appendix G) will be administered at the end of Session #8 and the group members will be encouraged to place their completed forms in a large envelop left by the door for anonymity. This program has the potential for future alterations and improvements. An interesting area for development that was outside of the scope of this project is the concept of utilizing a more comprehensive screening measure to serve as not only an indicator of appropriateness for the intervention itself but also to serve as a starting point of a much more comprehensive integrated care and referral process. It could be vitally important to develop a screening measure that triggers and assesses areas of concern such alcohol and substance abuse, diagnosis severity mental health problems, social support or lack of, trauma history, high risk sexual behaviors, access to financial or employment services, access to other healthcare services, and possibly sexual orientation adjustment related concerns while also identifying stigma and HIV diagnosis adjustment. With this screening measure would also come a decision tree for specific referrals. One method for implementing this would be to administer a measure for each topic at the beginning of each group with similar topic. The last group session would include providing group members with a comprehensive referral packet based on the outcome of the measures. In conclusion, the " Simply Thrive" program should offer a combination of Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Positive Psychology to promote self-management for increased resiliency and improved general well-being in a homeless adult HIV/AIDS population. Clinicians should find materials for facilitating this group intervention with included group members handouts.