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ARTICLE

Evaluating the Solution Focused Wellness for HIV Intervention for Women: A Pilot Study


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Abstract

Women living with HIV experience a gender gap in wellness outcomes in the U.S., and women of color are particularly vulnerable to this gap. To address this, the Solution Focused Wellness for HIV (SFWH) intervention for women was created. In this paper, we report the quantitative results of the most recent SFWH pilot study. The seven-session, group intervention was provided to (N=14) women living with HIV to evaluate it for effectiveness. Results showed the intervention was associated with significant multidimensional wellness improvements between baseline and five-week follow up. Participants' CD4 and Viral Load counts did not change significantly. To improve access to the intervention and increase retention in HIV care in the community, further adaptations of the SFWH are planned.

Keywords: HIV; Women; Solution Focused; Wellness, Intervention Research

Background

Wellness can be conceptualized as a multidimensional construct that includes not only physical, but also cognitive, emotional, spiritual and social well-being (Myers et al., 2004). In HIV research, this multidimensional conceptualization of wellness allows for a broader focus than the traditional medical model of narrowly examining morbidity, mortality and biomarkers. A multidimensional approach to wellness also allows researchers to better evaluate behavioral health interventions from the perspective of the person who is living with HIV. This provides a more individualized approach that is tailored to the unique life circumstances of wellness for participants. It is in keeping with the Solution Focused Brief Therapy (SFBT) mindset of taking a "stance of not knowing" and viewing the client as the expert in the helping relationship (DeJong & Berg, 2002).

Multiple wellness interventions exist for women living with HIV. However, the operationalization of wellness varies. For example, the WILLOW group focuses on prevention of HIV transmission and reducing parenting stress (Dale, et al., 2017), and the Making our Moms Stronger (MOMS) program also focuses on parenting as well as disease self-management skills (Johnson et al., 2015). Other interventions tailored for women living with HIV are aimed at addressing mental health and substance abuse issues because those factors are associated with poor HIV wellness outcomes (Mitrani et al., 2011). Given that not all women living with HIV are parents or experiencing substance abuse and mental health issues, the development of an intervention that takes a broader and more inclusive wellness perspective for women is needed.

It has been established that overall health and longevity in living with HIV depends on Antiretroviral Therapy (ART) (Aschengrau & Seage, 2014), but there are other factors that affect women's use of ART medication that would be beneficial for an intervention to address in community-based settings. Those include childcare, food security, transportation, as well as some of the above-mentioned factors including parenting, mental health and substances abuse (Yates, 2019). The existing wellness programs for women living with HIV focus primarily on preventing transmission to others including sexual partners and children. This narrow focus of existing wellness programs, from a Foucauldian perspective, can be seen as a process of disciplining women rather than helping them, and may contribute to the negative stigma associated with living with HIV (Foucault, 2004).

Solution Focused Brief Therapy was chosen as the main component of the current intervention due to its ability to broadly incorporate the needs of women without expert imposition of wellness conceptualization by practitioners. This allows the unique factors affecting the wellness of each woman receiving the intervention to be addressed by her, as she defines her own wellness needs, and creates specific goals to reach the best solution. Interventions that are promoted as improving wellness for women living with HIV should focus on broad, client-centered conceptualizations of wellness. Due to its social constructionism roots (Gergen, 2009), the SFBT intervention is uniquely able to do this.

Evidence-based interventions need to be created and tested for efficacy in real world settings with sustained results over time. More clinical trials should be performed in combination with qualitative input from participants to improve uptake of effective programs. Furthermore, these programs should be listed on evidence-based registries so doctors, social workers, nurses and case managers can locate them. Training should also be provided to improve implementation in the community. From a policy perspective, funding must continue to support the research and programs that are aimed at improving outcomes for women living with HIV.

SFBT

Solution Focused Brief Therapy (SFBT) is a talk therapy treatment model that is delivered in individual, family and group formats, as well through case management processes. The SFBT method is comprised of three mindset components (future focus, strengths orientation, client as expert) and eight therapeutic techniques (scaling questions, goal setting, miracle question, finding exceptions to the problem, therapeutic breaks, genuine compliments, relationship questions and asking about the client's best hopes; Trepper et al., 2012).

A recent meta-analysis of randomized controlled trials involving SFBT in healthcare settings indicated it is a promising approach for addressing behavioral outcomes (Zhang et al., 2017). The therapeutic methods were originally developed by Insoo Kim Berg, Steve de Shazer, and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin in the 1980s. They developed SFBT as a strengths-based, rather than problem-oriented approach, that is future-focused, goal-oriented, and primarily driven by the client's individualized experiences rather than expert imposition by the professional (De Jong & Berg, 2002). Privileging the experiences of clients and trusting in their inherent ability to develop their own knowledge about how to best address their problems has made the approach amenable to client-centered research methods (Froerer et al., 2009; Szlyk, 2018).

SFBT is a popular case management and counseling method that has been embraced by the fields of social work, marriage and family therapy, counseling, and public health due to its emergent base of outcome studies (Kim, 2008; Kim et al., 2019). SFBT takes a culturally competent approach that values the unique experiences and backgrounds of diverse individuals and communities (Kim, 2013).

Applying SFBT to the lives of persons living with HIV involves helping clients explore their own ideas for how to overcome social and psychological problems experienced in their environment. Therefore, it is plausible that the method

could have a positive effect on factors associated with HIV wellness. Those needs may include substance use, mental health, housing and food security and parenting needs (Blashill et al., 2015). SFBT enables practitioners to partner with clients to co-construct meaningful and lasting change (Blundo & Simon, 2015). The significance of this co-construction process within SFBT was highlighted as one of the most important keys to the success of SFBT outlined by Franklin et al. (2017) in their meta-analysis of SFBT change process research.

Current Intervention-SFWH

To more comprehensively address the wellness needs of women living with HIV, the Solution Focused Wellness for HIV (SFWH) intervention for women was created. This intervention was developed by adapting the current treatment manual for SFBT and SFBT wellness intervention research by Beauchemin (2018). After combining those elements, the intervention was written as a session-by-session group counseling manual and adapted to meet the needs of women living with HIV according to previous literature. During the initial phase of the intervention development, the researcher sought feedback from SFBT and HIV experts and this work is outlined in the publication of the qualitative findings used in the manual adaptation process (Yates et al., 2019). The SFBT expert who provided feedback has published several meta-analyses of solution focused methods as well as multiple large-scale clinical trials related to substance abuse and child welfare. The HIV expert who provided feedback has published intervention studies related to women who are living with HIV and other social service programs. Both are Associate Professors and Program Directors of schools of social work in the United States. After incorporating their feedback into the manual, the researcher delivered the intervention to a small group of women (n=4) living with HIV (Yates et al., 2019). Those women participated in a focus group to provide expert client feedback in keeping with the SFBT mindset of honoring the client as the expert, (Blundo & Simon, 2015). This manualized SFBT intervention, which is named Solution Focused Wellness for HIV (SFWH), was implemented and evaluated in the current study.

The purpose of this study is to (a) determine whether the SFWH Intervention for Women significantly improves the wellness of women living with HIV, (b) to determine if the intervention is safe and well-tolerated by participants and (c) to aid in the continued development of the treatment manual. The results from the qualitative components of the study will be detailed in a separate paper. This paper reports the quantitative results of the study only.

Methods

Research Design

During this pilot study, participants were compared at baseline and a 5-week post-intervention follow-up time. All participants received the intervention and an intent to treat approach was used for data analysis. Pilot studies “are typically small prospective studies that evaluate a treatment’s potential and may or may not be randomized (Cook & DeMets, 2008, p. 76).” The goal of clinical trial phases is to assess safety and feasibility and to determine if further study is warranted. The desired outcome of early phase studies is that most participants improve (Cook & DeMets, 2008).

The dependent variable in this study was wellness; a multidimensional construct that may include spiritual, physical, cognitive/emotional and relational/social well-being (Myers et al., 2004). A multidimensional approach to wellness also allows researchers to evaluate health interventions from the perspective of the person who is living with HIV, rather than narrowly focusing on CD4 and Viral Load counts alone. The multidimensional approach leads to an individualized intervention that is tailored to the unique lifestyle of each participant.

In an effort to strengthen the research design, wellness was also assessed using biomarkers that are typically associated with HIV disease progression. This allowed for a triangulation of data collection and measured the effect the intervention had on HIV wellness from a disease progression standpoint. We used data from existing case management records as a less invasive approach in contrast to asking participants to undergo additional testing procedures.

The independent variable was the SFWH intervention for women, a group wellness counseling intervention that has been adapted for women living with HIV. The intervention has been manualized with session-by-session instructions and handouts that incorporate the SFBT mindset components and techniques to improve treatment fidelity. Seven

sessions are included in the manual with five sessions focusing on specific areas of wellness and an introductory and wrap-up session at the beginning and end of the intervention.

Setting

The study was conducted at a non-profit organization which provides case management services to people living with HIV in North Georgia. The organization provides housing and food security services, and may assist with transportation, medical care coordination, medication adherence counseling, and parenting support. The clients served by the agency were located in 10 counties that covered urban, rural, and suburban communities.

Study Participants

A total of (N=14) women participated in the study, and the participants' characteristics are displayed in Table 1. To be included in the study, participants had to (1) identify as female, (2) be living with HIV, and (3) be over the age of 18. Intent to treat was used to determine whether participants who only participated in some sessions of the intervention should be included or excluded from the analysis. Therefore, all participants were included in the analysis regardless of their level of participation. Some attrition occurred and the number of sessions received was inconsistent among participants. The mean number of sessions received was three (out of the seven recommended sessions) with a standard deviation of (SD=2.60). Participant flow is shown in Figure 1.

Procedures

Recruitment was conducted at the research site through the case managers of the participants via a flyer. Three existing support groups for women living with HIV were being conducted in the community, and participants shared the study information with each other, which resulted in a convenience sample. The group was offered at all three locations operated by the study site, but only two were used for groups due to small recruitment numbers at the third location. Informed consent was obtained prior to data collection and the start of the first session.

Fidelity

Fidelity to SFBT was encouraged and monitored in several ways during the study. The training of the facilitator in SFBT, the development of a session by session treatment manual, a fidelity checklist and a rigorous study design were the fidelity improvement, and monitoring techniques that were used. A fidelity checklist was completed by the group facilitator to monitor a randomly chosen session for adherence to the SFBT components and measured the extent to which each SFBT component was used by the facilitator. The checklist helps to monitor the amount of the intervention that is received by participants.

The use of a treatment manual was intended to improve treatment fidelity. All the components identified by SFBT researchers in the treatment manual published by the Solution Focused Brief Therapy Association (Trepper et al., 2012) were incorporated into scripts and instructions in the session-by-session manual. The use of a manual has been recommended by behavioral intervention researchers to improve fidelity (Gitlin & Czaja, 2015).

Ethical Considerations

The Institutional Review Board of the Human Subjects Office at the University of Georgia Human Research Protection Program approved the study. Permission to conduct research with the clients at the agency was obtained from the Executive Director prior to IRB submission. Participants received \$20 grocery gift cards to encourage participation and transportation vouchers, refreshments, and childcare vouchers to improve access to the intervention. No names or other identifying information were associated with the participant data. Participant numbers were used to maintain privacy during data analysis.

Measuring Multidimensional Wellness

To measure multidimensional wellness, the Five Factor Wellness Inventory or 5F-Wel was used. The instrument is a 92-item scale that is valid and reliable with a Chronbach's alpha score of ($\alpha=0.89$) (Myers et al., 2004). There are 74 scored items which include questions like "I am satisfied with how I cope with stress," and "I eat a healthy amount of fruits, vegetables and fiber each day." Confirmatory factor analysis indicated that the five wellness factors addressed in the instrument include physical, spiritual, cognitive/intellectual, emotional and social/relational wellness. The instrument consists of self-reported Likert-type scale responses ranging from 1=strongly agree to 5=strongly disagree. Higher scores reflect greater wellness. Chronbach's alpha scores for the SFWH study were acceptable ($\alpha = .67$), indicating reliability in measuring participants' multidimensional wellness.

Measuring HIV-related Wellness

HIV related wellness was measured using biomarkers typically obtained from the medical care providers of people living with HIV. They include the viral load (HIV-RNA) and CD4 T-Cell Lymphocyte counts. These biomarkers indicate the presence of HIV in the body (viral replication) as well as the body's immune response to the virus. They also indirectly measure use of Antiretroviral therapy. The viral load can range from 0 (undetectable) to millions, with lower counts being associated with better HIV wellness. CD4 counts determine the immune system's response to the virus. Higher CD4 counts are associated with wellness as these cells are used to fight off opportunistic and secondary infections (Aschengrau & Seage, 2014). A CD4 count below 200 indicates progression to the final stage of HIV-AIDS.

Data Analysis

To analyze the quantitative results, SPSS Version 25.0 (IBM, 2017) and R Software were used to perform paired samples T-Tests and Chi-Square tests. Effect sizes were calculated using Cohen's d. Due to the exploratory nature of this pilot study which was performed in the early phases of the research pipeline, we used a p value of <0.10 to determine statistical significance. Because an improvement in wellness was hypothesized, a one-tailed test was used. The research questions included:

1. Does the SFWH Intervention for women (IV) significantly improve wellness as measured by the *Five Factor Wellness Inventory* among participants between baseline and five weeks after the intervention is provided?
2. Does SFWH significantly increase *CD4 counts* of women living with HIV between baseline and follow up?
3. Does SFWH significantly decrease HIV-RNA *viral loads* of women living with HIV between baseline and follow up?

To answer research questions one and two, the Five Factor Wellness Inventory scores, CD4 counts and viral loads of participants were analyzed using a paired samples t-test. This test was used to check for differences between the baseline and follow up scores of participants. According to Randolph and Myers (2013), the t-test is used to "determine if there is a statistically significant difference between the scores from two samples in which the individual values or cases in the sample are paired with each other for some reason related to the research question (p.89)." In this instance, one sample of participants was measured at two different time points (before the intervention took place, and at a 5 week follow up time).

To answer question three, the data was first cleaned to account for viral load lab results reporting "less than 20 or "less than 40." Viral loads less than 20 or 40 are considered "undetectable." This is a clinically important cut off point because it indicates uptake of antiretroviral therapy as well as lack of HIV disease progression (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2018). These categories are typically used in HIV medical care to determine disease progression based on the number of copies of HIV RNA present in the person's system. The categories range from 0-40 (undetectable) to 41 and above (detectable). A chi-square test was used to detect differences between participants' categorical viral load values at baseline and follow-up. The chi-square is a non-parametric test that measures the difference between observed and expected results (McHugh, 2013).

Results

Participants

The baseline demographic and clinical characteristics of the women who participated in the study are displayed in Table 1. The mean age of the women was 48.21 years old ($SD=11.86$, range 21-63). In terms of race and ethnicity, all participants identified as African American and one participant identified with multiple races. Depression was indicated among 53.33% of participants and anxiety was endorsed by 60% of participants. No participants reported substance abuse issues at the time of the study. About 87% of the women in the study reported some form of care responsibility including children under the age of 18 or another adult.

The scores on the wellness outcomes at baseline are displayed in Table 2. The results of the data analysis indicated that the intervention favorably increased the participants' mean CD4 Counts and Five Factor Wellness Inventory Scores between baseline and five-week follow-up. However, the mean Viral Load increased, which is not a desired or positive outcome.

To answer research question number one: *Does the SFWH Intervention for women (IV) significantly improve wellness (DV) as measured by the Five Factor Wellness Inventory among participants between baseline and five weeks after the intervention is provided?* an additional t-test was performed. Five Factor Wellness Inventory scores were obtained before the intervention began and at a five-week follow-up time. They were analyzed using a paired samples t-test. The test result was $t = -1.56$ ($df=13$) indicating that scores obtained at the follow-up time ($M=63.03$, $SD=5.75$) were higher than those obtained before the intervention ($M=60.84$, $SD=6.71$). The test results were statistically significant at the $p < .10$ level ($p=0.07$). Consistent with Cohen's interpretation of effect sizes (Cohen, 1992) the effect size was medium ($d=.42$). Figure 2 displays the mean changes in scores over time.

To consider the effect that the dose (measured by number of sessions attended) had on wellness measured by the Five Factor Wellness Inventory scores, a regression analysis was performed. Pre-test scores and dose were used as independent variables with post-test scores as dependent variables. The results indicated that the number of SFBT sessions or dose was not a significant predictor of multidimensional wellness for this sample ($\beta=.061$, $p=.82$). The overall model fit was $R^2=.14$, indicating that 14% of the variance of multidimensional wellness scores were explained by the predictors.

To answer research question number two, *Does SFWH significantly increase CD4 counts of women living with HIV between baseline and follow up?* a paired-samples t-test was performed. CD4 counts were obtained before the intervention began and at a five-week follow-up time. The test revealed that scores obtained at the follow-up time ($M=739.13$, $SD=579.19$) were higher than those obtained before the intervention ($M=684.25$, $SD=411.24$). This is a favorable increase. However, the results were not significant at the predetermined level of $p < .10$.

To answer research question number three *Does SFWH significantly decrease HIV-RNA viral loads of women living with HIV between baseline and follow up?* a chi-square test was indicated. The mean Viral Load levels of participants collected at follow-up ($M=81616.46$, $SD=183258.1$) were higher than the pre-intervention levels ($M=794.8$, $SD=1889$). A Pearson Chi-square was used to identify whether there was a difference between the baseline and follow up groups of data in the sample according to Viral Load detectability. Results showed a significant difference between the groups ($X^2(1,13) = 4.8$, $p < .10$). At follow-up, 50% of participants had undetectable HIV, versus at baseline, 62.5% of participants had undetectable HIV. Significance was derived from Fisher's Exact Test ($p=0.07$).

Fidelity

To address intervention fidelity, the SFWH intervention for women manual was used as instructed for each session, and each session in the manual was delivered as written. Participants were offered each session outlined in the manual. However, some participants did not attend each session. The range of sessions attended was from 0 (no sessions) to 7 (all sessions). The average number of sessions received by participants was 3.07 ($SD=2.60$).

In addition to number of sessions, fidelity was monitored by an SFBT checklist that detailed the techniques and mindsets of SFBT. The score was 70% SFBT fidelity for one randomly monitored session. This is considered adequate SFBT fidelity given the flexible nature of this counseling method (not all techniques are delivered in each session). The

Miracle Question and Therapeutic Break techniques were not used in the scored session. Fidelity was also addressed through SFBT training. The intervention was delivered by a licensed therapist who attended three multi-day trainings before delivering the intervention.

Discussion

A gender disparity in HIV wellness outcomes exists in the U.S. according to a CDC review that indicated women living with HIV have more difficulty engaging in HIV care (Beer & Skarbinski, 2014). In a 2008 article, Eyakuze, Jones, Starrs, and Sorkin implored HIV care providers to shift their focus from prevention to the direct needs of women living with HIV to correct this disparity. However, behavioral interventions aimed at assisting women living with HIV with their wellness efforts have continued to focus primarily on prevention of the spread of the disease to others, particularly for mothers (Yates, 2019).

The current SFWH intervention was developed to address the gender disparity in HIV wellness outcomes using a culturally competent behavioral intervention that capitalizes on the strengths and skills of the women (Yates et al., 2019). Using Solution Focused Brief Therapy allowed the group leader to employ a client-centered approach and take a stance of not knowing where the women are the experts in their HIV wellness. The wellness component of the intervention is based on Myers et al. (2004) research about a multidimensional approach to wellness that takes into account the physical, spiritual, cognitive/emotional and social/relational factors from the individual's perspective. Solution focused wellness was initially developed for college students with positive effects (Beauchemin, 2018) and is being applied to people living with HIV for the first time in this intervention.

In the current study, we provided the SFWH intervention for women to (N=14) African American participants who agreed to complete the seven-session, strengths-oriented counseling program. This article addressed the variables, procedures, measures, analysis plan and fidelity measurement plan for evaluating the SFWH Intervention for Women. Participants' experiences of the intervention as well as changes in solution building skills were also recorded in the study but are reported in a separate paper.

Wellness was measured with a valid psychometric instrument as well as two traditional HIV biomarkers taken from case management records. Quantitative methods including a t-test and chi-square were used to analyze a psychometric multidimensional wellness measure and HIV disease biomarkers. Intervention fidelity was also measured and reported as favorable. In sum, the intervention was effective at increasing the multidimensional wellness of participants according to the t-test results from the Five Factor Wellness Inventory ($p < .10$). However, the t-test of the CD4 counts showed no significant results. Though the results of the Viral Load analysis showed significant results, the analysis should be interpreted with extreme caution due to missing data. Because the data was taken from existing records, 50% of participants did not have reportable Viral Load test results at the time of the five-week follow-up data collection.

Limitations

The intervention was not delivered entirely as intended because the participants did not receive all the sessions due to difficulties of accessing the intervention. Despite efforts to engage participants by including incentives and supports for transportation and childcare, recruitment was limited. More research is needed to address recruitment and retention issues during research in community-based settings serving women living with HIV. This is addressed in the qualitative findings of the study, which will be presented in a separate paper. The issues around recruitment and retention contributed to the major limitation of this study, which is sample size. Missing data was also a limitation that affected the sample size of the study. Data collection issues were related to the choice of using existing case management records for HIV biomarker data rather than collecting that data, which would have been too invasive and burdensome for participants.

Implications

Behavioral interventions developed in community-based agencies serving women with HIV may improve wellness outcomes for women living with the disease. However, the burden to participants must be considered if a study is to be feasible in this setting. Though attempts were made to improve engagement in the study, including conducting it in a community-based setting, offering incentives and providing childcare and transportation, more efforts are needed.

Adjustments that make it easier to engage and retain African American women in this and other HIV care interventions are also necessary if the needs of this vulnerable population are to be met in their communities. This is important to note since though it was not a criterion for inclusion in the study, all the women identified as African American. While this was due to the recruitment issues in the study that led to a convenience sample, it also reflects the population of women living with HIV in the United States. Like many other chronic illnesses that affect women, HIV unfortunately makes African Americans vulnerable to health disparities (Beer & Skarbinsky, 2014).

The women in this study had caregiving responsibilities and transportation issues that may have interfered with their attempts to address their wellness. This result is consistent with other studies addressing women's HIV wellness outcomes (Yates, 2019). Further adaptation of the SFWH Intervention for Women is needed to address care responsibilities and transportation more specifically. Though these factors were addressed in the funding of the intervention to improve recruitment, they were not specifically addressed in the counseling manual. Future studies involving the SFWH intervention for women will continue to focus on improving access to services to improve not only retention and recruitment, but overall HIV and multidimensional wellness for women.

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Table 1*Participants' Baseline Demographic and Clinical Characteristics*

Demographics	Frequency	Percentage
Gender		
Biological female	14	93.33
Transgender female	1	6.67
Race		
White	0	0
African American	15	93.33
Multiple Races	1	0.67
Providing care to children under 18		
Yes	9	60
No	6	40
Providing care to adults		
Yes	4	26.67
No	11	73.33
Current Homelessness		
Yes	1	6.67
No	14	93.33
Current depression		
Yes	8	53.33
No	7	46.67
Current anxiety		
Yes	9	60
No	6	40
Current other mental health issue	3	20
Yes	3	20
No	12	80
Current substance abuse issue	0	0
Yes	0	0
No	15	100
Time since HIV diagnosis in years (categorical)		
<1 year	0	0
1-5 years	3	20
6-10 years	3	20
11-15 years	3	20
16-20 years	1	6.67
21 or more years	3	20
Missing	2	13.33
Time since most recent HIV medical care visit (categorical)		
0-3 months	7	46.67

4-6 months	3	20
7-10 months	2	13.33
11 or more months	0	0
Missing	3	20

Table 2*Paired Samples t-test Results for Wellness Measures over Time*

Measure	Baseline Mean (SD)	Follow-up Mean (SD)	Test Statistic	Effect Size	Sig (1-tailed)
CD4 Count	684.25 (411.24)	739.13 (579.19)	-0.66	0.23	0.53
5FWel Score	60.84 (6.71)	63.03 (5.75)	-1.56	-.42	0.071