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## Group Positive Psychotherapy Improves Resilience of Gay People Living with HIV/AIDS

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### Abstract

Gay people living with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) face two stigmas, being gay and having HIV/AIDS, thus making their daily lives very complicated. To survive their life challenges, they need strong resilience. This study examined the sustainability effects of Group Positive Psychotherapy in improving the resilience of gay people living with HIV/AIDS. Participants were 18 gay people (9 each in experimental and control groups) living with HIV/AIDS and experiencing resilience problems. The study's design was quasi-experimental, with an untreated control group and pretest and posttest dependent samples using switching replications. The instruments used were the Resilience Scale, the Positive Psychotherapy Inventory (PPTI), and the Day Reconstruction Method (DRM). Besides qualitative analysis, quantitative analysis was conducted through statistical testing using the Mann-Whitney U Test. Results showed that Group Positive Psychotherapy significantly improved participants' resilience ( $U = 0.000$ ;  $p < 0.01$ ), and its effects lasted for at least two weeks post-intervention. In this study, the Group Positive Psychotherapy sessions on "three good things" and "savoring" proved most effective in improving the resilience of gay people living with HIV/AIDS. Group Positive Psychotherapy also effectively reinforced groups as a positive forum for sharing.

### Psikoterapi Positif Kelompok untuk Meningkatkan Resiliensi pada Lelaki Homoseksual Penyandang HIV/AIDS

#### Abstrak

Seorang penyandang HIV/AIDS dengan faktor risiko homoseksual harus menghadapi menghadapi dua stigma berbeda (sebagai homoseksual dan HIV/AIDS) yang melekat pada diri mereka. Kemampuan menyesuaikan diri terhadap perubahan kehidupan yang menekan ini disebut dengan resiliensi. Penelitian ini bertujuan untuk menguji efek berkelanjutan Psikoterapi Positif Kelompok dalam meningkatkan resiliensi pada lelaki homoseksual penyandang HIV/AIDS. Penelitian ini merupakan suatu studi kuasi eksperimen dengan desain *untreated control group design with dependent pretest and posttest samples using switching replications*. Sebanyak 18 lelaki homoseksual penyandang HIV/AIDS yang mengalami masalah resiliensi dibagi dua menjadi kelompok eksperimen dan kelompok kontrol. Instrumen penelitian yang digunakan adalah Skala Resiliensi, *Positive Psychotherapy Inventory* (PPTI), dan *The Day Reconstruction Method* (DRM). Analisis kuantitatif dilakukan melalui uji statistik *Mann-Whitney* serta menggunakan analisis kualitatif. Hasil penelitian menunjukkan bahwa Psikoterapi Positif Kelompok signifikan dalam meningkatkan resiliensi pada lelaki homoseksual penyandang HIV/AIDS ( $U=0,000$ ;  $p<0,01$ ) dan efek terapeutik intervensi ini bertahan paling tidak selama dua minggu. Di Amerika, penelitian sebelumnya telah menemukan bahwa Psikoterapi Positif terbukti efektif meningkatkan kesejahteraan pada mahasiswa. Di Indonesia, Psikoterapi Positif Kelompok sesi "menemukan tiga hal baik dalam hidup" dan "menikmati pengalaman dengan menyenangkan" terbukti paling efektif meningkatkan resiliensi pada penyandang HIV/AIDS. Psikoterapi Positif kelompok semakin menguatkan bahwa kelompok sebagai wadah untuk saling berbagi.

**Keywords:** *gay, group positive psychotherapy, people living with HIV/AIDS, resilience*

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## 1. Introduction

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) are serious global health problems about which we must all be concerned. HIV/AIDS spreads quickly, and so far, no cure has been found. Thus, the disease's victims are often inconsolable. In 2015, the United Nations Programme on HIV/AIDS (UNAIDS) reported that by June 2015, 36.9 million people worldwide had been infected with HIV, 34.3 million adults and 2.6 million children (0–15 years old).

In Indonesia, the first case of HIV and AIDS occurred in Bali, in 1987, and the disease has continued to spread until 2015. Compared with the period from 1987 to 2010, HIV cases have been increasing by five times every 6 months. Therefore, Indonesia has been classified as a country with a concentrated epidemic level, because it has prevalence of more than 5% in certain subpopulations (Depkes RI, 2015). In most countries, at least the growth of HIV/AIDS incidence is decreasing.

On the other hand, Indonesia is one of nine countries that has increased the spread of HIV/AIDS (KPAN & IBCA, 2015). Data show that the spread of the HIV virus is so quick that HIV/AIDS cases are an iceberg phenomenon: Many cases have not yet surfaced. Besides that, statistical data cannot express the depth and breadth of health problems suffered by people living with HIV/AIDS.

According to Nasronudin (2007), HIV stresses the human body, and at least three stressors are linked. First is the biological stressor of HIV itself, the disease's journey, such as complications to the nervous system and immunity problems. People infected with HIV are easily attacked by illness because the virus works by weakening the immune system. This is one of this virus's many characteristics, for instance, easy infections by tumors, bacteria, and fungi. Moreover, people living with HIV/AIDS have to face the often serious side effects of antiretroviral (ARV) medicine. The second stressor is psychological because of the disease's social stigma and familial and social discrimination against its victims.

The third stressor is often associated with physical and psychological breakdown and attitudes. Continued long-term stress, often caused by social stigma linked to HIV/AIDS, and strict rules for living with the virus and/or the disease can be a heavy stressor (Morin et al., 2008). Physical changes due to effects of HIV infection become psychological and social stressors for those living with HIV/AIDS. Conversely, psychological and social stress affects the central nervous system, lowering a person's immunity and allowing the disease to progress into AIDS (Djoerban & Djauzi, 2006).

According to early assessment from a focus group discussion (FGD), linked with Organization X that deals with HIV/AIDS, five HIV/AIDS infected individuals reported that they experience their social life as comfortable only around others with HIV/AIDS. Outside that world, they close off their true selves. For gay people, the burden is much worse because they live with two stigmas—being gay and being infected by HIV/AIDS. Another FGD result by another researcher confirmed these results; two gay people living with HIV/AIDS said that life as a gay person is already too much for them. This is worsened by lesbian, gay, bisexual, and transgender (LGBT) issues that have now become national issues, ensuring discrimination against LGBT people. On top of that lies the stigma of HIV/AIDS.

One stigma about gay people is that they often hedonistically change partners. Therefore, they are blamed for spreading HIV/AIDS (Lyons, Heywood, & Rozbroj, 2016) and frequently face physical, psychological, sexual, social, and/or economic harassment and violence (Oetomo, 2001). Based on Ministry of Health statistics (2017), Indonesian groups who risk HIV/AIDS are those who inject drugs (sharing needles), heterosexuals, and gays who occasionally change their partners, among others.

**Table 1. Numbers of Indonesians infected with HIV/AIDS in 2017**

No.	Risk Factor	Total
1	NAPZA	802
2	Heterosexual	9,873
3	Gay	4,241
4	Unidentified	4,677

Based on data displayed in Table 1, we know that gay people disproportionally contribute to the number of HIV/AIDS sufferers. To deal with all the pressure and stress, including that of forced life changes, people living with HIV/AIDS must adapt to survive. According to Crawford, Wright, and Masten (2006), people who must adapt to changes in their lives do so through resilience. *Resilience* is the ability to adjust to pressing life changes, making it possible for people to face difficulties (Vaishnavi, Connor, & Davidson, 2007). Herrick, Stall, Goldhammer, Egan, and Mayer (2014) also explained resilience as the ability to face challenges and to regenerate from bad experiences. Skodol et al. (2007) found that resilience involves individual characteristics that can prevent and overcome difficulties; resilient individuals can overcome future stress and keep it in balance, so mental disorders do not



occur when they are under pressure. Based on that definition, resilience is an individual's ability to adapt to a pressing situation and develop strategies to work through it. People considered flexible are able to adapt to new situations quickly, constantly develop, and have hope and faith that they will rise again (Siebert, 2005). Conversely, Sturgeon and Zautra (2010) stated that in a pressing situation, a person with low resilience tends to behave rigidly and is unorganized and maladaptive.

Many researchers have found social support effective in reducing stress (Reich, Zautra, & Hall, 2010). Dale, Weber, Cohen, Kelso, Cruise, & Brody (2015) explained that resilience does not depend only on individual attributes but also on the individual's protective structures, for example, family, society, and the environment. Indeed, social support has an important role in individual resilience. For people living with HIV/AIDS, their social group offers a place to communicate, especially in pressured and desperate moments (Liu et al., 2013). Therefore, important in interventions to change the behavior of people living with HIV/AIDS is providing a program and an environment that have great chemistry as a main element and also providing an environment to create strong and healthy relationships (Jones et al., 2007). Moreover, the values inherent to the support process are crucially important for those who have experience of rejection (Feigelman, Gorman, Beal, & Jordan, 2008).

This research involves initiating a previously untried psychological intervention in resilience care for gay people living with HIV/AIDS. A previous study by Yuen et al. (2013) showed that psychological intervention as the Personal Resilience and Enrichment Programme (PREP) had significant effects in improving the resilience and psychological state of people living with HIV/AIDS. In Indonesia, Risnawati (2011) conducted an intervention addressing psychological aspects. She found that Cognitive Behavior Therapy through psychoeducation, relaxation, thought catching, reality testing, interoceptive exposure, home duty, and self-presentation effectively lowered depression in people living with HIV/AIDS.

Effendy (2008) somewhat similar study found that Transpersonal Psychology with meditation, visualization, and compliments brought positive changes for people living with HIV/AIDS. Transpersonal Psychology improved their quality of life through centering, which can help fix a participant's energy system so that it raises their quality of life. Self-centering can cause changes in behavior and the immunity system by integrating the physical, biological, and physiological condition, that is, mind, body, and spirit.

Furthermore, another result of FGD conducted by this researcher showed that Organization X provides

medical help, for instance, medications and regular blood checks. No psychological help is offered, but it is badly needed. According to Organization X, patients reach saturation in ARV therapy. Consuming ARV medication for a couple of months, or even years, is so tiring that patients cease taking the medicine because they are bored and tired. Besides, they also tire of facing society's stigma. They often ask themselves "How long can I endure a life like this?" This pessimism indicates why psychological intervention is needed.

One intervention aiming to build individual potential is Positive Psychotherapy (Seligman, Rashid, & Parks, 2006), which is based on Positive Psychology for preventing psychological problems. Guney (2011) stated that Positive Psychotherapy aims to minimize psychopathological disturbance by building positive emotion, strength, and the meaning of life as an effort to pursue happiness through optimism, hope, humor, and defense. For 6 weeks, Seligman, Rashid, and Parks (2006) employed Group Positive Psychotherapy with 40 University of Pennsylvania students who showed symptoms of mild to moderate depression. Results showed reduction in depressive symptoms and improved well-being at 3 months, 6 months, and 1 year after intervention in the group receiving direct treatment.

So far, psychological interventions for people living with HIV/AIDS have focused only on negativities, such as depression and fear, which do not go well with the positive function of intervention, for example, resilience. Improving resilience through psychological intervention is badly needed because improving good emotions through Positive Psychotherapy has helped improve immunity and slow development of HIV/AIDS (Baumgardner & Crothers, 2010). Consequently, Positive Psychotherapy can be used as a psychological alternative to improve the resilience of gay people living with HIV/AIDS.

Some previous studies have shown that in-group psychological intervention significantly reduced depression for people living with HIV/AIDS. Such intervention can reduce psychosocial and social isolation and improve coping through experience sharing (Honagodu, Krishna, Sundarar, & Lepping, 2013). This result follows that of research by Yalom and Leszcz (2005), who found that group intervention can improve hope of change and provide a feeling of community, rather than aloneness. Other than that, group intervention can improve all of the following: feelings of togetherness, altruism, the sense of helping each other, learning to have good relationships with people, adapting good behavior from the group, catharsis, and one's own meaning through self-reflection or group reflection. Therefore, the researcher plans further to study Positive Psychotherapy inside the group.

As mentioned above, gay individuals living with HIV/AIDS must bear their declining physical conditions due to the virus inside their bodies and to the resulting isolation, discrimination, and harassment or mortification. They often feel hopeless and rejected by themselves, their families, and society. These stressors trigger negative effects, resulting in low resilience. In contrast, a supportive group of people living with HIV/AIDS offers space to open up and to support and strengthen each other. Similarly, for gay people living with HIV/AIDS, improving their positive affect is crucial in improving their resilience. Furthermore, achieving improved resilience requires suitable intervention, and positive group psychotherapy is expected to fulfill that requirement. Figure 1 illustrates this framework.

Based on the background above, this study examined the sustainability effects of Group Positive Psychotherapy in improving the resilience of gay people living with HIV/AIDS. Thus, the hypothesis is that Group Positive Psychotherapy can improve the resilience of gay people living with HIV/AIDS. Too, the study is practically beneficial because the result is expected to be a resilience care reference for that population.

## 2. Methods

**Participants.** This study's participants were 18 gay people living with HIV/AIDS. The inclusion criteria were: (a) having been infected by HIV/AIDS for a month; proving by letter a first HIV diagnosis, (b) being gay, as stated by the organizer, (c) having low resilience as shown by a Resilience Scale score, (d) residing in Yogyakarta, (e) undergoing antiretroviral therapy. All 18 subjects were divided into an experimental group ( $n = 9$ ) and a control group ( $n = 9$ ) by paired matching based on their Resilience Scale score in the pretest.

**Materials and Tools.** Materials and tools employed in this study were the following. First, An Interventional Module. By Retnowati, Anjarsari, Wibowo, and Tanau (2015), the Group Positive Psychotherapy module uses process and Positive Psychotherapy techniques based on Positive Psychotherapy modules arranged and used by Seligman, Rashid, and Parks (2006). These modules were modified by the researcher considering the research participants and variables.

Measurement tools for manipulation check: Positive Psychotherapy Inventory (PPTI). In this study, the PPTI used was a modified scale especially developed by Seligman, Rashid, and Parks (2006) to help understand the results of Positive Psychotherapy intervention. This scale measures the intervention process, which is directly connected by Positive Psychotherapy's three main components, a "pleasant life," a "meaningful life," and an "engaged life." From these three components come a score for "full life" (overall happiness).

The result of Aiken's V calculation showed that the V value for the Group Positive Psychotherapy module averaged 0.83, demonstrating its good content validity. Next, this module was tested for use with gay people living with HIV/AIDS, who were suitable, that is, with the inclusion criteria of a real research participant. Based on data resulting from a manipulation check with the PPTI scale, the researcher conducted analysis by the Wilcoxon Signed Rank Test ( $Z = -2.023$  by signification  $0.0215 [p < 0.05]$ ), which showed significant difference between PPTI measurements before and after Group Positive Psychotherapy with the pilot participant.

Second, Resilience Scale. Developed by Vaishnavi, Connor, and Davidson (2007), the Resilience Scale used here was modified and validated by Hermaleni (2012). Its internal consistency had a Cronbach's alpha of 0.931, and 19 items with a correlation index from 0.636 to 0.884.

This scale proved effective in differentiating individual resilience based on health status. Moreover, the scale was also sensitive in measuring individual changes of resilience according to treatment (Vaishnavi, Connor, & Davidson, 2007).

Third, Evaluation Sheets and Monitoring Subjects. The DRM uses evaluation sheets to measure resilience based on daily positive aspects by describing individuals' experiences on certain days and then systematic and descriptive reconstruction of them on the next day (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009).

Fourth, Observation Sheets. The researcher and the therapist used observation sheets that contained observational guidance and successful indicators to examine the participants' process in each session. The study involved three observers.

Fifth, Assignment Sheets. The research team prepared assignment sheets for participants to use in the organization of each session's tasks.

**Research Design.** This is a quasi-experimental study with an untreated control group design and dependent pretest and posttest samples using switching replications (Shadish, Cook, & Campbell, 2002). Figure 2 shows this experiment's measurement design.

$O_1$	$X_1$	$O_2$	$X_0$	$O_3$
$O_1$	$X_0$	$O_2$	$X_1$	$O_3$

**Figure 2. Experimental Design.**  $O_1$  = Measuring before Treatment was given (pretest);  $O_2$  = First Measurement after Treatment (posttest 1);  $O_3$  = Second Measurement after Treatment (Posttest 2);  $X_1$  = Positive Psychotherapy Treatment;  $X_0$  = Without Treatment.

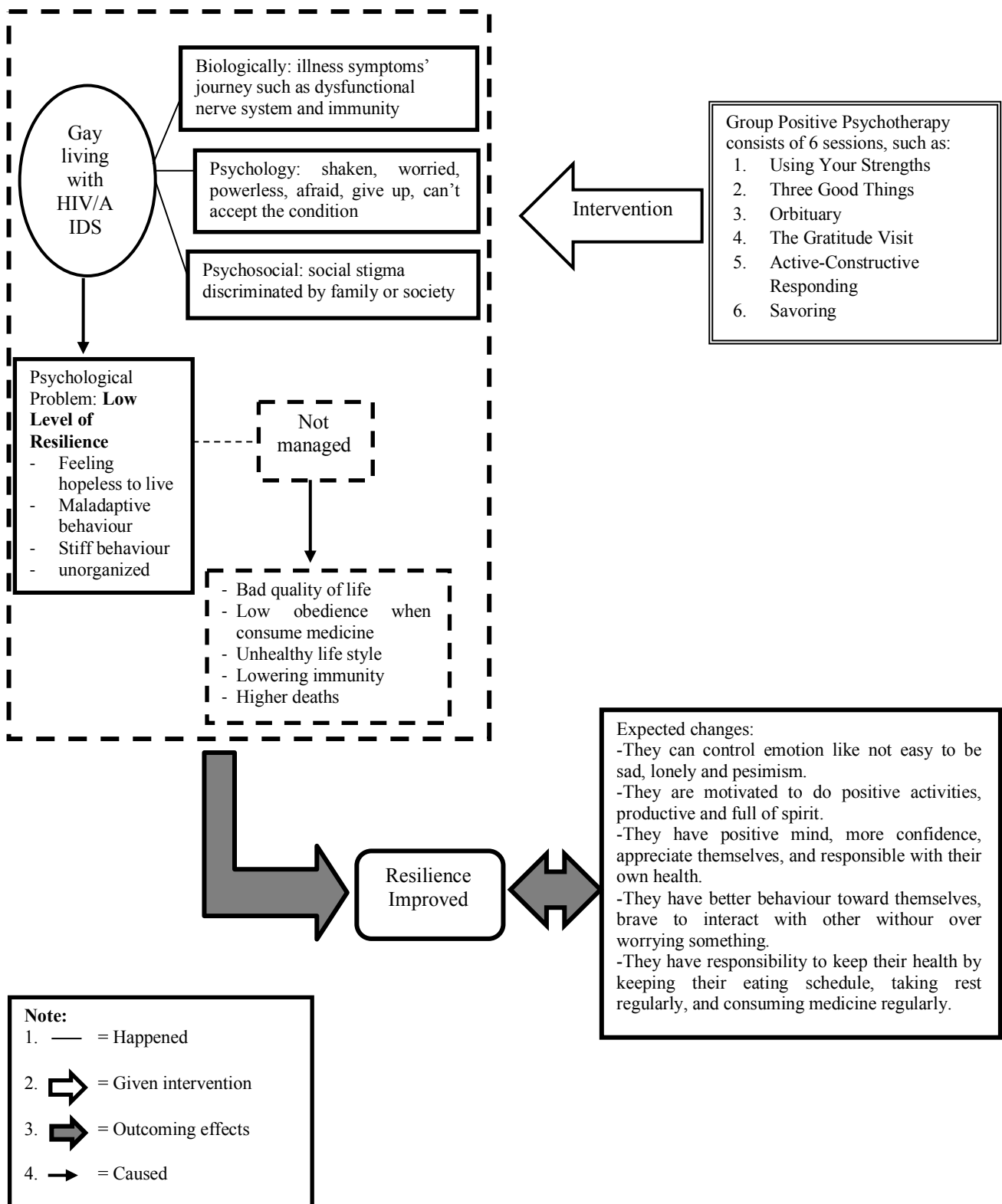


Figure 1. Framework Thinking of Group Positive Psychotherapy to Improve Resilience on Gay Living with HIV/AIDS.

Table 2. Group Positive Psychotherapy Session

Session	Theme	Activity	Time	Indicators of success
I	Session I Using Your Strengths	1. Opening and introduction 2. Check your mood 3. <i>Games</i> 4. Intervention session I 5. Exercise I 6. Closing	120 '	1. The research participant to find strength and know how to use it
II	Session II Three Good Things	1. Opening 2. Check your mood 3. Discussion of exercises I 4. <i>Games</i> 5. Intervention session II 6. Exercise II 7. Closing	120 '	1. Research participant exercises I 2. Research participants can find positive things in themselves and interpret them
III	Session III Obituary	1. Opening 2. Check your mood 3. Discussion exercise II 4. <i>Games</i> 5. Intervention session III 6. Exercise III 7. Closing	120 '	1. Research participant exercises II 2. Research participant can visualize his life and make the best life story
IV	Session IV The Gratitude Visit	1. Opening 2. Check your mood 3. Discussion of exercises III 4. <i>Games</i> 5. Intervention session IV 6. Exercise IV 7. Cover	120 '	1. Research participant exercises III 2. Participant to write a thank-you letter and deliver it 3. Participants can be given the benefit of others
V	Session V Active-Constructive Responding	1. Opening 2. Check your mood 3. Exercise IV 4. <i>Games</i> 5. Intervention session V 6. Exercise V 7. Closing	120 '	1. Research participant exercises IV 2. Participant to respond actively and constructively 3. Participant to know how the other person responds appropriately 4. Participant can practice giving an active and constructive joint response to therapist
VI	Session VI Savoring	1. Opening 2. Check your mood 3. Discussion exercise V 4. <i>Games</i> 5. Intervention session VI 6. Exercise VI 8. Wrap up	120 '	1. Participant exercises V 2. Participant to imagine something fun to be enjoyed 3. Participant can imagine and recall achievements 4. Participant can replace negative thought patterns with positive ones 4. Participant to find a way to enjoy the experience with fun.

**Intervention.** Group Positive Psychotherapy aimed to improve resilience or to focus on simple exercises involving positive aspects of life that participants possess and experience. Participants were not only trained to reduce negative emotion, but also to strengthen positive emotion by concentrating and emphasizing the positive compared to the negative.

With an experimental and a control group, six sessions of Group Positive Psychotherapy took place over 3 weeks. Each session spanned 120 minutes with a succeeding session after an interval of 3 or 4 days. Table 2 displays positive group psychotherapy activities.

**Implementing the Intervention:** First, a clinical psychologist who has been a researcher and is experienced in guiding Group Therapy. Second, three observers, with qualifications as a student of the Faculty of Psychology, as having passed the course on psychodiagnostics (observation, interview), and having technical training on the observation therapy process

**Analysis.** Data analysis was both quantitative and qualitative. Quantitative data analysis employed the Mann-Whitney U Test. Qualitative analysis employed descriptive results of face-to-face assignments, the DRM, and other supporting data like observations and mood checks in each session.

### 3. Results

**Quantitative Analysis.** Hypothetical testing was conducted by using the non-parametric Mann-Whitney U Test, which showed differences between pretest, posttest 1, and posttest 2 scores on experimental and control groups. Of course, the researcher used pseudonyms to preserve participants' confidentiality. Table 3 lists data descriptions of experimental and control groups' resilience scores.

Table 3 helps explain that in the experimental group, Adit had the greatest difference in scores between baseline and posttest (46 points). Heri's scores show the least change between baseline and posttest (20 points). Next, Figures 3 and 4 illustrate resilience score changes by the experimental and control groups before and after Group Positive Psychotherapy.

The Mann-Whitney U Test revealed resilience score changes in the experimental and control groups by counting each participants' gain score. In this research, gain score 1, the difference between baseline and posttest 1, showed differences between groups before and after receiving Group Positive Psychotherapy. Gain score 2 showed differences in resilience in baseline and posttest 2, to see whether changes had long-term influence and to compare them with the control group. Gain score 3 showed differences in resilience scores on

posttest 1 and posttest 2, to compare the groups post-intervention.

Results shown in Table 4 confirm the study's hypothesis: Resilience rose in gay people living with HIV/AIDS. The experimental group compared with the control group showed  $U = 0.000$  ( $p = 0.000$ ;  $p < 0.01$ ). Resilience enhanced by Group Positive Psychotherapy survived for at least 2 weeks, as shown by posttest 2:  $U = 0.000$  ( $p = 0.000$ ;  $p < 0.01$ ). There was a downward trend of resilience with the result of G2  $U = 35.000$ ;  $p = 0.313$ .

According to Fritz, Morris, and Richler (2011) effect size to nonstatistical test parametric can be known by dividing  $Z$  by  $N$  squared ( $r = Z/\sqrt{N}$ ). From the result of this calculation,  $r = 0.71$  (a big effect), that is, an effect size of Group Positive Psychotherapy for resilience increment of 71%.

The explanation above confirms that the Group Positive Psychotherapy intervention improved the experimental group's resilience, but the control group's resilience remained stable. Conversely, when the experimental group did not receive treatment, but the control group did between posttest 1 and posttest 2, the control group's resilience improved, while experimental group's was stable. This means that Group Positive Psychotherapy improved the resilience of gay people living with HIV/AIDS, and the therapeutic effect lasted at least 2 weeks. Thus, the effect size of Group Positive Psychotherapy in improving resilience was 71%.

**Manipulation Check.** After the hypothesis test, described above, researchers then analyzed the differences in PPTI scale scores--a manipulation check. Table 5 shows PPTI score data descriptions for the experimental and control groups.

As Table 5 shows, in the experimental group, Adit had the greatest score difference between baseline and posttest 1 (35 points). Kadin had the lowest change in scores between baseline and posttest 1 (10 points). The manipulation check (PPTI) and the Mann-Whitney test ( $U = 0.000$ ;  $p < 0.01$ ) showed significant differences between the experimental and control groups before and after Group Positive Psychotherapy.

**Qualitative Analysis.** Qualitative analysis here explains the intervention's actual process and supports the quantitative data, based on researcher observations, field notes, DRM sheets, daily notes, face-to-face assignments, house assignments, and intervention evaluations by participants.

Overall, the intervention process ran smoothly even though two subjects resigned. Other than that, some

subjects sometimes looked unhealthy because they were ill. Adding to some discomfort, the weather was bad, raining on two days. During the process, however, participants expressed enthusiasm to the therapist through facial and verbal expressions and their participation in group work. For instance, when they discussed, they also shared personal experiences, offered others support or opinions, and joked with one another to “break the ice.”

Generally, all participants were able to open up and support each other. A participant started telling stories in sessions 3 and 4. Other participants hesitated to tell their stories, but the therapist motivated and persuaded them to speak freely. In the experimental group, a problem arose because a participant joked inappropriately. This triggered problems for participants, and the therapist had to intercede for them.

Participants' conditions deteriorated when times between sessions were too long, for instance between sessions 5 and 6. This caused the therapist to work harder to counter boredom. On the other hand, participants looked enthusiastic when intervention activities differed every day. Thus, the therapist included more sharing sessions and positively affirmed and strengthened participants, actions that effectively improved participants' conditions.

Participant Sawit changed the most. In the session 1, Sawit looked shy about expressing his opinion. Even though he was encouraged by the therapist, he was mostly quiet. The face-to-face process showed that Sawit could not find positive potential inside himself. However, in sessions 2 and 3, he did start to find the positive in himself, and he was more active and friendly with the others. In session 4, Sawit actively participated and interacted with the whole group. He was able to recount how his experience started with the person he loves the most, his family, how he contracted HIV, and his process as a person living with HIV/AIDS. In session 5, Sawit expressed his positive and negative characteristics. But in session 6, he felt sad because his uncle had passed away, and he was quiet. In the last meeting, Sawit said that even though the intervention process was over, each group member must always help and support each other.

According to the observer's evaluation, the therapist conducted a good intervention by actively listening, reflecting emotion, giving feedback, and assessing each participant's condition well. Nevertheless, the observer made some notes about the therapist, who did not thoroughly understand HIV/AIDS, gay or LGBH people, and people living with HIV/AIDS. During the intervention, some participants asked about the latest news on HIV/AIDS and the lives of gay people and people living with HIV/AIDS. Although participants

seemed to trust the therapist, the lack of knowledge and understanding hampered his ability to master Group Positive Psychotherapy.

#### 4. Discussion

This study examined the sustainability of Group Positive Psychotherapy's effects on improving the resilience of gay people living with HIV/AIDS. Based on the result, Group Positive Psychotherapy significantly improved their resilience by encouraging participants on a daily basis, and the effects lasted for 2 weeks after the intervention.

Group Positive Psychotherapy ran smoothly overall. Participants attended to all the research, and the intervention was conducted in a decent place. The group numbers matched with previous effective interventions, that is, not more than 9 or 10 people (Berg, Landreth, & Kevin, 2013). Following Parks-Sheiner (2009), this intervention offered six sessions for 6 weeks.

According to Ampuni (2005), Indonesian people believe or hope that psychotherapy can address psychological problems briefly and practically. Setiyawati, Blashki, Wraith, Calucci, and Minas (2014) also found that psychologists, as therapists, are expected to treat clients briefly. Ampuni's (2005) invention, however, also proved a constraint in this study's search for candidates. Those who received an offer were not willing to participate because of the high number of meetings (9) within a month. Another obstacle was participants' physical conditions. They were very susceptible to illness so during some sessions, they could not join in to the maximum. According to Nasronudin (2007), these illnesses occurred because of their weakened immunity systems. Moreover, illness is likely to bring on psychological breakdown.

Based on analysis of resilience scores from baseline and posttest 2 in the two groups, there was not a significant result,  $p = 0.313$  ( $p > 0.01$ ), meaning that when measurements are not widely separated, they are likely to be the same or similar. According to Tusaie and Dyer (2004), resilience can fluctuate depending on the variety of interaction.

The analysis result also strengthened with the manipulation check. The Mann-Whitney U Test showed  $U = 0.000$ ;  $p < 0.01$ , indicating significant differences between the PPTI scale for the experimental and control groups. This means that the PPTI scale has good construct validity so that it accurately measured the intervention process as a theoretical construction of Group Positive Psychotherapy and showed differences before and after intervention.

The “stand-up” process in Group Positive Psychotherapy, including sharing, discussion, and interaction between therapist and group members, made participants comfortable. The therapist was also able to provide examples from the given materials, express his own experiences, and joke around. This confirms Berg, Landreth, and Kevin (2013) that *mutual* relationship is important for clients because from that relationship, they trust that a cure will be found. Furthermore, Hartman and Zimmeroff (2006) asserted that with the catharsis technique and effective facility, a client can return to a condition of resilience.

In this study, participants had mostly happy thoughts when they shared and talked with other gay people living with HIV/AIDS. They also felt that a support group was built during the process. For instance, one group member told his stories while others supported him. Even outside the intervention process, group members buoyed each other’s spirits.

In each session, subjects felt different benefits and had individual impressions. Some received the most benefit in session 2 (“three good things”). More than ever before, they blamed themselves for being gay with HIV/AIDS, but after session 2, they felt gratitude for their lives. This is consistent with Seligman, Rashid, and Parks (2006) who said that through the exercises, group members would find three good things to neutralize their negative emotions and to encourage them to be grateful.

To start sessions, the therapist provided exercises for relaxation, which was also part of session 6 (“savoring”), that is, supporting an individual’s positive emotion and life satisfaction (Synder & Lopez, 2009). Participants, impressed with the relaxation process, were then more ready and focused during therapy. Some--Bagus, Mamik, Adit, and William--applied relaxation daily. Additionally, participants also revealed that they planned to focus on the positive and to achieve goals, thus helping them return to a resilient condition.

In this study, participants’ perceived benefits certainly differed from the findings of Seligman, Rashid, and Parks (2006), whose Group Positive Psychotherapy with a U.S. student population improved well-being and lowered symptoms of depression. In this Indonesian study conducted with gay people living with HIV/AIDS, the sessions “three good things” and “savoring” proved most effective in improving resilience. Other sessions, “using your strengths,” “obituary,” “the gratitude visit,” and “active-constructive responding,” were not perceived as positively. Gay people living with HIV/AIDS still have wounding (unfinished business), including problems in the face of two distinct stigmas (gayness and HIV), so they have trouble undergoing certain sessions. Surely this is contrary to the principles of Positive Psychology,

but it also differentiates this study from studies conducted with healthy participants in the United States. In general, however, Group Positive Psychotherapy had the same effects, making participants able to control their emotions and accept bad events from a positive viewpoint. According to Brownell, Schrank, Jakaite, Larkin, and Slade (2015), accepting negative life events contains potential development, forgiveness, and gratitude.

Group Positive Psychotherapy’s effects on resilience can be explained through a mechanism of positive emotion building (Frederickson, Tugade, Waugh, & Larkin, 2003; Harrington, 2013). Positive emotion through Group Positive Psychotherapy can activate neurotransmitters, along with other networks in the human brain (Kringelbach & Berridge, 2010; Salesman & Miskowitz, 2015). It can also support the brain’s path of emotion (Davidson, Jackson, & Kalin, 2000) so that participants easily experience happiness and satisfaction. According to Frederickson, Tugade, Waugh, and Larkin (2003), positive emotion can cause the mind to be flexible toward happiness and satisfaction in life.

This study’s result proved that Group Positive Psychotherapy can improve resilience for gay people living with HIV/AIDS, but the study also has weaknesses. The quasi-experimental design has limitations (Shadish, Cook, & Campbell, 2002) in that recounting retroactive history threatens its internal validity. Some study events persuaded research participants like the member of Sawit’s family, and Adit who broke up with his boyfriend. As previously mentioned, the time lapse between sessions 5 and 6 seemed to lower both groups’ conditions. Another limitation involves the research design, that is, the switching replication design necessary to equalize the two groups (Shadish, Cook, & Campbell, 2002). Finally, one subject could not join the sessions because they were scheduled at the same time as his work. Of all the limitations, the switching replication has supremacy. With this design, research can have high validation based on treatments (Shadish, Cook, & Campbell, 2002). Moreover, the researcher can see the sustainability effects—at least 2 weeks--from the Group Positive Psychotherapy.

## 5. Conclusion

The research result showed that Group Positive Psychotherapy significantly improved the resilience of gay people living with HIV/AIDS, and the therapeutic effect lasted for at least 2 weeks post-intervention. The manipulation check strengthened these effects by revealing significant changes before and after the intervention. For example, after posttest 2, subjects were still focused on their action plans to achieve their goals. Some were able to reach those goals, while others were

still making efforts. Other than that, subjects felt the intervention's benefits, especially from sessions 2 and 6, linked with resilience. Compared with their conditions before the intervention, participants became more grateful, were able to think more positively, and to focus on relationships and goals. In fact, the intervention process itself contributed positively. Inside their groups, participants were happy to be heard, accepted, and appreciated. At the same time, they heard people emphasized, learned from others, and, in opposition to their previous loneliness, gained feelings of togetherness.

**Recommendation.** First, For Research Participants. Through the intervention process, research participants are expected to apply the positive, that is, using the positive potential on a daily basis, focusing more on the positive in themselves and the environment, being grateful for little things, having good relationships with people through active-constructive responses, and having a more positive mindset than before undergoing the intervention.

Second, For the Psychologist. In this study, the Group Positive Psychotherapy therapist did not really understand HIV/AIDS information and the living conditions of gay people and/or people with HIV/AIDS. Because this therapy is so important, the therapist in future interventions should have broad, deep knowledge about HIV/AIDS and the population served.

Third, Society Organization for PLWHA. In this study, Group Positive Psychotherapy improved resilience. Thus, the intervention can be used to prevent psychological breaks in people living with HIV/AIDS, for instance, maladaptive behaviors and lack of self-confidence. This study's results strengthened the importance of groups as spaces for sharing and of Organization X's use of this method with the guidance of a facilitator.

Lastly, For the Next Researcher. In this study, participants' conditions seemed to worsen when the session ended, especially because of sessions being scheduled at too-long intervals. Thus, the next intervention of Group Positive Psychotherapy should have a firm schedule for the sessions. Relaxation should be used to start the intervention process so that participants feel comfortable and are in a "here and now" condition.

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# Group Positive Psychotherapy Improves Resilience of Gay People Living with HIV/AIDS

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## Group Positive Psychotherapy Improves Resilience of Gay People Living with HIV/AIDS

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### Abstract

Gay people living with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) face two stigmas, being gay and having HIV/AIDS, thus making their daily lives very complicated. To survive their life challenges, they need strong resilience. This study examined the sustainability effects of Group Positive Psychotherapy in improving the resilience of gay people living with HIV/AIDS. Participants were 18 gay people (9 each in experimental and control groups) living with HIV/AIDS and experiencing resilience problems. The study's design was quasi-experimental, with an untreated control group and pretest and posttest dependent samples using switching replications. The instruments used were the Resilience Scale, the Positive Psychotherapy Inventory (PPTI), and the Day Reconstruction Method (DRM). Besides qualitative analysis, quantitative analysis was conducted through statistical testing using the Mann-Whitney U Test. Results showed that Group Positive Psychotherapy significantly improved participants' resilience ( $U = 0.000$ ;  $p < 0.01$ ), and its effects lasted for at least two weeks post-intervention. In this study, the Group Positive Psychotherapy sessions on "three good things" and "savoring" proved most effective in improving the resilience of gay people living with HIV/AIDS. Group Positive Psychotherapy also effectively reinforced groups as a positive forum for sharing.

### Psikoterapi Positif Kelompok untuk Meningkatkan Resiliensi pada Lelaki Homoseksual Penyandang HIV/AIDS

#### Abstrak

Seorang penyandang HIV/AIDS dengan faktor risiko homoseksual harus menghadapi dua stigma berbeda (sebagai homoseksual dan HIV/AIDS) yang melekat pada diri mereka. Kemampuan menyesuaikan diri terhadap perubahan kelompok yang menekan ini disebut dengan resiliensi. Penelitian ini bertujuan untuk menguji efek berkelanjutan psikoterapi Positif Kelompok dalam meningkatkan resiliensi pada lelaki homoseksual penyandang HIV/AIDS. Penelitian ini merupakan suatu studi kuasi eksperimen dengan desain *untreated control group design with dependent pretest and posttest samples using switching replications*. Sebanyak 18 lelaki homoseksual penyandang HIV/AIDS yang mengalami masalah resiliensi dibagi dua menjadi kelompok eksperimen dan kelompok kontrol. Instrumen penelitian yang digunakan adalah Skala Resiliensi, *Positive Psychotherapy Inventory* (PPTI), dan *The Day Reconstruction Method* (DRM). Analisis kuantitatif dilakukan melalui uji statistik *Mann-Whitney* serta menggunakan analisis kualitatif. Hasil penelitian menunjukkan bahwa Psikoterapi Positif Kelompok signifikan dalam meningkatkan resiliensi pada lelaki homoseksual penyandang HIV/AIDS ( $U = 0,000$ ;  $p < 0,01$ ) dan efek terapeutik intervensi ini bertahan paling tidak selama dua minggu. Di Amerika, penelitian sebelumnya telah menemukan bahwa Psikoterapi Positif terbukti efektif meningkatkan kesejahteraan pada mahasiswa. Di Indonesia, Psikoterapi Positif Kelompok sesi "menemukan tiga hal baik dalam hidup" dan "menikmati pengalaman dengan menyenangkan" terbukti paling efektif meningkatkan resiliensi pada penyandang HIV/AIDS. Psikoterapi Positif kelompok semakin menguatkan bahwa kelompok sebagai wadah untuk saling berbagi.

**Keywords:** *gay, group positive psychotherapy, people living with HIV/AIDS, resilience*

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## 1. Introduction

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) are serious global health problems about which we must all be concerned. HIV/AIDS spreads quickly, and so far, no cure has been found. Thus, <sup>35</sup> disease's victims are often inconsolable. In 2015, the United Nations Programme on HIV/AIDS (UNAIDS) reported that by June 2015, 36.9 million people worldwide had been infected with HIV, 34.3 million adults and 2.6 million children (0–15 years old).

In Indonesia, the first case of HIV and AIDS occurred in Bali, in 1987, and the disease has continued to spread until 2015. Compared with the period from 1987 to 2010, HIV cases have been increasing by five times every 6 months. Therefore, Indonesia has been classified as a country with a concentrated epidemic level, because it has prevalence of more than 5% in certain subpopulations (Depkes RI, 2015). In most countries, at least the growth of HIV/AIDS incidence is decreasing.

On the other hand, Indonesia is one of nine countries that has increased the spread of HIV/AIDS (KPAN & IBCA, 2015). Data show that the spread of the HIV virus is so quick that HIV/AIDS cases are an iceberg phenomenon: Many cases have not yet surfaced. Besides that, statistical data cannot express the depth and breadth of health problems suffered by people living with HIV/AIDS.

According to Nasronudin (2007), HIV stresses the human body, and at least three stressors are linked. First is the biological stressor of HIV itself, the disease's journey, such as complications to the nervous system and immunity problems. People infected with HIV are easily attacked by illness because the virus works by weakening the immune system. This is one of this virus's many characteristics, for instance, easy <sup>2</sup>fections by tumors, bacteria, and fungi. Moreover, people living with HIV/AIDS have to face the often serious side effects of antiretroviral (ARV) medicine. The second stressor is psychological because of the disease's social stigma and familial and social discrimination against its victims.

The third stressor is often associated with physical and psychological breakdown and attitudes. Continued long-term stress, often caused by social stigma linked to HIV/AIDS, and strict rules for living with the virus and/or the disease can be a heavy stressor (Morin et al., 2008). Physical changes due to effects of HIV infection become psychological and social stressors for those living with HIV/AIDS. Conversely, psychological and social stress affects the central nervous system, lowering a person's immunity and allowing the disease to progress into AIDS (Djoerban & Djauzi, 2006).

According to early assessment from a focus group discussion (FGD), linked with Organization X that deals with HIV/AIDS, five HIV/AIDS infected individuals reported that they experience their social life as comfortable only around others with HIV/AIDS. Outside that world, they close off their true selves. For gay people, the burden is much worse because they live with two stigmas—being gay and being infected by HIV/AIDS. Another FGD result by another researcher confirmed these results; two gay people living with HIV/AIDS said that life as a gay person is already too much for them. This is worsened by lesbian, gay, bisexual, and transgender (LGBT) issues that have now become national issues, ensuring discrimination against LGBT people. On top of that lies the stigma of HIV/AIDS.

One stigma about gay people is that they often hedonistically change partners. Therefore, they are blamed for spreading HIV/AIDS (Lyons, Heywood, & Rozbroj, 2016) and frequently face physical, psychological, sexual, social, and/or economic harassment and violence (Oetomo, 2001). Based on Ministry of Health statistics (2017), Indonesian groups who risk HIV/AIDS are those who inject drugs (sharing needles), heterosexuals, and gays who occasionally change their partners, among others.

*Table 1. Numbers of Indonesians infected with HIV/AIDS in 2017*

No.	Risk Factor	Total
1	NAPZA	802
2	Heterosexual	9,873
3	Gay	4,241
4	Unidentified	4,677

Based on data displayed in Table 1, we know that gay people disproportionally contribute to the number of HIV/AIDS sufferers. To deal with all the pressure and stress, including that of forced life changes, people living with HIV/AIDS must adapt to survive. According to Crawford, Wright, and Masten (2006), people who must adapt to changes in their lives do so through resilience. *Resilience* is the ability to adjust to pressing life changes, making it possible for people to face difficulties (Vaishnavi, Connor, & Davidson, 2007). Herrick, Stall, Goldhammer, Egan, and Mayer (2014) also explained resilience as the ability to face challenges and to regenerate from bad experiences. Skodol et al. (2007) found that resilience involves individual characteristics that can prevent and overcome difficulties; resilient individuals can overcome future stress and keep it in balance, so mental disorders do not



occur when they are under pressure. Based on that definition, resilience is an individual's ability to adapt to a pressing situation and develop strategies to work through it. People considered flexible are able to adapt to new situations quickly, constantly develop, and have hope and faith that they will rise again (Siebert, 2005). Conversely, Sturgeon and Zautra (2010) stated that in a pressing situation, a person with low resilience tends to behave rigidly and is unorganized and maladaptive.

Many researchers have found social support effective in reducing stress (Reich, Zautra, & Hall, 2010). Dale, Weber, Cohen, Kelso, Cruise, & Brody (2015) explained that resilience does not depend only on individual attributes but also on the individual's protective structures, for example, family, society, and the environment. Indeed, social support has an important role in individual resilience. For people living with HIV/AIDS, their social group offers a place to communicate, especially in pressured and desperate moments (Liu et al., 2013). Therefore, important in interventions to change the behavior of people living with HIV/AIDS is providing a program and an environment that have great chemistry as a main element and also providing an environment to create strong and healthy relationships (Jones et al., 2007). Moreover, the values inherent to the support process are crucially important for those who have experience of rejection (Feigelman, Gorman, Beal, & Jordan, 2008).

This research involves initiating a previously untried psychological intervention in resilience care for gay people living with HIV/AIDS. A previous study by Yuen (2013) showed that psychological intervention as the Personal Resilience and Enrichment Programme (PREP) had significant effects in improving the resilience and psychological state of people living with HIV/AIDS. In Indonesia, Risnawati (2011) conducted an intervention addressing psychological aspects. She found that Cognitive Behavior Therapy through psychoeducation, relaxation, thought catching, reality testing, interoceptive exposure, home duty, and self-presentation effectively lowered depression in people living with HIV/AIDS.

Effendy (2008) somewhat similar study found that Transpersonal Psychology with meditation, visualization, and compliments brought positive changes for people living with HIV/AIDS. Transpersonal Psychology improved their quality of life through centering, which can help fix a participant's energy system so that it raises their quality of life. Self-centering can cause changes in behavior and the immunity system by integrating the physical, biological, and physiological condition, that is, mind, body, and spirit.

Furthermore, another result of FGD conducted by this researcher showed that Organization X provides

medical help, for instance, medications and regular blood checks. No psychological help is offered, but it is badly needed. According to Organization X, patients reach saturation in ARV therapy. Consuming ARV medication for a couple of months, or even years, is so tiring that patients cease taking the medicine because they are bored and tired. Besides, they also tire of facing society's stigma. They often ask themselves "How long can I endure a life like this?" This pessimism indicates why psychological intervention is needed.

The intervention aiming to build individual potential is Positive Psychotherapy (Seligman, Rashid, & Parks, 2006), which is based on Positive Psychology for preventing psychological problems. Guney (2011) stated that Positive Psychotherapy aims to minimize psychopathological disturbance by building positive emotion, strength, and the meaning of life as an effort to pursue happiness through optimism, hope, humor, and defense. For 6 weeks, Seligman, Rashid, and Parks (2006) employed Group Positive Psychotherapy with 40 University of Pennsylvania students who showed symptoms of mild to moderate depression. Results showed reduction in depressive symptoms and improved well-being at 3 months, 6 months, and 1 year after intervention in the group receiving direct treatment.

So far, psychological interventions for people living with HIV/AIDS have focused only on negativities, such as depression and fear, which do not go well with the positive function of intervention, for example, resilience. Improving resilience through psychological intervention is badly needed because improving good emotions through Positive Psychotherapy has helped improve immunity and slow development of HIV/AIDS (Baumgardner & Crothers, 2010). Consequently, Positive Psychotherapy can be used as a psychological alternative to improve the resilience of gay people living with HIV/AIDS.

Some previous studies have shown that in-group psychological intervention significantly reduced depression for people living with HIV/AIDS. Such intervention can reduce psychosocial and social isolation and improve coping through experience sharing (Honagodu, Krishna, Sundarachar, & Lepping, 2013). This result follows that of research by Yalom and Leszcz (2005), who found that group intervention can improve hope of change and provide a feeling of community, rather than aloneness. Other than that, group intervention can improve all of the following: feelings of togetherness, altruism, the sense of helping each other, learning to have good relationships with people, adapting good behavior from the group, catharsis, and one's own meaning through self-reflection or group reflection. Therefore, the researcher plans further to study Positive Psychotherapy inside the group.

As mentioned above, gay individuals living with HIV/AIDS must bear their declining physical conditions due to the virus inside their bodies and to the resulting isolation, discrimination, and harassment or mortification. They often feel hopeless and rejected by themselves, their families, and society. These stressors trigger negative effects, resulting in low resilience. In contrast, a supportive group of people living with HIV/AIDS offers space to open up and to support and strengthen each other. Similarly, for gay people living with HIV/AIDS, improving their positive affect is crucial in improving their resilience. Furthermore, achieving improved resilience requires suitable intervention, and positive group psychotherapy is expected to fulfill that requirement. Figure 1 illustrates this framework.

Based on the background above, this study examined the sustainability effects of Group Positive Psychotherapy in improving the resilience of gay people living with HIV/AIDS. Thus, the hypothesis is that Group Positive Psychotherapy can improve the resilience of gay people living with HIV/AIDS. Too, the study is practically beneficial because the result is expected to be a resilience care reference for that population.

## 2. Methods

**Participants.** This study's participants were 18 gay people living with HIV/AIDS. The inclusion criteria were: (a) having been infected by HIV/AIDS for a month; proving by letter a first HIV diagnosis, (b) being gay, as stated by the organizer, (c) having low resilience as shown by a Resilience Scale score, (d) residing in Yogyakarta, (e) undergoing antiretroviral therapy. All 18 subjects were divided into an experimental group ( $n = 9$ ) and a control group ( $n = 9$ ) by paired matching based on their Resilience Scale score in the pretest.

**Materials and Tools.** Materials and tools employed in this study were the following. First, An Interventional Module. By Retnowati, Anjarsari, Wibowo, and Tanau (2015), the Group Positive Psychotherapy module uses process and Positive Psychotherapy techniques based on Positive Psychotherapy modules arranged and used by Seligman, Rashid, and Parks (2006). These modules were modified by the researcher considering the research participants and variables.

Measurement tools for manipulation check: Positive Psychotherapy Inventory (PPTI). In this study, the PPTI was a modified scale especially developed by Seligman, Rashid, and Parks (2006) to help understand the results of Positive Psychotherapy intervention. This scale measures the intervention process, which is directly connected by Positive Psychotherapy's three main components, a "pleasant life," a "meaningful life," and an "engaged life." From these three components come a score for "full life" (overall happiness).

The result of Aiken's V calculation showed that the V value for the Group Positive Psychotherapy module averaged 0.83, demonstrating its good content validity. Next, this module was tested for use with gay people living with HIV/AIDS, who were suitable, that is, with the inclusion criteria of a real research participant. Based on data resulting from a manipulation check with the PPTI scale, the researcher conducted analysis by the Wilcoxon Signed Rank Test ( $Z = -2.023$  by signification  $0.0215 [p < 0.05]$ ), which showed significant difference between PPTI measurements before and after Group Positive Psychotherapy with the pilot participant.

**Second, Resilience Scale.** Developed by Vaishnavi, Connor, and Davidson (2007), the Resilience Scale used was modified and validated by Hermaleni (2012). Its internal consistency had a Cronbach's alpha of 0.931, and 19 items with a correlation index from 0.636 to 0.884.

This scale proved effective in differentiating individual resilience based on health status. Moreover, the scale was also sensitive in measuring individual changes of resilience according to treatment (Vaishnavi, Connor, & Davidson, 2007).

**Third, Evaluation Sheets and Monitoring Subjects.** The DRM uses evaluation sheets to measure resilience based on daily positive aspects by describing individuals' experiences on certain days and then systematic and descriptive reconstruction of them on the next day (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009).

**Fourth, Observation Sheets.** The researcher and the therapist used observation sheets that contained observational guidance and successful indicators to examine the participants' process in each session. The study involved three observers.

**Fifth, Assignment Sheets.** The research team prepared assignment sheets for participants to use in the organization of each session's tasks.

**Research Design.** This is a quasi-experimental study with an untreated control group design and dependent pretest and posttest samples using switching replications (Shadish, Cook, & Campbell, 2002). Figure 2 shows this experiment's measurement design.

$O_1$	$X_1$	$O_2$	$X_0$	$O_3$
$O_1$	$X_0$	$O_2$	$X_1$	$O_3$

**Figure 2. Experimental Design.**  $O_1$  = Measuring before Treatment was given (pretest);  $O_2$  = First Measurement after Treatment (posttest 1);  $O_3$  = Second Measurement after Treatment (Posttest 2);  $X_1$  = Positive Psychotherapy Treatment;  $X_0$  = Without Treatment.



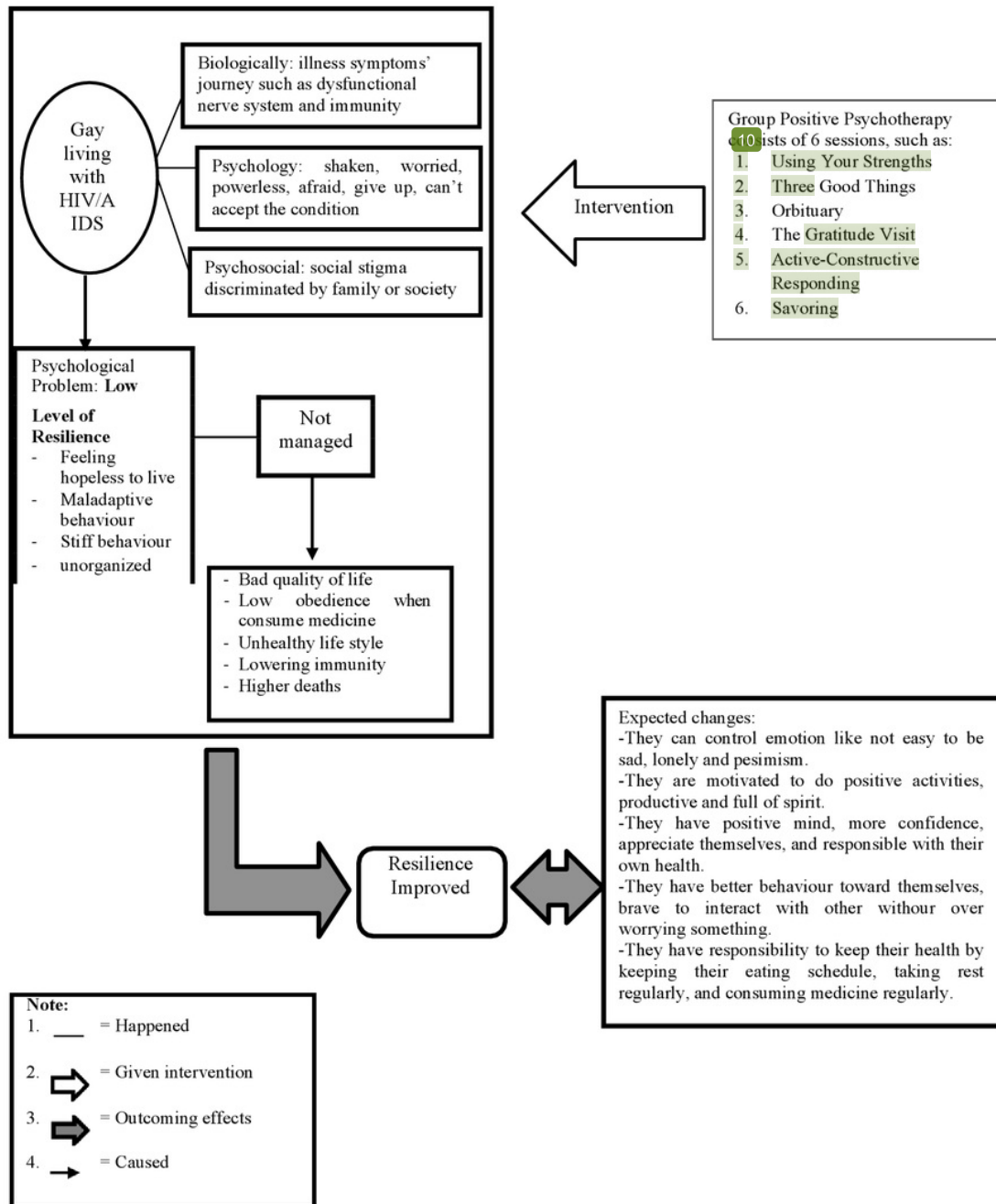


Figure 1. Framework Thinking of Group Positive Psychotherapy to Improve Resilience on Gay Living with HIV/AIDS.



Table 2. Group Positive Psychotherapy Session

Session	Theme	Activity	Time	Indicators of success
I	Session I Using Your Strengths	1. Opening and introduction 2. Check your mood 3. <i>Games</i> 4. Intervention session I 5. Exercise I 6. Closing	120 '	1. The research participant to find strength and know how to use it
II	Session II Three Good Things	1. Opening 2. Check your mood 3. Discussion of exercises I 4. <i>Games</i> 5. Intervention session II 6. Exercise II 7. Closing	120 '	1. Research participant exercises I 2. Research participants can find positive things in themselves and interpret them
III	Session III Obituary	1. Opening 2. Check your mood 3. Discussion exercise II 4. <i>Games</i> 5. Intervention session III 6. Exercise III 7. Closing	120 '	1. Research participant exercises II 2. Research participant can visualize his life and make the best life story
IV	Session IV The Gratitude Visit	1. Opening 2. Check your mood 3. Discussion of exercises III 4. <i>Games</i> 5. Intervention session IV 6. Exercise IV 7. Cover	120 '	1. Research participant exercises III 2. Participant to write a thank-you letter and deliver it 3. Participants can be given the benefit of others
V	Session V Active-Constructive Responding	1. Opening 2. Check your mood 3. Exercise IV 4. <i>Games</i> 5. Intervention session V 6. Exercise V 7. Closing	120 '	1. Research participant exercises IV 2. Participant to respond actively and constructively 3. Participant to know how the other person responds appropriately 4. Participant can practice giving an active and constructive joint response to therapist
VI	Session VI Savoring	1. Opening 2. Check your mood 3. Discussion exercise V 4. <i>Games</i> 5. Intervention session VI 6. Exercise VI 8. Wrap up	120 '	1. Participant exercises V 2. Participant to imagine something fun to be enjoyed 3. Participant can imagine and recall achievements 4. Participant can replace negative thought patterns with positive ones 4. Participant to find a way to enjoy the experience with fun.

**Intervention.** Group Positive Psychotherapy aimed to improve resilience or to focus on simple exercises involving positive aspects of life that participants possess and experience. Participants were not only trained to reduce negative emotion, but also to strengthen positive emotion by concentrating and emphasizing the positive compared to the negative.

With an experimental and a control group, six sessions of Group Positive Psychotherapy took place over 3 weeks. Each session spanned 120 minutes with a succeeding session after an interval of 3 or 4 days. Table 2 displays positive group psychotherapy activities.

**Implementing the Intervention:** First, a clinical psychologist who has been a researcher and is experienced in guiding Group Therapy. Second, three observers, with qualifications as a student of the Faculty of Psychology, as having passed the course on psychodiagnostics (observation, interview), and having technical training on the observation therapy process

**Analysis.** Data analysis was both quantitative and qualitative. Quantitative data analysis employed the Mann-Whitney U Test. Qualitative analysis employed descriptive results of face-to-face assignments, the DRM, and other supporting data like observations and mood checks in each session.

### 3. Results

**Quantitative Analysis.** Hypothetical testing was conducted by using the non-parametric Mann-Whitney U Test, which showed differences between pretest, posttest 1, and posttest 2 scores on experimental and control groups. Of course, the researcher used pseudonyms to preserve participants' confidentiality. Table 3 lists data descriptions of experimental and control groups' resilience scores.

Table 3 helps explain that in the experimental group, Adit had the greatest difference in scores between baseline and posttest (46 points). Heri's scores show the least change between baseline and posttest (20 points). Next, figures 3 and 4 illustrate resilience score changes by the experimental and control groups before and after Group Positive Psychotherapy.

The Mann-Whitney U Test revealed resilience score changes in the experimental and control groups by counting each participants' gain score. In this research, gain score 1, the difference between baseline and posttest 1, showed differences between groups before and after receiving Group Positive Psychotherapy. Gain score 2 showed differences in resilience in baseline and posttest 2, to see whether changes had long-term influence and to compare them with the control group. Gain score 3 showed differences in resilience scores on

posttest 1 and posttest 2, to compare the groups post-intervention.

Results shown in Table 4 confirm the study's hypothesis: resilience rose in gay people living with HIV/AIDS. The experimental group compared with the control group showed  $U = 0.000$  ( $p = 0.000$ ;  $p < 0.01$ ). Resilience enhanced by Group Positive Psychotherapy survived for at least 2 weeks, as shown by posttest 2:  $U = 0.000$  ( $p = 0.000$ ;  $p < 0.01$ ). There was a downward trend of resilience with the result of G2  $U = 35.000$ ;  $p = 0.313$ .

According to Fritz, Morris, and Richler (2011) effect size to nonstatistical test parametric can be known by dividing  $Z$  by  $N$  squared ( $r = Z/\sqrt{N}$ ). From the result of this calculation,  $r = 0.71$  (a big effect), that is, an effect size of Group Positive Psychotherapy for resilience increment of 71%.

The explanation above confirms that the Group Positive Psychotherapy intervention improved the experimental group's resilience, but the control group's resilience remained stable. Conversely, when the experimental group did not receive treatment, but the control group did between posttest 1 and posttest 2, the control group's resilience improved, while experimental group's was stable. This means that Group Positive Psychotherapy improved the resilience of gay people living with HIV/AIDS, and the therapeutic effect lasted at least 2 weeks. Thus, the effect size of Group Positive Psychotherapy in improving resilience was 71%.

**Manipulation Check.** After the hypothesis test, described above, researchers then analyzed the differences in PPTI scale scores--a manipulation check. Table 5 shows PPTI score data descriptions for the experimental and control groups.

As Table 5 shows, in the experimental group, Adit had the greatest score difference between baseline and posttest 1 (35 points). Kadin had the lowest change in scores between baseline and posttest 1 (10 points). The manipulation check (PP and the Mann-Whitney test ( $U = 0.000$ ;  $p < 0.01$ ) showed significant differences between the experimental and control groups before and after Group Positive Psychotherapy.

**Qualitative Analysis.** Qualitative analysis here explains the intervention's actual process and supports the quantitative data, based on researcher observations, field notes, DRM sheets, daily notes, face-to-face assignments, house assignments, and intervention evaluations by participants.

Overall, the intervention process ran smoothly even though two subjects resigned. Other than that, some

subjects sometimes looked unhealthy because they were ill. Adding to some discomfort, the weather was bad, raining on two days. During the process, however, participants expressed enthusiasm to the therapist through facial and verbal expressions and their participation in group work. For instance, when they discussed, they also shared personal experiences, offered others support or opinions, and joked with one another to "break the ice."

Generally, all participants were able to open up and support each other. A participant started telling stories in sessions 3 and 4. Other participants hesitated to tell their stories, but the therapist motivated and persuaded them to speak freely. In the experimental group, a problem arose because a participant joked inappropriately. This triggered problems for participants, and the therapist had to intercede for them.

Participants' conditions deteriorated when times between sessions were too long, for instance between sessions 5 and 6. This caused the therapist to work harder to counter boredom. On the other hand, participants looked enthusiastic when intervention activities differed every day. Thus, the therapist included more sharing sessions and positively affirmed and strengthened participants, actions that effectively improved participants' conditions.

Participant Sawit changed the most. In the session 1, Sawit looked shy about expressing his opinion. Even though he was encouraged by the therapist, he was mostly quiet. The face-to-face process showed that Sawit could not find positive potential inside himself. However, in sessions 2 and 3, he did start to find the positive in himself, and he was more active and friendly with the others. In session 4, Sawit actively participated and interacted with the whole group. He was able to recount how his experience started with the person he loves the most, his family, how he contracted HIV, and his process as a person living with HIV/AIDS. In session 5, Sawit expressed his positive and negative characteristics. But in session 6, he felt sad because his uncle had passed away, and he was quiet. In the last meeting, Sawit said that even though the intervention process was over, each group member must always help and support each other.

According to the observer's evaluation, the therapist conducted a good intervention by actively listening, reflecting emotion, giving feedback, and assessing each participant's condition well. Nevertheless, the observer made some notes about the therapist, who did not **38** roughly understand HIV/AIDS, gay or LGBH people, and people living with HIV/AIDS. During the interv **44** on, some participants asked about the latest **24** vs on HIV/AIDS and the lives of gay people and people living with HIV/AIDS. Although participants

seemed to trust the therapist, the lack of knowledge and understanding hampered his ability to master Group Positive Psychotherapy.

#### 4. Discussion

This study examined the sustainability of Group Positive Psychotherapy's effects on improving the resilience of gay people living with HIV/AIDS. Based on the result, Group Positive Psychotherapy significantly improved their resilience by encouraging participants on a daily basis, and the effects lasted for 2 weeks after the intervention.

Group Positive Psychotherapy ran smoothly overall. Participants attended to all the research, and the intervention was conducted in a decent place. The group numbers matched with previous effective interventions, that is, not more than 9 or 10 people (Berg, Landreth, & Kevin, 2013). Following Parks-Sheiner (2009), this intervention offered six sessions for 6 weeks.

According to Ampuni (2005), Indonesian people believe or hope that psychotherapy can address psychological problems briefly and practically. Setiyawati, Blashki, Wraith, Calucci, and Minas (2014) also found that psychologists, as therapists, are expected to treat clients briefly. Ampuni's (2005) invention, however, also proved a constraint in this study's search for candidates. Those who received an offer were not willing to participate because of the high number of meetings (9) within a month. Another obstacle was participants' physical conditions. They were very susceptible to illness so during some sessions, they could not join in to the maximum. According to Nasronudin (2007), these illnesses occurred because of their weakened immunity systems. Moreover, illness is likely to bring on psychological breakdown.

Based on an **23** is of resilience scores from baseline and posttest 2 in the two groups, there was not a significant result,  $p = 0.313$  ( $p > 0.01$ ), meaning that when measurements are not widely separated, they are likely to be the same or similar. According to Tusaie and Dyer (2004), resilience can fluctuate depending on the variety of interaction.

The analysis result **7**o strengthened with the manipulation check. The Mann-Whitney U Test showed  $U = 0.000$ ;  $p < 0.01$ , indicating significant differences between the PPTI scale for the experimental and control groups. This means that the PPTI scale has good construct validity so that it accurately measured the intervention process as a theoretical construction of Group Positive Psychotherapy and showed differences before and after intervention.



The “stand-up” process in Group Positive Psychotherapy, including sharing, discussion, and interaction between therapist and group members, made participants comfortable. The therapist was also able to provide examples from the given materials, express his own experiences, and joke around. This confirms Berg, Landreth, and Kevin (2013) that *mutual* relationship is important for clients because from that relationship, they trust that a cure will be found. Furthermore, Hartman and Zimmeroff (2006) asserted that with the catharsis technique and effective facility, a client can return to a condition of resilience.

In this study, participants had mostly happy thoughts when they shared and talked with other gay people living with HIV/AIDS. They also felt that a support group was built during the process. For instance, one group member told his stories while others supported him. Even outside the intervention process, group members buoyed each other's spirits.

In each session, subjects felt different benefits and had individual impressions. Some received the most benefit in session 2 (“three good things”). More than ever before, they blamed themselves for being gay with HIV/AIDS, but after session 2, they felt gratitude for their lives. This is consistent with Seligman, Rashid, and Parks (2006) who said that through the exercises, group members would find three good things to neutralize their negative emotions and to encourage them to be grateful.

To start sessions, the therapist provided exercises for relaxation, which was also part of session 6 (“savoring”), that is, supporting an individual's positive emotion and life satisfaction (Synder & Lopez, 2009). Participants, impressed with the relaxation process, were then more ready and focused during therapy. Some--Bagus, Mamik, Adit, and William--applied relaxation daily. Additionally, participants also revealed that they planned to focus on the positive and to achieve goals, thus helping them return to a resilient condition.

In this study, participants' perceived benefits certainly differed from the findings of Seligman, Rashid, and Parks (2006), whose Group Positive Psychotherapy with a U.S. student population improved well-being and lower symptoms of depression. In this Indonesian study conducted with gay people living with HIV/AIDS, the sessions “three good things” and “savoring” proved most effective in improving resilience. Other sessions, “using your strengths,” “obituary,” “the gratitude visit,” and “active-constructive responding,” were not perceived as positively. Gay people living with HIV/AIDS still have wounding (unfinished business), including problems in the face of two distinct stigmas (gayness and HIV), so they have trouble undergoing certain sessions. Surely this is contrary to the principles of Positive Psychology,

but it also differentiates this study from studies conducted with healthy participants in the United States. In general, however, Group Positive Psychotherapy had the same effects, making participants able to control their emotions and accept bad events from a positive viewpoint. According to Brownell, Schrank, Jakaite, Larkin, and Slade (2015), accepting negative life events contains potential development, forgiveness, and gratitude.

Group Positive Psychotherapy's effects on resilience can be explained through a mechanism of positive emotion building (Frederickson, Tugade, Waugh, & Larkin, 2003; Harrington, 2013). Positive emotion through Group Positive Psychotherapy can activate neurotransmitters, along with other networks in the human brain (Kringelbach & Berridge, 2010; Salesman & Miskowitz, 2015). It can also support the brain's path of emotion (Davidson, Jackson, & Kalin, 2000) so that participants easily experience happiness and satisfaction. According to Frederickson, Tugade, Waugh, and Larkin (2003), positive emotion can cause the mind to be flexible toward happiness and satisfaction in life.

This study's result proved that Group Positive Psychotherapy can improve resilience for gay people living with HIV/AIDS, but the study also has weaknesses. The quasi-experimental design has limitations (Shadish, Cook, & Campbell, 2002) in that recounting retroactive history threatens its internal validity. Some study events persuaded research participants like the member of Sawit's family, and Adit who broke up with his boyfriend. As previously mentioned, the time lapse between sessions 5 and 6 seemed to lower both groups' conditions. Another limitation involves the research design, that is, the switching replication design necessary to equalize the two groups (Shadish, Cook, & Campbell, 2002). Finally, one subject could not join the sessions because they were scheduled at the same time as his work. Of all the limitations, the switching replication has supremacy. With this design, research can have high validation based on treatments (Shadish, Cook, & Campbell, 2002). Moreover, the researcher can see the sustainability effects—at least 2 weeks—from the Group Positive Psychotherapy.

## 5. Conclusion

The research result shows that Group Positive Psychotherapy significantly improved the resilience of gay people living with HIV/AIDS, and the therapeutic effect lasted for at least 2 weeks post-intervention. The manipulation check strengthened these effects by revealing significant changes before and after the intervention. For example, after posttest 2, subjects were still focused on their action plans to achieve their goals. Some were able to reach those goals, while others were

still making efforts. Other than that, subjects felt the intervention's benefits, especially from sessions 2 and 6, linked with resilience. Compared with their conditions before the intervention, participants became more grateful, were able to think more positively, and to focus on relationships and goals. In fact, the intervention process itself contributed positively. Inside their groups, participants were happy to be heard, accepted, and appreciated. At the same time, they heard people emphasized, learned from others, and, in opposition to their previous loneliness, gained feelings of togetherness.

**Recommendation.** First, For Research Participants. Through the intervention process, research participants are expected to apply the positive, that is, using the positive potential on a daily basis, focusing more on the positive in themselves and the environment, being grateful for little things, having good relationships with people through active-constructive responses, and having a more positive mindset than before undergoing the intervention.

Second, For the Psychologist. In this study, the Group Positive Psychotherapy therapist did not really understand HIV/AIDS information and the living conditions of gay people and/or people with HIV/AIDS. Because this therapy is so important, the therapist in future interventions should have broad, deep knowledge about HIV/AIDS and the population served.

Third, Society Organization for PLWHA. In this study, Group Positive Psychotherapy improved resilience. Thus, the intervention can be used to prevent psychological breaks in people living with HIV/AIDS, for instance, maladaptive behaviors and lack of self-confidence. This study's results strengthened the importance of groups as spaces for sharing and of Organization X's use of this method with the guidance of a facilitator.

Lastly, For the Next Researcher. In this study, participants' conditions seemed to worsen when the session ended, especially because of sessions being scheduled at too-long intervals. Thus, the next intervention of Group Positive Psychotherapy should have a firm schedule for the sessions. Relaxation should be used to start the intervention process so that participants feel comfortable and are in a "here and now" condition.

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