

# A Vocational Development Group Program for Men Living with HIV/AIDS in Suburban and Small City Areas

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HIV/AIDS has a significant impact on the vocational development of those living with the disease, particularly with regard to unemployment; however, there are still few vocational programs aimed specifically toward the population, particularly outside of major metropolitan areas. This article describes a small-scale, structured, psycho-educational group program that assessed changes in vocational identities, occupational information levels, and perceived employment barriers for HIV-positive men in suburban and small city areas that was piloted in two group iterations. Results on standardized measures indicated favorable changes in vocational identity, occupational information, and perceived employment barriers for many participants. Most participants reported reductions in HIV-specific barriers to employment and increased knowledge of vocational information and services. Practical implications and recommendations for future programs and research are discussed.

*Keywords:* HIV, AIDS, employment, vocational rehabilitation

Human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) is a condition that affects all genders, races, ethnicities, sexual orientations, and communities. While epidemiology and demographics of the disease shifted over the last 30 years to include more women (Centers for Disease Control [CDC], 2013), infection rates for men continue to rise. Men are disproportionately affected by HIV/AIDS, as the ratio of men to women with the disease is almost three to one (CDC, 2013). Men who have sex with men (MSM) are most affected, as this population makes up more than two thirds of all men living with HIV/AIDS and accounts for over half of new HIV/AIDS cases (CDC, 2013). Although men with HIV/AIDS are members of all communities, there are unique implications for men in suburban and small city areas, including a steady rise in AIDS diagnoses in these types of localities (CDC, 2014).

Introduction of highly active antiretroviral therapies in the 1990s led to improved medical treatment for people living with HIV/AIDS (PLWHA); however, employment issues continue to be a concern

(Conyers, 2011; Conyers & Datti, 2008). Like other potentially disabling conditions, HIV/AIDS has significant impact on unemployment and employment loss, with rates of unemployment for PLWHA often exceeding 50% (Dray-Spira et al., 2005; Worthington, O'Brien, Zack, Mckee, & Oliver, 2012). While there are several vocational programs for individuals with various disabilities (e.g., state-federal vocational rehabilitation [VR] services), there remain few HIV-specific programs and limited evidence of effects of vocational counseling for PLWHA (Conyers, 2004; Kohlenberg & Watts, 2003). Given this, further development and implementation of HIV-specific vocational programs is necessary to better address their unique vocational needs.

While many PLWHA are able to and interested in work, health and medication issues, stigma, and fear of losing cash (e.g., Supplemental Security Income [SSI], Social Security Disability Income [SSDI]) and health (e.g., Medicare, Medicaid) benefits are some common real and perceived barriers to employment for PLWHA in most areas (Conyers & Datti, 2008; Hergenrather,

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Rhodes, & Clark, 2006; Worthington et al., 2012). In addition to fewer job opportunities and limited availability of vocational services, those in suburban and small city areas tend to have further difficulties, including increased stigma associated with HIV/AIDS, more significant poverty, and inadequate public transportation (Heckman, Somlai, Peters, & Walker, 1998), making pursuit of employment potentially more difficult.

Although policy initiatives for enhancing vocational development of people with disabilities and employment services for PLWHA have become more abundant in recent past, there remains a limited number of programs and studies on the impact of HIV/AIDS and employment (Conyers, 2004; Conyers, 2011). Further, while PLWHA are often eligible for VR (Rehabilitation Services Administration [RSA], n.d.) and other services to assist with vocational development, they tend to be underserved in the vocational service arena (Datti & Conyers, 2010; Datti, Conyers, & Boomer, 2013). The few studies on PLWHA that address VR use, for example, indicate that use rates tend to be less than 30% (Datti et al., 2013). Much like individuals with other illnesses and disabilities, PLWHA are often in need of services to assist them with vocational development (Datti et al., 2013); however, many may either not know about or not consider these services as an option.

For those PLWHA who do access services, many of their unique issues related to employment may go unaddressed or are beyond the scope of competence of many vocational providers (Kohlenberg & Watts, 2003). Moreover, many may not feel comfortable disclosing their HIV status or seeking vocational services from agencies whose providers may not be familiar with HIV/AIDS (Conyers, 2004). PLWHA are often provided medical and other primary services in AIDS Service Organizations (ASOs), and may feel more comfortable receiving services from these types of organizations as opposed to others such as VR (Conyers, 2004; Datti et al., 2013). For the most part, however, ASOs do not have adequate funding or trained personnel to provide vocational services to clientele (Conyers & Datti, 2008; Worthington et al., 2012). PLWHA who are in need of vocational services, yet are uncomfortable with or unaware of services outside of ASOs, may have limited options for such assistance.

Moreover, large and small scale HIV-specific vocational programs tend to be found in large urban areas. A review of the United States Department of Labor's (2012) list of HIV/AIDS service providers that offer employment services shows that each is located in a major metropolitan area. Examples of large scale programs include Positive Resource Center's (PRC)

*Employment Services Program* in San Francisco (PRC, 2014) and Gay Men's Health Crisis (GMHC) *Moving Ahead Toward Career Horizons* program in New York City (2014). Smaller, independent group programs are sparse as well and also tend take place in major metropolitan areas. Examples include Hergenrather et al. (2006), *Windows to Work* program, and Hergenrather, Geishecker, Clark, and Rhodes' (2013) *Helping Overcome Problems Effectively (HOPE)* program, both in Washington, DC. Other similar programs serving a larger number of participants include Kohlenberg and Watts (2003) *Making a Plan (MAP)* program in San Francisco, Kielhofner et al. (2004) *Employment Outcomes Program* in Chicago, Escovitz and Donegan's (2005) *Kirk Employment Empowerment Project (KEEP)* in Philadelphia, and Bedell's (2008) *Multi-Tasking Systems (MTS)* program in New York City.

While the development and implementation of these and other programs is encouraging, there remains a limited number of programs targeting specific vocational needs of PLWHA, particularly in suburban and small city areas. Given this, the authors present a small-scale inexpensive, fairly easy to execute piloted program that can be implemented in a variety of settings. Information is presented here in order to assist counseling and related professionals and researchers in developing and implementing similar programs and studies.

## Program and Method

The program was designed to be a pilot for future programs. Pilot studies are important in formative evaluation of programs and include methods such as pre-testing, seeking feedback, and participant observation to originate data for use in determining appropriateness of program features and plausibility of further implementation (Green & Lewis, 1986; Windsor, Baranowski, Clark, & Cutter, 1984). Overall goals were to gain information, provide assistance, and evaluate the program. It is important to note that a main goal was not for participants to find jobs, but rather to inform, educate, and provide skills for use when or if they wished to pursue vocational endeavors. The program was developed based on past research in the field of HIV/AIDS and employment (e.g., Escovitz & Donegan, 2005; Glenn, Ford, Moore, & Hollar, 2003; Kohlenberg & Watts, 2003) and also served to address unique needs of suburban and small city men.

The program included structured, psycho-educational sessions and assessment of vocational identity, occupational information, and perceived employment barriers. It was hypothesized that participants would experience: (a) positive changes in

vocational identity, (b) increased knowledge occupational information, and (c) reductions in perceived barriers to work. These constructs, as measured in part by My Vocational Situation (MVS; see description below), are described as follows by Holland, Daiger, and Power (1980):

*Vocational identity.* Vocational identity means the possession of a clear and stable picture of one's goals, interests, personality, and talents. This characteristic leads to relatively untroubled decision-making and confidence in one's ability to make good decisions in the face of inevitable environmental ambiguities.

*Occupational information.* [This] category provides the client the opportunity to indicate a need for vocational information, most of which is available in printed [or Internet] form; the counselor can quickly direct the client to the appropriate materials.

*Barriers to employment.* The barriers category invites the client to indicate perceived external obstacles to a chosen occupational goal...[which] may enable the counselor to focus promptly on a significant problem area. (p. 1)

These constructs were targeted in an effort to assist participants in clarifying vocational outlooks and directions as each may be affected by HIV/AIDS status. Vocational identity formation, for example, is important in career development (Savickas, 1985), and can be affected by disabilities and illnesses like HIV/AIDS. Strauser, Lustig, and Uruc (2006) found that individuals with disabilities were more likely to experience lower levels of vocational identity and noted this finding was consistent with past research. Lack of occupational information is also common issue among people with disabilities (Yanchak, Lease, & Strauser, 2005), and perceived barriers tend to be obstacles to employment for many with disabilities and illnesses such as HIV as well (Enright, Conyers, & Szymanski, 1996). Those in suburban or small city areas may be subject to more significant barriers due to remote locales and limited access to jobs and services.

### Participants

Participants included two groups of six HIV-positive men from suburban and small city areas in the Northeast, who were recruited from two separate agencies serving PLWHA on two separate occasions. Needs assessments were sent out to ASO consumers and those who expressed interest were screened and invited to participate. The only criteria for inclusion were an HIV/AIDS diagnosis and being at least 18 years of age. In both instances, no women or transgender individuals expressed interest or were

available for the program. Of the total (N = 12) participants, five indicated they were HIV-positive and seven indicated they had AIDS. Ten were White (non-Latino) and two were African American. Four identified as heterosexual and eight identified as gay. Age range was 37-66 (Mean = 49.25). Two were employed, and the rest were not working at the time of program inceptions. All had worked at some point, and all were at least high school graduates. See Table 1 for demographics.

### Instrumentation

In addition to a demographic form (requesting information on race, ethnicity, age, gender identification, sexual orientation, residential locale, HIV/AIDS status, education, employment status, and income), the MVS was administered at the beginning and end of the programs. The MVS is a 20-item, hand-scored instrument that measures vocational identity, occupational information, and perceived barriers to employment (Holland et al., 1980). It is used in vocational planning with various clientele, including individuals with disabilities, in both individual and group settings (Holland et al., 1980; Strauser et al., 2006; Yanchak, et al., 2005). Eighteen true-false items make up the Vocational Identity subscale, with questions such as, "I am uncertain about occupations I could perform well." The Occupational Information subscale consists of four true/false responses to the item, "I need the following..." (e.g., "More information about employment opportunities"). The Barriers subscale consists of four true/false responses to the item, "I have the following difficulties..." (e.g., "I am uncertain about my ability to finish the necessary education or training"; Holland et al., 1980). In all cases, a higher score is favorable.

Construct validity was established through the initial scale development process. Small to moderate correlations in expected directions between subscales and age, education level, and vocational aspirations were obtained for a sample of 824 individuals in high school, college, and business (Holland et al., 1980). Internal consistency for adult men was high on the Vocational Identity and Occupational Information subscales (.89 and .79 respectively), but lower on the Barriers subscale (.45). Studies on those with disabilities showed similar consistency for the subscales. For example, in Strauser et al. (2006) study on individuals with disabilities and traumatic symptomology, an internal consistency estimate of .87 was found on the Vocational Identity subscale. Similarly, Yanchak et al. (2005) found an internal consistency of .82 in a study of individuals with cognitive and physical disabilities. Also, test-retest reliability for this scale has been shown to be

**Table 1**  
**Participant Demographics**

**Group 1**

Participant	HIV Status	Sexual Orient.	Race	Employment Status	Education Level
1	AIDS	Heterosexual	AA	Unemployed	Trade/Vocational
2	AIDS	Gay	W	Unemployed*	Two Year Degree
3	AIDS	Gay	W	Unemployed	Trade/Vocational
4	HIV+	Gay	W	Employed (FT)	Trade/Vocational
5	AIDS	Gay	W	Unemployed	Four Year Degree
6	HIV+	Gay	W	Employed (PT)	Graduate (current)

**Group 2**

1	AIDS	Gay	W	Unemployed	Some College
2	AIDS	Gay	W	Unemployed	Two Year Degree
3	AIDS	Heterosexual	W	Unemployed	Two Year Degree
4	HIV+	Heterosexual	W	Unemployed	Some College
5	HIV+	Heterosexual	AA	Unemployed	Some College
6	HIV+	Gay	W	Unemployed	Trade/Vocational

Note. AA = African American; W = White; FT = Full-time; PT = Part-time.

\*Group 1 Participant 2 obtained a job during the program but was unemployed at its inception.

moderately high (.75) for periods of one to three months (Lucas, 1999).

Lastly, participants responded to these open-ended questions (OEQs) at the beginning and end of the programs: (1) Considering your HIV status, what do you consider to be your main barriers regarding obtaining or maintaining work? (2) What assistance do you need in order to help overcome those barriers? and (3) What do you know about state-federal vocational rehabilitation services? Questions 1 and 2 were incorporated to augment the limited barrier measures on the MVS for this population. Question 3 was added to augment occupational information measures and because facilitators had interest in measuring VR knowledge levels for this population. In addition, the following OEQs were presented at programs' end to assist with evaluation from participants' perspectives: (4) What was helpful for you in the program? (5) What was not so helpful? and (6) What suggestions do you have to improve the program?

## Procedures

Eight weekly or bi-weekly (depending on weather and scheduling) group sessions occurred on both occasions. Validity of topics was based on past research and through consultation with leading experts in the field of HIV/AIDS and employment (see Table 2 for an outline of sessions). Facilitators were a Certified Rehabilitation Counselor (CRC) and a Licensed Professional Counselor (LPC) who volunteered their time (Group 2 was run solely by the CRC). For both groups, participants were advised that participation was voluntary, had no bearing on services, and that they could drop out at any time without consequence. Confidentiality and informed consent were reviewed, and all participants agreed to participate. Meals were provided in each meeting, and both program iterations were approved by a university Institutional Review Board. Facilitators were awarded a small university grant to provide the second iteration.

**Table 2**  
**Group Session Outline**

Session Number	Description
1	Program description, group norms, confidentiality, informed consent, pre-testing.
2	To work or not to work and why? <sup>1</sup> Potential benefits/pitfalls of working, real and perceived stigma/discrimination, disclosure <sup>2</sup> , reasonable accommodation <sup>3</sup> issues.
3	Overview of SSI/SSDI/Medicare/Medicaid, review of public benefits counseling <sup>4</sup> and VR services <sup>5</sup> .
4	Review of the impact of work on health, medication issues, self-care, stress, and disability management (e.g., what to do if you become too ill to work).
5	Review of members' job skills, experience, training, and interests; demonstration of employment exploration tools (e.g., O*Net vocational data) <sup>6</sup> .
6	Resume building, provision of job seeking and interviewing skills training <sup>7</sup> .
7	Revisit disclosure, accommodations, stigma/discrimination, and topics of interest.
8	Discussion on future planning, provision of follow up support information and referrals, post-testing, program summary, termination.

Note. SSI = Supplemental Security Income; SSDI = Social Security Disability Income; VR = Vocational Rehabilitation

<sup>1</sup> Material used from "Why Work?" by K Escovitz, 2004 <http://www.gmhc.org/health/treatment/ti/ti1803.htm#8>. Copyright 2004 by the Gay Men's Health Crisis.

<sup>2</sup> Material from "Disclosing HIV Status in Employment," by B. Kohlenberg, 2001, <http://www.ctaidscoalition.org/hwpc/article1.htm>.

<sup>3</sup> Material from "Asking for Accommodations Under the ADA" by B. Kohlenberg, 2001, [http://www.bkohlenberg.com/asking\\_for\\_accommodations.htm](http://www.bkohlenberg.com/asking_for_accommodations.htm). Copyright 2001 by Betty Kohlenberg, M.S., CRC, AVEE.

<sup>4</sup> Material from "Returning to Work and Keeping Medicare and Medicaid," and "HIV and Employment: A Return to Work Guide." The latter is copyright 2002 by the AIDS Law Project of Pennsylvania.

<sup>5</sup> Material from "Office of Vocational Rehabilitation: What is OVR?" by the Pennsylvania Department of Labor and Industry, 2001, <http://www.dli.state.pa.us/landi/cwp/view.asp?A=128&Q=61197>. Copyright 2001 by the Commonwealth of Pennsylvania.

<sup>6</sup> Information used from "Welcome to O\*NET Online" by U.S. Department of Labor, 2008/2012, <http://online.onetcenter.org/>.

<sup>7</sup> Material adapted from "Vocational Assessment Services, Inc: Rehabilitation Manual," by J. Todd and G. Hubbard, n.d.

## Results

While data did not allow for decisive statistical analysis, descriptive terms are provided for pretest and posttest scores on the MVS along with qualitative information with regards to themes from participant feedback and group facilitator observations. Formative evaluation, to assess short term impact and field test measurements and interventions, was conducted via quantitative and qualitative methods regarding the pretest-posttest design (Green & Lewis, 1986; Windsor et al., 1984) on changes in vocational identity, occupational information, and perceived barriers of participants on the MVS. In addition, facilitators identified, categorized, and connected themes presented by participants on OEQs and throughout the program using multiple review of documents and individual interpretation of findings. Process evaluation, to examine structure and process and to monitor procedures, was conducted via participant observation with facilitators involved in the process and taking notes during or shortly after activities (Heppner, Kivlighan, & Wampold, 1999). Facilitators monitored activities and performed analysis of program process on an ongoing basis, and solicited feedback from participants. Process variables included information presentation format (e.g., verbal, written, and internet), opportunities to hear others' experiences, and hands-on activities (e.g. resume writing, computer use).

### MVS

See Tables 3 for score changes on the Vocational Identity, Occupational Information, and Perceived Barriers scales, respectively. Note that Group 1, Participants 2 and 6 discontinued attending near the end of the program. Participant 2 obtained a job out of state and Participant 6 experienced an increased work and study load. Of the ten who completed both pre- and posttests, five indicated positive changes in vocational identity, eight indicated positive changes in occupational information, and four indicated decreases in barriers to employment.

### OEQs

For OEQ 1, the following barrier themes emerged at pretest: (a) obtaining/maintaining health insurance, (b) ability to function for entire workday, (c) having to hide HIV status, (d) needing time off due to health, (e) inability to cope with increased stress, (f) financial loss, (g) explaining employment gaps, (h) needing frequent bathroom breaks, and (i) working while in school. At posttest, only a, b, c, f, and h emerged again; however, one participant noted the additional barrier of "finding a specific job or work environment." For OEQ 2, the following themes emerged about assistance needed at pretest: (a) uncertain/not sure, (b) job resources, (c)

Table 3

**Changes in Vocational Identity, Occupational Information, and Perceived Barriers to Employment  
as Measured by the MVS**

Participant	Vocational Identity			Occupational Information			Employment Barriers		
	Pretest	Posttest	Change	Pretest	Posttest	Change	Pretest	Posttest	Change
Group 1									
1	4	3	-1	2	3	+1	1	1	0
2	17	N/A		4	N/A		4	N/A	
3	5	14	+9	1	4	+3	4	3	-1
4	5	10	+5	0	4	+4	0	2	+2
5	17	18	+1	1	4	+3	1	3	+2
6	9	NA		4	NA		4	N/A	
Group 2									
1	7	4	-3	0	3	+3	1	1	0
2	10	10	0	0	4	+4	2	3	+1
3	3	6	+3	0	3	+3	2	2	0
4	12	2	-10	2	1	-1	2	2	0
5	9	12	+3	1	2	+1	2	3	+1
6	16	14	-2	1	4	+3	4	4	0

*Note.* Score range for vocational identity is 1-18 with 18 is the highest and most favorable. Score range for occupational information and employment barriers is 1-4 with 4 being the highest and most favorable.

obtaining health insurance, (d) legal assistance, (e) venues for support, and (f) information on Medicare and Social Security. At posttest, only need (d) emerged again; however, one participant noted that more education about VR would help, one noted that counseling would help, and one noted that he needed “more faith.” For OEQ 3 (VR knowledge) at pretest, six participants responded they knew “nothing,” three responded they knew “very little,” and three indicated that they help people with educational and/or employment goals. At posttest, all participants reported VR knowledge, including about the services they provide and how to contact them.

A process variable reported as effective was information presentation and its formats (e.g., verbal, written, and internet). Participants advised they preferred provision of information from facilitators in all forms as opposed to generating/researching on their own. Most members actively took notes as information was provided. In response to OEQ 4 (What was helpful for you in the program?), a common theme included information provision, particularly about Social Security benefits and job resources. For example, one participant offered the following: “For years I thought I couldn’t return to work without losing my [SSDI]

checks. But now that I have the information, I found that not only can I go back to work and keep the benefits I need, but the procedure is pretty easy...I am starting my job next month.” In fact, all but one participant noted that the information on Social Security benefits was especially helpful. Further, another noted, “The tangible resources are excellent. I can use them now or in the future. I am the kind of person that likes to gather as much information as possible in case I ever need it.”

Another process reported as helpful during the program and at posttest was the opportunity to hear others’ experiences. During each group, participants were encouraged to share employment-related experiences. Many did so, and many stated during the program and at posttest that it was quite helpful. For example, one participant noted that it was helpful “being around other people like myself...it was like a support group.” The only thing noted as “not so helpful” in the program at posttest (OEQ 5) was the interviewing skills portion (reported by a participant planning self-employment). Also, one participant indicated that he believed the resume writing workshop needed to be longer. In terms of program improvement (OEQ 6), four participants noted no suggestions, one

suggested “more information on writing a [business] plan,” (reported by the participant planning self-employment), and two suggested guest speakers from VR and/or Social Security. Lastly, one participant suggested the program be longer, and two suggested providing actual job placement services.

## Discussion

The goal of this pilot program and study was to provide and evaluate a small-scale vocational program for PLWHA in suburban and small city areas, including measuring changes in vocational identity, occupational information, and perceived barriers to employment. Positive changes in these areas are believed to elicit better vocational outlooks and directions for this and related clientele. In addition, evaluation of such programs is important for the counseling and related fields to add to literature regarding vocational issues for PLWHA. Findings make contributions to better understanding vocational development needs of suburban and small city men with HIV/AIDS. In particular, it highlights that a closed, structured psycho-educational group program can have a positive impact on vocational identities, occupational information levels, and perceived barriers to employment for this population.

Facilitators hypothesized that the program would elicit positive changes in vocational identity, which was evident by increased posttest scores for all completers in Group 1. Interestingly, only half of Group 2's scores increased. While reductions for the two groups were nominal, participant 3's score reduced by ten points; however, that participant was in the midst of legal issues, as such it is possible that they affected his vocational outlook thereby affecting his vocational identity. For those who experienced an increase, it suggests they may have gained clearer and more stable pictures of their vocational interests and goals, and increased confidence in making good decisions in the face of ambiguities (Holland et al., 1980). These findings are reflective of and enhance those of similar programs and studies. For example, while not specifically measuring vocational identity, Kohlenberg and Watts' (2003) found that their cycled eight-week group program was effective in assisting their sample ( $N = 67$ ) with increasing knowledge of job skills, lowering anxiety, and reducing perceived need for career planning assistance. Similarly, Hergenrather et al. (2006) found that their nine-week program using Community-Based Participatory Research and Photovoice was helpful in assisting participants ( $N = 11$ ) to identify and develop personal action plans. Also, Hergenrather et al. (2013) found similar results using their *HOPE* intervention. Their seven-week group

program assisted seven African American gay men in developing goal-setting and problem-solving skills, health-promoting behaviors, and job seeking skills.

Results also support the hypothesis that participants would increase their knowledge of occupational information, including about VR. All program completers in Group 1 and all but two in Group 2 reported positive changes on the MVS. Specific negative-to-positive changes included the need for information on how to find a job in chosen careers and need for information about employment opportunities. More-favorable score changes for Group 1 may be related to the more suburban setting as compared to Group 2. That is, they may have started with lower levels of occupational information, thus perhaps increasing their knowledge more significantly. In terms of VR, most participants gained knowledge about these services as a result of the program. At the beginning of the program, only one participant in Group 1 and two in Group 2 reported any specific knowledge of VR; however, in the end, all participants reported knowledge. Pretest findings are similar to those of other studies encompassing PLWHA and use of VR services (e.g., Conyers & Datti, 2008, Datti & Conyers, 2010; Hergenrather Rhodes, & Clark, 2004). Posttest findings have important implications for participants' future use of these services, which are geared toward assisting individuals with disabilities to obtain and maintain employment. In fact, three participants reported intent to pursue VR services at the end of the group, and the participant who was already enrolled advised he would continue with his services.

Regarding perceived barriers as measured by the MVS, of those completing the program, four reported a reduction (two in each group) and five reported no change. In addition, many initially listed HIV-specific barriers did not re-emerge at posttest. Participants did not note time off due health, inability to cope with stress, explaining work gaps, or frequent bathroom breaks as barriers; thus suggesting that information provided about disability management, resume and interviewing skills, and reasonable accommodation may have helped to alleviate some of these concerns. These results again reflect Kohlenberg and Watts (2003), who found that their program was associated with positive changes in perception of employment barriers. In addition, using a pretest-posttest design, Bedell (2008) found a significant improvement in participants' ( $N = 53$ ) perceptions of their ability to work, as well as increases with perceived ability to balance health, work, and daily life. Further, at posttest, participants did not report that obtaining health insurance, needing job resources, having venues for support, or having information on Medicare and Social Security were needed for overcoming barriers; thus suggesting that provision of information on these topics may have been

helpful in addressing such barriers.

Qualitative observations, analysis of program processes, and participant feedback supported the positive effects and evaluation of the program. This information is beneficial for practitioners and researchers of future similar programs who may want to consider such programs in efforts to assist clientele. Results also indicate that the program can elicit progress toward obtaining vocational goals, as some participants moved forward with vocational planning. In addition to those pursuing VR, two participants signed up for Social Security benefits counseling to determine how return-to-work may affect their benefits and one participant located and obtained a job during the program.

### Limitations

Caution should be exercised when considering these findings especially in the broader context of HIV/AIDS and employment programs and research. External validity is limited since they are based on a small sample of men with HIV/AIDS from suburban and small city areas, and data was not extensive enough to allow for decisive statistical analysis. The sample does not include those from major urban areas and does not represent the current demographics of men with HIV/AIDS. Also, participants were identified through agencies and expressed interest in the program; thus the sample was one of convenience. While convenience samples can provide useful information, especially for pilot studies (Simon, 2002), many demographics were not represented, including women, transgender individuals, and Latinos, each of which is becoming increasingly affected by the disease (Baral, Poteat, Stromdahl, Guadamuz, & Beyrer, 2013; Conyers & Datti, 2008; Datti et al., 2013). Regarding instrumentation, while the MVS is an appropriate instrument for measuring vocational identity, occupational information, and perceived barriers for several groups, including individuals with disabilities (Strauser et al., 2006; Yanchak, et al., 2005), the instrument does not directly address HIV-related employment barriers. Although participants in our program were asked to provide HIV-specific barriers via OEQs, those expressed may not be objectively valid and were not measured psychometrically. Further, we used self-report only, including on HIV-related barriers, knowledge of VR, and evaluation of the program. While self-reported information pertaining to the first two topics was supported by other studies (e.g., Datti et al., 2012; Hergenrather et al., 2004; Kohlenberg & Watts, 2003) and the latter supported by direct observation by the investigators, the information reflected issues as reported by the participants only and involved no other forms of measure.

### Implications for Practice

This program and study featured a population in which vocational development needs tend to go under-addressed. This is in part due to limited vocational service provision in HIV/AIDS community agencies. Because of the possibility of increased comfort in these environments and that stigma about HIV/AIDS may be higher in suburban and small city areas, increased provision of vocational services in such agencies and areas could be beneficial to assist many more individuals. Limited funding for these services in legislation (Conyers, 2011; Conyers & Datti, 2008) is a major deterrent for many agencies. Continuing to conduct and document programs such as the one described here may foster advocacy for more programs in community agencies and result in more funding for these needed services. In light of the recently implemented National HIV/AIDS Strategy, which has some focus on employment issues for PLWHA (Conyers & Boomer, 2014), the time is ripe to continue advocacy efforts to increase these needed services for a population who has historically been underserved (Datti et al., 2013).

Further, since ASOs and other agency staff are may be ill-equipped to handle HIV-positive clients' vocational needs, these organizations may benefit from guidance with services (Conyers, 2004; Kohlenberg & Watts, 2003). For this program's first iteration, the primary investigator provided qualified staff with comprehensive training and prepared a program manual for the agency for program repetition as needed. This can prove to be a cost-effective practice for integrating vocational services into ASOs and other agencies. While in this instance the primary facilitator was a CRC who volunteered time, other qualified CRCs or vocational professionals may be willing to do the same as part of pro-bono service endeavors or at affordable fees. Other possibilities include working with local universities with counseling and related programs that may have qualified faculty members willing to provide these services or to coordinate such experiences for their graduate interns or practicum students.

In addition, VR services can be a viable option for many PLWHA in need of vocational services (Conyers & Datti, 2008, Datti et al., 2013; Hergenrather et al., 2004). They tend to increase chances of successful employment for those who are eligible and use the services (Hayward & Schmidt-Davis, 2003), and can play an important role in health and prevention strategies for PLWHA (Conyers & Boomer, 2014). Similar to other studies, however, few participants had knowledge about these services. It is possible that limited outreach is a factor related to limited awareness by many PLWHA in general, which may be even more problematic for those in suburban and small city areas.

Increased provision of outreach and information to those in these areas seems warranted. Conyers and Datti (2008) suggest that VR professionals reach out to ASOs and related agencies and develop networks for clients to obtain information and access VR, and Misrok (2014) suggests that ASOs reach out to VR agencies to provide trainings on HIV-specific issues. These seem like viable and low cost ways of increasing knowledge of VR services for ASOs and vice-versa.

### Future Research

Repetition of this program and study, including with a larger sample may be helpful. Although the program is meant to be delivered in a small group counseling format, which does not allow for many participants at once, it may be beneficial to offer the program on a continuous basis while collecting data with each installment. Kohlenberg and Watts (2003) did this with their MAP program, serving 67 PLWHA and collecting data in several inceptions over a period of 15 months, as did Bedell (2008), whose program served 53 PLWHA over the course of two years in several iterations. This practice not only allows for a larger statistical sample, but also may allow for a more representative sample of PLWHA while at the same time providing needed services. Also, it is recommended that this program and study be repeated to include a cost-benefit analysis in terms of its long-term usefulness. By determining on a larger scale how benefits of programs may outweigh costs of execution, practitioners and researchers may be in a better position to advocate for more programs geared toward vocational needs of PLWHA. With this practice, practitioners and researchers can determine, on a more macro level, individuals' employment statuses, health conditions, and levels of use of SSI or SSDI, as well as further determine changes in vocational identity, occupational information, and perceived barriers after an extended period of time following programs completion.

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