



Published in final edited form as:

Qual Res Psychol. 2012 ; 9(2): 173–187. doi:10.1080/14780887.2010.500350.

Support group processes: Perspectives from HIV-infected women in South Africa

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Abstract

This study examined the experiences and perceived benefits of support group participation among HIV-infected women in South Africa. From a qualitative analysis of responses, key psychological processes through which support groups are potentially beneficial were identified. These processes included: identification; modeling; acceptance; and empowerment. The participants' consequent life changes were explored in order to associate these processes with the positive outcomes of support group participation. Through understanding the relationship between the psychological processes within a support group setting and the potential benefits, and by targeting these processes in the development and implementation of future support group interventions, a framework is provided for achieving positive outcomes associated with support group participation.

Keywords

SUPPORT GROUP INTERVENTIONS; HIV AND AIDS; PSYCHOLOGICAL PROCESSES; AFRICAN WOMEN

On International Women's Day, March 8, 2004, the secretary-general of the United Nations at the time, Kofi Annan, expressed his concern on how women are increasingly bearing the brunt of the HIV epidemic (Gross, 2004). This is clearly illustrated in South Africa where women account for an estimated 59% of adults living with HIV (UNAIDS, 2008). The risk of infection for women between the ages of 20 and 29 is almost six times that of males in the same age group (Rehle, Shisana, Pillay, Zuma, Puren, Parker et al., 2007). The South African Department of Health (2007) reported that 29.1% of all pregnant women are infected with the virus. Psychosocial support is a significant and unmet need among women living with HIV (Moultrie and Kleintjies, 2006). Previous research has confirmed a wide range of positive outcomes associated with psychosocial interventions (Angelino, 2002; El-Sadr, 2001; Kalichman et al., 1996; Summer et al., 2000). There is, however, a need to develop a better understanding of the processes involved during such interventions, so as to guide and inform their development and implementation in the future. With the continual improvement of prevention of mother-to-child transmission (PMTCT) programs (World Health Organisation, 2004), women in developing countries are increasingly discovering

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their HIV status during pregnancy (Dabis et al., 2000), making pregnancy a logical entry point for psychosocial intervention.

Feelings of sadness, worry, despair and confusion are among the assorted reactions to HIV that women often experience, and these emotions are often compounded by several other affective, cognitive and behavioral responses (Kalichman, 1995). Factors such as stigmatization, diminished social support, depression and anxiety, along with stressors such as poverty and violence, all interact to present a complex picture for people living with HIV and AIDS (Mdlalose, 2006; Serovich, Kimberly, Mosack, and Lewis, 2001; Skinner and Mfecane, 2004; Tshabalala, 2009). For women living with HIV in many countries around the world, the added burden of culturally defined roles amplifies their predicament. Women in Africa, especially, continue to experience a culture of inequality, despite the work that is being done to reverse this trend. These women are expected to be responsible for childcare, housekeeping and the health of their families (Bennett, 1990), and often their own needs are neglected, not only by their families, but also by themselves (Broun, 1999). With the continuing improvement and availability of HIV treatment, people infected with the virus are now living longer (Treisman and Kaplin, 2002), and an HIV-positive diagnosis is no longer the death sentence it was previously perceived to be (Gosling, 2008). HIV-positive women, particularly in Africa, however, continue to face the prospect of a chronic, potentially debilitating disease, and early death, despite the advances in treatment, because only a small number already receive antiretroviral treatment (ART). In addition, they face the challenge of coping with the emotional implications of living with the virus, often without adequate support.

Despite the need for psychosocial support, the work and research done in attempts to stem the tide of the epidemic in Africa have largely been focused on prevention and medical treatment. There has been less emphasis on the development and provision of care and support interventions for those infected with HIV (Amon, 2002; Skinner and Mfecane, 2004). The research conducted internationally in this regard, however, has regularly pointed towards the implementation of support groups as an effective intervention strategy. In fact, support groups have become the most common social intervention strategy used to deal with the variety of emotional consequences of HIV and AIDS over the past two decades (Beckett and Rutan, 1990; Fawzy, Namir, and Wolcott, 1989; Kalichman, Sikkema, and Somlai, 1996; Martin, Riopelle, Steckart, Geshke, and Lin, 2001; Nokes, Chew, and Altman, 2003; Spector and Conklin, 1987; Wallach, 2007).

There has been ample research confirming the positive effects of support groups for HIV-infected individuals, such as increasing long-term coping skills (Hedge and Glover, 1990), decreasing emotional stress (Kalichman et al., 1996), improving quality of life (Nunes, Raymond, Nickolas, Leuner, and Webster, 1995), and reducing sexual risk behaviors (Martin et al., 2001). Qualitative research conducted by Kalichman et al. (1996), in the United States, found that participants in support groups felt that the most common benefits of attending a support group include: relief from being alone; being able to share feelings; being able to obtain information on treatments and approaches to care; and being able to have questions answered. It has also been shown that people attending support groups are more likely to disclose their HIV status than those who do not attend support groups (Kalichman et al., 1996). Support groups provide HIV-positive people with a safe environment to talk about HIV, share their experiences and listen to the stories of others who are in a similar position (Summers et al., 2000). They are able to learn from one another's experiences and provide one another with the support they lack from family and friends within their community.

In South Africa, informal support groups are developing as a popular support structure for HIV-infected women, due to the lack of professional help and psychosocial interventions to assist the large number of women diagnosed HIV positive. A comprehensive literature search suggests, however, that there has been no research attempting to investigate HIV-infected women's experiences and perceived benefits of participating in support groups, or the psychological processes that might contribute to positive outcomes. Understanding the psychological processes that contribute to the desired outcomes in support groups can contribute to improving the effectiveness of similar interventions in the future.

Study Purpose

This study was conducted to complement research undertaken in which the impact of a support group intervention for HIV-infected pregnant women was quantitatively assessed (Mundell, 2006). While that research demonstrated some of the psychosocial benefits of support group interventions, the purpose of this study is to examine the psychological processes through which support groups are potentially beneficial. According to Needleman and Needleman (1996), "many important intervention research questions cannot be answered satisfactorily by measuring and counting, no matter how precise and intricate the data collection and analysis" (p. 329). The impact of an intervention is essentially a matter of individual perception (Jennings, 1991), and therefore positive and meaningful change from a participant's perspective may not be apparent in statistical analysis (Sandelowski, 1996), but may contribute substantially to an understanding of the processes and benefits of the intervention. A study using qualitative research methods to enhance understanding of the experiences and perceived benefits of South African women participating in HIV support groups, and the related processes, could potentially contribute to the improved development and implementation of future interventions.

Method

Participant recruitment

HIV-infected pregnant women attending antenatal care at four clinics in Tshwane, South Africa, were recruited into the research by voluntary counseling and testing (VCT) counselors in the clinics. The clinics are situated in two townships, Atteridgeville and Mamelodi, and provide services to a mainly Black, very low to middle socio-economic class urban population. The estimated prevalence of HIV in childbearing women in these communities is 33.8% (Kalafong Hospital, 2006). The counselors informed the women about the intervention during their initial interview in the Serithi Project¹, and those who were interested in participating voluntarily were invited to join the group. Of the 361 women interviewed, 144 (40%) women agreed to participate in the intervention. Women who declined the invitation primarily listed time restraints due to employment or staying too far from the hospital as reasons for not participating in the groups. Informed consent was obtained prior to support group participation. Participants were informed that they would be reimbursed for travel expenses to attend the groups, about the potential benefits of participation (knowledge and skills to assist them in coping with their HIV-infection), and that they may at any stage terminate their involvement in the project. Institutional review board approval for the study was obtained from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, South Africa and the Human Investigation Committee of Yale University School of Medicine, USA.

¹The Serithi Project (NIH R24HD43558) was done in two phases. Phase 1 aimed at developing an understanding of the experiences of women who tested HIV-positive at antenatal clinics in townships in Tshwane, South Africa. In phase 2, this understanding was used to develop a support group intervention.

Support group intervention

Women attended a 10-session program during their pregnancy. The program was developed using action research (Visser et al., 2005), and was designed to address the needs of HIV-infected women, which were identified through interviews with 317 HIV positive women during phase 1 of the Serithi Project. Sessions were outlined and implemented in two pilot groups with HIV-infected women not participating in the Serithi Project, but from the same communities. Thereafter, the feedback from the group facilitators and female participants was used to refine the content of the program. The finalized intervention (which forms the focus of the current study) involved women from phase 2 of the Serithi Project. During the development of the intervention, a facilitator manual was compiled, and this provides detailed descriptions of each session, consisting of a session outline, explanations of exercises, conversation points that should be covered during each session, and background information on each session for the facilitator. Sessions are semi-structured so as to encourage group participation and experiential learning through games, role-plays, exercises, story telling, case studies and the sharing of experiences, feelings and ideas. The focus of each of the ten sessions is displayed in Table 1. Over a period of 18 months, 15 support groups were implemented, involving 144 HIV-infected women. The groups involved approximately ten participants per group, with a mean attendance of approximately five of the ten sessions.

Training and Supervision of Facilitators

The groups were facilitated by six Masters level psychology students from the University of Pretoria, with the assistance of four HIV-positive women (two each from the Atteridgeville and Mamelodi townships), who were trained as co-facilitators. The co-facilitator, who was fluent in both English and the local languages, acted as translator in the group when the women could not understand or wanted to express themselves in their vernacular (mostly Sepedi). The co-facilitator also provided a 'role-model' figure for the group members. All facilitators took part in a training workshop, dealing with HIV and AIDS knowledge, counseling and group facilitation skills, how to implement the sessions, the ethics involved in working with HIV-positive women in a group setting, and practiced in role-play group sessions. During the implementation of the program, the facilitators were supervised by the project leaders. Debriefing sessions were held after each support group session, for reporting on and dealing with issues from the session and discussing the following weeks' session material.

Qualitative data collection

Following the completion of the intervention and approximately three months after the birth of their infants, participants took part in a structured individual interview. Additional to quantitative data collected, described by Mundell (2006), open questions were posed regarding the women's experiences during the group intervention and how their lives had changed since involvement. During this follow-up, the women were also asked about the expectations they had prior to their participation in the intervention. While the women's expectations were also informally discussed during the first session of the intervention, data on the participant's expectations were only formally collected post-intervention, which may have influenced the women's responses. Research assistants, fluent in English and the local languages, conducted the interviews in the women's vernacular and tape-recorded the interviews with the participants' consent. A second interview was then conducted approximately nine months after the birth of the baby. In this follow-up interview, the women were questioned on their well-being since their participation in the intervention, and on how their lives had changed. Interviews were conducted at three and nine-months post-partum because these were the times women had follow-up appointments at the clinics for the immunization of their babies.

Data Analysis

Interview transcripts from the three and nine-month follow-up interviews were translated into English and transcribed. To control for errors in translation (Drennan, Levett and Swartz, 2004), two research assistants, fluent in English and the local languages, worked together in translating and electronically transcribing the data. The data were then imported into QRS N6 qualitative data analysis software, for coding and thematic analysis (Braun and Clarke, 2006). The primary method of analysis utilized for this study was content analysis (Weber, 1990), in which data were systematically analyzed and organized into themes and sub-themes. The analysis was supported by some methods of grounded theory (Glaser and Strauss, 1980), in which theories were developed from the data through the systematic exploration and discovery of themes, categories and interrelationships. Selective coding (Glaser and Strauss, 1980) was also used, with participants' psychological processes being the pre-determined core category. The data were initially sorted into a coding schema, and then inductively analyzed to identify themes and sub-themes, with the primary aim of identifying the psychological processes involved in support group participation. Data was analyzed independently by two researchers who discussed their findings and resolved differences in interpretation through consensus. The use of two researchers to interpret the data independently has been shown to contribute to the trustworthiness of results (De Vos, Strydom, Fouché and Delpont, 2002).

In the attempt to identify these processes, it was important to examine the participants' *expectations prior to their involvement* in the intervention, which were likely to have an effect on an individual's experience of the intervention. The *psychological processes* were then identified through a thorough inductive analysis of the participants' experiences of the intervention, their perceived benefits, and their experience of interacting with other HIV-infected women. These processes were subsequently linked to the outcomes of the intervention by examining the women's responses on *how their lives had changed* after their participation, specifically at nine-month follow-up. It was also important to link the identified psychological processes to previous research on support group interventions, and literature on group therapy in general, so as to provide a firmer platform from which to make sense of the results.

Results

Participants

A total of 144 pregnant HIV-infected women took part in the support group intervention. The mean age of the group was 27.13 years, ranging from 16 to 39 years. All of the women were black, mostly Sepedi (41%) and Zulu (19.4%) speakers, coming from low socio-economic status. The women's average per capita income was ZAR 326 per month (approximately US\$ 32), with the majority of participants (77.1%) being unemployed. The majority of women (75%) had secondary school education, while 13% had some training after school and 12% had no or only primary school education. Only 23 (16%) of the participants were married, and 19 (13.2%) were without partners. The remaining 102 (70.9%) women were unmarried, with a partner.

The majority of the women (n=119, 82.9%) had tested HIV-positive for the first time during the current pregnancy and knew their HIV-status for an average of four weeks before they joined the groups. Seventy-one percent of the women had disclosed their HIV-status to at least one person, mostly their partners or their mothers, when they joined the support groups. Of the 144 women that took part in the intervention, 125 (87%) returned for the interview at 3-months post-delivery and 115 (80%) returned at 9-months post-delivery.

Expectations prior to their involvement

During the three-month post-delivery interview, participants were asked to recount what their expectations had been, prior to them joining the support group. The participants' responses were categorized into four sub-themes.

- The most common theme was the women's expectation for *support*, and a stigma-free environment where they could feel free to share their experiences, talk about their problems and escape stigmatization from the community. One participant, for example, responded that she expected "to receive support from some people who are HIV-positive and [they] are not going to mock each other."
- Another frequently identified theme was the expectation of receiving *advice* related to disclosure, living positively, and learning about coping with HIV infection. Others anticipated being able to "advise each other and share [their] problems and find solutions to these problems for one another," showing a good understanding of the mutually supportive environment that exists within a support group.
- Although less frequent than the previous two themes, another common response given was related to the expectation of new HIV-related *knowledge*.
- A few participants had *negative expectations*, such as anxiety around the possibility of meeting people they knew, reinforcing their fear of stigmatization, and meeting ill people, reinforcing their negative image of HIV and AIDS. There was also some concern "about the kinds of questions [they] will be asked."
- Other less frequent expectations included: giving health talks to people around the community; publicly disclosing; making house-visits or helping sick people in the hospital, receiving food and monetary donations; and taking part in counseling sessions.

Psychological processes

From the analysis of the participants' experiences in the intervention, four integral psychological processes, central to the overall impact, were identified.

- The first of these was *identification*, which took place through interaction with others "in the same situation"; sharing of ideas and the experience of companionship and support. The women experienced this process through the realization that they were not alone and that others have similar experiences. One woman commented, for example: "I made friends and seeing those women I realized that I was not the only one, it gave me courage and confidence to live my life." Another woman said "the support group helped me to open-up freely about my personal problems" which helped the women to regain their self-esteem and a sense of mental well-being, described by a woman as follows: "it brought happiness to my life."
- The second process identified was *modeling*. Participants were able to view the other women in the group as role models. They were, for example, positively influenced by the strengths and behavior of the women who had been living with HIV for a longer period than themselves: "I observed how the other women in the group talked so openly and freely, and I then also decided to try and be like them." In addition, participants gained perspective through their interaction with the other women, realizing that there are others who have much bigger problems than themselves. One woman commented: "I learned that I should be strong as there is someone else who is stronger, and is facing bigger problems than me."

- Another important process is the movement towards *acceptance* of their HIV infection. Participants mentioned that they felt comfortable and supported in the group, which helped them to explore fundamental issues such as their HIV status. The group interaction and acceptance in the group helped women to accept their HIV status, which is a psychological process that is critical to all people living with HIV. Acceptance of their status helped some women to disclose their status and to appreciate life more: “My mind has been renewed, and I now feel like I have a new life.” Acceptance of status is important in the attainment of a sense of empowerment, which is the final process that was identified.
- *Empowerment* was mentioned by a large number of participants as the most important gain from their involvement in the intervention. The women, for example, stated that they had benefited by giving other women advice, which had made them feel more empowered. The knowledge that they had gained during their participation was also an important part of this empowering process. The knowledge not only gave them a better sense of insight into their situation, but also empowered them to make positive changes in their lives, such as changes related to their sexual behavior and nutritional habits. One of the participants stated that before her involvement, she “did not like to use condoms but through the support group [she] realized that [she] need[s] to use a condom so [she] can live longer.” Participants described how they had become empowered through lessons they had learnt and skills acquired. Many of the women felt the group prepared them for disclosing their status. They also learnt how to deal with stress and the “importance of talking to somebody when [they are] stressed.” Finally, they also had become empowered to take control of their lives, and make positive changes to their living situations.

How their lives have changed

The participants’ responses at the 9-month follow-up revealed valuable information on how their lives had been directly impacted by their involvement in the support groups. Five areas of change were identified. The first area of change (mental well-being) confirms the strong relationship that exists between the above four psychological processes and group intervention outcomes, with a number of clear connections identified. The remaining four areas of change, while still very much linked to the identified processes, demonstrate the far-reaching and ongoing benefits of support group participation:

- Participants reported a number of changes related to their *mental well-being*, which were very closely linked to the psychological processes. A large number of the women commented on how they were far less stressed, since their participation in the groups, and that they no longer “constantly worry about having the virus.” One participant commented: “I was depressed when I joined the group but I am now stress-free.” The participants also felt empowered after their involvement, and felt that their “mind has been renewed,” feeling like they “have a new life”. Another commented: “I know now how to stand on my own.” The support group gave the women hope for life. According to one of the participants, “a lot has changed because initially after I received my status I felt alone, but the support group showed me that I’m not alone.” The women’s lives had also changed, due to the fact that they were able to accept their HIV status. “I learned to focus on other things in my life, and accept the fact that I am living with HIV,” was one participant’s response.
- Women reported *lifestyle changes*, such as changes in eating habits and sexual behavior. For example, the participants “learned not to be promiscuous, and this placed [them] in a better position of living standards.” Following the groups, the

participants understood the importance of condom use and communication about safe sex, with one woman stating, that “if [her] partner does not want to use condoms, then it would be better that [they] discontinue the relationship.”

- Many women reported to have the courage to *disclose* their status to their partners, their family, and to friends, community or church members. They reported that following their involvement in the groups, they felt free to talk about their status.
- Changes in *interpersonal relationships* were also reported, with participants commenting that they are now able to socialize with other people, build new friendships and had learned to share their problems with other people. One participant stated: “My life has changed because I made new friends from the group and I now have a new lease on life, after realizing that being infected is not the end of the world.” A few participants also indicated that they now felt empowered to help other people, such as becoming involved in HIV volunteer work, suggesting an increase in social consciousness.
- The participants also noted how their involvement in the support groups had led to a change in their *parenting*, such as better feeding choices and taking care of their baby’s health. They were also conscious of their relationship with the child, and “not to take out [their] anger on [their] own children.”

Discussion

This research aimed to not only examine the impact of a support group intervention from a qualitative perspective, but more importantly to examine the psychological processes that contribute to positive outcomes in such interventions. The processes identified in this study had a significant impact on the women’s experiences of their participation, and were essential to the outcomes of the intervention. These processes worked both independently and concurrently in the participants’ journey towards successful adjustment to HIV infection, but were not entirely expected by the participants. While all of the women’s expectations seem to have been addressed during the groups (support, advice and knowledge), it did not appear that the women had foreseen the extent to which they would experience the identified psychological processes.

The participants were questioned on their prior expectations *following* their involvement, and their responses, therefore, may have been influenced by their participation. Their expectations were, however, informally discussed during the first session of the intervention, and these responses were closely related to the data collected during the follow-up interviews. It would seem that their expectations were far more passive (primarily focused on receiving information and support) than what was actually experienced during the intervention. When reporting on their experiences, the women frequently identified the role that the other women played, their own responses, and the interactive process in general as contributing to change, in contrast to their more passive expectations. The changes described by the participants also demonstrate a broad and lasting impact of the group intervention. Many of the women continued to provide examples of the changes that were initiated through the identified psychological processes, during the follow-up interview at nine months post-partum. In addition, the women also displayed a number of important changes that speak to their improved abilities to cope with their HIV infection.

While some of the outcomes of the intervention can be directly linked to the psychological processes, other changes were less obvious but still very much dependent on the four identified processes. It is also important to note that some of the changes were specific to the group targeted (pregnant South African HIV-infected women), such as changes in lifestyle and parenting skills. The identified processes that contributed to the intervention outcomes

in this study, however, should be viewed within the broader context of group interventions, and fundamental to the success of such interventions. Although these processes work independently during a participant's involvement, and often long after, it is important that the interactions and relationships between these processes are understood, as it is these interactions and relationships that ultimately contribute to the positive intervention outcomes. It should be noted that while causal relationships may exist between these processes, it is difficult to ascertain the order in which these processes are triggered. Exploring the workings of and interactions between these processes provides valuable insight for the future development and implementation of similar interventions.

Upon joining the group, and through interacting with other infected individuals, participants could identify with people in a similar situation and felt less isolated (Roth and Nelson, 1997). Many participants entered the groups with a variety of needs, feeling isolated and apprehensive, with expectations primarily related to receiving support and advice. From the commencement of their involvement, the participants began to realize that these expectations could potentially be met, experiencing a supportive and encouraging environment, and seeing that they were not the only ones living with these particular difficulties. Within the context of group therapy, this could be described as related to the experience of universality (Yalom, 1995), which brings feelings of hope and the relief of knowing that one is not alone.

While this study does not attempt to assess either the intervention's implementation or outcomes as 'group therapy', similarities can be identified. The psychological processes that were identified in this study are in fact quite closely related to previous work in the field of psychodynamic group analytic theory (Corey, 2000; Yalom, 1995). Together with the development of universality within a group setting, as described by Yalom (1995), the experience of commonality is also one of the central aims of group therapy (Corey, 2000). These important factors of group therapy are closely related to what has been identified in this study as the process of 'identification.' Identifying with others can be understood as the spark that ignites the participant's forward movement, positively influencing and perhaps even instigating the other key processes and potential outcomes. Participants steadily began to build a sense of trust within the group, seeing the other participants as a reliable source of support and encouragement.

The women were also encouraged by the interaction with members of the group who seemed to be coping well with their situation, and began to view these members as role models. Modeling has been identified as the second psychological process. While Yalom (1995) has described imitation of the facilitator's behavior as a key factor in group therapy, this study suggests that the participants more often model the behavior of one another. The HIV-infected co-facilitators played an important role in setting a positive example for the participants, however, the women more regularly made mention of how they had viewed one another as role-models. They learned from one another and modeled themselves on the successful behaviors and attitudes of other participants. This in turn provided a positive example for others in the group to follow.

These first two processes (identification and modeling) are linked by the concept of interaction with "similar others" (Roth and Nelson, 1997), which can contribute to a sense of connectedness, eradicating feelings of isolation, providing encouragement and often different perspectives on their situation. Participants began to develop a sense of hope, courage and optimism for what was still to come. This instillation of hope is also described by Yalom (1995) as central to group therapy, further demonstrating the links between group theory and the psychological processes involved achieving successful intervention outcomes. Participants realized that they still have a life to live, and still have much to look

forward to. Other research has also highlighted the relationship between support group participation and increased feelings of hope (Hays, Chauncey, and Tobey, 1990), and decreased feelings of isolation (Moneyham et al., 1998).

Connectedness to the group and feelings of hope assisted the group members in feeling better about themselves and accepted in the group (Corey, 2000). As trust and openness developed, group members started to explore fundamental issues, which Yalom (1995) terms “existential factors.” This exploration can assist members with the acceptance of difficult realities, such as HIV infection. Acceptance of one’s HIV status, identified as the third psychological process, is one of the major challenges of HIV and AIDS (Ncama, 2007), and is critical for an infected individual to effectively cope with the diagnosis. Active acceptance is an adaptive reaction to an unchangeable situation, which can contribute to a number of positive psychological outcomes (Nakamura & Ulrich, 2005). Participants regularly mentioned how the support group had assisted them with coming to terms with their HIV status, empowering them and giving them hope. The acceptance of their status could therefore be considered active, as opposed to resigning, as it was very much an active and adaptive reaction to their HIV infection, followed by a variety of positive psychosocial outcomes. This process of acceptance, however, appears to be dependent on the two previously mentioned psychological processes and at the same time have a positive reciprocal effect on the continuation of those processes towards empowering the participants to take control of their situation.

Broun (1999) states, “the greatest challenge, yet the one that reaps the most benefit, is empowering women to become activists for their own health care” (p123). Participants’ responses on how their lives had changed since their involvement in the support group demonstrate how they had become empowered (the fourth psychological process), feeling stronger, taking charge of their own health and lifestyle, feeling comfortable to disclose, being motivated to help and educate others and become more socially conscious. The women gained knowledge, which also empowered them, consistent with what Yalom (1995) describes as the imparting of information. According to Beckett and Rutan (1990), support groups can provide individuals who spend much of their time preparing for death, with the empowerment and motivation to work together in trying to learn how to live. This seemed to be very much the case for these participants, who were empowered to live their lives, and not simply anticipate an inevitable death.

Some of the most important goals of group therapy are to increase self-direction, autonomy and responsibility toward oneself and others (Corey, 2000). The participants in the current study were encouraged not only to empower themselves, but also to empower one another. Past research has shown that people living with HIV and AIDS are excellent resources in helping others to cope with the disease (Haney, 1988). Yalom (1995) notes that this sense of “altruism” is a powerful therapeutic tool that can greatly enhance a member’s self-esteem and feeling of self-worth. This interaction between empowering oneself and others, and positively influencing one’s own mental well-being, again portrays the interdependent nature of these four processes. It has also been found that group members will often more readily accept observations or advice from fellow group members, than from a group therapist or facilitator (Yalom, 1995). For an HIV-positive woman, who has been flooded with feelings of helplessness and hopelessness, being given the opportunity to help other women in similar situations through sharing experiences, or giving advice, can often be what is needed to restore a sense of significance and empower her to take control of her own situation.

The qualitative nature of this research made the identification of processes and experienced outcomes of the intervention possible. As outlined in the study purpose, the impact of an

intervention is very much subjective, and largely dependent on individual perception (Jennings, 1991). Qualitative research therefore provides an ideal platform from which to assess the participant's experience of the effect of an intervention and determine the processes through which participants experience these effects. While assessing the impact of an intervention in this way provides an assessment of the impact from the participants perspective, it should be noted that this also presents limitations to the generalizability of findings. Women in resource-poor settings, for example, who do not generally have access to interventions of this kind, may react positively to an intervention merely because they had access to one. The individual's perception of the impact of such an intervention is therefore highly dependent on the context within which it is received. The impact of participating, however, remains very real to that individual, which ultimately is where the priority should be. The psychological processes involved, regardless of context, are constant and therefore invaluable to the attainment of positive intervention outcomes.

Conclusion

In this study, the experiences and consequent life changes of women participating in HIV support groups were explored, with the intention of shedding light on the psychological processes through which support groups are potentially beneficial. The processes that were identified (identification, modeling, acceptance and empowerment) guide the participant, simultaneously and interdependently, on a journey towards a variety of positive outcomes. It is apparent from the participant's responses that they perceived their involvement in the intervention as beneficial on a number of levels. Changes in the participant's lives following their participation, such as improved mental well-being, positive lifestyle changes, and being more comfortable talking about HIV, are associated with the psychological processes identified in this study. There is a notable similarity between the processes identified as part of support groups and some of those identified in group psychotherapy (Corey, 2000; Yalom, 1995). It is essential for future interventions to incorporate activities that could facilitate these four processes to maximize the positive outcomes of support groups.

Interventions should encourage participant interaction, as it is from such interaction that these processes stem. The results of this study also demonstrate how targeted interventions, developed to meet the specific needs of a group, can encourage the processes that were identified. If the needs of the group members were not addressed, these processes may not have been instigated. Interventions should also be designed to be flexible, as all groups, regardless of demographic, dynamic and focus, will differ. In addition, one of the main aims of supportive interventions is to give participants hope, and empower them to take control of their lives and their future. The focus in such groups should therefore not be limited to the past and the present, but should also be looking towards a hopeful future.

Identification, modeling, acceptance and empowerment have been identified as critical processes to the success of support group interventions, specifically in the case of HIV support groups. While the results of this study may be limited to HIV support groups, it is believed that the identified psychological processes are an important factor in most group intervention settings. Further research is required to assess whether these four processes are in fact key to group interventions outside of the field of HIV support groups, however. In addition, future research is also necessary to determine whether the impact of support interventions can be improved by utilizing the knowledge of these processes in their development and implementation.

Due to the wide array of psychosocial needs of HIV infected women (Moultrie and Kleintjies, 2006), it is imperative that support interventions are developed and implemented to enhance their adjustment. The processes identified here have been shown to ultimately

facilitate positive change. Through understanding the relationship between these processes and the potential benefits, and by targeting these processes in the development and implementation of support group interventions, it becomes possible to achieve a variety of positive outcomes associated with support group participation, and in the case of an HIV and AIDS intervention, assist in the successful adjustment to HIV infection.

Acknowledgments

This study was funded by NICHHD grant R24HD43558. The investigators would like to acknowledge the following groups and individuals for valuable contributions to the research: The women who agreed to participate in the support group intervention; The Serithi Project team (R Mkhondo, J Tatane, M Zondo, J Ramodike, R Kgoebane, M Dikolometsa, P Mabota, S Sono, Faith Nkomo, B Moalosi, W Sephiri and A de Villiers); University of Pretoria Masters psychology students; The HIV infected women who assisted with the facilitation of the groups; Tshwane Metro Healthcare Services; MRC Unit for Maternal and Infant Health Care Strategies; and the Center for Interdisciplinary Research on AIDS (CIRA), Yale University.

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Table 1

Support group intervention session outline

Session	Topic
1	Introduction and Orientation
2	HIV and access to Treatment
3	HIV, Pregnancy and Birth
4	The Emotional Experience of having HIV
5	The Emotional Experience of having HIV (continued)
6	HIV, Disclosure and Stigma
7	Coping, Problem Solving, and Stress Management
8	HIV and Relationships
9	HIV in the household, Human Rights and Stigma
10	Life Planning and Goal Setting