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Resilience Takes A Village: Black Women Utilize Support from their Community to Foster Resilience against Multiple Adversities

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Abstract

Black women living with HIV (BWLWH) represent the highest percentage of women with HIV in the U.S. and experience worse health outcomes than other women living with HIV, in part due to experiences of trauma, racism, HIV-stigma, and stressors they face as women. However, their own stories of resilience in the face of multiple adversities and insights of community stakeholders may inform our field on how to best empower this population to strive despite adversities. Thirty BWLWH in the U.S. and fifteen community stakeholders were interviewed about women's experiences and adaptive coping strategies used to cope with trauma, racism, HIV-stigma, and gender-related stressors. Interviews were coded using thematic content analysis. A major theme that spanned across interviews with BWLWH and community stakeholders was that resilience was fostered by members of their "village". In the midst of or following adverse experiences BWLWH used social support from their children, grandchildren, other family members, friends/peers, and caring providers in order to overcome their adversities and focus on their health and well-being. Promoting resilience among BWLWH requires an understanding of the most adaptive strategies utilized to "bounce back" following or in the face of adversities. Our findings highlight that both BWLWH and community stakeholders recognize social support from their "village" as an importance resilience resource. Research and applied efforts need to be geared at strengthening both BWLWH and their "village" in order to promote resilience and reduce health disparities.

Keywords

resilience; Black women; HIV; social support

Introduction

Black women living with HIV (BWLWH) in the U.S. bear a disproportionate burden of the HIV epidemic as they represent 62% of women living with HIV (CDC, 2017). These statistics have been cross-sectionally linked to both structural (e.g. poverty, racism, access to care) and psychosocial factors (e.g. violence and abuse) that may place Black women at

greater risk for HIV and poor health and behavioral outcomes once infected (e.g. lower viral suppression and medication adherence compared to white women) (Bogart, Wagner, Galvan, & Klein, 2010; Dale & Safren, 2017; Kelso et al., 2014; Machtiger, Wilson, Haberer, & Weiss, 2012). However, in the face of and despite these adversities BWLWH may find ways to be resilient (Smith, McCarragher, & Brown, 2015). Resilience conceptualized within a socio-ecological framework, is the ability to cope adaptively (mentally and behaviorally) in the face of adversity and/or to bounce back following adverse experiences by navigating to and negotiating for social, psychological, physical and cultural resources (Ungar, 2013). In this paper we qualitatively examine how social support as a resource promotes resilience among BWLWH in the context of multiple adversities.

Very few studies have explicitly studied resilience among BWLWH (Smith et al., 2015; Stokes, 2013). Among African American women living with HIV over 10 years, Smith and colleagues (2015) qualitatively assessed their resilience in living with an HIV positive status and briefly discussed how women received support from family members, partners, support groups, and agencies. Stokes (2013) found that for midlife African American women with HIV serving as informal kinship caregivers/providers for others may be a source of resilience as well as a source of challenges. In addition, several cross-sectional studies by Dale et al. (2014; 2014, 2015) among samples of majority black women living with HIV, found that higher resilience related to lower depressive symptoms, higher quality of life, undetectable viral load, higher antiretroviral treatment adherence, and lower gender-related coping.

Social support consists of actual and/or perceived emotional, tangible, or informational support (Uchino, 2013) and may be a resilience factor that helps BWLWH to cope adaptively and thrive in the context of multiple adversities. However, the peer-reviewed literature is limited on social support as a resilience factor specifically among BWLWH in the U.S. Nonetheless, a few studies have suggested that it is important to understand. For instance, Logie and colleagues (2014) found that among Black women in Canada higher social support (informational, emotional, tangible, and affectionate) was related to higher resilient coping, lower racial discrimination, lower gender discrimination, and lower HIV-related stigma. Similarly, Onwumere et al. (2002) found that higher social support was related to higher mental health quality of life among Black African women living with HIV in London. In addition, in a sample of Black women living in New York (Simoni, Demas, Mason, Drossman, & Davis, 2000), higher HIV-related social support was associated with higher frequency of HIV disclosure to family, friends, and lovers. Similarly, social support in the form of positive and trusting relationships with providers may have a positive impact on HIV medication adherence among BWLWH in the southern U.S. (DeMoss et al., 2014).

Given the limited literature examining social support as a resilience resource for BWLWH and the few existing literature on social support among BWLWH suggesting that social support may be a resilience resource, qualitative data and analyses are needed to shed greater light on the ways in which social support may be a resilient resource in the lives of BWLWH. It is especially important to understand Black women's resilience in the context of common adversities they face such as trauma/abuse, racial discrimination, HIV-stigma, and gender roles related stressors. The current study presents qualitative findings from

interviews with thirty BWLWH and fifteen community stakeholders (CS) in the U.S. on how BWLWH utilize social support from members of their “village” to foster their resilience.

Methods

Participants

BWLWH and CS were recruited in Boston, MA between June 2015 and December 2016.

In recruiting BWLWH, flyers and posters were distributed at local community health centers and clinics, community-based organizations, and community events. Participants were then screened for eligibility via phone once they called the study research coordinator. To be eligible participants had to meet the following inclusion criteria (1) Identify as Black and/or African American (2) Age 18 or older (3) Biologically female (4) English speaking (5) Prescribed ART for at least the last two months and (6) History of abuse/trauma (i.e., responding “yes” to “During your lifetime have you experienced trauma or abuse?”). Study visits for BWLWH were conducted at the research institution and BWLWH gave informed consent (written) prior to engaging in the study.

In recruiting CS, the principal investigator (PI) /first author initially presented information about the study to members of a HIV community advisory board who then suggested several individuals who were viewed as CS with extensive expertise and experience in providing services and/or advocating on behalf of PLWH (especially BWLWH). Board members contacted the stakeholders and informed them about the study and supplied the PI’s information or connected the community stakeholder with the PI directly (e.g. email, in person). At community events and while giving presentations additional CS were identified. If the stakeholders expressed interest in the study, the PI would then schedule a study visit at a time and location convenient for the stakeholder (e.g. community organization). At study visits the PI gave an overview of the study purpose, procedures, risks and benefits, etc. (accompanied by an handout) and obtained verbal consent from the stakeholders.

All BWLWH who met phone screen eligibility and CS who were approached agreed to participate in the study. Following visit completions BWLWH and CS were given \$25 to reimburse them for their time and efforts. The Institutional Review Board of Partners HealthCare approved all study procedures.

Measures

Black Women Living with HIV

Self-report Sociodemographic Survey: Using Research Electronic Data Capture (REDCap, a secure web-based application; Harris et al., 2009) BWLWH completed a self-report sociodemographic survey. The survey captured information on their age, country of birth, education level, employment status, living situation, number of children, relationship status, sexual orientation, years since HIV diagnosis, years on ART, self-reported ART adherence in the past two week, CD4 count, and viral load.

Semi-structured Interview: Individual, semi-structured interviews (60–90 minutes) asked about the following topics, with follow-up probes as needed: (1) experiences with trauma,

racism, HIV stigma, gender roles expectations, and medication adherence (e.g. “How did/ does that experience affect you?”) and (2) strategies to cope with adversities (“What did you do to cope with what happened?”) and promote medication adherence (What are things that make it easier [or harder] to keep taking your medications?).

Community Stakeholders

Semi-structured Interviews.: Interviews began with the quantitative questions that captured information about the stakeholder’s age, race/ethnicity, gender, level of education and employment position. The interviews then continued with the qualitative interview, including questions about (1) type of organization the stakeholder worked for and programs and services offered by the organization for PLWH and BWLWH, (2) healthy and unhealthy ways the stakeholder has seen BWLWH cope with trauma/abuse, racial discrimination, HIV stigma/discrimination, and gender-related stress. For instance the interviews asked “Based on your experience, what are ways that you have seen Black women who your organization serves cope with the following: trauma/abuse, racial discrimination, HIV stigma/discrimination, gender-related stress”.

Analyses

All interviews with BWLWH and CS were conducted and audio-recorded by a Black female Clinical Psychologist. The Psychologist has over 10 years of experience in conducting qualitative interviews. The psychologist also took brief notes of emerging themes during and following the interviews. A Black bachelor’s level female research assistant transcribed the audios into Microsoft Word. The Clinical Psychologist and a research assistant developed a coding manual for interview themes by independently coding nine participant narratives, noting common themes that emerged, and then arriving at a consensus about the themes together. Themes were defined and accompanied by exemplary quotes in the manual. Using this manual, a research assistant coded the narratives in Microsoft Word and then enter them into NVivo, a qualitative data analyses program (Gibbs, 2002). All coded narratives were reviewed by the Clinical Psychologist.

Results

Thirty women and fifteen CS participated in this study. Sociodemographic characteristics of the women are presented in Table 1 and sociodemographic characteristics of CS are presented in Table 2. Among women, the average age was 46 (range = 33 – 65), the average years since diagnosis was 17 (range = 6 – 30), and 73% had an undetectable HIV viral load. All CS worked in the HIV field for over 5 years and many had worked in the field for several decades. The most represented current job titles among CS were director of services and programs related to HIV/AIDS (n=3), health program and service coordinators (n=3), and medical case manager (n=3). A peer facilitator (n=1), HIV/AIDS educator (n=1), and medical liaison (n=1) were also represented in the sample. Three participants engaged in unpaid HIV advocacy work and served on numerous community advisory boards.

Participants’ job duties largely involved the provision of support for persons living with HIV. This support is provided in multiple ways and takes the form of education, counseling and

conducting research. These job responsibilities were often geared toward improving clients' experiences while using health care services. As such, some job duties aimed to improve the quality of health services through increased communication between health care users and providers, connecting users to resources in the community, encouraging medication adherence and assisting with general navigation of the health care system.

Themes that span across interviews with BWLWH and CS articulated that resilience was fostered by members of their "village". In the midst of or following experiences of their initial HIV diagnosis, trauma, racism, HIV stigma, and gender-related stressors, women used support from their children and grandchildren, other family members, friends and/or peers, partners, and caring providers in order to overcome these adversities and focus on their health and well-being. Also having seen the benefit of social support, CS often emphasized programming that strengthened social support for women. On a few occasions women also received support from people in their communities that they were not previously acquainted with. Quotes that exemplify the themes discussed below are presented in Table 3.

Children and Grandchildren as a Resilience Resource

A common theme that emerged was the support that women received from their children and grandchildren. Some women spoke of the general day to day support from children and grandchildren that enhanced their days (quote [Q] 1). Many of the children that the women referenced were now adults who they were able to lean on (Q2).

Women also sought and received support from their adult children following trauma and later as they continued to process past trauma and loss. For instance, one woman described the support she received from her children (Q3) following an abusive relationship that ended in a break-up and the resulting depression and lack of desire to take her HIV medication. However, their support helped her to pull through. Another woman shared how she reached out to and was supported by her adult daughter when she recalled the abuse she experienced from an ex-partner and the loss of a child (Q4).

Due to the issue of racism and mistrust of law enforcement, women also relied on the support of their children when they needed help that others may have contacted the police for (Q5). The support from children and grandchildren also helped women to cope with their HIV status and past substance use and motivated them to stay healthy. One woman shared how she was scared of disclosing her HIV positive status to her son, but that his response (similar to others in her family) reassured her that they support her (Q6).

Women also talked about how their children were instrumental in encouraging and reminding them to take their HIV medication and in making other health decisions when needed (Q7–9). Women also felt that their children were able to support them and encourage them to take their HIV medication and protect their sexual health during periods of substance use (Q10).

Family Members as a Resilience Resource

While children and grandchildren were often the family members who women talked about receiving support from to strive, women also talked about their mothers, fathers, and

siblings. For instance, two women shared how their mothers supported them through trauma and substance use and was a daily source of social support (Q11–13). Women's sisters also supported them by taking care of their children when needed. For instance, a woman talked about how her sister took care of her son while she worked through some issues (Q14). Support from sisters and brothers also helped women to adhere to their HIV medication. (Q15). Women also viewed social support from multiple family members as especially beneficial following an initial HIV diagnosis (Q16).

Partners as a Resilience Resource

Social support from romantic partners was also a resilience resource that helped women to take care of themselves and have a good quality of life irrespective of living with HIV. One woman shared how her partner supported her choice to be celibate (Q17). Another woman shared how her partner (now deceased) was supportive of her and her children (Q18).

Friends and Peers as a Resilience Resource

Women found social support to foster their resilience not only from their family members and partners, but also from friends and HIV-positive peers both informally and in the context of support groups. For instance, one woman talked about how co-workers called to check on her when she was not at work (Q19). Another woman discussed how she was anxious about disclosing her status to friends for fear that they would share that information with others, but once she disclosed they re-assured her that they would not and they continued to treat her with love (Q20).

Beyond friends and co-workers, women often formed bonds with and received social support from other HIV-positive women. Women and community stakeholders spoke about what it means to have peers who are different from friends yet supportive and nonjudgmental as women cope with living with HIV (Q21–23). Women not only got support in the form of a non-judgemental atmosphere, but genuine affection (Q24). This peer support was seen as especially important when women were newly diagnosed because it helped them to learn how to live adaptively with HIV (Q25). Some women would later become peers who offered support to newly diagnosed women (Q26, CS).

Social support from HIV-positive peers was also seen as a way that women buffered the impacts of HIV-related discrimination/stigma and race-related discrimination, healed from trauma, and learned helpful strategies to cope with stressors (e.g. parenting stress, relationships). Community stakeholders discussed how being together, and having support groups and events to build community is a way to combat the stigma (Q27–28).

According to a community stakeholder, via social support from peers, women also processed racial discrimination experiences (Q29). Support groups with peers also offer women a space to continue to heal from their traumas. One woman described how she calls a peer from a support group when a memory of her childhood trauma is triggered by something she sees (Q30). According to women and community stakeholders, women also obtain support from peers around parenting and various relationships (Q31–32).

Providers as a Resilience Resource

In addition to peers, women also consistently spoke of how various providers – doctors, nurses, case managers, etc. – helped them to optimize their resilience and push forward. Women felt most supported by doctors who are honest, empathic, and non-judgmental and doctors who offer feedback, give praises, and genuinely care about them. One woman described her doctor who embodies many of these qualities and under her care the woman reached an undetectable viral load (Q33).

Women spoke similarly about case managers and advocates who went beyond the call of duty to support the women through hard times and show them genuine affection (Q34).

Women also appreciated providers who took the time to get to know them and their stories, which often led to a stronger alliance and view of the provider as looking out for their best interest (Q35). CS also saw how providing support in the context of a trusting provider-client relationship and non-judgmental environment resulted in an improved sense of self-efficacy for some women (Q36). Social support from providers was also seen as important in fostering resilience immediately following initial HIV diagnosis (Q37) and as instrumental once women were diagnosed and in care and needed support around attending appointments and adhering to medications (Q38–39). For instance, a woman shared how her doctor used humor as a way to help her adhere to her HIV medications when she was getting tired of the medications (Q39).

In addition, women shared how they benefited from the support of providers who helped them to address health issues (mental and physical) beyond HIV (Q40–41). Similarly, CS recognized the need to provide support during moments of distress or mental health symptoms. For instance, one community stakeholder who has been in the field for several decades and currently works for a nonprofit shared how she would immediately support clients who contacted her in need (Q42). Supporting women with social issues that often intersect with living with HIV was also seen as important to helping women thrive. For instance two CS talked about the need to support women with legal issues and disclosure of their HIV status (Q43–44).

Women also discussed how supportive providers often created work environments that were welcoming and allowed for positive interpersonal exchanges that went beyond the medical visit (Q45). Women also described how they appreciate the resources that the clinic/team makes available to patients (i.e. snacks, transportation assistance, and donations) (Q46). For CS, creating a welcoming atmosphere in nonprofits and clinics was also seen as a way to enhance social support that women receive (Q47). CS working in their various organizations/clinics also saw the value of the tangible support and resources that case managers give to women and how it can help women to be resilient. One community stakeholder spoke about her own experience receiving resources as a BWLWH prior to working for the organization she now works for (Q48).

Wider Community as a Resilience Resource

Although not discussed as often, women also talked about a few instances where social support from strangers in their broader community helped them to cope. For instance, one

woman described a moment when she began crying on a bus and three women surrounded her and prayed for her (Q49). Another woman shared how she attempted to give CPR to a white child, whose mother yelled the N word at her. Following that incident she was distraught and went outside where a cab driver approached her and drove her home free of charge (Q50).

A Combination of Resilience Resources

While women often spoke separately about the sources of social support from family, peers/friends, and providers that helped them to be resilient and cope adaptively, these sources of social support likely benefited the women simultaneously. One woman demonstrated this point as she shared how with the support of peers, family, and providers she began taking her HIV medication again after stopping for a period of time (Q51).

Discussion

Our qualitative study examined social support as a resilience resource for BWLWH through interviews conducted with BWLWH and CS with expertise in serving and/or advocating on behalf of BWLWH. Our findings echoed that for BWLWH social support from members of their “village” helped to foster resilience. While the health disparities regarding the prevalence of HIV among Black women in the U.S. are linked to various structural and psychosocial adversities that BWLWH face (Bogart et al., 2010; Dale & Safren, 2017; Kelso et al., 2014; Machtinger et al., 2012), the stories of BWLWH are not simple stories of adversities or disparities, but are also stories of resilience and finding ways to cope and strive against the odds. Very little existing literature has specifically examined resilience among BWLWH (Smith et al., 2015; Stokes, 2013). Additionally, social support may be a resilience resource for BWLWH, but limited literature has explored this in general and even fewer has done so qualitatively (Dale et al., 2017, 2018; Demoss et al., 2014; Logie et al., 2014; Onwumere et al., 2002; Simoni et al., 2000). Our findings here among BWLWH in the U.S. are consistent with existing quantitative literature among BWLWH indicating that social support relates to higher resilience among BWLWH in Canada (Logie et al., 2014), social support relates to higher mental health quality of life among BWLWH in London (Onwumere et al., 2002), and that social support from providers may relate to medication adherence among BWLWH in the U.S. (Simoni et al., 2000)).

In the present study we found that social support from children and grandchildren helped women to enhance their day-to-day quality of life, process past trauma, and feel loved despite HIV-stigma. Children and grandchildren also helped women to adhere to their medication and take care of their health even during times of depression and substance use. Children and grandchildren gave BWLWH not only a reason to push through, but also love and tangible, functional support (e.g. daily reminders) to be resilient. Similar to children, family members including mothers, sisters, and brothers served as resilience resources for BWLWH by providing safe havens from abusive relationships, sheltering and caring for the children of BWLWH as they struggled with various issues, reminding them to take their medication, and loving them even in moments when BWLWH struggled to love themselves. Though talked about less often, partners of BWLWH also helped women to be resilient by

supporting women's decisions around sex/intimacy, having open communication, assisting BWLWH to fulfill the needs of their children, and accepting the women for who they are along with their HIV status.

Though not related by blood or through partnership, social support from friends and HIV-positive peers was viewed as an important resilience resource by both BWLWH and CS. Social support from peers and friends both informally and in support groups gave BWLWH spaces where they could hear and share similar stories of trauma, living healthy with HIV and adhering to their medication, coping with HIV-related discrimination and stigma, dealing with racial discrimination, parenting, and being in relationships. In addition to sharing their stories, in the company of peers BWLWH experienced comfort, non-judgmental attitudes, and love. Similar to peers, providers were also resilient resources for BWLWH. Specifically, provider-client relationships that consisted of honesty, trust, non-judgmental views, positive regard for the women's well-being, and love, appeared to foster resilience for BWLWH in terms of their appointment attendance, medication adherence, addressing other mental and physical health issues, self-efficacy, and self-love. Further providers who created environments that were welcoming, linked BWLWH to tangible resources (such as transportation assistance, housing, and food), and provided support around legal issues, helped women to grow and enhance their resilience. While less talked about in the present study, it is noteworthy that a couple of women spoke about social support that they obtained from people they did not know in their wider community as they coped with distress and racial discrimination.

Limitations, Strengths, and Implications

Given that this sample of BWLWH and CS were from a large metropolitan area in the Northeast United States, the generalizability of our results may be limited in other geographical areas. Nonetheless, strengths of this manuscript includes adding to the sparse existing literature on social support as a resilience resource for BWLWH and highlighting that the resilience of BWLWH can be fostered and enhanced by members of their "village" including children, grandchildren, other family members, partners, friends and peers, providers, and on a few occasions by strangers in their wider community. These findings suggest that research to develop interventions that (a) strengthen members of the village to provide the social support needed to enhance resilience among BWLWH and (b) build upon a women's network of children, grandchildren, partners, friends/peers, providers, and others may be especially beneficial in fostering resilience among BWLWH. This is consistent with a recent publication of a peer intervention for PLWH (Cabral et al., 2018) that showed higher retention in care for those with more face-to-face encounters during the intervention, although the peer intervention had no impact on HIV viral suppression.

Conclusion

In sum pre-existing studies examining social support as a resilience resource among BWLWH are limited, however our qualitative findings from interviews with BWLWH and CS demonstrates that social support is an importance resilience resource that help women to bounce back and strive in the face of various adversities including trauma and HIV stigma. Social support from children, grandchildren, other family members, partners, friends/peers,

and providers helped women to adhere to their HIV medication, feel valued and loved, cope with HIV stigma and racial discrimination, access safe shelter, care for their children, and share their stories, be heard, and encouraged in affirming spaces.

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Table 1.

Sociodemographics and Characteristics of Black Women Living with HIV

Characteristic	Mean (SD, range) or n (%) [*]
Age	46.5 (11.6, 33–65)
Education	
Less than high school diploma	8 (27%)
Completed high school	7 (23%)
Some college	13 (43%)
College degree	1 (3%)
Graduate degree	1 (3%)
Employment Status	
Full-time Work	1 (3%)
Part-time Work	2 (7%)
Full or Part-time School	3 (10%)
Neither Working or in School	9 (30%)
On Disability	20 (67%)
Living Situation	
Lives with Self	14 (47%)
Roommates	1 (3%)
Partner or Spouse	5 (17%)
Children	9 (30%)
Group Home or Residential Treatment	2 (7%)
Other	2 (7%)
Place of Birth	
U.S. Born	26 (87%)
Non-U.S. Born	4 (13%)
Parents of Children	29 (97%)
Number of Children	3.0 (1.4)
Religion	
Religious/Spiritual	28 (93%)
Baptist	8 (27%)
Christian	12 (40%)
Catholic	3 (10%)
Islamic	1 (3%)
Other	4 (13%)
Relationship Status	
Single	15 (50%)
Married	3 (10%)
In a Relationship	4 (13%)
Divorced	5 (17%)
Widow or Loss of Partner	3 (10%)
Sexual Orientation	

Characteristic	Mean (SD, range) or n (%) [*]
Exclusively Heterosexual	19 (63%)
Heterosexual, some Homosexual Experience	6 (20%)
Bisexual	2 (7%)
Chose Not to Answer	3 (10%)
Medical Characteristics	
Years since Diagnosis	17.23 (6.19, 6–30)
Years taking antiretroviral medications	11.7 (7.35, 1–31)
ART Adherence Self-Report	
Excellent	15 (50%)
Very Good	8 (27%)
Good	4 (13%)
Fair	2 (7%)
CD4+ count	695.32 (277.35, 280–1209)
Viral load	
Undetectable	22 (73%)
Detectable	6 (20%)
Don't know	2 (7%)

* Note: Percentages do not equal 100% due to rounding.

Table 2.

Sociodemographics and Characteristics of Community Stakeholders

Characteristic	Mean (SD, range) or n (%) [*]
Age	47.29 (10.73, 27–67)
Race/Ethnicity	
African American or Black	15 (100%)
Latino	2 (13%)
American Indian or Alaska Native	0 (0%)
Asian	0 (0%)
Native Hawaiian or Other Pacific Islander	0 (0%)
White	0 (0%)
Other	0 (0%)
Gender	
Male	4 (27%)
Female	11 (73%)
Education	
Less than high school diploma	0 (0%)
Completed high school/GED	1 (7%)
Some college	5 (33%)
College degree	5 (33%)
Some graduate school	
Graduate degree	4 (27%)

^{*}Note: Percentages do not equal 100% due to rounding.

Table 3.

Quotes from Women and Community Stakeholders

Children and Grandchildren as a Resilience Resource	
1	"We play games on the TV, I take my grandkids to the park. Me and my girls [daughters] we sit we talk and have fun, 'cause all my kids are grown."
2	"I have three kids. They all grown but sometimes I just lean on them."
3	"When he hurted me I was in big...I just didn't even wanna take my medicines. I did it for my grandson. I was depressed. And my daughter said "are you depressed? What's wrong. 'cause he left you? Come on, get up." My kids really helped me a lot. So I love my kids today. I deeply do. I went through so much."
4	"Why you cryin'?" and I say, "'Cause I'm just thinking about how your father used to abuse me and I think about my baby." I don't know if it was a boy or a girl. "I'm just coming to see you", "don't start crying and don't start thinking about what happened back in the day."
5	"Protect and serve has very little shots in it. I call my daughter before I call them. I will keep it real with you. I don't trust them. Black, White, Asian, I don't trust them. I call my older sister, I call my children first if anything bad happens to me. Law enforcement? No"
6	"I said, I have the AIDS virus. He said oh, I already knew that. I was like [laughs] Oh Jesus Christ, I was crazy because this child was extremely close to me and I just thought he was gonna think I was such a failure. Because he had stuck with me through my drug addiction and everything. He was like, oh yeah, I knew that. He was like my grandson. It was like so matter a fact. So I've actually been very lucky. But it helps me to know that I have people around that support me because it helps me want to stay healthy."
7	"Like my youngest child, he always remind me. He's like Mom, don't forget."
8	"My son he calls and tells me Mom, are you alright? Are you taking your medication?"
9	"My oldest daughter, she's my proxy. She does everything. If I can't make decisions, she make 'em for me."
10	"She said mom, you know you have to take your meds no matter what you do. Still take your medicine. She didn't agree with what [using substance] I was doing but she wanted me to be safe and she said mom, make sure if you're gonna have sex have protected sex."
Family Members as a Resilience Resource	
11	"He beat the crap out of me. I grabbed my daughter and the shirt on our back. And I thank God for her [mother] 'cause she never locked her door on any of her kids. Grabbed my daughter and I ran straight to my mother's house, legs swollen."
12	"You deal with what you got to deal with, but I'm going to take care of the baby. She took care of my daughter for a long while. I started at 14 drinking."
13	"Yes my mother's my everything. My mother, she was there when I was diagnosed, she came with me to my first women's group about the HIV. I talk to my mother every single day... Sometimes we sit on the phone and watch shows."
14	"I just got my son back. He was with my sister. I had sent him over to my sister because I had to clear up a lot of stuff and once I cleared it up I told her I wanted my son back."
15	"My brothers and sisters. You know they'll be like, did you take your medicine today and yesterday [laughs]."
16	"My family's love, my fiancé's love made me love myself again. So for the past 13, 12 years, I didn't care about [self], I didn't care. That's why they say it's important to have support. 'Cause if you don't have support..I felt so alone. I felt like nobody understood."
Partners as a Resilience Resource	
17	"Sometimes I have to take a minute to take care of me. This man is 9 years younger than me, he has a normal sex drive and here I am saying I don't have sex. But he said 'I'm not going anywhere'! He'd been there 20-21 years."
18	"He knew I was HIV-positive. We talked about everything. He was a good guy. He helped me with everything, that was important to him. All my kids stayed at his house and then they moved out. They didn't stay there long. Just me and him."
Friends and Peers as a Resilience Resource	
19	"People I work with at [name of nonprofit], was calling me and asking "are you okay, when are you coming back?"
20	"We're not gonna talk and we all love you, we all treat you the same. Doesn't matter what you have, you're the same [name] that we knew a long time ago so that made me feel comfortable. And they kept their word 'cause nobody has ever come back and told me what they said."
21	"They cope by trying to do things in the community, I'm sure that they form bonds and friendships with other women who are HIV positive."
22	"I have a lot of female friends now. Not friends that I call on the phone, but friends I feel really comfortable with socially and in support groups that I can talk and not feel like somebody's gonna judge me."
23	"In their group they feel comfortable they have the avenues to open up and talk about stuff without being judged, they feel welcomed."

Children and Grandchildren as a Resilience Resource	
24	"They're very supportive, they give you feedback, people just open their arms up to you and you can feel the love in there because I'm not the only one in there with it [HIV]."
25	"I remember when I first went there [name of nonprofit] when I got diagnosed and I'd just sit there like I ain't telling people my business, so everybody was there saying they been living with it for 20 years 30 40 years stuff like that. So I'm looking at them and I'm like god. Well if they lived that long, I could live long. And they said as long as you take your medication you could live a longer life. And it took me a while before it sunk in."
26	"A lot of women, they play the role as a peer so if there's someone who is new in the community with HIV. They tend to latch on and they tend to show them the ropes. And they're very supportive, the ones who are okay with their [own] status."
27	"Being together tones down the intensity of the [HIV-related] discrimination."
28	"They also have support groups, they do events, and they create a community and I think that's part of the map. The trick is to let people know you cannot live your life in isolation and live through the stigma."
29	"So they deal with it [racial discrimination] by coming and talking about it, getting it out. Some of them have been able to confront the person that even discriminated against them."
30	"I do a women's group. If it creeps up on me, like if I see a little girl or something like that on TV and I'll just shake my head and be like, dang that was me. I'll just hurry up and call [name] and talk about it. Instead of acting out, I just talk about it because you know talking about it and crying about it, it makes you feel better."
31	"Being around other parents...because I have a teenager now. Talking about what they going through with their teenagers... Getting other people's take on how they handled the situation. 'Cause maybe they've handled it better. Cause me less heartache, stress, and pain. Listen, be open. And I get to share my experience and I can help somebody just like how they help me."
32	"I get personal. So here's my life story. So I talk about my life, my struggles, I talk about children. I talk about family. I'll talk about my relationship. And then they're like oh, you're not so different from me because my story is your story."
Providers as a Resilience Resource	
33	"I love my doctor. She's honest, she listens to me, and she doesn't judge. She's not afraid to say you know I'm disappointed in you, I'm proud of you, you're doing good, because we need that. 'Oh I'm so proud of you'. She called me on the phone and she cried with me when I got the test to see if I'm undetectable and my numbers are just 'da bomb diggity' [very good]. She cried with me. She's really happy. It's not a front. She really cares about me. She cares about us."
34	"She's showing me the love that I need to learn how to do for myself. She's there to give me that advice, that motherly advice. Not only that sister-love, but that mother-love. She's not my mother, she's my advocate. But she's a damn good advocate. And trust me, she's been to more mental institutions with me, sitting there like she was the patient. That's why I say I love [name of clinic] because that's my team. They love me. Because they work with me until I, they love me until I could love myself."
35	"I really love her. You know, because when she first met me even though she knows me, she never heard my story. But then as she gradually heard me and found out my story, and what I've been through and my lifetime, she's like, nobody better not mess with her."
36	"The importance of building trust and providing information, once I've been able to build that trust with them they were willing to work with me. Education and support is huge for our women, for them to know that they can go someplace, and say something and not have it held against them. Showing and guiding them because I think once they get, it's like OK I got this I can do it."
37	"The people at the clinic where I went to they gave me a worker, a lot of people came to talk, and there was other people that were here for me, supported me, 'Don't be afraid, it happened to me so wait here'. That's what kept me going the whole time."
38	"I have a whole team of supportive people that will actually call me on the phone and be like [name] you missed several doctors' appointments what's going on with you?"
39	"I talk about everything and I tell her [doctor] when I'm feeling like I don't wanna take my [medications], I'm tired, my body is tired of taking these medications, and then she'll be like, 'did you know that there's this lady who she's really crying because she can't afford medications' and I be like ugh [makes sighing noises]."
40	"I talk to my medical provider about everything so she connects me [to other providers]. Like I had a issue where my stomach, my belly button was leaking."
41	"It made me feel good because I know that I got support. I got more support from them than I do my own family. I can go in there right now and tell them I feel depressed. They will clear somebody's schedule and make an appointment for me to come in and see somebody."
42	"I would say stay put where you are, if you are at work I'm coming, and I'll meet with you. Some days they say they cannot take it anymore. They tired of this world and my role is try to keep them from and have them not do something they will regret tomorrow."
43	"I even go to court with them and then having me standing in court with them, usually make a big difference."
44	"It's the medical and the social aspects of being HIV-positive. I have actually went into homes with clients or with my peers and helped them talk to their families where they've been positive for ten years twenty years and family members don't know."
45	"They're welcoming. They welcome everybody" and "We have a good time. We be sitting, laughing, and talking."

Children and Grandchildren as a Resilience Resource	
46	“They talk to me and they go by first name and.... They give us graham crackers and they even have [collect] donations with some clothes and they give us cards for transportation and I think it’s very nice of them.”
47	“It’s [nonprofit] a safe haven for them. When they feel like they cannot take it out there, they come to [name of nonprofit]. Spending time with other clients, seeing a case manager, watching a movie, and we always try to have food there regardless if it’s a little and they feel comfortable with us.”
48	“When I first came here, I didn’t have housing, so [nonprofit name] offered me a case manager to take me through their enrollment and food and they gave me a room at [housing facility] and helped me through that process so that helps me grow. [It] gives me the opportunity to relate to other people in the groups. It brought out something in me, so I think it does that to other people. They follow up with you, the progress of when you first came in and how far you’ve gone.”
Wider Community as a Resilience Resource	
49	“I was on the bus, and I sat back. It was like six people on the bus and the tears starting flowing, so three ladies just came around me and started praying. Lord they prayed for me all the way till [name] street. Yes, until we got to [train station]. By the time I got off there [bus] it was like everything lifted off my shoulders.”
50	“I went outside and I was crying [following racist incident] like really bad, my mom was on the phone with me. And this cab guy, he came and drove me all the way from where I was at, I was an hour away from where I lived. Free of charge, he was like get in I’m taking you home.”
A Combination of Resilience Resources	
51	“I remember back last year I stopped taking my medicine. And then when I went to my group I said ‘I’m just tired of taking f***** medicine all the time. I just wanna not take it until I’m ready to take it back again.’ And they said no, you can’t stop your medicine like that for all these days and then when you get back on the meds it may come resistant and it may not work anymore. I said, so what? And then when I thought about it, I said damn, my kids. They probably think I’m taking my medication all along and I’m really not. So I said I better get back on my medicine. I went to go see my doctor and I said I’m gonna be honest I’m not taking my medicine right now. She said well how long you been off of it? I said a month. She said oh no, that’s not good. She said we’re gonna put you on something else and they put me on this new medicine and ever since then I just been taking it every day.”