Journal of Community Psychology
Volume 21, October 1993

The Empowerment of Women: A Key to HIV Prevention

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We discuss the process underlying the success of an HIV-prevention project for young, inner-city women. The intervention was based on the concepts of empowerment and culturally sensitive skill building. Four critical points relevant to the translation of HIV prevention knowledge into behavioral change among the sample are examined: (1) integrating the important issues of the participants' lives into the HIV prevention program, (2) utilizing a group format to encourage cohesiveness and support, (3) engaging group facilitators to promote mutuality and equality, and (4) promoting ongoing, authentic relationships among the participants and staff members. Points are illustrated with vignettes reconstructed from the group facilitators' experiences with the participants.

Human Immunodeficiency Virus (HIV) prevention has received increasing attention as an issue of relevance for women. (See Ickovics & Rodin, 1992, for a review.) Empirical findings from intervention studies are much sparser but are beginning to emerge (Jemmott, Jemmott, & Fong, 1992; Kelly, St. Lawrence, Hood, & Brasfield, 1980; Rotherman-Borus, Koopman, & Haignere, 1991). Relevant conceptual models have been presented in the literature (Fisher & Fisher, 1992). What is virtually absent, however, are contextual accounts that explain and detail how the important issues for women are put into actual practice in successful empirical prevention projects. In this paper, we present process data reconstructed from our experiences with participants to describe our successful attempt at prevention of HIV infection among inner-city women.

For the past 3 years, we have instituted and examined an HIV-prevention program for young, inner-city women based on the concepts of empowerment and culturally sensitive skill building. The project was designed to assist women in empowering themselves by promoting a sense of owning and making healthy choices about their bodies. The program, conducted within a group setting, utilizes mutual support, imagery, cognitive rehearsal, role-playing, and goal setting. The results of this 3-year endeavor indicate

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This study was made possible by a grant from the National Institute of Mental Health (#1RO1 MH45669) and by support of the Kent State University Applied Psychology Center. The Center facilitates the application of psychological principles and research to problems of social significance. This study could not have taken place without the cooperation and support of the prenatal clinic staffs of Akron City Hospital, St. Thomas Medical Center, and Akron City Department of Health. We give special thanks to Susan Marshall, who was a fellow group facilitator, and to Brad Shepherd, who helped with revisions of this article. Correspondence should be sent to Oneida Levine, Applied Psychology Center, Kent State University, Kent, Ohio, 44242.

real and sustained behavioral changes in women. Women are reporting ongoing postintervention changes in their sexual behavior that reduce their risk of HIV infection (Britton et al., 1992; Hobfoll, Jackson, Lavin, Britton, & Shepard, submitted).

In reflecting on the success of this project, we believe that the project is effective because it utilizes women's strengths and resources within an acceptable cultural context. It has been well documented that education and information are often not enough to promote behavioral change (Flora & Thorensen, 1988; Ickovics & Rodin, 1992; Kegeles, Adler, & Irwin, 1988; Stall, Coates, & Hoff, 1988). People need to develop skills relevant to the proposed behavioral change, need to feel that the change is possible and will work for them, and need to feel that such change is approved and supported by others important in their lives (Fisher & Fisher, 1992; Hochbaum, 1958; Schinke, Blythe, & Gilchrist, 1981; Stall et al., 1988; Taylor, 1990). A group-based intervention provides a platform to encourage such change in more than one person at a time (Mulvey, 1988; Wallerstein, 1992) and has been found to be effective when working with women (Brown & Ziefert, 1988).

We contend that there are four critical points relevant to the translation of HIV-prevention knowledge into behavioral change among our target group: (1) integrating the real and important issues of the participants' lives into the HIV-prevention program; (2) utilizing a group format to encourage cohesiveness and support among participants; (3) engaging group facilitators (as opposed to group leaders) to promote mutuality and equality; and (4) promoting ongoing and authentic relationships among the participants and staff members. These four points represent not only a philosophy but also an approach to HIV prevention that encompasses valuing women as having responsibility and control over their behavior and that creates an atmosphere of empowerment by working with women's strengths and experiences in enabling them to find workable HIV prevention plans for their lives.

Overview of the Study and Preliminary Results

Although our major focus in this paper is on the process of assisting women in empowering themselves, we feel it is useful to review the nature of the intervention program and some of the empirical findings. (For more detail, see Britton et al., 1992; Hobfoll et al., submitted; and Hobfoll, Jackson, Lavin, Britton, & Shepherd, in press.)

These earlier articles focus on the theory underlying this research project and present empirical findings, whereas the present paper describes the actual process of the intervention and presents some process-based hypotheses about why the intervention has been successful. The sample for this study consisted of 246 women recruited from obstetrics clinics providing prenatal services for low-income women in a mid-sized, Midwestern city. These women had been approached by trained interviewers during routine prenatal visits and invited to participate in this research project. Approximately 80% of the women approached agreed to participate. At the time of recruitment, participants were single, pregnant, and between the ages of 16 and 29. The sample was almost equally represented by African Americans and European Americans. Over one third of the women had completed some high school, a third had graduated, and just over one fourth had some post high school or college training. Almost three fourths had incomes under $10,000 per year. Over half of the women already had children and almost two thirds had been pregnant before.

The project itself was based on an intervention format involving a series of four group sessions. Women who had agreed to participate were randomly assigned to either

the HIV-prevention group or to one of two control groups (one that received no intervention or one that was similar to the HIV-prevention intervention, however with a focus on general health promotion rather than specific HIV-preventive behaviors). Both the HIV-prevention and health promotion interventions focused on (1) increasing either HIV-prevention or general health knowledge, (2) promoting assertiveness and negotiation skills, and (3) increasing feelings of threat from either HIV infection or poor health practices. Women used discussion, cognitive rehearsal, guided imagery, and role play in practically every group session to expand their competencies and forward planning.

Discussion involved talking about issues; cognitive rehearsal (Meichenbaum, 1977) consisted of thinking about ways to handle situations and developing action plans; role play entailed acting out situations; and guided imagery (Wolpe, 1973) involved getting to know the feelings that would be experienced in particular situations. Guided imagery was based on Wolpe's aversive conditioning, but was expanded by having each aversive fantasy paired with a positive one in which the woman is competent and successful. Thus participants were encouraged to participate on three levels—cognitive, emotional, and behavioral.

In working with the women, we found that discussion was the easiest part of the intervention. Women were eager to talk about their pregnancies, their hopes, and their dreams. As they became more comfortable with the group facilitators and with each other, they readily talked about their worries, fears, and frustrations.

Guided imagery, an integral part of the intervention, was employed to increase fear of HIV exposure and to make HIV risk more relevant. This technique was new to most of the women but not difficult for them. During a guided imagery, women closed their eyes, relaxed, and affectively experienced a pair of situations, one fear inducing and the other empowering. An example of a typical pair of guided imageries follows.

> *Group facilitator*: I want to you to take a deep breath . . . inhale slowly . . . exhale slowly . . . and again . . . (Pause).
>
> Imagine that it is evening and your partner has gone to work. You two had a wonderful afternoon together. Sex was good. You're feeling warm and relaxed. Now, you're watching TV. A commercial comes on about AIDS. You begin to tense up as you remember that your partner said he'd heard that one of the girls he used to date might have AIDS now. You begin to think, to worry. . . .
>
> Could she have had AIDS when he was seeing her?
> Could she have given it to him?
> Could he have given it to you?
> Could you have AIDS now?
> What about your baby?
>
> You're feeling uncomfortable now. Your forehead is tight. Your stomach is queasy. You'd like to stop thinking this way, but the questions keep running through your head—
>
> What will happen to you?
> If you do have AIDS, will you die?
> If you die, who will take care of your baby?
> Will you live to see your baby die?
> Is there anything you can do?
> Is it too late for you? for your baby?
>
> (Pause) Take another deep breath . . . slowly . . . and another. . . .
>
> Imagine that it is evening and your partner has gone to work. You two had a wonderful afternoon together. Sex was good. You feel warm and relaxed. You are watching TV when a commercial comes on. It's about AIDS. You feel calm—good about yourself and good about your relationship. Condoms were used until you

were sure you could commit to each other and sure you wanted a baby, and then you both got tested. Thank goodness, you were both negative. It took some time, but the wait was worth it. You know you don't have to worry about AIDS for yourself or for the baby growing inside you. You place your hands on your belly and feel a warm glow.
(Pause) Now you can open your eyes.

Following a guided imagery, the women discussed the feelings they experienced as they listened to the two scenarios. This enabled them to more fully experience the consequences of positive and negative health behaviors.

Cognitive rehearsal was more active, but again, not particularly difficult for the women participating in the study. This technique was used to practice intimate behaviors that were not appropriate for role play. During a cognitive rehearsal, the women were directed to close their eyes, to imagine themselves in a situation, and to work out how they would handle themselves in that situation. A typical cognitive rehearsal might go like this:

Group facilitator: What we are going to do now is practice a technique called cognitive rehearsal. It is a way of forming an action plan to protect ourselves by thinking through what we would do in a situation. Close your eyes. Take a slow, deep breath. (Pause)

Imagine that you and your partner are together. You are going to have sex. You have been kissing and caressing each other very lovingly. You are getting more passionate with each other. It becomes obvious that he is getting ready to have intercourse without using a condom.

What will you do?
What will you say to him?
How do you think he will feel about your asking him to wear a condom?
How will you convince him to wear one?
Will you be straightforward?
Will you talk about the condom?
Will you play and tease him a little first?

Will you hand him the condom and simply expect him to use it? Imagine yourself helping him to put it on. How will you do this? In a rush? In a playful, teasing way? You can help to make condom use fun for your partner. (Pause) You can open your eyes. Now let's talk about what we just imagined.

Following such a cognitive rehearsal, the women talked about what they felt and how they imagined themselves handling the situation. They shared ideas, thought of reasons their ideas might not work, and then problem-solved with each other for more solutions.

The final technique, role play, was the most difficult and least popular, at least initially. In role playing, the women moved from talking about behaviors to practicing them with each ohter. Role plays typically revolved around some conflict. Sometimes, it was asking someone to help when that person might not be helpful. Other times, it might be resisting doing something someone else wanted.

The group facilitator encouraged the women in the group to suggest something they were really interested in doing as the basis for the role play. Frequently, the women were resistant to role playing. "I'm no good at this," "I can't ever think of anything to say," "I'll start laughing, and then I won't be able to talk" were some of the objections the women would make. Sometimes, they did laugh their way through the role plays. But more often, they did a good job of playing themselves and the other people important in their lives. (An account of an actual role play is presented later in the paper.)

To provide data for this study, women completed questionnaires prior to the intervention, at postintervention (approximately 4 months after recruitment), and at a 6-month follow-up (10 to 12 months after recruitment). Participants were also given a condom credit card that allowed them to obtain free condoms and spermicide from local pharmacies for 1 year. This allowed us an objective measure of intervention efficacy. Of the subjects that participated in groups, 61% completed all four groups and 71% completed three groups.

Overall, the HIV-prevention efforts were effective. Relative to the two control groups, women attending the HIV intervention demonstrated improvement in HIV knowledge, greater intention to buy condoms and spermicide, and reported more frequent condom and spermicide use during vaginal intercourse. Additionally, the HIV intervention group made more use of the condom credit card than did the no intervention control group and acquired more condoms than the health promotion control group. The finding that women who participated in the AIDS prevention intervention lowered their risky sexual behavior to a greater degree than women in the health promotion control intervention indicates that the beneficial results found are not due only to increased social interaction and support provided by these groups.

This paper intends to show how the four critical points that encompass our empowerment philosophy are crucial to the success of the project. It is further suggested that these points are essential aspects of HIV-preventive efforts targeted towards women.

Integration of HIV Prevention Material into Women's Lives

Responsivity of the Program

An important aspect of the program is its built-in responsivity to the participants' needs and issues. The program is designed to integrate aspects of the women's lives into the program's content and to facilitate the integration of intervention material into their lives. For example, women frequently wanted information on forms of birth control other than condoms. We dealt with these concerns during our condom segment by broadening the content to include other contraceptive methods, including the Norplant that was being frequently implanted at the prenatal clinic where we held our groups.

It has been recommended that prior to an intervention, the target population be studied so that base levels of knowledge, motivation, and behavioral skills can be determined and the intervention developed in response to these basic levels (Fisher & Fisher, 1992). The responsivity of our project is accomplished through the use of (1) a standard format with flexible content that is relevant to the participants' lives, (2) trained group facilitators, and (3) a target group with common interests and concerns. The content of the interventions was developed to be of interest to the target population and involved the effects of HIV prevention and good health on the women's lives, their pregnancies, and their children. A general topic was presented via a videotape for each group session. The specific issues and examples used in the live groups were typically provided by the women during the group sessions, so that the content became even more personally relevant to them. For example, during planning and developing the videotapes, it was anticipated that abstaining from alcohol while pregnant would be an important issue for our participants and thus alcohol use and how to refuse and limit its use were frequent topics on our tapes. However, for most of the women in this particular population, alcohol use was not presented as a major concern, whereas smoking was. Thus while

the taped group addressed ways to stop or decrease alcohol use, the live groups used the same skills and principles to stop or limit smoking, including ways to deal with smoking by others.

This format demands trained group facilitators. The facilitators' goal for each group session was to involve the women actively in sharing their specific concerns and problems relating to the general topic and in working together, to develop action plans and solutions that are likely to be successful for them. The group facilitators were trained in stimulating group interaction, encouraging women to share their concerns and experiences, using those concerns and experiences as the content for discussion, cognitive rehearsal, and role play, and guiding participants in confronting and supporting each other. An example that demonstrates how our project is responsive to the real issues of women's lives can be observed in the case of Tamara. (All names are fictitious, but events accurately reflect actual group interactions.)

> Tamara, one of our participants, is in her early twenties. She already has two children—the older one just started school and the younger one is still in diapers. Babysitting and child care are among her biggest concerns. She complains, "Everybody wants to keep your baby when there's only one, but nobody wants to keep two of them. And what am I going to do when I have three?"
>
> Tamara's boyfriend lives with them off and on, but she is uncomfortable leaving the kids with him. When she has left her children with him in the past, she has come home to find him passed out on the sofa and the kids "watching each other." Tamara's mother would like to be helpful, but she lives in another city. She will keep the kids if Tamara can get them there. Tamara's boyfriend's mother lives nearby but is only willing to keep the older child occasionally. She says she is "too busy, too tired, and too old to be watchin' babies." She says she will not even consider helping Tamara when the new baby is born.
>
> When it is time to role-play a situation involving asking someone to help you with something, Tamara volunteers. She wants to work on getting her boyfriend's mother to keep both kids for her. With the group facilitator's guidance, the other women in the group help her set up the role play. But they have some different ideas for her: "You know, maybe your boyfriend's mother really is too old and too tired. Maybe you should be satisfied with letting her keep the older kid and then find someone else to keep the baby." The women pursue it further: "You said your best friend has young children. Maybe you and she could take turns watching each other's children." Tamara's role play develops from an argument with her boyfriend's mother to a discussion with her best friend on plans for a babysitting exchange.

As mentioned, the intervention was presented to a target group—all of our participants were young, unmarried, inner-city, pregnant women. Using a restricted group increases the likelihood that the participants will have issues and concerns in common and also increases the likelihood that the general content of the group sessions can be tailored to fit those common issues and concerns while still presenting the intervention emphasis.

We believe that by putting these three components together—a participant group with common interests and concerns, trained group facilitator, and a program with standardized format and flexible content targeted to the participant group—we have produced an intervention that is highly responsive to the participant group, one that integrates the women's lives into the intervention material and that encourages the women to integrate the intervention material into their lives.

Cultural Sensitivity

The literature supports the need for cultural sensitivity when working with women (Ickovics & Rodin, 1992; Mays & Cochran, 1988). Thus, we made the structure and content of the intervention responsive to the economic, gender, and ethnic realities of the women involved. For example, participants were given money and bus tokens to offset transportation and babysitting costs involved in attending group meetings; arrangements were made so that group meetings could accommodate small children when mothers needed to bring them along; and attempts were made to schedule group meetings so that they did not interfere with school or work obligations. In terms of content material, as already described, rather than having only prescripted problems and solutions, the women in the groups presented problems from their own lives and worked together on finding solutions that were realistic and useful to them.

Furthermore, the use of a culturally diverse staff provided role models with which participants could identify and relate. Our group facilitators were African American, European American, and Hispanic American. They were single, married, and divorced. They were childless, mothers of teens and young adults, and one even became pregnant and had her first child during our study. Their backgrounds included public health, administration, education, childbirth education, and parenting. All were managing school, work, and personal lives. The diversity of the staff encouraged the staff members to draw on their collective strengths and experiences and to teach each other, which was also one of the goals in using the group intervention format.

The daily behavioral choices of women are highly influenced by their economic situations (Mays & Cochran, 1990). Unemployed and underemployed women who are coping with the inequalities of society still seek a sense of belonging, creativity, and achievement. They may find sexuality a ready means to demonstrate their womanhood through being sexually active and having children (Fullilove, Fullilove, Haynes, & Gross, 1990). Our program's HIV-prevention efforts recognized and supported educational and career aspirations that can provide more economic stability and a greater sense of empowerment, as well as the establishment and maintenance of protective sexuality. Indeed, strategies for making educational and career goals a reality were frequently the focus of discussions and role plays.

Additionally, gender-based social roles define the nature and type of activities pursued by women (Fullilove et al., 1990). These roles also define power in heterosexual relationships. HIV-prevention efforts with women must recognize this power differential. Male-female relationship inequalities need to be understood in the context of economic security, the sex-ratio imbalance among African Americans, and the meaning of sex as experienced by European American and African American women (Fisher, 1988). The development of negotiation skills as part of our intervention targeted issues of male dominance and control and encouraged women to acquire a sense of control in typically male-dominated situations (i.e., sexual behavior and the use of condoms). The example of Leigh illustrates the issues of control in sexual relationships.

> Leigh is expecting her second child. She is currently on welfare but talks of finding a job after this baby is born. One of her major concerns is having a job with health benefits and enough pay to cover child care expenses. Leigh and her boyfriend have been involved with each other for 9 years, but not steadily. He has had several periods in jail. He has sexual relationships with other women and has children by some of them. Leigh also has other sexual relationships, usually while her boyfriend is in prison. She insists that she is careful to use condoms when she is

not with him. "I don't want more kids, and I certainly don't want any diseases," she explains.

Leigh does not take birth control pills because she had too many side-effects when she did, and she is unwilling to try the popular Norplant implant. Her boyfriend does not like using condoms. He says "the feeling's not right." But they do use condoms occasionally. Leigh reports that she makes him use them when she is mad at him, especially after he has been gone for a while.

In one of our group sessions, Leigh suggests a role play where she asks her boyfriend to take some responsibility for not getting her pregnant again by using condoms all the time. While we are setting up the role play, one of the other women in the group challenges Leigh: "It sounds like you use condoms to punish your man for messin' around. Maybe you need to be using them to take care of yourself. You already said that you can make him use them when you want to." Instead of a role play, for that group meeting, we have a lively discussion on what condom use means to each of us and whether we need to be taking care of ourselves or expecting someone else to do that for us.

The sociopolitical history of African Americans has resulted in feelings of mistrust and suspicion of European American culture and its objectives. These feelings can impede the involvement of African Americans in HIV-prevention efforts (Dalton, 1989). Our intervention has worked to foster trust and respect through the multicultural nature of its staff and through the use of group facilitators who truly listen and learn from the study participants. These facilitators were trained to address culturally specific concerns, such as the controversy over the origin of AIDS, feelings of discrimination and stigmatization, myths about hypersexuality among African Americans, and fears of selective genocide. The facilitators also worked on unlearning their own internalized prejudicial myths in order to provide culturally specific historical facts and resources that encouraged a sense of empowerment, positive self-identity, and cultural group pride.

Promotion of Cohesiveness and Support

One of the strengths of this intervention scheme is that it allows people of different cultures to learn about and interact with each other and, in that process, to realize that they share common issues and concerns and can work together to develop solutions for themselves. The women in our groups learned to recognize that they were all in similar sociocultural situations, which meant that many of their problems were similar (i.e., a lack of financial resources, the stress of inner-city living, the priority of present demands, and single-parent family systems). Among the stigmas experienced with being low income are a sense of alienation from the middle class and distrust for "systems" (Dalton, 1989). The group format helped to create an understanding and supportive environment that countered these feelings of isolation and alienation, led to the building of relationships and trust in one another, and aided in the development of competencies and taking action in one's own behalf. The example of Kim demonstrates the dynamics of group support.

Many women in the groups were involved in interracial reltionships. One such woman was Kim, a young European American who has been seeing an African American man. She explains her position, "I've known James for 3 years now. This is our first baby, and we're really excited about it. But my parents still don't accept James." She shakes her head sadly, "After all this time, they still don't accept him. And I don't know how they're going to treat the baby. You know, my Dad has practically disowned me."

The group facilitator asks, "How does your boyfriend's family treat you?" "Oh, they treat me pretty good," Kim responds. "There were some problems at first. James' sisters didn't like me, but now we get along fine." Kim pauses, then continues thoughtfully, "I guess I consider them my family now. You know, my grandmother doesn't even speak to me anymore. His grandmother is really understanding; she tells me to be patient with my family, that things will be better once the baby is really here."

A woman from the group enters the conversation, "Kim, I used to go out with a Black guy, and my family treated me the same way yours is treating you. But you can't let them destroy your relationship. You two have too much invested in this, especially now that you're having a baby. You've got to spend your time and energy taking care of yourself, your man, and your baby. If your family can't accept you and your choices, that's their problem."

Kim smiles at her as she says, "I know you're right, and it sure feels good to know that I'm not alone, but this mess with my family is such a headache."

Group support was also helpful in providing encouragement and help in combating unhealthy behaviors. The story of Cassandra provides an example of this kind of health promotion.

Cassandra shared with her group that since their previous meeting, she had talked with her boyfriend about being tested for AIDS. She was aware that he had other girlfriends, and she expressed concern about getting AIDS from him. He had agreed to testing, and 2 days had later told her that his test was negative and that she had nothing to worry about. The group confronted her—"He was just lying to you. It takes 2 to 3 weeks to get the results from an AIDS test. He might have been tested for something, but it wasn't for AIDS." The women in the group were supportive and offered some common justifications—"Men are like that. They'll all lie when they want something from you." "But," one woman pointed out, "Why even bother with an AIDS test when he's still messin' around. No test is going to protect you from that."

Then the group gave her some suggestions on how she could protect herself: "Girl, you should just get rid of that guy. He's no good. He's never going to be faithful, and you're always going to be worrying about what he's bringing home." But Cassandra was not willing to give him up. She said, "I really love him. He's exciting to be with. And besides, I get along with his Mom. She said she will keep my baby after it is born, so I can finish school." The group's second suggestion was that Cassandra be sure she and her boyfriend used condoms every time they had sex. The women reminded her where to get condoms and where to keep them so they would be available when sexual encounters were spontaneous and unplanned (as hers tended to be).

For many of the women in this study, this was their first child. As such, issues of labor and delivery, child care, and child support were also discussed in the groups. Sometimes the women reported being uncomfortable talking with a nurse or physician about their concerns, but were comfortable talking to their group facilitator or to a peer, especially to those who "had already been through it." Again, the group, with its facilitator, provided a safe and supportive environment for women to work through some of their issues. The example of Rhonda demonstrates this.

Rhonda is young—not even out of high school yet. This is her first pregnancy. She and her boyfriend have been seeing each other for a while, but they did not plan this baby. Her family is supportive—they even let him move in and let the two of them live together in the basement. But her family does not want them to get married until they have finished high school.

Rhonda is having some problems with her pregnancy, and her doctor told her not to have sex. When the group topic is sex during pregnancy, Rhonda is quiet and does not participate. But she stays after the group is over to talk with her group facilitator. "What did you mean when you said there are other kinds of sex we could have?" The facilitator begins talking about oral sex. Rhonda interrupts, "Oh, I could never suggest that. How could I talk about that? I would be too embarrassed. What would my boyfriend think?" Together, Rhonda and her group facilitator decided that maybe she could just initiate oral sex rather than trying to talk about it, since the idea of talking about it makes her more uncomfortable than the idea of actually doing it.

Months later, after the baby is born, Rhonda returns for her follow-up interview. She asks the interviewer to make sure that her group facilitator knows that she tried out "that oral sex stuff" they had talked about. She reports that her boyfriend was shocked but really enjoyed it. He told her he never thought she would be interested in anything like that, so he had never mentioned it or tried it with her. She looked away sheepishly as she said she liked it too, once she got used to it. "But, best of all," she continued excitedly, "Now, we really talk to each other. At first, it was about sex and stuff, but now we can talk about anything.

The group format is the cornerstone of this intervention. It facilitates sensitivity to the women's needs, discussion of their most immediate concerns (such as their pregnancies, their partners, and income-related matters), presentation of HIV-preventive behaviors in the context of women taking care of themselves and their children, focusing on working together to find solutions to common problems, and the opportunity to practice new, protective behaviors. The empowering effects of groups have been observed in other interventions (Brown & Ziefert, 1988; Wallerstein, 1992; Zimmerman, 1990a), and our project adds support to their findings.

Promotion of Mutuality and Equality

As group facilitators, we found that when we joined with women as equals, in an attitude of respect and caring, we could facilitate discussion regrarding how all of us deal with the increasing prevalence of AIDS infection, and how we can sustain behavior change in our own lives. By working together, we could outline the problem, present the current behavioral prescription (e.g., practicing safer sex), and promote ways of managing the problem. Such a process follows Bandura's (1990) emphasis on the role of self-efficacy in facilitating changes in health behaviors as well as drawing from the recent work on empowerment (Brown & Ziefert, 1988; Rappaport, 1984; Wallerstein, 1992).

In beginning this project, it was easy to embrace a mind-set that we, as researchers and clinicians, had wisdom to impart, and that it was our job to get the message across effectively. Although perhaps we do have some information to impart, this conceptualization implies a power differential and a sense of superiority-inferiority. It clearly sets up a situation where subjects or participants feel that we assume they do not know what is best for them. Resentment and apathy often accompany feeling that one is in a position of needing help and being one-down (Fisher, Nadier, & Whitcher-Algna, 1982; Myers, 1986). Conversely, empowerment encourages the target population's participation in any intervention affecting its welfare (Rappaport, 1984; Wallerstein, 1992). It is the opposite of authoritarianism and paternalism in that it promotes an internal sense of control (Mulvey, 1988; Zimmerman, 1990b).

The concept of empowerment being internally motivated is a critical one. Empowerment is based on the belief that women own their lives, that they can know what is right

for them, and that by working together, they can positively influence what happens to them (Brown & Ziefert, 1988; Mulvey, 1988). We have example upon example of women who presented very workable solutions to their problems. The case of Barbara exemplifies this dynamic.

Barbara is a 19-year-old, African-American women who has a 2-year-old daughter, and at the time of our project was pregnant with her second child. She has been in a relationship with Tom, the father of her children, for several years. Barbara had considered the relationship monogamous and was committed to maintaining the relationship. However, recently she received a phone call from another woman, who stated that she too is involved with Tom, and that she thought that Barbara should know. Barbara became very upset and confronted Tom, who admitted to this other sexual association.

Barbara disclosed her disappointment, confusion, and anger during a group meeting: "What a fool I was. I really trusted him. I was faithful to him. How could he do this to me? How can I ever believe in him again?" She decided that she could no longer be involved in a sexual relationship with him, knowing that she could not trust him. Through role-playing with her group, Barbara practiced how to deal with Tom:

Group facilitator: Barbara, have you thought about how you're going to tell Tom?

Barbara: Yea, but it won't be easy.

Group facilitator: Let's role-play it. Who will be Tom? Crystal?

Crystal: (moving her chair so she faces Barbara): Sure, but all you have to help me.

Barbara: Tom, you know I've been really upset about what you did. I don't think I can trust you anymore and . . .

Tom/Crystal (interrupting): But Baby, you know I love you. She didn't mean anything to me. Really.

Barbara: No, let me finish. I don't think we should sleep together anymore.

Tom/Crystal: (interrupting again and speaking rapidly): Wait, you don't mean that. You're just mad. You won't feel that way for long. I know you love me. And I love you.

Barbara (to group): Now what do I say? I am mad. I do love him, and I really don't want him to leave me.

Another woman, Lynn: Don't let him distract you. Keep going. Tell him you can't sleep with him as long as you can't trust him.

Barbara (to Lynn): Ok, that sounds good. (Speaking slowly to Tom/Crystal): Tom, I am mad at you, and I do still love you, but I can't trust you anymore. And I can't sleep with you if I can't trust you.

Tom/Crystal: Baby, I'm sorry. It was a mistake. I didn't mean for you to get hurt. I'll never look at another woman. I promise. Baby, please, don't do this.

Barbara (her eyes starting to tear and her voice getting shaky): No, Tom, I . . . I . . . (Turning away from Tom/Crystal) I can't do this. I'll cry.

Group facilitator: So what? Just because you cry doesn't mean that you can't think or that you can't keep working on something. Here (hands her a tissue), have a kleenex and keep on going. You're doing a great job.

Barbara (blowing her nose): OK, here goes. (Turns back toward Tom/Crystal) Tom, I mean it. I can't trust you anymore. (Her voice cracks.) I believed in you, and you betrayed me. I've thought about this. We can't have sex until I'm sure you are committed to our relationship.

Crystal (obviously also shaken up by the emotion Barbara is expressing, to group): What now? I don't know what else to say.

(Lynn gets up and motions to Crystal to change seats with her.)

Tom/Lynn (in a soothing, coaxing voice): Now, Barb, you don't mean this. You're being rash. I love you. I love the kids. Think of our children. What will you say to the kids? Don't you want me to be involved with the kids? (to group): Thats what my Man said to me.

Barbara: Tom, I do want you to see the children. But you can't stay with me right now.
Tom/Lynn (anger in his/her voice): Hey, I'll just find somebody else. There are lots of women out there—women who'd forgive one little mistake.
Barbara (turning away from Tom/Lynn again): What if he really says that? How would I handle that?
Group facilitator: What do you want for you? What do you want from him?
Barbara: I don't know. I've got to think about this some more.
Group facilitator: Lynn, Crystal great job. You really got into that.
Lynn: Well, I've been there.

Barbara did think about it some more. She worked out a plan that allowed Tom to continue his relationship with their children. She also did not want to lose his mother's involvement with the children as his mother was an important part of their lives. Although Barbara knew Tom might really find someone else and she would miss him terribly, she felt her decision empowered her as a woman and a mother.

The group supported her decision, and pointed out that her plan was not punitive to the children but was setting clear limits for Tom. Several group members shared their own experiences with having to terminate relationships and, in so doing, helped Barbara deal with her loss. One group member who had developed a special friendship with Barbara, suggested that the two of them begin a weekly social event, "to get out and get over him." Barbara agreed that it would be good idea to expand her social life.

Many of these women have dealt with and are experiencing complex and difficult life concerns, and when we listen, we can learn how they cope successfully despite frequently having limited resources. The information we have is important, but they, and only they, can decide if and how to apply it. At most, we can spark the process, but the women determine its outcome. For this reason, we feel the term "group facilitator" rather than "group leader" more accurately reflects the position of mutuality and equality we attempt to create.

When women feel that they have something to contribute, instead of being perceived as inadequate, their self-esteem is raised and their sense of self is affirmed (Brown & Ziefert, 1988; Gutierrez, 1990). These self-esteem variables correlate highly to positive behavioral changes involving HIV-prevention behavior (Catania et al., 1989). For example, it is easier to ask a partner to wear a condom when one is coming from a position of strength and positivity rather than from a sense of incompetence and inequality.

Promotion of Authentic Relationships

Our program is effective in encouraging the development of relationships among women, in large part by giving women the time, intensity, and the frequency of contact needed for relationships to form. And relationships did develop, not only among the participants, but also between participants and staff. Women from the groups invited us to baby showers, gave us pictures of their babies and themselves, made special trips to our clinic office to talk and to show off the new babies, and wrote us letters when they moved out of the area.

As participants, women were typically involved in our program for 10 to 12 months during an emotional and exciting time in their lives. They had anywhere from four to six formal, face-to-face visits with our staff and received numerous phone calls, letters, and informal contacts at the clinics. Specifically, the women were involved in initial interviews, might have attended four group sessions, and probably participated in final interviews. Surrounding all the meetings were telephone calls and letters—scheduling

meetings, finding out why meetings were missed, or checking on someone who was hospitalized or had a personal crisis. This intensive contact included women who could not complete the study. One such woman was Carol, who became ill and during the course of her illness, delivered her baby prematurely. Both she and the baby were hospitalized for lengthy periods. Her group facilitator talked with her by phone once a week until her baby was out of danger and they were both safely home. By that time, it was too late for Carol to complete the groups. Another "drop-out," Marie, lost her baby. She was invited to stay in the study, but she decided that it would be too painful for her to be with other pregnant women right then. However, Marie did come back to our clinic office to visit with the group facilitators, to show pictures of the baby she lost, and to share her grief.

Group sessions were, by design, personally involving. As detailed above, women shared their hopes and disappointments, successes and failures during the group meetings. They gave each other support, encouragement, and comfort. Given this level of intensity, openness, and involvement, it would have been difficult not to care about each other.

Implications

We have demonstrated some of the key dynamics that contributed to the success of our project. The question remains what we would take from our learning and suggest as models for future HIV-preventive programs. A few recommendations follow:

1. Actual skills must be taught or improved. Such tools as role play, imagery, and planning are helpful techniques, but these techniques must be made contextually relevant to the participants' lives in order to be effective.
2. In designing and implementing programs, it is imperative that issues of diversity be integrated into the content of the program. Staff should reflect the diversity of the target population as well as manifest culturally sensitive and relevant behaviors and attitudes. The importance of cultural sensitivity cannot be overstressed.
3. We would recommend that the program have the continuity that cannot be achieved in a single-session format. Our data clearly underscore the need for ongoing and authentic connections among people.
4. The sessions should be interactive, occur in a small group format, and include active techniques, such as role play, cognitive rehearsal, and guided imagery. Again, the emphasis is to draw on the strengths of the participants, to encourage them to teach each other and themselves.
5. Intervention does not occur at a designated time and place alone. Rather, intervention must be interwoven with the irregularities of people's lives at times, places, and in ways that fit their needs rather than being tailored to traditional formats.

Conclusion

As the need for HIV-prevention among women increases, it is imperative that we gain information on what is working and why. It is our hope that we have presented critical and key components to the effectiveness of HIV-prevention efforts for women, especially those of low income. We suggest that our prevention project was successful due to its emphasis on empowerment and cultural relevancy, both in its design and implementation. Women need more than information; they need to develop skills, to own their choices, and to learn how to use their wisdom and experience. Our intervention encouraged the integration of HIV-prevention material into women's lives by recognizing and using the issues and concerns important in their lives as an integral part of the

prevention program. Through the development of authentic, ongoing relationships based on mutuality and equality in a culturally sensitive group environment, women learned to be responsible for their choices. In no issue is this more critical than that of HIV prevention and keeping ourselves safe and alive.

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