https://doi.org/10.36315/2026inpact058
Psychological Applications and Trends 2026

FROM STIGMA TO RESILIENCE: CULTURALLY RESPONSIVE PEER SUPPORT AS PSYCHOSOCIAL CARE FOR PEOPLE LIVING WITH HIV

Taufik Akbar Rizqi Yunanto, & Jesper Herup Dammeyer
Department of Psychology, University of Copenhagen (Denmark)

Abstract

People living with HIV (PLWH) continue to face stigma, identity disruption, and psychological distress that can undermine quality of life and engagement in care. Peer-led support groups are widely used, yet their psychological functions and cultural expressions are still under-specified. This qualitative cross-cultural study examined how peer support groups operate as psychosocial care for PLWH in Denmark and Indonesia, focusing on emotional regulation, identity reconstruction, and empowerment. Forty adults living with HIV were interviewed (20 in Denmark; 20 in Indonesia) between 2024 and 2025 using semi-structured, in-depth interviews. Participants were recruited via community organizations and networks and reflected diversity in age and gender identity. Interviews were audio-recorded, transcribed, and analyzed thematically using a phenomenologically informed approach to capture lived experience and meaning-making. Across both settings, peer groups were described as psychologically safe spaces that enabled emotion-focused disclosure and reduced shame. Peer dialogue supported identity reconstruction, helping participants move from self-blame to resilience by normalizing HIV as a manageable condition and strengthening self-worth. Participants also reported increased empowerment, including confidence in treatment self-management, communicating with healthcare providers, and navigating disclosure and intimate relationships. Cultural variations shaped how these processes were expressed: spirituality and collectivist support were more prominent in Indonesia, while autonomy, boundary-setting, and self-affirmation were emphasized in Denmark. Findings indicate that peer support can function as culturally adaptable psychosocial care that complements clinical services, with implications for integrating peer-led models into stigma-informed mental health and HIV care pathways.

Keywords: *HIV, peer support, stigma, psychosocial care, cross-cultural psychology.*

1. Introduction

People living with HIV (PLWH) continue to face psychological strain linked to stigma, disclosure concerns, and social isolation, even in contexts where antiretroviral therapy has transformed HIV into a manageable chronic condition. Stigma is commonly described as a multilevel process in which societal devaluation becomes internalized through shame, self-blame, and expectations of rejection, shaping emotional wellbeing and everyday participation (Earnshaw et al., 2019; Link & Phelan, 2014). These processes can reduce quality of life and undermine engagement in care, particularly when individuals have limited opportunities to speak openly about HIV.

Peer-led support groups are widely used in community responses to HIV and often serve as entry points to psychosocial support. In this paper, peer support groups are defined as regularly convened, non-clinical meetings facilitated by peers (typically PLWH) in which participants share lived experiences, coping strategies, and resources in a confidential environment. Existing research frequently emphasizes social connection or practical information exchange, but the psychological mechanisms through which peer groups function as psychosocial care are less consistently specified. This limits the ability to translate peer support into clinical pathways and to design culturally responsive models.

A cross-cultural perspective is important because peer support is embedded in norms about disclosure, autonomy, family roles, spirituality, and health systems. Denmark has established HIV services, yet internalized stigma can persist in workplaces, intimate relationships, and self-evaluations. In Indonesia, service expansion coexists with stronger social and structural stigma, including moralizing narratives and gendered expectations that can heighten disclosure risks. Comparing these contexts allows examination of which psychological processes of peer support remain stable and which are culturally shaped.

2. Objectives

This study examined how peer-led support groups function as psychosocial care for PLWH in Denmark and Indonesia. Specifically, it explored (1) how peer groups support emotional regulation and reduce internalized stigma, (2) how peer dialogue contributes to identity reconstruction, and (3) how participation strengthens empowerment in health-related decisions and everyday life, including self-advocacy and engagement in care.

3. Design

A qualitative, cross-cultural design was used. Data were generated through semi-structured, in-depth interviews and analyzed with reflexive thematic analysis. The study adopted a phenomenological orientation to capture lived experiences and meanings of peer support in everyday contexts, while using health psychology concepts to interpret psychological processes relevant to stigma and wellbeing.

4. Methods

4.1. Setting and participants

Forty adults living with HIV participated: 20 in Denmark and 20 in Indonesia. Participants were purposively recruited through community organizations and peer networks to reflect variation in gender, age, time since diagnosis, and engagement with peer support. In Denmark, recruitment was supported by AIDS-Fondet and HIV Denmark; in Indonesia, recruitment was supported by local NGOs and peer networks. Eligibility criteria included being aged 18 years or older, living with HIV, and having participated in a peer-led support group for at least six months. Participants' ages ranged from early adulthood to older adulthood, and the sample included men and women as well as participants who identified outside binary categories.

4.2. Data collection and interviewing procedure

Interviews were conducted between 2024 and 2025 by the first author. A semi-structured interview guide was developed in consultation with community partners and refined through pilot interviews to ensure cultural relevance and person-first language. Core domains included: pathways into peer support; experiences of enacted, anticipated, and internalized stigma; disclosure decision-making; emotional coping; changes in self-understanding; relationships and intimacy; healthcare navigation; and perceived impacts of peer support on treatment engagement and quality of life.

Interviews were conducted in participants' preferred language (Danish, English, or Indonesian). Most interviews took place in private rooms at partner organizations or other agreed confidential settings; when in-person meetings were not feasible, secure video or telephone calls were used. Interviews typically lasted 60-90 minutes. With consent, interviews were audio-recorded. Recordings were transcribed verbatim and anonymized by removing names and identifying details. Non-English interviews were transcribed in the original language; key excerpts were translated to English with attention to meaning equivalence.

4.3. Constructs and analytic approach

Major constructs were defined prior to analysis and refined iteratively during coding. Internalized stigma refers to the incorporation of negative societal beliefs about HIV into one's self-concept, including shame, self-blame, and perceived diminished worth (Earnshaw & Chaudoir, 2009). Emotional regulation refers to processes that reduce distress and help manage difficult emotions, such as relief through disclosure, validation, and learning coping strategies. Identity reconstruction refers to changes in self-understanding and meaning-making, including integrating HIV into a coherent life narrative and shifting from a stigmatized identity to a resilient one. Empowerment refers to strengthened agency, self-efficacy, and confidence in treatment self-management, healthcare communication, and social participation.

Transcripts were analyzed using reflexive thematic analysis (Braun & Clarke, 2006). The analysis followed six phases: familiarization, initial coding, theme development, theme review, theme definition, and reporting. Coding was primarily inductive (grounded in participants' accounts) but interpreted through a clinical and health psychology lens. Cross-cultural comparison was conducted by examining convergence and divergence in themes across countries, focusing on how cultural resources (e.g., collectivism, spirituality, autonomy norms) shaped the expression of the same psychological processes.

4.4. Trustworthiness, ethics, and reflexivity

Trustworthiness was strengthened through an audit trail of coding decisions, iterative memo-writing, and peer debriefing within the research team. Community partners were consulted during analysis to check resonance and cultural appropriateness of emerging interpretations. Ethical approvals were obtained in accordance with institutional requirements in Denmark and Indonesia. All participants provided informed consent and were reminded that participation was voluntary, withdrawal was possible without consequences, and data would be stored securely and reported in anonymized form. Reflexivity was maintained throughout data collection and analysis: the interviewer, a psychology researcher with experience collaborating with community partners in both settings, documented assumptions and potential power dynamics in analytic memos. Interviews started with rapport-building and a clear confidentiality explanation, and open-ended prompts were used to accommodate differences in communication style and to let participants set the pace and depth of disclosure.

5. Results

Peer support was consistently described as different from clinic-based care and everyday social interactions. Participants framed groups as psychologically meaningful spaces where HIV could be discussed without the fear of being reduced to a stigmatized label. Three interrelated themes captured how peer support operated as psychosocial care across contexts.

5.1. Emotional regulation through culturally grounded disclosure

Across both countries, participants described peer groups as safe environments for emotional disclosure. Speaking openly about fear, anger, sadness, or shame produced relief and reduced rumination. Members reported that being understood by someone with similar lived experience changed the emotional tone of disclosure from risk to connection. In Indonesia, emotional regulation was often anchored in collective reassurance and spiritual meaning-making. Participants described prayer, religious framing of adversity, and mutual care as calming resources that helped them tolerate uncertainty and maintain hope. In Denmark, participants emphasized open dialogue, privacy, and boundary-setting; the group was described as a place to name difficult emotions without needing to protect others from discomfort.

5.2. Identity reconstruction: moving from shame to resilience

Peer narratives enabled participants to reinterpret HIV as a manageable condition rather than a moral failing. Through comparison, recognition, and shared vulnerability, participants described a shift in self-concept from being “damaged” to being “still whole.” Indonesian participants frequently described identity reconstruction through belonging and family-oriented roles, often framing resilience as continuing to contribute to household responsibilities and maintaining social dignity. Danish participants more often described identity reconstruction through autonomy and self-affirmation, emphasizing personal growth, authenticity, and the ability to form relationships without hiding. In both contexts, identity reconstruction reduced internalized stigma by replacing shame-based narratives with narratives of survivorship and competence.

5.3. Empowerment in self-management and social participation

Participants reported increased confidence in treatment routines, healthcare navigation, and communication with providers. Peer dialogue provided language and scripts for disclosure decisions, medication adherence, and responding to stigmatizing remarks. In Indonesia, empowerment was commonly described as collective problem-solving, including sharing practical strategies for clinic visits, managing side effects, and negotiating disclosure within family settings. In Denmark, empowerment was often linked to self-advocacy and rights-based communication with healthcare systems and employers. Across both settings, empowerment included advocacy within peer networks, where members supported each other to seek respectful care and challenge misinformation.

5.4. Cross-cultural synthesis of shared mechanisms

Despite different cultural emphases, the findings indicate shared mechanisms: peer groups provided regulated spaces for disclosure, enabled new meanings for HIV, and strengthened agency in health-related decisions. Cultural context shaped which resources were most salient (spirituality and communal belonging in Indonesia; autonomy and privacy in Denmark), but the underlying psychological functions remained comparable.

Table 1. Summary of psychological functions of peer support and cultural expressions across settings.

Psychological function	Denmark (typical expressions)	Indonesia (typical expressions)
Emotional regulation	Safe disclosure; normalization; autonomy and self-affirmation; managing subtle stigma.	Collective reassurance; spirituality and meaning-making; managing stronger disclosure risks.
Identity reconstruction	Integrating HIV into a coherent self; reframing from shame to resilience; future orientation.	Rebuilding identity through belonging and family roles; dignity and social harmony; resilience as contribution.
Empowerment	Rights-based self-advocacy; communication with clinicians and employers; boundary-setting in relationships.	Collective problem-solving; navigating clinics and family disclosure; building confidence through group solidarity.

5.5. Communication within relationships and advocacy

Participants described that peer support improved communication in intimate and family relationships by providing language to explain HIV, treatment, and U=U in a calm and credible way. In Denmark, this supported conversations about dating, disclosure boundaries, and fear of rejection. In Indonesia, participants emphasized maintaining family harmony through selective disclosure and identifying supportive allies. Across settings, some participants also described moving from self-protection to advocacy, such as correcting misconceptions or volunteering in community activities.

6. Discussion

6.1. Implications for HIV care and mental health integration

Peer-led groups can function as a low-threshold extension of mental health support within HIV care by enabling safe disclosure, emotion-focused coping, and guided meaning-making that may not be feasible in routine clinical visits. Linking clinics and community organizations can strengthen referral pathways, facilitator supervision, and safeguarding, while maintaining confidentiality and clear boundaries (Berg et al., 2021; Chime et al., 2019).

6.2. Gender and intersectional considerations

Although the present analysis did not focus on specific sub-populations, participants' accounts suggest that gender norms and relationship expectations shape how stigma is experienced and managed. Women described additional concerns related to caregiving roles and fear of being judged as "irresponsible" partners or parents, while some men emphasized pressures around masculinity, sexual identity, and disclosure in dating contexts. These observations point to the importance of gender-sensitive facilitation and referral pathways, including links to mental health and violence-prevention services where relevant, and reinforce that stigma-informed peer support should be integrated with broader efforts addressing social determinants of health (Earnshaw & Chaudoir, 2009; Rai et al., 2020).

By specifying psychological processes, this study clarifies how peer-led support can function as psychosocial care rather than only social contact or information sharing. Emotional regulation, identity reconstruction, and empowerment formed a coherent pathway through which internalized stigma was reduced and quality of life improved. The cross-cultural comparison suggests that the same processes can be expressed through different cultural resources: spirituality and collectivism were prominent in Indonesia, while autonomy and self-affirmation were more explicit in Denmark (Earnshaw & Chaudoir, 2009; Yigit et al., 2025).

For clinical and health psychology, the findings support integrating peer support into HIV services as a complementary component of mental health care, especially where access to formal psychological services is limited or stigmatized. Training and supervision for peer facilitators could focus on creating psychologically safe disclosure norms, addressing shame-based narratives, and strengthening communication skills for healthcare interactions. Collaboration between clinics and community organizations is important for referral pathways, confidentiality protections, and sustainability (Lindgren et al., 2018; Øgård-Repål et al., 2022).

6.3. Limitations and future directions

Limitations include purposive recruitment through peer networks (which may under-represent individuals not connected to groups), possible social desirability in discussing stigma, and translation challenges when synthesizing across languages. Future research could combine qualitative mechanisms with quantitative testing of pathways (e.g., internalized stigma to wellbeing via empowerment) and evaluate implementation outcomes of culturally tailored peer models.

7. Conclusions

Peer-led support groups function as culturally adaptable psychosocial care for PLWH by enabling emotional regulation, identity reconstruction, and empowerment. Detailing the interviewing process and clarifying the constructs strengthens interpretability of the findings and supports transferability. Integrating peer support within HIV care and community services may reduce internalized stigma and improve psychological wellbeing across diverse settings.

Acknowledgments

The authors thank all participants and collaborating organizations in Denmark and Indonesia for their time, trust, and contributions.

References

Berg, R. C., Page, S., & Øgård-Repål, A. (2021). The effectiveness of peer-support for people living with HIV: A systematic review and meta-analysis. *PLoS ONE*, *16*(6), e0252623. https://doi.org/10.1371/journal.pone.0252623

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Chime, O. H., Arinze-Onyia, S. U., & Ossai, E. N. (2019). Examining the effect of peer-support on self-stigma among persons living with hiv/aids. *Pan African Medical Journal*, *34*, 1-11. https://doi.org/10.11604/pamj.2019.34.200.17652

Earnshaw, V. A., Bogart, L. M., Menino, D. D., Kelly, J. F., Chaudoir, S. R., Reed, N. M., & Levy, S. (2019). Disclosure, Stigma, and Social Support Among Young People Receiving Treatment for Substance Use Disorders and Their Caregivers: A Qualitative Analysis. *International Journal of Mental Health and Addiction*, *17*(6), 1535-1549. https://doi.org/10.1007/s11469-018-9930-8

Earnshaw, V. A., & Chaudoir, S. R. (2009). From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures. In *AIDS and Behavior, 13*(6), 1160-1177. https://doi.org/10.1007/s10461-009-9593-3

Lindgren, T. G., Reyes, D., Eller, L., Wantland, D., Portillo, C., Holzemer, W. L., Matshediso, E., Corless, I., Kemppainen, J., Mogobe, K. D., Webel, A., Nokes, K., Nicholas, P., Rivero Mendez, M., Reid, P., Baez, S. S., Johnson, M. O., Cuca, Y., & Rose, C. D. (2018). Understanding Health Literacy for People Living With HIV: Locations of Learning. *Journal of the Association of Nurses in AIDS Care*, *29*(2), 190-203. https://doi.org/10.1016/j.jana.2017.10.007

Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science and Medicine*, *103*, 24-32. https://doi.org/10.1016/j.socscimed.2013.07.035

Øgård-Repål, A., Berg, R. C., & Fossum, M. (2023). Peer Support for People Living With HIV: A Scoping Review. In *Health Promotion Practice*, 24(1), 172-190. https://doi.org/10.1177/15248399211049824

Øgård-Repål, A., Berg, R. C., Skogen, V., & Fossum, M. (2022). "They make a difference": a qualitative study of providers' experiences of peer support in outpatient clinics for people living with HIV. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-08810-9

Rai, S. S., Peters, R. M. H., Syurina, E. V., Irwanto, I., Naniche, D., & Zweekhorst, M. B. M. (2020). Intersectionality and health-related stigma: insights from experiences of people living with stigmatized health conditions in Indonesia. *International Journal for Equity in Health, 19*(1). https://doi.org/10.1186/s12939-020-01318-w

Yigit, I., Wilson, T. E., Taylor, T. N., Kassaye, S. G., Weiser, S. D., Cohen, M. H., Gange, S., Pence, B. W., Ofotokun, I., Wingood, G. M., Metsch, L. R., Brown-Friday, J., Floris-Moore, M., Kempf, M. C., Turan, J. M., & Turan, B. (2025). Association of experienced stigma in healthcare settings with health outcomes among Black women living with HIV: Mediating roles of internalized stigma, anticipated stigma, and trust in HIV care. *Social Science and Medicine*, *366*. https://doi.org/10.1016/j.socscimed.2025.117699