# Social Identity, Group Membership and Trust

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Abstract

The social identity theory postulates that membership in homogeneous groups could result in a strong identity derived from these groups. Under certain conditions this could result in ingroup bias where group members favour their own group over outgroups. Similar phenomena have been reported in the social capital literature, where dense bonding groups display high levels of intragroup trust, but less trust in other groups in the society. The present study applied the social identity theory as a framework for understanding the association between intragroup trust and trust in other networks. The participants of the study were 200 HIV positive men and women engaging in a support group in KwaZulu-Natal, South Africa. The study included three questionnaires, the first assessing motivation for joining a group, the second assessing social identity derived from the group (collective self-esteem scale) and the third examining the notion of trust against bonding, bridging and linking networks. The results were mixed: Social identity was both negatively and positively associated with general trust, and mostly positively associated with trust in linking networks. The findings imply that social identity theory and ingroup bias could be a fruitful explanation for the negative association between intragroup trust and general trust. Limitations of the study are discussed.

# Introduction

## *Background*

Membership in groups could potentially result in individuals strongly identifying with the particular group (Hinkle & Brown, 1990). Research has shown that strong identification with some groups could result in ingroup bias, where group members favour their own group over outgroups (Leach et al., 2008). This study will explore how social identity derived from a support group for HIV positives in KwaZulu-Natal, South Africa, relates to trust in different groups and networks in the society.

South Africa is confronted with severe social and economical difficulties. The economic inequalities within the population are one of the largest in the world. The unemployment rate, when including people who do not actively seek work, reaching almost 40%. The rates of crime, violence, rape and murder are high, some argue the highest in the world (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Williams et al., 2007). Additionally, HIV and AIDS is a major health problem (UNAIDS, 2008). In 1994 the estimated number of people living with HIV/AIDS in South Africa was approximately 5%, in 1998 the number had risen to 13%, and in 2008 the number was estimated to be as high as nearly 20% (WHO/UNAIDS/Unicef, 2008). The population is facing adversity, which could leave many fearful and uncertain concerning their present and future.

Concerns relating to medical, social and personal aspects of a HIV/AIDS diagnosis is common, and can have severe consequences for the well-being of the infected (Brashers, Neidig, & Goldsmith, 2004; Brashers et al., 2003). On the psychosocial level, fear of being discriminated, stigmatized and rejected is frequently observed (Bos, Schaalma, & Pryor, 2008; McCain & Gramling, 1992). This may prevent people from disclosing their illness (Kalichman et al., 2009). One study illustrates how HIV positive South Africans often are exposed to negative responses from family and friends when disclosing their status. Some experience accusations of having low morals, family trying to hide and deny their status, or at worst full rejection (Greeff et al., 2008). Other common worries are uncertainty and fear related to their family and their children's future (Regan-Kubinski & Sharts-Hopko, 1995), to their identity as sick (Baumgartner, 2007; Brashers et al., 2003), progression of the disease, fear of opportunistic diseases and concerns related to the access of medication (Weitz, 1989).

A possible way of coping with negative affects associated with an HIV diagnosis, is by joining support groups (Phillips & Morrow, 1998; Walch, Roetzer, & Minnett, 2006). Few studies have explored the effect of support groups for people living with HIV/AIDS in South Africa. However, Dageid and Duckert (2007) found that people living with HIV/AIDS in South Africa, benefited from being members of support groups. A review evaluating the effects of HIV support groups in western countries, concluded that membership in support groups overall enhances the members' quality of life (Spirig, 1998). Under circumstances where individuals living with HIV/AIDS experience lack of adequate support from family and friends, support groups may represent a valuable additional source of social support (Iwelunmor, Airhihenbuwa, Okoror, Brown, & BeLue, 2006).

By joining support groups, HIV infected people have an opportunity to learn from people in similar situations as themselves, receive information on how to handle the disease, and be part of a social support network. Literature has identified several motivations as to why HIV positive individuals join support groups. Social support, need for information concerning the illness, access to medication and changing family and friends attitude towards the illness, all seem to be important contributors when people decide to join support groups (Adams, 2002; Trojan, 1989). When people join groups due to common motivations, identification with the group is often observed.

*Social Identity & Group Dynamics*

There are many motivations for joining groups. The social identity theory has emphasized the need for enhanced self-esteem and the reduction of uncertainty, as important factors. The need for a positive self-esteem may potentially be achieved through categorization and identification as a group member (Abrams & Hogg, 1988). One way of enhancing or maintaining positive self-esteem is by regarding the ingroup more favourable than other groups, this is know as the ingroup bias. Feelings of uncertainty are also proposed as a motivation for joining groups. When categorized as a group member one can adopt the norms of the group and act in accordance with those. The norms and prototype of the group serve as guidance to how the individual should behave, think and feel, and thus could reduce uncertainty (Jetten, Hogg, & Mullin, 2000; Jetten, Postems, & McAuliffe, 2002).

The social identity theory emerged in the 1970s, proposed by Tajfel and Turner (1979). The theory has since the 70s become a widely used framework for understanding a large variety of

social psychological mechanisms like prejudice, crowd behavior and intergroup conflicts (e.g. Hogg & Grieve, 1999; Kemmelmeier, Broadus, & Padilla, 2008; Klein, Licata, Azzi, & Durala, 2003). The theoretical view is closely associated with the self-categorization theory (Tajfel & Turner, 1979). The self-categorization theory postulates that all people have an intuitive need to understand the social world surrounding them. To accomplish this, people extract differences and similarities between social concepts, and in light of this information form cognitive categories. Forming cognitive categories is an adaptive way of making sense of the social world; by categorizing who belong to which group (Abrams & Hogg, 1990). Self-categorization is believed to guide behaviour, emotions and cognition. A result of the categorization is the formation of social identity; people identify with the social categories they feel they belong to. Tajfel (1978) defines social identity as "that part of an individual's self-concept that derives from his knowledge of his membership of a social group (or groups) together with that value and emotional significance attached to that membership"(Tajfel, 1978:63). Hence, social identity is identity created as a consequence of group membership, and stands in contrast to personal identity. Because people often are members of multiple groups, they have several social identities. However, some social identities are stronger and more salient than others (Abrams & Hogg, 1990).

*Homogeneous Groups and Ingroup Bias*

Degree of group homogeneity is one of several conditions which could influence the strength of identification with a particular group (Doosje, Ellemers, & Spears, 1995). The perception of "sharing the same fate", facing the same obstacles and in short being similar to the other members of the group, has shown to reinforce the social identity derived from the group (Castano, Yzerbyt, & Bourguignon, 2003; Leach et al., 2008). Having the same motivations for joining the group, e.g. concerns related to a HIV diagnosis, could possibly strengthen the perception of homogeneity and similarity for the group members, and result in stronger social identification. Homogeneous groups are often characteristic for collectivistic societies. Hinkle and Brown (1990) argue that groups in collectivistic cultures are more concerned about their ingroup because the intragroup bond is tighter than in heterogeneous groups (Brown et al., 1992; Hinkle & Brown, 1990). Collectivistic cultures often value ingroup harmony highly, and make quite strong ingroup – outgroup distinction. They also define themselves more often in relation to the ingroup, than what is usual for individualistic cultures (Hui & Triandis, 1986; Triandis, Leung, Villareal, & Clack, 1985; Triandis, McCusker, & Hui, 1990). Because homogeneous groups in collectivistic societies are more preoccupied with their ingroup,

members potentially strongly identify with the ingroup. Accordingly, members can be prone to view their own group more positively than other groups, and lead them to disregard outgroups (Hinkle & Brown, 1990). A meta-analysis evaluating the effect of different predictors for ingroup bias, illustrated that ingroups salience increased the level of ingroup bias (Mullen, Brown, & Smith, 1992). Thus, merely being aware of social identity derived from a specific group contributes to ingroup bias. As homogeneous group members are concerned about their ingroup, their identity as ingroup members could more often be salient than for a less homogeneous group. This could result in highly homogeneous groups favouring their own group over outgroups (Leach et al., 2008).

The majority of research investigating cultural differences between individualistic and collectivistic societies, characterize traditional South African cultures as collectivistic (Hui & Triandis, 1986; Realo, Allik, & Greenfield, 2008). It is worth noting that individuals from collectivistic cultures not automatically derive strong social identification from all the groups they belong to (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). The value and emotional significance individuals ascribe the ingroup, will determine if strong social identification is derived (Tajfel, 1978). Luhtanen and Crocker (1992) label the value placed on one's social group, collective self-esteem, and define four constructs as important in order for people to derive a social identity. These four constructs are: *Evaluation of how good or worthy one is as a member of the social group*, *the personal evaluation of the social group*, *perception of how other evaluate the group*, *and the importance to their identity*. These factors combined will indicate how strongly the person identifies with the group. Thus, merely being part of a group does not automatically imply that individuals identify with a group.

Even though tight and homogeneous groups obviously could be beneficial for the individual, e.g. in form of strong emotional bonds, positive social identity, and enhanced self esteem, it could have negative consequences as well. These negative consequences have mostly been attributed to the ingroup bias, which at worst could result in conflict, prejudice and hatred between groups (e.g. Hogg & Grieve, 1999; Kemmelmeier et al., 2008; Klein et al., 2003). It is, however, also possible, that the ingroup could suffer from being too tight-knit in a more indirect manner. When taking the individual as a member of the society into account, this becomes evident. By disregarding outgroups, members of the ingroup will potentially neglect the fact that these groups could offer them something of importance. Society is made up of

diverse groups and networks, these networks have different qualities, and thus being member of a variety of different groups could be beneficial for the individual. In this case trust is important, and without trust, individuals will not be able to access resources (e.g. Bourdieu, 1986; Portes, 1998; Putnam, 1993). The social capital theory gives an account for the dynamics in interaction between structurally different groups, and emphasizes trust as one of the most important factors in allowing resources to be shared between groups and individuals. However, recent research in relation to social capital has revealed that dense and homogeneous groups have high levels of intragroup trust, but simultaneously display distrust in other structures in the society (e.g. Stolle, 1998; Yamagishi, Cook, & Watabe, 1998). This phenomenon has not been fully explained in the social capital literature, and it could be fruitful to view this in light of social identity and ingroup bias.

*Social Capital*

Social capital has recently been adopted by health psychology as a concept explaining how social relations influence health (Abbott & Freeth, 2008). Research has illustrated that social capital influences health outcomes, furthermore that higher levels of social capital enhance health (Bolin, Lindgren, Lindström, & Nystedt, 2003; Campbell, 2001; Cattell, 2001; Pronyk et al., 2008). The core features of social capital are networks, norms and trust. In short, the theory postulates how membership in different networks may be beneficial for the individual, and may foster social action (Bourdieu, 1986; Putnam, 1993). Because the concept has been used interdisciplinary, little consensus exists regarding the exact definition of the term (Macinko & Starfield, 2001). A main distinction is often made between two perspectives of social capital: Whether to view social capital as a property of the individual (Portes, 1998), or a property of the group (Putnam, 1993).

Bourdieu (1986), one of the original theorists on social capital, defines the concept as resources emerging in networks of people. Membership in networks is the key essential when accessing these resources. A support group is an example of how individuals may access and exchange resources like social support, emotional support and knowledge on how to handle the disease. Kawachi, Subramanian and Kim (2008) have labeled this view the "network theory of social capital". The understanding of social capital in this paper will be in line with Kawachi, Subramanian and Kim's definition, and could be summarized as all the different resources that individuals can access by being members of groups and networks.

*Levels of Social Capital*

In the social capital literature, distinction is made between three different levels of networks, labelled bonding, bridging, and linking (Kawachi, Subramanian, & Kim, 2008). Bonding networks are constituted by people that are alike, they share the same background, values and social identity. Since bonding networks often consists of people that are similar, they tend to be tight-knit. Typical examples of bonding groups are family and friends. Bridging networks are heterogeneous networks. Members of these networks may have different gender and age, different nationality or ethnicity, as well as different socioeconomic status and education. In short; they differ from each other on one or several dimensions. People's works place could be one form of bridging network. The third network is called linking. Linking networks consists of formal heterogeneous networks on higher levels, e.g. government and health systems. Because of the structural differences in bonding, bridging and linking networks, they could be said to serve different functions. Bonding networks are important in forming fellowship and cohesive groups where an outcome often is a group identity (Putnam, 2000). Bridging and linking networks consists of people that are dissimilar, and are often less tight than bonding groups. Because people in bridging and linking networks have different backgrounds, they also carry a diverse set of resources. Being a member of these networks could therefore allow the individual to access fairly diverse resources, more so than in bonding networks. In addition, access to resources on linking level may have the potential to influence wider social and political contexts. It is assumed that people get access to resources on linking level by moving through bridging networks (Harpham, 2008).

*Trust*

Individuals should preferably take part in several groups at bonding, bridging and linking levels to access a larger variety of resources. Traditionally, when assessing social capital in communities, researchers have mostly *described* the networks people take part in, rather than investigating the quality of the networks (Abbott & Freeth, 2008). It is important to examine how the individuals perceive their networks: Do they feel good about their networks? Do they value their group? In line with this, the notion of trust is essential. Trust is described as a lubricant which makes social interaction smoother (Igarashi et al., 2008). Without trust, resources will not be exchanged and networks may not voluntarily be formed (Putnam, 1993) Trust is not a one-dimensional concept, and because the networks in social capital theory are structurally distinct, trust within different networks may be expressed differently. In tight bonding groups, trust could potentially be easily formed, first of all, because the members

personally know each other and are similar. If the group is tight, members will most likely adhere to the norms and values of the groups. At bridging levels, which are looser and constituted by people that do not necessarily know each other that well, trust might resemble a general attitude. These different expressions of trust have been labeled generalized and particularistic trust, respectively (Igarashi et al., 2008). Generalized trust is a belief that on a general basis, people in a society are to be trusted; hence you do not need to know people personally in order to trust them. Particularistic trust on the other hand, is trust in people you personally know. Generalized trust is often obtained because a society communicate a norm which convey that people are to be trusted, and act in a trustworthy manner (Uslaner, 1999).

Investigating the level of trust will therefore be important when assessing the quality of social capital. However, diverse dimensions of trust need to be taken into account. High levels of one type of trust could omit trust in other networks. Stolle (1998) explored how ingroup trust in voluntary groups, like bowling leagues, self help groups and church choirs, related to general trust. It was found that the level of ingroup trust was high in voluntary groups which could be characterized as homogeneous and tight, and where people had adopted the group norms and identity. However, there was a negative association between ingroup trust, and trust in people in general. Thus tight and homogenous groups had high levels of trust within the group, but low levels of generalized trust. This association was reversed for heterogeneous groups (Stolle, 1998).

Similar results have been found in studies investigating trust on societal level. The particularistic vs. general trust dimension has typically been investigated across cultures, contrasting "collectivistic" and "individualistic" cultures. When exploring trust in the Japanese and North American societies Yamagishi, Cook and Watabe (1998) found that people in the Japanese society had higher levels of interpersonal trust than people in the North American society, however they also displayed less general trust than Americans did. According to the classical distinction between collectivistic and individualistic cultures, the authors expected to find higher degree of general trust in Japan, because of tighter social cohesion and interdependent self-conception associated with collectivistic cultures. However, it seems as though people living in collectivistic cultures often have tight ingroup bonds, but less trust in people outside their group, than what is the case for individualistic cultures. Realo, Allik and Greenfield (2008) sought to investigate the level of social capital in collectivist and individualistic cultures. Also here the collectivistic cultures had higher level

of ingroup trust, but displayed lower levels of generalized trust. The South African culture displayed relatively high levels of trust in ingroups, measured by family and friends, but scored low on generalized trust. The association was reversed for individualistic cultures, like Sweden.

Stolle (1998) argues that the negative association between ingroup trust and generalized trust needs to be explored further. Similar concerns have been expressed by Portes (1998). Portes has, however, not explicitly addressed the role of trust, but rather concern related to the potential negative effect tight bonding groups may have, a phenomenon he calls anti-social capital

*Anti-social Capital*

Portes (1998) argues that the potential negative consequences of social capital have been more or less ignored. For example, the structural social capital measured by number of networks in a community might be fairly high, but the quality of the networks might be poor. In his article, Portes describes four different ways social capital may have negative consequences. Firstly, tight networks, especially on bonding level, could obstruct the individual's sense of freedom because conformity with the group norms is expected. Secondly, strong group ties could exclude outsiders, and obstruct their chances of becoming members; thirdly, this could also prevent members from joining other groups. Fourthly, some groups are formed partly because of their identity as underdogs compared to the society as a whole. In these groups a down levelling norm could be at work, making sure people do not leave the group in order to pursuit a "better" life. Other theoreticians have discussed more or less the same arguments as Portes (E.g. Baum, 1999; Campbell, 2001). A reoccurring theme is how dense groups may have negative consequences both for the group members, as well as for individuals outside the group.

*Anti-social Capital and Social Identity*

Anti-social capital, as Portes describes it, has caught attention, but to our knowledge little has been done in order to understand the mechanisms involved. As trust is vital for social capital to materialize, investigating the relationship between tight bonding groups and trust could therefore be an attempt to understand some of the mechanisms involved in anti-social capital. It could be fruitful to explore how the social identity theory is related to trust in different networks in the society. As trust is an important factor when establishing relations with new

group, distrust or lack of trust in other groups, could be viewed as a form of discrimination (Paolini, Hewstone, Cairns, & Voci, 2004; Voci, 2006).

*Present Study*

The aim of this study is to investigate if the social identity theory could be one approach in understanding the association between tight bonding group and trust in other networks, furthermore, if social identity could be said to be involved in the formation of antisocial capital. We wish to investigate how the group members display general trust and trust in bonding, bridging and linking level and if a strong social identity is negatively associated with trust in these networks. The goal of this study is to get fairly homogeneous groups. If the members are similar and share social identity, the groups could be characterized as a bonding group.

The current study is conducted through the non-governmental organization (NGO) the Treatment Action Campaign (TAC) in KwaZulu-Natal, South Africa. TAC started as a HIV/AIDS advocacy group, with treatment coverage, care and support for HIV/AIDS infected individuals as one of their most important objectives (TAC, 2009b). As a result of their continuing pressure on official governmental structures, implementation of national treatment coverage has been initiated. Thus, on a national level, TAC has contact with the government and with the health system. TAC has over 16 000 members across all nine provinces in South Africa, and the provincial and local TAC branches have regular contact with support groups in the local communities (TAC, 2009a). Many of the members of the support groups are also involved in TAC, and thus the support groups have close contact with TAC. The support groups are situated in the local communities in South Africa, called townships. Townships are areas where the indigenous black population was restricted to live under substandard conditions, during the apartheid regime. The townships continue to be inhabited by black South Africans, and thus the population is fairly homogeneous. In KwaZulu-Natal, where the present study was conducted, the majority of people living in the township are of the same ethnicity, they have approximately the same socioeconomic status and the same educational status. Informants of this study share the same motivation for participating in support groups, namely their status as HIV positives. In this respect they could be said to share a “common fate”. The homogeneous character of these support groups serves as an important factor in defining them as groups on the bonding level.

*Research objectives*

Firstly, the motivation behind joining group is assessed, this will indicate if the support group members' share a common motivation and thus could be characterized as being homogeneous. Secondly, social identity derived from the support group will be explored in order to investigate the level of identification with the support group. Thirdly, the relationship between social identity derived from the support group, and level of trust in different networks on bonding, bridging and linking level is investigated. The final goal is to investigate if social identity could be one way of explaining some of the mechanisms involved in anti-social capital.

## Methods

*Participants*

A total of 212 isiZulu speaking, HIV positive people who were members of a support group took part in the study. Of these, four were excluded because of inconsistent answering, and eight were excluded because their membership did not exceed 1 month, the time needed in order to be able to form a social identity. 200 participants were included in the final analysis. Of these, 183 (91,5%) were females and 17 (8.5%) males. The mean age was 35 years (SD=9.391). 166 (83%) of the participants reported living in a rural area. 112 (56%) reported no income, 65 (33%) had an income between 500-999 rands, leaving 23 (11,5%) with an income of 1000 rands or more. The majority of the sample were single (72.5%), 18% were married, and 9% were either separated, engaged, divorced or a widow/widower. The mean level of education was 9.6 grade ( SD= 2.455), which in years of schooling correspond to $10^{th}$ grade in the Norwegian educational system. The mean time spent being member of the support group was 30 months (SD=25,843), or 2.5 years.

*Procedure*

With regards to assistance in locating support groups in the province of KwaZulu-Natal, South Africa, the Treatment Action Campaign (TAC) was contacted. All together 11 support groups took part in the study. Since the majority of the population in KwaZulu-Natal are isiZulu speaking, an isiZulu speaking, TAC employee was trained as an interpreter. The support groups were visited at their weekly meetings, where the purpose of the study was explained and their participation requested. Participants were asked to individually fill in

three questionnaires. The participants were instructed to answer the questionnaires, by ticking off the statement that best corresponded to their attitudes, thoughts and feelings. The questions were read out loud by the translator, making sure every participant understood the questions. If the questions were perceived to be ambiguous, the participants had an opportunity to address it via the translator. Each session took approximately two hours; both lunch and money for transportation to the meetings were provided for.

*Ethics*

The study was approved by the National Committee for Research Ethics in Norway (REK). After receiving a complete oral and written description of the study, all subjects gave written informed consent to participate. They were explained that participation was voluntary and that they at any time during the study could choose to withdraw without stating a reason. Participants were assured that information would be treated with confidentiality, and that data would be securely stored. The main findings will be shared with TAC, in form of a report. This will contribute to the continuous effort to improve and expand work relating to care and support for HIV positives, in KwaZulu-Natal, South Africa.

*Instruments*

The three instruments were translated from English to isiZulu, by an isiZulu speaking master student attending the University of KwaZulu-Natal. The master student was familiar with the concept of social capital, and psychological terminology in general. A TAC employee working at the provincial office in Durban, examined the IsiZulu translation, making sure the questionnaires would be understandable for the sample in question.

*Measure of Motivation.* In order to measure the degree of homogeneity related to the motivation for group membership, a questionnaire consisting of one item with eight response categories were developed. The response categories were constructed based on two studies which identified motivation for group membership (Adams, 2002; Trojan, 1989). The Item was: *Why did you become a member of this support group?,* with the following response categories: 1) *To obtain knowledge about HIV/AIDS*, 2) *To receive support from fellow group members*, 3) *To learn from what other have experienced/experience*, 4) *To obtain feelings of being "normal"*, 5) *Because my family/friends wanted me to*, 6) *To change how my family/friends think about HIV/AIDS*, 7) *To receive medical help,* 8) *Because of fear of being stigmatized*, 9) *To get access to grants*. The questionnaire was a five point likert scale, where

responses ranged from 1= agree to 5= disagree. The questionnaire was used as a background to assess the degree of homogeneity of motivation in the sample.

*Collective Self-esteem Scale.* The collective self-esteem scale (CSES) is a 16 item, 7 point (1= *strongly disagree* to 7= *strongly agree*) likert scale developed by Riia Luhtanen and Jennifer Crocker (1990). The CSES seeks to assess collective esteem in accordance with the social identity theory and is one of the most widely used scales measuring social identity (Aberson, Healy, & Romero, 2000). The CSES measures collective self-esteem using four subscales: Importance to identity, private collective self-esteem, membership esteem and public collective self-esteem. Four items constitute each subscale, where two are positively worded, and two negatively worded.

The "importance to identity" subscale measures people's social identity derived from groups that are important to them, using the following items: 1) *"Overall, my group memberships have very little to do with how I feel about myself*", 2) "*The social groups I belong to are an important reflection of who I am*". 3) "*The social groups I belong to are unimportant to my sense of what kind of a person I am*". 4) "*In general, belonging to social groups is an important part of my self-image*".

The "private collective esteem" subscale is a measure of group members evaluation of the social groups they belong to: 1)*"I often regret that I belong to some of the social groups I do"*, 2) *In general, I'm glad to be a member of the social groups I belong to"*, 3)"*Overall, I often feel that the social groups of which I am a member are not worthwhile*", 4)"*I feel good about the social groups I belong to*".

Four items measure what Luhtanen and Crocker describes as the most individualistic aspect of collective self-esteem, or in other words, the individual's esteem related to their status as group members; "Membership esteem": 1) "*I am a worthy member of the social group I belong to*", 2) "*I feel I don't have much to offer to the social group I belong to*", 3)"*I am a cooperative participant in the social group I belong to*", 4)"*I often feel I'm a useless member of my social group*".

The four last items assess the "public collective esteem"; the individuals' perception of how others evaluate their group: 1) "*Overall, my social groups are considered good by others*", 2)

"*Most people consider my social groups, on average, to be more ineffective than other social groups*", 3)"*In general, other respect the social groups that I am a member of*", "4) *In general, other think that the social groups I am a member of are unworthy*".

The CSES is originally designed to assess collective self-esteem in relation to all major social groups that are important to the individual. In this study however, only their collective self-esteem derived from the specific support group was of interest. The wording of the scale was therefore changed, from pertaining to plural groups to apply to the specific support group. E.g "the **social groups** I belong to are an important reflection of who I am" was changed to "the **social group** I belong to is an important reflection of who I am". The participants were asked to think of their membership to the specific support group when filling out the questionnaire. Luhtanen and Crocker (1992) report that altering the questionnaire to assess membership to a specific group, does not compromise the scale.

Both the total collective self-esteem scale, and each of the subscales have previously reached good internal reliability (Luhtanen & Crocker, 1992). The negatively worded items were reversed, and a total subscale score was calculated for the scale. A high score on the total scale score indicate a high social identity. The internal consistency of the scale was explored using Cronbachs coefficient alpha. Including all 16 items, the scale failed to reach acceptable alpha levels. When excluding three items; Membership 2, Membership 4 and Identity 1, the alpha increased to a level of $\alpha = .681$. Conventionally, Alpha levels of .7 or more are viewed as acceptable. However, taking the relatively low number of items into account, an alpha level of .681 could pass as acceptable. Each of the four subscale did not reach acceptable internal reliability, and total subscale scores was therefore not calculated.

*Trust- and Social Capital Questionnaire.* The social capital questionnaire is based on a survey developed by the World Bank with the intention to assess social capital at individual, community and institutional level (Grootaert & van Bastelaer, 2001; Krishna & Shrader, 1999). In this study, only items pertaining to perceived trust were included. Using a 5 point likert scale, responses ranged from 1 to 5. The response format varied in relation to questions, however it ranged from 1= disagree/not at all, to 5= Agree/total(ly), or mirrored the question e.g. *Do you think that most people would take advantage of you if they got the chance, or would they try to be fair?* 1 = Definitely try to take advantage to 5 = Definitely try to be fair. A high score on the variables indicate high levels of trust.

The social capital questionnaire included items assessing general trust, using five items: 1) *Generally speaking, would you say that people can be trusted or that people cannot be trusted?* 2) *Generally speaking, you can't be too careful in dealing with most people* 3) *Would you say that most of the time people try to be helpful, or are they mostly looking out for themselves?* 4) *Do you think that most people would take advantage of you if they got the chance, or would they try to be fair?* 5) *If you suddenly had to go away for a day or two, could you trust on your neighbours to look after something that is important to you, e.g. your children, your house etc?*

Trust in bonding levels included four items: 1) *I can trust each of the following to act in my best interest: My partner, my close family, my extended family and my friends.* 2) *When I need advice or emotional support I can count on the following to provide it: My partner, my close family, my extended family and my friends.* 3) *I'm certain that my family and friends trust me.* 4) *How much confident/trust do you have in your support group?*

Trust in bridging levels included 1) *Do you trust community based groups to provide support for people living with HIV/AIDS? E.g homebased care, saving groups (funeral), traditional healers.* 2) *How much do you trust, or how confident are you with, people that are different than you?* 3) *How much confident/trust do you have in other support groups?*

Trust in linking networks: 1) *How much do you trust, or how much confidence do you have in the following groups? National government, provincial government, Local government, Traditional leadership, the health system, The public services, NGO's* 2) *To what extent do you trust local government and local leaders to take into account concerns voiced by you and people like you when they make decisions that affect your community?* 3) *I do not trust that my group gets access to resources the government and larger NGOs possess.*

As the social capital instrument is a survey questionnaire and not a scale, there was low internal consistency in relation to trust on the separate levels. Each item was therefore handled as a separate variable, except two items. Two items measuring trust in bonding groups reached an acceptable alpha level $\alpha = .714$, and thus were collapsed into one item, called "Trust familiy/friend" This included : 1) I can trust each of the following to act in my best interest: My partner, my close family, my extended family and my friends, and 2) When

I need advice or emotional support I can count on the following to provide it: My partner, my close family, my extended family and my friends.

*Analysis*

Analysis was conducted with a two tailed significance test, with a significance level of .05. Frequency analysis was conducted in order to investigate if the sample had similar motivations for joining groups. Correlations and multiple regression analysis was conducted to explore whether social identity could predict lack of trust in different levels, and investigate which collective self-esteem item best predicted unique variance in trust in different levels.

## Results

In order to investigate whether the sample in question could be defined as homogeneous, frequencies of reported motivation for joining support groups were investigated, table 1.

*Table 1*

*Frequencies of agreement for motivation behind joining support groups*

| | *Agree* | | *Agree somewhat* | | *Unsure/Neutral* | | *Disagree somewhat* | | *Disagree* | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *N* | *%* | *N* | *%* | *N* | *%* | *N* | *%* | *N* | *%* |
| Obtaining Knowledge | 193 | 96.5 | 1 | 0.5 | | | | | 2 | 1 |
| Receive Support from Fellow Group Members | 186 | 93 | 6 | 3 | 1 | 0.5 | | | 2 | 1 |
| Learn from other's Experience | 190 | 95 | 3 | 1.5 | 2 | 1 | | | 1 | 0.5 |
| Obtain feelings of being normal | 173 | 86.5 | 4 | 2 | 5 | 2.5 | | | 7 | 3.5 |
| To change How family/friends think about HIV | 181 | 90.5 | 1 | 0.5 | 2 | 1.0 | | | 5 | 2.5 |
| To Receive medical help | 185 | 92.5 | 2 | 1 | 1 | 0.5 | | | 2 | 1 |
| Fear of being stigmatized | 142 | 71.0 | 13 | 6.5 | 2 | 1 | 4 | 2 | 18 | 9 |
| Access grants | 127 | 63.5 | 4 | 2 | 6 | 3 | 4 | 2 | 40 | 20 |

There is high agreement concerning motivations behind joining support groups in the sample. Obtaining knowledge, receiving support, learning from other's experience, changing family/friend's attitude and receiving medical help have an agreement rate of over 90%. There is least agreement concerning access to grants as a motivation behind joining support groups. Obtain feelings of being normal and fear of being stigmatized also had fairly high agreement rates.

To investigate social identity derived from the group, mean score on total collective self-esteem scale, and each item constituting the scale was calculated. Tabel 2.

*Table 2*

*Mean and standard deviation for total CSES, and each CSES item*

| | *M* | *SD* | *N* |
|---|---|---|---|
| **Membership** | | | |
| I am a worthy member of group | 6.15 | 1.66 | 195 |
| Cooperative participant of group | 6.47 | 1.35 | 192 |
| **Private** | | | |
| I often regret that i belong to the group (rev) | 5.46 | 2.3 | 185 |
| I'm glad to be member of the group | 6.22 | 1.72 | 186 |
| I often feel the group is not worth while (rev) | 5.68 | 2.11 | 180 |
| I feel good about the group | 6.44 | 1.58 | 190 |
| **Public** | | | |
| The group is considered good by others | 5.89 | 1.95 | 188 |
| People consider my group to be ineffective (rev) | 4.95 | 2.54 | 186 |
| Other respect my group | 6.15 | 1.72 | 195 |
| Other think my group is unworthy (rev) | 5.73 | 2.15 | 192 |
| **Identity** | | | |
| The group is an important reflection of me | 5.95 | 1.98 | 191 |
| The group is unimportant to my sense of self (rev) | 5.33 | 2.45 | 186 |
| Beloning to the group is important part of self-image | 6.69 | 1.1 | 196 |
| **Total CSES score** | 6.04 | 0.84 | 131 |

**Note: The negatively worded items are reversed. A high score indicate a high social identity.**

The mean score on total collective self-esteem scale, and each scale item was on the higher end of the scale. None of the means were under 4.

Correlations and multiple regressions were conducted to explore the relationship between collective self-esteem and trust, and to explore whether collective self-esteem could predict variance in trust in different levels. The next section has four parts, one section for trust in each level: general trust, trust in bonding networks, trust in bridging networks and trust in linking networks.

*Collective Self-esteem and General Trust*

To explore how collective esteem relates to general trust, the total CSES was correlated with the five items measuring general trust, shown in table 3.

*Table 3*

*Correlations between CSES and General trust*

| | | | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|---|---|
| 1 | Generally speaking people can be trusted | | - | | | | | |
| 2 | Are people generally helpful | | .149* | - | | | | |
| 3 | Would you trust your neighbour with your child | | .231** | .172* | - | | | |
| 4 | Do you have to be careful with people, or not | | .111 | .000 | -.076 | - | | |
| 5 | Do people take advantage or are they fair | | .004 | -.179 | -.023 | .070 | - | |
| 6 | Total CSES | | **.208*** | .080 | -.071 | **.259**** | **-.202*** | - |
| | | M | 2.51 | 3.31 | 2.90 | 3.02 | 2.35 | 78.47 |
| | | SD | 1.08 | 1.49 | 1.62 | 1.60 | .99 | 11.00 |
| | | N | 197 | 200 | 198 | 198 | 198 | 131 |

*p<.05, **p<.01

Three of the general trust items correlated significantly with collective self-esteem. "*Generally speaking people can be trusted*" and "*do you have to be careful with most people*" correlated positively with the CSES, indicating that higher collective self-esteem is associated with higher levels of trust. The third association differed from the other two. "*Do you think that most people take advantage of you if they got the chance, or would they try to be fair?*" was negatively correlated with the CSES, indicating that higher collective self-esteem was associated with lower trust.

In order to identify exactly which of the CSES items that were associated with the general trust items, further correlations were conducted. Reliability analysis of each individual sub scale failed to show acceptable alpha levels, or mean inter-item correlations. Each of the thirteen CSESS item was therefore correlated with the three general trust items that showed to be significantly correlated with collective self-esteem, table 4.

*Table 4*

*Correlations between each CSES item and general trust*

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Priv1, *I often regret that i belong to the group (rev)* | - | | | | | | | | | | | | | | | |
| 2 | Priv2 *I'm glad to be member of the group* | .100 | - | | | | | | | | | | | | | | |
| 3 | Priv3 *I often feel the group is not worth while (rev)* | .258** | .150* | - | | | | | | | | | | | | | |
| 4 | Priv4 *I feel good about the group* | .009 | .104 | .124 | - | | | | | | | | | | | | |
| 5 | Pub1 *The group is considered good by others* | -.147 | .361** | -.146 | -.074 | - | | | | | | | | | | | |
| 6 | Pub2 *People consider my group to be ineffective (rev)* | .212** | -.129 | .235** | .219** | -.119 | - | | | | | | | | | | |
| 7 | Pub3 *Other respect my group* | .063 | .182* | .320** | .260** | .061 | .058 | - | | | | | | | | | |
| 8 | Pub4 *Other think my group is unworthy (rev)* | .400** | .160* | .226** | .174* | -.108 | .144 | .140 | - | | | | | | | | |
| 9 | Memb1 *I'm a worthy member of my group* | .060 | .172* | .087 | .127 | .328** | .152* | .102 | .039 | - | | | | | | | |
| 10 | Memb3 *Cooperative participant of group* | .062 | .370** | .216** | .152* | .159* | .033 | .317** | .184* | .361** | - | | | | | | |
| 11 | Id2 *The group is an important reflection of me* | -.118 | .444** | .072 | .039 | .584** | -.139 | .127 | -.088 | .100 | .225** | - | | | | | |
| 12 | Id3 *The group is unimportant to my sense of self (rev)* | .405** | .071 | .403** | .064 | -.122 | .150* | .157* | .288** | .038 | .190* | .029 | - | | | | |
| 13 | Id4 *Belonging to the group is important part of self-image* | .021 | .240** | .169* | .249** | .074 | -.085 | .291** | .121 | .089 | .132 | .131 | .037 | - | | | |
| 14 | Generally speaking people can be trusted | .066 | .101 | **.312**** | -.027 | .053 | .077 | -.012 | .136 | .044 | **.254**** | .108 | **.161*** | .081 | - | | |
| 15 | You can't be too careful in dealing with people | **.184*** | **.172*** | .073 | -.015 | **.198**** | .114 | **.144*** | .023 | .092 | **.142*** | .083 | .094 | .030 | .111 | - | |
| 16 | Do people take advantage, or are they fair | **-.151*** | -.062 | -.095 | -.079 | .002 | -.105 | **-.142*** | **-.169*** | -.043 | .000 | -.002 | -.131 | -.094 | -.004 | -.070 | - |
| | M | 5.46 | 6.22 | 5.68 | 6.44 | 5.89 | 4.95 | 6.15 | 5.73 | 6.15 | 6.47 | 5.95 | 5.33 | 6.69 | 3.49 | 2.98 | 2.35 |
| | SD | 2.32 | 1.72 | 2.12 | 1.58 | 1.95 | 2.57 | 1.72 | 2.15 | 1.66 | 1.35 | 1.98 | 2.45 | 1.06 | 1.08 | 1.60 | .995 |
| | N | 185 | 186 | 180 | 190 | 188 | 185 | 195 | 192 | 195 | 192 | 191 | 186 | 196 | 197 | 198 | 198 |

*p<.05, **p<.01

**Note: The negatively worded items are reversed. A high score indicate a high social identity.**

The *Generally speaking people can be trusted* - correlated with three CSES items; membership 3, Private 3 and Identity 3. *You can't be too careful dealing with most people*, correlated with a total of five CSES items. Private 1 & Private 2, Public 1 & Public 3 and Membership 3. *Do you think that most people would take advantage of you if they got the chanee , or would they try to be fair* correlated significantly with three CSES items, Private 1, Private 3 and Private 3.

In order to get an understanding of how much the significant collective self-esteem items predicted levels of trust, and identify which items explained most of the variance in general trust, simple multiple regression was conducted for each of the three general trust items. Only the CSES items which correlated significantly with each of the general trust items were included in the multiple regressions.

Standard multiple regression was conducted in order to assess how membership 3, Private 3 and Identity 3 predicted levels of trust measured by the *generally speaking people can be trusted* item, shown in table 5.

*Table 5*

*Multiple regression analysis with general trust item as criterion-variable.*

| | B | SE B | B |
|---|---|---|---|
| Constant | 1.681 | .406 | |
| Membership 3 | .155 | .059 | .194* |
| Private 3 | .134 | .041 | .262* |
| Identity 3 | .008 | .035 | .019 |

Note: $R^2$ = .134 Dependent variable: Generally speaking people can be trusted? * $p \leq .01$

The three CSES items together explained 13.5% of the variance in the general trust item $p<.001$. Only private 3 and membership 3 made significant unique contribution in the variance, with private 3 contributing slightly more than membership 3.

Private 1 & private 2, Public 1 & public 3 and membership 3 were entered as predictors in the next model, and "*Do you have to be careful with people, or not"* was entered as criterion variable, table 6.

*Table 6*

*Multiple regression analysis with careful item as criterion-variable.*

| | B | SE B | B |
|---|---|---|---|
| Constant | .086 | .735 | |
| Membership 3 | .061 | .096 | .052 |
| Private 1 | .137 | .051 | .199** |
| Private 2 | .042 | .078 | .045 |
| Public 1 | .162 | .065 | .197* |
| Public 3 | .088 | .071 | .094 |

Note: $R^2$ = .104 Dependent variable: You can't be too careful. * p < .05, **p<.01

The items together explained 10.4% p< .01 of the variance in the general trust item. Only private 1 and public 1 made unique contributions in the prediction of trust, with almost identical standardized betas.

Private 1 & public 3 & public 4 were entered as predictors, and *Do people take advantage, or are they fair* was entered as criterion variable, table 7

*Table 7*

*Multiple regression analysis with advantage item as criterion-variable*

| | B | SE B | B |
|---|---|---|---|
| Constant | 3.302 | .330 | |
| Private 1 | -.042 | .034 | -.099 |
| Public 3 | -.069 | .043 | -.120 |
| Public 4 | -.052 | .037 | -.112 |

Note: $R^2$ = .051 Dependent variable: do people take advantage, or are they fair?

Private 1, Public 3 and public 4 together significantly explained 5.1 % p<.05 of the variance in the do people take advantage, or are they fair – item, table 10
None of the CSES items made unique contributions in the variance.

*Collective Self-esteem and Trust in Bonding Networks*

The total bonding scale and the two other items measuring trusts to bonding groups, where correlated with the total CSES. The CSES correlated significantly with one item measuring trust in bonding groups, namely the "How much trust or confidence do you have to you support groups". R=.202**. A standard multiple regression was conducted in order to investigate in specific which of the collective self-esteem items explained most of the variance in the trust item. The independent variables explained 8.8% in the variance of the

dependent variable. Private 1 made significant contribution to the prediction of the dependent variable, Private 1. p<.05.

*Collective Self-esteem and Trust in Bridging Networks*

The total Collective self-esteem scale was correlated with the three items intended to measure trust in bridging groups. However, none of the correlations reached significance, and further analysis was thus not conducted.

*Collective Self-esteem and Trust in Linking Networks*

As with the general trust items, the total CSES was correlated with trust in different linking networks. This included: trust in national government, provincial government, local government, traditional leadership, the health system, public services and non governmental organizations (NGOs). Tabel 8.

*Table 8*

*Correlation between CSES and trust in linking level*

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | National Government | - | | | | | | | |
| 2 | Provincial Government | .537** | - | | | | | | |
| 3 | Local Government | .274** | .382** | - | | | | | |
| 4 | Traditional Leadership | .222* | .425** | .414* | - | | | | |
| 5 | The Health system | .170* | .149 | .138 | .286** | - | | | |
| 6 | Public services | .170* | .312** | .383** | .214** | .125 | - | | |
| 7 | NGO's | .023 | .031 | -.046 | .119 | .098 | -.027 | - | |
| 8 | Total CSES | **.202*** | .048 | -.112 | .069 | **.206*** | -.159 | **.221*** | - |
| | M | 2.64 | 2.29 | 2.09 | 2.22 | 3.35 | 2.48 | 3.41 | 78.47 |
| | SD | 1.45 | 1.23 | 1.29 | 1.29 | 1.54 | 1.45 | 1.71 | 11.00 |
| | N | 191 | 187 | 177 | 160 | 173 | 178 | 186 | 131 |

*p<.05, **p<.01

The CSES correlated significantly with three of the linking networks; trust in national government, trust in health system and trust in nongovernmental organization. In all three instances higher Collective self-esteem was associated with higher trust in the three different linking networks.

In order to investigate which of the Collective Self-esteem constructs that was associated with the linking networks, all thirteen items composing the scale were correlated with each of the three significant linking items, table 9

*Table 9*

*Correlations between each CSES item and general trust*

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Priv1, *I often regret that i belong to the group (rev)* | - | | | | | | | | | | | | | | | |
| 2 | Priv2 *I'm glad to be member of the group* | .100 | - | | | | | | | | | | | | | | |
| 3 | Priv3 *I often feel the group is not worth while (rev)* | .258** | .150* | - | | | | | | | | | | | | | |
| 4 | Priv4 *I feel good about the group* | .009 | .104 | .124 | - | | | | | | | | | | | | |
| 5 | Pub1 *The group is considered good by others* | -.147 | .361** | -.146 | -.074 | - | | | | | | | | | | | |
| 6 | Pub2 *People consider my group to be ineffective (rev)* | .212** | -.129 | .235** | .219** | -.119 | - | | | | | | | | | | |
| 7 | Pub3 *Other respect my group* | .063 | .182* | .320** | .260** | .061 | .058 | - | | | | | | | | | |
| 8 | Pub4 *Other think my group is unworthy (rev)* | .400** | .160* | .226** | .174* | -.108 | .144 | .140 | - | | | | | | | | |
| 9 | Memb1 *I'm a worthy member of my group* | .060 | .172* | .087 | .127 | .328** | .152* | .102 | .039 | - | | | | | | | |
| 10 | Memb3 *Cooperative participant of group* | .062 | .370** | .216** | .152* | .159* | .033 | .317** | .184* | .361** | - | | | | | | |
| 11 | Id2 *The group is an important reflection of me* | -.118 | .444** | .072 | .039 | .584** | -.139 | .127 | -.088 | .100 | .225** | - | | | | | |
| 12 | Id3 *The group is unimportant to my sense of self (rev)* | .405** | .071 | .403** | .064 | -.122 | .150* | .157* | .288** | .038 | .190* | -.029 | - | | | | |
| 13 | Id4 *Belonging to the group is important part of self-image* | .021 | .240** | .169* | .249** | .074 | -.085 | .291** | .121 | .089 | .132 | .131 | .037 | - | | | |
| 14 | National Government | .134 | .104 | -.051 | .070 | .036 | **.173*** | -.058 | .140 | .074 | .065 | .115 | **.154*** | .012 | - | | |
| 15 | Health System | .064 | **.227**** | .056 | .003 | .123 | -.028 | .087 | -.003 | **.214*** | .107 | **.205**** | .137 | .044 | .170* | - | |
| 16 | Ngos | **.163*** | .014 | **.184*** | .130 | **-.270**** | **.258**** | .036 | **.179*** | -.078 | -.033 | -.128 | .136 | .044 | .023 | .098 | - |
| | M | 5.46 | 6.22 | 5.68 | 6.44 | 5.89 | 4.95 | 6.15 | 5.73 | 6.15 | 6.47 | 5.95 | 5.33 | 6.69 | 2.64 | 3.35 | 3.41 |
| | SD | 2.32 | 1.72 | 2.12 | 1.58 | 1.95 | 2.57 | 1.72 | 2.15 | 1.66 | 1.35 | 1.98 | 2.45 | 1.06 | 1.45 | 1.54 | 1.71 |
| | N | 185 | 186 | 180 | 190 | 188 | 185 | 195 | 192 | 195 | 192 | 191 | 186 | 196 | 191 | 173 | 186 |

*p<.05, **p<.01

**Note: The negatively worded items are reversed. A high score indicate a high social identity.**

Trust in national government correlated significantly with two of the CSES items, public 2 & identity 3, where higher social identity and public esteem was associated with higher trust in the national government. Trust in the health system correlated significantly with private 2, membership 1 and identity 2, thus higher scores on these items was associated with higher trust in health system. Trust in Non governmental organizations differed from the other to trust items. All together five CSES items correlated significantly with trust in NGOs. Private 1, private 3, public 4 and public 2 correlated positively with trust in NGOs, thus higher score on these CSES items was associated with higher levels of trust in Nongovernmental organizations. However, Public 1 "*overall, my social group is considered good by others*", correlated negatively with trust in NGO; higher public esteem was associated with lower trust.

To identify whether each of the significant CSES items made unique contribution to the variance in the trust in linking networks items, and to identify what item explained most of the variance, multiple regression was conducted, Tabel 10,11,12.

*Table 10*

*Multiple regression analysis with trust in NGO item as criterion-variable*

| | B | SE B | β |
|---|---|---|---|
| Constant | 3.012 | .676 | |
| Private esteem 1 | .024 | .061 | .032 |
| Private esteem 3 | .063 | .063 | .032 |
| Public esteem 1 | -.195 | .065 | -.221* |
| Public esteem 2 | .124 | .051 | .184 |
| Public esteem 4 | .078 | .064 | .098 |

Note: $R^2 = .143$ Dependent variable: How much trust do you have in NGOs? * $p < .01$

The model in total explained 14.3 % of the variance in trust in NGO's, however, only the public 1 item made an significant unique contribution to the prediction of the NGO variable.

*Tabel 11*

*Multiple regression analysis with trust in national government as criterion-variable*

| | B | SE B | β |
|---|---|---|---|
| Constant | 1.790 | .315 | |
| Public 2 | .087 | .043 | .153* |
| Identity 3 | .078 | .045 | .131 |

Note: $R^2 = .047$ Dependent variable: How much trust do you have in National Government? * $p < .01$

*Tabel 12*

*Multiple regression analysis with trust health system as criterion-variable*

| | B | SE B | β |
|---|---|---|---|
| Constant | .974 | .592 | |
| Private 2 | .126 | .076 | .141 |
| Membership 1 | .165 | .071 | .178* |
| Identity 2 | .097 | .065 | .124 |

Note: $R^2 = .095$ Dependent variable: How much trust do you have in Health system? * $p < .01$

The total model explained 9.5% of the variance in trust in health system. Membership 1 was the only item that made a significant unique contribution to the prediction of the trust in health system variable

## Discussion

The results indicate that individuals taking part in this study constitute a fairly homogeneous group, and share common motivations for joining groups. Furthermore, they strongly identify with their support group. In relation to general trust, the results are somewhat mixed. Social identity relates both positively and negatively to general trust. On the bonding level, there is an association between social identity and intragroup trust, where those scoring high on social identity also display more trust in their support group. No significant association between social identity and trust emerged at the bridging level. On the linking level, there was mainly a positive association between social identity and trust.

### *Motivations*

The first objective of this study was to identify homogeneous bonding groups. Sharing a "common fate" has shown to contribute to a tight and homogeneous group, leading the group members to develop a strong social identity derived from the group (Castano et al., 2003; Leach et al., 2008). The sample in this study could be characterized as homogeneous. The vast majority of informants agreed to identical motivations for joining the group, the single most important motivation, being to obtain knowledge on HIV/AIDS. Brasher et al. (2004) reported how HIV positive individuals regard the support group as a way of receiving information and knowledge about HIV. By receiving information from fellow group members, uncertainty concerning some aspects of the disease is reduced. Uncertainty reduction is regarded as a motivation for joining groups by the social identity theory. Joining

group could be a way of reducing uncertainty, because individuals will adopt the norms of the group. As norms guide how you should think and behave, following the norms will reduce uncertainty (Jetten et al., 2000). The high agreement rate concerning this particular item in this study, could indicate that uncertainty was one motivation behind joining the support groups, in line with Brasher et al. (2004).

Social identity theory also postulates enhanced self-esteem as a motivation behind joining groups (Abrams & Hogg, 1988). However, research in relation to the self-esteem hypothesis has been mixed. Aberson, Healy and Romero (2000), when reviewing the literature on ingroup bias and self-esteem, argue that self-esteem can both be understood as a motivating factor as well as a consequence of group membership. In this study, the group members' self-esteem derived from the group, was high: they felt good about being members of the support group, and valued their membership highly. However, since this is a correlational study, it is impossible to know if high self-esteem is a motivation or a consequence of their group membership.

There were also high agreement rates on the following items: Receiving support from fellow group members, learn form other's experience, change how family and friends think about the disease and receive medical help. Lack of social support and rejection from family and friends are identified as important motivations for joining support groups (Adams, 2002; Dageid & Duckert, 2007; Trojan, 1989). Thus, the result in this study support previous research regarding motivations behind joining support groups for HIV positive individuals. In regard to demographical variables, the sample was also quite homogeneous. The participants had the same educational level, socioeconomic status, and were also of the same ethnicity.

*Social Identity*

The mean score on the collective self-esteem scale came close to the higher extreme. When investigating the scores on each of the collective self-esteem scale items, none of the items had a mean lower than 4. The sample as a whole felt as valuable members of the support group. As well as feeling good about their group membership, they perceived other people to view their group positively, and perceived their group membership as an important part of their identity. Tafjel's (1978) definition of social identity incorporates identification with the group, together with the emotional significance and value members ascribe to their social group. The scores on the collective self-esteem scale in this study support this: the sample

both values their group highly, and identifies with the support group. Somewhat surprisingly however, was the relatively high score on public esteem. Thus, the members perceived other people to view their group positively. Crocker, Luhtanen, Blain and Broadnax (1994), when investigating the effect of collective self esteem on well-being, found that African Americans scored lower on the public esteem subscale, relatively to the other three subscales. Crocker et al. reasoned that this might be due to the history of stigma and discrimination directed towards African Americans. Crocker's study and this study are similar in the sense that both samples probably have experienced discrimination. Based on previous study, Campbell et al. (2005), Dageid and Duckert (2007) and Visser, Makin and Lehobye (2006) report that HIV/AIDS infected South Africans in a quite large extent, still are victims of discrimination and stigmatization due to their illness. The fact that these individuals score high on public self esteem, suggests that their group is considered well by other individuals. This could be understood by the support groups association with TAC. TAC has a strong profile in South Africa and has contributed to enhanced well-being of HIV/AIDS infected and their family (TAC, 2009b). Thus, it is not unlikely that the participant in this study perceive others to view their group positively. However, as individuals they might still experience discrimination due to HIV/AIDS.

Previous research has shown that highly homogeneous groups in collectivistic countries could lead individuals to strongly identifying with the groups, more so than heterogeneous groups in individualistic countries (Brown et al., 1992; Doosje et al., 1995; Leach et al., 2008). The support groups in this study are homogeneous, working in a collectivistic country, and sharing a strong social identity derived from the group. However, we can only speculate that the similarity and homogeneity of the support groups lead them to share a strong social identity. The setting under which they completed the study, may have contributed the members to identify more strongly with the support group. Research has shown that merely being aware of group membership and social identity could lead to ingroup bias (Mullen et al., 1992). The participants in this study were visited while attending support group meetings, and it was during this time they participated in the study. Their identity as support group members could consequently be highly salient. Filling in the questionnaires in the support group context, could have resulted in the members overestimating the importance of their social identity. If the participants were contacted outside the group context, a larger variance in scores on the self-esteem questionnaire could have emerged. However, the primary goal of this study was to

explore whether social identity was related to trust. A necessity was to make their social identity as group members salient, which was accomplished.

*Collective Self-esteem and Trust in Bonding Networks*

Collective self-esteem was associated with trust in the support groups, where higher collective self-esteem was associated with higher trust in the support group. This supports theory and research on social capital, which state that bonding groups foster particularized trust in ingroup members (Portes, 1998; Stolle, 1998). Yamagishi, Jin and Miller (1998) argue that strong identification and a highly salient social identity often is observed in collectivistic cultures where homogeneous groups are common. A consequence of this is intragroup trust. The findings in this study seem to indicate this; the social identity derived from the support group lead the group members to display intragroup trust. Again, whether this could be explained by the homogeneous nature of the group can not be answered by this design.

It might seem counter intuitive that collective self-esteem was not associated with the other measures of trust in bonding groups, e.g. trust in family and friends. However, the majority of the support group members reported that changing family's and friends' attitude concerning their HIV status, motivated them to join the support group. This might indicate that the participants experience lack of support from family and friend, as a consequence of their HIV status. Greeff et al. (2008) found that many South African HIV positives felt reluctant to disclose their status to family and friends, because of stigmatizations due to their HIV status. Some of those who did disclose their status experienced discrimination and neglect. This could indicate that individuals, who join support groups, do this in order to receive additional support, while simultaneously wishing to change the attitude of family and friends.

The results of this study showed that private esteem best predicted level of trust in bonding group. High levels of private self-esteem derived from the group predicted higher levels of trust in bonding groups. Discrimination and rejection because of HIV status has shown to decrease levels of self-esteem. A longitudinal study investigating the effect of stigmatization and rejection for HIV positive Asians, showed decreased levels of self-esteem (Kang, Rapkin, & DeAlmedia, 2006). Social identity theory predicts that people may be motivated to join groups to enhance self–esteem. Based on these findings it could be reasonable to assume that support group members felt neglected and discriminated by their family, which resulted in lowered self-esteem. By joining the social group their private self-esteem derived from the support group increased. Furthermore, the fact that collective self-esteem was not associated

with trust in family and friends could indicate that low self-esteem was a result of family and friends behaviour. However, in order to determine whether this was the case, a controlled study needs to be conducted. We do not know whether informant's self-esteem really was low prior to joining groups, or if their family and friends really did discriminate them.

*Collective Self-esteem and General Trust*

Our third research objective was to investigate how social identity is associated with trust in different groups in the society. The results from the analysis showed that collective self-esteem was associated with general trust. In relation to the advantage item, higher collective self-esteem was associated with the participants perceiving people, more often than not, trying to take advantage of them. This illustrates that social identity is associated with trust, and that strong social identity leads to less trust. Homogeneous groups with a salient social identity could lead to ingroup bias, whereby they disregard, and in worst case discriminate against outgroups (Hinkle & Brown, 1990; Leach et al., 2008; Mullen et al., 1992). As some theorists have viewed distrust as a form of discrimination (Paolini et al., 2004; Voci, 2006), the association emerging in this study, could illustrate a form of ingroup bias.

The association between social identity and the advantage item give support to the predictions that social identity and ingroup bias possibly could result in less trust to other networks. However, the association between social identity and general trust was ambiguous. Two of the associations were positive; illustrating that higher collective self-esteem was associated with higher general trust. This could indicate that the five items intended to measure general trust, possibly did not measure the same aspects of trust. Different psychological conceptualisations exist of the term "trust" (Kramer, 1999). Some view trust as a cognitive aspect, which in the strictest form address the cost- benefit dichotomy (Morrow, Hansen, & Pearson, 2004). When evaluating whether to trust someone, the individual considers the potential benefits and costs involved. If the benefits of trusting someone exceed the potential risk, the likelihood of displaying trusting behaviour will increase. Others emphasize the affective and social embedded aspects of trust (Cummings & Bromiley, 1996; Garfinkel, 1963). Trust is dependent on the social context: if trust is directed towards a party, which the social codex promotes as trustworthy, like an authority, trust could be displayed. Furthermore, if a person's instinct and intuition concerning another individual are positive, it could influence the display of trust towards that individual. Others again, view trust as a behavioural approach, namely the willingness of the individual to be vulnerable to the actions of another party (Mayer,

Davis, & Schoorman, 1995; Tanis & Postems, 2005). These aspects of trust do interplay, and a combination of all of these is probably at work when evaluating whether to trust or not. However, it might be that the wording of the general trust items in this study has cued the participants to consider different aspects of trust. The items "*generally speaking people are to be trusted*" and "*you can't be too careful dealing with most people*" are quite general and could pertain to the general perception or attitude members of the support group have towards other people. These items might evoke the social embedded and affective features of trust. However, when presented with the item "*do people take advantage or not*" the behavioural and risk taking aspects of trust could become more salient.

To get a better understanding of the discrepancy between the general trust items, it is necessary to take contextual factors into consideration. First of all, the support groups are situated in the local communities of its members. This means that the members who constitute the support group are neighbours, they are friends and family. They not only constitute the support group, they may also constitute the community. Although some people travel to the nearest cities to work, few have the opportunity to travel far, in short their activities and opportunities are mainly restricted to the community they live in. The townships also have a history of being the indigenous South Africans' sphere, as it was here black South Africans were restricted to live under the apartheid regime. This could contribute to a sense of togetherness. In addition, the spirit of "ubuntu", in short meaning "I am, because you are", is passed down through generation, and is of importance especially for people living in rural areas of South – Africa (Bonn, 2007). When the informants were asked if they perceive people to be trustworthy or not, they would most likely think of people in their own community. Their identity as community members might be stronger than in individualistic societies, and thus the socially embedded attitude could be that most people in their community are trustworthy. The "advantage" item on the other hand might evoke different associations for the participants. This item could relate to the behavioural, and risk – taking approach of trust. As South Africa suffer from high levels of crime and violence, it would be wise not to trust the actions of strangers as it involves an imminent risk.

*Collective Self-esteem and Trust in Bridging Networks*

We also wanted to investigate if social identity was associated with lack of trust in bridging and linking levels. None of the items intended to measure trust in bridging networks, yield significant association with the collective self-esteem questionnaires. This could be explained

by the lack of variance in response to the collective self-esteem scale, and does not necessarily mean that no relationship exists between the variables. However, the lack of association between collective self-esteem and trust in other support groups could come across as surprising. Other support groups would be the most clear cut example of an outgroup, similar in both structure and statues as their own ingroup. Tajfel and Turner (1979) originally argued that ingroup bias would be especially strong in relation to groups that are similar to the ingroup. Because of this, we could also expect to find less trust in these groups. However, there is a need to take the motivation for joining HIV support groups into consideration. The individuals joining the support groups do this because they are diagnosed with HIV. They have similar concerns related to the development of the disease, fear of social discrimination and their future. Their identity as HIV positives could overshadow the fact that they are members of different groups. Deaux, Reid, Mizrahi and Cotting (1999) argue that people are not always motivated to join groups solely to enhance their social identity, which could lead to ingroup bias. Motivations like insight and understanding, ingroup cooperation and cohesion could also be important motivators. The fact that there existed little evidence of ingroup bias towards other support groups, could support this. Thus, the different support groups do not necessarily have conflicting interests. In addition, many of the support groups in the area of KwaZulu-Natal were initiated by TAC, and their common identity as a TAC support group could be salient.

The lack of association between social identity and trust in bridging networks could also indicate that there in reality are few existing bridging networks in the community. Many HIV/AIDS NGOs in sub-Saharan Africa have few resources, which either could force them to shut down, or obstruct exchange of resources (Rau, 2006; Swidler, 2006).

*Collective Self-esteem and Trust in Linking Networks*

The first picture that emerged, with regards to collective self-esteem and trust in linking networks, was that collective self-esteem predicted trust in the health system and trust in the national government. Research on social capital has shown that tight bonding groups could obstruct generalized trust (Stolle, 1998) and the assumption of this study was that social identity was negatively associated with trust in linking networks. The positive association was therefore somewhat surprising. However, this does not necessarily mean that social identity theory and the ingroup bias fail to explain the negative association between intragroup trust and general trust. On the contrary, it could be that the homogeneous bonding groups in this

study differ from other bonding groups. Considering the fact that these support groups are closely associated with TAC might be one explanation of these findings. Social capital theory postulates how contact with diverse groups on bonding, bridging and linking level, will foster general trust (Putnam, 1993). Literature on social capital, states that bridging level is the link between bonding groups and linking groups. Thus, if individuals are to access resources on linking level, this most likely is achieved through being members to bridging networks (Harpham, 2008). TAC is a national non-governmental organization with branches in local municipalities in South Africa. Thus, TAC could therefore be characterized as a linking network at national level and as a bridging network on local levels. TAC has played an important role in changing the government's attitude towards the HIV/ AIDS infected, in addition, TAC has worked for increased treatment coverage in South Africa (TAC, 2009b). By being a member of a TAC initiated support group, the participants in this study could have had a positive experience with TAC as an organization on both bridging and linking level. This positive experience could hence influence the trust shown by the participants towards the government and the health system.

Higher collective self-esteem was associated with higher levels of trust in both the health system and the national government. In regard to NGOs, the associations were somewhat mixed. However, the public esteem best predicted trust in NGOs. When the group members perceived their group to be considered good by others, they also showed less trust in NGOs. While TAC has been a successful NGO on national and local basis, other NGOs struggle to survive. Many NGOs in the local communities lack resources (Rau, 2006; Swidler, 2006). This could lead other NGOs to fail in helping the community. As the support group members in this study could associate themselves with TAC, the negative relationship between social identity and trust in NGOs could be an expression of ingroup bias. The members could contrast TAC with other NGOs, and thus favour TAC. The negative association between public esteem and trust to NGOs, could therefore support the prediction of this study, and could be understood as an expression of ingroup bias towards other NGOs.

The positive association between social identity and trust in government and in health system could also indicate something else. Hinkle and Brown (1990) argue that the group's status in relation to other groups and networks need to be accounted for when investigating the ingroup dynamic. They argue that the groups are affected by the status they have in the society, which could make them mirror the views of the society and in the most extreme make them display

outgroup favorism (Hinkle & Brown, 1990). The positive association between collective self-esteem and trust in linking networks could partially be explained by the support group's status. In relation to the society, HIV remains a stigma (Campbell et al., 2005), which could lead a HIV positive support group to experience low status. However, the Collective Self-esteem scale measured how the group members perceived other people's view of the group. The scores indicated that they perceive their own group to be viewed positively by other people. The government, at least until October 2008, had to a large degree neglected the HIV/AIDS problem, which could have resulted in a low status in relation to the government, but not in relation to groups in for instance bridging networks. Thus, the question related to their public esteem, could be an assessment of how other people in their community think about their group, not necessarily the government, which traditionally has acted discriminating and neglecting against HIV positive individuals. This could be an alternative explanation as to why there was a positive association between collective self-esteem and trust in government and the health system.

*General Discussion*

In relation to trust in NGOs and general trust, our predictions received support. In these instances high collective self esteem predicted less trust. Lack of trust has been viewed as a form of discrimination, which could indicate that ingroup bias could be one of several mechanisms explaining anti-social capital, postulated by Portes (1998). Looking at the bigger picture, this could indicate how strong social identity derived from a group could obstruct chances of accessing resources from these networks in the society. This could especially be devastating for people living with HIV/AIDS, in rural areas of South Africa, where resources are scarce. Swidler (2006) and Rau (2006) report that there often exists a gap between bonding and bridging/linking level in poor rural areas in sub-Saharan Africa, and that people do not access resources that actually may be available. As there are many explanations for this gap, the mechanism involved in strong social identity could be one of several understandings. However, this study also shows how social identity is positively associated with trust to health system and trust to the government. This could be understood through the support groups' association with TAC. TAC could be characterized both as a bridging and linking network, and through being member of a TAC initiated support group, the individuals of the group simultaneously access resources on bridging and linking level. Contact with networks on structurally different levels in the society has been associated with more trust to these networks (Putnam, 1993; Stolle, 1998).

*Limitations*

The majority of the group members strongly identified with the support groups, and a minority of the sample was categorized as having a low social identity. This could explain why some of the associations failed to reach significance, and in some cases, relatively low effect sizes emerged. Lack of variance could be a limitation of this study, however the fact that significant association did emerge, could indicate that the results are important.

Since this is a correlational study, inferring causal relationships between the concepts is not possible. Since this was an exploratory study, we see that the concepts are associated with each other, and one might believe that in relation to general trust, high levels of social identity could lead to outgroup discrimination in form of less general trust. However, to be sure e.g. longitudinal or qualitative studies need to be conducted.

The cultural aspects also need to be considered. First of all the collective self-esteem scale is developed in the United States, and might therefore not apply to this sample in the same way. Even though the questionnaires were translated from English to isiZulu by an isiZulu speaking master student, and later examined by an isiZulu speaking TAC employee, we do not know for sure if the nuances of the scale were properly conveyed. The translator's first language was not English, and even though the translator was trained, the same limitations apply. However, these limitations will always be a concern when researchers and participants come from different cultures.

*Further Research*

As this study was an exploratory correlational study, further research should apply longitudinal or qualitative studies in order to get a better understanding of the causal relationship between social identity and the lack of trust in different networks in the society. A longitudinal study could assess how both social identity and trust develop on the course of group membership, and reveal if stronger social identity relates to less trust in other groups and networks. Further research should be applied in the effort to explain the finding of how high levels of social identity relates to higher levels of trust in government and health system. It would be of interest to explore whether the multi-structural aspects of TAC, and its contact with the support groups, is an important factor in yielding higher trust in linking networks.

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Appendix

*Appendix A: Measure of Motivation*

We will now ask you a question regarding why you became a member of this specific support group. There are listed different reasons for why you might have joined this group, below. There are no right or wrong answers. Please indicate in what degree the following reasons apply to you.

**Why did you become a member of this support group?**

| | Agree | Agree somewhat | Neutral /unsure | Disagree somewhat | Disagree |
|---|---|---|---|---|---|
| To obtain knowledge about HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| To receive support from fellow group members | 1 | 2 | 3 | 4 | 5 |
| To learn from what other have experienced/experience | 1 | 2 | 3 | 4 | 5 |
| To obtain feelings of being "normal" | 1 | 2 | 3 | 4 | 5 |
| Because my family/friends wanted me to | 1 | 2 | 3 | 4 | 5 |
| To change how my family/friends think about HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| To receive medical help | 1 | 2 | 3 | 4 | 5 |
| Because of fear of being stigmatized | 1 | 2 | 3 | 4 | 5 |
| To get access to grants | 1 | 2 | 3 | 4 | 5 |

*Appendix B: Collective Self-esteem Scale*

**CSE INSTRUCTIONS:** We are all members of different social groups or social categories. Some of such social groups or categories pertain to gender, nationality, family, or work. We would like you to consider your membership in this particular support group, and respond to the following statements on the basis of how you feel about this group and your membership in the group. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions. Please read each statement carefully, and respond by using the following scale from 1 to 7:

| | Strongly Disagree | Disagree | Disagree Somewhat | Neutral | Agree Somewhat | Agree | Strongly Agree |
|---|---|---|---|---|---|---|---|
| 1. I am a worthy member of the social group I belong to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. I often regret that I belong to the social group I do. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Overall, my social group is considered good by others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Overall, my group membership have very little to do with how I feel about myself. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I feel I don't have much to offer to the social group I belong to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. In general, I'm glad to be a member of the social group I belong to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Most people consider my social group, on the average, to be more ineffective than other social groups. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. The social group I belong to is an important reflection of who I am. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. I am a cooperative participant in the social group I belong to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Overall, I often feel that the social group of which I am a member is not worthwhile. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. In general, others respect the social group that I am a member of. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. The social group I belong to is unimportant to my sense of what kind of a person I am. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. I often feel I'm a useless member of my social group. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. I feel good about the social group I belong to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. In general, others think that the social group I am a member of is unworthy. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. In general, belonging to the social group is an important part of my self image. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*Appendix C: Trust- and Social Capital Questionnaire*

Trust can be directed towards specific people and institutions. It can also be a general feeling of trust and trustworthiness. The questions below concern how you trust other people and groups. Remember that there are no right or wrong answers. Please circle or write the most appropriate answer to each question.

Thank you!

Name/id: _____ Date: ___/___/___

1. Age:……

2. Gender: Male: 1 Female: 2

3. Marital status:

| | |
|---|---|
| Married | 1 |
| Single | 2 |
| Widow / widower | 3 |
| Divorced | 4 |
| Separated | 5 |
| Engaged to be married | 6 |

Other (specify) …….

4. Level of highest education (grade / degree completed):

……...

5. What is your estimated monthly income?

| | |
|---|---|
| No income | 1 |
| 1 – 499 Rands | 1 |
| 500 – 999 Rands | 2 |
| 1000 – 1999 Rands | 3 |
| 2000 – 2999 Rands | 4 |
| 3000 – 5999 Rands | 5 |
| 6000 Rands or more | 6 |

6. Monthly income (estimated total, household):

| | |
|---|---|
| No income | 1 |
| 1 – 499 Rands | 1 |
| 500 – 999 Rands | 2 |
| 1000 – 1999 Rands | 3 |
| 2000 – 2999 Rands | 4 |
| 3000 – 5999 Rands | 5 |
| 6000 Rands or more | 6 |

7. Do you live in a rural or urban area? Please tick the appropriate box.

Rural: ☐

Urban: ☐

8. Generally speaking, would you say that people can be trusted or that people cannot be trusted?

| | |
|---|---|
| Generally people cannot be trusted | 1 |
| Some people cannot be trusted | 2 |
| Unsure / neutral | 3 |
| Some people can be trusted | 4 |
| Generally people can be trusted | 5 |

9. Generally speaking, you can't be too careful in dealing with most people

| | |
|---|---|
| Agree | 1 |
| Agree somewhat | 2 |
| Neutral | 3 |
| Disagree somewhat | 4 |
| Disagree | 5 |

10. Would you say that most of the time people try to be helpful, or are they mostly looking out for themselves?

| | |
|---|---|
| Mostly looking out for themselves | 1 |
| Not very helpful | 2 |
| Neither helpful nor unhelpful | 3 |
| Somewhat helpful | 4 |
| Mostly very helpful | 5 |

11. Do you think that most people would take advantage of you if they got the chance, or would they try to be fair?

| | |
|---|---|
| Definitely try to take advantage | 1 |
| More often than not try to take advantage | 2 |
| Neither take advantage nor be fair | 3 |
| More often than not try to be fair | 4 |
| Definitely try to be fair | 5 |

12. If you suddenly had to go away for a day or two, could you trust on your neighbours to look after something that is important to you, e.g. your children, your house etc?

| | |
|---|---|
| Definitely not | 1 |
| Probably not | 2 |
| Unsure / neutral | 3 |
| Probably | 4 |
| Definitely | 5 |

13. I can trust each of the following to act in my best interest:

| | Disagree | Disagree somewhat | Neutral | Agree somewhat | Agree |
|---|---|---|---|---|---|
| My partner | 1 | 2 | 3 | 4 | 5 |
| My close family | 1 | 2 | 3 | 4 | 5 |
| My extended family | 1 | 2 | 3 | 4 | 5 |
| My friends | 1 | 2 | 3 | 4 | 5 |

14. When I need advice or emotional support I can count on the following to provide it:

| | Disagree | Disagree somewhat | Neutral | Agree somewhat | Agree |
|---|---|---|---|---|---|
| My partner | 1 | 2 | 3 | 4 | 5 |
| My close family | 1 | 2 | 3 | 4 | 5 |
| My extended family | 1 | 2 | 3 | 4 | 5 |
| My friends | 1 | 2 | 3 | 4 | 5 |

15. I'm certain that my family and friends trust me.

| | |
|---|---|
| Agree | 1 |
| Agree somewhat | 2 |
| Unsure / neutral | 3 |
| Disagree somewhat | 4 |
| Disagree | 5 |

16. How much trust do you have in other support groups, beside the one you take part in?

| | |
|---|---|
| Not at all | 1 |
| To a somewhat small extent | 2 |
| Neutral | 3 |
| To a somewhat great extent | 4 |
| Total | 5 |

17. Do you trust community based groups to provide support for people living with HIV/AIDS? E.g homebased care, saving groups (funeral), traditional healers.

| | |
|---|---|
| Not at all | 1 |
| To a somewhat small extent | 2 |
| Neutral | 3 |
| To a somewhat great extent | 4 |
| Totally | 5 |

18. How much do you trust, or how confident are you with, people that are different than you?

| | |
|---|---|
| To a very small extent | 1 |
| To a somewhat small extent | 2 |
| Neither great or small extent | 3 |
| To a somewhat great extent | 4 |
| To a very great extent | 5 |

19. How much confident/trust do you have in your support group?

| | |
|---|---|
| Not at all | 1 |
| To a somewhat small extent | 2 |
| Neutral | 3 |
| To a somewhat great extent | 4 |
| Total | 5 |

20. How long have you been a member of your support group?

…….

21. How much do you trust, or how much confidence do you have in the following groups?

| Group | Not at all | To a somewhat small extent | Neutral | To a somewhat great extent | Totally |
|---|---|---|---|---|---|
| National government | 1 | 2 | 3 | 4 | 5 |
| Provincial government | 1 | 2 | 3 | 4 | 5 |
| Local government | 1 | 2 | 3 | 4 | 5 |
| Traditional leadership | 1 | 2 | 3 | 4 | 5 |
| The Health system | 1 | 2 | 3 | 4 | 5 |
| The Public services | 1 | 2 | 3 | 4 | 5 |
| NGO's | 1 | 2 | 3 | 4 | 5 |

22. To what extent do you trust local government and local leaders to take into account concerns voiced by you and people like you when they make decisions that affect your community?

| | |
|---|---|
| Not at all | 1 |
| A little | 2 |
| Unsure / neutral | 3 |
| To a certain extent | 4 |
| A lot | 5 |

23. I do not trust that my group gets access to resources the government and larger NGOs possess.

| | |
|---|---|
| Agree | 1 |
| Agree somewhat | 2 |
| Neutral | 3 |
| Disagree somewhat | 4 |
| Disagree | 5 |

*Appendix D: Informed Consent*

**Request for participation in the research project**

**The relationship between social identity, group membership and trust among people taking part in a HIV support group in KwaZulu-Natal, South Africa**

**Background and purpose**
This is a request for your participation in a research project which deals with examining the relationship between group membership, social identity and trust for HIV positive people taking part in a support group in KwaZulu- Natal, South Africa. We will recruit HIV positive people taking part in a support group in the eThekwini municipality, in South Africa. The relevant participants are HIV positive adult (18 years or more), Zulu-speaking women and men taking part in a support group. This study is conducted by the University of KwaZulu-Natal in cooperation with the University Of Oslo, Norway.

**Procedure**
Information will be collected through quantitative methods in form of three questionnaires. The information we request from you will depend on your involvement in a support group or a HIV organization. You only participate and answer questions if you are willing to do so. You have the right to withdraw from the research any time you want to.

**Possible advantages and disadvantages**
A possible disadvantage for you is that some questions might make you feel uncomfortable. Some may feel that answering the questionnaire is time-consuming. The information you give can however contribute to new knowledge on how taking part in a support group may relate to psychological mechanisms like self-esteem, social identity and trust toward other people.

**What will happen to the information you give in this study?**
The information given by you will be registered and used only in accordance with the purpose of this study. A code will be used to identify the information you give. This means that the information you provide is treated with confidentiality.

It will not be possible to identify you through the results of the study when these are published.

**Voluntary participation**
Participation in this study is voluntarily**.** You may at any time and without stating a reason withdraw from the study. If you wish to participate in the study, please sign the informed consent on the last page of this document. If you at this stage agree to participate, you may still withdraw your consent at any point of the study. If you at a later stage wish to withdraw, or have any questions regarding the study, please contact Wenche Dageid on telephone +47 22845184 or 072 760 2448, address Department of Psychology, University of Oslo, Forskningsveien 3, P. O. Box 1094, NO-0317 Oslo, Norway, or email

wencheda@psykologi.uio.no, Or Kjersti Nesje on telephone + 47 47 64 25 70, or E-mail kjersne@student.sv.uio.no

Additional information about the study can be found in **Section A**

Additional information about protection of personal data and economy can be found in **Section B**
Statement of informed consent follows after section B.

**Section A. Thorough explanation of the study**

**Criteria for participation**
Informants must be HIV positive, Zulu-speaking adults (minimum 18 years old) taking part in a HIV support group residing in the eThekwini municipality, in South Africa. Equal numbers of men and women will be recruited where possible.

**Background information about the study**
This study aims at examining the relationship between group membership, social identity and trust toward people and networks, for HIV positive people taking part in a support group in KwaZulu-Natal, South Africa. Research has shown that people who feel threaten and uncertain often strongly identify with a homogeneous group and in some instances make discriminations towards other groups. We want to investigate how group membership for HIV positive people relate to trust on different network levels, and how social identity relates to group membership for these people.

**Specific research objectives**
1) How is group membership related to social identity?
2) In what way does the person express trust?
3) How is trust related to social identity and group membership?

**Procedure and instruments**
This study takes place during late fall 2008-spring 2009, and mainly quantitative methods and questionnaires will be used. In-depth interviews may be relevant; however the interviews will be based on the items in the questionnaires. The instruments will be adapted to the local context and translated into isiZulu, and a Zulu-speaking assistant will help out as a translator in the field.

**Advantages and disadvantages**
The study could give valuable information on both positive and negative psychological mechanisms related to group membership for people living with HIV and taking part in a support group. We might find that some participants think it is positive to share their stories, and contributing to research may be seen as positive. Disadvantages could be that the questions evoke negative feelings and reflection over the current situation as HIV positive. Some may also feel filling the questionnaire is time-consuming.

**Section B – Protection of personal data, and economy**

**Protection of personal data**
The information that will be registered about you will be treated with confidentiality by the research team at all stages of data collection, analysis, and during report writing. The research team is responsible for making sure that all participants are informed of the nature and purpose of the research and have autonomy to choose whether to participate in the research

**The right to access personal information and maculate information about you**
If you agree to participate in this study, you have the right to access registered information about you.
You also have the right to correct eventual mistakes in the information we have registered about you. If you withdraw from the study, you can demand that all information about you should be maculated, unless the information has already been analysed or used in academic publications.

The study is financed by the Norwegian Research Council and the National Research Foundation South Arica.

Information about the results of the study
Participants have the right to know the results of the study. The project emphasises continuous dissemination and discussion of findings. A final report will be distributed after the completion of the project.

CONSENT TO PARTICIPATE IN THE STUDY

I am willing to participate in the study

---

(Signed by respondent, date)

I confirm that I have conveyed correct information about the study
I will observe the anonymity and confidentiality of the respondent

---

(Signed by the interviewer/researcher, date)

# UNIVERSITETET I OSLO

**DET MEDISINSKE FAKULTET**

Wenche Dageid
Psykologisk institutt
Universitetet i Oslo
Pb. 1094 Blindern

**Regional komité for medisinsk og helsefaglig forskningsetikk Sør-Øst A (REK Sør-Øst A)**
Postboks 1130 Blindern
NO-0318 Oslo

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**Dato:** 21.10.08
**Deres ref.:**
**Vår ref.:** S-08635a 2008/17833

**S-08635a The relationship between social identity, group membership and trust among HIV positive people taking part in a support group in KwaZulu-Natal, South Africa [6.2008.2213]**

Vi viser til søknad mottatt til fristen 16. september

Komiteen behandlet søknaden i sitt møte tirsdag 14. oktober 2008. Prosjektet er vurdert etter lov om behandling av etikk og redelighet i forskning av 30. juni 2006 nr. 56, jfr. Kunnskapsdepartementets forskrift av 8. juni 2007 og retningslinjer av 27. juni 2007 for de regionale komiteer for medisinsk og helsefaglig forskningsetikk.

Studien er en del av et større prosjekt som er vurdert og godkjent av REK.

Denne søknaden gjelder en undersøkelse om sosial identitet, gruppetilhørighet og opplevelse av og uttrykk for tillit. Som informanter til studien skal det rekrutteres 150 HIV positive menn og kvinner som deltar i en støtte gruppe i KwaZulu-Natal, Sør Afrika. Data skal innhentes ved hjelpe av ulike spørreskjemaer og muligens dybdeintervjuer, som i så fall vil utdype svar kategorier fra disse skjemaene.

Siden deltagerne er HIV positive kan noen av spørsmålene aktivere emosjonelle reaksjoner knyttet til den sårbare situasjonen de kan være i. Slike spørsmål omkring deltakernes sårbarhet og frivillighet i forbindelse med deltakelse i undersøkelsen er drøftet på en tilfredsstillende måte under punkt 10 i søknadsskjemaet.

Vedtak:

Komiteen godkjenner at prosjektet gjennomføres i samsvar med det som fremgår av søknaden.

Med vennlig hilsen

Kristian Hagestad
Fylkeslege cand.med., spes. i samf.med
Leder

Jørgen Hardang
Komitésekretær

Kopi: Kjersti Nesje, kjersne@student.sv.uio.no

**Norsk samfunnsvitenskapelig datatjeneste AS**
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Wenche Dageid
Psykologisk institutt
Universitetet i Oslo
Postboks 1094 Blindern
0317 OSLO

Vår dato: 12.06.2008 Vår ref: 18806 / 2 / JE Deres dato: Deres ref:

## TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 07.03.2008. All nødvendig informasjon om prosjektet forelå i sin helhet 10.06.2008. Meldingen gjelder prosjektet:

| | |
|---|---|
| *18806* | *The Role of Social Capital in Promoting Community Based Care and Support for People Living With HIV/AIDS in KwaZulu-Natal, South Africa* |
| *Behandlingsansvarlig* | *Universitetet i Oslo, ved institusjonens øverste leder* |
| *Daglig ansvarlig* | *Wenche Dageid* |

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil væ regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomfø

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningslov helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding ett år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 31.12.2015, rette en henvendelse angående status behandlingen av personopplysninger.

Vennlig hilsen

Bjørn Henrichsen

Janne Sigbjørnsen Eie

Kontaktperson: Janne Sigbjørnsen Eie tlf: 55 58 31 52
Vedlegg: Prosjektvurdering

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# Personvernombudet for forskning

## Prosjektvurdering - Kommentar

18806

Personvernombudet forstår det slik at prosjektet er et samarbeid mellom University of Kwa-Zulu Natal i Sør Afrika og Universitetet i Oslo hvor sistnevnte er behandlingsansvarlig institusjon. Ombudet forutsetter at denne behandling/ansvarsfordeling formelt er avklart mellom institusjonene og anbefaler at det utarbeides en avtale som bl.a. omfatter ansvarfordeling, ansvarsstruktur, hvem som initierer prosjektet, bruk av data og eventuelt eierskap.

Utvalget består av voksne kvinner og menn i KwaZulu-Natal, Sør-Afrika.

Data samles inn gjennom blant annet spørreskjema, dybdeintervju, fokusgrupper, deltakende observasjon, notater, tegninger og narrativt teater. Alle instrumenter vil bli adaptert til den lokale konteksten og oversatt til isiZulu.

Det registreres sensitive opplysninger om helseforhold og medlemskap i fagforeninger, jf. personopplysningsloven § 2 punkt 8 c) og e).

Det gis skriftlig informasjon og innhentes skriftlig samtykke fra alle deltakerne. Informasjonsskrivet som forelå 10.06.2008 finnes tilfredsstillende forutsatt at dato for prosjektslutt oppdateres til 31.12.2015 og teksten "unless the information has already been analysed or used in academic publications" slettes i avsnittet "The right to access personal information and maculate information about you". Dette unntaket i trekkmulighet gjelder kun for biologisk materiale og kan dermed ikke benyttes i det foreliggende prosjektet.

Behandlingen kan hjemles i personopplysningsloven §§ 8 første ledd og 9 a), samtykke.

Prosjektleder opplyser at det skal ikke foretas datainnsamling om husholdet likevel. Det skal dermed ikke etterspørres informasjon om tredjepersoner. Det tas likevel høyde for at informasjon om tredjepersoner etter all sannsynlighet kan dukke opp gjennom datainnsamlingen, særlig i narrativer og intervjuer. Ombudet legger til grunn at opplysningene vil være av begrenset omfang og av betydning for prosjektets formål. Personvernombudet finner at behandlingen kan hjemles i personopplysningsloven §§ 8 d) og 9 h). Med bakgrunn i at opplysningene om eventuelle tredjepersoner avgis tilfeldig og gjerne uten direkte personidentifiserende opplysninger, er det ombudets vurdering at prosjektleder kan unntas for sin informasjonsplikt overfor tredjepersonene, jf. personopplysningsloven § 20 annet ledd b).

I tillegg til prosjektleder Wenche Dageid og forskerteamet vil også masterstudenter, forskerassistenter og en PhD-student ha tilgang til materialet.

Prosjektet skal avsluttes 31.12.2015 og datamaterialet skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte og indirekte personidentifiserende opplysninger slettes eller omkodes (grovkategoriseres), navneliste/koblingsnøkkel slettes.

Prosjektet er meldt til Regional komité for medisinsk og helsefaglig forskningsetikk som har vurdert prosjektet som ikke fremleggelsespliktig.