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Training Paraprofessionals to Implement Hold Me Tight in South Africa: Outcomes and Experiences

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ABSTRACT

No studies have examined the effectiveness of Hold Me Tight (HMT) delivered outside of North America by paraprofessionals. In this study, paraprofessionals were trained to deliver HMT experientially by personally receiving the intervention along with didactic training on establishing and delivering HMT groups. Paraprofessionals' outcomes and their qualitative experiences learning and delivering HMT were assessed. Paired-samples *t*-tests comparing pre- and posttest scores showed significant positive differences for emotional control, relationship trust, attachment avoidance, and psychological distress. There were no statistically significant differences for relationship satisfaction and attachment anxiety. Qualitative interviews showed that paraprofessionals had a positive experience of the training and that most facilitators felt confident in delivering HMT after the training. Their experiences receiving the training and establishing and delivering HMT are described.

1 | Introduction

The Hold Me Tight (HMT) relationship education (RE) program was developed based on principles of the evidence-based couple therapy intervention Emotionally Focused Couple Therapy (EFT; Johnson 2019). Similar to EFT, HMT is grounded in attachment theory and focuses on the importance of establishing secure bonds between partners. HMT (Johnson 2008) is a structured RE program designed to help couples strengthen attachment bonds, resolve conflict, and deepen intimacy. HMT facilitators lead discussions, show videos, and facilitate role-plays to address the following topics: (1) love and attachment, (2) the demon dialogues, (3) finding the raw spots, (4) revisiting a rocky moment, (5) HMT conversation, (6) forgiving injuries and trusting again, (7) tender touch and synchrony sex, and (8) keeping love alive and caring for your relationship (Johnson 2008). HMT is commonly delivered in eight sessions once a week or in a weekend format.

HMT has been studied in a number of settings globally with largely positive results (Borjali and Sadr 2021; Conradi et al. 2018; Hedayati et al. 2023; Kennedy et al. 2019; Petzke et al. 2022; Wong et al. 2018). In a recent meta-analysis, McKibben et al. (2024) concluded that across eight studies, HMT was associated with a statistically significant (although small) effect on relationship adjustment as reported by couples. HMT has been evaluated in several studies with couples in the United States and Canada (Conradi et al. 2018; Kennedy et al. 2019; Morgis et al. 2019). HMT has also been evaluated in other studies with different populations and presenting issues including Canadian-Chinese couples (Wong et al. 2018), women in Iran experiencing a breast cancer diagnosis (Hedayati

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et al. 2023), couples in Iran (Borjali and Sadr 2021), and couples in the Netherlands who are dealing with the diagnosis of Huntington's Disease (Petzke et al. 2022). There has been one HMT study conducted in South Africa in which the fit of HMT was evaluated with Black South African Couples (Lesch et al. 2018).

In their qualitative study of HMT delivered by master's-level clinicians in South Africa for Black couples, Lesch et al. (2018) concluded that HMT was a good fit for South African couples and that the couples had an overall positive experience in the program. Two of their future recommendations were related to "the importance of training local practitioners or lay people, who share the demographics of the participants, to implement the HMT in diverse communities" (p. 326) and "It should also be a priority to train local people to present the HMT in their own communities, rather than professionals with different backgrounds coming from outside" (pp. 332–333). It was this call to action that informed our goal of training lay people, or paraprofessionals, who did not have a professional background in mental health or couple therapy, to deliver HMT in their own communities in South Africa. We first studied the outcomes associated with HMT delivered by paraprofessionals in South Africa (Blow et al. in press). Our findings showed positive improvement in relationship satisfaction, among other variables, and participants' qualitative interviews revealed positive experiences receiving HMT by paraprofessionals. The current study is an extension of that work where we present the findings associated with our experiential training approach of providing HMT to the paraprofessionals and the qualitative findings on paraprofessionals' experiences establishing and facilitating HMT groups, as well as cultural concerns encountered.

RE programs are usually offered to couples in group formats and have an emphasis on psychoeducation. The goal of RE is to provide couples with an understanding of intimate relationships and skills to negotiate difficulties that partners may encounter (McKibben et al. 2024). RE curricula are facilitated by a range of individuals with varying qualifications, including trained clinicians and professionals such as religious leaders (Hawkins et al. 2008). In their review of RE programs, Markman et al. (2022) suggest that many facilitators of these programs around the world do not have a clinical background and that this has both positive and negative effects on treatment effectiveness. They suggest that facilitators should "have better support, training, supervision, and backup for handling things well and staying on task" (p. 274). This suggestion indicates that RE group facilitation requires sound training and support to deliver effective programs.

There is still much that is not known about facilitator effectiveness and the best qualifications required to deliver HMT, but there is some support for the use of paraprofessional facilitators. The dissemination of one common RE program was tested in a randomized trial, and researchers found that paraprofessionals and religious leaders were able to deliver the program as effectively as clinicians and family professionals (Stanley et al. 2001). Thus, it is important to consider preparing paraprofessional facilitators to deliver HMT in South Africa. The use of paraprofessionals provides a low-cost approach that could expand the accessibility of HMT to more couples in need of support. Paraprofessionals may also be better prepared to connect with members of their community given their shared culture and language. For example, South Africa is a highly diverse country with 12 official languages spoken and many different cultural and religious traditions. In addition, there are differences in relationship norms and practices across each of these cultural groups.

1.1 | The Current Study

In this study, we prepared paraprofessionals to deliver HMT by providing them with an experiential opportunity to receive HMT with a loved one and through didactic training. We also provided extended support and supervision. Our goal was to examine paraprofessionals' experiences receiving HMT. In addition, we sought to understand their experiences establishing and delivering HMT. Further, we investigated what cultural challenges they experienced delivering HMT with couples in South Africa.

1.2 | Research Questions and Hypothesis

Both quantitative and qualitative data were collected to understand facilitators' experiences receiving HMT, as well as their experiences learning how to facilitate HMT groups and delivering HMT. This study examined the following research questions:

1. Did paraprofessionals report improved outcomes after receiving HMT?

Hypothesis *After receiving HMT, paraprofessionals will demonstrate significant improvement at posttest on relationship satisfaction, relationship trust, emotional control, attachment anxiety, attachment avoidance, and psychological distress compared to pre-test.*

2. *What were paraprofessionals' experiences of learning how to deliver HMT?*
3. *How did paraprofessionals describe their sense of preparedness and confidence to lead HMT groups after completing the training?*
4. *What successes and challenges did paraprofessionals experience when establishing and facilitating HMT groups?*
5. *What cultural challenges did paraprofessionals encounter while delivering HMT?*

2 | Methods

2.1 | Design

This study used a mixed methods design to assess facilitators' outcomes after receiving HMT through quantitative surveys and to explore their experiences learning and facilitating HMT through qualitative interviews. All participants provided quantitative survey responses, and a subsample of paraprofessionals participated in qualitative interviews.

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2.2 | Procedures

The training occurred over 2 weekends. In the first weekend, participants received HMT; in the second weekend, they learned how to establish and facilitate HMT groups. The first weekend started by reviewing the study details, participation requirements, and collecting informed consent. After signing the consent forms, participants completed pre-test surveys. Posttest surveys were completed after the second weekend concluded. Surveys were completed on the web-based platform Qualtrics, and study team members were available to answer questions about the survey questions if needed.

Whether or not paraprofessionals established a group, they were invited to participate in a qualitative interview through an email from the study PI. If they agreed, an interview time was scheduled. All interviews were conducted via Zoom by the first two authors. Before the interview, all participants re-reviewed the study consent form and consented to participate in the audiotaped interview. Five individuals, three couples, and one sister dyad (13 total) volunteered to participate in a one hour qualitative interview to provide in-depth information about their experiences. Nine interviews in total occurred with the five individuals taking part alone, and the three couples and the sister pair all interviewed as dyads. All paraprofessionals were interviewed using the Zoom video-conferencing platform except for one who was interviewed using WhatsApp voice notes due to a poor internet connection. Individuals were interviewed several months after they took part in the 2 weekend trainings, and after they had facilitated their own HMT groups, or after they had made serious attempts to establish a group. Paraprofessionals were asked questions about their experiences of the 2 weekend HMT trainings and their experiences facilitating HMT, including their successes and challenges. Interviews were then transcribed, and all identifying information was removed. Figure 1 details the study procedures.

2.3 | Participants

Study participants were paraprofessionals who were trained to be HMT facilitators. We recruited participants by asking (i) EFT therapists to refer paraprofessionals who worked in under-resourced Western Cape communities to the study; (ii) a local center, which provides support and training to Western Cape religious leaders and counselors to invite paraprofessionals in their network to participate; and (iii) other local religious network organizations and other counseling organizations to identify potential participants. Interested participants contacted the third author who provided them with study information. If they were still interested in participating after reviewing the study information, they were asked to inform the third author and to send the following information: the capacity in which they do lay-counseling, their highest qualification, the under-resourced community in which they worked, and their commitment to attend the 2 weekends of training.

In total, we enrolled 24 paraprofessionals to receive HMT training. Participants who enrolled agreed to attend the full HMT training, including the HMT group with a spouse/partner. They also committed to establish and facilitate their own HMT group in their local community. The paraprofessionals formed

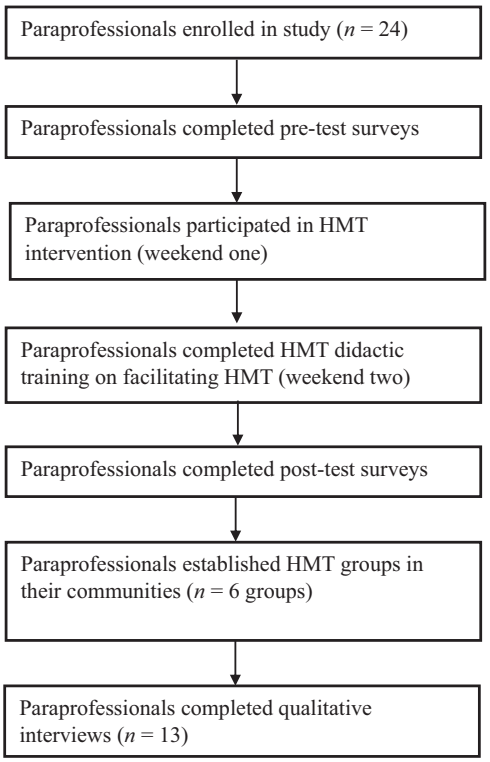

FIGURE 1 | Flowchart of the study procedures.

and facilitated six HMT groups in their local communities. The majority of paraprofessionals were church ministers with a degree or diploma in theology who provided counseling in their ministerial work. The remaining paraprofessionals provided lay counseling in their communities on a voluntary basis.

2.4 | Intervention

HMT is a RE intervention rooted in attachment theory that aims to improve couple relationship outcomes. This study was based on the HMT curriculum described in Johnson (2008). HMT is most often delivered in a multiple-couple group format with approximately six couples. HMT is delivered in eight 2-h sessions or during a 2-day weekend. The topics of the eight sessions are: (1) love and attachment, (2) the demon dialogues, (3) finding the raw spots, (4) revisiting a rocky moment, (5) HMT conversation, (6) forgiving injuries and trusting again, (7) tender touch and synchrony sex, and (8) keeping love alive and caring for your relationship (Johnson 2008). The HMT manual was translated into Afrikaans for those who preferred this language.

2.5 | Training and Supervision

2.5.1 | Experiential Component: Receiving the HMT Intervention

Paraprofessionals received the HMT intervention, as described in the HMT treatment manual, over the course of 1 weekend. This intervention occurred in the Western Cape region of South Africa, and it was designed to give potential facilitators the experience of receiving HMT. All paraprofessionals initially

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attended with a spouse/partner, though one spouse dropped out early in the process. In addition, one sister pair attended. Our goal was to teach HMT to the paraprofessionals by immersing them in the HMT curriculum. Two mental health professionals who were experienced in delivering HMT were the lead trainers for the event, and they delivered the HMT training as they typically would to participants. The trainers were White, South African women who spoke both English and Afrikaans. The HMT facilitators provided psychoeducation on HMT concepts, video clips illustrating important HMT concepts, breakout sessions for activities among individual couples, and large group processing. The HMT groups began in a large group format, and the facilitators worked to create safety. Next, they presented each HMT module, and after this, they facilitated an experiential component. Notably, the topic of sexuality elicited many questions and requests for further information, and, subsequently, additional time and information were dedicated to this issue. The experiential component involved activities during the breakout sessions for individual couples as well as processing experiences with the larger group.

2.5.2 | Didactic Component: Training in Establishing and Facilitating HMT Groups

Since the paraprofessionals did not have formal training in the facilitation of psychosocial groups such as HMT aside from experiences working with groups in their employment or religious setting, we spent one full weekend teaching group facilitation specific to HMT. This included how to recruit and screen potential participants, orient participants to the program, teach the HMT content, manage challenging group dynamics, and understand when to seek support and supervision. This part of the training was facilitated by a team of seven experts, including one of the facilitators who delivered HMT to the paraprofessionals, a South African academic well versed in EFT/HMT, and 5 HMT clinicians/scholars from the United States, two of whom grew up in South Africa.

2.5.3 | Supervision and Support

After their training, paraprofessionals established groups and facilitated them in their communities. During this process, the clinical research team provided supervision and support on an as-needed basis and checked in with facilitators as they facilitated their groups. Members of the research team were available on WhatsApp or via phone call throughout the process. On one occasion, group facilitators also met to provide peer support and tips for running a group based on their experiences.

2.6 | Ethical Considerations

The study was approved by IRBs in both South Africa and the United States. Participants received a R125 (about $8 USD) shopping voucher for each survey completed, and R300 (about $16 USD) as a couple for completing a qualitative interview. All participants were provided with an informed consent to review before participating in the study. Study personnel explained the study requirements and answered questions. Before the qualitative interviews, participants reviewed the consent form again with the interviewer and agreed to be audiotaped for the study. All quantitative and qualitative data were stored on password-protected computers. To protect participants, we deidentified the transcribed interviews to remove all identifiers such as names, employers, or other similar information. The deidentified transcripts were used in the analysis.

2.7 | Measures

Measures included demographic information, such as gender, age, race/ethnicity, religion, yearly income, marital status, number of children, language, employment status, and highest education, as well as the following standardized measures.

2.7.1 | Relationship Satisfaction

To assess satisfaction in the couple relationship, participants completed the Couple Satisfaction Index (CSI-16; Funk and Rogge 2007). The CSI-16 assesses important relationship qualities including their relationship quality perceptions, happiness, comfort, enjoyment, cooperation, and feelings. In this study, we used the total score, with higher scores indicating higher relationship satisfaction. The CSI has good internal consistency, with Cronbach's alphas ranging from 0.84 to 0.99 in a prior study (Funk and Rogge 2007) and 0.74 (pre) and 0.71 (post) in this sample.

2.7.2 | Relationship Trust

The Relationship Trust Scale (RTS; (Holmes et al. 1990) assessed changes in levels of trust in the couple relationship before and after HMT. The RTS measures interpersonal trust in intimate relationships and is composed of 31 items. We used the total score by summing all items. Higher scores indicated a stronger level of trust between partners. In this study, Cronbach's alpha was 0.96 (pre) and 0.89 (post).

2.7.3 | Emotional Control

The Courtauld Emotional Control Scale-Revised (CECS-R; Feeney 1995; Watson and Greer 1983) is a 21-item measure that was completed by participants at pre- and posttest to assess emotions in relationships and how participants react relationally when they are feeling a particular emotion (e.g., angry, anxious, and sad). We used the total score of responses, with greater emotional control representing higher scores. In this study, alphas were 0.88 (pre) and 0.93 (post).

2.7.4 | Attachment Anxiety and Avoidance

Attachment anxiety and avoidance were assessed with the 36-item version of the Experiences in Close Relationships scale (Fraley et al. 2000). This scale is a measure of adult attachment,

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and it incorporates the avoidance and anxiety dimensions of attachment. Higher scores indicated higher levels of attachment avoidance and attachment anxiety. This measure has excellent internal consistencies of 0.90 or higher for anxiety and avoidance (Fraley 2012), and alphas were 0.90 (pre) and 0.82 (post) for anxiety and 0.94 (pre) and 0.88 (post) for avoidance in this study.

2.7.5 | Psychological Distress

The Brief Symptom Inventory (BSI-18; Derogatis 2001) assessed psychological distress among paraprofessionals before and after HMT. This is a brief screening tool assessing psychological symptoms that may be of concern to an individual. Participants responded to each item in reference to how much a specific problem distressed or bothered them during the prior week. They responded on a Likert scale ranging from not at all to extremely. Scores across all items were summed with higher scores indicating more psychological distress. Alphas for the BSI-18 in this study were 0.95 (pre) and 0.63 (post).

2.8 | Quantitative Data Analysis

All quantitative analyses were conducted in SPSS version 29 (IBM Corp. Released 2023). Preliminary analyses were completed to confirm normality, linearity, and homoscedasticity of the data. We then ran descriptive statistics and frequency distributions to examine demographic characteristics of the participants. Two-tailed paired-samples *t*-tests were then used to examine changes between pre- and posttest scores on outcome variables, including relationship satisfaction, relationship trust, emotional regulation, attachment anxiety, attachment avoidance, and psychological distress.

2.9 | Qualitative Data Analysis

All interviews were conducted by the first two authors, and the first author was the primary coder. Interviews were transcribed word for word, and the transcriptions were used for analysis. The goal of the analysis was to identify themes related to each research question. Thematic content analysis (Braun and Clarke 2006; 2021) was used to develop themes in response to the research questions. Thematic analysis involves six main steps: (1) familiarization with the data, (2) initial coding, (3) searching for and generating themes, (4) checking the quality of themes, (5) finalizing themes and determining their significance, and (6) writing the report (Braun and Clarke 2006). The first author led the data analysis, reviewing each transcript twice before beginning detailed coding. He was already highly familiar with the data having conducted more than half of the interviews. Coding was guided by each research question, and transcripts were analyzed with the following questions as a guide: (1) What were the experiences of paraprofessionals in learning HMT?, (2) Did paraprofessionals feel equipped and confident to run their own groups following training?, (3) What were the paraprofessionals' successes and challenges in establishing and delivering HMT groups?, and (4) What cultural challenges were encountered? After reviewing each transcript, responses from participants related to each research question were highlighted and labeled. Next, each of these passages were reread and larger codes were created based on these reviews. Patterns of meaning were considered across these codes, allowing for main themes to be generated. These main themes were reviewed to be sure that each was sufficiently defined and that they were well supported by the data. The prolonged engagement with the data through these methods allowed rich themes to be generated. Within each part of the analysis, reflection occurred related to the four questions that guided the analysis, comparing and contrasting participant responses. The second author provided a check on the themes through engaging in a discussion with the first author about the themes, and this discussion continued until there was consensus.

Lincoln and Guba's (1985) trustworthiness criteria of *credibility, confirmability*, and *transferability* are important when it comes to the rigor of a qualitative study. In regard to credibility, it was important to bracket the experiences of the primary coder. The first author was born and raised in South Africa for 27 years. He worked as a church minister in Cape Town for 7 years before moving to the United States to further his education. This ministerial role was similar to the work of many of the study participants, and because of this, it is possible that he over-identified with study participants. He was also able to connect with the challenges described by several in the study. Having a second coder (the second author) review the themes generated added an additional layer of credibility to the findings.

3 | Results

3.1 | Demographics for Paraprofessionals

Twenty-four paraprofessionals engaged with the study assessments and 18 completed all the surveys before and after participating in HMT. Table 1 summarizes the demographic information. Of the 18 participants who completed all assessments, 61% were women and 39% were men. The majority (89%) were married and attended as a couple, except for one individual whose partner dropped out and one sister dyad. All were South African, and they reported their ethnic/racial identities using South African classifications as Black (17%), Colored (33%), and White (50%). They reported a range of incomes, with the majority (67%) falling in the R6400 to R51,200 monthly income group, which is reflective of the middle class in South Africa. Eighty-nine percent of participants had at least one child. All participants reported that their religion was Christian. Approximately 56% spoke Afrikaans as their primary language, 17% spoke Xhosa, and 27% spoke English. Participants reported they were employed in one job (89%), with 17% working two or more jobs and 11% reporting no employment. Regarding education, 78% reported having a high school diploma, and 61% had a post-high school degree or diploma.

Paraprofessionals came from a diverse array of work backgrounds that included work in religious settings, counseling, education, and other helping professions; the majority had a background in a religious context. Out of the 13 paraprofessionals who were interviewed, seven (two couples, three

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TABLE 1 | Sample characteristics of facilitators.

Sample characteristics	Facilitators ($N = 24$)[a]	Facilitators who completed pre- and posttest
Mean age in years	52	52
Gender %		
Men	44%	39%
Women	57%	61%
Marital status %		
Married	91%	89%
Unmarried	0%	0%
Long-term committed relationship	0%	0%
Other	9%	11%
Highest education level %		
No high school	13%	17%
Grade 12/Std10/ NTCIII	17%	17%
Post matric diploma	9%	11%
Bachelor's degree	8%	6%
Post-graduate diploma	17%	17%
Honors degree	13%	11%
Higher degree (e.g., master's, PhD)	17%	16%
Other	4%	5%
Self-identified population group %		
Black	17%	17%
Colored	30%	33%
White	52%	50%
Monthly household income %		
No income	4%	6%
R1–R6400	13%	17%
R6401–R12,800	9%	11%
R12,801–R25,600	22%	17%
R25,601–R51,200	35%	39%
R51201–R102,400	9%	5%
R204,801 or more	4%	5%
Missing	4%	0%
Number of children %		
0	9%	11%
1	4%	6%
2	57%	56%
3 or more	31%	27%
Religion %		
Christian	100%	100%
Muslim	0%	0%
Home language %		
Afrikaans	52%	56%
Xhosa	17%	17%
English	30%	27%
Other	0%	0%
Employment %		
No employment	9%	11%
Employed with one job	78%	72%
Employed with two or more jobs	13%	17%
Retired	0%	0%
Volunteer	0%	0%

[a]24 facilitators completed the training and 18 completed both surveys and were included in the analysis.

individuals) successfully established and facilitated a group, while six (one couple, two individuals, one sister dyad) made attempts to establish a group without success. Out of the facilitators interviewed who successfully established and facilitated a group, all were middle-aged, four were female, and three were male; according to South African racial classifications, three were Colored, one was Black, and three were White. Out of the facilitators interviewed who were unsuccessful in establishing a group, most were middle-aged aged except for one couple who was retirement age. Two were Colored, one was Black, and three were White; four were female and two were male.

3.2 | Research Question 1: Did Paraprofessionals Report Improved Outcomes After Receiving HMT?

Paired-samples *t*-tests were conducted to evaluate the impact of HMT on paraprofessionals. There were significant positive differences in facilitators' pre- and posttest scores for emotional control, relationship trust, attachment avoidance, and psychological distress. However, no statistically significant differences in pre- and posttest scores were found for relationship satisfaction and attachment anxiety (see Table 2). For emotional control, there was a statistically significant decrease from pre- ($M = 70.23$, $SD = 16.15$) to posttest ($M = 57.23$, $SD = 16.28$), $t(12) = 3.22$, $p < 0.05$. The eta-squared statistic (0.89) indicated a large effect (Cohen 1988). For relationship trust, there was a statistically significant increase from pre- ($M = 143.86$, $SD = 45.32$) to posttest ($M = 171.14$, $SD = 24.03$), $t(13) = -2.50$, $p < 0.05$. The eta-squared statistic (−0.67) indicated a large effect

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TABLE 2 | Paired-samples *t*-tests.

	Facilitators ($N = 16$[a])						
	Pre-HMT		Post-HMT				
	M	SD	M	SD	*t*	*p*	*d*
Relationship trust	143.86	45.32	171.14	24.03	−2.50*	< 0.05	−0.67
Emotional control	70.23	16.15	57.23	16.28	3.22*	< 0.05	0.89
Attachment-anxiety	56.50	17.32	46.14	15.66	2.04	0.06	0.54
Attachment-avoidance	54.50	24.71	43.71	17.00	2.36*	< 0.05	0.63
Couple satisfaction	56.92	10.15	60.85	8.10	−1.68	0.12	−0.47
Psychological distress	27.86	12.61	20.00	2.25	2.25*	< 0.05	0.60

[a]Of the 24 facilitators who were trained in HMT, 18 eligible participants completed both the pre- and posttests. Of these, the sister dyad was excluded from this analysis, as neither was currently in a relationship. Thus, a total of 16 facilitators were included in the paired-samples *t*-tests.
*$p < 0.05$.

(Cohen 1988). For attachment avoidance, there was a statistically significant decrease from pre- ($M = 54.50$, SD = 24.71) to posttest ($M = 43.71$, SD = 17.00), t (13) = 2.36, $p < 0.05$. The eta-squared statistic (0.63) indicated a large effect (Cohen 1988). For psychological distress, there was a statistically significant decrease from pre- ($M = 27.86$, SD = 12.61) to posttest ($M = 20.00$, SD = 2.25), t (13) = 2.25, $p < 0.05$. The eta-squared statistic (0.60) indicated a large effect (Cohen 1988).

3.3 | Research Question 2: What Were Paraprofessionals' Experiences of Learning How to Deliver HMT?

Three themes emerged in response to this question for paraprofessionals: (1) the HMT training was a positive and meaningful experience, (2) the facilitators who delivered the HMT program to them were critical in the success of the training, and (3) HMT training resulted in self-recognition regarding readiness to start a group. Overall, participants reported that the training experience prepared them for success when it came to the facilitation of their own groups. For two couples, it also led them to realize that they were not ready to facilitate a group of their own.

3.3.1 | HMT Training Was a Positive and Meaningful Experience

Qualitative interviews explored paraprofessionals' experiences receiving HMT. Paraprofessionals reported a positive experience personally receiving HMT and that it was very helpful for their own relationship. Of note is that they were able to *experience* the HMT intervention and used this to inform their approach as they anticipated running their own groups. This in-depth experience of HMT was emphasized as *the* key component of their preparation. The experiential parts of the weekend allowed the couples to experience their relationships in a different way. They reported that this was very different from other couple enrichment events they had participated in, which were more cognitive/lecture-focused. One participant (MH, female, White) stated:

> *"It was good. It was really good. That first weekend was amazing. I think it's one of the best I want to say seminars or sessions or whatever and we've been through quite a few marriage courses. So, this one was really—it was the first time we you know, we allowed to connect emotionally with the other person."*

Some described HMT as working for their own relationship, and because it worked for them, they were able to authentically deliver it in their communities. KM (male, Colored) stated:

> *"...we were looking forward to the next day to the sessions that were following, because we were not only thinking of ourselves but thinking about how are we going to make this practical within the community. So, first, it had to work with us, and we said it to each other the whole weekend, if it's working with us, we can take it to our community."*

KM (male, Colored) stated that the HMT weekend was extremely positive for their relationship and allowed them to deepen their relationship:

> *"So, we attended the HMT course, and the content of the HMT had a profound influence on our marriage and our relationship...I think we discovered on the day of the training...I think it was the rocky part that there were feelings and issues that we just put under the carpet that we didn't touch on. So, we had an opportunity to go deeper and talk about it and resolve those issues..."*

Some couples reported that it was in these breakouts that they talked about relational topics for the first time in their entire relationship. Others talked about how these sessions gave them opportunities to talk through difficulties, and some talked about resolving some of these issues, even though it was a relatively short weekend. One participant (BW, female, Black) stated:

> *"I'm so grateful for that weekend because we got to talk about things that we wouldn't have necessarily spoken about. What I liked about it is the fact that he opened up so easy, [and it] gave us an opportunity for me to get to know him even to the point of his feelings and not just the man outside. All I can say is that I enjoyed it. In fact, it has enriched our marriage."*

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One individual (HD, female, White) described an intense experience of discovery:

> *"My husband was with me and that was one of the first weekends that he allowed himself to go deeper than usual. So, it was an outstanding weekend for me. I really haven't experienced anything close to it, especially in the relationship between the two of us. And I think what really struck me is within the first session, when I realized I wasn't the hero and he wasn't the bad guy not understanding me, it was something else, that I'm triggering certain actions on his side, that I wasn't aware of...So, I think it was a huge aha moment of discovering that I am not the hero after all. And I think maybe that realization made him open up a little bit more and motivated him to go to deeper emotions than he previously allowed himself to go to."*

3.4 | The HMT Trainers Provided an Exceptional Experience for Paraprofessionals

Participants' experiences with the two HMT trainers were viewed positively. One individual (MH, male, White) stated:

> *"Everything was fantastic. The two ladies that facilitated the session. They were very open. They were, you know, with us the whole time. They've guided the emotions. They did exceptionally well. The first weekend was really fantastic."*

The facilitators approached the training from a position of genuineness and authenticity and used self-disclosure where appropriate. One participant (HD, female, White) described how meaningful this was:

> *"...what would really give me a tool for the future was the willingness of all the professional people to be vulnerable and to shape their own story. And that brings a level of willingness to be vulnerable yourself. I love that..."*

Another interviewee (JI, female, Colored) described the facilitators as creating a safe space.

> *"They made it a very safe space and those present felt safe to share whatever was needed...and we felt safe and held by them."*

3.4.1 | HMT Training Resulted in Self-Recognition Regarding Readiness to Start a Group

One unexpected outcome for two participants was that the weekend brought up unresolved issues in their relationship that they were not aware of, and this was an unexpected occurrence that influenced their decisions to not begin a group of their own. One individual (MH, male, White) stated:

> *"I noticed that the certain barriers in our marriage that sometimes one is not aware of. I'm happy in marriage, we've been happily married for 26 years, so, very happily married. But you realize that your measurement for happiness is different than what it should be. I think it opened a lot for us. Both me and my partner, we did a lot of crying that weekend."*

For another couple, the first weekend brought up intense feelings for one partner that led him to decide he did not want to be part of facilitating a group. This was an important realization but also distressed his spouse, who was eager to start a group. She (HD, female, White) said,

> *"My husband enjoyed it so much that he actually requested whether he could also go in the training session. So, everybody's spouse was invited to join the training, and I was caught off guard a week before the training was to happen, when he announced that I mustn't expect him to go to that weekend and this is not for him. And, you know, he turned, and I didn't understand it. I didn't understand how he could change from what we experienced in the first weekend to the second."*

3.5 | Research Question 3: How Did Paraprofessionals Describe Their Sense of Preparedness and Confidence to Lead HMT Groups After Completing the Training?

In interviews, almost all paraprofessional facilitators interviewed described feeling prepared and confident to facilitate HMT groups. Most participants not only reported feeling prepared to run their own groups but were also excited to do so. One participant (DL, female, White) stated:

> *"Absolutely. I felt absolutely prepared to do it. I was excited about it... I felt extremely confident. I felt very prepared."*

Another participant (HD, female, White) stated:

> *"Yes, I did feel prepared, and I think it was broken down nicely to bite sized portions, making it accessible. I felt quite well prepared."*

Another participant (NP, female, Black) was less confident but still ready to try:

> *"I won't say that I was ready, because I was also having fear about what kind of group I would have and also the challenges that I would have. But the material and support that I had, it made things easier... everything was prepared to make it easy when we are doing it."*

One couple who ran their own very successful group stated that they felt prepared after the training, but they also felt worried

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that something would go wrong. He (KM, male, Colored) stated:

> *"We felt equipped, but we also had, what is that - butterflies in the stomach. Will it work? Will people say yes? What will happen?...That first evening, that half an hour before the start is the most nervous part of the session because you asked yourself - all of them said, yes, but who will pitch up? Will they ever pitch up? Will they come? What will happen? 5 min to time when one come, two come, you say ooh, thank God, at least two came. [laughter]"*

Some of the confidence reported by facilitators was their motivation to take part in the training. They saw the training as a way to obtain more skills to give back to their communities. Individuals desired to bring HMT back to their communities and viewed that this was another way to help people. They were also motivated because they experienced the ways in which HMT helped their own relationships. One member (BW, female, Black) said:

> *"...having done the training myself, I've actually enjoyed it. And I felt that if we could bring that back to our church community, they would gain much more from the program."*

KM (male, Colored) stated a similar sentiment:

> *"...the content of the HMT had a profound influence on our marriage and our relationship. So, we felt that it is something that we can take to our community and test how it will work in our community and that is how we became interested in becoming facilitators."*

3.6 | Research Question 4: What Successes and Challenges Did Paraprofessionals Experience When Establishing and Facilitating HMT Groups?

About half of the HMT paraprofessional facilitators were successful in establishing a group. Several themes emerged from the interviews related to successes and challenges in group establishment and facilitation. Themes included: community-connected couples had an easier time setting up groups, successful facilitators were deliberate and prepared, and some did not feel confident or prepared in some aspects of group facilitation.

3.6.1 | Community-Connected Couples Had an Easier Time Setting up Groups

Individuals took different approaches to setting up their groups, and this was met with varied success. Those who were most successful seemed to have well-connected networks, and they had positions of influence in their communities. Some recruited individuals who they thought might benefit from the HMT program the most, for example, it was perceived that they might be struggling in their relationships. One used a gatekeeper to help her recruit participants for her group in a low-income rural area. One couple took a personal approach to recruitment, and they approached couples personally and asked them to take part. One (KM, male, Colored) individual stated:

> *"We followed guidelines in the training manual to select the couples, but in our community, it was best to go to them personally. So, we went to their houses, and we talked to them in their context and explained to them, and that is how they agreed to come to the program."*

This personal approach was highly effective for this couple (who also had strong interpersonal ties in their community). The couples who were in their group had 100% attendance.

3.6.2 | Successful Facilitators Were Deliberate and Prepared

Group facilitators each integrated their own style into delivering their groups. There were different approaches to success. One paraprofessional spent a great deal of time preparing for the groups, almost like she was delivering an exam.

> *"So, we were given notes that we could look at and very specifically the entire book, the actual Sue Johnson's actual book. Every week I read through the chapter, and I added to the other notes, and I read them separately and put the message together from that."*
>
> (DL, female, White).

Our team also provided a great deal of resources, helping paraprofessionals prepare, including a translation of materials, as well as being available for consultation.

> *"Having the availability of the slides, the pictures, and all the media was good. And we used most of the videos. We actually just set them aside and decided we'd stick them anywhere that would be most effective. And it worked really well. We had good responses to it."*
>
> (DL, female, White).

The facilitators who did well also did extra things that made the group a success. One couple would start each week by recapping the previous week's session. They also provided couples with short notes after each week, notes that summarized the key points from the session. This couple also played background music during breakout sessions to enhance privacy.

In our training of facilitators, we emphasized group composition as important to group success. All facilitators took time to screen members and not allow individuals in the group who they worried would be disruptive. One individual stated:

> *"There were couple of people who we thought could do the course and benefit from it, but that they might be in a position where they are a distraction. So, there were some personalities that we avoided."*
>
> (DL, male, White).

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3.6.3 | Some Did Not Feel Confident or Prepared in Aspects of Establishing a Group

Even though the second weekend of training focused on recruitment and engagement, some paraprofessionals did not feel completely equipped when it came to establishing a group. For example, one participant wanted more training in recruitment skills such as how to call people and ask them to participate. She (BW, female, Black) said: "I feel bad that I wasn't able to form a group, but maybe I didn't learn how to call people." While our training focused on learning HMT content and important group processes, some struggled to establish groups because they did not view themselves as having "sales skills" to attract potential group participants. Making the case for HMT was difficult in some contexts, especially in some cases where people were afraid of the stigma of such a group, believing that it was only for couples who had problems. This process led to frustration. An individual (BW, female, Black) stated about her recruitment attempts:

> *"My aim was just to convince them to come on board. And the more I tried, because I would speak to younger couples, they would say, no, we don't have problems in our marriage. We are fine.... So, I think we just need more [training] to be equipped on how to create a group and develop a group. Maybe you can throw a skill or two in your next training."*

3.6.4 | Logistical/Resource Barriers

Logistical challenges existed for some when it came to establishing a group, and these were more prominent in poorer communities. For example, in some cases, transportation of potential group members to the group was a barrier. For others, they had very busy work schedules with long hours as they worked to make ends meet, and finding time for a group was difficult. One couple who struggled to start a group described work barriers in potential participants. He stated (SP, male, White):

> *"...the weeknight to them is out of the question because they come home from work. They do manual labor and work long hours. When they go home, then they've got to prepare the kids... Also, it's a bit dangerous at night for them walking alone at night."*

Another individual (JI, female, Colored) stated:

> *"I think what's the barrier was as well, finding a suitable time to run this group because the people involved, were working 5 days a week or even some 7 days, 6 days a week, or with children. And I think the timing finding a suitable time for everyone was the story."*

One woman (NP, female, Black) discussed the tremendous challenges faced by members of her community in attending such a group:

> *"The biggest struggles were to make the time for people to come because most of the people were working. And to have them show up on time was an issue because most of the people were staying different places and the transport is difficult for them to get to the same place and also to have a way of going home...And some people are coming straight from work or church and so I needed to make them something to drink or eat."*

3.6.5 | Stigma Barriers

Some struggled to establish groups because people in their context were not interested or they viewed the group as a threat. For some, a church was an ideal place to recruit members and establish a group. For others, this was a challenge because church members first wanted to screen the content. One participant (BW, female, Black) stated:

> *"So, I didn't get as much support even from the [church] leadership."*

One barrier that some described was that there was a reluctance to engage in "therapy." Even though HMT is not a therapy approach, that perception existed in some communities. This raised considerations for how RE programs are presented to participants. A woman (JI, Colored) stated:

> *"I think they think it is therapy. So, I actually use the word conversations ... just makes it a little less intimidating for them. Especially the males...The females are open."*

Some agreed with the above sentiment that men were a barrier to establishing a group as some men were reluctant to join, particularly in this cultural group. One participant recommended establishing groups for women only. The participant (JI, female, Colored) stated:

> *"Some of the females are very open to it, but to get their husbands to join them, that's a bit of a difficult one because men don't see their problems you know, they can do it themselves and they can solve it themselves."*

One individual suggested that they struggled to establish a group because some may be worried about meeting in a group with members of their church because they do not want others to know or even think that they may have problems. She (JI, female, Colored) stated:

> *"Well, their friends, but some are also in leadership, I think, you know, are they going to think I have problems in my marriage that I am having the Hold Me Tight session."*

3.7 | Research Question 5: What Cultural Challenges Did Paraprofessionals Encounter While Delivering HMT?

We asked participants about specific cultural challenges or mismatches in their HMT experiences. There were varied

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responses and views on the cultural fit of HMT with many reporting no issue at all and some reporting cultural fit concerns.

3.7.1 | Positive Cultural Synchrony

In general, those interviewed thought that HMT concepts translated well across cultures and relationship types. For example, one Black individual (BW, female, Black) stated the following when asked about cultural challenges in the HMT program:

> *"Oh, in our case, nothing much.... but I know there are other African couples that might not have been comfortable such as the older folks."*

This same individual attributed their ability to relate to HMT to their religion, which essentially filtered their experiences of HMT or minimized culture: "...there are people that practice Christianity without culture. So, it's as if they drop the African culture [they practice] Christianity full-stop."

One facilitator (MH, male, White, Afrikaans speaking) described the HMT training experience on the first weekend and their encounter with another couple from a completely different ethnic group. He viewed them as having a positive shared experience of the HMT program, despite socio-cultural differences.

> *"We experienced an emotional experience. They (the Black couple) also experienced that; we sat at the same table with them, and we shared between the two families, we shared, and we realized, you know, they experienced what we experienced."*

Another individual (SP, male, White) stated: "Not at all for me. We are pretty similar [to US and Canada] as White Africans in culture..." This participant also thought that one of the black couples' testimony of "how the impact on their marriage was unbelievable" demonstrated the relatability of HMT across cultures.

A woman of color (JI, Colored) stated:

> *"I didn't actually see any problems with different cultures exposed....I think everyone had the same desire to learn, everyone despite culture wanted to improve the relationships."*

3.7.2 | Stigma and Culture

Culture seemed to be an issue for some when it came to establishing a group. Some cultures or settings seemed more open to a group of this kind. One member stated:

> *"In our culture, the so-called people of color, we are not used to therapy. When you grow up, our parents said this is your problem, you deal with it. You don't let anybody else know about your issues. So, I think that's the difficulty and there is still some form of a mindset like that... that we can deal with it on our own."*
>
> (JI, female, Colored).

3.7.3 | Culturally Sensitive Topics

Some topics came up that participants thought may not be a good fit for some individuals or some cultures. One interviewee suggested that some cultural groups may not want to process and share their emotions. A facilitator who ran a group in a rural farming community described this challenge:

> *"The one struggle I have usually among the farm workers, is that they struggle to open up, to go deep. Especially getting them to acknowledge what is going on underneath."*
>
> (HD, female, White).

It was clear that across the facilitator group that sexuality was an important topic, both in their own relationships and in the relationships in the groups that they were to facilitate. Several members of the facilitator group described the extra time spent in training around the topic of sexuality as very meaningful and helpful. This normalized some of their concerns about a sensitive topic. For example, group facilitators described the module on sex in their own training as being important in preparing them to discuss the topic of intimacy in their own groups and it allowed them to be more comfortable in approaching the topic. One individual (MK, male, Colored) stated,

> *"The information session provided on sex gave us more angles and more good information, and people used them in other trainings. It was good to go through that session."*

4 | Discussion

This study sought to examine recommendations made by Lesch et al. (2018). After conducting a pilot study of HMT delivered by master's-level clinicians in South Africa, Lesch et al. recommended that HMT be tested with facilitators from the local community who share the demographics of the diverse group members. Therefore, this study aimed to examine paraprofessional facilitators' experiences receiving HMT, as well as their experiences learning how to establish and facilitate HMT groups.

4.1 | Paraprofessionals' Experiences Receiving HMT

Both the quantitative and qualitative data revealed that paraprofessionals benefited from receiving HMT. All those interviewed reported positive experiences of the impact of HMT on their relationships. There were significant pre- to posttest changes in emotional control, relationship trust, attachment avoidance, and psychological distress. Attachment anxiety was

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not significant but approached significance ($p = 0.6$), and there was no significant difference in relationship satisfaction from pre- to posttest. While we expected relationship satisfaction scores to reach significance, relationships may not have been significantly affected by the intervention because the couples in the paraprofessional group were highly motivated couples with already stable relationships. In addition, because they were selected as future HMT leaders, they may have overinflated their responses on the relationship satisfaction questionnaire. Other studies found a positive impact on both relationship satisfaction and on some other variables we examined. For example, Conradi et al. (2018) found the following outcomes improved after receiving HMT: relationship satisfaction, security of partner bond, and psychological complaints, while Kennedy et al. (2019) found that HMT had a positive impact on relationship satisfaction and trust but did not change attachment anxiety or attachment avoidance. In our study (Blow et al. in press) of outcomes for HMT group members delivered by the paraprofessionals in the current study, we found significant pre- to posttest improvement in emotional control, relationship trust, relationship satisfaction, attachment anxiety, attachment avoidance, and psychological distress.

4.2 | Training Paraprofessionals

In our approach to training paraprofessionals, we used an experiential and didactic approach that aligned with the HMT process. Providing paraprofessionals and their spouse/partner HMT provided an ideal context for an immersive HMT experience. Not only was it reported as helpful, but the quantitative data show that it was efficacious for these facilitators. Many of the studies on the implementation of HMT do not provide clear details on how facilitators were trained (e.g., Conradi et al. 2018; Kennedy et al. 2019; Wong et al. 2018). In our study, participants described how being immersed in HMT provided an important experiential learning opportunity that prepared them to facilitate HMT. Receiving HMT also served to "weed out" facilitators who may not have been ready or well suited to facilitating their own groups. Without this first intensive experience, they may not have been fully aware of their own personal preparation for leading a relationship-focused intervention. After receiving HMT, two facilitators decided not to facilitate groups of their own. These were not bad or negative experiences; rather, they identified concerns in their relationships that they had not worked through and delayed facilitating groups.

Some of the paraprofessionals in our study were able to set up groups and deliver the intervention with positive results (Blow et al. in press). Paraprofessionals have been found to be able to deliver interventions effectively in other studies and often with the same effects as mental health professionals with extensive training (Smith et al. 2024; Tandon et al. 2021). As Markman et al. argued, it is common for nonmental health professionals to deliver RE programs, and our findings show that it is possible for paraprofessionals to achieve excellent outcomes in an under-resourced international context.

It was also important for paraprofessionals to receive support as they established and facilitated HMT. Facilitators contacted the research team with questions or concerns, and they were provided support. Paraprofessionals who were not able to establish their own groups may have benefited from more intensive support or even co-facilitators to help them establish and facilitate the first group.

4.3 | Barriers to Group Establishment

It was evident that not everyone who desires to facilitate a group will be successful. Out of those who attended the first weekend, only about one-third ended up establishing HMT groups (6 groups total). The reasons why individuals struggled varied. Some paraprofessionals had life circumstances that changed (e.g., one couple retired suddenly), and others decided that they were not ready to facilitate a group based on perceptions of the state of their own relationship. Other paraprofessionals struggled to recruit participants. Paraprofessionals who were successful at establishing groups were well connected in their religious communities and were able to use their connections to engage participants. Other paraprofessionals planned to run groups in their places of worship but ran into difficulties with religious leaders when they set out to establish their groups. Others struggled because of logistical factors. For example, members of their communities had very little time in their schedules due to multiple transportation, family, and work commitments. There were also safety concerns at night in some of these communities. These logistical challenges were some of the most difficult to overcome, and in hindsight, we should have addressed these types of challenges more directly with facilitators. Additional resources might be helpful for these individuals in paying for transportation or in renting a suitable place to meet. These physical challenges were exacerbated by stigma in some communities where men in particular were reported to be reluctant to join a "counseling group."

4.4 | Cultural Challenges

Even though HMT has been studied in several international contexts, we identified cultural challenges. Some groups implemented by paraprofessionals were held in church settings where church leaders frowned on women leading a group. The topic of sexuality drew great interest in the facilitator group, leading us to add a special discussion section on the second weekend to work through concerns that were raised about the topic. This ended up being a meaningful session that facilitators referenced in their interviews. In some cases, female facilitators ran into some difficulties in trying to gain access to group members, and their gender may have played a role in some instances.

4.5 | Implications

This study showed that it is possible to train paraprofessionals to deliver HMT effectively in South Africa. Providing paraprofessionals with the opportunity to experience HMT as participants may be a key component to successful implementation. Regarding the didactic training, it might be helpful to incorporate training on how to assess barriers to recruitment

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and identify ways to resolve them. Additional resources may be needed in low-resource communities, including transportation. Group leaders who were successful in establishing their groups had more support, structure, and resources available to support them and were able to overcome barriers such as stigma and transportation. In training facilitators, it is important to train them in skills such as creating community connections and networking, in addition to the HMT curriculum. Some groups were more successful when physical resources were easily obtained, and those who had to go through existing community structures struggled more. Providing modest material support to some facilitators may be an ideal way to support paraprofessionals.

4.6 | Limitations

This pilot project had several limitations. We were limited by the sample we were able to recruit for this study. Paraprofessionals were largely Christian and came from church leadership backgrounds. This may have had an influence on group successes and failures. It also meant that participants were eager to learn and offer the curriculum in their communities. We were also limited by a small sample of paraprofessional participants, which limited statistical power. We were also limited by resources available and the proximity of the study team, all of which were barriers to enrolling more participants and conducting follow-up data collection. The data collected were pre- and post-HMT, and longer term follow-up could have provided additional information, such as a diminishment of gains as was found in another HMT study (e.g., Kennedy et al. 2019). In addition, paraprofessionals may have provided more favorable positive assessments of their relationships to please the training team, which may have created a ceiling effect. Finally, while we showed we were able to do this study in one region of Africa, that is, the Western Cape region of South Africa, this study may not be as easy to carry out in other regions of South Africa or other places on the African continent where there are different religions, socioeconomic backgrounds, cultural norms, or fewer lay leaders. It is important to evaluate these types of studies.

5 | Conclusion

In this study, we trained paraprofessionals to deliver HMT in their local South African communities. Paraprofessionals were trained in two phases, an experiential training where they received HMT as participants and a didactic training to learn how to establish and facilitate HMT. Paraprofessionals reported that the training was helpful, and they generally felt equipped to establish and facilitate their own groups. The training also served to identify some paraprofessionals who were not yet ready to facilitate HMT. Supportive supervision as well as physical resources were identified as helpful in this process. Future studies should examine more diverse samples of participants with larger sample sizes. The continuation of this study is valuable since paraprofessionals are an excellent means of providing interventions that strengthen relationships in resource-poor contexts.

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