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Community, Compassion, and Chronic Illness: Support Circle Viability in Urban Healthcare Settings of Andhra Pradesh

Penumatsa Vinya Tejeswini

Department of Commerce and Management, Centre for Distance and Online Education, Jain (Deemed-to-be University), Bengaluru, Karnataka, India
Email: *vinyapenumatsa95[at]gmail.com*

Abstract: ***Chronic illness carries significant psychosocial burden, yet Indian hospitals rarely offer structured peer-support mechanisms. This qualitative case study examines the perceived need, emotional readiness, and feasibility of hospital-based "support circles" for chronically ill patients across five private healthcare settings in Guntur, Vijayawada, and Visakhapatnam, Andhra Pradesh, spanning rheumatology, nephrology/dialysis, diabetes, oncology, and thalassemia. Using purposive sampling, a 20-item semi-structured interview schedule was administered to 41 respondents (ages 4–80+), with participant-reported, researcher-observed, and staff-reported evidence treated as analytically distinct throughout. Thematic analysis of interviews and field notes was combined with descriptive analysis of questionnaire responses. Findings show meaningful but condition-sensitive openness toward support circles: rheumatology and thalassemia patients displayed exceptionally strong doctor-centred trust; oncology patients showed high emotional intensity and desire for comparable lived experience despite physical proximity to other patients; diabetes was comparatively normalised; and nephrology patients showed pronounced stigma and privacy concerns despite naturally occurring informal peer contact. The study concludes that support circles are a viable complementary psychosocial resource provided they are condition-sensitive, confidential, voluntary, and integrated with existing clinician relationships rather than replacing them.***

Keywords: chronic illness; peer support; support circles; psychosocial support; healthcare settings

1. Introduction

Noncommunicable diseases account for roughly three-quarters of deaths worldwide, and chronic illness affects far more than physical health- it reshapes routines, work, family roles, and a person's sense of future [1]. Evidence consistently links chronic physical conditions with elevated depression, anxiety, and social disconnection [2,3], yet adjustment is uneven: some patients develop persistent distress while others gradually incorporate illness into daily life. Social support- particularly peer support from others who share lived experience of a similar condition- offers a distinct form of understanding that professionals and family members cannot always provide [4]. This study examines the feasibility of structured, hospital-based "support circles"- small, confidential peer groups facilitated within a healthcare setting - in urban Andhra Pradesh, where such psychosocial structures are largely absent from routine care.

2. Literature Survey

Peer-support interventions across chronic conditions have been shown to improve quality of life, self-efficacy, and treatment adherence, though effectiveness varies by context and population [4,5]. Reviews of cancer-specific peer support report benefits for quality of life, depression, anxiety, and self-efficacy [5], while peer support among type 2 diabetes patients improves self-management and glycaemic control, with less consistent effects on depression [6]. Social Support Theory frames support as operating through emotional, informational, and practical channels that buffer stress [7], while Maslow's hierarchy situates belonging and esteem needs as extending beyond the physiological and safety needs addressed by medical treatment alone [8]. In India, a substantial national gap between mental-health need and treatment provision [9], combined with an uneven distribution of psychosocial services, creates a rationale for low-cost interventions integrated into existing hospital contact rather than requiring a separate service pathway. What remains comparatively unexamined is whether a specific hospital population in an Indian urban setting is practically ready and willing to participate in such a model, and what facilitates or blocks that participation- the gap this study addresses.

3. Problem Definition

Chronic-illness care in most Indian hospital settings remains centred on diagnosis, medication, and follow-up, with the emotional and social consequences of long-term illness receiving comparatively little structured attention. Family support, while valuable, does not necessarily substitute for the understanding that arises from shared lived experience. The literature establishes that peer support can be beneficial in principle, but a practical gap remains: whether a specific hospital population is ready, willing, and practically able to participate in a structured support circle. This study therefore asks (a) whether chronically ill patients in Andhra Pradesh perceive a need for structured support circles, and (b) whether they are emotionally and practically willing to participate if such circles were introduced.

4. Methodology

A qualitative case-study design combined semi-structured interviews with descriptive analysis of structured questionnaire items. Purposive sampling was used across five private healthcare settings representing rheumatology,

nephrology/dialysis, diabetes, oncology, and thalassemia (Table 1). Each of the 41 respondents contributed one interview; 36 of these are matched by a corresponding Google Form entry, while the remaining 5 (all at Loving Sai Clinic) are documented through researcher field notes only. Audio recording was used only where institutionally permitted (not at the diabetes site). The thalassemia sample included three minors/young participants (aged 4, 12, and 18); informed consent was obtained from the accompanying parent/attendee in each case, and the 18-year-old additionally gave personal consent as a legal adult. A separate formal child-assent procedure was not administered; each participant's own brief verbal contributions were recorded and reported alongside, rather than in place of, the parent/attendee account. Interview data and field notes were analysed thematically following Braun and Clarke's framework [10], with participant/parent reports, researcher observations, and staff/clinician observations treated as three analytically distinct evidence layers throughout- a distinction preserved in the Results and Discussion below. Questionnaire data were analysed descriptively (frequencies and percentages); no inferential statistics were computed given the small purposive sample.

Table 1: Sample distribution across healthcare settings (N = 41)

Setting	Condition	n
Pratyusha Rheumatology Care	Rheumatology	10
Aswini Hospitals	Nephrology/Dialysis	5
Loving Sai Clinic	Diabetes	15
Omega Hospitals	Oncology	8
Mamata Children's Hospital	Thalassemia	3

5. Results

Across settings, physical pain/fatigue (21 mentions), lifestyle restrictions (17), and frequent hospital visits (15) were the most commonly reported participant challenges, with financial burden and work/study disruption also prominent. Family and friends were the most frequently cited emotional-coping resource across all five settings.

Prior informal peer contact varied by setting: participants reported that it occurred naturally during dialysis and was common among diabetes patients, whereas oncology participants reported being physically surrounded by other patients in waiting areas without necessarily forming meaningful connections- several oncology participants asked about other patients with similar diagnoses even before the support-circle concept was introduced, an unprompted expression of interest recorded directly from participant accounts.

Regarding preferred format, participants favoured one-to-one mentoring (19 mentions) and patients sharing personal experience (12) markedly over group discussions or guest-speaker sessions (4 each). Overall support for introducing structured circles was positive: 16 of 41 respondents answered "definitely yes," 13 "probably yes," and 11 "not sure," with no respondent opposed outright.

Researcher observations, recorded separately from participant self-report, indicated exceptionally strong doctor-centred trust at the rheumatology and thalassemia sites: participants and parents at both sites indicated willingness to travel considerable distances or incur expense if the treating doctor endorsed participation. At the nephrology/dialysis site, participants reported concealing their condition from relatives, neighbours, and employers; hospital staff independently and separately reported observing similar secrecy as a recurring pattern among nephrology patients generally, a staff-level observation kept analytically distinct from individual participant accounts. At the diabetes site, several participants reported that access to a specialist would be more valuable to them than peer contact with other diabetes patients.

6. Discussion

The overall pattern of openness (29 of 41 respondents answering "definitely" or "probably yes") is consistent with reviews reporting that peer-support interventions are generally viewed favourably across chronic conditions, though effectiveness and acceptability vary by context [4]. What this study adds beyond that general finding is a setting-specific account of why acceptability varies: rather than a uniform readiness gradient, condition-specific factors- treatment burden, stigma, and existing informal peer contact - appear to independently shape perceived need.

The doctor-centred trust observed at the rheumatology and thalassemia sites extends House's formulation of social support as operating through emotional, informational, and practical channels [7]: here, the treating doctor appears to function simultaneously as an informational authority and an emotional anchor, such that the doctor's endorsement could plausibly substitute for an independent trust-building phase that many peer-support implementations require. This is a mechanism-level contribution the general Social Support Theory literature does not specify, and it suggests a practical implementation pathway- clinician-introduced, professionally facilitated circles- rather than externally recruited support groups.

The muted interest observed among diabetes participants aligns with Chen et al.'s finding that peer support for type 2 diabetes improves self-management but shows inconsistent effects on depression [6]; our field data suggest a explanatory mechanism for that inconsistency- where diabetes is already normalised and informal peer networks already exist within participants' own families, a formal circle may add comparatively little emotional value, though participants' preference for specialist access indicates unmet need still exists, just not primarily a peer-connection need.

By contrast, the oncology finding- patients physically proximate to similar others yet reporting a distinct, unprompted desire for connection- helps explain why cancer-specific peer support shows consistent benefit for quality of life, depression, and anxiety in prior meta-analytic evidence [5]: physical co-location in a waiting area does not, on its own, satisfy the need those interventions address, since participants in acute emotional distress or denial did not spontaneously initiate contact with similarly situated patients. This indicates that structured facilitation, not mere physical proximity, is the active ingredient peer-support programmes would need to supply in oncology settings.

The nephrology stigma finding, corroborated independently by both participants and staff, extends the informational/ emotional support framework [7] by identifying confidentiality as a precondition for participation rather than a design refinement: where patients actively conceal their diagnosis from their immediate social circle, a support circle perceived as insufficiently confidential is unlikely to be viable regardless of its content or facilitation quality. Read through Maslow's hierarchy [8], this suggests belonging-level interventions cannot proceed until safety-level concerns- here, informational safety rather than physical safety- are addressed.

Collectively, these condition-specific mechanisms indicate that a single standardised support-circle template would be inadequate for the Indian hospital settings studied. Given the documented gap between mental-health need and service provision in India [9], the findings suggest that support circles introduced through, and endorsed by, existing clinician relationships may offer a low-cost route to psychosocial support that does not require new infrastructure- provided implementation is adapted per condition rather than applied uniformly.

7. Conclusion

Hospital-based support circles appear feasible as a complementary psychosocial resource for chronically ill patients in urban Andhra Pradesh, but viability is condition-sensitive rather than uniform. Success is likely to depend on confidentiality, voluntary participation, flexible scheduling around treatment burden, and a facilitation model in which trusted clinicians introduce or endorse- without mandating - participation, while psychologists or trained facilitators manage emotional safety. Peer support should be positioned as an additional layer of care alongside, not instead of, existing medical and family support.

8. Future Scope

Future research should replicate this study in public hospitals and rural settings with larger, more diverse samples, and should pilot an actual support-circle intervention to evaluate outcomes such as quality of life, self-efficacy, and treatment engagement using pre/post measures. Comparative studies of doctor-led versus psychologist-led referral pathways, and of disease-specific versus mixed-condition groups, would help refine implementation models. Developing culturally appropriate, condition-sensitive facilitation protocols for Andhra Pradesh and other Indian states remains an important next step toward translating these findings into practice.

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