

# Support Groups in Nursing Practice

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## Abstract

*Nurse led support groups can help individuals live with disease, increase social support and reduce psychological burdens. The nurse can develop or expand group leading skills and maintain practice standards by working with a supervisor or skilled co-leader. Leading a group can expand the nurse's professional and clinical role. Benefits of groups include helping patients understand their problems are universal, they can support others, and they are not alone. People in support groups often learn new coping skills. Support groups are cost effective and offer multiple benefits. The concepts, types, phases and leadership of support groups are discussed and illustrated by clinical examples and sound research. Often nurses without experience in this area are asked to lead support groups, but they need skill and know how for this task.*

Nurses may wish to expand their skill and knowledge in leading support groups to help patients cope with their disorders. Support groups are widely used as the context of treatment, counseling, and education for patients because they can improve emotional support, social contact, and control. However, a review of the literature found that most publications focus on support groups in geriatrics or in oncology. A meta-analysis showed that groups are at least as effective and sometimes more effective than individual treatment and more efficient because more patients are treated for the same cost (Brodaty, Green & Koschera, 2003). Support groups may improve patients' psychological and psychosomatic symptoms, coping strategies, and stress management. They have effectively provided a supportive and psychoeducational approach for patients (Nettina, 2001). Studies show that professionally led support groups can significantly reduce the number of hospitalizations and therefore may have considerable importance for health economics (Diehl, Mayer, Kurz & Forstl, 2003). Some of the texts on groups are older and classic references (Maram, 1978; Yalom 1995).

In healthcare, groups offer therapeutic interaction and encouragement and enhance mental health and health education. People frequently interact in groups and depend on others for important feedback about their personal achievement and fulfillment in family, work and social settings. Benefits include realizing problems are universal: learning problem solving, developing social support, social skills, and altruism (Zabalegui, Sanchez, Sanchez, & Juando, 2005). Groups also offer a sense of security, belonging, and companionship. Individuals reported they attended a support group to share information, connect with and help others (Baum, 2004; Williams, Young, & McRae, 2004). A group approach is cost-effective and useful for diverse individuals in various settings. Personal goals can be accomplished when people work together to reduce weight or stop smoking. A professionally led caregiver support group produced significant reductions in mood symptoms and it increased knowledge, enhanced coping, increased resilience, improved relationships, and improved performance (Gance-Cleveland, 2004; Winter & Gitlin, 2006). The research, literature,

and program evaluation of support groups are limited (Brodaty, Green, Koschera, 2003; Diehl, Mayer, Forstl, 2003).

Many nurses want to improve their knowledge of the structure, dynamics, leadership and processes of small groups. The purpose of this article is to explain the design, organization, and conduct of support groups.

The leader should understand group dynamics, the disease or problem. If the group focuses on a disease or health problem, the leader needs to know about the disease, its symptoms, and how people cope with it. With an understanding of small group dynamics, nurses from diverse educational backgrounds can lead therapeutic or psychoeducational groups (Friedman, 1994; Kurtz, 1997; Maram, 1978). The principles of group dynamics help the leader decide what discussions to enhance, when to encourage a silent member's participation and when to set limits or clarify issues. Knowledge of interpersonal interaction and psychological dynamics helps the leader evaluate an individual's functioning. Understanding the situation such as bereavement helps the nurse decide how to respond to questions and issues-- for instance hearing the voice of the deceased person is a common experience, so such hallucinations are normal and not typically a symptom of psychopathology.

Qualified advanced practice psychiatric nurses can serve as group therapists. The effective group will accomplish its specified goals, develop cohesiveness, and manage termination while effectively supporting the members as they develop effective coping skills. Groups can focus on tasks, self awareness, support, growth, and psychoeducation (Chao, Liu, Wu, Jin, Chu, Huang, Clark, 2006; Hoffman, 2006; Milberg, Rydstrand, Helander, & Friedrichsen, 2005).

Before starting a support group, leaders will find it useful to interview each of the prospective members and evaluate their symptoms, needs, concerns, and goals. This helps the leader connect with members, start a relationship, and anticipate the general topics likely to arise. However, on an inpatient psychiatric unit, the nurse will be expected to include all patients except for those who are disruptive to group process, so an interview may not be needed. For instance, in a support group for people with a life threatening illness, the interview can suggest how open people are to talking about end of life topics, personal fears of dying, and alienation.

## Designing A Support Group

The leader designs the group by specifying the aims, purpose, format, participants, inclusion criteria for participation, and ground rules for the group (See Table 1). The design may reflect a need in the clinical practice setting. For instance, hospice might decide to start a bereavement group for family members. In another agency, a nurse may conduct a needs assessment and creates a group to respond to the patient's needs for information about coping with their disorder such as cancer or Parkinson's. The design

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reflects the leaders' theoretical background and philosophy, the characteristics of the client population, the agency goals and requirements, and legal or professional standards (Kurtz, 1997; Maram, 1978). The leader specifies the group goals, time and length of meetings; place for meeting, beginning and ending dates, addition of new members, attendance, confidentiality, roles of participants, and fees.

In psychiatric or geriatric settings, nurses may decide to create a "current events and socialization group" where inpatients would discuss a current event, build social skills, and interact with others. The leader encourages each person's participation but understands that psychiatric symptoms may influence participation. The leader identifies the potential client base and referrals, and obtains administrative approval as needed. Another typical focus would be a psychoeducational group where people with a similar disorder (e.g., cancer, diabetes, HIV or bereavement support group) would how they cope with the disorder. (See Table 4)

### **Group Design and Format**

The leader is the architect of the design and the size, aims, length, and duration of the group. Typically one skilled group leader can manage up to 10-12 people and two leaders would be needed for 20 or more. If more than 20 members attend, it becomes difficult to ensure everyone's participation. Yalom (1995) suggests that groups with fewer than four or five members can be less effective. The leader also outlines group aim, purpose, format, ground rules and criteria for participation. In the bereavement group above, most parents agreed they had accomplished the goals in 3 months. For those who still wanted more social support, the members discussed options for joining volunteer or community activities. Some parents also planned to continue their psychotherapy. If goals are not met at the end, the leaders can recommend referrals or solutions.

The leader selects the target population, the location and site of the meeting, the type of group (support, psychoeducational, etc), whether it is open or closed to new members, and the length (see Table 2). If it is closed, new members may arrive at the beginning of any meeting. In a psychiatric setting, a nurse may have open membership where patients attend after admission and leave when they are discharged. Selecting an open or closed membership depends on the purpose and goals. The bereavement group was closed because parents needed to become comfortable in order to share intense sadness, guilt, and confusion, and new members would disrupt the developing atmosphere of trust and acceptance. An open group offers more opportunity for people to attend but constantly adding new members can disrupt cohesiveness and development. Other decisions include the criteria for group membership and whether significant others may attend. The leader may need to advertise, market, or announce the group and seek referrals. An effective group will accomplish its goals, maintain cohesion, and develop or modify its structure to improve its effectiveness.

In addition, taking notes or charting is typically assigned to the leader, co leader or a recorder (Kuer, Hallauer, Jansen & Diehl, 2004). The leader or co-leaders identify the criteria for membership and typically select people with similar issues who will interact effectively with others. They also provide an orientation, encourage participation, help members reflect on their feelings, and often redirect general questions to the members to encour-

age interaction (See Table 3). To improve collaboration, co-leaders typically meet between group sessions to compare notes, decide on approaches to specific issues, discuss dynamics, and evaluate the dynamics. For instance, if one group member monopolizes the conversation, the leaders decide how to respond and whether to redirect the conversation.

The location for the meetings is important and should be free from interruption and allows confidential discussions and easy access. When conducting some groups (e.g., a bereavement group after a child's suicide) leaders should select a place without obvious references to or pictures of children so they avoid selecting a nursery school or a church with children's classes.

In some instances, an agency administrator may recommend a location for a support group that is problematic. For example, one clinic administrator wanted the support group held in the clinic waiting room, which had a loud TV playing re-runs and many interruptions. This was not a suitable area for discussing private issues related to disease management. In addition, the patients viewed the waiting room as their area and complained when they had to hear someone else's personal business while they were waiting.

### **Leadership Functions**

The leader maintains a functional atmosphere, oversees growth, and focuses the on the goals. For instance, the leader might call someone who had missed one or more sessions to check on that person and set limits when several people talk at once. The leader ensures that everyone has an opportunity to participate, monitors the beginning and ending time of group, and facilitates interactions. The leader may post a flyer that invites people to join who meet the criteria are set for participation. The leader notifies everyone if there is some change in the meeting time or if a meeting is cancelled (e.g., for a holiday).

Other leadership functions include managing issues that arise such as a nonstop talker or one who introduces issues that are outside the goals (e.g., long discussions of political elections in a bereavement session). How this is handled reflects the leader's theoretical framework, goals, and leadership skills. For instance, if someone tends to talk nonstop, the leader may choose to bring this issue out in the open at the beginning of the session and encourage discussion about how this influences the interaction. The leader may also remind everyone of the ground rules. Alternatively the leader can tactfully interrupt and reinforce the goal of having time for everyone's participation. The leader can then redirect the discussion or call on another member for comments. For example, in a suicide bereavement support group, one woman wanted to share long stories from Russian literature about suicide - and this was outside the goals. The group leader agreed this was very interesting and then skillfully redirected the discussion to the "here and now" issues about coping with their child's suicide.

Another leadership task is to facilitate interaction among members. The leader may invite a quiet member who has listens intently to share his or her response. The goal is to stimulate useful exchange and interaction and allow people to share their feelings and concerns. For instance, in the same suicide bereavement group, one couple agonized and asked the leaders how to respond to strangers who asked, "How many children do you have? Because the parents did not want to explain that one child died and disclose the mode of death, which was suicide. Since all members had some

experience with this issue, the leaders encouraged everyone to respond. The leaders asked other parents how they handled this emotionally-laden situation and a productive discussion of this shared problem ensued.

The leader can be designated, but members can also provide leadership and can sometimes serve as co-leaders. Co-leaders do not necessarily need to know each other well but they do need to respect and trust each other and have some agreement about the goals and format. Co-leaders need to be motivated and able to work together as a team. The advantages of a co-leader are several: when one leader focuses on an individual, the other can observe the group members, each co-leader may notice different issues; both can compare notes about interactions in a post-group discussion, and they can divide leadership tasks. For example, in a bereavement group, the parents of a teen who committed suicide brought in an article from the school paper. The headline said, "Poor Parenting Causes Suicide." This distracted one of the leaders who was busy imagining writing a rebuttal. The other leader ran the session initially until the other one refocused on the group. In the analysis after the session, the leaders discussed what happened.

In another example, an HIV group had one leader who was particularly skillful with chemical dependency issues while the other was more knowledgeable about HIV and lifestyle issues. Some cancer bereavement groups typically have one nurse and one lay or parent co-leader who has been a member of previous groups. Group members often appreciate having a lay member who shares their particular problem and who can serve as a role model for sharing experiences and learning new approaches.

To establish and maintain a group, the leader needs to know principles of group process and psychosocial adaptation in small group settings. Basically, theory suggests that people symbolically reenact their past relationships. Therefore, groups provide a learning laboratory where members can challenge some of their assumptions and experiment with new behaviors. For instance, a member who typically keeps silent and always goes along with others because he or she fears rejection can experiment with speaking up, self disclosure and some confrontation. After trying the new behavior, the person can ask the others for feedback about fears of rejection or whether the behavior was offensive.

Although the preparation for leadership is often diverse, most leaders recommend professional training. Training in interpersonal theory, communication, and group dynamics is useful. Supervision can be extremely valuable and help the new leader analyze their theoretical foundation, motivation, strengths and limitations as a leader. It also can provide constructive feedback about their interaction and leadership activities (Maram, 1978). Discussing challenges and interventions with a supervisor can improve one's perception of the interactions. A supervisor can help a new leader see how an intervention went awry or how to respond more effectively to highly emotional situations.

### **Process and Development**

Although many theorists assert that groups are in a constant state of flux. They also grow and develop as members build trust, establish connections, confront issues, negotiate authority and intimacy, conduct work, and resolve termination. Each member arrives with expectations and may compete with others for time to talk. Sometimes, personal expectations conflict. For

instance one member may constantly want to ask "Why did this happen to me? but others may find this frustrating and want to move on to other issues. Individuals may have different needs for intimacy, control and authority. For example, members may decide to be supportive and so nice to everyone that they never confront issues about conflict or disagreement. The leader needs to distinguish between the healthy and unhealthy behaviors and identify what activities help facilitate growth.

In one organizational training group, there were two members who constantly argued with each other about everything. One person would say, "let's discuss this" and the other would say, "No! I want to discuss a different topic." Initially members were immobilized, the leaders were passive, and the consultant's advice about the problem was ignored. This could have continued to make the meetings worthless as two strong people continued to argue. The consultant spoke to everyone and described the conflict between the two participants and said the competition for control was frustrating and preventing any work from going forward. The two fighters loudly ridiculed that idea and started a fight that monopolized the meeting. However, another member expressed distress with this fighting and suggested that everyone discuss how they wanted to proceed. This started a productive discussion.

### **Developing Group Leadership Skills**

Often the leader also needs to break down complex concepts about symptoms into concrete examples and sometimes humor helps. For example in one group when people were discussing depression, the leader explained that if you find that you no longer enjoy your favorite activity (e.g., watching the ball game, sitting on the porch watching the sunset, or gossiping with friends) that should indicate that you are feeling depressed and you should seek assessment and treatment. This concrete example finally made sense to everyone. A sense of humor is always useful. In another group, where the members were worried that their friends told them they were going "crazy" because their behavior had changed (they had become more assertive and were saying "no"), the nurse leader asked if anyone was "seeing or hearing things that were not there" or "walking down the street naked and peeing on the flowers." These examples cause several giggles and allowed the members to go past their immobilizing fear to examine criteria for being crazy as opposed to being difficult or changing their typical passive behavior.

### **Summarizing Progress**

One leadership task is to help the individuals reflect and review their progress. In a suicide bereavement group, the members took several important steps toward growth that the leader summarized. After one member's guilt stalled her vacation, the others suggested that her deceased daughter would not want her to suffer, and they gave permission for a good time. The leader emphasized that the decision to take and enjoy a vacation was a major step forward. In another instance, one parent worried about her depressed son, who wanted to leave therapy and move into her tiny apartment. She feared this would increase their conflicts and his suicidal risk. The members helped her plan to tell him that both leaving therapy and moving home were bad ideas. She reinforced that she loved him and that he needed to continue therapy and find other living arrangements. Both the freedom to enjoy pleasure and the prevention of suicide risk were important growth

experiences that might have gone unrecognized without a leader's summary and emphasis.

Supervision and mentorship are important. Whether the nurse is a beginner or a seasoned practitioner, supervision and mentorship provide important support, encourage reflection, and help evaluate the dynamics and discuss challenges. The nurse who wants to develop these skills is wise to work with a skilled colleague and take a course in group dynamics, leadership skills, or Tavistock group relations meetings. A senior colleague can role model interventions and discuss issues and how to resolve them. Challenges may occur when a member stops attending the meetings prematurely, when difficult interactions occur, and when members do not progress with building norms, trust, intimacy, sharing, and confronting issues. Supervisors can help co-leaders

work collaboratively and reflect on their interactions. Discussing issues of referrals, increasing pathology or crisis management in supervision is helpful.

### Conclusion

Leading a support group can be a very rewarding and satisfying activity when the leader understands group process and has supervision and mentoring. Support groups can be a useful and cost effective method to help participants and/or patients improve their coping strategies, knowledge of their disease, social support, symptom management, and interactions with the health care team. Support group participation for patients has a positive impact on coping, emotional support, and disease management. Nurses should promote support groups as a crucial part of their nursing care.

**Table 1: Example of Ground Rules- Support Group**

Ground Rule	Description
Confidentiality	All individuals in the group agree to keep discussions confidential and not to repeat things outside the group.
Respect	People may express views contrary to your beliefs, but we respect each person's right to his/her opinions.  Reasonable people may disagree about values and issues. Discussion of differences is encouraged. We encouraged people to speak one at a time so everyone could hear.
Attendance	We asked people to attend at least 3 group meetings. If after that time, they wanted to stop attending, we asked that they let us know so we could inform the group. An open group invites members at any time; a closed group only invites new members to the introductory or first meeting.
Other meetings	Often in group, people want to meet each other outside the group and alliances develop. We asked group members to let the group know if they were meeting with each other outside group. Our goal was to be aware of hidden agendas that might develop among members.
Sharing Perspectives	We also said we wanted the group to meet individual's needs so if they wanted the group to change in some way, we invited them to discuss those issues in group.
Communications	Communication is a two way street. Each person's feelings and ideas are shared. An individual may offer or receive feedback, suggestions and ideas.  Each person has something to offer others so sharing ideas, successes, and feelings is important to the group's success. Directions are given for when and how individuals are invited to contact group leaders if a crisis or issue emerges. Generally, one ground rule concerns the prohibition of threats or violence in the group. In support groups, leaders often ask for a commitment that suicidal impulses will be communicated to the group leader and not acted upon.
Note Taking	We also explained that we would keep notes of the group process to help us in leading the group. If notes must be put in the patient's clinical record, clarify this.

**Table 2: Types and Description of Support, Self Help and Psychoeducation Groups**

Types of Groups	Description	Selected Examples
Self Help	Members provide the help typically without health professionals input. Some are very structured in format, while others are open discussions. People who share a concern or problem come together seeking help through sharing their perspectives and experiences. Some of these groups began because members believed that the professionally led groups were not effective.	Alcoholics, Recovery, or Gamblers Anonymous TOPS - Take of Pounds Compassionate Friends (grief) Weight Watchers Smoke watchers anonymous La Leche League (breast feeding)
Support Group	These groups may consist of patients and/or family members. The goal is to share support, education, and encouragement to those coping with similar problems often related to a specific disease or health care problem.	Bereavement Group Living with HIV group
Psychoeducational Group	The aim is to share mental health information and education to improve self care skills. They also encourage sharing of feelings (isolation, helplessness, sadness,) and ways to cope with these feelings.	Medication teaching group Family education group

**Table 3: Phases of Groups**

Phase	Description	The leader's Role
Beginning	Anxiety and uncertainty is high. Members are not sure of what to say and need to feel included. Members are unclear about the contract and process of group. Members may test the leader and members on issues related to trust, values, attitudes.	Take steps to reduce anxiety by empathy, giving information, orientation, and asking for responses. Provide structure; invite members to introduce themselves; work to introduce group goals rather than ongoing social chit chat. Encourage members to share but set limits on monopolizing group. Clarify the group and individual goals and norms. Clarify ground rules.
Middle	Beginning steps to move from "I" to 'we" ness; self disclosure and sharing increases. Interactions are more "here and now" and the group develops ability to focus on a topic or issue.  Members are concerned about those who are absent or new.	Encourage cohesion and expression of warm feelings, problem solving, and comments on the "here and now" process. Encourage exploration of topics in depth.
Termination	Members may express a wide range of feelings about leaving the group; some may feel a sense of loss and lack of focus	Provide time to reflect on the ending of the group and what members have experienced and learned. Identify positive changes within group; explore support systems to help as they leave the group. Encourage discussion of other activities to maintain support. At the end of our bereavement group, we encouraged volunteer work or other activities.

Adapted from Wilson, H. & Kniesl, C. (1996). Psychiatric Nursing (5th ed). Addison Wesley

**Table 4: Clinical Examples**

**Parental Bereavement Group:** A closed 2-hour weekly bereavement support group for parents whose child had died by suicide was organized and met weekly for 3 months. The 2 hour time frame was selected because suicide bereavement would be emotional and parents would need that time to interact. Invitations for prospective members were posted and an article in the news yielded several prospective members. Although leaders expected to have parents of young children, most members were actually older because the deceased had been an adult. The ground rules were typical (see Table 1). The group goals were to: 1) facilitate support for grieving parents; 2) help parents make meaning of their child's death; 3) encourage reflection about feelings experienced in bereavement; 4) alleviate excessive guilt and recrimination; 5) help parents reconsider how their lives, roles, and relationships had changed after this death; and 6) facilitate group process. As the parents struggled to make sense of this painful loss, they asked questions.

**HIV Support Group:** In this group for clinic patients, the goal was to encourage discussion and to offer information about living with HIV to members and significant others. A psychiatric nurse with expertise in HIV and a psychologist co-lead the group. Both leaders had expertise and experience in leading therapeutic groups. This group met weekly and membership ranged from 5-12 people. The issues that arose ranged from disclosing the diagnosis, HIV-related symptoms, substance abuse and abstinence from drugs and sex, HIV medication effects, fears of dying, and housing problems. Patients also discussed the stigma of HIV, feelings about the nature and characteristics of suicide and strategies for suicide prevention. They also explored how the death had changed their identity, role, and self perception, alienation, concerns about treatment, and their grief when loved ones died. In this case, chart notes in the patient's clinical records indicated that the patient "attended support group". However, notes can also contain detail about the interactions or issues discussed.

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