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Women and Support Groups: Successful Approaches to Facilitation

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Women and Support Groups:

Successful Approaches to Facilitation

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Abstract

Support groups are quite prevalent in our country today. Studies suggest that support groups are beneficial in that they increase survival rates, offer a safe environment for disclosure, improve participant's coping skills and emotional and psychological health, are a platform for sharing information and resources, and give women an avenue in which to help others in similar situations. Different facilitators vary greatly in their roles, as well as in their philosophies and methods. This paper examines the facilitation of support groups to determine what approaches are most effective and healthy for the participants through a review of current literature and interviews with facilitators of various support groups. While the answers given in the interviews differed greatly, some themes emerged that are transferable to practical application.

Women and Support Groups:

Successful Approaches to Facilitation

Support groups specifically designed for people with different illnesses and other life

stressors are quite common today. "Health concerns are the most frequently cited reason for

joining a support group" (Davison, Pennebaker, & Dickerson, 2000, p. 207). Studies suggest

that support groups are beneficial for women with illnesses, including HIV/AIDS, in that they:

increase survival rates, offer a safe environment for disclosure, improve the participant's coping

skills and emotional and psychological health, are a platform for the sharing of information and

resources, and provide women an avenue to help others in similar situations. Facilitators vary

greatly in their perceptions of their roles, as well as in their philosophies and methods. This

paper will examine the facilitation of support groups and determine what approaches are most

effective and healthy for the participants.

Victims of various diseases need social support to help them cope and even survive.

"Feelings of hopelessness, helplessness, and fear of death are present in the minds of patients

during each stage, and patients typically lack the social and emotional support they desperately

need, which may lead to feelings of loneliness" (Rokach, 2000, p. 3). People living with cancer

and especially HIV/AIDS are most prone to loneliness and other psychological distress due to

the highly stressful nature of their illness and the stigmatization of their diseases, which can

cause isolation and decreased social support (Kornblith et al., 2001; Rokach, 2000; Cawyer &

Smith-Dupre, 1995). As Silver, Wortman, and Crofton point out, "those in greatest need of

social support may be the least likely to get it" (Cawyer & Smith-Dupre, 1995, p. 2). This

stigmatization and social rejection is more intense for people with HIV/AIDS, as they not only

are suffering with their physical disease but also with "emotional agony that is created because

there is no known cure for AIDS as well as because of the public frenzy that results in blaming

the victim" (Rokach, 2000, p. 3). The results of this stigmatization are often avoidance of social

contact, feelings of depression and anxiety, and an unwillingness to communicate about their

disease (Cawyer & Smith-Dupre, 1995). This is even worse for women than men, probably due

to hormonal differences, increased burdens, and isolation ("Women, HIV, and Depression,"

2001, p. 2). In addition, some HIV medications actually cause depression or other psychosocial

disorders and many anti-depressants can have adverse interactions with HIV medications

("Women, HIV, and Depression," 2001). It is for all these reasons that people with serious

illnesses, especially HIV positive women, benefit from participation in support groups.

Some experts disagree on whether support groups are a better means of support than

others. Kornblith et al. (2001) suggest that not only group work, but also "individual

psychotherapy, or the use of patient-to-patient volunteers on a longer term basis, as suggested by

the AA model, may all be potentially effective (p. 453). In their study, conducted by surveying

people with HIV/AIDS, cancer, or with no life-threatening illness, they found that "any of the

different types of [psychosocial] interventions had a small, but statistically significant effect on

improving adjustment, with no one particular intervention being significantly better than any

other" (Kornblith et al., 2001, p. 453). In other words, social support is important but support

groups are not necessarily the most effective means of providing this. However, it is one viable

and widely available solution when other social supports are lacking.

Benefits of Support Groups

Many authors found support groups to be highly beneficial for participants. There are

definite positive outcomes derived from support group participation that improve quality of life

for women. The opportunity for disclosure is an important aspect of support group participation

(e.g. Davison et al., 2000; Trisdale, 2000; Center for Women Policy Studies, 1998a). People often do not feel comfortable discussing their disease with their friends or family, especially if the disease carries a stigma or fear, such as HIV or AIDS. This can severely limit their support system and encourage isolation. Support groups provide a safe environment where people often feel less inhibited by their fears (Greenberg, Motenko, Roesch, & Embleton, 1999). Also, there is an element of comfort in knowing that the other participants are dealing with the same issues (Center for Women Policy Studies, 1998a; Cawyer & Smith-Dupre, 1995). "When patients with the same disease have an opportunity to share these unique experiences in a supportive environment, they are able to receive a critically important level of understanding" (Serlin, Classen, Frances, & Angell, 2000, p. 126). This group understanding encourages disclosure and open, honest dialogue. As Thoits (1986) points out, people with the same disease and experiences are seen as being less threatening, especially because they "can accept feelings that others find aversive or socially inappropriate. Acceptance allows the individual to ventilate or discuss those feelings freely, a crucial first step for many individuals that reduces pent-up tension" (Cawyer & Smith-Dupre, 1995, p. 11). People can share their thoughts, feelings, and experiences at the deepest level without fear of judgment or rejection.

Another central benefit of support group participation is improved coping skills and psychological functioning (e.g. Kornblith et al., 2001; Davison et al., 2000; Rokach, 2000; Serlin et al., 2000; Gore-Felton & Spiegel, 1999; Center for Women Policy Studies, 1998a; Francis, 1997; Cawyer & Smith-Dupre, 1995). In order to deal with their disease, "patients need a place where their fears can be examined" (Serlin et al., 2000, p. 126). Support groups provide an environment in which this is acceptable, and even encouraged. In the support group setting, participants are able to "give and receive support, as well as express their thoughts and feelings

about what it means to live with this disease" (Serlin et al., 2000, p. 124). They are able to

finally open their hearts to share, which promotes the coping and healing process. They can also

observe other women who may be further along in the process of healing and examine their

coping strategies. These women who have gathered more wisdom, are usually willing to share

what they have learned. "Similar experiences also allow the supportive person to suggest coping

techniques based on personal experience" (Cawyer & Smith-Dupre, 1995, p. 8). As Hagerty et

al. have shown, "through interpersonal interactions, people survive, develop, and grow" (Rokach,

2000, p. 1). This is a healthy way for women to learn new patterns of behavior and expand their

social and support networks (Serlin et al., 2000; Center for Women Policy Studies, 1998a).

"Rather than being immersed in pain, helplessness, and sadness, [support group participants can]

seek to reenter society and behave as other healthy members do by continuing to pursue their

daily activities, thus creating new opportunities for social contact and belonging" (Rokach, 2000,

p. 8).

An important and more tangible function of support groups is the sharing of resources

and information (Serlin et al., 2000). It is often difficult for clients to receive the information

and support they need from other sources. Medical and social service providers often use

specialized terminology or jargon that is difficult for clients to understand. Most service

providers are also very busy. Often they do not have the time necessary to build a trusting

relationship with clients or help them confront the issues raised by their situation. In addition,

society separates the physical person from the emotional or spiritual aspects of the person. Some

providers are even unwilling to consider the person as a whole being. "All too often those who

care for your body actually avoid your psychological issues, social history, and spiritual

concerns" (Gordon & Curtin, 2000, p. 78). Support groups can fill in the gaps between the needs

of the individual and the services provided by doctors and social workers. "The best information, especially for women, is going to come from another woman" (Rolands, 1994, p. 2). Both support group participants and knowledgeable facilitators can play key roles in providing important information to other participants.

Another important benefit of support groups is the opportunity for the participants to help other women (Serlin et al., 2000; Greenberg et al., 1999). This can be through dissemination of information, as mentioned above, but also through support of each participant. As many studies suggest, helping to emotionally support other people also helps the individual who is offering the support (Cawyer & Smith-Dupre, 1995). In an interview survey of women participating in a rural breast cancer support group, the participants reported that both receiving support from and providing support for the other participants was what gave the group meaning for them (Serlin et al., 2000). Participants in a support group for HIV positive women "were inspired to know that they had been of help to others" (Center for Women Policy Studies, 1998a, p. 2). Helping to heal others can be healing in itself.

The last benefit of support groups is an improved physical health. Recent studies have shown a possible link between psychological and physical health. "Loneliness has been linked to depression, anxiety, and interpersonal hostility and to an increased vulnerability to health problems" (Rokach, 2000, p. 2). Thus it follows that fighting loneliness and its accompanying psychosocial problems may improve health. In fact, according to Ornish (1998), "social support can cause changes in the immune system that tend to make people more resistant to infections and even cancer" (Rokach, 2000, p. 8).

Summers et al. (2000) showed a possible connection between survival for HIV positive women and their participation in a support group. The authors compared two groups of HIV

positive women: those in a support group and those who chose not to participate. The women all took a neurobehavioral assessment, which examined all possible issues that might correlate with increased length of survival. On average, women who attended at least 4 support group sessions in 12 weeks survived longer than women who did not participate. The women in support groups survived an average of 73 months after diagnosis and the women who were not survived an average of 45 months. This is a substantial connection, although the authors admit that more studies will need to be completed in order to confirm these initial results.

Other studies have shown this strong connection between survival and social support, as well (e.g. Rokach, 2000; Serlin et al., 2000; Rolands, 1994). Serlin et al. (2000) suggest a link seen frequently between increased survival time and support group participation in women with many different diseases, including cancer, cardiovascular disease, and hemodialysis. Gordon and Curtin (2000) give examples of three studies that illustrate this phenomenon in people with cancer. The first study was performed by Spiegel, a Stanford University psychiatrist. Originally, he was studying the connection between support group involvement and quality of life improvement, but during a follow-up study he discovered that, on average, women who had participated in his support group had lived twice as long as those who did not. Gordon and Curtin (2000) also describe a similar study completed by Fawzy with melanoma patients. After six years, only 9% of those who were in his support group had died as opposed to 29% of those who had not participated in the group. The last study discussed by Gordon and Curtin (2000) was performed by Richardson and showed that there was a "39% reduction in the rate of death" in leukemia patients who participated in a support group (p. 86). Although none of these studies are conclusive, there is definitely a correlation between support group participation and physical health that compels further study.

Most Effective Approaches to Support Group Facilitation

Social Scientists' Observations Although support groups can be beneficial, some are more effective than others. Participant satisfaction is strongly influenced by the individuals' preferences, but also by the methods or techniques utilized by the facilitator. Every group is slightly different in the approach, especially in the amount of facilitator participation and control. There are many opinions regarding which methods are most effective.

Serlin et al. (2000) advocate that having two co-facilitators is ideal. They suggest that one be an expert in psychotherapy and that the other be an expert in the particular disease or situation the group is dealing with. The authors also point out that it is important "to facilitate interaction among the group members so that communication occurs in all possible directions and not through the group leaders" (Serlin et al., 2000, p. 128). In their opinion, this web of communication is important to increase the comfort of the group with one another and to encourage the participants to support each other, rather than looking to the facilitator(s) for support.

The authors also use body movement in their groups of breast cancer patients. Participants develop their own healing imagery and use their bodies as its expression. The results of this physical group work have been positive: participants have reported feeling less fatigue, tension, depression, and anxiety. They also describe an improved body image. This seems to be a positive way to improve the physical as well as the psychological health of the women participating (Serlin et al., 2000).

Cawyer and Smith-Dupre (1995) describe their experiences observing a more traditional support group. This group was for people either infected or affected by HIV/AIDS. Their group included two ground rules for participation: everyone must protect the groups' anonymity and

everyone must be willing to share some of their own feelings during the session. During the author's observation of this group, they observed that feedback was one of the most important components of the group dynamic, stating that it played "an important role in what [was] said and how much [was] disclosed" (Cawyer & Smith-Dupre, 1995, p. 13). They also suggest that sympathy can be either positive or negative, sometimes helpful in generating solutions but sometimes encouraging frustration and isolation. These are things that facilitators can be aware of, in order to determine whether the group interactions are positive or whether they are unhealthy and should be altered.

Hayes et al. (1998) also describe an experience with a more traditional support group. The authors developed and initiated a support group for family and friends of people with HIV or AIDS. They describe some concerns they had during their support group facilitation. The authors were faced with the issue of whether or not to meet the needs of the individual over the needs of the group when one out-spoken participant had dramatically different expectations for his group experience than the rest of the group. Their article questions the collective foundations of support group. Through the process of facilitating each week the authors decided to "give up [their] power and let the group take care of itself" (Hayes et al., 1998, p. 42). They came to the conclusion that their role was simply to provide a safe environment for open and honest dialogue, and that they needed to step out of their participatory role in the group and allow the group to " 'go where it needs to go' " (Hayes et al., 1998, p. 45). They advocated for collective group ownership and less facilitator participation in the group process.

Davison et al. (2000) believe that "the experience of illness is a profoundly social one" (p. 205). Because of this, they feel that the support group environment, with its variety of people and experiences, is the natural place for people facing illnesses to gain emotional support. The

authors advocate a self-help style group. They feel that people working together can face challenges that individuals alone cannot and that "collective wisdom is born through the shared experience of participants rather than through the professional training or style of the leader" (Davison et al., 2000, p. 206). Every participant has something worthy and important to offer to the group and his or her contribution is no less important than that of the facilitator. In other words, the facilitator should not be the main source of feedback and validation. Instead, the facilitator's role is to encourage the entire group to participate and share their experiences.

Francis (1997) agrees that the best support comes from the people who have the shared experience. However, she takes a slightly different facilitation approach. Her article is much more focused on the facilitator's role in the group, which is much more direct than in the model explained by Davison et al. (2000) or Hayes et al. (1998). According to Francis (1997), the function of the facilitator is to help participants to manage their emotions. Her ideas on facilitation are based on the premise that "we look outside ourselves for clues in interpreting our emotional signals" (Francis, 1997, p. 1). This is giving the facilitator much more control of the group and its emotions and identities as well as promoting the free use of that control. Because the facilitator is naturally perceived to be in a position of power, she frames this control over the group as a responsibility, rather than a possibility.

Another perspective that includes a more direct approach to facilitation is outlined by Gore-Felton and Spiegel (1999). In his research on breast cancer support groups, Spiegel has developed Supportive-Expressive Therapy (SET) as a specific method for facilitators to follow in illness support groups. The authors list the presence of "social support, expression of emotion, detoxifying dying, reordering life priorities, family support, effective communication, and symptom management" (Gore-Felton & Spiegel, 1999, p. 3) as the necessary components of the

most beneficial groups. SET is a more structured approach where the facilitators actively guide the conversation. The authors have even created a SET training program to teach people their methods of group facilitation. They offer two specific purposes for including a trained facilitator as an active part of the group process. First is to help the group move toward and discuss the topic of death and dying. The second is to help the participants deal with losses they may experience. The requirements of the facilitator using this model are quite rigid.

Participants' Preferences Although many people have studied support groups, there is no better source for feedback than that of the actual participants. Not only can they identify what they appreciate about and desire from a group, they can also describe barriers to participation that facilitators and other "experts" might not observe or understand. This is key to developing a support group program; without the support of the participants, your support group will rapidly disintegrate.

Some themes emerged in the literature around what HIV positive women want in a support group. First, facilitators play an important role in creating a successful support group. One group of young women stated that they appreciated facilitators and group leaders who were older and that had more of a mentoring role in the group (Center for Women Policy Studies, 1998b). Other women preferred facilitators that were trained in facilitation or therapy. Co-facilitation with one HIV positive woman and the other woman a trained facilitator was also suggested (Center for Woman Policy Studies, 1998a; Rolands, 1994). Participants also prefer facilitators that follow-up with women to provide on-going support (Center for Woman Policy Studies, 1998a).

Other preferences for support groups included groups for only women, the ability to bring friends and family, a relaxed atmosphere, and a combination of support, education and fun

(Center for Women Policy Studies, 1998a). Many women also felt that groups only focusing on exchanging problem stories rather than problems solving were not useful. Having a goal-orientation was important in order to prevent stagnation, depression, and hopelessness, according to the participants (Center for Women Policy Studies, 1998a).

There seem to be many barriers to support group participation. One is economic. "What we don't see in support group are women who are economically disadvantaged. They just don't come" (Rolands, 1994, p. 2). This could be for many reasons. Childcare and transportation can be issues for women, many of whom can afford neither. Assistance with these two realities is important to many women, and providing refreshments or a meal during the group is also greatly appreciated (Center for Women Policy Studies, 1998a; Center for Women Policy Studies, 1998b). Women also stated that they wanted a support group with members they could relate to across life experience (Center For Women Policy Studies, 1998a). Drastically different socio-economic statuses and backgrounds can make this difficult. As one support group participant from a lower socio-economic background said of the middle-class women, "there are times that we can be helpful to each other, but they don't understand my life" (Center for Women Policy Studies, 1998a, p. 3). Also tied in with this is the fact that many women "struggle with multiple, competing needs; often, they put themselves last" (Center For Women Policy Studies, 1998a, p. 2). Many HIV positive women have children, work, attend school, take care of partners or parents, and much more, leaving them little time or energy to take care of themselves.

Denial and fear are major barriers. "Some young women say that their own desire not to dwell on their HIV status is another barrier to attending support group" (Center for Women Policy Studies, 1998b, p. 1). Another study found that people with AIDS find denial to be a more helpful coping strategy than people with cancer or with neither (Rokach, 2000). Attending

a support group, sharing information and emotions, and listening to others in similar situations might make the disease too real for some people who are not yet ready to deal with it.

Another key barrier to support group attendance is the fear that confidentiality will be broken. Many women have had "experiences with support group members who revealed their HIV status to others outside the group" which deter them "from seeking the psychological support that they urgently need" (Center For Women Policy Studies, 1998b, p. 1). It is important for facilitators to stress the importance of confidentiality, but a facilitator can only do so much. An alternative that many women favor is to attend support groups provided in another community (Center for Women Policy Studies, 1998a; Center for Women Policy Studies, 1998b). According to HIV positive women, this is likely to increase their participation, as they feel more confident that their HIV status will not be discovered by people they know. Support group should feel like a safe, welcoming place, and people cannot feel safe when they are worried about basic confidentiality.

The purpose of this study was to examine support groups for women. Facilitators of support groups for women across Western Washington and Arizona were interviewed. The interviews focused on benefits of support groups and different facilitation styles. The questions that guided this research were, "what approaches to facilitation are currently used in support groups for women" and "which techniques seem to be the most effective in meeting the participants' needs?"

Method

Participants

During the course of this research, eleven facilitators of support groups for women were interviewed. Three facilitate support groups for women with HIV. The first is a woman who identifies herself as an HIV positive lesbian. She is the executive director of a grass-roots organization for HIV positive women in Seattle and has been working with this organization since she was diagnosed, in 1989. During her time working there, she has facilitated support groups for HIV positive women. The second facilitator works with HIV positive women in Snohomish County. She founded and facilitates a similar group for HIV positive women and has been executive director for six years. The third facilitator works for an agency that serves individuals with HIV or AIDS in Phoenix, Arizona. She facilitates a variety of support groups and has been working with the program for only two months.

Three women interviewed work with women in Whatcom County who have experienced or are experiencing domestic violence. The first has facilitated her community drop-in support group for 2 years. The second woman co-facilitates with the former and has been working with this group for nearly five years. The last domestic violence support group facilitator currently facilitates a group at a domestic violence shelter. For the past three years she has facilitated the group anywhere from once a week to twice a month, although she facilitated the group twice a week for seven years prior.

Two facilitators of support groups for women with cancer were interviewed. The first facilitates a support group for women with any kind of cancer in Bellingham, Washington and has been working with this program for three and a half years. The second facilitates two kinds

of support groups: one for women with early-diagnosed breast cancer and one for women with advanced breast cancer.

Three other facilitators work with a variety of groups. One facilitator works with a group for women with eating disorders. Another has worked with divorce groups, abuse recovery groups, co-dependency groups, 12-step groups, and depression groups. The last facilitator works with depression groups, sexual assault groups, and also does group work with children in schools.

Apparatus

All eleven facilitators were asked the questions included in appendix A. Two questions addressed the facilitator and her experience specifically. Six questions focus on the different approaches to facilitation. The other two questions address the purpose of support groups. All the questions were open-ended.

As the interviewer practiced, improved, and refined both interview skills and questioning techniques, she was able to develop follow-up questions and improvise during the interviews. The questions in the initial interviews were chosen to fill in gaps in the interviewer's knowledge. However, as the literature and initial interviews uncovered more information, questions were added to illicit more in-depth information. This information might have not seemed as relevant during the earlier interviews, as there was no context for it to fit into.

The interviewer recorded seven of the interviews onto a Dictaphone. A Panasonic micro-cassette recorder (RN-305) with a voice-activated system was used.

Procedure

The interviewees were selected on the basis of the gender of the support group they facilitate. All the facilitators currently or in the past had worked with groups composed solely of

women. The facilitators were also chosen by their relevance to an HIV support group for women—each group has a common element to that of an HIV support group, whether its another life-threatening illness or an issue many HIV positive women face, like domestic violence, substance abuse, or mental health issues. They were also interviewed due to their interest in this research and their availability for an interview.

The interviewer conducted ten in-person interviews. The interviewer located these ten interviewees by using the phone book, a community resource directory, and through networking with colleagues. The first ten who the interviewer contacted all agreed to be interviewed, so the interviewer did not search for any other interviewees.

Of these ten facilitators, each woman was contacted by phone. All ten were interviewed based on the list of questions in appendix A. For two of the interviews, Michelle Dever, the former women's program coordinator at Evergreen AIDS Foundation, was present. Seven interviews were recorded on tape. The other three were only recorded on paper. The interviews ranged from 30 to 100 minutes long. All ten facilitators were interviewed in their office at a time convenient to them. The seven interviews that were recorded on tape were then transcribed by the interviewer. The transcriptions were not exact, due to the low quality of the recordings. Precise transcription was also not felt to be important; rather, the interviewer looked for themes and broader topics and included these in the transcription. Direct quotes were recorded whenever possible and considered especially relevant or important.

One interview was conducted via email. The interviewer searched the internet for support groups in rural/semi-urban areas across the country. Ten groups were located and contacted via email, with an explanation about the study. Two responded to the initial inquiry. The interviewer gave both the choice of whether they preferred to conduct the survey in writing or

over the phone. Only one person responded to this second message; she requested a written survey. The interviewer sent the survey via email and facilitator completed and returned it, also via email.

After the interviews and transcriptions were all completed, the interviewer then compiled a list of answers for each question that was asked. Similar answers were grouped together and which facilitator gave each answer was logged. The interviewer then used these lists for the results and discussion sections of this paper.

Results

Six of the eleven women interviewed informed the researcher that they had dealt with, or were currently dealing with, the issue that the support group was centered around. All eleven women had at least a Bachelor's degree. They had worked with their current support group for anywhere from 3 months to 12 years. The mean was almost 5.02 years (sd=3.90).

The support groups were quite varied in style. Nine were traditional while two were not, in that one group included an activity or outing and one included an artistic component. Two groups provided food. Nine groups were open, meaning anyone could attend while two had a closed membership. Seven contained a specific education component, although each group was quite different in delivery. All eleven facilitators felt that their group provided a safe and confidential environment in which participants could share.

There were many similar answers to why women join support groups and the purpose of support groups. The most commonly mentioned reason is connection and companionship with other women in similar situations. This included a sense of belonging, a feeling of community, and finding healthy friendships. Eight facilitators cited this as a reason. Six facilitators suggested support groups combat isolation. According to five facilitators, support groups help

women to realize that they are not alone in experiencing their issues or problems. Four

facilitators suggested that support groups are important because they give women a venue from

which to share their story and to be heard. Observing other women and seeing themselves

mirrored in their experiences were also answers given by four facilitators. Emotional support, a

place to for education and to gain information, and a place to not be judged or disbelieved were

all answers given by three facilitators. Two facilitators gave the following reasons:

responsibility or opportunity to be of help to others, feeling overwhelmed, desire to feel

understanding and empathy from others, safety, and others, such as therapists or family members

urging them to join. Other answers for why women participate in support groups included

addressing problems, healing, gaining hope, learning resources, learning to cope, making

changes in their selves, learning to trust, gaining control of their lives, understanding their selves

and their situations, and the relationship between support group and survival.

There are many components to a successful, effective support group. Responsiveness to

the group and ownership taken by the group were both cited by three people as successful. Three

facilitators also suggested that positive feedback from participants is a good way to determine a

group's effectiveness. Co-facilitation, clear structure, continual evaluation, and a feeling of

connectedness were all answers given by two facilitators. Each of the following were answers

given by one facilitator: genuine care among the members, connections outside the group, use of

silence, wind-down at the end, the participants' energy level, not letting one person dominate,

meeting the participants' goals, people feeling validated, one-on-one time if needed, developing

coping skills, and not sacrificing the group for an individual.

Although many of the answers were the reverse of the previous question, there was a vast

array of answers given to the question regarding an unsuccessful support group. Many answers

were given but no real agreement surfaced. Disregard for the ground rules (or lack thereof) was an answer given by just three facilitators. A group that spends time only complaining or giving support without any real benefit or moving forward was also an answer given by three facilitators. Participants who are inappropriate for group work and lack of structure and honest communication were answers given by two facilitators. Other ideas offered by only one facilitator include: participants who do not return, disregard for the facilitator, cross-talk, disruption, unsafe atmosphere, too much structure, people who don't want to be there, too much structure, problem-solving, giving advice, lack of trust, focusing on individual problems rather than general issues, no confidentiality, participants who don't feel accepted, controlling facilitator, and using theories that participants don't agree with.

The interviewees reported vastly different ways to create an open and comfortable atmosphere for sharing. Two answers were given most often: a non-judgmental atmosphere and the use of ground rules. Four facilitators cited each of these reasons. Three people also suggested confidentiality and not giving advice. Modeling the actions and attitudes that you wish to see in the group, having a defined structure, being aware of and discouraging domination by one or a few members of the group, and giving the participants ownership and leadership in the group were all answers given by two people. One facilitator mentioned each of the following: no agenda, safety, informal, no service-providers, healthy relationships, including an ice-breaker, limiting other physical distractions, sitting in a circle, creating opportunities for sharing, not putting people on the spot, making it easy for people to pass, developing and maintaining boundaries, sharing the facilitator's personal story or why they are working with the group, lightening it up, avoiding sarcasm, and talking about support groups and what to expect.

Most facilitators agreed that their role was to be involved in the group process as little as possible and only when necessary. Seven people said that the facilitator needs to step in to correct issues or problems with in the group, in effect, monitoring their process and dialogue. Four people suggested that a facilitator should draw group members out, especially the quieter participants. Dealing with dominating members was an answer given by three people, as well as to provide education and to ask compelling questions of the group. Three people also said that it varies from group to group, how much interaction the facilitator has. The following answers were given by only one facilitator when asked about their role: to open/start the group, offer opinions to help guide others, useful as only a reference, be someone participants can seek guidance from, model positive behaviors, use interactive exercises, engage clients, have a plan, offer casual emotional support, be an observer, help people feel safe, and step out because sometimes the group can run itself.

The next question was regarding remedying the problem of participants only talking to the facilitator, rather than each other. Given by five facilitators, the most popular answer was to name the problem and discuss it with the group. Three facilitators suggested the use of eye contact as well as asking individuals to discuss issues they are known to be familiar with. Modeling positive group skills was given by two people. Other answers given by only one facilitator include: leaving, participant ownership, stepping out of the conversation, asking questions, using inclusive words such as "we," reminding the group of its ground rules, admitting you don't know the answers, forcing the group to mingle either before or after the meeting time, encouraging interaction outside the group, co-facilitation, and creating opportunities for conversation without facilitator involvement.

The answers varied quite dramatically when the facilitators were asked how to deal with differences between their agenda or plan, and the movement of the group. Overall, seven facilitators favored flexibility and compromise while two agreed that a group should stay on its agenda. Specifically, four people suggested a more direct approach, which included talking about the difference in the group and making a decision together. Three facilitators suggested that if their interaction is good, to let them go because the agenda is flexible and not as important as the process and support. Other ideas included: covering the agenda item at the next meeting, intervening and redirecting if the process becomes unhealthy or inappropriate, making decisions based on what is best for the group and what is aligned with its purpose, seeing the facilitator only as a navigator, compromise, talking about issues not relevant to the group with individuals at a different time, seeing the facilitator as only a resource, letting the group organize as they want, and seeing the facilitator only as support.

Discussion

Clearly there is no singular best way to facilitate a support group that will meet every participant's needs. However, some themes emerged in the process of reviewing the literature and interviewing facilitators regarding both the purpose of and approach to support group facilitation. These themes are noteworthy and applicable to facilitators of many kinds of groups.

First, the group must belong to the participants. It is imperative that they have the driving voice in the group. They are the group and as such it is their responsibility to make it what they need and desire. Without their direction, a facilitator is just blindly planning and supporting without any knowledge of why or how. Although the facilitator should be skilled in drawing this type of information out of the group, it is ultimately their responsibility to participate at that level in order for them to get the most out of the group process. In addition, the facilitator must also

be flexible enough to accommodate the needs of the group. Both the facilitator and the participants must be willing to work together to create a group in which the members have ownership and really want to come, without sacrificing the basic purpose of the group.

Many of the answers focused clearly around the perceived safety of the participants, whether it was in the purpose, successfulness, or comfort of the group. Confidentiality, ground rules, a non-judgmental atmosphere, and many other examples all illustrate how the different components of safety improve the atmosphere of a support group. If there is no safety, participants will be unwilling to share and the group process will not be effective. If confidentiality is broken, many women are unwilling to even attend (Center for Women Policy Studies, 1998b). As one facilitator explained, safety is one of the basic five human needs. Only when this need is met can participants begin to share their experience, challenge themselves, and explore. Having a reliable, consistent structure is one piece of this safety.

Although one facilitator outright disagreed, the majority of those interviewed felt that structure was an important component of support groups. Whether this is through an educational piece, routines, ground-rules, or healthy boundaries, structure serves to increase individual comfort and participation. Structure also provides each participant room to share and be heard, which is a major reason that people join support groups, as almost all the interviewees state. Without structure, some individuals can get lost while others dominate. Still other may be stuck in the same figurative place and use the groups' time for personal sharing that may not benefit anyone. Structure can be beneficial in others ways, as well, such as an educational piece that teaches something new or a facilitator that models healthy boundaries to a group who lacks boundaries at all.

There seems to be some disagreement around the purpose of group work. Some facilitators felt that the most important aspect was just to be listened to and receive support. Other facilitators felt that healing and coping in the present were important goals. Still others felt that practical application and changes to oneself while looking toward the future were most important. According to one study, participants felt that "groups that only focused on exchanging problem stories instead of problem-solving were not useful because they were 'too depressing' " (Center for Women Policy Studies, 1998a, p. 2). Given this wide variety of purposes and goals, it seems logical that not every group will be a perfect fit for everyone. As one facilitator kept reinforcing, it is important for the leader to be up front and honest about the purpose of that group and to make sure that all interactions and processes are aligned with that purpose. If this is happening, a new participant, with the assistance of the facilitator if needed, should be able to evaluate for herself whether or not this group will be a good match and act accordingly, whether it is to find a new group or to remain with the one she is in.

When issues arise within the group, most facilitators agree that direct but gentle action is the most beneficial. Hayes et al. suggested giving up the power as the facilitator and "let[ting] the group take care of itself" (1998, p. 42) when difficulties arise. However, they seem to be in the minority. Although there was disagreement on what outcome is best, initiating discussion and making a collective decision seem to be the favored process. This process seems to be similar for all the facilitators. Steps should be taken inside the group to address whatever difficulty or issue has occurred. Modeling honest and respectful confrontation helps the participants to learn trust and develop boundaries. It also lets the group identify and work on the problem so that they can move forward with their purpose, whether it is to address problems and make changes or to simply to provide and receive support.

These themes put into practice have provided positive outcomes for the facilitators interviewed. Each interviewee reported that clients are most receptive to these ideas and stated that they have had success using these approaches. Clearly, it is of the utmost importance for the group members to have ownership and participation in molding the group to fit their needs. There needs to be a basic sense of safety in the group in order for the process to begin or move forward. Often they need structure in order to feel productive in the group experience. There must also be agreement about the purpose of the group and the facilitator must monitor the interactions to ensure that this purpose is being carried out. When problems arise, it seems that the best approach is for the facilitator to encourage discussion of the issues and take action if needed. By using these approaches, support groups are healthier and more effective in meeting the needs of the participants.

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Appendix A

Interview Questions

1. How has your education or experience background led you to facilitating support groups?

2. What is your experience working with support groups? Tell me a little about your current group(s) (some basic demographics, your methods/philosophies, the structure, etc.).

3. Why, in your opinion, do people join support groups?

4. What is the purpose of support groups?

5. How do you create an atmosphere in which participants feel comfortable in sharing?

6. What makes a support group successful or effective? What can a facilitator do to promote this?

7. What can make a support group ineffective? In these circumstances, what should you as the facilitator do?

8. How much involvement or participation should the facilitator have in the support group? In other words, how much guiding of the conversation should the facilitator do?

9. How does the facilitator take the attention off herself and help the group focus on communicating with each other?

10. What is the best way to deal with a conflict between the facilitator's agenda and the needs or desires of the group?

11. Do you have anything else relevant or pertinent to share with me?