In differentiating modalities of group technique, this article presents an explicit definition of and systematic criteria for characterizing the support group. A theoretical base for the support group is proposed, and comparisons are made among this group, the self-help group, and group psychotherapy.

SUPPORT GROUPS
A Special Therapeutic Entity

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Support groups seem to have been around since time immemorial. Until recently, however, there has been little careful documentation and examination of the phenomenon in terms of how a support group is to be defined, where and how it works most efficiently, and how it compares and contrasts with other group techniques. This article focuses on these issues and represents the beginning of a process that will formalize the technique as a specific therapeutic tool, with a relatively well-defined identity worthy of a solid place in the armamentarium of group techniques available to the trained professional.

The core of the most common definition of the support group—that is, sharing one's problems with others suffering from the same stress—has always been recognized as a powerful weapon for ameliorating that stress (Caplan and Killilea, 1976). The support group may potentially become a major therapeutic technique that professionals can use to build on the dynamic strengths for personal growth derived from sharing common problems.

Historically the support group was a precursor of group therapy itself. In the first decade of this century, Dr. Josiah Pratt began treating his physically ill patients in groups and

SMALL GROUP BEHAVIOR, Vol. 15. No. 2, May 1984 173-186

found serendipitously that they were more likely to follow necessary treatment plans as members of a group than when worked with individually (Pratt, 1963). With few exceptions, however (Elpers et al., 1978), the literature on support groups has not related to theory or process but has focused on the effectiveness of the support group process with various populations (Sipers, 1967; Lambi, 1974; Menning, 1976; Pelty et al., 1976; Rosenberg, 1971; Seigel and Donnelly, 1978).

A professional technique, if it is to be generalizable, must rest on a body of theory and on carefully delineated boundaries. One can begin to develop such a theoretical base by differentiating the support group from the therapy group with which it shares many characteristics, as well as from the self-help group, which it also resembles somewhat. Each of the three constitutes a support system defined as:

> "an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychic and physical integrity of the individual over time....[They] are attachments among individuals or between individuals and groups that serve to improve adaptive competence in dealing with short-term crises and life transitions as well as long-term challenges, stresses, and privations" (Caplan and Killilea, 1976: 41).

Each of the three constitutes a form of social aggregate that acts as a buffer against disease, a window on the world through which the individuals can be guided through reality and safely explore their behavior and its functional effect on the self and on others with whom they must relate. The fundamental function of a support system is to be an organizer and disseminator of information about the world—a feedback guidance system. When this system is effective, the individual's sense of confidence about his or her behavior is raised, self-esteem enhanced, and social competence increased.

There has been, to the present, no clear-cut definition of how these three closely related support systems differ and what, if any, are the differing professional responsibilities of those who

would prescribe one or the other. We now have enough experience, however, to begin to understand the parameters of the group and its professional demands. The framework detailed in this article presents an attempt to define more carefully the characteristics and boundaries of a professionally led support group, and to suggest how it differs from a therapy group on the one hand and a self-help group on the other. It should be noted that the characteristics and boundaries of a support group are not idiosyncratic to support groups, but obviously overlap with either or both of the other two groups noted.

Observe also that both therapy and self-help groups are enormously varied. This preliminary theoretical examination of the three deliberately simplifies the issue by describing them in the most widely accepted terms. Core differences among the three types of groups tend to revolve around questions of membership screening and interactions, goals, dynamics of change, and leadership strategy.

CHARACTERISTICS OF A SUPPORT GROUP

(1) Homogeneity of the problem. Support groups gain their strength from the interdependence of the fate of their members. Whether the members are parents of leukemic children, incest victims, battering or battered men, or first-year medical students, they all can identify a common stress as their criterion for membership. The stress can be transitory, as for patients just released from a hospital; crises related, as in parents of suicide victims; or chronic, as with the emotionally or physically disabled — but it is definable, and each member is aware that every other member is laboring under the same "handicap." Members feel that by improving their own competence in handling the situation they are also improving the competence of other group members and perhaps the social conditions of the group as a whole.

(2) Members of the group are not necessarily ill, but rather are victims of a negative ecobiological system. Medical students, for instance, are usually well-adjusted young people; but they are creative, autonomy-minded, self-directed, compulsive individuals who must spend four years in a rigidly defined environment where it is functionally impossible to finish completely the task of covering all the cognitive material. They are therefore under stress. The combination of an individual personality structure and an environment setting unsuited to that personality structure creates a situation that tends to be pathogenic and stressful.

(3) Members of the group publicly "confess" their qualifications for membership, and this becomes an important criterion for joining the group. Members, such as oncology patients (Baker, 1977), often share what they feel is a stigmatized attribute and obtain comfort and a greater sense of cohesion by being in a setting where they are the majority.

(4) Members speak a common language. Often, despite possible differences in social or economic status, words relating to the stress situation are common to all and represent a familiar and comfortable jargon through which members communicate and support their common identity.

(5) The group tends to function most effectively when organized along homogeneous horizontal rather than vertical lines. It is possible in work situations for a total staff to become a support group; it is, however, more difficult to obtain the mutual trust and confidence required for effective support groups than when the group is composed of all nurses, students, patients, and so forth. Where the problem relates to nonwork situations, such as occurs with widows, heterogeneity is of no concern.

GOALS OF A SUPPORT GROUP

(1) The basic goal of the group is to increase the members' coping abilities, relative to narcissistic injuries, real or

imagined, caused by stress. The group provides positive reinforcement for successful coping attempts and selective empathy for unsuccessful ones. Similar to behavior modification techniques, it deemphasizes the negative. Such support increases the members' self-image and self-esteem.

(2) The group stresses interpersonal insight rather than generic insights. The group is concerned largely with interpersonal skills and focuses in a nonpunitive understanding setting on better understanding of effective or ineffective behavior in the here and now.

(3) The group has an educational purpose; it operates as a feedback guidance system. The members give advice and feedback and provide reality testing in a "safe" situation. It collects and disseminates to its members information about the world in which they must survive.

DYNAMICS OF CHANGE IN A SUPPORT GROUP

(1) The group is used for reinforcement rather than for reconstruction. Positive reinforcement of effective coping behavior and interpersonal insights relating to ineffective coping patterns can result in functionally autonomous behavior change without requiring major intrapsychic personality change.

(2) The focus of control is in the group members. It is the group members who bear the major share of the group's work. They advise, suggest, reality test, empathize, and support each other.

(3) The group provides concrete guidance for membership behavior. Support group members frequently share personal examples of successful coping behavior for imitation by other members. They also share factual information regarding important resources, such as one parent telling other parents how to organize the home so that fire fighters are immediately directed to the disabled child's room.

(4) Therapy that takes place via the group can be considered "soft" rather than "hard" therapy. Much of what

occurs is therapeutic, but the therapeutic aspect is tangential since the emphasis of the group is on comfort rather than cure.

LEADERSHIP IN A SUPPORT GROUP

(1) Leadership transparency is high. The leader of a support group is an active role model rather than a member of the group; the leader shares feelings and carefully demonstrates the positive supportive attitudes, which members then assume toward one another. Leaders do not use the group for their own problem solving but will often give an example of a personal positive coping pattern, question a behavior style, share a sensitivity or reaction, or empathize with a member's pain. The leader will assist the group by performing those roles the group needs to have played in order to work effectively, but he or she will stand aside and provide only nonverbal support and acceptance when the group is operating successfully on its own.

(2) The leader places emphasis on building trust, support, and communication among group members. The leader actively reinforces positive attributes, recognizes narcissistic injuries, and deliberately builds bridges between members' contributions to sharpen the awareness of, as well as enhance, the group's cohesion.

(3) The leader is usually the only member of the group who avails himself or herself of analogous reasoning or interpretation. Group-qua-group interpretations of the discussion process must be a major factor in the leader's awareness of the group's dynamics, but it is infrequently of crucial importance to the membership itself, and they rarely need to be aware of it.

(4) The leader has the role of helping the group become the prototype of the well-regulated integrated family, the most effective natural support group one may have. In the healthy family individuals feel loved and protected and able to reveal the negative aspects of self they would hide from the world.

Support groups are obviously significantly therapeutic since they supply most of the curative factors of groups detailed by Yalom (1970) in his classic text on the theory and practice of group psychotherapy. They provide for the following:

Installation of hope—Members believe the group will make a difference in handling the common problem situation.

Universality—Members feel each one of them is not alone in one's concern or is to be considered crazy to believe the concerns are stress provoking.

Imparting of information—Meeting time is often devoted to sharing facts.

Development of socializing techniques—Members encourage practice in the group setting of suggested new behaviors for each other.

Imitative behavior—Both members and leader demonstrate better coping patterns, which other members are encouraged to copy.

Intrapersonal learning—Members learn to appreciate the difference between the way they behave and the way they believe they behave. They hear how their behavior looks to others and become more adept at understanding the consequences of these different perceptions.

Catharsis—Members enjoy the ability and relief of being able to share anxieties, angers, follies, rumors, and the like.

The most significant curative factor for support groups seems to be *cohesion*—the lowering of the feeling of alienation. Cohesion is crucial to a support group, the glue by which the group is held together and enabled to function. Cohesion can be defined as the "we"ness of a group, the result of all the forces acting on all the members to remain in the group, or the attractiveness of the group for its members (Rosenbaum and Berger, 1975). Intermember acceptance is high; the members value and will defend the group and each other. Participation and attendance are voluntary and consistent, and there is frequent evidence of mutual help.

SUGGESTED THEORETICAL BASE FOR THE SUPPORT GROUP

The importance of cohesion for the support group becomes clearer when we review issues regarding the group members, the group itself, and the culture in which the group and members operate as a total system. Lewin (1948) studied the role of minority persons in a majority culture to which they yearn to belong. Lewin designated this individual as a marginal person. Characteristic effects of marginality include uncertainty as to group belongingness, constant frustration, and a state of perpetual adolescence (Lewin, 1951). The continued stress and conflict engendered in marginal persons leads them to take on the characteristic attitudes of the majority even if this includes stigmatizing stereotypes of the minority self. One becomes vulnerable to negating the values, habits, and traditions that are considered most essential and representative of the self—or what, according to Lewin, constitutes one's central core. Self-hate is antithetical to the adjusted healthy individual. In order to operate successfully in society, a person needs to move out from solid ground—a solid ground that comes from knowing who one is and being positive about one's central core. Operating from this positive base gives one strength and security to cope, willingness to plan for the future, a realistic picture of the world, and the certainty of belonging. Paradoxically, therefore, the marginal individual's self-hate makes it more rather than less difficult to move comfortably within the majority culture.

Lewin suggests that the only way of solving the problem in a healthy manner is to respond to the situation in terms of the appropriate group membership accompanied by a positive program of self-esteem. One cannot reaffirm one's central core in isolation; one must work with a group of individuals with a similar core and together define one's habits, traditions, values, and abilities. The strength of the central core of a person grows geometrically rather than arithmetically when joined by others in the soothing, affirmative setting of the

group. The support group, therefore, becomes the obvious mechanism for reaffirming and strengthening the central core of individuals who consider themselves marginal to society due to any particular defined stress or stigmatized stereotype.

SUPPORT GROUP VIS-À-VIS THERAPY GROUP

Experienced group leaders perhaps by now will have reached their own conclusions as to how and why the support group differs from traditional group therapy. The main thrust of the support group constitutes the development of cohesion and the enhancement of self-esteem, which in turn produce better coping patterns in society at large. Group therapy, on the other hand, usually focuses on problem-solving, increased self-awareness, and individual self-analysis through generic insights with a deliberate attempt at personality change. The leaders of support groups (a) are often transparent (whereas most group therapists are not; (b) focus on interpersonal rather than generic insights; (c) deliberately seek all opportunities for positive strokes or reinforcement and focus on supportive rather than interpretive issues; (d) relinquish the control and helping functions to group members; (e) are not a tabula rasa in that along with members they also provide guidance, advice, and information to group members whenever appropriate; (f) consciously seek to increase cohesion among members by pointing out similarities and differences among their contributions to the discussions, showing how one statement builds on another, and reinforcing the interdependency among them; and (g) in every way role-model an attitude of trust and confidence that the leaders hope group members will show toward each other.

This does not mean, however, that the leader never objects to anything, disagrees, or suggests that a member might examine an issue differently. The leader's voice is the most powerful voice of reality in the group, but it speaks objectively, nonpunitively, and—when necessary—confrontively. Such

confrontation is seen as a helpful way of arriving at more valid perceptions and not as yet another narcissistic injury.

Leadership behavior will, of course, be tailored and adapted to the particular problems with which the group is wrestling. Groups of well-adjusted individuals laboring in time-limited pathogenic settings (such as students, nurses, counselors, and so forth) can handle a more assertive leadership role earlier than those groups whose members share an uneasy psychic equilibrium. Leaders must also, as in every other treatment medium, find and be true to the style they find most comfortable. But no leader is immune from the need to be as well versed as possible in both individual and group dynamics. The support group leader requires as much training and expertise as the therapy group leader. One must be aware of individual and group defense mechanisms, transference and countertransference phenomena among members and leaders, and in-depth personality characteristics of members. Transactions with the group are based on this knowledge, even though the understanding may not be verbalized in the group.

SUPPORT GROUP VIS-À-VIS SELF-HELP GROUP

The importance of the leadership role is the key feature separating support and therapy groups from the other end of the support system spectrum, the self-help group.

Self-help groups have been a spontaneous and informal phenomenon since the creation of the back fence. The scientific community, however, has now defined it in terms of the helper-therapy principle and has studied it extensively. Caplan and Killilea (1976), in their article on mutual help organizations, present a bibliography of at least 220 items on self-help organizations from Al-anon to Weight Watchers. They are very similar to support groups, for they are based on homogeneity of members' problems and are effective due to the development of strong cohesive units that build trust and confidence and often increase self-esteem.

The basic and most critical difference between self-help and support groups is in the role of the leader. Leaders of self-help groups must be experiencing or have experienced the same stress situation as the group members. Experience with the problem usually constitutes the authority necessary to lead the group. In support groups, authority for leadership emanates from expertise and training in groups or human development. The self-help movement appears to be anti-intellectual, holding the belief that "having been there" and working through the problem is the superior, and perhaps, only basis for emotional understanding. A deliberate intent to "turn away from dependency on the professional" provides behavioral evidence of the anti-intellectualism and is often freely verbalized.

Support group leaders deliberately encourage cognitive learning to supplement the experiential awareness fostered in the group, while many self-help leaders dismiss cognitive discussion as mental gymnastics or attempts to avoid the emotional intensity engendered by facing the problem.

Most self-help groups, however, have no designated leader, and therefore no one person is responsible for the efficient functioning of the group and for fostering the satisfaction of the needs of each of the members. A support group leader is a conscientious gatekeeper for the group, making sure everyone has an opportunity for participation, encouraging, sharing, guiding discussion, and ensuring its ambience as the prototype of the well-regulated family, the benign feedback guidance system. While there are individuals in the self-help group who can take and do take this role, as the intensity of the problem situation increases, the objectivity of the spontaneous leader often is threatened, if not overwhelmed.

It is this lack of self-imposed objectivity of the leader that produces the greatest danger for self-help groups—the self-fulfilling prophecy. Without responsible feedback, a group may become vulnerable to its own heightened sensitivity about its marginality, producing subsequent self-fulfilling prophecies and/or delusions that make the group a negative rather than a

positive force in the community (Caplan and Killilea, 1976). When this occurs (mostly in the political arena), the distortion between the central cores of the minority and the perception of the majority is heightened, and the strength of the central core of the individual is artificially maintained.

Another danger may be found in the tendency of the self-help group to use peer pressure to force group members to conform as the price of membership. The support group accepts individual differences and, with the help of the leader, learns to understand and evaluate the degree of appropriateness of deviant behavior and the effect of such behavior on the surrounding community. Succumbing to peer pressure rather than working through one's own decision-making with the support of peers cannot help but be a self-harming process.

Self-help groups, therefore, tend to be less stable than support groups. With little continuity of leadership, once the first glow of companionship and sharing is diminished, cliques form, scapegoats emerge, power rivalries arise, and no one is either given or takes the authority to work them through. In support groups, leaders help members work through these phenomena, bringing to each member an increased feeling of competence and potency. The support group by definition is dedicated to work; the self-help group may work, may quarrel, or may simply play.

The self-help group, however, has the potential—as do other therapeutic mediums—to build on the individual's need for attachment to a group system as a vehicle for change. The mechanism whereby one receives help in solving problems by being the helper is very effective indeed (Somers, 1972). When the makeup of the self-help group is fortunate enough to have leadership roles well played by group members, much work and significant behavior change and comfort is gained, as in the familiar Al-anon or AA groups.

CONCLUSION

Both therapy groups and self-help groups provide important services for individuals in stress, and this article in no

way means to devalue the effectiveness of either. Group and group-analytic therapy are extremely important, skillful, and effective tools for patients suffering from neurotic as well as psychotic illnesses. Self-help groups are often the one factor allowing certain individuals to find their way back or to sustain themselves in the community.

This article is, however, directed to the individual concerned about or planning to conduct a support group and who would find the description of such a group's goals, dynamic of change, leadership function, and membership functions useful. It defines the support group as a specific therapeutic medium, has suggested a theoretical base or framework for its functioning and has attempted to clarify the characteristics, boundaries, and processes that make it unique. The practitioner who wishes to work with support groups should recognize it as a separate therapeutic modality requiring training and cognitive understanding of its characteristic properties—properties we are just beginning to determine. While there is clearly much overlap along the group continuum addressed here, it is vital to the group dynamics field to accurately and systematically distinguish its differing modalities. One hopes that further research and documented experiences will enable us to define still more clearly the theory and practices of the support group and to establish it more firmly as a well-defined treatment modality in the group field.

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