

Fostering Partnerships Between Peers and Professionals

Miriam J. Stewart and Linda Reutter

La participation du public figure parmi les cinq principes sur lesquels reposent les soins primaires. Les partenariats entre professionnels et clients s'inscrivent à ce principe. Cet article décrit comment les professionnels et les pairs peuvent travailler conjointement pour intervenir dans le cadre de groupes de soutien. Les auteures présentent des exemples tirés de trois études de terrain portant sur les survivants d'infarctus du myocarde et leurs conjoints, sur les parents d'enfants atteints de maladies chroniques et sur les femmes âgées handicapées. Dans chacun des groupes de soutien, pairs et professionnels partageaient le leadership et œuvraient en partenariat. L'article décrit les points suivants : les caractéristiques, les rôles et la formation des pairs et des professionnels; la collecte de données portant sur les pairs, les professionnels et les participants; et les processus d'intervention pertinents. Pairs et professionnels collaboraient en tant que co-leaders et partenaires dans 21 groupes de soutien s'inscrivant dans trois études. Les participants ont dit avoir été satisfait du leadership exercé dans les groupes. De plus, les animateurs professionnels et les animateurs œuvrant en tant que pairs ont reconnu l'importance du rôle et de la perspective de l'autre.

One of the 5 principles of primary health care is public participation. Partnership between professionals and their clients is compatible with this principle. This article describes how professionals and peers can work together in support group interventions. Examples are cited from 3 intervention studies focused on myocardial infarction survivors and their spouses, parents of children with chronic conditions, and older women with disabilities. Each of the support groups entailed co-leadership by and partnerships between peers and professionals. The article describes the characteristics, roles, and training of peers and professionals; data collection involving peers, professionals, and participants; and pertinent intervention processes. Peers and professionals collaborated as co-leaders and partners in 21 support groups in the 3 studies. Participants expressed satisfaction with the leadership of the support groups. Moreover, professional facilitators and peer facilitators each acknowledged the important role and perspective of the other.

The evolving health needs and accompanying health-system constraints in Canada cannot be addressed by professional resources alone. Accordingly, primary health care, which reflects a philosophy of citizen involvement, is being espoused increasingly by professionals. Nurses,

Miriam J. Stewart, PhD, is Professor, Faculty of Nursing and Department of Public Health Sciences, Faculty of Medicine, University of Alberta, Edmonton, Canada, and Scientific Director, Institute of Gender and Health, Canadian Institutes of Health Research. Linda Reutter, PhD, is Professor, Faculty of Nursing, University of Alberta.

who constitute the largest category of health personnel, proclaim primary health care as the key to the achievement of health for all Canadians in the new millennium (Canadian Nurses Association, 1995). One of the five principles of primary health care, public participation, is compatible with consumer control, client participation, professional-client interactions, consumer perceptions, empowerment, self-care, mutual aid, and professional-lay partnerships. This paper focuses on professional-lay partnerships in mutual aid groups.

The past several years have seen a growth in the *consumer-control* movement and increased tension in professional-lay relationships. Client *participation* at both the individual and collective level can be promoted through such mechanisms as volunteers, self-help mutual aid groups, and self-care, as professional roles are not rigidly defined in these areas (Gottlieb & Peters, 1991; Mezzina, Mazzuia, Vidoni, & Impagnatiello, 1992). Kristjanson and Chalmers (1990) observed *nurse-client interactions* and found that they were either nurse-controlled or jointly controlled. Further study of nurse-client interactions may help to promote public participation and to elicit public perceptions about nursing care (Powell-Cope, 1994). There have been few studies of *consumer perceptions* of nursing services. In one study, elderly clients perceived benefits from nurses' encouragement, support, education, and advice (Laffrey, Renwanz-Boyle, Slagle, Guthmillar, & Carter, 1990). *Empowerment* implies that clients have the authority to influence decisions and interventions through participation, choice, support, and negotiation (Connelly, Kleinbeck, Schneider, & Cobb, 1993; Wallerstein, 1992).

Health-system reform documents, at both the national and provincial level, that emphasize empowerment of populations and public participation (Angus, Auer, Cloutier, & Albert, 1995; National Forum on Health, 1997; Rootman & Goodstadt, 1996) reinforce the important role of self-help and mutual aid. *Self-care* and *mutual aid* are key mechanisms for promoting health (Romeder, 1990), and mutual aid groups can enable self-care. Gottlieb and Peters (1991) found that approximately 420,000 Canadians, or 2% of the population, had participated in a self-help mutual aid group in the preceding year. Such groups allow consumers to participate actively in their own health care and in health policy issues (Lavoie & Stewart, 1995) and are a cost-effective complement to professional services (Katz, 1993).

The community-based support provided by self-help groups augments the more specialized care provided by health professionals

(Elliot, 1999; Eng & Smith, 1995; McFarlane & Fehir, 1994). People experiencing chronicity, caregiving, and aging may require support that is not available in their depleted or strained networks. Yet the formal health system does not consistently acknowledge or address such needs. Frequently, peer support may be needed to supplement professional support. The nursing literature stresses the importance of lay-professional partnerships for people in rural areas (Cagle, 1993), Hispanic people (Courtney, 1995), and families of people with mental illness (Peternell-Taylor & Hartley, 1993). Such partnership models have been proposed by nurses (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Stewart, 1990; Stewart, Banks, Crossman, & Poel, 1994). A distinct advantage, beyond shared control, is the pooling of experiential (first-hand) and professional knowledge (Borkman, 1990). The professional's traditional "expert" role in dealing directly with individual patients/clients differs greatly from the collegial consultant role (Riessman, 1990) called for in working with self-help and support groups. Moving from expert provider to equal partner requires role modification and preparation (Courtney et al.; Stewart, 1990). The requisite role changes, ideological and control issues, mechanisms to expand interactions, and barriers posed by different knowledge bases have all been delineated in discussions of partnership (Lavoie & Stewart, 1995).

Despite embryonic efforts at partnership, "we have yet to determine mechanisms on how to synergistically blend professionally delivered services with mutual aid activities in a way that capitalizes on and preserves the unique contributions of each sector, and makes the two sectors equally legitimate and accessible" (Gottlieb, 1995, p. 233). After studying the role of public health nurses in Alberta in enhancing client competence, Reutter and Ford (1997) concluded that future research should explore "the intricacies of developing partnerships between professionals and clients that embrace a sharing of professional and experiential knowledge" (p. 150).

This paper describes how peers and professionals can work in partnership in mutual aid interventions. It cites examples from three nationally funded intervention studies focused on myocardial infarction (MI) survivors and their spouses, parents of children with chronic conditions, and women over age 65 with disabilities. It describes the characteristics, roles, and training of peers and professionals; data collection involving peers, professionals, and participants; and pertinent intervention processes.

Three Intervention Studies

In our preliminary assessments of the support needs of persons with various chronic conditions and their family caregivers, health professionals were identified only infrequently as a source of support (Stewart, 2000). In one study, for example, mothers of chronically ill children encountered "conflicted support" involving critical or condescending behaviour, predominantly on the part of health professionals. Indeed, the traditional relationship between health professionals and clients can be conflictual and disempowering (Borkman, 1990; Chesler, 1991). Because of the support deficiencies identified by people with chronic conditions and their family caregivers in these assessments, the participants expressed a wish for peer support. To illustrate, mothers of young children with cystic fibrosis wanted to have support groups consisting of other mothers of young children with cystic fibrosis, not mothers of children of any age with any chronic condition (Stewart, Ritchie, McGrath, Thompson, & Bruce, 1994). Participants also expressed a preference for joint leadership of mutual aid/support groups by peers and professionals.

Consequently, we designed mutual aid/support groups for MI survivors and their spouses, parents of young children with chronic conditions, and elderly women with disabilities. Each of these support groups entailed co-leadership by and partnership with peers and professionals.

Cardiac Study

Despite the importance of spousal support for readjustment among MI survivors, there are no reports of interventions that test the efficacy of support from both professional *and* peer sources for *couples* coping with first-time MI. Accordingly, face-to-face support groups were designed to convey emotional, informational, and affirmational support specific to stressful situations encountered by MI survivors and their spouse/partner. These groups, which met weekly over a 12-week period, were led jointly by a couple coping with MI and a health professional. Group discussions were augmented by various techniques and resources depending on the topic (e.g., role playing, invited consultant or guest speaker, focused group discussions, guided group exercises). Twenty-eight people (14 couples) participated in five support groups in this demonstration project (Stewart, Davidson, Klassen, Makrides, & Wolf, 2000). All but one of the MI survivors were male. Survivors ranged in age from 42 to 71 years (mean = 57 years), while spouses ranged in age from 40 to 66 years (mean = 56 years). Half of the

participants reported incomes greater than \$40,000/year; 40% had incomes under \$30,000/year. Only 36% were employed; 64% were not employed or were retired. Almost all (96%) were Caucasian.

Parents' Study

Our earlier investigation of the support needs of mothers of children with a chronic condition revealed deficiencies in support from spouse/partner and professionals. Although mothers wanted support from their peers, they found it difficult to join face-to-face support groups because of caregiving demands and geographic isolation. Therefore, 12 telephone support groups, each co-facilitated by a parent and a health professional, were formed and met once weekly over a 12-week period. A total of 120 parents of young children with chronic conditions (cystic fibrosis, spina bifida, diabetes) participated in this randomized control trial (Ritchie et al., 2000). Most were mothers ($n = 103$). Of the 64 parents who participated in the telephone support groups (intervention condition), 54 were women. The mean age of the parents was 30 years; 84% had completed at least high school; 82% were married or living common-law. On average, the children of parents who participated in the support groups were aged 3 to 6 years and had one sibling; 36 children had spina bifida, 13 had cystic fibrosis, and 15 had diabetes.

Seniors' Study

As women's life expectancy is greater than men's, there are more elderly women than men living with some form of chronic disability such as stroke or arthritis. Given that these women frequently suffer losses from their natural network associated with aging and their social network is further limited by immobility, their support needs can be partly met by peers in mutual aid groups. In this study, women over age 65 with limited mobility (which prevented them from attending face-to-face support groups) met weekly over a 12-week period via teleconference. The telephone groups were co-led by a peer (i.e., an elderly woman with limited mobility) and a health professional. Twenty-six women with diverse disabilities (e.g., polio, spinal cord injury, osteoporosis, cardiovascular disease, arthritis) participated in four telephone support groups (Stewart et al., 2001). The mean age of participants was 75 years (range 66–93). Most women were widowed (61%) and most lived alone (78%). Participants were almost equally divided between urban and rural sites.

In all three of these support interventions, the peers and professionals were carefully selected and trained. Their characteristics, training, and roles are described below.

Characteristics of Peers and Professionals

In the *cardiac* support groups, peer leaders were couples (in which one spouse was at least 1 year post-MI) who demonstrated interpersonal skills, potential for leadership, and insight into requisite lifestyle adjustments. All peer leaders had extensive experience with community organizations (e.g., heart health). The health professional leaders (from nursing, social work, health education, and psychology backgrounds) had experience working with persons with cardiac illness and with community-based client groups.

The health professionals in the telephone support intervention for *parents* were nurses, occupational therapists, and physiotherapists. Although the intervention was open to couples, the peer leaders were all mothers.

One peer leader in the telephone support intervention for *elderly women* was 71 years of age and confined to a wheelchair because of polio. The other peer leader was 68 and legally blind. The professional leaders included a social worker and a physiotherapist whose practice focused on seniors, and a health educator with self-help group experience.

Training of Peers and Professionals

In these telephone and face-to-face support interventions, co-leadership was promoted by a joint orientation session for peers and professionals. Particular attention was paid to beliefs that might affect facilitators' ability to interact with participants, ways of using personal strengths to assist others, and strategies for building the abilities of group members. The training session addressed: (1) the purpose and intended outcomes of the support group; (2) the responsibilities of participants; (3) the nature, scope, and sequencing of topics for discussion; (4) strategies for handling group process issues, documenting support processes, and assisting individuals who required more support than the group could offer; (5) complementary roles of peer and professional facilitators; and (6) operational matters involving the use of technology (if relevant) and administrative details. Simulated situations and role play focused on group facilitation techniques. Feedback revealed that the training

session had anticipated issues that arose subsequently during the group sessions and had suggested appropriate strategies.

[The initial training was] very helpful...I learned a lot about what my role was as a facilitator in the group. It helped me feel confident about my ability to do this group. [peer leader of parent group]

Check-in, or "booster," sessions for facilitators of the group interventions also proved successful. Every 4 weeks, peer and professional facilitators connected by phone with other facilitators, the trainer, and members of the research team to discuss progress, roles, and challenges. These sessions were viewed as helpful because of the exchange of feedback, guidance, and affirmation:

[The booster session] was really good. Quite a few issues came out and it was...supportive to hear about other groups. Good to have the reminder about group endings. [professional leader of seniors' group]

That was a good session. It was interesting to talk to others about their experiences with their group. [peer leader of seniors' group]

Resource manuals for facilitators were distributed and discussed during the training. For example, the facilitator manual for the *cardiac* support group outlined the responsibilities of the co-facilitators, the goals of the project, and themes for sessions. The initial session focused on the proposed topics and the expectations and commitments of group members. The outlines for the subsequent sessions focused on stressful situations for both MI survivor and spouse (e.g., hospitalization, health behaviours/lifestyle changes, health-care routines, recovery, caregiving roles, return to work, economic constraints, emotional impact of cardiac disease, intimacy, conflict, dependency), coping strategies, and support needed/available. Information on these topics was based on the literature and on feedback from a preliminary focus group of four couples who had coped with MI in the past. Case study scenarios, developed for each weekly theme, were distributed to participants. Similar resource manuals were developed for the peer and professional facilitators of the telephone support interventions for *parents* and *seniors*. To illustrate, weekly topics in the parents' groups were based on support needs pertaining to family routines and activities, child development, physical care, coordinating the child's health care, personal needs, roles other than caregiving, relationship with child with chronic condition, and relationship with spouse/partner. These support needs were expressed in the previous assessment study of mothers of children with a chronic condition.

Roles of Peers and Professionals

In the face-to-face *cardiac* support groups, information about the disease process, its treatment and management, and formal services was primarily the domain of the professional facilitator, whereas support related to coping strategies and informal help-seeking was the forte of the peer facilitator. Both facilitators addressed issues of family functioning and the relationship between the affected person and his/her spouse. In the telephone support groups, created for *parents* and for *seniors*, the professional facilitator contacted participants to determine a mutually agreeable time for the group meetings and worked with the telephone operator to initiate each teleconference session. Both professional and peer facilitators encouraged group members to voice their experiences and contacted individual group members between sessions regarding concerns or missed sessions.

In all three studies, the co-facilitators consulted participants during the initial session regarding specific foci of discussion and timing of sessions. Furthermore, they invited members to change topics in subsequent sessions. Hence there was shared decision-making pertaining to discussion themes.

Data Collection

In the three support group interventions, the professional and peer facilitators recorded field notes following each session, with particular attention to topics of discussion, coping strategies suggested, sources of support identified, support processes (i.e., social exchange, social learning, social comparison), and factors that might have influenced the discussion. The co-facilitators also recorded reasons for dropouts, their contact with members and members' contact with each other between sessions, and other intervening processes.

Peer and professional facilitators were interviewed jointly in some studies and individually in others about the training session; leadership issues; facilitators' roles, contributions, communication, and partnership; group processes; the advantages, disadvantages, and impact of the intervention; and interactions with group members following the intervention. Some of the interview questions were as follows:

During the session, what did the peer leader do that was different from the other group members and from the professional leader? Describe the frequency and focus of communications between the professional and peer group leaders. In your opinion, what were the advantages and disadvantages of having a peer leader? Was the professional leader a resource for

the peer leader? If so, in what ways? Was there a partnership between the peer and professional leader? If so, please describe.

Following each session, participants made diary entries on the perceived importance of the topics discussed, their contribution to the discussion, group processes, leaders' roles, and co-leadership. Participants were also interviewed following the intervention about these intervention process issues and the perceived impact of the support groups.

The diaries, field notes, and post-intervention interviews yielded rich qualitative data on intervention processes such as participant input, roles of peers and professionals, and professional-peer partnerships. These intervention processes are reported here. (Standardized measures administered pretest, post-test, and delayed post-test generated quantitative data pertaining to outcomes in each study. These results are reported elsewhere.)

Data Analysis

For each of the three intervention studies, the qualitative data (participants' diaries, leaders' field notes, leaders' interviews, participants' interviews) were subjected to content analysis using a category system of key concepts and themes that were developed inductively from the data. The coding framework focused on content of the group discussion, group processes and other intervention processes, perceived impact of the intervention, and evaluation of the intervention. The derived categories met the following criteria: inclusive of the data provided, useful in describing participants' experiences and perceptions, mutually exclusive, and clear and specific. Reliability of selection of data elements for coding was achieved by setting the inter-rater reliability between coders at 80%. To assist with the management of the data, the computer-based software program Ethnograph was used. This paper describes common themes in the intervention processes across the three studies.

Intervention Processes: Common Themes

The facilitator field notes, participant diaries, and interviews of participants and facilitators revealed the following intervention processes: participant input, social comparison, social learning, social exchange, perceptions of peer-professional roles, and satisfaction with peer-professional partnership.

Participant Input

The success of the groups can be attributed in part to the fact that participants could control the content of discussions. One professional facilitator said:

I know I sort of relaxed after the first three or four sessions and...almost instinctively knew the next session is going to go okay... I relaxed and allowed the group to work the process themselves.

In the parents' groups, for example, the choice of peer and professional facilitators, and the relationship between them, helped to set the tone and to create an atmosphere in which participants were encouraged to contribute. One mother reported: "Whatever we wanted to talk about was more or less what we discussed."

Some facilitators believed that the structure and facilitator guides were particularly useful during the early sessions:

It was good for us as facilitators, and also for them, to know that it was safe, at first, to have those topics to rely on. Now, near the end, they're more open and into their feelings.... But it was really good to have those topics at first, because people didn't know each other well enough to just say, "I've had an awful week. This is what's bothering me and can we talk about it?" Whereas if we were looking at physical care and looking at some specific kinds of things, they could contribute.

Parents concurred that it was easier to select topics for discussion as group cohesion developed over time:

And the more we talked...each week everybody would open up a little bit more and talk.

All facilitators of the seniors' support groups acknowledged the high level of member input in selection of topics. Sessions usually commenced with facilitators introducing potential topics, with members subsequently assuming responsibility for the direction of the discussion and identification of other topics. Facilitators reported that members preferred free-flowing conversation to structured discussion. The selection of topics was collaborative:

Leaders usually picked the topic. Usually it started that way, but something someone said would lead us off in other directions. [senior]

Everyone has input...that was really nice about the group. Everyone felt part of the process. It wasn't a group run by two leaders. It was a collaborative effort. [senior]

Three key processes were evident within these three support group intervention studies: social comparison, social learning, and social exchange.

Social Comparison

Social comparison is a process whereby people evaluate themselves and elicit information about their behaviour, abilities, and opinions through comparison with similar others. In the face-to-face support groups for couples dealing with a *cardiac* condition, all participants mentioned social comparison as a benefit. Similarity of life experiences played an important role in group development. In some groups, perceived lack of similarity with peers hindered comparison and depth of discussion. For example, some participants noted that they were younger than the other members of the group and had different circumstances, such as full-time jobs and young children. The tone of the group discussions was often set by the peer leaders describing situations similar to those experienced by members. Participants found solace in the realization that they were not the only ones facing these stressful situations.

Parents compared caregiving demands, ways of coping, age(s) of children, and severity of the child's condition. Dissimilar circumstances hindered the process of social comparison and the effectiveness of group interactions. As one mother said:

My daughter has spina bifida, but...she was more severe and had more problems than what the other children had. So I found it a little difficult there.

Social Learning

Social learning involves a process of role modelling by peers and the fostering of self-efficacy. In the *cardiac* support groups, the process of social learning included receiving information based on both professional and experiential knowledge. Problems resulting from a lack of understanding about the cardiac condition were addressed through information exchanged among group members or offered by peer and professional facilitators. Participants also had the opportunity to gain insight into their reactions and behaviours through role modelling by other members. Furthermore, some participants learned about themselves by observing the behaviour of other members and peer leaders (vicarious learning). During post-intervention interviews, participants commented on the positive impact of informational support provided by the group on their knowledge, coping, and confidence.

In the telephone support groups for *parents* of children with chronic conditions, peer facilitators and other parents were the role models. One woman said she "looked up to" the other mothers and wanted to be more like them. Experiential knowledge was often solicited by the facilitators in the initial sessions and offered more spontaneously as the group developed.

Well, we bounced a lot of ideas off of one another. Like, "When I do this, this happens." You know, we did a lot of that... When you are doing that with others, you are learning. When situations arise, you remember, "Oh, I remember so and so said, or suggested..." And that stuff is in your mind and you think of it. It's got to help in the long run.

Social Exchange

Social exchange refers to the give and take in groups through the sharing of ideas, information, and experiences. There was a strong sense of mutuality and equality among members of the support groups. In the three studies, most participants indicated that they both contributed to the group and benefited from it. Some peer facilitators reported that they learned from group members:

I feel I just gave and got support. That seems to be the way this group is. We listen to each other and then we offer up a [similar] situation or a potential solution. [parent]

I think there was equality actually involved in everything.... We grew to respect each other's views, which is good. [spouse of MI survivor]

Perceptions Among Participants of the Roles of Peers and Professionals

In the face-to-face support groups for couples dealing with *cardiac* conditions, scientific explanations (i.e., informational support) seemed to be received more favourably when delivered by a professional: "She explained everything" [survivor]. Peer facilitators provided information (on dealing with conflict, setting the mood for intimacy, relaxing, dieting, returning to work, etc.) in a user-friendly form and offered a realistic outlook on issues:

The support couple...was really able to explain things so very well, and give us [their] own experience on how [they] handled things and what was good. You really felt that [they] knew what [they] were talking about. [survivor]

According to participants, peer facilitators offered positive feedback (i.e., affirmational support), reassurance, and hope that things would

ultimately return to normal. Peer and professional facilitators also demonstrated concern regarding the difficulties experienced by group members (i.e., emotional support). Participants believed that professional leaders set the tone, monitored the group process, and ensured that all members were heard, whereas peer leaders encouraged them to participate and provided reassurance and information on coping strategies.

In the telephone support groups for *parents*, the professional facilitator was perceived to be an "encyclopedia" who provided information and kept the discussion flowing and on topic. Many participants expected the professional facilitator to have current information related to their child's condition. The peer facilitator was viewed as the seasoned veteran who could provide information, having "been through it." The peer facilitators shared personal experiences and suggested strategies for coping with diverse issues, ranging from daily routines to life-and-death decisions. The participants contended that this experiential knowledge was valuable:

She was wonderful, and I did learn a lot from her. Her child was the oldest, with CF, and she knew just what to say. I know a couple of times I was having difficulties when we were talking about certain subjects. Like, we got talking about our fears one night, and my worst fear is losing her [daughter]... And when we were discussing that, she knew just what to say... as a parent and someone so associated with the disease, she really knew what I was thinking and feeling and she knew what to say to get me out of it.

Satisfaction with Professional-Peer Partnership

In the telephone support group for *seniors*, participants believed that both peers and professionals offered unique support:

The peer [leader] could share her actual experiences with aging. She was one of us.

[Professional] had a gift of making us speak, very comfortable. She made us all feel so special... [Peer] had a sympathetic understanding.

Participants expressed satisfaction with the co-peer and professional leadership of the *cardiac* support groups. Moreover, the professional facilitators acknowledged the important role and perspective of the peer facilitators, as illustrated in the following quotations:

There was almost an instinctive identification from many of the people around the table to what the peer leaders experienced.

I think that it's like anything in life, if you've had some experience with the problem, you bring a different perspective to it.

The leadership fluctuated between the peer and professional facilitators. The joint interview of facilitators in the cardiac study revealed a consensus about the benefits of balanced leadership and egalitarian relationships.

I think we had similar values about how the process should go. It seemed to come out in those early weeks.... I don't think we had any clashes about how we felt we might support the process or intervene in any way with the process. I always felt very supported. [peer facilitator]

The other thing that always challenges me as a [professional] facilitator is to...get out of the way of the process and to not control it too much. [professional facilitator]

Parents also found the shared leadership of the telephone support groups effective. One parent said, "I think you need both. I mean, it's the theoretical and the applied. They go hand in hand." One benefit of co-facilitation was the different perspectives and experiences shared with the group. A mother observed, "They kept one another in balance. What one might have lacked, the other one made up for." A benefit noted by the facilitators was shared responsibility for the group. Furthermore, co-facilitation ensured continuity if one facilitator was absent, and it provided someone with whom to discuss concerns and to validate feelings following sessions:

I would always call my co-leader up immediately after the meeting and say, "How did you think that went?" We would post-mortem it for 10 minutes, which also helped very much.... I think that if I didn't have my co-leader's reaffirmation that we each share the same impression, it would have been extremely difficult to proceed.... I think there was a lot of self-support or mutual support.... It was excellent to have a co-leader.

The peer and professional facilitators could rely upon each other in the initial stages of group formation and work together to maintain momentum when discussion slowed. One parent facilitator said, "It was less...imposing. The job was easier to take knowing there was someone else there for you."

Similarly, the shared leadership of the *seniors'* groups was viewed as effective and as creating a comfortable environment. As one elderly participant said:

[The shared leadership] was very effective. They knew more than we did and were very knowledgeable about the topics. They were both really good, interesting people. They were able to stimulate conversation

without making people feel imposed upon. A good blend of practical experience and professional knowledge.

Discussion

Peers and professionals collaborated as partners in these 21 support groups. Participants reported that the partnership yielded affirmation, information, and emotional support. According to the qualitative data from interviews and the quantitative results of standardized measures, the need for support diminished and satisfaction with support increased following the interventions. Moreover, the interventions enhanced participants' competence and confidence, and diminished their feelings of loneliness. The National Forum on Health (1997) concluded that health-enhancing non-medical interventions can help to mobilize support at various levels of society (e.g., family, volunteer organizations, groups, communities). The group interventions reported in this paper mobilized supplementary support for people at risk for isolation, loneliness, and health-related problems. Participants, peers, and professionals were impressed by the positive contributions of partnership in these mutual aid interventions.

The collaboration between peers and professionals and the rapport underpinning their relationships contributed to the success of these support interventions. The guidelines for the preparation and practice of community health nursing in Canada (Canadian Public Health Association, 1990) clearly call for nurses to work collaboratively with self-help and support groups. In other studies, relationships between self-help groups and professionals that have been depicted as positive are those that are supportive, respectful, and helpful (Warner, 1992) and that involve shared leadership (Weiss, 1992). Partnerships that have been portrayed as effective by health professionals and members of self-help groups are those that are understanding, reciprocal, collaborative, egalitarian, and trusting (Banks, Crossman, Poel, & Stewart, 1997). Moreover, partnership necessitates role clarification, shared goals, risk-taking, flexibility, and an easing of professional control (Stewart, Banks, et al., 1994). In this context, a "coalition" or partnership between self-help groups and professionals can help to redefine professional-client relationships (Chesler, 1991) and roles.

In primary health care, the role of nurse changes from chief actor or expert provider to partner, and the role of client changes from passive recipient to partner (Courtney et al., 1996; Stewart, 1990). Nurses as professionals have a role to play in enabling consumers to empower themselves (Singer & Powers, 1992). The intervention studies reported in this

paper reflect the unique role that nurses can assume in both clinical and community settings — that of animator and facilitator of supportive social ties among populations in similar stressful circumstances (Gottlieb, in press a). Nurses can prolong the benefits of support groups by offering members the opportunity to transform themselves into a self-sustaining support group and by changing their professional role from that of facilitator to that of consultant and trouble-shooter (Gottlieb, in press b).

Barriers to collaboration between self-help organizations and health professionals lie in differences between professional and lay discourse (Simpson, 1996) and attitudes (Rogers & Pilgrim, 1997) and between professional and experiential knowledge (Borkman, 1990). Partnerships can feature tension between self-help/support groups and professionals (Wilson, 1993) as a result of differences in knowledge, roles, status, and power. In one study, professionals and self-help group members described relationships that were authoritarian, territorial, and competitive (Stewart, Banks, et al., 1994). Even relationships based on principles of partnership are not immune from power struggles (Banks et al., 1997). Whereas some professionals perceive self-help/support groups as a challenge to their professional authority and a threat to their power base and livelihood, other professionals willingly share power and control (Constantino & Nelson, 1995). Although support groups can develop problematic relationships with professionals resulting in "professionalization" and co-optation (Wilson), they can also enjoy empowering and positive relationships with professionals (Mitchell, 1996). Empowerment in health services requires a shift from hierarchical processes of control to horizontal processes of partnership (Townsend, 1994). Nursing practice can be informed by these three group interventions, which were characterized by shared power and control and in which professional and experiential knowledge were considered unique but complementary.

Despite positive attitudes towards the principles of primary health care, nurses report deficiencies in their knowledge, skills base, and education pertaining to social support groups and lay helpers (Stewart, 1989; Stewart, Banks, Crossman, & Poel, 1995). Nursing education should emphasize partnership roles (Hughes, 2000) and include training in consumer issues, mutual support principles (Simpson, 1996), and collaborative problem-solving. Intervention programs that foster collaboration should incorporate training and check-in sessions for peer and professional co-facilitators.

The nursing literature emphasizes the importance of partnerships in conducting research (Clarke, 1997; Dickson, 2000), and the principles of participatory research call for an equal partnership between researchers and participants. Nurses should document the flow of leadership between peers and professionals, and the unique and shared roles of peers and professionals in support groups and support dyads for different life stages and different stressful situations. While there has been some research on nurse-client interactions at the individual and family level, there is a lack of research exploring partnerships at the community level (Chambers et al., 1994). Moreover, the mechanisms for effectively blending professional and mutual aid activities should be examined in the context of future intervention studies (Gottlieb, 1995; Reutter & Ford, 1997). Clearly, peers and professionals can be effective partners in programs and in research.

References

- Angus, D., Auer, L., Cloutier, E., & Albert, T. (1995). *Sustainable health care for Canada: Synthesis report*. Ottawa: Ottawa Economic Projects.
- Banks, S., Crossman, D., Poel, D., & Stewart, M. (1997). Partnerships among health professionals and self-help group members. *Canadian Journal of Occupational Therapy*, 64(5), 259-269.
- Borkman, T. (1990). Self-help groups at the turning point: Emerging egalitarian alliances with the formal care system. *American Journal of Community Psychology*, 18, 321-332.
- Cagle, C. (1993). Commentary on health promotion for rural populations: Partnership interventions. *AWHONN'S Women's Health Nursing Scan*, 7(6), 6.
- Canadian Nurses Association. (1995). *The role of the nurse in primary health care*. Ottawa: Author.
- Canadian Public Health Association. (1990). *Community health~public health nursing in Canada: Preparation and practice*. Ottawa: Author.
- Chambers, L., Underwood, J., Halbert, T., Woodward, C., Heale, J., & Isaacs, S. (1994). 1992 Ontario survey of public health nurses: Perceptions of roles and activities. *Canadian Journal of Public Health*, 85(3), 175-179.
- Chesler, M. (1991). Participatory action research with self-help groups: An alternative paradigm for inquiry and action. *American Journal of Community Psychology*, 19, 757-768.
- Clarke, H. (1997). Research in nursing and cultural diversity: Working with First Nations peoples. *Canadian Journal of Nursing Research*, 29(2), 11-25.
- Connelly, L.M., Kleinbeck, S.V.M., Schneider, J.K., & Cobb, A.K. (1993). A place to be yourself: Empowerment from the client's perspective. *Image: Journal of Nursing Scholarship*, 25(4), 297-303.

- Constantino, V., & Nelson, G. (1995). Changing relationships between self help groups and mental health professionals: Shifting ideology and power. *Canadian Journal of Community Mental Health*, 14(2), 55–69.
- Courtney, R. (1995). Community partnership primary care: A new paradigm for primary care. *Public Health Nursing*, 12(6), 366–373.
- Courtney, R., Ballard, E., Fauver, S., Gariota, M., & Holland, L. (1996). The partnership model: Working with individuals, families, and communities toward a new vision of health. *Public Health Nursing*, 13(3), 177–186.
- Dickson, G. (2000). Participatory action research: Theory and practice. In M.J. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (2nd ed.) (pp. 542–563). Toronto: W.B. Saunders.
- Elliot, H. (1999). Use of formal and informal care among people with prolonged fatigue: A review of the literature. *British Journal of General Practice*, 49(439), 131–134.
- Eng, E., & Smith, J. (1995). Natural helping functions of lay health advisors in breast cancer education. *Breast Cancer Research Treatment*, 35(1), 23–29.
- Gottlieb, B. (1995). Research on mutual aid and social support: Progress and future directions. *Canadian Journal of Community Mental Health*, 14(2), 229–234.
- Gottlieb, B. (in press a). Self-help, mutual aid, and support groups: A synthesis of the literature. *Canadian Journal on Aging*.
- Gottlieb, B. (in press b). Accomplishments and challenges in social support intervention research. In M. Stewart (Ed.), *Chronic conditions vs. caregiving in Canada: Social support strategies*. Toronto: University of Toronto Press.
- Gottlieb, B., & Peters, L. (1991). A national demographic portrait of mutual aid group participants in Canada. *American Journal of Community Psychology*, 19(5), 651–666.
- Hughes, J. (2000). Effects of health care reform on helping relationships. In M.J. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (pp. 461–485). Toronto: W.B. Saunders.
- Katz, A.H. (1993). *Self-help in America: A social movement perspective*. New York: Twayne Publishers.
- Kristjanson, L., & Chalmers, K. (1990). Nurse-client interactions in community-based practice: Creating common ground. *Public Health Nursing*, 7(4), 215–223.
- Laffrey, S.C., Renwanz-Boyle, A., Slagle, R., Guthmiller, A., & Carter, B. (1990). Elderly clients' perception of public health nursing care. *Public Health Nursing*, 7(2), 111–117.
- Lavoie, F., & Stewart, M. (1995). Mutual aid groups and support groups: The Canadian context. *Canadian Journal of Community Mental Health*, 14(2), 5–12.
- McFarlane, J., & Fehir, J. (1994). De Madres a Madres: A community, primary health care program based on empowerment. *Health Education Quarterly*, 21(3), 381–394.

- Mezzina, R., Mazzuia, P., Vidoni, D., & Impagnatiello, M. (1992). Networking consumers' participation in a community mental health service: Mutual support groups, "citizenship" and coping strategies. *International Journal of Social Psychiatry*, 38(1), 68-73.
- Mitchell, F. (1996). Carer support groups: The effects of organizational factors on the character of groups. *Health and Social Care in the Community*, 4(2), 113-121.
- National Forum on Health. (1997). *Canadian health action: Building on the legacy*, Vol. 2. Ottawa: Minister of Public Works and Government Services.
- Peternell-Taylor, C., & Hartley, V. (1993). Living with mental illness: Professional-family collaboration. *Journal of Psychosocial Nursing and Mental Health Services*, 31(3), 23-28.
- Powell-Cope, G.M. (1994). Family caregivers of people with AIDS: Negotiating partnerships with professional health care providers. *Nursing Research*, 43(6), 324-332.
- Reutter, L., & Ford, J.S. (1997). Enhancing client competence: Melding professional and client knowledge in public health nursing practice. *Public Health Nursing*, 14, 143-150.
- Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990's. *American Journal of Community Psychology*, 18(2), 221-230.
- Ritchie, J., Stewart, M.J., Ellerton, M., Thompson, D., Meade, D., & Viscount, P. (2000). Parents' perceptions of the impact of a telephone support group intervention. *Journal of Family Nursing*, 6(1), 25-45.
- Rogers, A., & Pilgrim, D. (1997). The contribution of lay knowledge to the understanding and promotion of mental health. *Journal of Mental Health*, 6(1), 23-35.
- Romed, J.M. (1990). *The self-help way: Mutual aid and health*. Ottawa: Canadian Council on Social Development.
- Rootman, I., & Goodstadt, M. (1996). *Health promotion and health reform in Canada*. Position paper prepared on behalf of the Canadian Consortium for Health Promotion Research. Toronto: Centre for Health Promotion, University of Toronto.
- Simpson, R. (1996). Relationships between self help health organizations and professional health care providers. *Health and Social Care in the Community*, 4(6), 359-370.
- Singer, G., & Powers, L. (1992). *Families, disability and empowerment: Active coping skills and strategies for intervention*. Baltimore: Brookes Publishing.
- Stewart, M. (1989). Nurses' preparedness for health promotion through linkage with mutual aid self help groups. *Canadian Journal of Public Health*, 80, 110-114.
- Stewart, M., Banks, S., Crossman, D., & Poel, D. (1994). Partnerships between health professionals and self-help groups: Meaning and mechanisms. *Prevention in Human Services*, 11(2), 199-240.

- Stewart, M., Banks, S., Crossman, D., & Poel, D. (1995). Health professionals' perceptions of partnerships with self help groups. *Canadian Journal of Public Health*, 86(5), 340–344.
- Stewart, M.J. (1990). From provider to partner: A conceptual framework for nursing education based on primary health care premises. *Advances in Nursing Science*, 12(2), 9–27.
- Stewart, M.J. (2000). Common themes and lessons learned. In M.J. Stewart (Ed.), *Chronic conditions and caregiving in Canada* (pp. 274–293). Toronto: University of Toronto Press.
- Stewart, M.J., Davidson, K., Klassen, G., Makrides, L., & Wolf, H. (2000). In M.J. Stewart (Ed.), *Chronic conditions and caregiving in Canada* (pp. 90–116). Toronto: University of Toronto Press.
- Stewart, M.J., Mann, K., Jackson, S., Downe-Wamboldt, B., Bayers, L., Slater, M., & Turner, L. (2001). Telephone support groups for seniors with disabilities. *Canadian Journal on Aging*, 20(1), 47–72.
- Stewart, M.J., Ritchie, J.A., McGrath, P., Thompson, D., & Bruce, B. (1994). Mothers of children with chronic conditions: Supportive and stressful interactions with partners and professionals regarding caregiving burdens. *Canadian Journal of Nursing Research*, 26(4), 61–82.
- Townsend, E. (1994). *Enabling empowerment or managing medical cases? Occupational therapy's mental health work*. Unpublished doctoral thesis, Dalhousie University.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, 6(3), 197–205.
- Warner, A. (1992). *Participants' views on the impact of self-help on health: Self-help connection*. Unpublished manuscript.
- Weiss, J. (1992). Support groups for patients with genetic disabilities and their families. *Pediatric Clinics of North America*, 39, 13–23.
- Wilson, J. (1993). Vital yet problematic: Self-help groups and professionals – A review of the literature in the last decade. *Health and Social Care*, 1, 211–218.

Authors' Note

Comments or queries may be directed to: Miriam J. Stewart, Centre for Health Promotion Studies, 5-10 University Extension Centre, 8303 – 112 Street, Edmonton AB T6G 1K4 Canada. Telephone: 780-492-9413. Fax: 780-492-9579. E-mail: <miriam.stewart@ualberta.ca>.