CONCEPTIONS OF HELP IN SELF-HELP GROUPS FOR FORMER PSYCHIATRIC PATIENTS

by

Chris A. Hertler

A thesis submitted to
the Faculty of Graduate Studies
in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

Department of Psychology
University of Manitoba
Winnipeg, Manitoba

ISBN 0-315-81749-6

Canada

CONCEPTIONS OF HELP IN SELF-HELP GROUPS FOR FORMER PSYCHIATRIC PATIENTS

BY

CHRIS A. HERTLER

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

ABSTRACT

Former psychiatric patients may gain understanding, increase self-acceptance, learn effective coping skills, and become willing to engage in advocacy as a result of participating in self-help groups (e.g., Levine, 1988; Rappaport et al., 1985). There have been few attempts to specify the aspects of self-help groups that are most likely to promote these outcomes. However, several investigators (e.g. Antze, 1978; Suler, 1984) contend that a group's ideology (i.e., its beliefs and prescriptions for countering problems) is crucial to helping its members.

The study examined (a) variables promoting endorsement of a group's ideology and (b) implications of attributional models of help for members' mental health and attitudes towards professionals. Brickman et al.'s.. (1982) theory of responsibility for problems and solutions predicts that liberation ideology rather than illness ideology promotes autonomy, advocacy, and coping effectiveness.

Eighty-six members in six groups, varying in the extent to which they endorsed the medical model (low self-attribution of responsibility for both problems and solutions) and the compensatory model (low self-attribution of responsibility for problems but high self-attribution of responsibility for solutions) completed questionnaires. Results indicate that members tend to endorse their group's ideology, even if they are not extensively involved in the

group. Supportive group interactions (e.g., sharing, empathy, explanation) promote endorsement of a group's ideology, indicating that members who view their group as an important place for discussing problems tend to adopt its beliefs.

Although members tend not to adopt exclusive models of help, endorsement of the medical model is directly related to lower self-esteem and mastery, whereas endorsement of the compensatory model is directly related to higher self-esteem and mastery. Members who strongly endorse the medical model also tend to place greater importance on professional help relative to help from their group. Thus, the medical model may inhibit a group's potential for promoting members' well-being.

Members of diverse groups favor mental health system change, suggesting that self-groups may promote such attitudes, perhaps by offering new sources of help.

Further research could clarify relationships among organizational, leadership, role, process, ideological, and member characteristics in self-help groups.

ACKNOWLEDGEMENTS

Dr. Bruce Tefft and the other members of my Advisory Committee (Dr. Marvin Brodsky, Dr. Barry Trute, and Dr. Alexander Segall) provided valuable advice at crucial moments during the course of this project. While they remain anonymous, the six participating groups provided fine examples of the cooperation, dedication, and good will that are seminal to the success of the self-help movement.

By serving as raters, Dr. Richard Townsend, Deborah Townsend, Richard Jaeger, Rodney Dannehl, John Cuff, Janine Cutler, and Diane Hiebert-Murphy helped to define a major dependent variable in the study. Lawrence Erdile's prompt, friendly technical assistance was indispensable during the statistical analysis of the data. Marion Eastman and her professional staff were always helpful, sensible, efficient, and courteous through the course of several drafts of the materials as well as the final manuscript for the study. Tim Aubry directed my attention to the article that originated the idea for the study. Cyndy Erickson and members of the administrative and secretarial staff at the University of Manitoba Department of Psychology provided cheerful assistance, as well as space to work. My experience in working with the Last Boost Club in Winnipeg formed the basis of my initial interest in research with self-help groups for former psychiatric patients. It would

have been impossible to complete this project without the assistance of all of these individuals and groups.

Several persons have provided indispensable help and support in many aspects of my life. Leonard Greenwood, Linda Cantelon, Rebecca Broder, Mary Warmbrod, Pat Rycroft, and Joan Lawrence have always been affectionate and generous during difficult times. Dr. Ross Hartsough offered his hospitality at a moment's notice. Dr. James Forrest, Don Sharpe, and Marlo Gal often provided companionship and support during the period when I was separated from my family.

Thanks to Dr. Barry Johnson, L. Joe Fry, and other friends at Badlands Human Service Center in Dickinson, North Dakota, for the time, means, and confidence to allow me to carry this project through to its completion. Roommates, friends, and other members of the cooperative movement in Madison, Wisconsin interested me in the personal and political relevance of collective effort.

I am grateful to my family and in-laws, especially my wife, Renee and son, Gabriel. Their love has made possible everything that is good in my life.

In closing, I would like to give special thanks to Roger and Mary Ann Ebert, who know that a revolutionary must keep an open mind.

CONTENTS

LIST OF TABLES

LIST OF APPENDICES

INTRODUCTION

A self-help group can be defined as having the following characteristics: (a) it is composed of individuals with a problem or set of experiences in common; (b) members have a common goal of helping and supporting other members to cope with difficulties; (c) members meet regularly to share experiences, discuss alternatives for coping, and identify community resources for solving or alleviating problems; and (d) members structure, sanction, and control their group and are thus its primary providers of knowledge, skills, and work (Gussow & Tracy, 1976; Hinrichsen, Revenson, & Shinn, 1985; Levy, 1976; Lurie & Shulman, 1983).

The relation of researchers and service providers to self-help groups, the prevalence of self-help groups, the history of self-help movements in relation to other social structures, and the success of self-help groups are discussed in reports by Frankel (1983) and Lieberman (1986). By providing members with opportunities to form affliliative, egalitarian relationships with others who have been in similar circumstances, self-help groups may correct for deficiencies and inequities that are inherent in the role of client within institutions controlled by professionals (Levine, 1988; Lieberman, 1986). Self-help groups can offer a diverse, accessible, and inexpensive complement to professional help (Levine, 1988). It has been estimated that there are half a million self-help organizations in the United States (Katz, 1981). Prevalence

rates taken from a national probability sample suggest that 14 million adult Americans utilized self-help groups in the course of one year (Mellinger & Balter, 1983, cited in Lieberman, 1986). Government administrators have taken an increased interest in the prospective role of self-help groups in the formulation of national health policy (Epp, 1987; Koop, 1987, cited in Nicholaichuk & Wollert, 1989). An example is the fact that federal health agencies in the U.S. and Canada award funding to some mental health self-help organizations ("Drop Feared", 1988; Finnen, 1989).

Investigators of the functions of self-help groups have contended that the groups facilitate giving help to others, receiving help from others, and helping oneself (Riessman, 1985). Proponents of self-help groups have asserted that members acquire new information and coping skills in their groups, apply these abilities to their focal problem and to other problems in settings outside their groups, and become more likely to work for changes in economic and political institutions (Rappaport et al., 1985; Riessman, 1985). Professionals who want to promote social change have shown interest in identifying the central features of self-help groups and in specifying features that are precursors to advocacy. Information about these features would be useful to professionals who want to initiate, facilitate, or collaborate with self-help groups.

Similarly, people who are interested in establishing

self-help groups for themselves might want to promote certain attitudes among their members. For example, people who are planning to initiate a self-help group that emphasizes political advocacy might be interested in promoting different attitudes than people who are planning to initiate a group that emphasizes recreational outings. Information about the processes and beliefs in self-help groups that promote certain attitudes could be used to guide the creation and organization of new groups.

Some researchers (e.g., Levine, 1988; Salem, Seidman, & Rappaport, 1988) use "mutual help" instead of "self-help" to emphasize the premise that members of the groups of interest benefit from giving as well as receiving help. Mental health researchers and practitioners have taken a keener interest in these groups since the decline in government funding for social intervention programs in the United States (Jacobs & Goodman, 1985). Some researchers contend that these organizations can provide flexible, continuous social support and can thereby reduce the risk of rehospitalization among individuals with a chronic history of psychiatric disorder (Rappaport et al., 1985; Salem et al., 1988). Mutual help might thus be part of an important social movement in health care (Kronenfeld, 1986). This contention suggests that the research on mutual help group outcomes merits attention and review (Lieberman, 1986).

Self-Help Groups and Mental Health

In accordance with the principle that self-help groups are directed at enabling members to adapt and cope more effectively, several investigators have attempted to specify relationships between self-help group participation and members' mental health. Although controlled studies that use measures of mental health as outcome variables have become more frequent within the past five years, there have been few studies of mental and emotional well-being among members of mental health self-help groups. Studies of mental and emotional well-being in mental health self-help groups are reviewed because the present study focuses on self-help groups for people who have a history of psychiatric treatment. Evaluations of self-help groups for other kinds of problems are reviewed because some of the outcome variables in those studies are the same as some of the dependent variables in the present study.

Lieberman and Videka-Sherman (1986) used measures of general well-being, life satisfaction, self-esteem, mastery, depression, anxiety, and medication use to assess mental health in a self-help group for widows and widowers. The study included three comparison groups: (a) widows and widowers who did not want to join the self-help group; (b) a normative sample of widows and widowers matched with members on sex, age, race, and education; and (c) a general matched sample of people who were not widows or widowers. The

assessments were on two occasions, one year apart. Members and non-joiners were more distressed than the two normative samples at Time 1. Self-esteem, depression, and anxiety improved, and reliance upon medication decreased among the members who formed friendships with other members outside regular group meetings. Mental health did not improve among the widows and widowers who did not want to join the group. Depression improved, but the other aspects of mental health declined in the widows' and widowers' normative sample. Professional help did not contribute to the self-help group members' improvement. Social engagement in the self-help group resulted in improved mental health.

Videka-Sherman and Lieberman (1985) assessed marital role functioning, parental role functioning, and mental health in bereaved parents' self-help groups. The mental health measures were life satisfaction, self-esteem, mastery, depression, anxiety, somatic symptoms, and medication use. Comparison samples were bereaved parents who did not want to join groups and non-bereaved parents, matched with members on age, sex, race, education, and employment status. The assessments were on two occasions, one year apart. The two bereaved parents' samples had more marital and mental health problems than the non-bereaved parents at Time 1. Self-help group members' role adjustment and mental health did not improve, though the active members learned to attribute their anger and discomfort to

outsiders' insensitivity. Self-help group participation and psychotherapy did not compensate for the trauma caused by the child's death.

Lieberman (1990) assessed motherhood adjustment, marital adjustment, and mental health in new mothers' self-help groups. The mental health measures were the same as those in the previously cited study. Comparison groups were new mothers who did not want to join the self-help groups and a normative sample of mothers, matched with members on age and education. Again, the assessments were on two occasions, one year apart. Members and non-joiners had more parenting, marital, and mental health problems than the normative sample at Time 1. Self-help group participation did not result in improved mental health or marital functioning, and may have increased members' parental distress. The self-help group was not an important influence in members' lives.

Nicholaichuk and Wollert (1989) assessed health distress, attitude toward health action, and self-reliance in self-help groups for psychiatric disorders and chronic illnesses. The health distress measure included items that assessed anxiety, depression, and self-efficacy. Comparison groups were: (a) chronically ill non-members matched with members on age, sex, race, marital status, education, and chronicity; and (b) acutely ill non-members matched with members on the demographic variables. The researchers

hypothesized that self-help group members' distress level and treatment attitudes would be more similar to the acutely ill group than to the chronically ill group. Levels of distress among the self-help group samples were lower than in the chronically ill sample and were similar to those in the acutely ill sample. The self-help group members were as willing as the chronically ill group and more willing than the acutely ill group to take action in response to illness. There were no significant differences in self-reliance. The educational and supportive components of self-help groups may allow members to decrease anxiety, overcome denial, and effectively consult with their physicians to make informed decisions about health care.

Maton (1988) examined the relationship of group structure and support roles to group appraisal and members' well-being in self-help organizations for bereaved parents, overeaters, and multiple sclerosis. He surveyed members of five chapters of each organization. The group structure variables were order and organization, role differentiation, and leadership. Aspects of support roles were support given in relation to support received. Aspects of group appraisal were satisfaction and perceived benefit from group. Aspects of well-being were self-esteem and depression.

Comparisons indicated that the bereaved parents' groups were more orderly and organized and had more capable leaders than the multiple sclerosis groups. Role differentiation in

the overeaters' groups was greater than in the multiple sclerosis groups. Members of the bereaved parents' and overeaters' groups were more satisfied and reported greater benefits than members of the multiple sclerosis groups. Maton attributed these differences to the greater variety of needs, reasons, and expectations that individuals with multiple sclerosis may bring to their groups.

Regression analysis controlling for group type indicated that role differentiation was inversely related to depression and directly related to self-esteem. Organization was directly related to group benefits, and leadership was directly related to satisfaction. The three group structure variables together accounted for 87% of the variance in group benefits, 83% of the variance in satisfaction, 70% of the variance in depression, and 51% of the variance in self-esteem. Thus, group structure was strongly related to appraisal and well-being in these groups.

In each chapter, a median split identified four subgroups of members: (a) those who gave and received more support than other members; (b) those who gave but did not receive more support than others; (c) those who received but did not give more support than others; and (d) those who gave and received less support than others. Bidirectional supporters reported higher self-esteem, less depression, and greater benefits than the other three subgroups. Unilateral

providers were less satisfied than the other three subgroups. Unilateral receivers were the most depressed subgroup. These differences were not related to sex, age, social class, duration of membership, duration of problem, or type of group. Members who both gave and received support gained the greatest social and emotional benefits from their group.

Galanter (1988) assessed employment, psychiatric treatment, neurotic distress general well-being, social cohesiveness, and ideological commitment in Recovery Inc. (RI), a mental health self-help organization. Scores from a normative community sample were available for the well-being scale.

Participants were chapter leaders (mean length of membership = 14 years) and recent members (mean length of membership = 1.5 years). Individuals from the community sample were matched with participants on age and sex. Participants rated their current status and their recollection of what their status had been before joining RI. Members' current employment rate was higher than that reported before joining RI. Members' hospitalization rate since joining RI was lower than that before joining RI.

The percentages of leaders reporting psychotherapy and somatic treatments (medication and ECT) before joining RI were similar to the percentages of recent members reporting psychotherapy and somatic treatments before joining RI.

However, the percentages of leaders currently receiving psychotherapy and somatic treatments were significantly lower than the percentages of recent members receiving such treatment. Leaders' current rates of contact with nonpsychiatric professional help providers were also lower than recent members' rates. Leaders seemed to decrease their reliance on psychiatric treatment and professional help since joining RI. The percentage of members currently reporting significant nervousness and depression was smaller than that reporting significant problems before joining RI. Leaders and recent members reported significantly improved neurotic distress since joining RI. Leaders' and recent members' prior distress was not significantly different, but leaders' current distress was significantly lower than recent members' distress. Leaders' well-being was similar to that of the matched community sample, but recent members' well-being was significantly lower than that of the matched sample. Although validity is limited by a cross-sectional design and retrospective reports, these results suggest that length of RI membership is positively associated with mental health.

As indicated by responses to the social cohesiveness scale, the majority of participants cared about other RI members. In response to the ideological commitment scale, the majority affirmed that the RI program met their needs and agreed that their coping ability could improve through

more effective application of the RI method. Items from the social cohesiveness and ideological commitment scales predicted 17% of the variance of participants' well-being and 19% of the variance of decline in neurotic distress. These results indicate that affiliation and ideological commitment are directly related to RI members' mental health.

Kurtz (1988) assessed hospitalization rate, medication use, perceived benefit from medication, acceptance of disorder, ability to cope with disorder, and group satisfaction among former psychiatric patients who were members of the Manic Depressive and Depressive Association of Chicago (MDDA). The percentage of these members who reported that they had been hospitalized since joining MDDA was lower than the percentage reporting that they had been hospitalized before joining MDDA. The percentages of members who reported that they definitely took medication and benefited from medication since joining MDDA were also higher than the percentages who reported taking and benefiting from medication before joining MDDA. The majority of these members reported that their acceptance and ability to cope with disorder had improved since joining MDDA. These members reported that they were at least moderately satisfied with MDDA, and particularly rated its public lectures, support, and acceptance as valuable and important. Length of membership and extent of involvement

with MDDA were directly related to ability to cope with disorder and satisfaction, but were not significantly related to hospitalization or acceptance of disorder. Although validity is limited by retrospective reports, these results suggest that former patients' mental health improved since joining MDDA.

Although members usually express satisfaction and report improved coping ability since joining their groups, longitudinal studies do not consistently indicate that self-help group participation results in improved mental health, particularly when improvement is assessed by means of standard instruments (Lieberman, 1990; Videka-Sherman & Lieberman, 1985). Reports of improvement may be influenced by retrospective bias, because members expect to benefit from their groups and because groups can be expected to elicit reports of progress. Furthermore, most studies do not attempt to specify the features of self-help groups that may promote or hinder members' mental health.

In explaining why two organizations for new mothers did not benefit their members, Lieberman (1990) cites four sets of factors of central importance to self-help groups' success. First, groups need to foster acceptance, social support, and mutual commitment between members. Since the new mothers' organizations featured enjoyable meetings and low drop-out rates, it can be assumed that they offered some basic elements of group cohesiveness.

Second, Lieberman (1990) states that successful groups (a) persuade their members to behave in accordance with a set of prescriptive and proscriptive norms, and (b) offer salient experiences that are not available from other components of their members' social networks. The new mothers' groups presented a clear set of norms, but results indicated that the mothers did not frequently abide by them. Furthermore, since mothers reported that they relied more on advice from family members and their other friends than on advice from members, they were not significantly influenced by their groups.

Third, Lieberman (1990) claims that successful groups provide members with a diverse set of cognitive and emotional experiences. Successful groups (a) provide information that directly bears on members' presenting problems, and (b) emphasize processes such as universality, altruism, catharsis, identification, self-understanding, interpersonal learning, and communication of hope. Lieberman's results indicated that, though the new mothers' groups offered opportunities for community and social comparison, they were ineffective because they neither addressed members' adjustment problems nor emphasized processes that promoted understanding, emotional expression, or role change.

Finally, Lieberman (1990) states that successful self-help groups provide members with new ways of thinking. Most

groups promote a set of beliefs that is meant to alter members' means of coping with problems outside their group. Lieberman points out that the mothers' groups did not present an organized conception that addressed the career conflicts, loss of freedom, and marital difficulties that can result from parenthood. According to Lieberman, self-help groups that do not offer a clear conceptual framework for coping with problems may simply provide informal support. Thus, a conception of means for coping with problems may be a fundamental feature of an effective self-help group. The importance of such a conception, which investigators identify as a group's ideology, will be discussed at length in the following section.

Ideologies in Self-Help Groups

Definitions and Conceptions

The ideology of a self-help group has been defined as the epitome of the requirements that its members must meet if they are to recover from their problems. These tenets include explicitly prescribed beliefs, rules of conduct, slogans, and other statements (Antze, 1976, 1979). Antze (1976, 1979) and Suler (1984) made the following claims: (a) Self-help group members tend to hold some identifiable beliefs that are associated specifically with their focal problems; (b) self-help groups encourage members to adopt a new set of beliefs that enable them to learn new ways to cope with their problems; (c) each self-help group promotes

its own distinctive belief system, in accordance with the kinds of problems that its members present and the new coping responses that the group sanctions; and (d) explanations concerning the causes of problems and the ways they can be solved are important tenets of self-help groups' belief systems.

Several investigators contend that a self-help group's ideology provides members with elements of a new, more adaptive identity (Levy, 1979; Suler, 1984). Group tenets offer new criteria for self-evaluation and may thereby enable members to overcome self-ostracism resulting from evaluation according to normative ideals (Levine, 1988). Alternatively, individuals who fear stigmatization may resist self-disclosure and association with others with similar problems and, thus, may not be interested in joining self-help groups (Dixon, 1981).

Some investigators liken the process of becoming a committed self-help group member to that of religious conversion (O'Brien & Bankston, 1984). A self-help group's ideology can promote solidarity by establishing similarity among members, distinguishing members from non-members, and providing a shared set of concepts for discourse (Antze, 1976, 1979; Suler, 1984). The people who join self-help groups are often in crisis and may consequently be more inclined to adopt new convictions (Antze, 1979). According to Levine (1988), new members adopt a group's ideology after

identifying with the leaders, who use the group's language to illustrate how they have learned to master their problems. If members form close bonds, evaluate themselves according to the group's standards, and define themselves in terms of their status and role in the group, then self-help groups may become important reference groups. Alternatively, members who criticize or reject their group's prescriptions may drop out or engender group conflict (Jurik, 1987).

The ideology of a self-help group may be related to allocation of power and status in the group. Groups with authoritarian structures may require strict and unquestioning compliance to a set of unrealistic or rigid norms. For example, O'Brien and Bankston (1984) observed that a chapter of Overeaters Anonymous had two classes of members. Long-term members who believed in the organization's spiritual prescriptions for weight loss dominated the less successful, less committed members. In contrast, members of GROW, a network of groups for former psychiatric patients, are exhorted to "love people back to health," and are told that "to really help a maladjusted fellowman we must so value and appreciate him that he becomes aware of his tremendous value and worth" (GROW, 1981; McFadden, 1987, cited in Levine, 1988). Self-help groups that construe problems and solutions in collectivist terms might have more equitable power structures and might

have more uniformly self-assured members than groups that prescribe change through moral effort.

Several investigators contend that ideological endorsement is necessary if groups are to help their members change. Antze (1979) asserted that a group's ideology provides members with a set of beliefs that they need to counter their problem. Suler (1984) argued that self-help group members learn to define causes of their problems, specify goals for themselves, and identify means for attaining their goals by adopting their group's precepts. Levine (1988) stated that (a) adoption of the group's ideology may be a precondition for giving and receiving effective emotional and instrumental support, (b) use of the group's concepts to designate everyday experiences can direct members' everyday choices outside the group, and (c) application of tenets to more and more sectors of life experience tends to enhance members' adaptation outside the group.

Suler (1984) argues that there is a need to assess potentially beneficial and potentially detrimental implications of ideology in self-help groups. An important issue in the study of ideologies in self-help groups is whether groups foster internal or external attributions for members' problems. Though emphasis on internal attributions may correlate with emphasis on changing members' personal characteristics, emphasis on external attributions may

correlate with emphasis on social and political change (Jurik, 1987; Suler, 1984).

Brickman, Rabinowitz, Karuza, Coates, and Kidder (1982) presented a typology of helping conceptions based on attribution theory. Brickman et al. contended that adoption of a particular conception of help relates to psychological characteristics of the members of helping relationships and to the effectiveness of helping programs in several domains. They conceptualized beliefs about help in terms of a two-dimensional matrix. The first dimension of the matrix describes attributions about responsibility for problems. The second dimension describes attributions about responsibility for solutions. This matrix is presented in Table 1. According to a medical model of help, recipients are not responsible for their problems and are not responsible for the solutions to these problems. For example, Rabinowitz (1978) found that students in an infirmary waiting room tended to see themselves as sick, not responsible for their problems, and in need of the help of skilled professionals.

According to an enlightenment model of help, recipients are responsible for their problems but others are responsible for the solutions to these problems. For example, members of the Campus Crusade for Christ tended to see themselves as self-destructive and in need of guidance

Table 1

Attributions of Responsibility to Self in Four Models of Help and Coping

Responsibility for Problem	Responsibility for Solution: High	Responsibility for Solution: Low
High	Moral Model	Enlightenment Model
Low	Compensatory Model	Medical Model

Note. From "Models of helping and coping", by P. Brickman et al., 1982, American Psychologist, 37, 368-384. Copyright 1982 by American Psychological Association.

from others with similar experience (Rabinowitz, 1978). Alcoholics Anonymous requires that members take responsibility for their past drinking and then entrust their lives to God and AA (Antze, 1976; Gartner, 1976). Brickman et al. (1982) cite AA as an example of a group that may adopt the enlightenment model.

According to a moral model of help, recipients are responsible both for their problems and for solutions to these problems. Typical proponents of this model are Erhart training seminar (EST) graduates, who see themselves as responsible for their past, present, and future (Brewer, 1975; Rabinowitz, 1978).

Finally, according to a compensatory model of help, recipients are not responsible for their problems but are responsible for the solutions to these problems. Members of a Comprehensive Educational Training Administration (CETA) work training program, who see themselves as deprived individuals needing temporary help, typify proponents of a compensatory model of help (Rabinowitz, 1978). The medical, enlightenment, moral, and compensatory models of help can be used to analyze the attributions about problems and solutions that may be implicit in self-help groups' ideologies.

Types of Self-Help Groups

Levy (1976, 1979) distinguished between behavior control groups and stress coping self-help groups. Behavior control groups are directed at decreasing or eliminating harmful habits. Groups for alcoholics, gamblers, and abusive parents are examples of behavior control groups. Stress coping groups are directed at remedying the damaging effects of an unfortunate life event. Bereavement, divorce, and chronic illness are examples of problems addressed by stress coping groups. Levy (1979) classifies mental health self-help groups as stress coping groups based on an assumption that mental and emotional problems can be relieved but not eliminated. Ideologies in behavior control groups have been studied more closely than ideologies in stress coping groups and will therefore be discussed first.

Ideological Differences in Behavior Control Groups

Antze (1976, 1979) compared the ideology of Alcoholics Anonymous with that of Synanon, a self-help organization for heroin addicts. Antze argued that male alcoholics have a high need for power and overestimate their control over events in their lives. Their exaggerated estimation of their own influence disposes alcoholics to blame themselves when their plans fail, to drink to assuage their guilt, and to believe that they can stop drinking whenever they wish. The canons of Alcoholics Anonymous state that alcoholics are

not able to control their drinking, that their attempts to control their lives are vain and unrealistic, and that events that they thought they could control are actually controlled by a higher power (Alcoholics Anonymous, 1955). Antze (1976, 1979) argued that AA's ideology replaces alcoholics' belief that they are able to drink or stop drinking whenever they like.

In his analysis of Synanon, an organization for treating heroin addition, Antze (1976, 1979) argued that heroin addicts have two definite characteristics: (a) they are exquisitely attuned to precursors of physical pain; and (b) they seek to blunt the emotional impact of events by using heroin and avoiding social contact. The Synanon ideology calls for sessions of training in strict deportment alternated with sessions of cathartic self-expression. In the first condition ("the Floor"), members must believe that whatever they do is important but that their feelings are unimportant. In the second condition ("the Game"), members must believe that they should vent all suppressed feelings, as if they are in an "emotional bathroom." Antze argues that these phases alert addicts to the social antecedents of distress and teach them to attribute emotional states to aspects of social interaction instead of to heroin use or withdrawal. These methods of changing the ways that addicts construe emotions decrease their temptation to rely on heroin as their source of pleasure or relief.

There are some occasions when several different groups are available to people who have a defined problem. For example, a person who wants to lose weight might choose between Overeaters Anonymous and Take Off Pounds Sensibly. Each of these groups has a different ideology of weight control.

Norman (1983) has been the only researcher to compare two self-help groups with similar purposes but different ideologies. Lose Extra Weight Sanely (LEWS)[1] and Overeaters Anonymous (OA) are intended to help their members lose weight by controlling overeating. According to Norman, OA fosters toleration and acceptance in members because it does not blame them for overeating or for failures in their attempts to stop. Like Alcoholics Anonymous, OA suggests a 12-step program for recovery in which overeaters are exhorted to admit that they are powerless over food, to confess their shortcomings, and to surrender their lives to God. This ideology treats overeating as a compulsion that must be overcome through self-transformation.

In contrast, LEWS members compete with each other to lose weight (Norman, 1983). Members are applauded if they lose weight and can be fined or ridiculed if they gain weight. Each chapter publicizes its contests and awards to other chapters. The LEWS pledge exhorts members to control

---

[1]A pseudonym, probably for an organization named Take Off Pounds Sensibly (TOPS).

their emotions and to think of themselves as mature individuals. This pledge implies that people overeat only because they are lazy or immature. Accordingly, members of LEWS say that they value competition and feel foolish if they do not meet their goals.

Norman's (1983) comparison between OA and LEWS suggests that ideological differences between behavior control groups may relate to differences in the ways members perceive themselves in relation to their problems. With the exception of Antze's (1976, 1979) examination of Recovery Inc. (to be discussed in the following section), detailed analysis of self-help ideology has been limited to behavior control groups. By inquiring into relations between ideology and member characteristics in groups for former psychiatric patients, the present study is the first to examine the importance of ideological differences between stress coping groups with similar purposes.

Ideologies in Groups for Former Psychiatric Patients

In August, 1986, the second annual national U.S. convention for people with a history of psychiatric treatment split into factions led by two nationwide organizations. In 1987, the two organizations held competing conventions at the same site. One organization, the National Mental Health Consumers Association (NMHCA) presents itself as a civil rights organization. Emerick

(1989, 1990) describes NMHCA as a moderate-to-conservative organization. One of NMHCA's goals is to gain equal status and representation for mental health consumers on policy-making boards. In pursuit of this goal, it is willing to form coalitions with government agencies and self-help organizations for people with a mentally ill family member. However, NMHCA's pro-civil rights ideology is compromised by its leader's position that involuntary hospitalization and treatment is sometimes justified (Rogers, 1988).

The National Alliance of Mental Patients (NAMP), now renamed the Nation Association of Psychiatric Survivors (NAPS), led the second faction of the 1986 and 1987 conferences. Emerick (1989, 1990) classified NAMP-NAPS as a radical separatist organization because it does not allow professionals within its membership. NAMP-NAPS points to economic and societal factors as contributing causes of mental and emotional distress and has worked uncompromisingly for the abolition of involuntary commitment and forced psychiatric treatment (NAMP, 1987). The division between NAPS and NMHCA suggests that ideological differences between mutual help organizations for former psychiatric patients can take on political significance. Brickman et al.'s (1983) four models of help will now be applied in an attempt to explicate ideological differences between self-help groups for former psychiatric patients.

Brickman et al. (1983) argued that collective social

action groups are special cases of agencies that adopt a compensatory model because they aim to control their circumstances and are committed to permanent struggle against an adversary. Chamberlin (1984) identifies affiliates of the ex-patients' liberation movement as active members of a political coalition. These affiliates communicate through regular publications, (e.g., Dendron, Madness Network News), conventions, (e.g., the North American Conference for Human Rights and Against Psychiatric Oppression), and regularly scheduled teleconferences.

Chamberlin (1984) described the principles of self-help groups for former psychiatric patients that identify themselves as part of a political movement:

> It is through working together with others who have had the experience of being defined as "mentally ill" that I have become strong....I have been involved in the psychiatric inmates' liberation movement, and my experience, first as a victim of psychiatric control and now as one who struggles against it, have convinced me of the need for true alternatives, run and controlled by their communities and their clients...Often, as patients, we have been taught that our failures are due to permanent defects, and it is only within the ex-inmate group that an individual will be praised and admired for his or her accomplishments (pp. 56-57).
>
> One of the primary functions of ex-inmate groups is to empower their members. Indeed, a growing sense of self-worth and ability is a frequent experience among people who join these groups...The ex-inmates' movement proposes the development of user-controlled alternatives, which promote independence and competence (p. 58).
>
> It is important to remember that so-called "mental health problems" are largely political problems, not individual ones. The medical model

> speaks of individual defects and pathology, ignoring the economic/social/political context of people's lives. Psychiatric diagnoses and "treatments" are functions of power and powerlessness...The psychiatric inmates' liberation movement is making these power relations explicit: Mental health professionals tend to ignore them. As people recognize that it is larger social forces and not their presumed medical inferiority that are responsible for their plight, they become better able to work together to devise collective solutions (p. 63).

The Mental Patients' Association in Vancouver, the Mental Patients' Liberation Front in Boston, and the Committee to Stop Psychiatry in Springfield, Massachusetts have been part of the movement for former psychiatric patients. The excerpts cited above suggest that these organizations characterize their members as people with difficulties that have been imposed on them by the institution of psychiatry and who are working together to overcome them. They imply that groups that are part of the movement for former psychiatric patients increase the self-esteem, competence, and power of their members. Affiliates of the liberation movement for former psychiatric patients can be expected to endorse a compensatory model of help.

According to Brickman et al. (1982), helping agencies apply an enlightenment model when people request help for undesirable impulses and behavior that are beyond their control. They argue that Alcoholics Anonymous is an example of an enlightenment model organization because it requires new members to own up to their history of drinking, admit

that it is beyond their control, and acknowledge that they can stop drinking only with the help of God and AA. Thus, a self-help group that endorses the enlightenment model would expect members to claim responsibility for problems but credit the group for helping to overcome them.

The mental health self-help organization Emotions Anonymous (EA) is patterned after Alcoholics Anonymous. EA's ideological tenets are adapted from the Twelve Steps of Alcoholics Anonymous (see Table 2). AA and other Twelve Steps organizations are a referral source for EA members (Kurtz & Chambon, 1987). According to EA, people with emotional difficulties make their problems worse by becoming disagreeable, making excuses, and misusing prescription drugs or other substances (Emotions Anonymous, 1974). On the other hand, the organization's literature states that EA unity is the condition for personal recovery and that the common welfare of EA members has precedence over the interests of any individual member (Emotions Anonymous, 1986). These tenets suggest that EA groups hold their members responsible if their problems worsen but attribute responsibility for resolving problems to God or EA rather than individual effort. These aspects of EA's ideology indicate that the organization endorses an enlightenment model of help.

Table 2

The Twelve Steps of Emotions Anonymous

1. We admitted we were powerless over our emotions--that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of his will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message and to practice these principles in all our affairs.

Note. From Welcome to Emotions Anonymous: Handout to New Members, pamphlet available from Emotions Anonymous International Services, PO Box 4245, St. Paul, MN. Revised 1986 by Emotions Anonymous.

Brickman et al. (1982) state that the medical model of help is applied whenever the parties in a helping relationship designate problems as diseases that have befallen the recipients and will remain beyond their control. Several mental health self-help organizations that identify themselves by their members' diagnosis endorse an illness conception of mental and emotional problems. Some of these organizations include family members as well as people who have a history of psychiatric disorder. The National Depressive and Manic Depressive Association (NDMDA) is one example of such an organization. NDMDA declares that affective disorders are biochemical illnesses which disrupt the lives of patients and their families but can be treated successfully through medication, therapy, and comprehensive support (NDMDA, 1986). These positions suggest that NDMDA could be expected to endorse a medical model of help.

Results of studies by Levy (1981) and by Medvene and Krauss (1989) indicate that self-help organizations for families of the mentally ill, including those that have some members with a history of disorder, tend to attribute psychiatric problems to organic causes. Medvene and Krauss (1989) argue that these attributions may reduce parents' risk of self-blame and promote their comfort in relationships with the disabled family member. Self-help organizations that include both family members and former patients can be expected to favor a medical model of help.

According to Brickman et al., (1982), agencies attributing problems to laziness or lack of effort endorse a moral model of help. Recovery Incorporated (RI) appears to be the most extensive self-help organization for people with psychological problems. It has a formal leadership hierarchy and was founded by a psychiatrist, who wrote the book containing its ideology (Medvene, 1985). According to Mental Health Through Will-Training (Low, 1950), people are endowed with an invincible Will and are able to choose their thoughts and feelings. People with emotional problems who claim to be overwhelmed by stress are willfully self-indulgent or are resisting the efforts of their physicians. People who are distressed can feel secure by acting normal. These tenets imply that people with emotional problems bring them on themselves and can overcome them through effort and compliance with authority. RI appears to be the self-help organization for people with mental and emotional problems that would be most likely to promote a moral model of help.

Antze (1976, 1979) and Grosz (1972) asserted that people who join Recovery Incorporated tend to have intermittent attacks of acute distress. Antze argued that RI members are able to overcome and manage their distress by believing that action is important and feelings are negligible. This belief enables members to replace a sense of sickness with self-confidences and initiative. Antze claimed that by discounting distress, RI members become more

self-confident, show more initiative, and are able to overcome the tendency to believe that they are sick and helpless.

In summary, then, ideologies of self-help groups for former psychiatric patients differ with regard to attributions about responsibility for members' problems and with regard to attributions about responsibility for prescribed solutions. Some organizations, such as the Mental Patients' Liberation Front, do not appear to hold their members responsible for their problems, but appear to hold them responsible for solutions to these problems. Groups modelled after Alcoholics Anonymous appear to hold members responsible for their problems but not for solutions to problems. Groups that endorse biological theories of etiology and intervention do not appear to hold their members responsible for either problems or solutions. Recovery Inc. seems to hold its members responsible for their problems and for solutions to them.

Examples suggest that the differences between ideologies in self-help organizations for former psychiatric patients may have significant psychological concomitants. Aspects of social functioning within self-help groups that might promote endorsement of a group's ideological tenets will now be considered.

Social Relationships in Self-Help Groups

Comparisons of Self-Help Groups with Other Kinds of Groups

Levy (1979) formulated a conception of interpersonal processes in self-help groups, defined 28 interaction patterns that are aimed at changing members' beliefs and behavior, and argued that those patterns are specific to self-help groups. Included among them are patterns that establish a context for a member's problem, present new facts about the problem, specify cause-effect relationships that bear on the problem, and offer a wider range of alternatives for a solution. Levy argued that such patterns enable self-help group members to improve their understanding of their problems and cope with their problems more effectively.

In a comparison of self-help groups with civic, political, religious, and recreational groups, Politser and Patison (1980) found that self-help groups emphasize cooperation, interrelatedness, conformity with a specified behavior code, and adherence to an explicit belief system. Results of several studies comparing self-help groups with psychotherapy groups indicate that while both types of groups emphasize supportive interactions such as empathy, catharsis, and affirmation, interactions that involve anger, confrontation, and criticism occur less often in self-help groups than in psychotherapy groups (Hill, 1975; Lieberman, 1979; Toro, Rappaport & Seidman, 1987; Wollert, 1986;

Wollert et al., 1982). Within self-help groups, discussion tends to limit reference to a single common problem and members are reinforced for progress towards a fixed goal (Riordan & Beggs, 1988). Interaction in self-help groups involves less emphasis on interpersonal feedback, relies less on formal behavioral interventions, and is not as flexible as interaction within psychotherapy groups (Toro et al., 1987; Wollert, 1986; Wollert et al., 1982). These findings suggest that self-help group members seek solutions to their common problem through supportive interaction.

Differences Between Self-Help Groups for Dissimilar Problems

Self-help groups can differ in structure and can vary in their emphasis on certain interaction patterns. An example of this variation is found in Maton's (1988) comparison of chapters of self-help organizations for three different kinds of problems. Members' reports suggested that chapters of Compassionate Friends (for bereaved parents) were more orderly, more organized, and had more capable leadership than Multiple Sclerosis chapters. Overeaters Anonymous chapters were perceived as having greater role differentiation than Multiple Sclerosis chapters. According to Maton, group satisfaction and perceived group benefits were greater in the Compassionate Friends and Overeaters Anonymous chapters than in the Multiple Sclerosis chapters. Maton argued that Multiple

Sclerosis chapters had lower levels of organization, order, role differentiation, and leadership capabilities than those found in Overeaters Anonymous chapters and Compassionate Friends chapters because multiple sclerosis sufferers may bring a wider range of needs and expectations to their groups.

Wollert et al. (1982) compared the prevalence of different interpersonal processes in two sets of self-help groups. Activities such as reinforcement, modeling, and extinction were more prevalent in groups for alcoholics, abusive parents, and overeaters than in groups for recovering heart surgery patients, divorced parents, and people with mental and emotional problems. Thus, behavioral interventions have a more substantial function in groups directed against harmful habits than in groups attempting to mitigate a traumatic event.

The aspect of interaction regarded as most helpful varies between self-help groups for different problems (Droge, Arnston & Norton, 1986; Llewelyn & Haslett, 1986). Universality (the realization that one is not alone) is the most helpful pattern in widows' groups, perhaps because it decreases the isolation that can be a major feature of bereavement. Altruism, sharing common experiences, and insight are the most helpful patterns in epilepsy groups, perhaps because they decrease the sense of devaluation, alienation, and helplessness that can result from

stigmatization. Guidance (advice about the problem) is the most helpful process in asthma groups, perhaps because it increases members' sense of self-efficacy. In contrast, depressives much prefer cohesiveness (acceptance and support) over guidance, perhaps because they appreciate unconditional assurance but resist tacit demands for change. Thus, members' evaluations of interaction patterns might be related to the needs that they bring to their self-help groups.

Evaluations of group interaction patterns can also vary with the extent of members' involvement in their group. Members of epilepsy groups (Droge et al., 1986) are similar to those of asthma and widowhood groups (Llewelyn & Haslett, 1986) in viewing self-disclosure as the least helpful pattern. However, support and advice are more important to epilepsy sufferers who contact other members outside group meetings than to members who limit their contact to group meetings. Thus, patterns that elicit intimacy and direct attention to solutions may be more valuable to committed members than to members who take a casual interest in the group.

Interaction Patterns in Mental Health Self-Help Groups

A team of investigators has been conducting a longitudinal study of GROW, a mutual help organization for individuals with mental and emotional problems. Preliminary

assessments using continuous in vivo coding techniques indicate that 33% of the verbal communication between members at meetings entails self-disclosure, explanation of other members' experiences, or direct offers of guidance and support (Rappaport et al., 1985). Social climate in GROW groups is more structured, more cohesive, includes greater emphasis on socializing and problem-oriented tasks, encourages greater independence, and provides members with more prominent leadership roles than social climate in psychotherapy groups (Toro et al., 1987).

Recent presentations suggest that emphasis on agreement, information-giving, guidance, questioning, and self-disclosure varies between GROW meetings (Luke, 1987, cited in Levine, 1988). Nevertheless, GROW members report that communications of encouragement, support, hope, and help to others are more important than communications that emphasize emotional expression and psychological understanding. Unlike experts who observe GROW meetings, members prefer meetings with low levels of personal questioning over meetings in which personal probing is emphasized (Rappaport, 1988). The investigators argue that GROW's supportive climate is consistent with its position that help and concern for others are conditions for personal improvement.

Interestingly, Rappaport (1988) reported that although individual differences predict who will attend a few initial

meetings of GROW, group interaction variables predict who will attend more than three meetings. Individuals who appear to be higher functioning and who appear less likely to have been hospitalized tend to stop attending after only a few meetings. Furthermore, even individuals who appear to be in crisis and to have been hospitalized tend to drop out shortly after their third meeting if their first two meetings are characterized by negative talk and lack of support. These observations suggest that within the population of individuals who visit mental health self-help groups, group process variables may be the determining factor during a critical period in which someone decides whether or not to become a regular member.

Lavoie (1981) compared social climate in a Recovery Inc. chapter with social climate in a self-help group for single parents. RI has a hierarchical leadership, recruits and trains members according to explicit policies, conducts meetings according to formal procedures, and instructs members to use the methods for managing mental and emotional problems prescribed by a psychiatrist, Dr. Abraham Low. Each RI chapter has only one appointed leader (Low, 1950; Raiff, 1984). Lavoie observed that both groups encouraged support and cohesiveness but discouraged anger and aggression. However, Lavoie also observed higher control by the leader and lower levels of innovation, self-disclosure, and expressiveness in the RI chapter than in the single

parents' group. These observations suggest that RI's didactic leadership structure may influence the interpersonal processes in meetings.

The members of Emotions Anonymous groups take turns reading from the organization's literature at the beginning of each meeting. A member then introduces one of EA's Twelve Steps and illustrates it by telling a story to testify the effect of the EA program on his or her life. The speaker recounts the event that led to his or her entry into EA, describes what life was like before entering it, then describes what his or her life has been like since being in the program. Meetings end with a closing statement and a prayer (Kurtz & Chambon, 1987). Ryback (1971) observed that meetings of Schizophrenics Anonymous, a defunct organization, followed a similar format, except that meetings for veteran members were separate from meetings for new members. Like Emotions Anonymous, Schizophrenics Anonymous patterned its meeting format and Twelve-Step philosophy after the format and philosophy of Alcoholics Anonymous.

Some mental health self-help organizations include people who have a family member with a history of disorder. The National Depressive and Manic Depressive Association (NDMDA) is one such organization. Kurtz (1988) reported on demographic characteristics, diagnoses, treatments, programs, satisfaction, and perception of outcome within the

Manic Depressive and Depressive Association of Chicago (MDDA), which is the founding chapter of NDMDA. Patient members of MDDA are similar to members of GROW (Rappaport, 1988) and members of a self-help group for depressives (Llewelyn & Haslett, 1986) in reporting that acceptance and support are their organization's most important benefits. Family members report, however, that information is the organization's most important benefit to them. Acceptance and support may counteract patients' sense of stigma, while information may reduce family members' confusion and helplessness by increasing their knowledge of psychiatric disorders (Medvene & Krauss, 1989).

The National Schizophrenia Fellowship (a British organization) and the Society for Depression and Manic Depression (based in Manitoba) are two other mental health self-help organizations that include family members. Although an observer's report suggests that family members in the former organization sometimes use group meetings as a forum to air complaints about their afflicted kin, members of both organizations state that their group meetings emphasize mutual exchanges of empathy, explanation, and support (Finnen, 1989; Levy, 1981).

Informal reports state that identification of achievable objectives, specification of solutions to problems, and practice in essentials of decision-making, as well as acceptance, encouragement, and mutual support are

emphasized in some other mental health self-help groups (Group de support emotionnel Inc., 1989).

To review, both informal reports and systematic inquiry suggest that some of the social interaction patterns in mental health self-help groups can be specified and distinguished from those in psychotherapy groups and self-help groups for other kinds of problems. Some interaction patterns may also be related to aspects of a group's leadership style. In the following section, it will be argued that some interaction patterns may relate specifically to the likelihood of members endorsing the ideological tenets of their group.

Interaction Patterns That Promote Belief in Group Tenets

Sharing

Some theorists argue that self-help groups refer to members' experiences and, thereafter, reconstruct and reconceptualize them to fit the group's terms (Van der Vort & Van Harboorden, 1985). They argue that self-expression provides the group with information which it can use to formulate members' problems in its own terms. As members share more of their experiences and describe them using the group's terms, they may become more committed to their group's conception of help (Antze, 1976, 1979; Jurik, 1987; Levine, 1988; Watts, 1967; Yalom, 1985). This process of talking with other members about everyday experiences,

thoughts, and feelings is called sharing. Sharing is reported to be one of the most common and most important processes in self-help groups for people who are experiencing severe long-term stress (Wollert et al., 1982). If it is true that self-help groups tend to formulate members' experiences in the group's terms, then emphasis on sharing should be related to members' tendency to endorse their group's tenets.

Empathy

Members of stress coping groups report that empathy is the most important activity in their groups (Wollert et al., 1982). Empathy is the process wherein other members respond to an expression of emotion with assurances that they understand and share a member's feelings. Empathy conveys reciprocation, validates an individual's experiences, and relates experiences to membership in a community. This sense of community demarcates the group as a unit with its own distinctive practices and beliefs, reduces members' anxiety and alienation, and thus enables members to become more receptive to adopting the group's beliefs. Therefore, it can be predicted that emphasis on empathy would encourage members to endorse their group's tenets.

Explanation

Members report that explanation is second only to empathy as an important process in stress coping groups (Wollert et al., 1982). Explanation is the activity through which members help each other to better understand themselves and their reactions to situations (Wollert et al., 1982). Group terminology becomes meaningful when it is used to explain members' experiences. Group terminology can reduce uncertainty and can provide a basis for making everyday decisions if members apply it to everyday experiences outside their group (Suler, 1984). If members are confused about themselves and their situations, or if they are not already committed to another explanation of their problems, then they will be inclined to accept their group's explanations. Therefore, it can be predicted that emphasis on explanation will be related to members' tendency to endorse their group's tenets.

The influence of explanation, empathy, and sharing is apparent in the following example of processes that promote endorsement of the ideology of Recovery Inc. Jurik (1987) gave a detailed analysis of the process through which individuals join RI and adopt its ideology. On the basis of case histories, observations, and interviews with 17 members and three dropouts in a representative sample from seven RI groups, she defined successfully affiliated members as those who: (a) attended at least three weekly group meetings per

month; (b) stated that they accepted the accuracy of Dr. Abraham Low's philosophy and would be willing to try to convince others of its accuracy; and (c) were observed to report successful application of RI principles in at least four or five panel discussions in group meetings.

Jurik (1987) argued that identification with other group members is a crucial condition for a new member's continued participation and adoption of the organization's precepts. Identification involves (a) the perception that other members are friendly, receptive, and concerned about helping and (b) the perception that his or her own experiences are similar to the nervous symptoms recounted by veteran members. People who dropped out of RI observed discrepancies between their background characteristics and the group.

Jurik (1987) also argued that members adopt RI's ideology through a process of persuasion. The process has three phases: (a) members are persuaded that the decision to join RI is a turning point in their lives; (b) members are taught to identify their problems as resulting from psychological tensions that they are able to control; and (c) members are encouraged to apply RI techniques to problems in their daily lives and are convinced to interpret life events as examples of the successful application of RI methods. These phases are consistent with the conception of ideological endorsement offered by Levine (1988).

During the first phase, veteran members cite examples from their own early experiences to point out similarities to those of new members, explain their decision to join RI, and praise the significance of the new member's decision to try the group.

During the second phase, the group prescribes explanations for problems using RI's terms. Members are induced to explain that they can solve their problems by modifying their reactions to situations and are sanctioned against attributing problems to historical or current circumstances.

During the third phase, which begins at about the time of a member's fifth meeting, veteran members assure new members that RI techniques can lead to success only through work and perseverance. They share the setbacks and doubts that preceded their acceptance of Dr. Low's precepts. Any attempt to apply RI methods is called an improvement; members are assured that they may have used RI techniques even without being aware of them. Members' current behavior is contrasted with accounts of their behavior before joining RI; merely thinking of RI techniques is endorsed as progress. Occasions when RI techniques could have been applied but were not are discussed in sessions called "I Need Help." Jurik (1987) observed that, as members participate in more panel discussions, the frequency and intensity of their expressions of enthusiasm for RI methods

increase, and their expressions of hesitation and confusion diminish. At this point, members tend to report significant improvement in their lives, attribute improvement to their use of RI methods, and approach others to persuade them to accept RI's methods and ideals. Jurik's analysis suggests that this last phase is the crucial period in which members adopt RI's ideology.

Self-Help Group Involvement and Belief in Group Tenets

Analysts of self-help group ideologies tend to assume that a group's members uniformly adopt its tenets (Antze, 1976, 1979; Suler, 1984). However, members vary in the extent of their involvement with their group. Findings from several studies are converging to indicate the aspects that define the extent of a member's involvement in his or her self-help group. Research conducted on groups for various kinds of problems tends to employ the following indicators of involvement: (a) regularity of attendance, (b) formation of social relationships with members outside group meetings, and (c) bidirectional support in relationships with fellow group members. These findings will be reviewed in an attempt to specify aspects of involvement that may relate to members' endorsement of their group's tenets.

In an early contribution to the literature on the importance of member involvement in self-help groups, Videka-Sherman and Lieberman (1985) designated individuals

who attended meetings regularly, assumed a leadership role, and gave or received support outside group meetings as the active members of a bereaved parents' group. They found that active members were more likely than other members to adopt their group's position of externalizing anger, attributing members' emotional discomfort to outsiders' insensitivity, and recognizing that there are some good ways for outsiders to respond to members' grief.

In a longitudinal outcome study of self-help groups for widows and widowers, Lieberman and Videka-Sherman (1986) refined their classification scheme by defining members who attended meetings regularly, gave or received support outside meetings, or said that at least one of their best friends was a group member as the members who had some social linkages to others in their group. They found that members who attended meetings regularly and met either of the other two criteria benefited from the group. Members who attended regularly yet did not form social linkages did not benefit from the group.

In a comparison of self-help organizations for overeaters, bereaved parents, and people with multiple sclerosis, Maton (1988) analyzed social linkage even further by differentiating between members who were bidirectional supporters, support receivers, support providers, and low supporters. He defined bidirectional supporters as those members whose scores for both support provided and support

received exceeded the median score for their organization. Bidirectional supporters reported lower levels of depression, higher self-esteem, greater benefits, and greater group satisfaction than other members. Receivers reported greater depression but also greater satisfaction with their groups than did providers or low supporters. Providers reported less satisfaction than other members of their group.

Recent presentations on GROW suggest that members can vary in the extent of their involvement in the organization and that the organization may generate several different kinds of social network clusters (Salem, 1987; Stein, 1987, cited in Levine, 1988). Studies of other mental health self-help organizations also distinguish between levels of members' involvement (Jurik, 1987; Kurtz, 1988; Rappaport, 1988). In conjunction with the results of Maton's study and the two studies conducted by Videka-Sherman and Lieberman, findings from these studies indicate that members who attend meetings regularly, are bidirectional supporters, form friendships with fellow group members, and contact other members outside regular group meetings are those who may be most likely to identify with their group and endorse its positions about help.

Thus far in this review, general issues in self-help group research have been identified, the possible importance of ideology in self-help groups for former psychiatric

patients has been defined, and processes that might promote ideological endorsement in such groups have been proposed. In addition, a taxonomy for classifying belief systems in self-help groups according to four different major conceptions of help has been introduced. Possible relationships of help conceptions to differences in psychosocial adaptation and appraisal of mental health services among members of self-help groups for former psychiatric patients will now be considered.

Model of Help, Adaptation, and Attitudes in Self-Help Groups

Self-Esteem and Sense of Mastery

Self-esteem has been conceptualized in a multitude of ways by several different theorists (Wells & Marwell, 1976). For the purposes of this study, self-esteem is defined as the positive or negative evaluation that an individual gives to all of his or her characteristics on a particular occasion. According to this conception, such an evaluation can differ across situations and/or over time. For instance, people may esteem themselves highly in one setting but not in another. More specifically, self-help group members might have high self-esteem in their groups but have low self-esteem in other settings.

Sense of mastery is defined as the extent to which people perceive life changes to be under their own control (Pearlin & Schooler, 1978). This concept includes the

belief that one can act on one's intentions, deal with the problems of life, and control events in one's own life (Pearlin & Schooler, 1978). Mastery entails some aspects of self-efficacy (Bandura, 1977), helplessness (Seligman, 1975), and locus of control (Rotter, 1966), but arguably is a simpler, clearer concept (Oakes, 1982; Palenzula, 1984; Tennen, 1982).

Self-esteem and sense of mastery are characteristics that help people withstand environmental threat (Pearlin & Schooler, 1978). People who have high self-esteem and believe they can master their environment adapt more successfully to occupational and domestic problems. Each of these two characteristics independently reduces the psychological impact of such problems. Stress reduction due to these characteristics is independent of stress reduction due to specific coping acts. Thus, self-esteem and mastery can be expected to mediate general psychosocial adaptation.

People who evaluate themselves positively and believe that they can act effectively tend to be more willing to act on their problems than people who denigrate themselves or believe that their actions are ineffectual. For example, people who receive help that supports their self-esteem engage in more self-help than people who receive help that threatens their self-esteem (Morris & Rosen, 1973). People with high self-esteem solve problems more accurately after being helped, but people with low self-esteem make more

errors after being helped (DePaolo, Brown, & Greenberg, 1983; DePaolo, Brown, Ishii & Fisher, 1981).

People who are self-confident and believe that their actions are effective may perceive more courses of action as available to them in a given situation than people who denigrate themselves or feel ineffectual. People who deprecate themselves or think that their acts are futile may exclude certain alternatives from consideration ("I'm not competent enough to do that," "That won't work for me"). Thus, self-esteem and sense of mastery may relate to the diversity of coping responses that a person is likely to initiate.

A history of hospitalization might relate to self-esteem and sense of mastery among former psychiatric patients. As a consequence of a debilitating disorder, or of the stigma or discrimination associated with hospitalization, psychiatric inpatients might come to doubt their ability to cope with ordinary life situations. Such beliefs might be especially prevalent among people who had been involuntary inpatients or whose affairs are legally controlled by a family member, guardian, or trustee. These considerations suggest that inpatients, and especially those who have been involuntarily hospitalized, may have lower self-esteem and sense of mastery than other people with psychological problems.

Relation of Model of Help to Self-Esteem and Mastery

Model of Help and Sense of Mastery

Brickman et al. (1982, 1983) argued that the model of help adopted by members of helping relationships bears on the fairness and effectiveness of helping attempts. Their theory can be used to make predictions about psychological characteristics of self-help group members.

Brickman et al. (1983) defined fair help as that which redistributes resources so that deserving people get what they need. Agencies that endorse the compensatory and medical models do not blame recipients for problems. Consequently, they are more likely to provide fair help than agencies that endorse the moral and enlightenment models. Moreover, Brickman et al. (1983) defined effective help as that which promotes recipients' chances of meeting their own needs. Agencies that endorse the compensatory and moral models hold recipients responsible for solutions. Consequently, they are more likely to provide effective help than agencies that endorse the medical and enlightenment models. Therefore, agencies that endorse the compensatory model are most likely to provide fair, effective help.

Brickman et al. (1982, 1983) argue that people who adopt the moral or compensatory model assume responsibility for solving their own problems and, therefore, attribute success to their own efforts. Conversely, they argue that people who adopt the medical or enlightenment model do not

assume responsibility for solving their own problems and, therefore, attribute success to a helping agent. Several sets of findings indicate that people who attribute success to their own efforts show more permanent improvement and persist longer in the face of difficulty than people who attribute success to external factors. This phenomenon has been observed in laboratory studies, educational settings, and several treatment settings, including a therapy group for psychiatric outpatients (Dweck, 1975; Glass & Singer, 1972; Liberman, 1978).

People who endorse a social conception of the causes of psychopathology tend to take more responsibility for solving problems than do people who endorse an illness conception of disorder. For example, people who are told that social learning causes psychological disorder feel more in control of their emotional problems and take more action on their problems than people who are told that psychological disorder is a disease (Farina, Fisher, Getter, & Fisher, 1978; Fisher & Farina, 1979). People who believe that social factors cause psychological disorder impute more responsibility for decisions in psychotherapy to clients and report a greater general sense of control over life events than people who believe that psychological disorder is endogenous (Hill & Bale, 1980). Moreover, psychiatric outpatients who endorse a psychosocial model of psychopathology are more independent of mental health

professionals than are outpatients who endorse a medical model of psychopathology (Morrison, Bushell, Hanson, Fentiman, & Holdridge-Crane, 1977; Thompson, 1989). These findings suggest that mental health self-help group members who believe that their problems are caused by social factors will be more likely to believe that they can act effectively on their problems than members who believe that their problems are caused by a disease.

Model of Help and Self-Esteem

Brickman et al. (1983) argue that agencies that work under a compensatory model of help promote the competence of help recipients, thereby decreasing their present difficulties and promoting the success of their future efforts. In contrast, they argue that helping agencies that adopt a medical model are not as likely to promote the success of a recipient's future efforts:

> In the medical model, recipients have a just claim for help because they are not responsible for their suffering and do not deserve their plight. It is fair to help people in this condition but it is not maximally effective because, by assuming no responsibility for the solution, they run the risk of becoming dependent and perhaps requiring perpetual or undue amounts of help (p. 39).

Fisher, Nadler, and Whitcher-Alagna (1983) argue that aid that decreases the current need of recipients and promotes their future success will support their self-esteem:

> To the extent that aid (i) decreases threat

> associated with one's current condition, and (ii) increases the probability of future success, it will contain supportive elements. Thus, aid that fully meets recipients' current needs and enables them to avoid future dependency. . . is more supportive than a "handout" that meets only current needs. . . In contrast, aid that is not instrumental in significantly relieving one's need state (e.g., because it is insufficient or ineffective) will be threatening because (i) one continues to bear both the failure that caused the current need state and the prospect of future problems, (ii) persisting problems often become more embarrassing, (iii) ineffective help may suggest one is being exploited, and (iv) accepting ineffective help may call into question one's judgment, status, means or power (p. 76).

Taken together, the positions of Brickman et al. (1983) and Fisher et al. (1983) imply that agencies endorsing a compensatory model of help will be more conducive to recipients' self-esteem than agencies endorsing a medical model of help.

With reference to the moral model of help, Brickman et al. (1982) indicate that people who endorse this model view themselves as masters of their fate. According to the moral model, an individual can be persuaded to change through others' exhortation or counsel, but change depends upon the individual's choice. The paradox of this model is that people who endorse it may blame themselves for problems that are beyond their control. Individuals who endorse a moral model might have a higher sense of mastery than people who endorse a medical model but might have lower self-esteem than people who endorse a compensatory model of help.

Help that is provided in accordance with the

enlightenment model may offer recipients relief as a result of surrender of their problem to others, hope that others may be able to solve their problems, and affiliation with others who have experienced a similar problem. However, Brickman et al. (1982) argue that people who receive help under the assumptions of the enlightenment model are required to accept negative images of themselves and be submissive to agents of social control. In an undergraduate sample, endorsement of the enlightenment model was associated with lower self-esteem (Mitchell, 1988). Despite its apparent prevalence among self-help groups, the enlightenment model may be the most authoritarian model of help (Karuza, Zevon, Rabinowitz, & Brickman, 1982).

Self-Esteem, Sense of Mastery, and Self-Help Group Participation

Some investigators have contended that certain activities in self-help groups are specifically directed at increasing members' self-esteem and sense of control over their lives (Levine, 1988; Levy, 1979; Wollert et al., 1982):

> As group members begin to see their problems and experiences in a new light and begin to try out new and more effective ways of coping, their previous views of themselves as ineffectual, powerless, and unworthy begin to give way to new ones in which they see themselves as capable of achieving mastery over their circumstances and as worthwhile individuals. And as members express these different views of themselves, the confirmation that they receive from their peers

> within the group serves as a powerful reinforcement for them, especially since, in most instances, these changes are also consistent with the body of precepts to which the group subscribes (Levy, 1979, p. 253).
>
> Thus, if our speculations are correct about the roles of self-help groups' social structure and norms in the rebuilding of personal identities and self-esteem, this would suggest that they may be the "treatment of choice" for persons for whom stigmatization and loss of self-esteem constitute major components or consequences of their problems (p. 256).

The fact that self-esteem and mastery have been employed as outcome measures in several evaluations of self-help groups suggests that these two concepts are of central interest to groups and researchers (Lieberman & Videka-Sherman, 1986; Maton, 1988; Videka-Sherman & Lieberman, 1985). Despite the focus on these two variables, self-esteem and sense of mastery were not observed to increase significantly after participation in some groups and were not found to be significantly greater among members of some groups than among non-members with similar problems. Significant changes or differences in these two variables were predicted but not observed in groups for bereaved parents (Videka-Sherman & Lieberman, 1985), elderly people (Lieberman & Bliwise, 1985), and scoliosis victims and their families (Hinrichsen et al., 1985). Such results were obtained even in some cases where most members reported feeling more self-confident and more in control of their situations as a consequence of their group involvement.

In contrast, self-esteem was observed to increase after

participation in THEOS, a self-help organization for widows and widowers (Lieberman & Videka-Sherman, 1986). Participants who formed social linkages with other members showed greater improvement in self-esteem than members who attended meetings only. Mastery was also assessed in this study, but was not observed to increase over a one-year interval or in relation to formation of social linkages with other participants. Results of the study indicated that increased self-esteem in response to self-help group participation may be contingent on some specific aspects of social interaction in the group.

Maton (1988) used self-esteem as a criterion variable in a cross-sectional comparison of self-help organizations for several different kinds of problems. He found that self-esteem varied with perceived aspects of group structure, as well as with the extent of members' involvement in their groups. Formation of friendships and amount of support given to other members related directly to self-esteem. Perceived order and organization, role differentiation, and leadership capability related directly to self-esteem regardless of the kind of problem an organization addressed. Friendship and support accounted for 34% of the variance, and organizational features accounted for 51% of the variance in self-esteem among members of groups for overeaters, bereaved parents, and people with multiple sclerosis. Results of this study

suggest a need to specify the relation of belief systems to self-esteem in the context of social interaction and group structure.

Some investigators of self-help organizations contend that they may be a primary means of empowerment for former psychiatric patients and other disenfranchised citizens (Rappaport, 1981). The concept of increased control over one's situation is likely to be central to an empowerment paradigm of self-help for former psychiatric patients (Chamberlin, 1984). Despite ideological differences, enhancement of members' self-esteem is a common goal of mental health self-help groups (Harp, 1987). These considerations suggest that self-esteem and mastery are important aspects of psychological adaptation among members of self-help groups for former psychiatric patients.

Models of Help and Attitudes Towards Mental Health Professionals

The medical model of help states that people who need help are not responsible for origins of problems or remedies for them. Special experts are the only qualified providers of help (Brickman et al., 1977, cited in Rabinowitz, 1979; Brickman et al., 1982). Their services are necessary and largely sufficient for amelioration of problems. Actions by the person in need or by other ordinary persons are no more than adjuncts to experts' skill. This argument implies that

mental health self-help group members who endorse a medical model of help would tend to enlist professional help, defer to professional advice, and follow professionals' recommendations for recovery. Members' opinions about how to help themselves would be subordinated to their caregivers' advice. Self-help group members who endorse a medical model of help would thus regard their mental health professional as a more important source of help than their group. Proponents of the medical model would be more inclined to support the existing mental health system than try to change it.

The position of the compensatory model of help is that people who need help are not responsible for the causes of their problems but are responsible for solving them. The model implies that recipients know, at least generally,what kind of help they need and know how best to use it (Brickman et al., 1982). Endorsement of the compensatory model would be related to a preference for autonomy from the influence of professionals. Self-help group members who endorse a compensatory model would tend to assume responsibility for identifying and meeting their own needs, with help from other members. Members might not discourage each other from seeking professional help, but would encourage each other to seek it for discrete problems and only for a limited time. Members would want to influence the conditions of help and would not allow mental health professionals to detract from

the importance of their group. Proponents of the compensatory model would tend to credit themselves and their group for alleviating and preventing emotional distress.

Groups that adopt a compensatory model of help may be committed to permanent struggle against an adversary (Brickman et al., 1983). Accordingly, members of mental health self-help groups that endorse this model may attribute their problems to abuse by the psychiatric system or to societal factors that are beyond their control. Since the compensatory model also implies that people who receive help will take action to solve their own problems, its proponents would be more willing than proponents of a medical model to advocate for change in the current mental health system (Chamberlin, 1984).

Rationale for the Study

Investigators of self-help groups claim that members become more self-confident and learn new ways to cope with their problems by believing group tenets. Results of outcome research do not consistently support this claim. Comparisons of self-help groups with similar purposes but different ideologies suggest that groups can vary in the degree to which they reduce self-blame, foster self-confidence, and promote effective coping among their members. Such comparisons have not been conducted with groups for former psychiatric patients.

The present study investigates relationships of individual differences in conceptions of help to attitudes and adaptation among members of mental health self-help groups. Two conceptions, the medical model and the compensatory model, are of principal interest. Endorsement of the compensatory model rather than the medical model may be differentially related to members' self-esteem, sense of mastery, reliance upon mental health professionals, and attitudes toward change in the current mental health system.

Results of several studies indicate that members who attend meetings regularly, give help and receive help, and form relationships with members outside group meetings are those who are most likely to endorse their self-help group's ideology. The present study attempts to confirm these findings among members of various mental health self-help groups. The relationship of perceived emphasis on interactions involving sharing, empathy, and explanation to members' endorsement of their group's tenets is also assessed.

The present study is the first to employ standard instruments to assess the relation of help models to self-esteem and mastery across a variety of self-help groups for former psychiatric patients. If certain beliefs about help tend to promote members' self-esteem and mastery, then self-help organizations may want to foster those beliefs among their members. Similarly, information about members'

help beliefs may be used to foster cooperation or autonomy in relationships between self-help groups and the mental health system. If certain social interaction patterns promote endorsement of a group's ideological tenets, then members can work to cultivate these interaction patterns within their groups. Thus, in its attempt to integrate conceptions of help with social dynamics, the present study may yield information that could facilitate success in self-help groups for former psychiatric patients.

HYPOTHESES

1. Self-help group members will be more likely to endorse their group's model of help than to endorse any other model of help.
2. Perceived empathy, sharing, and explanation within the group will relate directly to members' endorsement of their group's tenets.
3. Attendance rate, duration of membership, and contact with other members between group meetings will relate directly to members' endorsement of their group's tenets.
4. Endorsement of the compensatory model of help will be more directly related to members' self-esteem than will endorsement of the medical model of help.
5. Endorsement of the compensatory model of help will be more directly related to members' sense of mastery than will endorsement of the medical model of help.
6. Endorsement of the medical model of help will be more directly related to the importance members ascribe to help from mental health professionals than to the importance members ascribe to help from their self-help group.
7. Endorsement of the compensatory model of help will be more directly related to the importance members ascribe to help from their self-help group than to the

importance members ascribe to help from mental health professionals.

8. Endorsement of the compensatory model of help will relate more directly to the importance members attach to change in the mental health system than will endorsement of the medical model of help.

METHOD

Participants

Sampling

The researcher sent a letter and preliminary questionnaire to 169 organizations listed in a resource manual for mental health self-help groups (Zinman, Harp, & Budd, 1987) or a mental health consumers' directory (Irick, 1987). The study was directed at member-controlled groups that emphasize face-to-face contact as the principal means of overcoming problems shared by former patients. Thus, organizations not controlled by ex-patients (e.g., day activity centers), as well as member-controlled organizations serving other purposes (e.g., political action committees), were excluded from the sample.

The letter identified the researcher, described the general purpose of the research project, and requested organizations to send printed materials that described their philosophy of self-help (Appendix A, 'Letter 1'). The preliminary questionnaire asked for the group's meeting schedule, number of members, whether or not non-members were allowed to attend group meetings, a telephone number for the group, and the address and telephone number of a member who could be contacted for more information (Appendix A, 'Preliminary Questionnaire'). A stamped self-addressed envelope accompanied the request.

Thirty-two groups replied to the initial request. Groups that promoted biochemical etiology and treatment for mental disorders were considered for further participation, because they were expected to endorse the medical model. Groups that promote social justice and civil rights for psychiatric patients were also considered, because they were expected to endorse the compensatory model.

Nine groups were asked to participate in the study. Groups that published explicit, detailed statements of their principles and purpose were given preference. Groups that had 12 or more members, were located near the researcher, were similar to each other in most characteristics except ideology (e.g., years in existence, number of meetings per month, meeting format) were also favored for participation.

Two of the nine groups refused to participate in any part of the study. The first group, which adopts an active antipsychiatry stance, voted against participation because the purpose of the study, its hypotheses, and how its results would be applied were not fully disclosed in advance. The leader of the second group, which endorsed a biochemical philosophy, refused to allow professionals into the group and maintained that its members were too disabled to complete the questionnaires. Both of these groups cited distrust of professionals as a reason for refusing to participate in the study.

One group participated only in the first part of the study. This group provided background information on the group's model of help when the researcher administered questionnaires in person, but did not complete questionnaires for the remainder of the study and return them by mail. Data on this group's model of help were incomplete, because some members asserted that questions about the group's position, apart from their individual views, were arbitrary and irrelevant. This group adopts an activist position, but it did not appear to endorse the compensatory model of help.

Six groups participated in the entire study. The groups were receptive, cooperative, and interested to learn that they were selected for their philosophy of help. Three groups (Groups 1, 4, and 5) presented themselves as endorsing a medical philosophy, and three groups (Groups 2, 3, and 6) presented themselves as endorsing an activist stance. All groups had existed for at least 16 months (M = 8.4 years) and held at least two meetings per month. All groups were controlled only by their members. These groups are briefly described below.

Description of Groups

Group 1 (n = 9 patients + 2 family members) is a group for people with affective disorders and people who have a relative with an affective disorder. It is an independent

group, i.e., not a chapter of a national organization. It is located in a moderately large city in central Canada. Family members were included only for the purpose of defining the group's model of help. This group identifies its members as suffering from a biochemical illness.

Group 2 (n = 6) is an independent advocacy group located in a moderately large city in the northeastern United States. It is one of the first advocacy-oriented groups for psychiatric patients in the U.S.

Group 3 (n = 30) is a member-controlled drop-in center located in western Canada. This center serves up to 50 members per day. The organization presents itself as advocating for rights and social change on behalf of psychiatric patients.

Group 4 (n = 13) is a chapter of a national organization for people with affective disorders. It is located in a moderately large city in the U.S. midwest. Although the national organization also includes family members, all the members of this group had a history of psychiatric treatment. This group identifies its members as suffering from a biochemical illness.

Group 5 (n = 11) is a chapter of a national organization for families of the mentally ill and for mental health consumers. This chapter is distinctive in that it is composed exclusively of consumers. The group is located in a medium-sized city in the western U.S. This group states

that all mental illnesses are the result of chemical imbalances in the brain.

Group 6 (n = 17) is an advocacy organization for psychiatric patients, operates a drop-in center, and offers an emergency telephone counseling service. It is located in a metropolitan center on the U.S. eastern seaboard. This group reformed mental health policy in its state through implementation of a Bill of Rights for psychiatric inpatients.

Description of Individuals

Eight-six members of the six groups completed valid questionnaires. The median age of the participants was 39. Fifty-one percent of the participants were males. Approximately half (52.3%) of the sample had at least some college or university education. The majority of participants (70.5%) had been members of their group for more than one year.

The sample has a significant history of mental health treatment. Almost all participants reported contact with a mental health professional (94%) and contact with a treatment facility (92%) within the past three years. Forty-eight percent reported full-time hospitalization during that period. Using a scale ranging from 1 (no extent) to 5 (great extent) to rate types of treatment received in the past three years, participants reported

medication as the most extensive (M = 3.9), followed by psychotherapy (M = 2.7), group activities (M = 2.6), and electroconvulsive treatment (M = 1.3). Thirty-two percent of participants were currently receiving treatment. Seventy-six percent of those receiving treatment indicated that their treatment provider had a positive attitude toward their self-help group.

Forty percent of participants reported that they currently or previously belonged to another mental health self-help group. Of these, however, only 29% reported that their experience with the other group encouraged them to join their current group. This suggests that participants' principal allegiance is to their current group.

One member of each group declined to participate in the study, except in Group 5, where all members participated. Eleven questionnaires from Group 3 and one questionnaire from Group 6 were deleted because the respondent did not appear to understand the questions, had an obvious response bias, or omitted data from two of more of the dependent variables in the study. These members may not have been able to complete the questionnaires because of limited education, disability, and/or more extensive history of psychiatric treatment. In general, members were receptive to participating in the study and completed the questionnaires without difficulty.

Procedure

Recruitment

The researcher sent a letter (Appendix B) to each group, requesting permission to attend a meeting to administer questionnaire(s) to the membership. The letter identified the researcher, described the purpose of the research, and described how long it would take to complete the questionnaire(s). It also stated the confidentiality procedures, informed members how the study's findings would be used, offered to report findings to the group, specified compensation for participation, and indicated how the researcher could be contacted. Copies of the questionnaire(s) accompanied the letter.

The parcel included a handwritten letter to the contact person identified on the preliminary questionnaire. This letter cited reasons for the importance of the group's participation, with reference to distinctive characteristics reported by the group or known first-hand to the researcher. The researcher later telephoned the contact person to arrange a time when he could visit the group and administer the questionnaire(s).

Identification of Group Tenets

The researcher examined materials provided by the six participating groups and selected statements of their purpose and philosophy. Excerpted statements represented

each group's tenets. Each group had from 4 to 11 tenets, depending on the length and detail of materials provided in response to the preliminary questionnaire. These tenets made up the items of a questionnaire (Appendix C, 'Rater's Questionnaire'). Examples of tenets are, "People who have been involved in the psychiatric system deserve a member-controlled setting that is designed to foster equality, empowerment, mutual caring and self-esteem" (Group 2); and, "Mental illnesses are the result of chemical imbalances in the brain and are no one's fault" (Group 5).

The researcher distributed the group's materials and the questionnaires to three independent judges who were blind to the purpose of the study. The judges were three mental health professionals (Groups 1-5) or three senior graduate students in clinical psychology (Group 6). The judges studied the group's materials and rated items for accuracy in representing the group's positions. The researcher included the accurate items in a questionnaire that was later administered to members to measure endorsement of their group's tenets (Appendix C, 'Members' Questionnaire').

Confidentiality and Informed Consent

The letter requesting permission to administer questionnaire(s) stated that members' responses would be confidential. It stated that members would be asked not to

put their names on the questionnaire(s), that the questionnaire(s) would be kept in a secure place, and that members' responses would not be shown to anyone except the researcher. The researcher stated the confidentiality procedures again when he administered the questionnaire(s). These procedures were also stated on a cover letter attached to each questionnaire.

The letter requesting permission to administer questionnaire(s) stated that the study would compare the philosophies of various self-help groups for people with emotional or mental health problems. It went on to state that the study's results would help members understand how their group works and could provide information about how the group can be more helpful to its members. The researcher also presented this information before administering the questionnaire(s) and added that the study's findings might be presented at a conference of ex-patients' self-help groups.

The researcher informed the group that individual members could elect not to participate in the study and could discontinue their participation at any time. A representative of each group signed a form to verify these stipulations (Appendix D).

In summary, the above procedures presented the confidentiality provisions, described the study's general purpose, and encouraged voluntary participation.

Administration

The study was initially designed as a comparison between groups that endorsed either the medical or the compensatory model of help. According to this strategy, members would provide information about their group's model of help on one occasion, using Questionnaire 1 (Appendix E), then provide information about their own model of help and the other dependent variables on another occasion, using Questionnaire 2 (Appendix F). It was necessary to revise the initial strategy when it became apparent that it might not be possible to identify groups that strictly endorsed either the medical or compensatory model. At that point, it became more practical to seek out large groups that approximated one of the two models and then administer Questionnaire 1 and Questionnaire 2 on the same occasion. This strategy was advantageous because it also reduced travel expenses, required only one meeting, allowed for prompt compensation, and guaranteed that both questionnaires could easily be identified for each participant.

The researcher pretested the questionnaires on a small Recovery, Inc. group. Table 3 summarizes variations in administration for Groups 1-6. For Group 1, the researcher

TABLE 3

Administration of Questionnaires to Groups

Group	Questionnaire 1	Questionnaire 2
1	in person	in person
2	in person	by mail
3	in person	in person
4	in person	in person
5	in person	in person
6	in person	in person

Note. Members of Group 1 and Group 2 completed questionnaires on two separate occasions. All other groups completed both questionnaires on one occasion.

administered Questionnaire 1 and Questionnaire 2 at two separate meetings. For Group 2, the researcher administered Questionnaire 1 at a group meeting; members subsequently completed Questionnaire 2, enclosed questionnaires in separate envelopes to ensure confidentiality, then mailed these materials to the researcher. For Group 3, a drop-in center, the researcher administered both questionnaires over the course of an entire day. For Groups 4 and 5, the researcher administered both questionnaires at a single meeting. For Group 6, another drop-in center, the researcher again administered both questionnaires over the course of an entire day to encourage every member to participate. Regardless of these variations, participants who completed Questionnaire 2 had previously completed Questionnaire 1.

The researcher supplied pencils, repeated the instructions and confidentiality guidelines, and offered members assistance whenever questionnaires were administered in person. The researcher asked the members to complete every item on the two questionnaires and encouraged members to write comments on the questionnaires if they liked. The researcher stressed that members should describe their group's beliefs by using Questionnaire 1 and describe their own beliefs by using Questionnaire 2.

Participants from several groups remarked that some items on the Help Orientation Test, which was used to

measure groups' and members' models of help, did not apply to their group or themselves. Some participants remarked that it was difficult or unfair for them to ascribe general beliefs to their group as a whole. The researcher replied that participants could use the scale to indicate disagreement and encouraged participants to write comments so they could define their group's position on help. This instruction communicated a desire to collaborate rather than require participants to perform a task that might seem irrelevant.

Debriefing

The researcher disclosed the purpose of the questionnaires after members completed them. For Group 1 and the pretest group, the researcher told about the purpose of Questionnaire 1 after all members had returned it, and followed the same procedure in disclosing the purpose of Questionnaire 2. For Group 2, the researcher followed the same procedure in telling the purpose of Questionnaire 1, then explained the purpose of Questionnaire 2 by sending a letter to the group after receiving questionnaires by mail. For Groups 3-6, a letter attached as the final page of Questionnaire 1 and Questionnaire 2 stated the explanations. The researcher observed that none of the members read the explanation until after they completed the questionnaire. Debriefing explanations for the two questionnaires are

presented in Appendix G. The researcher shall also send a summary of the study's findings to the participating groups when the project comes to an end.

Compensation

As compensation, the researcher donated $7.50 to Groups 1, 2, 4, and 5 for each set of completed questionnaires. The compensation procedure for Group 3 and Group 6 (the drop-in centers) was slightly different. In these settings, the researcher paid each participant $5.00 for completing the questionnaires and donated the remaining $2.50 to the group. This procedure prompted the majority of the members to participate in the study as they arrived at the center throughout the day.

Instruments

Demographics

Participants recorded their age in years, and indicated their sex by checking "male" or "female." Participants checked to indicate their level of education. The levels of education were taken from a measure developed by Trute, Tefft, and Scuse (1983). Scores assigned to level of education ranged from 1 (grade six or less) to 6 (post-graduate education). Demographic measures are in Appendix E ('Background Questionnaire').

Models of Help

Rabinowitz (1978) designed the Help Orientation Test (HOT) to assess the moral, enlightenment, medical, and compensatory models of help. In the present study, participants used the HOT to rate their group's endorsement (Appendix E) and their own endorsement (Appendix F) of each model of help. The test has four scales, one for each model, and each scale has 10 items. Items assess (a) the kind of help recipients need, (B) recipients' reasons for needing help, (c) characteristics of donors, and (d) consequences of not receiving help. The rating for each item can range from 0 (not at all true) to 6 (completely true). Example of items are: "People receiving help need only to get themselves together and discover where they personally want to go" (moral model); "People receiving help need something like a friend" (enlightenment model); "People receiving help need the fair chance they have been so far denied" (compensatory model); and, "People receiving help need something like a doctor" (medical model). Item ratings are summed to yield a score ranging from 0 to 60 on each scale. High scores on a scale indicate high endorsement of that model of help.

The present study and Mitchell (1988) are the only studies known to use the HOT since it was developed by Rabinowitz (1978). Rabinowitz used the HOT to assess model of help in community groups. The HOT yielded four principal

factors that corresponded to the four predicted models of help and accounted for 77% of score variance. Cronbach's alpha for the four scales ranged from .58 (enlightenment model) to .74 (medical model). Each group scored highest on the model it was meant to typify and scored no higher than the scale's midpoint (30) on other models of help. These results suggest that the HOT assesses four distinct models of help.

Rabinowitz (1978) also designed six items that directly assess attributions of help recipients' responsibility for their pasts and futures, including past and future successes and failures. In the present study, these items assessed each group's attributions (Appendix E) and also assessed members' attributions (Appendix F). Each item is scored separately on a scale ranging from 0 (not at all true) to 6 (completely true). Theoretically, low attributions of responsibility for past and future should correspond with high medical model scores on the HOT. Low attributions of responsibility for the past but high attributions for the future should correspond with high compensatory model scores on the HOT.

Group Tenets

As indicated earlier, tenets were statements of a group's philosophy and purpose excerpted from materials provided by the group. The researcher excerpted 4 to 11

tenets for each group, depending on the length and details of the materials provided. These statements made up the items of a questionnaire (Appendix C, 'Rater's Questionnaire'). Three independent judges read the materials provided by the group and then rated each item on a scale from 1 (completely inaccurate) to 5 (completely accurate). A statement was verified as accurate if the judges' mean rating exceeded 3.5. The judges' ratings indicated that all of the statements which had been proposed as tenets were accurate.

The verified tenets for a group made up the items of a second questionnaire (Appendix B, 'Members' Questionnaire'). Members used this questionnaire to rate their belief in each tenet on a scale from 1 (strongly disbelieve) to 5 (strongly believe). The mean of the item ratings was used as the measure of the extent that a member endorses the ideological tenets of his or her group.

Group Interaction Patterns

Items used to assess emphasis on sharing, empathy, and explanation were adapted from Wollert and Levy's (1979) Helping Processes Questionnaire (HPQ). The HPQ has been used to assess interaction patterns in several samples of self-help groups, some of which were groups for mental and emotional problems (Nicholaichuk & Wollert, 1989; Wollert,

1986; Wollert et al., 1982). The 27 items of the complete HPQ are defined in Wollert (1986).

The original HPQ assessed 27 interaction patterns. Each item assessed the frequency, emphasis, and representativeness of an activity in the group on a scale from 1 (inaccurate) to 5 (very accurate). The present study assessed only sharing, empathy, and explanation. The scale was revised slightly so that participants rated only emphasis on a scale from 1 (no emphasis) to 5 (very strong emphasis). Participants' rating of each activity was treated as a separate variable. Thus, higher ratings indicated higher perceived emphasis on that activity within the group. Items from the three group interaction variables are in Appendix F.

Member Involvement in Group

The researcher and project supervisor designed the measures of members' involvement in their group. Participants reported attendance by checking how many of the last four group meetings they had attended. Duration of membership was assessed on an interval scale ranging from 1 (less than 1 month) to 6 (more than 12 months). Extent of help and support given to members outside group meetings was rated on a scale from 1 (no extent) to 5 (great extent). Help and support received from members outside meetings was rated on a similar 5-point scale. Attendance, length of

membership, support given, and support received were treated as separate variables. The measures for these variables are in Appendix F.

Self-Esteem

The Rosenberg Self-Esteem Scale has been used in several evaluation studies of self-help groups (Hinrichsen et al., 1985; Lieberman & Videka-Sherman, 1986; Maton, 1988; Videka-Sherman & Lieberman, 1985). Scores on the Rosenberg scale are more consistent with other empirical criteria for self-esteem, more independent of self-concept stability, and more independent of irrelevant variables than are scores on some other self-esteem scales (Tippett & Silber, 1965). Males tend to have higher scores than females, older people tend to have higher scores than young people, and scores vary directly with education (Pearlin & Schooler, 1978). Scores tend to be inversely related to depression and physiological symptoms (Rosenberg, 1979; Wylie, 1974). The construct of self-esteem assessed by the scale is congruent with the definition of self-esteem in this study (Rosenberg, 1965, 1979).

The 10 items of the original Rosenberg scale were constructed according to Guttman Scaling techniques (Rosenberg, 1965). The scale's reproducibility coefficient of .92 suggests that it is unidimensional (Rosenberg, 1979; Wylie, 1974). The rating for each item can range from 1

(strongly agree) to 4 (strongly disagree). Items are balanced to prevent response acquiescence. In the present study, item scores were reversed as needed and summed to yield a total score on a single factor. Scores can range from 10 to 40. High scores indicate high self-esteem. The Rosenberg scale is part of Appendix F.

Mastery

The study used Pearlin and Schooler's (1978) scale to assess mastery. The seven items comprise a single factor. This scale has been used in several outcome evaluations of self-help groups (Hinrichsen et al., 1985: Lieberman & Videka-Sherman, 1968; Videka-Sherman & Lieberman, 1985).

Pearlin and Schooler (1978) validated the scale on a sample of 2300 adults in a community sample. Males tend to score higher than females, younger people tend to have higher scores than older people, and scores vary directly with education (Pearlin & Schooler, 1978). Scores correlate inversely with intensity of reaction to stress; this relationship is independent of relations between self-esteem and reaction to stress.

The rating for each item on the mastery scale can range from 1 (strongly agree) to 4 (strongly disagree). Item scores were reversed as needed and summed to calculate a total score. Scores can range from 7 to 28. High scores

indicate high sense of mastery. The mastery scale is included in Appendix F.

Mental Health Treatment History

The researcher and project supervisor designed items to assess mental health treatment history (Appendix F). Participants checked to indicate whether they had been treated for mental or emotional problems by any of the following health professionals within the past three years: psychiatrist, family physician, psychologist, nurse, social worker, community mental health worker, and other professional.

If treated within the past three years, participants checked to indicate whether treatment was full-time hospitalization, partial hospitalization, residential treatment outside a hospital, outpatient treatment in a hospital or clinic, and treatment in another facility. A scale ranging from 1 (no extent) to 5 (great extent) assessed extent of psychotherapy, medication, electroconvulsive therapy, group activities, and other treatment.

Participants checked to indicate whether or not they were currently receiving mental health treatment. Those who were receiving treatment wrote a description of it. Those receiving treatment also used a scale ranging from 1 (very

negative) to 5 (very positive) to rate their treatment provider's attitude toward their self-help group.

Involvement in Other Self-Help Groups

The researcher and project supervisor designed items to assess participants' involvement in other self-help groups (Appendix F). Participants checked to indicate whether they had belonged to another group. Those who had belonged to another group stated the group's name, indicated their dates of membership, and wrote a description of the group. They also used a scale ranging from 1 (strongly discouraged) to 5 (strongly encouraged) to rate the influence of their experience with the previous group on their decision to join their current group.

Importance of Help From Professionals and Help From Group

The researcher and project supervisor designed two items to assess the importance members ascribe to help from professionals and help from their group. Participants used a scale ranging from 1 (not at all important) to 5 (extremely important) to rate the importance of help they and other group members receive from mental health professionals. Participants used a similar scale to rate the importance of help that they and other members receive from their self-help group. Both items are in Appendix F.

Attitude Toward Mental Health System Change

The researcher and project supervisor designed two items to assess attitudes toward the mental health system. Participants used a scale ranging from 1 (not at all important) to 5 (extremely important) to rate the importance of change in the present mental health system. This rating was a score on a separate variable. The last item was an open-ended question asking participants to state what changes should be made in the mental health system to benefit people with emotional and mental health problems. These items are part of the questionnaire presented in Appendix F.

RESULTS

Preliminary Analyses

Participants' self-ratings on the four models of help are significantly correlated (Table 4). Scores on the enlightenment model are highly correlated with scores on the moral, compensatory, and medical models (r = .66, .64, .56, respectively, $p<.001$). Moral model scores correlate highly with scores on the compensatory model (r = .75, $p<.001$). Medical model scores are moderately correlated with scores on the compensatory model (r = .47, $p<.001$) and are moderately correlated with scores on the moral model (r = .34, $p<.01$). These results indicate that the Help Orientation Test does not assess four independent conceptions of help in this sample.

Most of the demographic and background characteristics are not significantly related to any of the dependent variables. Participants' age, sex, education, contact with a treatment facility within the past three years, current mental health treatment, treatment provider's attitude towards self-help group, and previous experience with mental health self-help groups are not significantly related to tenet endorsement, self-esteem, mastery, importance ascribed to help from professionals, importance ascribed to help from

Table 4

Correlations Between Members' Scores on Four Models of Help

Scale	Enlightenment	Moral	Compensatory	Medical
Enlightenment	---	.66***	.64***	.56***
Moral		---	.75***	.43**
Compensatory			---	.47***
Medical				---

Note. N = 86.

**p<.01, two-tailed. ***p<.001, two-tailed.

group, or importance ascribed to mental health system change.

Contact with a mental health professional within the past three years is inversely related to participants' sense of mastery, $X^2(16, N = 83) = 32.0$, $p = .01$, but is not significantly related to any of the other dependent variables. Self-help group members who have not contacted a mental health professional are likely to feel that they can master their problems.

Extent of medication, psychotherapy, and other treatments within the past three years is positively related to importance ascribed to help from professionals ($r = .27$, $p<.05$[2]), importance ascribed to help from group ($r = .23$, $p<.05$), and endorsement of group tenets ($r = .26$, $p<.05$), but is not significantly related to self-esteem, mastery, or importance ascribed to mental health system change. In other words, members who have a history of extensive mental health treatment tend to affirm the importance of professional help, to affirm the importance of help from their self-help group, and to endorse their group's beliefs.

---

[2]Values of p for two-tailed test. Except where noted, all other p values are for one-tailed test.

Hypothesis 1

Hypothesis 1 states that self-help group members will be more likely to endorse their group's model of help than to endorse any other model of help. Table 5 shows the means for groups' endorsement of medical, enlightenment, compensatory, and moral models of help.

Three analyses tested Hypothesis 1. In the first analysis, the average of members' ratings of a group's endorsement of a model determined a group's score on the medical, enlightenment, compensatory, or moral model. The linear combination of these four means defined the group's model of help. The linear combination of a member's self-ratings on the moral, medical, compensatory, and enlightenment models defined his or her model of help. The canonical correlation between the group's linear combination and member's linear combination is significant, $F(16, 230) = 4.92$, $p<.001$. Examining the different models of help, the correlation between the group's score and the member's score is significant for the medical model ($r = .60$, $p<.001$), the enlightenment model ($r = .41$, $p<.001$), the compensatory model ($r = .53$, $p<.001$), and the moral model ($r = .39$, $p<.001$). Group's endorsement predicted members' endorsement of each of the four models of help.

Table 5

Characteristic Models of Help Endorsed in Six Self-Help Groups for Former Psychiatric Patients

		Model of Help							
		Medical		Enlightenment		Compensatory		Moral	
Group	n	Group	Members	Group	Members	Group	Members	Group	Members
1	9	37.7	37.2	36.8	35.6	27.4	31.8	24.2	28.6
2	6	16.0	11.8	27.2	20.8	31.8	25.8	28.3	25.6
3	30	36.3	36.9	37.3	38.7	35.9	37.9	35.4	36.6
4	13	38.8	37.8	36.1	33.8	24.1	22.8	26.4	23.5
5	11	34.6	34.0	31.8	32.8	29.9	26.4	29.1	27.0
6	17	39.4	41.8	36.2	38.0	34.9	36.8	28.9	32.9
Total	86		37.1		35.7		32.3		30.9

Note. Mean scores on scale ranging from 0-60, higher scores indicate stronger endorsement.

In the second analysis, the results of a repeated-measure, within-subjects multivariate analysis of variance (MANOVA) conducted on members of groups 3-6[3] do not indicate that members' endorsement differs from their rating of their group' endorsement of any model of help, $\underline{F}(1, 66) = .34$, $\underline{p} = .56$. Thus, members' endorsement does not differ from their ratings of their group's endorsement of the medical, enlightenment, compensatory, and moral models of help.

In the third analysis, the mean of members' ratings of their group's endorsement of each of the models was computed, these four means were compared, and the model with the highest mean score was defined as the group's model of help. Similarly, the mean of members' endorsement of each of the models was computed, those four means were compared, and the model with the highest mean score was defined as the members' model of help. The results of a chi-square analysis indicate that, if a group scores highest on a given model of help, individual members are likely to score highest on the same model of help, $X^2(6, \underline{N} = 86) = 18.2$, $\underline{p}<.01$. Members are likely to endorse the model of help that is predominantly endorsed by their group. In summary,

---

[3]In Group 1 and Group 2, members' self-rating could not be paired with their rating of the group, because members were not individually identified and the ratings occurred on separate occasions; consequently, the ratings from these groups could not be included in the MANOVA.

results of canonical correlation, MANOVA, and chi-square analyses indicate that members' model of help is similar to their group's model of help, thus confirming Hypothesis 1.

Examination of each group's scores on the medical, enlightenment, compensatory, and moral models provides an impression of the group's model of help. Consistent with their position that mental health problems are biochemical illnesses, Groups 1, 4, and 5 endorse the medical model. Although Group 3 promotes a social change orientation in its literature, it scores high on all four models, with little apparent difference amongst them. Although Group 6 also promotes a social change orientation in its literature, it scores highest on the medical model. Group 2, which identifies itself primarily as an advocacy organization, does not strongly endorse any model and is the only group that rejects the medical model. Thus, excepting Group 2, most groups and their members tend to endorse the medical model of help.

Hypothesis 2

Hypothesis 2 states that perceived emphasis on sharing, empathy, and explanation will relate directly to members' endorsement of their group's tenets. On a five-point scale, members generally endorse their group's tenets (M = 4.4, SD = .70). Table 6 shows correlations between sharing, empathy, explanation, and tenet endorsement. The

Table 6

Correlations Between Perceived Group Interaction Patterns and Tenet Endorsement

Variable	Sharing	Empathy	Explanation	Endorsement
Sharing	---	.54***	.63***	.33**
Empathy		---	.53***	.33**
Explanation			---	.33**
Endorsement				---

Note. N = 86.

**p<.01, two-tailed. ***p<.001, two-tailed.

significant correlations between sharing, empathy, and explanation suggest that these three variables are interrelated aspects of group process. All three variables correlate positively with tenet endorsement ($p<.01$).

Results of a standard multiple regression analysis indicate that although none of the three variables alone is a significant predictor, the linear combination of sharing, empathy, and explanation significantly predicts tenet endorsement, $R^2 = .15$, $F(3, 81) = 4.80$, $p<.01$. Table 7 shows parameter estimates for the three group process variables. In other words, members who see their group as an important setting for understanding and communicating personal experiences are likely to endorse their group's tenets. These results confirm Hypothesis 2.

Hypothesis 3

Hypothesis 3 states that attendance, membership duration, help given, and help received outside group meetings will relate directly to members' endorsement of their group's tenets.

Table 8 shows the correlations between tenet endorsement and the group involvement variables. The correlation between tenet endorsement and help given outside group meetings is positive and significant ($r = .22$, $p<.05$). The correlation between tenet endorsement and membership duration is similarly positive and significant ($r = .24$,

Table 7

Standard Multiple Regression Parameter Estimates for Three Perceived Group Interaction Patterns in Relation to Tenet Endorsement

Variable	B	t	p	sr^2
Empathy	.18	1.43	.16	.024
Sharing	.15	1.06	.29	.014
Explanation	.14	.98	.33	.012

R^2 for the regression model = .151.

Table 8

Correlations Between Group Involvement Variables and Tenet Endorsement

Variable	Help Given	Duration[a]	Help Received	Attendance	Endorsement
Help Given	---	.29**	.50***	.13	.22*
Duration		---	.18	.21	.24*
Help Received			---	.08	.18
Attendance				---	.09
Endorsement					---

Note. N = 86.

[a]Membership duration

*p<.05, one-tailed. **p<.01, one-tailed. ***p<.001, one-tailed.

$p<.05$). The correlation between tenet endorsement and help received outside meetings tends to be positive but only approaches significance ($r = .18$, $p = .10$). There is no significant correlation between tenet endorsement and attendance. Thus, although tenet endorsement may be clearly related to help given outside meetings and membership duration, is it not significantly related to help received outside meetings or attendance.

Results of a standard multiple regression analysis indicate that help given, membership duration, help received, and attendance are positively but not significantly related to tenet endorsement, $R^2 = .09$, $F(4, 78) = 1.85$, $p = .13$. Table 9 shows the parameter estimates for the group involvement variables. Participants do not need to attend meetings regularly, be long-term members, or help each other outside group meetings in order to strongly endorse their group's tenets. These results fail to confirm Hypothesis 3.

Hypothesis 4

Hypothesis 4 states that endorsement of the compensatory model of help will be more directly related to members' self-esteem than will endorsement of the medical model of help.

Table 9

Standard Multiple Regression Parameter Estimates for Aspects of Self-Help Group Involvement in Relation to Tenet Endorsement

Variable	B	*t*	*p*	sr^2
Help Given	.14	1.10	.28	.015
Membership Duration	.17	1.46	.14	.027
Help Received	.06	.50	.62	.003
Attendance	.03	.29	.77	.001

R^2 for the regression model = .087.

Table 10 shows means for self-esteem in the six groups and the sample as a whole. Self-esteem in all six groups and the sample as a whole is above the midpoint on a scale ranging from 10 to 40. Self-esteem is highest in Group 2, whose members reject the medical model and tend to endorse the compensatory model. Self-esteem in Group 1, whose members endorse the medical model, is higher than self-esteem in Groups 3, 4, 5, and 6.

The results of a standard multiple regression analysis do not indicate that the linear combination of compensatory model endorsement and medical model endorsement significantly predicts self-esteem, $R^2 = .05$, $F(2, 79) = 2.05$, $p = .14$. Table 11 shows the parameter estimates for compensatory model endorsement and medical model endorsement in relation to self-esteem. Self-esteem is positively but insignificantly related to compensatory model endorsement and is negatively but insignificantly related to medical model endorsement. However, the semipartial correlation coefficient between self-esteem and medical model endorsement is significant ($sr = -.21$, $p<.05$), indicating that self-esteem is negatively related to medical model endorsement when the correlation between medical model and compensatory model endorsement is controlled.

Table 10

Self-Esteem and Coping Mastery in Self-Help Groups for Former Psychiatric Patients

		Self-Esteem[a]		Mastery[b]	
Group	n	M	SD	M	SD
1	9	31.0	4.9	20.3	5.1
2	6	34.0	3.9	22.8	1.0
3	30	28.2	4.0	18.7	3.2
4	13	27.2	7.5	19.2	2.6
5	11	26.0	5.8	17.9	2.5
6	17	25.8	7.0	19.4	4.2
Total	86	28.1	5.8	19.2	3.5

[a]Rosenberg Self-Esteem Scale (1965). Scale range 10-40, higher scores indicate higher self-esteem. [b]Pearlin and Schooler Mastery Scale (1978). Scale range 7-28, higher scores indicate higher mastery.

Table 11

Standard Multiple Regression Parameter Estimates for Endorsement of Compensatory Model and Medical Model of Help in Relation to Member's Self-Esteem

Variable	B	t	p	sr^2
Compensatory Model	.19	1.5	.14	.028
Medical Model	-.24	-1.9	.06	.044*

R^2 for the regression model = .049

*$p<.05$, one-tailed.

The results of a t-test between interdependent r's indicate that the positive correlation between compensatory model endorsement and self-esteem (r = .09, p = .44) is significantly different from the negative correlation between medical model endorsement and self-esteem (r = -.15, p = .18), $t(60)$ = 2.59, $p<.05$. Self-esteem is more positively related to compensatory model endorsement than to medical model endorsement. This result partially confirms Hypothesis 4.

As indicated by results based on endorsement of the compensatory and medical models of help, attributions of responsibility for problems and solutions are not simply related to members' self-esteem. Results of adjunct analyses are consistent with these findings. Although members believe that people in their group are responsible for their future (M = 4.0 on a scale from 0 to 6) but not responsible for their past (M = 2.3), these beliefs are not related to their self-esteem. Although members believe that people in their group are responsible for their future successes (M = 4.2) and past successes (M = 4.0), but not their future failures (M = 2.7) or past failures (M = 2.2), these beliefs are also not related to their self-esteem. Moreover, members' endorsement of their self-help group's tenets is not related to their self-esteem. In general, the results do not indicate that members' conceptions of help are significantly related to their self-esteem.

Participants' self-esteem does not correlate significantly with help given outside meetings, help received outside meetings, membership duration, or attendance. Self-esteem also does not correlate significantly with emphasis on sharing, empathy, or explanation. Thus, overall, these results do not indicate that the self-help group involvement and interaction variables assessed in this study relate significantly to participants' self-esteem.

Hypothesis 5

Hypothesis 5 states that endorsement of the compensatory model of help will be more directly related to members' sense of mastery than will endorsement of the medical model of help.

Table 10 (previously presented) shows the means for mastery in the six groups and the sample as a whole. Sense of mastery in all six groups and the samples as a whole is above the midpoint on a scale ranging from 7 to 28. Sense of mastery is highest in Group 2, whose members reject the medical model and tend to endorse the compensatory model. Mastery in Group 1, whose members endorse the medical model, is higher than mastery in Groups 3, 4, 5, and 6.

Results of a standard multiple regression analysis do not indicate that the linear combination of compensatory model endorsement and medical model endorsement significantly predicts participants' sense of mastery, R^2 = .04, $F(2,82)$ = 1.85, p = .16. Table 12 shows the parameter estimates for compensatory model endorsement and medical model endorsement in relation to mastery. Parameter estimates indicate that mastery is positively but insignificantly related to compensatory model endorsement and is negatively but insignificantly related to medical model endorsement. However, the semipartial correlation between mastery and medical model endorsement is significant (sr = -.21, $p<.05$), indicating that mastery is negatively related to medical model endorsement when the correlation between medical model and compensatory model endorsement is controlled.

The results of a t-test between interdependent r's indicate that the positive correlation between compensatory model endorsement and mastery (r = .03, p = .75) is significantly different from the negative correlation between medical model endorsement and mastery (r = -.18, p = .09), $t(60)$ = 1.81, $p<.05$. Mastery relates more positively to compensatory model endorsement than to medical model endorsement. This result partially confirms Hypothesis 5.

Table 12

Standard Multiple Regression Parameter Estimates for Endorsement of Compensatory Model and Medical Model of Help in Relation to Members' Sense of Mastery

Variable	B	t	p	sr^2
Compensatory Model	.11	.90	.37	.010
Medical Model	-.24	-1.93	.06	.043*

R^2 for the regression model = .043.

*p<.05, one-tailed.

As indicated by results pertaining to endorsement of the compensatory and medical models of help, attributions of responsibility for problems and solutions are not simply related to members' sense of mastery. Consistent with these findings, members' attributions about help recipients' responsibility for their future and their past, including successes and failures, are not related to their sense of mastery. Similarly, members' endorsement of their group's tenets is not related to their sense of mastery. In general, the present results do not indicate that conceptions of help are strongly related to participants' sense that they can master their problems.

Help given outside meetings, however, is positively related to mastery, $r = .23$, $p<.05$ (two-tailed). The other aspects of group involvement (help received outside meetings, membership duration, attendance) are not significantly related to mastery. Participants who help other members are likely to think that they can master problems.

Emphasis on explanation is also positively related to mastery, $r = .25$, $p<.05$ (two-tailed). The other two group interaction variables (empathy and sharing) are not significantly related to mastery. Members who see their group as a place to increase their understanding of themselves and their problems are likely to think that they are able to master their problems.

Hypothesis 6

Hypothesis 6 states that endorsement of the medical model of help will be more directly related to the importance members ascribe to help from mental health professionals than to the importance members ascribe to help from their self-help group.

Table 13 shows group means for the importance members ascribe to professional help and the importance they ascribe to help from their groups. Members affirm that the help they receive from mental health professionals is important (M = 4.2, SD = 1.3). They also affirm that their group provides important help (M = 4.2, SD = 0.9).

Table 14 shows the correlations of medical model and compensatory model endorsement with the importance members ascribe to help from professionals and help from their group. Medical model endorsement is directly related to the importance ascribed to professionals' help (r = .31, p<.01) but is not significantly related to the importance ascribed to the group's help.

A t-test for difference between interdependent correlation coefficients indicates that the correlation between medical model endorsement and importance ascribed to professional help exceeds the correlation between medical model endorsement and importance ascribed to the group's

Table 13

Importance Attributed to Help from Mental Health Professionals and to Help from Self-Help Group

		Professionals' Importance		Group's Importance	
Group	n	M	SD	M	SD
1	9	4.6	0.7	4.4	1.1
2	6	1.8	1.0	4.3	0.8
3	30	4.0	1.3	4.0	0.8
4	13	4.9	0.3	4.3	0.6
5	11	4.5	1.0	4.5	0.5
6	17	4.6	0.6	4.5	0.7
Total	86	4.2	1.2	4.3	0.8

Note. Mean scores on scale ranging from 1-5, higher scores indicate greater importance.

help, $t(60) = 2.67$, $p<.01$. Medical model endorsement is more directly related to the importance participants place on professional help than to the importance they place on help from their group. This result confirms Hypothesis 6.

Hypothesis 7

Hypothesis 7 states that endorsement of the compensatory model of help will be more directly related to the importance members ascribe to their self-help group than to the importance members ascribe to help from mental health professionals.

As seen in Table 14, compensatory model endorsement is not significantly related to the importance members ascribe to help from their group or to help from mental health professionals. Furthermore, the correlation between compensatory model endorsement and importance ascribed to group's help is not significantly different from the correlation between medical model endorsement and importance ascribed to group's help. These results fail to confirm Hypothesis 7.

Hypothesis 8

Hypothesis 8 states that endorsement of the compensatory model will relate more directly to the importance attached to change in the mental health system than will endorsement of the medical model of help.

Table 14

Correlations Between Medical Model Endorsement, Compensatory Model Endorsement, Importance Attributed to Help from Mental Health Professionals, and Importance Attributed to Help from Self-Help Group

Variable	Medical	Compensatory Model	Professionals' Help	Group's Help
Medical Model	---	.47***	.31**	-.05
Compensatory Model		---	.10	.04
Help from Professionals			---	.40***
Help from Group				---

**p<.01, two-tailed. ***p<.001, two-tailed.

Table 15 shows group means for importance ascribed to mental health system change. In all six groups and in the sample as a whole, members indicate that change in the present mental health system is important (M = 4.3, SD = 1.2). The results of a standard multiple regression analysis do not indicate that the linear combination of compensatory model endorsement and medical model endorsement significantly predicts the importance given to mental health system change. Table 16 shows the parameter estimates for the regression equation. Participants indicate that change in the present mental health system is important, notwithstanding their endorsement of the compensatory or medical model of help.

Emphasis on change in the mental health system is negatively correlated with both medical model endorsement (r = -.22, p<.05, two-tailed) and compensatory model endorsement (r = -.19, p = .08, two-tailed). Furthermore, a semipartial correlation shows that the negative relationship between compensatory model endorsement and emphasis on change approaches significance when the correlation between the two models of help is controlled (sr = -.20, p = .07, two-tailed). The members who stress the importance of mental health system change may not be those who strongly endorse either the compensatory model or the medical model. The negative relationship of compensatory model endorsement to importance of system change contradicts Hypothesis 8.

Table 15

Mean Importance Ascribed to Mental Health System Change in Six Self-Help Groups for Former Psychiatric Patients

Group	n	M	SD
1	9	4.9	0.3
2	6	5.0	0.0
3	30	3.6	1.6
4	13	4.5	0.7
5	11	4.9	0.3
6	17	4.5	0.9
Total	86	4.3	1.2

Note. Mean scores on scale ranging from 1-5, higher scores indicate greater importance.

Table 16

Standard Multiple Regression Parameters Estimates for Endorsement of Compensatory Model and Medical Model of Help in Relation to Importance Ascribed to Mental Health System Change

Variable	B	t	p	sr^2
Compensatory Model	-.11	-.87	.38	.040
Medical Model	-.17	-1.39	.16	.004

R^2 for the regression model = .090.

Consistent with their affirmation of the importance of mental health system change, the majority (79%) of members specified changes that should be made in the mental health system to benefit people with emotional and mental health problems. Recommended changes include: (a) Increase access and funding for treatment, work, and social assistance programs (cited by 34% of the sample); (b) increase public education and other programs for reducing stigma against people with a history of psychiatric treatment (19%); (c) improve health professionals' knowledge, competence, and sensitivity to clients' needs (12%); (d) abolish involuntary treatment and harmful treatment methods (10%); (e) grant more recognition, resources, and influence to organizations controlled by former patients (7%); (f) advocate for and enforce patients' rights (3%); (g) generate non-coercive treatment alternatives (2%); and (h) increase funding for mental health research (2%). Notwithstanding a general tendency to endorse the medical model of help, the majority of members recommend significant changes in the mental health system.

Recommended changes in the mental health system differ from group to group. Recommendations to increase access to assistance programs, improve public education, improve mental health professionals' understanding, ensure patients' rights, and increase funding for mental health research come only from groups that tend to endorse the medical model

(Groups 1, 3, 4, 5, and 6). Recommendations to generate non-coercive treatment alternatives come only from the group that tends to endorse the compensatory model (Group 2). Recommendations to abolish certain kinds of treatment and increase the prominence of organizations controlled by former patients come from both medical and compensatory model groups (Groups 1, 2, 3, and 6). According to these observations, recommended changes in the mental health system may vary in relation to a group's model of help.

DISCUSSION

The present study examined different ideologies in former psychiatric patients' self-help groups and found that members generally adopt their group's ideology. In addition, supportive interpersonal processes such as sharing, empathy, and explanation were found to promote members' adoption of their group's ideological tenets. Members are more likely to adopt their self-help group's explanations and directives if they identify their group as an important setting for understanding and communicating their personal experience. Finally, active exchange of personal information with reference to the group's position and to other members makes the group's positions about problems and solutions more meaningful and may encourage its members to apply them in external settings.

Instead of affirming only one model, members tended to affirm positions deriving from several different models of help. They also attributed such positions to their group. Although support for the medical model of help prevailed, it did not exclude support for other models of help. For example, participants from every group tended to agree that help recipients need the fair chance they have been so far denied (compensatory model) and also need something like a friend (enlightenment model). Thus, self-help groups for former psychiatric patients may have some central positions in common despite ideological differences.

Results indicate that the medical model tends to be endorsed by members of msot groups in the study. According to this model, people in need of help are sick and must receive continuous care from experts until they are cured. The predominance of the medical model in this sample is consistent with Emerick's (1989) observation that the liberation ideology of the founders of the self-help movement for psychiatric patients has been largely superseded by conservative or moderate ideology. The prevalence of the medical model suggests that members learned it through their experience as psychiatric patients. It may also reflect the relative hegemony of this conception among mental health professionals. Thus, competing paradigms within the mental health profession may have significant ramifications for self-help organizations for former psychiatric patients.

The medical model prevailed in the two member-controlled drop-in centers even though both organizations profess to challenge the authority of the mental health system. This finding is consistent with Emerick's (1989) assertion that drop-in centers tend to socialize ex-patients to accommodate to societal rules and norms. Although these informal settings provide opportunities for members to develop supportive networks, they may not foster criticism, define roles, or provide incentives to prompt members to act for social change.

Education is directly related to self-esteem and mastery in the general population (Pearlin & Schooler, 1978). Although education was not significantly related to self-esteem or mastery in the current sample, participants tended to have at least some post-secondary education. This tendency may have reduced the variability of self-esteem and mastery scores and, thus, attenuated any relationship between model of help and these two variables. Even so, there is a modest relationship between psychological well-being and members' model of help. Specifically, members who exclusively endorse the medical model tend to have lower self-esteem and mastery. In order to offset the potential for the harmful consequences of medical model endorsement, self-help groups may need to communicate to members that their contributions are useful, important, and appreciated.

Since medical model endorsement is directly related to the importance members place on professional help and is inversely related to the importance they place on help from their group, a self-help group that strongly encourages its members to follow professional advice may need to show that it provides specific kinds of help that are not available from professionals. Otherwise, members may tend to see their group only as a source of undifferentiated social contact rather than as a setting that offers distinctive coping resources. A group that sanctions the medical model should articulate a belief system and assert its importance

in order to clearly and effectively complement professional help.

Contradicting predictions based on Brickman et al.'s (1982) theory, compensatory model endorsement was not related to higher mastery and self-esteem. Some members of the ex-patients' movement have gained self-confidence and increased their sense of empowerment through attempts to redress inequities and injustices. However, awareness of social inequality may aggravate alienation, frustration, and impotency unless people are ready to take collective action to promote change. As well, people may need to be cognizant of alternatives and convinced of their ability to utilize them before they become willing to take collective action. Endorsement of the compensatory model is, thus, not sufficient to promote competence and self-worth among members of these self-help groups.

Self-help group members' self-esteem and mastery may be more closely related to a group's organizational and leadership structure than to its beliefs about help (Maton, 1988). For example, a group that has a highly differentiated role structure can provide a sense of value by offering each member the opportunity to make an important contribution. On the other hand, a group that states clear positions about solutions may be of minimal benefit if it allocates most of its resources to a few members while relegating the majority to negligible roles (Lemberg, 1984).

Budd (1987) and Frankel (1983) cite examples of the harmful effects of authoritarian leadership in mental health self-help groups. Ideology may not be a group's principal resource for helping its members.

Ideology may be more prominent in self-help groups that endorse the enlightenment model than in groups that endorse other models of help. Enlightenment model groups are founded on the conviction that spiritual reform, discipline, and benevolence are the principal means of overcoming problems. For example, the Twelve Step ideology is the index of progress in organizations based on the Alcoholics Anonymous paradigm. Mental health self-help organizations such as Emotions Anonymous, GROW, and Recovery, Inc. are similar to Alcoholics Anonymous in their emphasis on individual reform as the basis of recovery. Most investigations of mental health self-help groups have focused on chapters of these organizations. For example, Galanter (1988) found that ideological endorsement was significantly related to general well-being and self-reported decreases in distress among Recovery, Inc. members. Enlightenment model groups may enhance members' sense of value by offering a new identity within a close-knit community.

The groups in the current study were selected because they tended to endorse either the medical or compensatory model of help. Although they may place less emphasis on

ideology, medical model groups can provide information about biochemical disorders. Likewise, compensatory model groups can initiate systemic social change. Both types of groups can benefit people who have a history of psychiatric treatment, but they may not define themselves in the same terms, organize themselves according to the same principles, or identify themselves as solving the same kinds of problems. Hence, it may be mistaken to assess them according to uniform criteria. More inquiry into their differences might lead to a clearer understanding of their purposes, strategies, and actions.

Results of the present study do not suggest that endorsement of the compensatory model or the medical model is positively related to participants' emphasis on the need for mental health system change. Participants who perceive their problems as resulting from powerlessness may feel disaffected about change in the mental health system or may prefer to divorce themselves from the system rather than work to change it. Participants who perceive professionals as fundamentally benign may see little need to change the system. Some factor other than their model of help may explain the finding that these self-help group members tend to favor mental health system change.

Results indicate that members of several of the groups, including some groups whose literature states that their members have a biochemical illness, affirm the importance of

mental health system change. In addition, some groups with a small minority of active advocates have accomplished significant policy change even though the majority of their members accept the medical model of help. Since these facts would not be predicted by Brickman et al.'s (1982) theory of helping roles, there is a need to explain why self-help groups are capable of fostering attitudes and action for social change without formulating a radical critique.

Droge et al.'s (1986) examination of epilepsy self-help groups suggests the following explanation for why medical model self-help groups can become meaningful alternatives to dependence on help provided by professionals: (a) Perceived physical and psychological health problems are not related to seizure activity, but may be related to a lack of social support; (b) nonmedical problems result from prejudice by nonepileptics, not from members' psychological characteristics; (c) self-help groups provide social support and leisure opportunities that offer respite from stigma; (d) members use narrative as the means of revealing their experiences to one another; (e) after using information from new narratives to form a better understanding of their problem, members adopt a more critical, proactive stance in their relationships with health professionals and the general public.

According to the above analysis, self-help groups that primarily define members as ill, as well as groups that

primarily define members as disenfranchised, are capable of promoting changes in relationships and attitudes towards health professionals. Thus, self-help groups may promote changes in relationships and attitudes by organizing new sites of information, rather than by taking power away from existing institutions.

Recommendations for Future Research

Usefulness of the HOT

This study was the first attempt to use the Health Orientation Test (HOT) to assess ideological differences in self-help groups for former psychiatric patients. These groups and their members tended to have high scores on more than one of the test's four scales, indicating that the HOT did not assess four mutually-exclusive belief systems. Moreover, for reasons discussed below, the HOT may not be a very sensitive or accurate indicator of ideological differences in this population.

Although their materials indicated that groups held different ideological positions, these differences were not reflected by groups' or members' scores on the HOT. Instead of rejecting them (rating 0-2), participants tended to give neutral ratings (3) to items they did not endorse. Although this may indicate an acquiescence bias in some cases, it may also have occurred because participants considered many items to be vague, irrelevant, or non-controversial.

Discriminant analysis might be used to select the items that are most likely to distinguish between groups and so define a group's unique model of help.

Assessment of differences on the four models of help might be more accurate if HOT items were adapted to refer more specifically to issues that concern self-help groups for former psychiatric patients. For example, "Group members advocate for patients' rights" could substitute for "People receiving help see helpers as people who enjoy seeing justice done" (compensatory model); "Members respect the advice of mental health professionals" could substitute for "People receiving help see helpers as people who enjoy doing a job for which they are highly respected" (medical model); "Members share practical advice about problems in living" could substitute for "People receiving help see helpers as people who enjoy giving advice on how to cope" (moral model); and "Members overcome emotional problems by caring for others" could substitute for "People who receive help see helpers as people who enjoy discovering a new 'brother or sister'" (enlightenment model). Clearer, more meaningful items may discriminate better between groups.

Group Process in Relation to Tenet Endorsement

Results of the study confirmed that sharing, empathy, and explanation encourage members to adopt their self-help group's ideology. In other words, members are likely to

endorse their group's explanations and prescriptions if they see the group as an important setting for communicating and understanding personal experiences. Researchers may be able to further specify these influences by assessing (a) examples of the problems that members bring before the group, (b) the group's explanations and recommendations for these problems, (c) the decisions that members base on their group's recommendations, and (d) consequences of the actions that members take on their group's advice. These assessments could explicate the aspects of a group's processes and positions that lead to differences in members' lives.

Contributions of Members to Their Groups

Results of the study indicate that participants' reactions to their self-help group may be more strongly related to the help they give other members than to other aspects of group involvement. Participants who help other members strongly endorse their group's tenets and are likely to think that they can master problems. These results are consistent with those of previous research (Maton, 1986), indicating that self-help groups benefit their members by providing opportunities for them to help others. This confirmation of the principle of mutual help suggests that it may be informative to further specify the relationship between helping others and coping effectiveness.

One way to specify the relationship between helping others and coping effectiveness would be to examine members' contributions to their group in greater detail. For example, members could be asked to document the occasions when they have provided help over a three-month period. Members' contributions could be used to define their roles in the group. Information about roles could then be aggregated to compare members with different roles and also to compare groups with different role structures. Both kinds of differences may relate to members' sense of value and competence in their group.

Attitudes Toward Mental Health Professionals

Results indicate that participants think professional help is important and that medical model endorsement is positively related to the importance placed on professional help. However, since it used only one question to assess the importance of professional help, the present study does not provide detailed information about participants' evaluation of mental health professionals in relation to their group.

In a survey of 104 ex-patients' groups, Emerick (1990) examined three aspects of relations with mental health professionals: (a) level of interaction with professionals (ranging from "none" to "high", based on responses to an open-ended question); (b) evaluation of psychiatry (ranging

from "a progressive science which helps people cope with problems" to "the enemy of people with mental/emotional problems"); and (c) evaluation of various treatment methods from occupational/recreational therapy through psychosurgery (ranging from "very positive" to "very negative"). While the present study provides general information, use of these other instruments would provide more detailed information about the relationship between ideology and attitudes towards mental health professionals in self-help groups for former psychiatric patients.

Changes in the Mental Health System

This is the first study of psychiatric patients' self-help groups to assess recommendations for changes in the mental health system. An open-ended question asked participants to describe the changes that should be made to benefit people with emotional and mental health problems. Members made recommendations to improve: (a) treatment and social programs, (b) public education, (c) professionals' relations with clients, (d) involuntary commitment and treatment policy, (e) allocation of resources to member-controlled services, (f) patients' rights, (g) availability of non-coercive treatment alternatives, and (h) funding for mental health research. Since the researcher assigned recommendations into these categories after members had responded to the question, they must be regarded as

tentative. However, they could be considered for use as part of further inquiry into members' recommendations for mental health system change.

Preliminary observations suggest that members of groups with different ideologies may recommend different changes in the present mental health system. For example, members of a group that attributes mental health problems to a chemical imbalance in the brain may tend to favor increased funding for psychopharmacological research. In contrast, members of a group that aims at correcting excesses of the psychiatric system may tend to favor abolition of involuntary commitment and treatment. Since members of all the groups in this study emphasize that change is needed and recommend various changes in the mental health system, recommendations for change should be addressed in future investigations of self-help groups for former psychiatric patients.

April 24, 1991

To: Psychology Graduate Students

From: C. Erickson

1991 Mini-University Instructor

I will be accepting written applications for the 1991 Mini-University instructor position (duties are outlined below) until noon, Thursday, May 2nd. The total salary of $ 3,256. is payable over a 16 week period commencing in early May.

April 24, 1991

Grades

	Advisor's Input (5%)	Oral (15%)
Best	4	
Das	4	
Drobot	4.8	
Foster	4.5	
Larson	4.3	
Robertson	4.5	
Spice	3.3	
Vincent	4.5	

REFERENCES

Alcoholics Anonymous. (1955). Alcoholics anonymous. Alcoholics Anonymous Services. (Pamphlet available from Alcoholics Anonymous, Box 459, Grand Central Station, New York, NY 10163.)

Antze, P. (1976). The role of ideologies in peer psychotherapy organizations: Some theoretical considerations and three case studies. Journal of Applied Behavioral Science, 12, 323-346.

Antze, P. (1979). Role of ideologies in peer psychotherapy group. In M.A. Lieberman & L.D. Borman (Eds.), Self-help groups for coping with crisis; Origins, members, processes, and impact (pp. 272-304). San Francisco: Jossey-Bass, Inc.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84, 191-215.

Borkman, T. (1984). Mutual self-help groups. In A. Gartner & F. Riessman (Eds.), The self-help revolution (pp. 205-125). New York: Human Sciences Press, Inc.

Brewer, M. (1975, August). Erhard seminars training: "We're gonna tear you down and put you back together." Psychology Today, pp. 35-40, 82-89.

Brickman, P., Kidder, L.H., Coates, D., Rabinowitz, V., Cohn, E., & Karuza, J. (1983). The dilemmas of helping: Making aid fair and effective. In J.D. Fisher, A. Nadler, & B.M. DePaolo (Eds.), New directions in helping (pp. 18-51). New York: Academic Press.

Brickman, P., Rabinowitz, V.C., Coates, D., Cohn, E., Kidder, L. & Karuza, J. (1977). The dilemmas of helping. Unpublished manuscript, Northwestern University, Department of Psychology, Evanston, IL.

Brickman, P., Rabinowitz, V.C., Karuza, J. Jr., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. American Psychologist, 37, 368-384.

Budd, S. (1987). Leadership and meeting facilitation. In S. Zinman, H. Harp, & S. Budd (Eds.), Reaching across: Mental health clients helping each other. (Available from California Network of Mental Health Clients, 3773 Tibbetts St., Suite C, Riverside, CA 92506.)

Chamberlin, J. (1984). Speaking for ourselves: An overview of the ex-psychiatric inmates' movement. Psychosocial Rehabilitation Journal, 8, 56-63.

DePaolo, B.M., Brown, P., Ishii, S., & Fisher, J.D. (1981). Help that works: The effects of aid on subsequent task performance. Journal of Personality and Social Psychology, 41, 478-487.

Dixon, J.K. (1981). Group-self identification and physical handicap: Implication for patient support groups. Research in Nursing and Health, 4, 299-308.

Droge, D., Arntson, P., & Norton, R. (1986). The social support function in epilepsy self-help groups. Small Group Behavior, 17, 139-163.

Drop feared in NIMH support of national consumer/ex-patient/inmate movement: Emergency action required, say movement leaders. (1988). Your Choice, NMHCA Newsletter, 1(3), pp. 1, 10.

Dweck, C.S. (1975). The role of expectations and attributions in the alleviation of learned helplessness. Journal of Personality and Social Psychology, 31, 674-685.

Emerick, R.E. (1989). Group demographics in the mental patient movement: Group location, age, and size as structural factors. Community Mental Health Journal, 25, 277-300.

Emerick, R.E. (1990). Self-help groups for former patients: Relations with mental health professionals. Hospital and Community Psychiatry, 41, 401-407.

Emotions Anonymous (1974). My chart of illness and recovery. (Pamphlet available from Emotions Anonymous International Services, P.O. Box 4245, St. Paul, MN 55104).

Emotions Anonymous (1986). Welcome to Emotions Anonymous: Handout to new members. (Pamphlet available from Emotions Anonymous International Services, P.O. Box 4245, St. Paul, MN 55104).

Epp, J. (1987). Achieving health for all: A framework for health promotions. Canadian Journal of Public Health, 77, 393-407.

Farina, A., Fisher, J.D., Getter, H., & Fischer, E. (1978). Some consequences of changing people's views regarding the nature of mental illness. Journal of Abnormal Psychology, 87, 272-279.

Finnen, G. (1989, June). Self-help for serious mood disorder: A Manitoba story. Canada's Mental Health, 37, 5-7.

Fisher, J.D., & Farina, A. (1979). Consequences of beliefs about the nature of mental disorders. Journal of Abnormal Psychology, 88, 320-327.

Fisher, J.D., Nadler, A., & Whitcher-Alagna, S. (1983). Four theoretical approaches for conceptualizing reactions to aid. In J.D. Fisher, A. Nadler, & B.M. DePaolo (Eds.), New directions in helping (pp. 52-59). New York: Academic Press.

Frankel, S.I. (1983). Facilitative intervention with a self-help group. Unpublished M.S.W. practicum thesis, University of Manitoba, Winnipeg, Manitoba.

Galanter, M. (1988). Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery, Inc. American Journal of Psychiatry, 145, 1248-1253.

Gartner, A. (1976). Self-help and mental health. Social Policy, 7, 28-40.

Gartner, A., & Reissman, F. (Eds.). (1984). The self-help revolution. New York: Human Sciences Press, Inc.

Glass, D.C., & Singer, J.E. (1972). Urban stress: Experiments on noise and social stressors. New York: Academic Press.

Grosz, H.J. (1972). Recovery, Inc., survey. (Available from Recovery, Inc., 802 Dearborn St., Chicago, IL 60610).

GROW (1982). GROW: First aid for mental crisis. (Pamphlet available from GROW, Inc., P.O. Box 3667, Champaign, IL 61821).

GROW, Inc. (1981). Organizer's training manual. (Pamphlet available from GROW, Inc., P.O. Box 3667, Champaign, IL 61821).

Group de Support Emotionnel Inc. (1989). Self-help and mental health: One group's point of view. Initiative, The Self-Help Newsletter, 5, 6.

Gussow, Z., & Tracy, G.S. (1976). The role of self-help clubs in adaptation to chronic illness and disability. Social Science & Medicine, 10, 407-414.

Harp, H.T. (1987). Philosophical models. In S. Zinman, H.T. Harp, & S. Budd (Eds.), Reaching across: Mental health clients helping each other (pp. 19-24). (Available from California Network of Mental Health Clients, 3773 Tibbetts St., Suite C, Riverside, CA 92506.)

Hill, D.J., & Bale, R. (1981). Measuring beliefs about where psychological pain originates and who is responsible for its alleviation: Two new scales for clinical researchers. In H.M. Lefcourt (Ed.), Research with the locus of control construct: Vol. 1. Assessment methods (pp. 281-320). New York: Academic Press, Inc.

Hill, W.F. (1975). Further considerations of therapeutic mechanisms in group therapy. Small Group Behavior, 6, 421-429.

Hinrichsen, G.A., Revenson, T.A., & Shinn, M. (1985). Does self-help help? An empirical investigation of scoliosis peer support groups. Journal of Social Issues, 41, 65-87.

Irick, P.J. (Ed.). (1987). Mental health consumers' directory. (Available from Patrick J. Irick, 4713 Jenewein Rd., #3, Madison, WI 53711.)

Jacobs, M.K. & Goodman, G. (1989). Psychology and self-help groups: Predictions on a partnership. American Psychologist, 44, 536-545.

Jurik, N.C. (1987). Persuasion in a self-help group: Processes and consequences. Small Group Behavior, 18, 368-397.

Karuza, J., Zevon, M.A., Rabinowitz, V.C., & Brickman, P. (1982). Attribution of responsibility by helpers and recipients. In T.A. Wills (Ed.), Basic processes in helping relationships (pp. 107-129). New York: Academic Press.

Katz, A. (1981). Self-help and mutual aid: An emergent social movement? Annual Review of Sociology, 7, 129-155.

Knight, B., Wollert, R.W., Levy, L., Frame, C.L., & Padgett, V.P. (1981). Self-help groups: The members' perspectives. American Journal of Community Psychology, 8, 53-65.

Koop, C.E. (1987, September). Keynote Address to U.S. Surgeon General's Workshop on Self-help and Public Health, U.C.L.A., Los Angeles, CA.

Kronenfeld, J.J. (1986). Self-help and self-care as social movements. Advances in Health Education and Promotion, 1, 105-127.

Kurtz, L.F. (1988). Mutual aid for affective disorders: The Manic Depressive and Depressive Association. American Journal of Orthopsychiatry, 58, 152-155.

Kurtz, L.F. & Chambon, A. (1987). A comparison of self-help groups for the mentally ill. Health and Social Work, 12, 275-283.

Landy, D., & Singer, S.E. (1961). The social organization and culture of a club for former mental patients. Human Relations, 14, 31-40.

Lavoie, F. (1981). Social atmosphere in self-help groups: A case study. Canada's Mental Health, 29, 13-15.

Leff, J.P. (1976). Schizophrenia and sensitivity to the family environment. Schizophrenia Bulletin, 2, 566-574.

Lemberg, R. (1984). Ten ways for a self-help group to fail. American Journal of Orthopsychiatry, 54, 648-650.

Levine, M. (1988). An analysis of mutual assistance. American Journal of Community Psychology, 16, 167-188.

Levy, L. (1981). The National Schizophrenia Fellowship: A British self-help group. Social Psychiatry, 16, 129-135.

Levy, L.H. (1976). Self-help groups: Types and psychological processes. The Journal of Applied Behavior Science, 12, 310-322.

Levy, L.H. (1979). Processes and activities in groups. In M.A. Liberman & L.D. Borman (Eds.), Self-help groups for coping with crisis: Origins, members, processes, and impact (pp. 235-271). San Francisco: Jossey-Bass, Inc.

Liberman, B.L. (1978). The role of mastery in psychotherapy: Maintenance of improvement and prescriptive change. In J.D. Frank, R. Hoehn-Saric, D.D. Imber, B.L. Liberman, & A.R. Stone (Eds.), The effective ingredients of successful psychotherapy. New York: Brunner/Mazel.

Lieberman, M.A. (1979). Analyzing change mechanisms in groups. In M.A. Lieberman & L.D. Borman (Eds.), Self-help groups for coping with crisis: Members, processes, and impact (pp. 194-233). San Francisco: Jossey-Bass, Inc.

Lieberman, M.A. (1986). Self-help groups and psychiatry. American Psychiatric Association Annual Review, 5, 744-760.

Lieberman, M.A. (1990). Understanding how groups work: A study of homogeneous peer group failures. International Journal of Group Psychotherapy, 40, 31-52.

Lieberman, M.A., & Bliwise, N.G. (1985). Comparisons among peer and professionally directed groups for the elderly: Implications for the development of self-help groups. International Journal of Group Psychotherapy, 35, 155-175.

Lieberman, M.A., & Videka-Sherman, L. (1986). The impact of self-help groups on the mental health of widows and widowers. American Journal of Orthopsychiatry, 56, 435-449.

Llewelyn, S.P., & Haslett, A.V.J. (1986). Factors perceived as helpful by the members of self-help groups: An exploratory study. British Journal of Guidance and Counselling, 14, 252-262.

Low, A.A. (1950). Mental health through will-training. Boston: Christopher.

Luke, D.A. (1987, May). The impact of organizational culture on group behavior. Paper presented at the First Biennial Conference on Community Research and Action, University of South Carolina, Columbia, S.C.

Lurie, A., & Shulman, L. (1983). The professional connection with self-help groups in health care settings. Social Work in Health Care, 8, 69-77.

Maton, K.I. (1988). Social support, organizational characteristics, psychological well-being, and group appraisal in three self-help group populations. American Journal of Community Psychology, 16, 53-77.

McFadden, L. (1987, May). Espoused theories and the ideology of mutual-help. Paper presented at the First Biennial Conference on Community Research and Action, University of South Carolina, Columbia, SC.

Medvene, L.J. (1985). An organizational theory of self-help groups. Social Policy, 15, 35-37.

Medvene, L.J., & Krauss, D.H. (1989). Causal attributions and parent-child relationships in a self-help group for families of the mentally ill. Journal of Applied Social Psychology 19, 1413-1430.

Mellinger, G., & Balter, M. (1983). Collaborative project, GMIRSB report. Washington, DC: National Institute of Mental Health.

Mitchell, C.L. (1988). Attributions of responsibility for problem cause and problem solution: Their relationship to self-esteem. Journal of Psychology, 122, 511-518.

Morris, S.C., III, & Rosen, S. (1973). Effects of felt adequacy and opportunity to reciprocate on help-seeking. Journal of Experimental Social Psychology, 9, 265-276.

Morrison, J.K., Bushell, J.D., Hanson, G.D., Fentiman, J.R., & Holdridge-Crane, S. (1977). Relationship between psychiatric patients' attitudes toward mental illness and attitudes of dependence. Psychological Reports, 41, 1194.

NDMDA (1986). Depression and manic depression devastate millions of lives: Join the National Depressive and Manic Depressive Association. (Pamphlet available from NDMDA, Merchandise Mart, Box 3395, Chicago, Illinois 60654).

National Aliance of Mental Patients. (1987 August). Goals & Philosophy Statement. Distributed at Alternatives '87, Marshall University, Huntington, WV.

Nicholaichuk, T.P., & Wollert, R. (1989). The effects of self-help on health status and health-services utilization. Canadian Journal of Community Mental Health, 8, 17-29.

Norman, W.H. (1983). Self-blame in self-help: Differences in two weight-loss groups. Journal of Applied Social Science, 8, 137-153.

Oakes, W.F. (1982). Learned helplessness and defensive strategies: A rejoinder. Journal of Personality, 50, 515-525.

O'Brien, M.S., & Bankston, W.B. (1984). The moral career of the reformed compulsive eater: A study of conversion to charismatic conformity. Deviant Behavior, 5, 141-150.

Palenzuela, D.L. (1984). Critical evaluation of locus of control: Towards a reconceptualization of the construct and its measurement. Psychological Reports, 54, 683-709.

Pearlin, L.D., & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.

Plummer, E., Thorton, J.F., Seeman, M.V., & Littman, S.T. (1981). Living with schizophrenia: A group approach with relatives. Canada's Mental Health, 29, 17.

Politser, P.E., & Pattison, E.M. (1980). Social climates in community groups: Towards a taxonomy. Community Mental Health Journal, 16, 187-200.

Rabinowitz, V.C. (1978). Orientations to help in four natural settings. Dissertation Abstracts International, 39, 5149B-5150B. (University Microfilms No. 79-07928).

Raiff, N.R. (1984). Some health related outcomes of self-help participation: Recovery, Inc. as a case example of a self-help organization in mental health. In A. Garther & F. Riessman (Eds.), The self-help revolution (pp. 183-203). New York: Human Services Press, Inc.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9, 233-246.

Rappaport, J. (1988, June). Brief summary of GROW Evaluation Project as of June, 1988. (Available from Julian Rappaport, PhD, Professor of Psychology, University of Illinois at Urgana-Champaign, 603 E. Daniel St., Champaign, IL 61820).

Rappaport, J., Seidman, E., Toro, P.A., McFadden, L.S., Reischl, T.M., Roberts, L.J., Salem, D.A., Stein, C.H., & Zimmermanm M.A. (1985). Collaborative research with a mutual help organization. Social Policy, 15, 12-24.

Riessman, F. (1985). New dimensions in self-help. Social Policy, 15, 2-4.

Riordan, R.J., & Beggs M.S. (1988). Some critical differences between self-help and therapy groups. Journal for Specialists in Group Work, 13, 24-29.

Rogers, J. (1988). Is psychiatric force ever right? Your Choice, NMHCA Newsletter, 1(3), p. 16.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton: Princeton University Press.

Rosenberg, M. (1979). Conceiving the self. New York: Basic Books, Inc.

Rotter, J.A. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs, 80, 1-28.

Ryback, R.S. (1971). Schizophrenics Anonymous: A treatment adjunct. Psychiatry in Medicine, 2, 247-253.

Salem, D. (1987, May). The culture of mutual help: Characteristics of the GROW membership. Paper presented at the First Biennial Conference on Community Research and Action, University of South Carolina, Columbia, SC.

Salem, D.A., Seidman, E., and Rappaport, J. (1988). Community treatment of the mentally ill: The promise of mutual-help organizations. Social Work, 33, 403-408.

Seligman, M.E.P. (1975). Helplessness. San Francisco: Freeman.

Stein, C.H. (1987, May). Social networks, social support and psychological adjustment among participants in a mutual help organization for the mentally ill. Paper presented at the First Biennial Conference on Community Research and Action, University of South Carolina, Columbia, SC.

Suler, J. (1984). The role of ideology in self-help groups. Social Policy, 14, 29-36.

Tennen, H. (1982). A re-view of cognitive mediators in learned helplessness. Journal of Personality, 50, 526-540.

Thompson, E.H. (1989). Recovery networks and patient interpretations of mental illness. Journal of Community Psychiatry, 17, 5-15.

Tippet, J.S., & Silber, E. (1965). Self-image stability: The problem of validation. Psychological Reports 17, 323-329.

Toro, P.A., Rappaport, J., & Seidman, E. (1987). Social climate comparison of mutual help and psychotherapy groups. Journal of Consulting and Clinical Psychology, 55, 430-431.

Trute, B., Tefft, B., and Scusa, D. (1983). An overview of mental health information systems. In E. Bennet & B. Trute (Eds.), Mental health information systems: Problems and prospects (pp. 205-222). Lewiston, NY: Edwin Mellen Press.

Van Der Vort, A., & Van Harbooden, P. (1985). Helping self-help groups: A developing theory. Psychotherapy, 22, 269-272.

Videka-Sherman, L., & Lieberman, M. (1985). The effects of self-help and psychotherapy intervention on child loss: The limits of recovery. American Journal of Orthopsychiatry, 55, 70-82.

Watts, W. (1967). Relative persistence of opinion change induced by active as compared to passive participation. Journal of Personal and Social Psychology, 5, 4-15.

Wells, L.E., & Marwell, G. (1976). Self esteem. Beverly Hills: Sage Publications, Inc.

Wollert, R.W. (1986). Psychosocial helping processes in a heterogeneous sample of self-help groups. Canadian Journal of Community Mental Health, 5, 63-76.

Wollert, R. (1988). An evaluation of a communications training program within a self-help group for sexually abusive families. Community Mental Health Journal, 24, 229-235.

Wollert, R.W., Levy, L.H., & Knight, B.G. (1982). Help giving in behavioral control and stress coping self-help groups. Small Group Behavior, 13, 204-218.

Wylie, R.C. (1974). The self-concept (Vol. 1). Lincoln, Nebraska: University of Nebraska Press.

Yalom, I.D. (1985). The theory and practice of group psychotherapy (3rd ed.). New York: Basic Books, Inc.

Zinman, S., Harp, H.T., & Budd, S. (Eds.). (1987). Reaching across: Mental health clients helping each other. (Available from California Network of Mental Health Clients, 3773 Tibbetts St., Suite C, Riverside, CA 92506).

APPENDIX A

Request for group's materials (Letter 1)

Preliminary Questionnaire

[Letter 1]

[Date]

Dear member:

I am a graduate student in clinical psychology at the University of Manitoba. I live and work in North Dakota. My background includes work with self-help groups for people who have emotional and mental health problems. I am a sup-porter of the National Mental Health Consumers Association (NMHCA) and the National Alliance of Mental Patients (NAMP). I attended a national mental health self-help conference in August, 1987. I learned of your organization through its listing in the self-help handbook Reaching Across: Mental Health Clients Helping Each Other and in the Mental Health Consumers' Directory.

I am conducting a research project on philosophies of self-help groups for people with emotional and mental health problems. The study examines the relation of different self-help philosophies to personal characteristics of group members. Participation in the study will help you learn more about how your group communicates its philosophy and helps its members.

I would like to know more about [group name]'s philosophy of self-help. I would especially like to read brochures, newsletters, and other materials that describe the purpose of [group name], its views of mental health problems, and its beliefs about how people with such problems are helped. The information that you provide will be used to decide the appropriateness of your group's further participation in the study.

A brief questionnaire attached to this letter contains some basic questions about your group and asks for the name of a member who could be contacted for more information. Please send the requested materials and the completed questionnaire in the self-addressed envelope that I have provided.

Thank you for helping me to learn more about your group.

Sincerely,

Chris Hertler

Enclosures

[Preliminary Questionnaire]

GROUP NAME_____

QUESTIONNAIRE

1. When was your group founded? _____ _____
   month year

2. Does your group have regular meetings? (Check one)

   _____yes _____no

   If answer to #2 is yes, please answer questions 3 and 4 before answering question 5. If answer to #2 is no, please go on to question 5.

3. How many meetings does your group normally have each month?

   _____ meetings per month

4. What day of the week and time of day does your group meet?

   _____ day of the week

   _____ time of day

5. Please list the anticipated dates and times of your next 3 meetings.

   _____ _____
   date time of day

   _____ _____
   date time of day

   _____ _____
   date time of day

6. Please list a telephone number where your group can be contacted during meetings:

   _____ _____
   (Area Code)

7. Please list a telephone number where your group can be contacted at other times.

_____ _____
(Area Code)

8. How many members are in your group? _____ members

9. How many members normally attend your meeting?

_____ members

10. May non-members attend meetings of your group?

_____ yes _____ no

11. Please list the name of a member who can be contacted for more information about your group:

Name _____

Address _____

_____

Telephone _____
(Area Code)

After you complete the questionnaire, please send it by mail using the stamped, addressed envelope provided. The researcher will be contacting you about your further participation in the study.

Thank you for your participation.

APPENDIX B

Request to administer questionnaire(s) (Letter 2)

[Letter 2]

(Date)

Dear [group name] members:

I am a graduate student in clinical psychology at the University of Manitoba. I live and work in North Dakota. My background includes work with self-help groups for people who have emotional and mental health problems. I am a supporter of the National Mental Health Consumers Association (NMHCA) and the National Alliance of Mental Patients (NAMP). I attended a national mental health self-help conference in August, 1987. I learned of your organization through its listing in the self-help handbook Reaching Across: Mental Health Clients Helping Each Other and in the Mental Health Consumers' Directory.

I was very pleased to receive materials from your group describing its purpose, philosophy, and activities. They were informative and interesting. Thank you very much!

As I stated in the request for materials from your group, I am conducting a research project on self-help groups for people who have had emotional or mental health problems. I will be comparing the self-help philosophies of various groups. As part of that process, I would like to learn more about [group name] and its membership.

I would like to attend a meeting of [group name]. At the meeting, I would introduce myself to the members and distribute two questionnaires. The first questionnaire asks members to provide some background information about themselves and to describe the philosophy of [group name]. It takes about 15 minutes to complete the first questionnaire. The second questionnaire asks members to describe themselves and their self-help group in greater detail. It takes one hour to complete the second questionnaire. Members can ask me to help them fill out the questionnaires. The questionnaires would be administered to every member who attends that meeting of [group name]. I hope that every member of [group name] will attend the meeting. To show my appreciation, I will compensate your group for its participation in the study. I am willing to donate $7.50 to [group name] for each questionnaire for Part 2 of the study that its members complete. I can consider providing your group with an alternative form of compensation if you prefer not to accept a donation.

Members' responses to the questionnaires will be confidential. Members will be asked not to put their name on the questionnaires so that information on the questionnaires cannot be used to identify the person who completed it. The completed

questionnaires will be kept in a secure place. The responses to the questionnaires will not be shown to anyone else. I will read and explain these procedures to members when I administer the questionnaires. A letter that is attached to every questionnaire also states the confidentiality procedures.

I plan to call a representative of your group so that I can answer questions about the study and discuss a time to administer the questionnaires to members. A representative of your group may call me collect at home if that would be more convenient than receiving a call from me. My home telephone number is
I can be reached after 6:30 p.m. MST every day except Thursdays.

The results of the research project will help members understand how their group works and may provide information about ways that your group can be more helpful to its members. I will be happy to share the study's findings and discuss them with your membership after the project has been completed.

Thank you for your willingness to cooperate in this important project. I look forward to our future communication. I hope that we will meet each other soon.

Sincerely,

Chris Hertler

APPENDIX C

Rater's Questionnaire

Members' Questionnaire

[Rater's Questionaire]

Below is a series of statements. How accurate is each statement in representing the positions of [group name] as stated in its brochures, pamphlets and other materials? Please base your ratings on your own reading of the organization's publications.

1. [Group name] benefits individuals who have spent time in psychiatric facilities by joining together with them to advocate for their rights and needs.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

2. [Group name] advocates that the State of [State name] provide adequate legal services to patients in state-run psychiatric facilities.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

3. [Group name] seeks to improve the legal rights of persons in [State name] psychiatric facilities, works on committees and boards to upgrade conditions in psychiatric facilities, and works to develop community alternatives.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

4. Members of [group name] teach legal rights in state-run psychiatric facilities.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

5. [Group name] provides a valuable service by offering mutual support as well as social, recreational and educational activities to individuals who have been in psychiatric facilities.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

6. [Group name] works to decrease the stigma that follows people who have undergone psychiatric treatment.

Completely Inaccurate		Neither Accurate Nor Inaccurate		Completely Accurate
1	2	3	4	5

[Members' Questionnaire]

Please rate the extent to which you believe or disbelieve the following statements:

1. [Group name] benefits individuals who have spent time in psychiatric facilities by joining together with them to advocate for their rights and needs.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

2. [Group name] advocates that the State of [State name] provide adequate legal services to patients in state-run psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

3. [Group name] seeks to improve the legal rights of persons in [State name] psychiatric facilities, works on committees and boards to upgrade conditions in psychiatric facilities, and works to develop community alternatives.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

4. Members of [group name] teach legal rights in state-run psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

5. [Group name] provides a valuable service by offering mutual support as well as social, recreational and educational activities to individuals who have been in psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6. [Group name] works to decrease the stigma that follows people who have undergone psychiatric treatment.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

APPENDIX D

Consent forms

CONSENT FORMS

The membership of _____ consents to participate by completing the questionnaire for Part 1 of the self-help research project conducted by Chris Hertler under the supervision of the Department of Psychology, University of Manitoba. Individual members may elect not to participate now or at any time during the course of the study.

_____ _____

Group Representative's Signature Date

The membership of _____ consents to participate by completing the questionnaire for Part 2 of the self-help research project conducted by Chris Hertler under the supervision of the Department of Psychology, University of Manitoba. Individual members may elect not to participate now or at any time during the course of the study.

_____ _____

Group Representative's Signature Date

APPENDIX E

Questionnaire 1

(a) Cover letter

(b) 1-1 to 1-4: Background information

(c) 2-1 to 2-40: Help Orientation Test (HOT) - group's model of help

(d) 2-41 to 2-46: Attributions for past and future

[Questionnaire 1 - Cover Letter]

I am requesting that all members of [group name] complete the attached questionnaire. Please do not put your name on the questionnaire and do not write anything on the questionnaire except for what is asked. These procedures are being used to ensure that none of the information on the questionnaire can be used to identify the particular person who completes it. The questionnaires will be kept in a secure place. The information on each questionnaire will not be shown to anyone else.

Please feel free to ask me questions and to ask me for help as you complete the questionnaire. Thank you for helping me to learn more about your group.

Sincerely,

Chris Hertler

BACKGROUND INFORMATION

Please answer the following questions as completely as possible:

1-1. How old are you? _____ years

1-2. What is the highest level of schooling you have completed? (Check one)

Grades 6 or less _____

Grades 7 to 9 _____

Some High School _____

Some Technical or Vocational training after High School _____

Technical or Vocational school graduate _____

Some College or University _____

College or University graduate _____

Post-graduate University education _____

1-3. How long have you been a member of your group? (Check one)

Less than 1 month _____

1-3 months _____

4-6 months _____

7-9 months _____

10-12 months _____

More than 12 months _____

1-4. Are you: (Check one) Female _____

Male _____

[Help Orientation Test]

RATING SCALE FOR GROUP'S BELIEFS

Please use the following statements to rate your self-help group's beliefs about help. If your group thinks that a statement is not at all true, circle 0. If your group thinks that a statement is completely true, circle 6. If your group thinks that a statement is somewhere in between not at all true and completely true, circle the number between 0 and 6 that best represents how true it is.

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-1. Need to see that they are not alone. [E]

Not at all true						Completely true
0	1	2	3	4	5	6

2-2. Need the fair chance they have been so far denied. [C]

Not at all true						Completely true
0	1	2	3	4	5	6

E = Enlightenment
Mo = Moral
C = Compensatory
Me = Medical

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-3. Need only to be shown how. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-4. Need therapy. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-5. Are deprived. [C]

Not at all true Completely true

0 1 2 3 4 5 6

2-6. Are stubborn. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-7. Are sick. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-8. Are unaware. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-9. Need something like a doctor. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-10. Need something like a friend. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-11. Need something like time to think. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-12. Need something like a tutor. [C]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-13. Would become increasingly self-destructive if they did not get help. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-14. Would be all right even if they did not get help. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-15. Would become increasingly sick if they did not get help. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-16. Would become hostile or violent if they did not get help. [C]

Not at all true Completely true

0 1 2 3 4 5 6

2-17. Need help to be given for a fixed, temporary period. [C]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-18. Need help to be given until they are cured. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-19. Need a long-term relationship with someone who had similar experiences. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-20. Need only to get themselves together and discover where they personally want to go. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-21. Will fail unless they accept guidance from those who have "been there." [E]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-22. Will fail unless they are completely self reliant. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-23. Will fail unless they are given the resources they deserve. [C]

Not at all true Completely true

0 1 2 3 4 5 6

2-24. Will fail unless those helping them are skillful enough. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-25. See helpers as people who enjoy seeing justice done. [C]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-26. See helpers as people who enjoy doing a job for which they are highly respected. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-27. See helpers as people who enjoy giving advice on how to cope. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-28. See helpers as people who enjoy discovering a new "brother" or "sister". [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-29. Need to reorient themselves and get back on their feet. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-30. Need experienced, trained care. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-31. Need to dedicate themselves to a higher cause. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-32. Need the resources of those more fortunate. [C]

Not at all true Completely true

0 1 2 3 4 5 6

2-33. Without help, would withdraw and fall apart. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-34. Without help, would seek a means to success that society might not approve. [C]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT PEOPLE RECEIVING HELP:

2-35. Without help, would pursue the illusion that they can do everything by themselves. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-36. Without help, would miss the discovery of their deepest inner strength. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

2-37. Will need help again only if they fall sick again. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

2-38. Will need help again only as a reminder that they are responsible for themselves. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT:

2-39. Will need help again as a matter of being part of a community. [E]

Not at all true Completely true

0 1 2 3 4 5 6

2-40. Will need help again only if a further unfairness occurs to them. [C]

Not at all true Completely true

0 1 2 3 4 5 6

2-41. People receiving help in our group are responsible for their pasts.

Not at all true Completely true

0 1 2 3 4 5 6

2-42. People receiving help in our group are responsible for their futures.

Not at all true Completely true

0 1 2 3 4 5 6

MY GROUP THINKS THAT:

2-43. People receiving help in our group are responsible for their past successes.

Not at all true Completely true

0 1 2 3 4 5 6

2-44. People receiving help in our group are responsible for their future successes.

Not at all true Completely true

0 1 2 3 4 5 6

2-45. People receiving help in our group are responsible for their past failures.

Not at all true Completely true

0 1 2 3 4 5 6

2-46. People receiving help in our group are responsible for their future failures.

Not at all true Completely true

0 1 2 3 4 5 6

Please return your questionnaire to the researcher. Thank you for participating in this part of the study.

APPENDIX F

Questionnaire 2

(a)	Cover letter	
(b)	3-1 to 3-5:	Involvement in group (attendance, length of membership, give help outside meetings, receive help outside meetings)
(c)	4-1 to 4-3:	Interaction processes (sharing, empathy, explanation)
(d)	5-1 to 5-40:	Help Orientation Test (HOT) - member's model of help.
(e)	5-41 to 5-46:	Attributions for past and future.
(f)	6-1 to 6-6:	Belief in group tenets (tenets vary by group)
(g)	7-1 to 7-10:	Rosenberg self-esteem scale
(h)	8-1 to 8-7:	Mastery scale
(i)	9-1 to 9-9:	History of mental health treatment, treatment provider's attitude towards group, membership in other self-help groups.
(j)	10-1 to 10-2:	Importance of help from professionals and self-help group
(k)	11-1 to 11-2:	Importance of and suggestions for mental health system change

[Questionnaire 2 - Cover Letter]

Dear Group Member,

This questionnaire includes questions about your self-help group, your involvement in it, and your opinions about help. It has some questions that ask your opinion about mental health professionals and the existing mental health system. It also has some questions that ask you to describe yourself.

Please do not put your name on the questionnaire. The information that you provide will not be used to identify you and will not be shown to anyone else.

Please be careful to read and answer each question. Take as much time as you need to finish the entire survey. Please feel free to ask me questions and to ask for help if you need it. Thank you very much for your cooperation and help!

Sincerely,

Chris Hertler
Researcher

3-1. Were you a participant in the first part of this study? (Check one)

_____yes _____no

3-2. How many of the last four meetings of your self-help group have you attended? (Check one)

1 _____

2 _____

3 _____

4 _____

3-3. How long have you been a member of your group? (Check one)

Less than 1 month _____

1-3 months _____

4-6 months _____

7-9 months _____

10-12 months _____

More than 12 months _____

3-4. To what extent do you give help and support to members of your group outside group meetings? (Circle one)

No Extent		Some Extent		A Very Great Extent
1	2	3	4	5

3-5. To what extent to you receive help and support from other members of your group outside group meetings? (Circle one)

No Extent		Some Extent		A Very Great Extent
1	2	3	4	5

[Interaction Processes]

Below is a list of statements that describe some activities that occur in self-help groups. Please circle the number that represents the extent to which each activity is emphasized in your self-help group.

4-1. Group members share everyday experiences, thoughts and feelings with other members.

No emphasis	Little emphasis	Some emphasis	Strong emphasis	Very Strong emphasis
1	2	3	4	5

4-2. When a person expresses his emotions in the group, other group members let that person know that they understand and share his or her feelings.

No emphasis	Little emphasis	Some emphasis	Strong emphasis	Very Strong emphasis
1	2	3	4	5

4-3. Members provide explanations which help other group members to better understand themselves or their reaction to a situation.

No emphasis	Little emphasis	Some emphasis	Strong emphasis	Very Strong emphasis
1	2	3	4	5

RATING SCALE FOR MEMBER'S BELIEFS

Please use the following statements to rate your own beliefs about help. If you think a statement is not at all true, circle 0. If you think a statement is completely true, circle 6. If you think a statement is somewhere between not at all true and completely true, circle the number in between 0 and 6 that best represents how true it is.

I THINK THAT PEOPLE RECEIVING HELP:

5-1. Need to see that they are not alone. [E]

Not at all true						Completely true
0	1	2	3	4	5	6

5-2. Need the fair chance they have been so far denied. [C]

Not at all true						Completely true
0	1	2	3	4	5	6

5-3. Need only to be shown how. [Mo]

Not at all true						Completely true
0	1	2	3	4	5	6

E = Enlightenment
Mo = Moral
C = Compensatory
Me = Medical

I THINK THAT PEOPLE RECEIVING HELP:

5-4. Need therapy. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-5. Are deprived. [C]

Not at all true Completely true

0 1 2 3 4 5 6

5-6. Are stubborn. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

5-7. Are sick. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-8. Are unaware. [E]

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT PEOPLE RECEIVING HELP:

5-9. Need something like a doctor. [Me]

Not at all true					Completely true
0	1	2	3	4	5	6

5-10. Need something like a friend. [E]

Not at all true					Completely true
0	1	2	3	4	5	6

5-11. Need something like time to think. [Mo]

Not at all true					Completely true
0	1	2	3	4	5	6

5-12. Need something like a tutor. [C]

Not at all true					Completely true
0	1	2	3	4	5	6

5-13. Would become increasingly self-destructive if they did not get help. [E]

Not at all true					Completely true
0	1	2	3	4	5	6

I THINK THAT PEOPLE RECEIVING HELP:

5-14. Would be all right even if they did not get help. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

5-15. Would become increasingly sick if they did not get help. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-16. Would become hostile or violent if they did not get help. [C]

Not at all true Completely true

0 1 2 3 4 5 6

5-17. Need help to be given for a fixed, temporary period. [C]

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT PEOPLE RECEIVING HELP:

5-18. Need help to be given until they are cured. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-19. Need a long-term relationship with someone who had similar experiences. [E]

Not at all true Completely true

0 1 2 3 4 5 6

5-20. Need only to get themselves together and discover where they personally want to go. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

5-21. Will fail unless they accept guidance from those who have "been there". [E]

Not at all true Completely true

0 1 2 3 4 5 6

5-22. Will fail unless they are completely self reliant. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT PEOPLE RECEIVING HELP:

5-23. Will fail unless they are given the resources they deserve. [C]

Not at all true Completely true

0 1 2 3 4 5 6

5-24. Will fail unless those helping them are skillful enough. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-25. See helpers as people who enjoy seeing justice done. [C]

Not at all true Completely true

0 1 2 3 4 5 6

5-26. See helpers as people who enjoy doing a job for which they are highly respected. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-27. See helpers as people who enjoy giving advice on how to cope. [Mo]

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT PEOPLE RECEIVING HELP;

5-28. See helpers as people who enjoy discovering a new "brother" or "sister". [E]

Not at all true					Completely true	
0	1	2	3	4	5	6

5-29. Need to reorient themselves and get back on their feet. [Mo]

Not at all true					Completely true	
0	1	2	3	4	5	6

5-30. Need experienced, trained care. [Me]

Not at all true					Completely true	
0	1	2	3	4	5	6

5-31. Need to dedicate themselves to a higher cause. [E]

Not at all true					Completely true	
0	1	2	3	4	5	6

5-32. Need the resources of those more fortunate. [C]

Not at all true					Completely true	
0	1	2	3	4	5	6

I THINK THAT PEOPLE RECEIVING HELP:

5-33. Without help, would withdraw and fall apart. [Me]

Not at all true						Completely true
0	1	2	3	4	5	6

5-34. Without help, would seek a means to success that society might not approve. [C]

Not at all true						Completely true
0	1	2	3	4	5	6

5-35. Without help, would pursue the illusion that they can do everything by themselves. [E]

Not at all true						Completely true
0	1	2	3	4	5	6

5-36. Without help, would miss the discovery of their deepest inner strength. [Mo]

Not at all true						Completely true
0	1	2	3	4	5	6

I THINK THAT PEOPLE RECEIVING HELP:

5-37. Will need help again only if they fall sick again. [Me]

Not at all true Completely true

0 1 2 3 4 5 6

5-38. Will need help again only as a reminder that they are responsible for themselves. [Mo]

Not at all true Completely true

Will need help again as a matter of being part of a community. [E]

Not at all true Completely true

0 1 2 3 4 5 6

5-40. Will need help again only if a further unfairness occurs to them. [C]

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT:

5-41. People receiving help in our group are responsible for their pasts.

Not at all true Completely true

0 1 2 3 4 5 6

5-42. People receiving help in our group are responsible for their futures.

Not at all true Completely true

0 1 2 3 4 5 6

5-43. People receiving help in our group are responsible for their past successes.

Not at all true Completely true

0 1 2 3 4 5 6

5-44. People receiving help in our group are responsible for their future successes.

Not at all true Completely true

0 1 2 3 4 5 6

I THINK THAT:

5-45. People receiving help in our group are responsible for their past failures.

Not at all true					Completely true	
0	1	2	3	4	5	6

5-46. People receiving help in our group are responsible for their futures failures.

Not at all true					Completely true	
0	1	2	3	4	5	6

[Belief in Group Tenets]

Please rate the extent to which you believe or disbelieve the following statements:

6-1. [Group name] benefits individuals who have spent time in psychiatric facilities by joining together with them to advocate their rights and needs.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6-2. [Group name] advocates that the State of [State name] provide adequate legal services patients in state-run psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6-3. [Group name] seeks to improve the legal rights of persons in [State name]'s psychiatric facilities, works on committees and boards to upgrade conditions in psychiatric facilities, and works to develop community alternatives.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6-4. Members of [group name] teach legal rights in state-run psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6-5. [Group name] provides a valuable service by offering mutual support as well as social, recreational and educational activities to individuals who have been in psychiatric facilities.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

6-6. [Group name] works to decrease the stigma that follows people who have undergone psychiatric treatment.

Strongly Disbelieve		Neither Believe Nor Disbelieve		Completely Believe
1	2	3	4	5

[Rosenberg Self-Esteem Scale]

Below is a list of statements with which you may agree or disagree. Beneath each statement is a scale which ranges from strongly agree to strongly disagree. Please circle the number that represents the extent to which you agree or disagree with each statement.

7-1. On the whole, I am satisfied with myself.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-2. At times I think I am no good at all.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-3. I feel that I have a number of good qualities.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-4. I am able to do things as well as most other people.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-5. I feel I do not have much to be proud of.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-6. I certainly feel useless at times.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-8. I wish I could have more respect for myself.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-9. All in all, I am inclined to feel that I am a failure.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

7-10. I take a positive attitude toward myself.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

[Mastery Scale]

Below is a list of statements with which you may agree or disagree. Beneath each statement is a scale which ranges from strongly agree to strongly disagree. Please circle the number that represents the extent to which you agree or disagree with each statement.

8-1. I have little control over the things that happen to me.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-2. There is really no way I can solve some of the problems I have.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-3. There is little I can do to change many of the important things in my life.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-4. I often feel helpless in dealing with the problems of life.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-5. Sometimes I feel that I'm pushed around in life.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-6. What happens to me in the future mostly depends on me.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

8-7. I can do just about anything I really set my mind to do.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

[Treatment and Self-help History]

9-1. Have you been treated for mental or emotional problems by any of the following health professionals in the past three years (check all that apply):

Psychiatrist _____

Family Physician _____

Psychologist _____

Nurse _____

Social Worker _____

Community mental health worker _____

Other (briefly explain)_____

_____

9-2. If you <u>have</u> been treated in the past three years, did it involve (check all that apply):

Full time (24 hours/day) hospitalization _____

Partial (less than 24 hours/day) hospitalization _____

Residential treatment outside a hospital _____

Outpatient treatment at a hospital or clinic _____

Other (briefly explain) _____

_____

9-3. If you <u>have</u> been treated in the past three years, to what extent did it involve the following types of treatment (circle the most appropriate rating for <u>each</u> type):

	To No Extent		A Moderate Extent		A Great Extent
Psychotherapy	1	2	3	4	5
Medication	1	2	3	4	5
Electroconvulsive Therapy (ECT)	1	2	3	4	5
Group Activities	1	2	3	4	5

Other (briefly explain)_____

_____

9-4. Are you currently receiving any form of mental health treatment (check one): _____yes _____no

9-5. If you <u>are</u> currently receiving mental health treatment, please describe it briefly:

_____

_____

9-6. If you <u>are</u> currently receiving mental health treatment, what attitude does your treatment provider have toward your self-help group (circle the most appropriate rating):

Very Negative		Neither Negative Nor Positive		Very Positive
1	2	3	4	5

9-7. Have you ever belonged to any other self-help group for individuals who are having, or in the past have had, mental or emotional health problems (check one):

_____yes _____no _____don't know

9-8. If you <u>have</u> belonged to another group, give the name, approximate dates, and a brief description of the group.

Name_____

From month ____ year ____ to month ____ year ____

Description of group:_____

_____

9-9. If you <u>have</u> belonged to another group, what influence did your experience with it have on your decision to join your current self-help group (circle the most appropriate rating):

Strongly Discouraged Me From Joining		Neither Discouraged Nor Encouraged Me		Strongly Encouraged Me to Join
1	2	3	4	5

[Importance of Help from Professionals and Group]

10-1. How important is the help that mental health professionals provide to you and other members of your self-help group?

Not at all Important		Neither Important Nor Unimportant		Extremely Important
1	2	3	4	5

10-2. How important is the help that your self-help group provides to you and other members of your self-help group?

Not at all Important		Neither Important Nor Unimportant		Extremely Important
1	2	3	4	5

[Importance and Suggestions for Mental Health System Change]

11-1. How important is change in the present mental health system?

Not at all Important		Neither Important Nor Unimportant		Extremely Important
1	2	3	4	5

11-2. What changes, if any, should be made in the mental health system to benefit people with emotional and mental health problems?

_____

_____

_____

_____

_____

Please return your questionnaire to the researcher. Thank you for participating in the study.

APPENDIX G

Debriefing Explanations

[Explanation following Questionnaire 1]

The purpose of this questionnaire was to identify some basic characteristics of the members of your group and to identify your group's beliefs about help. The questionnaire is being administered to several self-help groups for people who have had emotional and mental health problems. The results of your questionnaire are used to identify those groups that have similar basic membership characteristics (e.g., average education, gender composition) but different beliefs about help. Your group's beliefs about help will be compared with the beliefs of the other groups that are participating in this study.

Your responses to this questionnaire have helped to identify your group's beliefs about help. The questionnaire for the second part of the study has further questions about your self-help group, your involvement in your group, your opinions about the mental health system, your beliefs about help, and your perceptions of yourself. I hope that you will take the time to complete the second questionnaire, too.

Thank you very much for participating in the study!

[Explanation following Questionnaire 2]

You and other members of your group have participated in a study of beliefs about help and characteristics of members of self-help groups for people with emotional and mental health problems. Your group's philosophy of help is different from that of some other self-help groups. Members' beliefs about help may be related to their self-esteem and their perceived ability to influence their lives as well mental health professionals and the mental health system. Your perceptions of emphasis on processes such as explanation, empathy, and mutual support in your group may be related to your belief in your group's philosophy of help.

I will send a report of the study's findings to your group after the data analysis is finished. The report will describe your group's distinctive characteristics, relate them to its philosophy of help, and compare them to a self-help group that has a different philosophy of help. Your group can use that information to help support your members and communicate your group's philosophy.

Do you have any questions about the purpose of the study? I have enjoyed working with you, and I hope that your group will continue to succeed in helping its members. I am happy to compensate you and your group for its participation in the study. Thank you very much!