Starting a Self-Help Group

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By

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MASTER OF SOCIAL WORK

In Memory of my Mother,

For my Father,

Thank You to my Dear Wife Margot

and to our Son Gavriel.

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CHAPTER ONE

SELF-HELP GROUPS--INTRODUCTION

The phenomenon of self-help is here to stay. The creation of self-help groups, particularly in the 1960's and 1970's is still continuing. This has resulted in the increasing attention from helping professionals. Self-help not only offers an alternative to traditional methods of providing services, it also offers a very valid criticism of existing conceptual and structural inadequacies and deficiencies in the human service field.

Self-help is an ancient philosophy. It is a philosophy that recognizes and promotes the strength of people to help themselves as well as reaching out to help other people to help themselves. In Canada and the United States a recent directory of self-help groups identifies over 400 distinct kinds of groups that serve about 15 million people (Evans, 1979). Not only has there been a growth in numbers, but also in the range of problems addressed by the groups. There are self-help groups for nearly every disease category listed by the World Health Organization as well as groups concerned with a wide variety of psycho-social problems. Self-help groups have arisen to help people through literally the whole range of life crises, from

birth to death (Gartner & Riessman, 1982).

Barish states that it is our inherent social character "to band with others to act for survival and for the gratification of group needs that is the basis on which organized groups have formalized the concept of mutual aid and helpfulness." (Barish, 1971, pp. 1163-1164).

The common experience of any self-help group is the key to the way that self-help groups can solve the problems of their members. The usefulness of this common experiential knowledge on the part of all members of a self-help group is logical;

> By pooling the experiences of a number of people, the common elements of the problem and attempts to cope with it emerge, while simultaneously highlighting the uniqueness of each individual's situation. Consequently, the individual learns how his problem is both similar to and different from that of others, which forces him to utilize the knowledge selectively to fit his situation. Similarly, the group is protected against inapplicable knowledge that is too idiosyncratic or peculiar because a number of people rather than just one or two persons are pooling their knowledge. (Borkman, 1976, pp. 450-451)

The group itself is the central component. Everyone works together for the group's continuing development. However, individual needs are met in the process. The message of self-help is that people do not have to be passive and that individuals can do something for themselves and that in a group setting this power becomes intensified. With its pooling of exper-

ience the self-help group demands that the individuals do something for each other as well. Although dependence is permitted, autonomy and independence are demanded. Support is given but action and work are also demanded. According to Barish (1971) most self-help groups differ from other types of groups because "they almost always represent individuals with stigmatized differences of a social, emotional or physical nature." (Barish, 1971, p. 1164). Since they are neglected and rejected by the larger society, these individuals meet their personal and human needs through the setting up of their own self-help groups.

> In essence, one of the most significant characteristics of mutual-aid (self-help) groups is the fact that they are empowering and thus dealienating. They enable their members to feel and use their own strengths, their own power, to have control over their own lives. This empowering dimension is extremely important for people's health and mental health. (Riessman, 1976, p. 41)

The popularity of self-help has also resulted in a voluminous outpouring of publications--both professional and commercial in North America and the rest of the world (Katz, 1981). This report will hopefully be a worthy addition to the further understanding and appreciation of self-help groups.

What This Report is About

This report presents a synthesis of my work as a

graduate student in social work. The initial portion of the text focuses on a review of the literature in the area of self-help/mutual-aid groups. The remainder of this report deals with the process of initiating a self-help group.

This practicum was pursued with the following objectives:

The general objectives of the practicum were:

1. To examine the literature pertinent to the concept of self-help groups and to relate this information to social work practice with a student-initiated self-help group for former and current mental health clients.
2. To develop knowledge and enhance skills in the area of beginning a self-help group.

It should be stated that publications, articles and books pertaining to network theory and self-care (or "how-to-do books") are excluded from this report. Although boundaries of exclusion are often arbitrary and cloudy at best, the decision was made to work with material whose primary focus is self-help groups.

The discussion of the literature will hopefully provide the reader an opportunity to understand what self-help groups are; why they have proliferated in the last two decades; the history of mutual aid and self-help; the types of self-help groups; their relationship

to professionals; how self-help groups are organized and the benefits of being a member.

The practicum report will also provide the reader with the experiences that this writer and his colleagues had in establishing a self-help group.

CHAPTER TWO

SELF-HELP GROUPS

THE EMERGENCE OF MODERN SELF-HELP

> Everyone ought to be in a mutual-aid or peer group (for the bearing and sharing of 'one another's burdens') not as 'therapy' but as a way of life. (Mowrer, 1972, p. 7)

During the 1960's and 1970's, self-help groups (also known as mutual-support groups or mutual-aid groups) have grown in increasing numbers. It is estimated (Evans, 1979) that more than 500,000 groups exist and 15 million people are members in the U.S.A. alone. By 1990, the U.S.A. Department of Health and Human Services (1980) predicts that these numbers should actually double in order to reduce the gap in mental health services.

What is behind the self-help explosion of the last 25 years? There are a number of contributing factors put forth by the various commentators to describe this phenomenon.

The twentieth century has witnessed an overwhelming growth and influence of technology. Along with the ever increasing complexity and size of communities and institutions, the result has been a depersonalization, dehumanization and alienation of individuals from one another and the breakdown of

traditional supports such as family, church, neighbourhood and community (Katz & Bender, 1976a; Lieberman & Borman, 1976). Toffler (1981) describes societal change in this century as being created by a collision of three waves: agrarian, industrial and post-industrial factors. Governments, large institutions and professional services which are often impersonal have replaced to a great degree the disintegrating traditional supports, ideologies and resources. This has led Mowrer and Vattano (1976) to describe our modern era as being characterized by alienation, isolation and loneliness as well as a generalized lack of community. One significant response to this affliction has been the dramatic growth of the self-help movement.

> They are the grassroots answer to our hierarchical, professionalized society--to a society which attempts in so many ways to render impotent the individual, the family, the neighbour. Not only are self-help groups providing desperately needed services but they are returning to the individual a feeling of competence and self-respect and they are forging new links, new connections among people. (Sidel & Sidel, 1976, p. 67)

In particular, one type of mutual-help group that was founded to combat alienation and to help people rescue themselves from an identity crisis, actual or impending is the Integrity Groups (Mowrer & Vattano, 1976). They are predicated and operate on three fundamental principles: honesty, responsibility and involvement. Human beings needing human fellowship in a world

that has produced rapid change in our social institutions is one factor responsible for the growth of the modern self-help movement.

A second major theme which is a factor in the emergence of the self-help movement is the disillusionment with existing helping services and anti-professionalism (Robinson & Henry, 1977, pp. 8-12).

Thoresen (1977) sees self-help groups as:

> a growing preference for over-the-counter rather than over-the-desk (or on-the-couch) strategies. (Thoresen in Stuart, 1978, p. 697)

Several explanations provide possible answers for this apparent retreat from professionalism in the pursuit of remedies for a host of problems. One such explanation asserts that:

> in part, the reaction is due to a growing public suspicion of professions that have long been cloaked in mystery. (Levin, Katz & Holst, 1976, in Stuart, 1978, p. 697)

The rise of the women's health movement, for example, has taught women facts about their own bodies and is a conscious effort to demystify medicine and give women more control over their own health (Lieberman & Borman, 1976).

Secondly, many professional care-giving systems that have evolved to help people in trouble are fragmented to a degree which is beyond belief. Poor people with other problem areas must be seen by

specialists in specialized agencies and institutions (Vattano, 1972).

A third concern in the rise of anti-professionalism is what Thompson (1977) refers to as the clash between the emergence of individualism and the dehumanization that increasingly characterizes professional and especially medical services. Hoffman and Singer (1979) noted the conflicting message given to the consumers of professional services in the following way:

> On the one hand, they are given the impression that they are adults who are responsible for their own lives. On the other hand, they are given to understand that their actions are beyond their control since they are manifestations of illness. (Stuart, 1978, pp. 697-698)

Another factor is that the cost of professional care has risen at a geometric rate, while the benefits of care have risen little (Knowles, 1977; Kristein, 1977). According to Fielding (1977) one factor in this problem is the "illness" as opposed to the "health" orientation of virtually all branches of medicine, which as a result reduces the capability of the professions to develop effective technologies for prevention.

> The recent increase in the number of medical self-help groups has been linked to the increase in chronic conditions (such as heart disease, stroke, epilepsy and cancer) that have no known cure but permit patients to maintain a modified lifestyle (Gussow & Tracy, 1976). Despite the widespread impact of these chronic illnesses on many Americans and their families, medical treatment in the United States is oriented toward acute illnesses, which have declined with the development of cures

> and vaccinations for most infectious diseases. The prognosis has also improved dramatically for many conditions previously considered hopeless. However, programs devoted to helping patients adapt psychologically to their physical illness have not kept pace with these medical advances. In this time of rising health care costs, are medical professionals most appropriately employed in day-to-day care and rehabilitation? These factors have encouraged the development of alternative community support networks. Self-help groups are one such non-professional support system organized for the chronically ill. (Bond, Borman, Bankoff, Daiter, Lieberman & Videka, 1979, pp. 43-44)

A shortage of personnel and resources along with growing and more diverse demands for services has strained the availability of providing a service which is acceptable and cost efficient (Gartner & Riessman, 1982). Self-help groups have emerged to assist those whose needs are not being met by professionals because they "fall between the cracks" of available services. Gartner and Riessman (1982) argue that in contrast to professional services, self-help groups are inexpensive, highly responsible and accessible as well as providing a more personalized approach to human services. It is a way of expanding services and reaching more people.

There has also been a disenchantment with the professions resulting from disclosures of unethical practices, from the reporting of false experimental data, from public promises of undeliverable and overstated "cures" and from the disclosures of the business

side of health services in particular--all of which have helped so seriously compromise the level of respect which has been given to professionals in the past (Gartner & Riessman, 1977; Stuart, 1978).

A third factor, but with close links to the above is the viewpoint that self-help groups have developed as an alternative to services that are both acknowledged and offered in other institutions of our society. Here, the question of control--who makes policy is more significant than the function of the provided service (Lieberman & Borman, 1976). Hess attributes the emergence of self-help groups for the ageing as an attempt by people to take more control of their lives. Hess describes old age as a:

> decreasing involvement in family, neighbourhood and relationships, death of siblings and friends, separate residence from family, decline of income, increase in medical costs and the result is the loss of those anchors of security. (Hess, 1976)

Self-help groups for the aged have emerged to create a new order and meaning in one's life--a result which professional and institutionalized services cannot provide. In self-help groups the power of decision and control, ideology and values rests with the member (Toch, 1965; Lieberman & Borman, 1976). Research in the community mental health field further supports that the self-help group processes have powerful effects in enhancing health (Bender, 1971; Dumont, 1974). The

importance of active participation by those in a particular situation or affected by a specific problem is believed to have significant potential for improving people's health (Gartner & Riessman, 1982). The helper-therapy principle (Riessman, 1965) simply states that those who help are helped most. The emergence of the self-help mental health movement came as a result of an alternative explanation as to the cause of mental illness (Dumont, 1974). This explanation pointed to social disorganazation rather than intra-psychic conflict as the heart of mental difficulties. Coupled with this explanation was the growing criticism of traditional psychotherapy and patienthood and the racial, ethnic, social-class and sexual bias of its theories (Szasz, 1961; Goffman, 1962). Self-help groups offered an alternative to those practitioners and patients who believed that the hierarchical distance between helper and helpee was too great (Dumont, 1974).

There are a number of researchers who describe the emerging self-help movement as a social movement. Toch (1965) views self-help groups as a social movement to the extent that self-help groups have a mission.

> When people feel themselves abandoned or frustrated by conventional society, they can sometimes bypass established institutions and create informal organizations 'on the side'. Such grassroots movements serve to provide otherwise unavailable services, to protest indignities, to escape suffering, to relieve tension, to explain confusing events or in some way to create a more

> tolerable way of life than is afforded by existing formal organizations. (Toch, 1965, p.3)

Change is the essence of a social movement. Whether it is to redistribute the power within society, or change the culture or the social structure, the main characteristic of a social movement is change (Bender & Katz, 1976a).

Back and Taylor (1976) relate the origin and functioning of modern self-help groups to general social movements. They suggest, but on a smaller scale that some self-help groups parallel the five-stage social movement development model as is designed by Blumers (1969): (a) dissatisfaction among a group of persons with unmet needs, (b) formalization of a group to meet needs, (c) development of morale on group and individual levels, (d) formulation of an ideology, and (e) final meeting of needs.

Toch (1965) sees self-help groups as social movements which collectively promote change for the individual. Consequently he describes the nature of the self-help movement as:

> each individual's efforts to solve his own problems become part of his efforts to solve a social problem--one with which he is intimately familiar, and about which he has reason to be concerned. Since the member has learned to see himself as an example of a general problem, he can view his efforts as directed at both the particular and universal goal. (Toch, 1965, p. 84)

The contemporary social climate, the questionable

results of traditional approaches in meeting needs and the shortage of professional manpower have all contributed to a social movement of emerging client power which has resulted in the growth of a number of self-health groups.

Finally, Tax (1976) sees self-help groups as stemming directly from other affiliative arrangements outside of kith and kin, which have been in evidence throughout the history of mankind. Tax (1976) views the self-help movement as evolving in a similar way to the Friendly Societies of the 18th century in England. Dumont (1974) perceives the self-help movement as being deeply rooted in the American traditions of pragmatism and populism and as a result derive from the main currents of American philosophy and political roots. Tax (1976) argues that the state historically has strengthened primary groups and suggests that public policy can do nothing more helpful for self-help groups than to provide a general framework in which they can exercise their own options free of interference and pressures from outside. The history of mutual-aid is examined in more detail in a following chapter and links the modern phenomenon with its historical roots.

There is no single model or simple explanation which in itself can totally describe the emergence of

the modern self-help movement. We can only suggest that all of the above factors have contributed to the growth of the self-help movement.

CHAPTER THREE

SELF-HELP GROUPS

AN HISTORICAL PERSPECTIVE

As discussed elsewhere in this report, there has been a tremendous proliferation of self-help groups in the last twenty years as a result of several contributing factors. Self-help groups, also known as mutual-aid groups or voluntary associations have also been prominent in the past. They are found in the pre-industrial age of Rome and medieval Europe. They can also be found in those societies whose political and economic systems appear to be less complex. That is, the tribes and societies of some parts of Africa, Oceania, the North American plains as well as the Pacific coast of North America (Lowie, 1953; Kropotkin, 1972).

This chapter will examine several lines of historical development which lead to the present state of the self-help movement. Although no definite history of mutual-aid has been written which traces its origins from primitive to modern times, several sources do deal with various aspects of this phenomenon.

Early Forms of Mutual Aid

Kropotkin (1972), whose book Mutual Aid can be

viewed as a blending of political Darwinism and actual human experience writes:

> ...in all these scenes of animal life which passed before my eyes, I saw Mutual Aid and Mutual Support carried on to an extent which made me suspect in it a feature of the greatest importance for the maintenance of life, the preservation of each species and its further evolution. (Kropotkin, 1972, p. 13)

Affirming his belief in mutual aid, Kropotkin (1972) adds:

> Man is no exception in nature. (Kropotkin, 1972, p. 113)

Anderson (1971) refers to the formally constituted voluntary groups that came together to practice mutual aid (i.e. mutual aid in hunting) as associations. Anderson excludes from the definition those individuals who were related through kinship and/or co-residence. Lowie (1953) indicates that these early associations were based on common characteristics of its members (i.e. bachelors or elderly, etc.) He adds that the dominant characteristic between the early associations was their exclusion of non-members.

> They will punish the membership for breach of confidence or like transgressions and inflict penalties on outsiders for antagonizing their interests. (Lowie, 1953, p. 288)

Banton (1968) suggests that a general pattern of functions can be seen in the development of associations. Groups that were small and technically primitive created associations that provided recreational

activities and established distinctions of ranking. In larger tribes, the added dimension of governmental functions was evident. In groups where the division of labour became more complex, the associations served the purpose of pursuing and defending economic interests.

Gibbs (1965, pp. 219-221) describes the political functions of the secretive Poro society as it occurs among the Kpelle of Liberia while Little (1949) discusses secret societies as being effective in their function of guarding traditions in West African tribal societies. Little (1949) concludes that associations in Africa took the form of secret societies and sanctioned everyday social and community behavior.

The antecedents of modern-day self-help groups are evident from the beginnings of early associations. Kropotkin (1972) describes how mankind agglomerated into gentes, clans and tribes to maintain common descent. These organizations voluntarily kept people together for thousands of years. Even when migrations took place on a large scale in subsequent times and the unity of the clan emerged in the development of the separate family, mankind's need for mutual aid evolved eventually into the village community.

> This institution, again, kept man together for a number of centuries permitting them to further develop their social institutions and to pass through some of the darkest periods of history without being dissolved into loose aggregations of

> families and individuals to make a further step in their evolution, and to work out a number of secondary social institutions. (Kropotkin, 1972, p. 129)

MacIver (1931) concluded that voluntary associations are found even in our complex states and religious and economic institutions because these institutions are unable to deal completely successfully with all the forces of conflict and tension inherent in modern society. He sees voluntary associations as having:

> ...a flexibility, an initiative capacity for experiment, a liberation from the heavier responsibilities of taking risks which the state rarely, if ever, possesses. They can foster the nascent interests of the groups, and encourage enterprise, social and economic, at the growing points of a society. (MacIver, 1931, p. 201)

Anderson (1971) points out that small groups have formed continually because of political, economic and religious reasons. Even today self-help groups form around medical and health issues because the medical establishment cannot meet all the needs of the individual.

The village community whose membership bonds were based on communal membership and mutual protection of the village territory evolved as family and kinship systems emerged; tribal bonds loosened; weaker clans split off and disintegrated; and the newer and stronger clans formed this new type of social organization. Katz and Bender (1976a, 1976b) view these early village

communities as the ascendents of later and more complex medieval cities.

Kropotkin (1972) believes that despite the rise of the city-state autocracies and their attempt to suppress mutual aid principles, the philosophy did not die out but instead appeared more covert in the social life. The leaders of the medieval city-states, in their desire for complete control over the population were wary of the threat that the various crafts and guilds held.

The Middle Ages

By the middle ages, Kropotkin (1972) feels that mutual aid and cooperative action are distinguishable and were flourishing.

> In a word, federations between small territorial units, as well as among men united by common pursuits within their respective guilds, and federations between cities and groups of cities constituted the very essence of life and thought during that period. (Kropotkin, 1972, p. 169)

Mutual aid in the middle ages is in evidence in a variety of groups in the community including trade guilds, culture groups and social orders. In these groups members shared commonalities and found protection against outsiders. Katz and Bender (1976a, 1976b) cite the example of the Freemasons who reorganized after the Black Death and provided a supportive social

anchor during those turbulent times.

Katz and Bender (1976a, 1976b) indicate that although mutual aid had evolved as a cooperative effort to solve problems, it also evolved into a largely exclusive number of in-groups. The many guilds and crafts excluded those who were physically and mentally disabled or those who were strangers and travellers. This growing population received assistance from the church which was independent of the communities themselves.

Katz and Bender (1976a, 1976b) attribute a number of political and social factors that emerged which changed the fabric of European social life in the 16th century.

> 1. The Protestant challenge to the dominance of Catholics in government.
> 2. Partly because of the Enclosure Acts and the beginnings of domestic industry the population became more mobile.
> 3. At the same time it became evident that local and state machinery as well as the church charities became inadequate in dealing with the poor and other deviants. (Katz & Bender, 1976a, p. 16)

In England, for example, a series of Poor Laws were passed between 1601 and 1605 which required local parishes to provide for their own poor. These Elizabethan Poor Laws, however, equated poverty and disabilities with crime. As a consequence, less fortunate individuals were controlled through incarceration, disenfranchisement and public punishments. The Poor

Laws were amended many times during the next three centuries. The laws provided both health benefits and statutory welfare to all citizens based on an evidence of need. Because of the various and stringent means tests and workhouses and the actual minimal relief that was given, the series of Poor Laws passed by the state government were in most cases ineffective.

The 19th Century and Voluntary Associations

Discussing the emergence of voluntary societies in the 19th century, Rooff (1957) describes the popularity of laissez-faire philosophy as well as rapid industrialization as further expanding social, economic and health problems as the population increased. Despite expanded government and philanthropic programs to deal with the needy, the onus remained on these individuals to prove their need.

Katz and Bender (1976a, 1976b) stress that not only were the forementioned factors responsible for the apparent destruction of mutual aid as experienced in the European cities by the end of the 15th century, but they were also responsible for the emergence of a new evolution in mutual aid with direct links to the 20th century.

Nineteenth century England witnessed the emergence of the Friendly Societies.

> The essence of a friendly society is that men who know one another pay money regularly into a common fund when they are in need. The need that has been felt most generally as calling for this provision is the need that arises when sickness of a wage-earner interrupts his earning. Desire for security in sickness is the original seed from which above all friendly societies have grown. (Beveridge, 1948, p. 21)

The Friendly Societies early prototypes were the outgrowths of the guild system. They were founded by local groups of workers who required collective support for financial and other stresses due mainly to the industrial revolution. Early examples are the Incorporation of Carters (1555), the United General Sea Box (1634), the Fraternity of Dyers (167Ø) and the Ancient Society of Gardners (1716) (Katz & Bender, 1976a, p. 268).

Thompson (1963) and Drakeford (1969) describe some significant similarities between early Friendly Societies and many contemporary self-help groups.

> Rules which survive of the Manchester small-ware weavers in the 175Ø's show already meticulous attention to procedure and to institutional etiquette. The committee members must sit in a certain order. The door must be locked...(Thompson, 1963, p. 418)

> The meetings necessarily follow a structured format of introductions by first names, voluntary participation in reading from Dr. Low's book, four members presenting examples, "spotting" on the examples, a free will offering, then the question period for newcomers, and last, the period of mutual aid where individuals informally discuss Recovery methods. (Katz & Bender, 1976a, p. 43)

The descriptions of the above were meetings held

over two hundred years apart.

The societies were locally organized and directed, self-governing and multi-functional. They provided loans for the needy and insurance for the sick. They also served as centres or initiators of social activities such as picnics. They in effect became primary support groups embodying kinship values.

> The most important feature of the organization of the local societies was their complete independence. Each society had its own funds and was governed by its own rules as decided by the members. (Gosden, 1973, p. 14)

Thompson (1963) states:

> In the very secretiveness of the friendly society, and in its opaqueness under upper-class scrutiny, we have authentic evidence of the growth of independent, working class culture and institutions. (Thompson, 1963, p. 420)

The growth of the societies between 1700 and 1900 is quite staggering (Gosden, 1967; Thompson, 1963; and Katz & Bender, 1976).

Year	Estimated No. of Societies	Estimated Membership
1711-90	118	648,000
1803	---	704,350
1815	---	925,429

By 1900, there were over 27,000 societies in Great Britain. Even in 1945 there were still 18,000 of these societies.

> The friendly societies might even be considered as the pioneers of the self-help movement among the working men of the time. Their membership numbers show their importance in the self-help movement--4,000,000 members by 1872. (Gosden, 1967, p. 7)

The 18th and 19th centuries as a whole were an age of steadily advancing capitalism. This increased rate in industrial development resulted in the growing needs of the industrial workers and triggered rapid growth in the development of friendly societies and related mutual aid movements such as trade unions and cooperative societies.

Beveridge (1948, pp. 89-90) considers trade unions as a voluntary association because they are independent of elected public authorities whether local or national. Like the friendly societies, the trade union movement began in the 19th century because of repressive legislation and were the most influential form of voluntary action in Britain. The trade unions' primary purpose was to regulate conditions of employment. However, they had and still have the friendly society attribute of providing systematic benefits to their members because of sickness, unemployment and old age.

The producer-consumer cooperatives were also a 19th century innovation. They were predominately a British phenomena because of the direct effect of the industrial revolution and the rise of monopoly capitalism. However, Roy (1964) cites examples of other coop-

eratives occuring in Europe.

Numerically, the consumers' cooperative was the largest of all the mutual aid organizations.

In 1862, there were 440 cooperative movements registered in England and Wales with 90,000 members. By 1890, 1300 cooperatives were registered with a membership of 900,000 (Hobhouse, 1906, pp. 33-34).

Despite the rapid increase in membership the beginnings of the cooperative movement were small and unpretentious like the other mutual aid movements. Rochdale, one of the more successful cooperatives began in 1844 when twenty-eight flannel weavers of Rochdale put their pence together and purchased and divided among themselves the commodities that they required. The Rochdale Society developed new innovations to the working structure. Profits from all sales were divided among all the members who made purchases in proportion to the amount they spent. They can be described as shareholders. Besides the revolutionary impact this practice had in the method of working and in the cooperative movements, Rochdale, and the cooperative movement provided other benefits.

The cooperatives provided cash from time to time to members for spending. They also put their strength into one particular job. Like the other mutual aid movements they would eventually become concentrated

into larger units.

Katz and Bender (1976a, 1976b) describe two shortcomings in the consumer-cooperative movements. Firstly, they struggled against the domination of the larger and wealthier monopolistic and capitalistic producers. Secondly, because cooperatives by nature were for the most part an economic entity, it was difficult for members to identify with any particular social anchor as they would in the friendly societies. Thus the obvious fraternalism of the friendly societies was missing in the cooperative movement.

The government ultimately could not be the answer in attempting to be the only bond of union among loose aggregations of individuals.

> Friendly societies, cooperatives and trade unions represent in a sense, the ways in which those without political power sought to protect themselves in an increasingly industrialized society. (Gosden, 1967, p. 7)

Even after the state government in England nationalized the health system and instituted guaranteed minimum incomes, the various mutual aid movements continue to exist in England today because of their mutual support and extra financial help above the minimum income to its members. "The instinct of cooperation is self-help." (Holyoake, 1908, p. 587)

In summary, the history of mutual aid in Europe and in particular England is a uniting of those with common

interests who strengthen themselves in the struggle for the enhancement and protection of those interests. As members of mutual-aid groups, individuals are more easily made aware of their interests and the result is the formulation of appropriate opinions with respect to specific problems they face. As the opinions become crystalized, the association facilitates the spread of the opinion as to influence others. The individual through the association thus becomes involved in the political and social process of the society thus enabling him to understand the meaning of events, the mechanics of government and society generally.

Equally important, as we have seen, is the function of mutual aid associations in history meeting the psychological needs of individuals as social persons. Various mutual aid societies were able to bring together those isolated from human ties--a result in part of living in the evolving industrial and urban communities created by the Industrial Revolution--back into interaction with other human beings just as modern self-help groups render.

Finally, we may identify three major functions of the mutual aid movement and voluntary associations as observed in this historical survey. One, they have prevented a concentration and centralization of power. Secondly, they have helped individuals in understanding

how the political and social processes operate. Third, they are mechanisms for social change.

Mutual Aid--America--Beginnings

The early American experience with mutual aid practice is similar but with some significant differences when compared with Great Britain.

Initially, early American colonialists banded together to produce goods and to protect themselves against various Indian bands. However, the rise of capitalism, the fertility of the earth and the freedom from oppressive state controls led Americans to abandon the communal forms of farming and crafts production and to develop the sense of individualism and ownership which still characterizes modern day America. The principle of self-help was not totally lost or abandoned. Farmers still assisted each other with seeding and harvesting. Many Americans who were moving westward practiced mutual aid principles. Homesteads were collectively created and defended through the taming of the wilderness. By the 1800's mutual assistance associations were formed by dairymen to purchase fodder for their cattle. Many Morman farmers in Utah (Wieting, 1952) pooled their resources to bring water to Utah for irrigation purposes.

Although there are other examples of the practice

of mutual aid principles by early American colonialists, the meeting of individual needs rather than of organized groups was the more characteristic of this period.

According to Sagarin (1969), the earliest group organized as a self-help group was formed in the early 1800's. The Washingtonians, organized by six drinkers who desired to abstain from drinking and reform other drinkers has become the clear forerunner of Alcoholics Anonymous.

The various stresses and ills of the Industrial Revolution took their toll on many Americans during the 19th century. Low wages and long hours, child labour, unemployment and illness were issues which the cooperative movement addressed with some success. One response to these conditions according to Katz and Bender (1976a, 1976b) was the creation of utopian cooperative communes and villages in which members collectively owned sufficient amounts of land and tools in order to subsist independently. A second response by workers was the formation of trade unions. However, a number of factors, including repressive legislation, poor leadership and the advent of the Civil War prevented the survival of these early attempts to unionize.

Further cooperative action took place in the years immediately following the Civil War. Soldiers return-

ing from the war, unemployed city dwellers and a large wave of European immigrants (Handlin, 1959) became partners in consumer cooperatives particularly in the western United States.

> Among the Jews, in addition to the large philanthropic societies which are formed by the wealthier to assist in the Americanization of the newcomers and to care for the poor of their faith, there are many smaller societies which are organized and supported principally by the more recently arrived Russian, Polish and Rumanian Jews. (Handlin, 1959, p. 86)

The Knights of Labor, the first industrial union, integrated the largest consumer cooperative--the Sovereigns of Industry. Despite some successes for a number of years the cooperative movement declined once again. Their failure can be attributed to economic difficulties, non-supportive legislation by state governments and generally open hostility towards the labour movement. However, a number of unions were able to thrive because of membership dues. The unions became involved in a number of activities involving their membership (Katz & Bender, 1976a).

Unions initiated health and pension plans; the organization of cooperative housing projects; the establishment of workers' education institutions and the creation of labour banks, thus emulating the capitalists.

Barish (1971) states that self-help groups began

to develop significantly as a means of dealing with social, physical and emotional problems by the turn of the century. The settlement house movement stressed neighbours helping newcomers in adjusting to their new environment. This innovation was a radical departure from the popular charity Organization Society movement where the rich helped the poor through charity rather than through the ideals of self-help which emphasized a different social-political philosophy.

Lighty and Bowman (1939) discuss the emergence of the first parents associations around 1896. The parents associations' objectives were to develop a working relationship with teachers and to discuss and share common problems of parents.

A significant number of diversified self-help groups developed during the Depression years. Barish (1971) discusses the existence of an "Unemployed Cooperative", where members joined together to deal with the effects of unemployment and to protest the degrading "Pauper's Oath", which was a requirement in obtaining public assistance.

By the middle and late 1930's, self-help groups began to extend their emphasis of concern to emotional and physical disabilities as well as the area of social problems. Two major trends in self-help organizations emerged at this time. The most significant self-help

event of the 1930's was the formation of Alcoholics Anonymous in 1935. A.A. was started by Bill W. and Dr. Bob and according to Evans (1979), 30,000 chapters exist in 92 countries today. A.A. was the forerunner of other and later formed "anonymous" groups.

The second major trend in professional-patient self-help collaberation was the concept of the therapeutic community. Professionals and ex-patients organized clubs of former mental patients. Ex-patients were encouraged to become more responsible and more active in their own treatment. According to Evans (1979) there are over 1000 chapters in the U.S.A., Canada, Ireland and Peurto Rico today.

In the 1940's independent local groups of parents and relatives of people suffering from a variety of physical or disease disabilities began to form national organizations. Among the many nationalized groups were the American Association of Retarded Children and the United Cerebral Palsy Foundation. These groups provided mutual support for parents as well as raising monies for research.

During the 1950's a new wave of self-help organizations developed. These groups were organized to advocate self-determinism and mutual aid along with the alleviation of common problem conditions. Organizations concerned with civil rights and poverty were the

major creation of this new wave in self-help groups.

History has shown that a simple human concept, that is, people in groups helping each other with common problems has and is still working today. This chapter has described the historical link between modern day self-help groups and its roots in prehistoric times; the emergence of mutual aid in Europe, Great Britain and the United States. It shows an historical connection between people mutually reaching out in support.

> During the first years you were busy with the stark necessities of life. Religion fed your emotions, its severe discipline guided your conduct. As you came to know of other communities, oddly enough, you began to feel more isolated than you had before. There were neighbours not far away. What were they saying or doing? The preacher brought tales and the stage brought glamorous travellers. What you needed, though, was some sense of extended fellowship with the world of which you began gradually to be aware. You wanted to talk, to rub shoulders, with men like yourself. (Ferguson, 1979, pp. 6-7)

CHAPTER FOUR

SELF-HELP GROUPS

THE PROFESSIONAL LITERATURE

> For too long, mental patients have been faceless, voiceless people. We have been thought of, at worst, as subhuman monsters, or, at best, as pathetic cripples, who might be able to hold down menial jobs and eke out meager existences, given constant professional support. Not only have others thought of us in this stereotyped way, we have believed it of ourselves. It is only in this decade, with the emergence and growth of the mental patients' liberation movement, that we ex-patients have begun to shake off this distorted image and to see ourselves for what we are a diverse group of people, with strengths and weaknesses, abilities and needs, and ideas of our own. Our ideas about our "care" and "treatment" at the hands of psychiatry, about the nature of "mental illness", and about new and better ways to deal with (and truly to help) people undergoing emotional crises differ drastically from those of mental health professionals. (Chamberlin, 1978, p. XI)

Despite the rapid changes in the social climate which is so much part of our times (Toffler, 1981) and the burgeoning but often volatile "grabbag" of new ideas and trends, as well as the many new theories and practice modalities which are evident in human care services, one phenomenon is quite clear and obvious. The self-help movement is now a permanent fixture in our times. The principle of self-help or mutual-aid is the casting and re-casting of social ties through the vehicle of self-organization. Self-help assists individuals in coping with the destructive capacity of our

society while at the same time it offers both an alternative to or an extension or expansion of existing social and professional helping services. According to Katz (1981) 80% of all help is self-help.

According to Katz and Bender (1976a) there has been a proliferation of self-help groups in the 1960's and 1970's. It seems apparent (Katz, 1981) that many more social scientists and helping professionals have begun to pay more attention to the self-help phenomenon. Thus we have had a voluminous rise of publications of self-help material in the last 15 years (Katz, 1981).

The discussions center around such areas as clinical techniques (Wollert, 1980, pp. 130-138), relationships between self-help groups and professionals (Kleiman, Mantell & Alexander, 1976, pp. 403-410), principles useful in the understanding of self-help groups (Barish, 1971), and effectiveness of self-help groups (Dean, 1970-71, pp. 72-78), and so on.

There have been publications in most if not all of the professional human service areas--social work, (Todres, 1982, pp. 91-98) psychology, (Lavoie, 1981, pp. 13-15) nursing, (Bumbalo & Young, 1973; and Rosenbaum, 1981) and so forth.

Publications about self-help groups have appeared world-wide. In Australia, Rockwell (1976) examines a

number of aspects with regards to Weight Watchers. There have been numerous publications in England including Robinson and Henry (1977) and Robinson and Robinson (1979) which look at the history, objectives, relationship to professionals and other features of self-help groups. Fichter (1977) and Moeller (1975) have published in the self-help area in Germany. McGennis (1977) in Ireland published his findings about a self-help group for agoraphobics called Out and About. Two publications from Israel include Cromer's (1978) discussion about Gamblers' Anonymous while Vinokur-Kaplan (1978) considers the relationship between self-help groups and social work. Maeda (1975) discusses the growth of old people's groups in Japan. Thompson (1976) discusses the establishment of self-help groups for the mentally ill among other areas from a Scottish perspective.

The self-help movement has certainly become a world-wide movement as evidenced by the above examples.

The literature about self-help groups, particularly before the 1970's was not of great quantity or of scope. According to Katz (1981, pp. 132 + 135) there was a lack of theorizing and investigating as well as a resistance on the part of professionals to acknowledge the place of the self-help movement up to the 1970's. This is despite the proliferation of self-help groups,

particularly in the 1960's. However, a number of publications did appear before the 1970's that dealt with specific case studies of self-help groups or in mentioning this phenomena indirectly or in comparison to other concepts.

Petr Kropotkin's pioneer work, Mutual Aid: A Factor in Evolution (1901,1972) questioned the evidence posed by the Darwinists who saw the struggle for existence among members of the same species as the central theme of evolution. In contrast, Kropotkin observed that mutual-aid was:

> carried on to an extent which made me suspect in it a feature of the greatest importance for the maintenance of life, the preservation of each species, and its further evolution. (Kropotkin, 1901, p. 18)

Two works appeared in publications in 1944. Schlesinger (1944) examined self-help groups in relation to voluntary associations. Bales (1944) presented a study on the therapeutic role of Alcoholics Anonymous.

> The job of attacking the fixation on drinking and replacing it by a set of effective inhibitions, through social and religious means, is the job which Alcoholics Anonymous is naturally fitted to do, and this is the job it does best. (Bales, 1944, p. 276)

Many other studies about Alcoholics Anonymous have been published including Gellman (1964) and Trice (1966).

It was not until 1957 that further investigations

could be found in the literature about self-help groups. Katz's (1957) doctoral dissertation was published later in 1961 and entitled Parents of the Handicapped. The purpose of the study was to conduct an exploratory investigation of such groups.

In 1960, Wechsler, a psychologist, interviewed members and was a participant observer in meetings of Recovery, Inc. and subsequently published his observations of this self-help group.

> The Recovery method is characterized by a search for order amidst a labyrinth of complex psychological problems and processes. Personal experiences are restructured within the cognitive framework provided by Recovery so that events which may be anxiety-promoting and unfamiliar may be translated into a more familiar and understandable form. (Wechsler, 1960, 1976, p. 200)

Since the late 1960's hundreds of articles and books have appeared on self-help groups. The literature, unfortunately, can be quite confusing to newcomers and students in the field. Often it is contradictory in nature and one can sense in some cases the work of an "instant expert". However the literature surveyed covers a wide range of self-help group behaviour.

The benefits of self-help groups can be found in the published works of Ryback (1971) and Petrillo (1976).

Functional characteristics of self-help groups can

be found in the writings of Traunstein and Steinman (1973) and Tyler (1976).

A number of interested professionals have defined self-help groups including Katz and Bender (1976, pp. 265-282) and Robinson and Henry (1977).

The future of self-help groups has been discussed by Gartner and Riessman (1977) and Rodolfa (1982).

Self-help group processes can be found in the literature (Katz, 1970; Levy, 1976).

A number of researchers have discussed how one begins a self-help group (Evans, 1979; Harris, 1981).

There has also been a proliferation of case studies about specific types of groups or about a specific self-help group. Without a doubt, Alcoholics Anonymous leads the list as the most researched and described self-help group. A.A.'s history, philosophy and effectiveness can be found in the published works of Antze (1976), Alford (1980) and McAfee (1980).

Besides the many articles and books on self-help groups, at least three journals have devoted entire issues to self-help groups: Social Policy, 1976; The Journal of Applied Behavioral Science, 1976; and Prevention in Human Services, 1982.

A National Self-Help Clearinghouse has been established at the University of New York which provides information and is involved in research about self-help

groups. The journal, Self-Help Reporter has now been published for several years.

Five literature reviews about self-help groups have appeared in publications.

Killilea (1976) presented a comprehensive review of the literature on mutual aid and self-help groups. Killilea suggests that the literature on mutual aid and self-help demonstrates the following views:

1. as a form of social assistance
2. as support systems
3. as a social movement
4. as a spiritual movement and a secular religion
5. as a product of social and political forces which shape the helping services
6. as a phenomenon of the service society
7. as an expression of the democratic ideal-consumer participation
8. as an alternative care-giving system
9. as an adjunct to the professions and a solution to the manpower problem
10. as an element in a planned system of care
11. as an international community
12. as a subculture--a way of life
13. as a supplementary community
14. as a temporary/transitional community
15. as agencies of social control and a resocialization process
16. as expressive/social influence groups
17. as organizations of the deviant and stigmatized
18. as a vehicle to and coping with long-term deficits and deprivations
19. as a vehicle to and coping with life-cycle transitions
20. as a therapeutic method

Baker (1977) reviewed the literature on the alternative systems of help-givers who work parallel to but outside of the professional care-giving system.

Brieff (1978) provided a literature review of

self-help and mutual-aid groups for the elderly.

Katz's paper (1981) reviews the social science literature on self-help groups which has been published since 1960.

Spiegel (1982), in a chapter, synthesized the recent literature about self-help and mutual support groups.

Professional Literature--Canada

A survey of the literature indicates that between 1970 and 1983 twenty-seven publications have focused either directly on, or mentioned Canada in discussing the self-help movement. The literature is both in English and French and can be organized under a variety of headings. A number of articles deal with several areas.

Evans (1979) and Harris (1981) discuss how to start a self-help group.

Farquason (1975), Evans (1979) and Romeder (1981, 1982) describe the phenomena of the self-help movement, as well as defining and categorizing self-help groups.

Small (1980) and Todres (1982) discuss professional functions and attitudes towards self-help groups.

Home (1978), Evans (1979), Lavoie (1981, 1982, 1983) and Gottlieb (1982) discuss group and change processes in self-help groups.

Romeder (1981), Gottlieb (1982) and Lavoie (1983) describe the benefits of self-help groups.

Criticisms and limitations about self-help groups can be found in the writings of Romeder (1982) and Lavoie (1983).

The future for self-help has been presented by Plummer (1981) and Romeder (1982).

Lavoie (1983) discusses the development of the self-help movement in Quebec. Evans (1979) and Gottlieb (1982) surveyed existing self-help groups in Canada while the Volunteer Centre of Winnipeg (1983) published a directory of self-help groups in Winnipeg.

There have also been published articles discussing research completed about specific self-help groups. Included in chronological order are:

1. Dean's (1970-71) case study of Recovery Inc. which mentions Canada as it is home to a number of local chapters of this international organization.
2. Ryback (1971) presents a case study of Schizophrenics Anonymous, a group that began in Saskatoon, Saskatchewan, 10 years ago.
3. Petrunik (1972) discusses the helping process in Alcoholics Anonymous.
4. Home (1978) explored the patterns of change by group members in 15 anglophone women's consciousness raising groups in Montreal.

5. Williams (1980) looked at self-help groups for single parent families.
6. Torjman (1980) described a self-help group for the family and friends of the mentally ill.
7. Shosenberg (1980) described and evaluated a self-help group for the parents of premature infants.
8. Rogers (1980) examined a self-help group for widows.
9. Rosenbaum (1981) studied the use of psychotropic medication and alcohol and the level of depression in a self-help group for widows and widowers
10. Plummer (1981) described a professionally initiated group for relatives of schizophrenic patients.
11. Lavoie (1981) discussed the effectiveness of the Group Environment Scale (G.E.S.) in data gathering on group process with two different types of self-help groups; a group for single parents and a group for ex-psychiatric patients.
12. Cantin and Daoust (1981) examined 12 chapters of a self-help group in Quebec.
13. Borman and Lieberman (1981) reported a study on an international self-help group for the widowed, THEOS, which has chapters in Canada.

The professional literature on self-help groups is increasing yearly and it is a reflection of the growing

significance of the movement in providing aid to millions of individuals.

CHAPTER FIVE

SELF-HELP GROUPS

DEFINITIONS AND CHARACTERISTICS

> Only those who have actually experienced depression can really understand the problem. Our self-help groups are designed to allow people to relax in the company of those who understand. One need not necessarily relate all one's problems, but...in the company of those who won't mind if you burst into tears...it is so much easier to find the courage to talk about your problems.--from a Depressives Associated newsletter

Self-help groups appeal to millions of people for a variety of reasons. The decision to join, the various ideologies of the groups, their relationship to professional care-givers and their general process of functioning form much of the basis of understanding and defining the nature of self-help groups.

There is a basic difficulty in the literature when it comes to arriving at a conclusive definition of what self-help is. Self-help definitions tend to be self-fulfilling as the various scholars cite specific group attributes which tend to fit comfortably with the characteristics of self-help as they view them. Seen in a more positive light, the many definitions of self-help illustrate the dynamic quality of the phenomenon. It also gives us the opportunity to set up boundaries so that we may define and exclude other forms of help. Excluded from this report are the numerous publications

which focus on self-care and network theory.

The definitions and characteristics which follow may be seen as building horizontally on Samuel Smiles' definition of self-help which was first published in England in 1859. In his preface to the 2nd edition of his book Self Help, in 1866, Smiles points out that a number of readers misunderstood the book from its title. The readers felt at that time, that Smiles was supporting the notion of selfishness. As Smiles declares;

> ...the very opposite of what it really is...although its chief object unquestionably is to stimulate youths to rely upon their own efforts in life rather than depend upon the help or patronage of others it will also be found that the duty of helping one's self in the highest sense involves the helping of one's neighbours. (Smiles, 1869, p. 111)

Rodolfa and Hungerford (1982) define self-help groups as:

> a process of mutual aid between peers who meet together to try and ameliorate their troubles. (Rodolfa & Hungerford, 1982, p. 345)

Borkman (1976) agrees with the above by defining self-help groups as:

> a human service-oriented voluntary association made up of persons who share a common problem and who band together to resolve the problem through their mutual efforts. (Borkman, 1976, p. 445)

Lavoie (1981) expands on the above by suggesting why people join self-help groups and what they might be interested in changing.

> Self-help groups are made up of individuals sharing the same situation or behavior, identified by them as a problem with psychological repercussions, who choose to meet together in small volunteer groups. They find themselves ill-served by the existing services. Their major aim is either to change themselves (attitude and behavior) or to adapt to the problem situation; some groups are also concerned with changing society's reaction to their members. These groups are controlled by their members who decide on the standards and modes of interventions; there may be participation by specialists, but control must be in the hands of the members. These groups count on the efforts, abilities, sustained presence and commitment of their members as a source of aid and on the peer relationship structure. Recreation may be added to the activities of these groups but this is not essential to the change process. (Lavoie, 1981, p. 13)

Katz and Bender (1976) also proposed a fairly broad definition.

> Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumptions of personal responsibility by members. They often provide material assistance, as well as emotional; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity. (Katz & Bender, 1976, p. 9; Katz, 1981, pp. 135-136)

Borman (1975, 1979) describes a number of attributes and characteristics which help to define what self-help groups do and how they are structured to perform their tasks.

> Their membership consists of those who share a common condition, situation, heritage, symptom or experience. They are largely self-governing and self-regulating, emphasizing peer solidarity rather than hierarchical governance. As such, they prefer controls built upon consensus rather than coercion. They tend to disregard in their own organization the usual institutional distinctions between consumers, professionals, and boards of directors, combining and exchanging such functions among each other. They advocate self-reliance and require equally intense commitment and responsibility to other members, actual or potential. They often provide an identifiable code of precepts, beliefs, and practices that includes rules for conducting group meetings, entrance requirements for new members, and techniques for dealing with "backsliders". They minimize referrals to professionals or agencies since, in most cases, no appropriate help exists. Where it does they tend to cooperate with professionals. They generally offer a face-to-face or phone-to-phone fellowship network usually available and accessible without charge. Groups tend to be self-supporting, occur mostly outside the aegis of institutions or agencies, and thrive largely on donations from members and friends rather than government or foundation grants or fees from the public. (Borman, 1975; 1979, pp. 14-15)

Silverman (1974), like Borman (1975, 1979) identifies a number of characteristics with which to describe self-help groups. Chief among those is her restating Riessman's (1976) "helper-therapy" principle.

> The self-help group has several important characteristics. Primary among them are: that the care-giver has the same disability as the care receiver, that a recipient of service can change roles to become a care-giver; and all policy and program is decided by a membership whose chief qualification is that they at one time qualified and were recipients of the service of the organization. (Silverman, 1974, p. 241)

Silverman (1974) goes on to add that Alcoholics Anonymous (A.A.) is the prototype for self-help groups

because it is organized by alcoholics for alcoholics. Furthermore, Silverman states that the A.A. program has remained basically independent from the formal health care system even though it uses professionals on occasion as consultants but not in the defining of programs or policy.

In addition to his definition of self-help groups, Katz (1981) added a further list of defining attributes which helps to distinguish self-help groups from other "mutual-aid" groupings.

1. Self-help always involves "face-to-face interactions.
2. The origin of self-help groups is spontaneous (they are not usually set up by an outside group).
3. Personal participation is an extremely important ingredient; bureaucratization is antithetical to the self-help organization.
4. The members agree on and engage in some action.
5. Typically, the groups start from a condition of powerlessness.
6. The group fills needs for a reference group, a point of connection and identification with others, a base for activity and a source of ego-reinforcement. (Katz, 1981, p. 136)

Finally, Levy (1976, 1982) in his survey of mutual support groups offers five conditions which must be met before an organization is defined as a self-help group.

1. PURPOSE: Its express, primary purpose is to provide help and support for its members in dealing with their problems and in improving their psychological functioning and effectiveness.

2. ORIGINS AND SANCTION: Its origin and sanction for existence rests with the members of the

group themselves, rather than with some external agency or authority...

3. SOURCE OF HELP: It relies upon its own members' efforts, skills, knowledge and concern as its primary source of help, with the structure of the relationship between members being one of peers, so far as help-giving and support are concerned. Where professionals do participate in the group's meeting...they do so at the pleasure of the group and are cast in an ancillary role.

4. COMPOSITION: It is generally composed of members who share a common core of life experiences and problems.

5. CONTROL: Its structure and mode of operation are under the control of members although they may, in turn, draw upon professional guidance and various theoretical and philosophical frameworks. (Levy, 1976; 1982, p. 1266)

Many similarities can be found in the above definitions and characteristics of self-help groups. The definitions tend to agree that self-help groups are formed by peers whose desire is to work together as they attempt to overcome common problems and by changing themselves and/or society (Gussow & Tracy, 1973; Tracy & Gussow, 1976).

Nonprofessional involvement is also a common denominator in the above definitions. Although there are many self-help groups which were initiated by professionals and utilize professional services--the professional, ideally, serves the group as requested by the group. Hurvitz (1974) points out that there are many differences between professional help and self-help.

Particularly significant is that in the professional-client relationship, the professional has more status and control; while in self-help the helper and the recipient are the same person. Gartner and Riessman (1977) state that the professional-client relationship is based on therapy while the self-help relationship is an interaction between peers and is itself therapeutic.

In a study of 264 self-help groups in Canada, Romeder (1982) reports that 232 (88%) indicated general agreement with the definition proposed by Katz and Bender (1976a). It is not known, however, whether these groups were asked their opinions about the other definitions.

Whether the definitions stress an internal orientation about improving the "psychological functioning and effectiveness" of its members (Levy, 1982, p. 1266), or an external orientation in advocating societal change; (Katz & Bender, 1976a; Lavoie, 1981) the definitions ring of optimism. The definitions suggest that self-help groups are organizations which attempt to maximize the self-determination and participation of its members in defining their needs and utilizing their strengths.

CHAPTER SIX

SELF-HELP GROUPS

CATEGORIES AND TYPES

> I was in hock up to my ears, I had lost all my self-respect. I couldn't look anybody in the face...I was always trying for the big score...and the harder I tried, the more I kept getting in deeper and deeper. And what the hell was the big score anyway? I made it a couple of times so what did I do with it? I blew it...my wife never even got a dress or a pair of shoes out of it...But you know the routine...we're all the same...we've all gone the same route. But things are different now since I've joined G.A.
> --from a Gamblers Anonymous member's "weather report"

There exists today a significant number of classification systems and typologies as theorists grapple with their understanding of self-help groups. Many of them lack clarity, are too narrow, and are often cumbersome when attempting to utilize them. Some writers have developed a two-fold classification system while others have developed one which includes eight different types of groups. One thing is very clear, however, and that is self-help groups will continue to spring up to deal with contemporary and future problems and a more coherent way of describing them will also be required.

A number of researchers offer a classification system which identifies groups as being one of two types.

Bender (1971) has chosen to classify self-help

groups on a continuum from "sacred" to "secular". As the socio-psychological nature of the problem increases the more the symbols and structural arrangements of the groups take on an orientation which is more "sacred"-like. Using Bender's (1971) description would require careful observation as to the kind of arrangements a group makes structurally in helping its members. Alcoholics Anonymous is a self-help group whose mutual forms of helping has taken on a highly ritualistic dimension.

Jennings (1947) identified two distinct types of groups. They are the psyche-groups and the socio-groups. The differences between the two types of groups are due to structural differences or the choices group members make during various times in the group's life.

Psyche-groups are personally meaningful, they have intense personal interaction and have qualities of spontaneity. The socio-group is more formal and impersonal and more task-oriented than the psyche-group. Operationally, psyche-group members choose those members whom they would like to relax with while the socio-group selects those members whom they would like to work with. The distinction is in the form of choice: psyche--friendship; socio--work with primarily but also secondary gains such as friendship and compan-

ionship.

Wechsler (1960) and Sagarin (1969) characterize self-help groups in relation to deviancy. They each postulate two types of self-help groups.

Wechsler (1960) identifies groups as either being led by deviants or under professional leadership and direction. As we see elsewhere in this report not all groups perceive themselves as being deviant or led by a deviant. As well, most groups are not professionally led.

Sagarin's (1969) description is more broad than Wechsler, (1960) but, like Wechsler, Sagarin excludes many groups from being classified because it is still too narrow. Writing from the perspective of the sociology of deviant behavior, Sagarin classifies groups as either being organized to reduce the stigma members feel and experience or groups are formed whose members accept the stigma of their particular deviancy.

The first type of self-help group identified by Sagarin can be viewed as conforming to the norms of the larger society. For example, A.A. and other groups of that kind, adhere to society's normative order by re-forming the behaviour which is deemed deviant. These self-help groups paint deviants as individuals who are worthwhile while viewing deviance itself as sinful, self-defeating and immoral. They function somewhat

like a therapy group and often incorporate religious or pseudo-religious concepts to reinforce their function and goals.

The second type of self-help group identified by Sagarin combats deviancy by attempting to change society's attitudes, often by social reform activities. Gay self-help groups would be an appropriate example of Sagarin's type 2 group.

Sagarin (1969) goes on to say that the two types of groups have irreconcilable attitudes towards their labelled deviance. The first type of group condems the behavior while the second attempts to convince the world of their normalcy.

Steinman and Traunstein (1976) in their study of self-help groups identify two distinct types which they see as becoming more apparent. They refer to the two emerging groups as the "Redefiners" and the "Ameliorators". This two-fold typology is not unlike that of Sagarin (1969).

> The "Redefiners" are those groups which:...reject the prevailing societal definition of their members' inherent condition as something which needs to be reversed, modified, or excised; and instead seek to persuade or coerce the public to redefine that condition. Included in this category are blacks, women, homosexuals, poor people. (Steinman & Traunstein, 1976, p. 358)

On the other hand, the "Ameliorators" are those groups which:

> while rejecting the prevailing societal definition, nevertheless acknowledge that there is something about their members' inherent condition which is problematic and which the members themselves need to modify. Those who suffer periodic mental illness and victims of developmental disabilities fall in this category. (Steinman & Traunstein, 1976, p. 358)

Steinman and Traunstein (1976) caution however, that even where amelioration is conceded by groups, self-help groups strive to redefine themselves. They cite such conditions as gambling, alcoholism, child battering and other abuses as being redefined as "sick" rather than "bad".

Tracy and Gussow (1976) have drawn up a typology which refers specifically to self-help health groups.

> The first type...provides direct services to patients (and relatives) in the form of education, coping skills, peer encouragement and other supporting activities in helping the afflicted deal adaptively with the medical problem. (Tracy & Gussow, 1976, pp. 381-382)

Groups such as Mended Hearts (open-heart surgery) and Emphysema Anonymous are examples of a Type I group according to Tracy and Gussow (1976).

The second type of group identified by Tracy and Gussow (1976) is the group which concerns itself with activities such as fund raising, public education, the promotion of medical research, lobbying, etc. The Canadian Diabetics Association and the Muscular Dystrophy Association of Canada are examples of Type II groups.

The two types of groups described above are not mutually exclusive. In 1967, for example, a self-help group, The Committee to Combat Huntington's Disease was initiated by a patient's wife initially to help those with the disease cope with its process and outcome. It was soon realized that no amount of mutual support could retard the disease's progress. Instead, the group shifted from a Type I group to primarily a Type II group by placing its primary support into medical research and in finding a cure for the condition and therefore doing what professionals had failed to do heretofore.

Jaques and Patterson (1974) also describe two group types. The first type involves an individual who has a problem or condition where the group's focus is directed towards personal problem-solving and programs.

The second type of group is for family or friends of persons who have a problem or condition. This type of group frequently functions as an advocacy or social action group.

Both group types described above are directed towards the learning of a new coping life style.

Generally speaking, the above typologies, (although enlightening for the student of self-help) are too narrow in scope, too specialized to be generalized and frequently exclude a variety of other forms of

self-help groups.

This literature survey produced four sources which have developed a three-fold typology. The three-fold typologies are not only different in emphasis from the two-fold typologies but they are also in distinct contrast from each other.

Perlman (1976) visited over sixty grassroots groups and developed a three-fold typology to describe them:

> 1. direct action groups that pressure existing authorities for accountability and specific policy outputs;
> 2. electoral groups that attempt to become the existing authorities; and
> 3. alternative institution groups that bypass the existing authorities (such as community development corporations, cooperatives and self-help enterprises). (Gartner & Riessman, 1977, p. 141)

Perlman (1976) characterizes these groups as needing to affect something at some level, as well as feeling that they have some degree of influence and control. They tend to focus on a great variety of consumer issues including housing, women's issues, the environment, local services and taxes. The groups are fairly loose in their structure and generally do not endure. The groups are generally unconnected with each other but oftentimes form movements such as the welfare rights movements in the 1960's in the U.S.A., the women's movememt and the environmental movement. These consumer groups boycott, demonstrate, use the media and

the legal system to show their concern with the problems of everyday living.

Bean (1975) develops her typology by focusing on the severity of a problem--but she does not discriminate between problems.

The first type of group deals with "crisis" problems. The second type of group exists for people who are in a permanently fixed stigmatized condition. The third type of group focuses around those individuals who are addicted, trapped in a habit, or their life is self-destructive.

Durman (1976, pp. 433-443) discusses the role of self-help in the area of service provision. The dimensions of service provision considered are: client needs and characteristics, treatment variables and outcome and situational aspects of providing direct help. Durman's typology then appears to be the outgrowth of this relationship between self-help and the public system of service provision. He categorizes self-help groups into (a) those groups in which the focal problem is services in the present mix of public categorical grant programs (b) those groups in which the focus is not prominent in such programs but which might eventually become a focus of public concern and (c) those groups in which the focal problem is irrelevent to public policy except where their characteris-

tics can be generalized to groups in the other categories.

Hansell (1976, pp. 157-163) has constructed a three-fold typology which classifies self-help groups according to the nature of the bond that draws its members into a relationship.

Type I groups, "predicament" groups, face a common condition which is viewed and experienced in a similar fashion by its members. Hansell identifies Alcoholics Anonymous and Parents-Without-Partners as examples of a Type I group. Hansell collapses (to be discussed later) Levy's (1976) Type I and Type II groups.

Hansell (1976) identifies the Type II groups as "Bridging Groups". These groups are quite unlike the ones identified by Levy (1976). "Bridging" groups are in direct contrast to the predicament groups.

> They provide a brief, regulative context for an individual in distress while a more enduring mutual-help group is located...The characteristic feature of bridging groups is that they invite brief, immediate contact with individuals in distress under a wide range of circumstances. (Hansell, 1976, p. 159)

Telephone "hot-lines" (i.e. suicide or rape, etc.) or "drop-in" centres emphasize immediate and usually temporary service.

The third type of group that Hansell (1976) identifies is "Professionally Assisted Groups". The origin of these groups is in contrast to both the predicament

and bridging groups. In this type of group potential members are composed of isolated individuals who have been brought together by a professional. The members may have been receiving similar help for a similar problem but on an individual basis. Because the professional has a number of these individuals to deal with, the decision might be made to link them together so that they might work together with their mutual concern.

According to the literature, there are three different four-fold typologies describing primary functions.

Silverman's (1978) typology characterizes self-help groups according to their most predominant activity. Type I groups' main function is fundraising. Type II groups are concerned with political action. Type III groups are concerned with consumer advocacy. The Type IV self-help groups' primary activity is personal help. Silverman acknowledges that in certain instances a particular group might have more than one primary function.

Levy (1976, pp. 310-322) also distinguishes among four types of self-help groups.

Type I groups, Levy points out, have the objective of providing their members some form of behavioral control or conduct reorganization. Alcoholics Anony-

mous is an example of a Type I group. A.A. is composed of individuals who see and acknowledge their problem, alcoholism, and encourage their members to actively become normal, functioning and coping citizens.

Type II groups are characterized by members who share a predicament which causes a certain amount of stress. An example of this kind of group is Parents-Without-Partners. Parents-Without-Partners has been organized to meet very specific and personalized sets of problems; that is, the difficulty in raising children as a single parent.

Levy describes Type III groups as being survival oriented. Gay groups best reflect the nature of this category. The gay groups' primary function is in creating and establishing alternative living and working styles. Some members along the way may find the opportunity for self-fulfillment and personal growth. However, this is an indirect benefit and not the primary objective and function of the group.

Levy, also describes a fourth type of group; that is, groups which pursue self-actualization, personal growth and increased effectiveness of its members. There is a significant difference between this type of group and the other three types identified by Levy. The previously mentioned commentators have also ignored

classifying this group as a distinct type. That is, members come together because they believe that they can help each other to live a better life. The other types of groups were formed around a specific core problem. Sensitivity groups, T groups, informal experientially-oriented groups and Mowrer's (1972) Integrity groups are examples of Levy's (1976) Type IV self-help group. Integrity groups, according to Mowrer (1972) are predicated and operate on three fundamental principles: honesty, responsibility and involvement. Integrity groups help people recover their sense of identity and integrity. These individuals have become alienated or "lost" because of an actual or impending identity crisis.

Lieberman and Borman (1979) have also developed a typology of four types of self-help groups based on their composition and purpose. They criticize (to be discussed elsewhere) Katz and Bender's (1976a:36-37) five-fold typology because it includes too many Type I groups (Katz and Bender's typology) and they also question the psychological meaningfulness in the distinction between Katz and Bender's (1976a, 1976b) second and third types of groups. They also cite their own research and the literature of various groups to dispute Katz and Bender's (1976a, 1976b) identifying certain groups as attempting to create an alternate pat-

tern for living even though these groups are also engaged in a significant amount of social advocacy.

The four types of self-help groups as identified by Lieberman and Borman (1979) are:

1. Behavioral Control or Conduct Reorganization Groups. The membership of these groups are made up of individuals whose usual sole purpose is to eliminate or control a behavior that has become problematic. Alcoholics Anonymous, Gambler's Anonymous and Take off Pounds Sensibly are examples of Type I groups.

2. Stress Coping and Support Groups. These are groups whose members are experiencing some degree of stress because of a common status or predicament. The groups attempt to utilize mutual support and the sharing of advice and coping strategies to ameliorate the felt stress. However, no attempt is made to change the status of the members as their state is accepted as basically being a fixed one. The group tries to help its membership to carry on despite the identified problem. Al-Anon, Emotions Anonymous, Make Today Count, Parents-Without-Partners and Recovery Inc. are cited as examples of Type II groups.

3. Survival Oriented Groups. These groups are formed and attract individuals who have either been labeled or discriminated against because of their values, lifestyle, race, sex, sexual orientation or soc-

ioeconomic class. The function of these groups is to maintain or enhance their members' self-esteem through mutual support and activities of consciousness-raising. They hope to gain legitimacy for their lifestyle and to eliminate the reasons for discrimination and stigmatization by educational and political activities aimed at the public. National organizations for women, gay groups, Black and other racial and ethnic groups are examples of Type III groups.

4. Personal Growth and Self-Actualization Groups. Membership includes individuals who share a common goal of enhancing the effectiveness of all aspects of their lives. In particular, sexuality, emotionality and the capacity to relate to others are areas that are developed in group participation. There is no major problem which brings members together which is in direct contrast to the other three group types. Instead, members believe that through mutual support they can help each other improve the quality of their lives. Lieberman and Borman's (1979) Type IV group appears to be compatible with Levy's (1976) Type IV group.

Evans (1979) discussing self-help groups in a best selling popular trade book characterizes five types of self-help groups. The typology's function is to give readers headings for an extensive self-help directory which is found in the book. Self-help groups in Canada

and the U.S.A. are listed under the following headings (types).

1. General Health
   (a) Acute Disabilities
   (b) Chronic Illnesses
   (c) Special Health Problems, Concerns, Situations
   (d) Surgical Trauma
2. Mental Health
3. Addiction
4. Consciousness-Raising
5. Consumer Advocacy

Evan's book is an excellent introduction for the general public about self-help groups.

Katz and Bender (1976a, 1976b) and Katz (1981) like Evans have developed a five-fold typology. Unlike Evans however, their typology is directed towards the scholarly community. The five types of self-help groups are:

1. Groups that are primarily focused on self-fulfillment or personal growth. Recovery Inc. is an example of this type of "therapeutic" group.

2. Groups that are primarily focused on social advocacy. Advocacy activities include agitating, educating, confrontation and social crusading directed at the public, professionals and existing institutions. Welfare rights groups and groups for the rights of the disabled are examples of Type II groups.

3. Groups whose primary focus is to create alternative patterns for living. Gay liberation groups and various communal associations are typical of Type

III groups who begin new and alternative living and working arrangements of their own and in the process, although not the primary objective, enable individuals to grow and gain self-fulfillment.

4. "Outcast haven" or "rock-bottom" groups. The membership of these groups is made up of individuals who are in desperate straits and who require secure personal protection from life's pressures as to save themselves from declining mentally and physically. The X-Kalay Foundation is an appropriate example of this type of group. The commitment of the group is total--living arrangements are taken care of and supervision is by peers who have dealt successfully with similar problems.

5. Mixed type groups are those groups who do not have a predominant focus as the above group types but may have the characteristics of two or more of the identified categories. Parents-Without-Partners and ex-prisoner groups are examples of the "mixed" type.

In a pamphlet written for the lay person Ogg (1978) develops a six-fold typology comprised of groups whose function is for:

1. those who want to break a bad habit;

2. former mental patients;

3. people with physical health or disability problems;

4. those in stressful life transitions;

5. relatives of a child or adult having a problem; and

6. social activists seeking change on behalf of their group.

Romeder (1981) describes eight major categories of self-help groups according to the problem area they address.

Type I groups are for people with compulsive behaviours (i.e. Alcoholics Anonymous and the parallel groups for friends, relatives and children of alcoholics or drug addicts).

The second type consists of those groups oriented towards family problems. In particular, this would involve parents whose children have specific problems such as diabetes, learning disabilities, etc. Other problem and issue areas identified by Romeder include groups that promote a certain behavior towards their children (La Leche League), single parent groups and groups for parents who have abused their children.

The third type is comprised of individuals presently experiencing or recently recovered from psychological or emotional problems. Romeder includes in this grouping parents or friends of the physically or psychologically ill. Emotions Anonymous, Recovery Inc. and Friends of the Schizophrenic are examples of a

Type III group.

The largest number of groups are found in Type IV. Membership includes those individuals suffering from a chronic disease or physical handicap.

The object of a Type V group is to help its members to free themselves from societal or psychological pressures by supporting the choice for an alternative lifestyle. Gay groups are a good example of Romeder's Type V group.

A sixth type of group described by Romeder contains individuals who have suffered from a result of numerous forms of discrimination. Women's groups are cited by Romeder as Type VI groups.

A seventh type includes groups whose primary orientation is directed towards a specific social action; changing laws, creation of new services and the improvement of existing services.

The final type of group is that which has been formed to help individuals deal with recently experienced traumatic separations such as death, divorce or separation.

New self-help groups are being formed everyday to cope with recently discovered problems and concerns and it seems apparent that more typologies will be developed. As groups begin and end, splinter and divide into yet other groups because of factors such as pur-

pose, principles or expansion the categorizing of these groups becomes more complicated. However, the variety of typologies described creates a framework in which to observe group similarities and differences, the special qualities of each group, the limitations of a group, their direction and the services and support they offer to their membership.

CHAPTER SEVEN

SELF-HELP GROUPS

THE RELATIONSHIP WITH PROFESSIONALS

> They pretend drug addiction's a disease, treating it with white hospitals, nurses, and pills. They pull you off one trip to put you on another. They never realize (because they've never been one of us) that it's not a disease, but a person. A disordered person that's what I am. I need order. (comment by a member of Synanon)

The purpose of this chapter is to examine the relationship between self-help groups and professionals. This is a particularly significant area in our understanding of self-help groups as over 70% of 264 groups surveyed in Canada in 1980 (Romeder, 1982) reported as receiving some assistance from a variety of professional care-givers.

In attempting to clarify this relationship, this chapter will focus on the awareness that professionals have of self-help groups; the attitudes towards this relationship; an overview of selected interactions between the two systems; and finally the roles and functions that professionals are serving and can serve in working with self-help groups.

Are professionals generally aware of the self-help resource? Three studies indicate that the answer probably is one of an increasing but not a substantial awareness.

Two recent studies indicate that professional awareness of self-help groups is increasing. Stuart and Mitchel (1978) collected data from 106 of the 164 professional participants in the Tenth Banff International Conference on Behavior Modification. The group's composition included: 33% PhD. level psychologists; 18% M.A. and B.A. level psychologists; 15% were teachers; 13% were social workers; 9% were nurses; and 2% were listed as other. There was an overall average of 14.4 years of experience among the participants in professional settings. The survey indicates a general recognition of the value of the self-help approach to problems of behavioral self-management.

Todres (1982) directed a project which focused on the professions of social work, psychology, psychiatry and medicine and nursing. Todres attempted to discover the degree of awareness that these professionals had about selected self-help groups in Toronto. The data collected from 308 professionals indicated that they did have some degree of familiarity with self-help groups in the community.

Lieberman and Borman (1979) suggest that some professionals are well informed about self-help groups while other professionals are actively involved with one or more of them. Toseland and Hacker (1979,1982) state however that most professionals know little about

self-help groups. In one particular study, Toseland and Hacker (1979) found that most self-help groups had professional involvement, however, the professional did not refer clients to the group despite the unavailability of appropriate professional services.

Toseland and Hacker's (unpublished) survey of a chapter of the National Association of Social Workers in a northeastern New York community revealed that awareness about self-help groups by social workers varied depending on where the social worker practiced. Social workers who worked in hospital settings, family and mental health agencies were able to name more local self- help groups than professional social workers who practiced in public social welfare agencies, in agencies serving the developmentally disabled and those who worked in residential settings. The survey also indicated that a significant proportion of the 247 respondents wanted additional information about self-help groups. Twenty-four percent of the respondents also indicated that their agencies did not keep a directory or manual of community resources which included self-help groups. Ninety percent of the respondents noted that a directory of local self-help groups would be desirable.

Other significant results of the survey indicated that 80% of the respondents felt that self-help groups

are under-utilized by professional social workers. Nineteen percent said that they were properly utilized while 1% said that they were over-utilized. Seventy-one percent indicated that it was their responsibility to acquaint themselves with local self-help groups which are relevant to their clients' problems. Finally 54% of the respondents stated that self-help groups should improve their methods of reaching out to social service providers.

Table I indicates that about one-half of the respondents have been actively involved in self-help groups but a significant minority had no contact or awareness. The study covered the year 1982.

Finally the results of the survey suggest that agency policy and procedures and familiarity with self-help groups were the most significant predictors of referrals to self-help groups. Not surprisingly, the results from the regression analysis of the survey suggest that social workers who use self-help groups as treatment resources work in agencies whose policies encourage and inform workers of these groups as a community resource and social workers who attend self-help group meetings or serve as consultants to the groups refer more often to them.

It is unclear just how much professional caregivers know about self-help groups. Knowing about

TABLE I

Social Workers Past and Current Involvement with Self-Help Groups-1982

Toseland and Hacker--1983

	Percent	
	Past	Current
Participation as a non-professional member of a self-help group	30	9
Advisor or consultant to a self-help group	40	21
Attended meeting(s) to become more familiar with self-help groups	50	18
Assisted in the initiation of a self-help group	38	22
Member of the Board of Directors or Steering Committee of a self-help group	13	7
Leader or co-leader of a self-help group	27	17
Speaker at a self-help group meeting	37	16
Total number of respondents		247

self-help groups is of course crucial in using them effectively in practice. However, it is probably safe to conclude that the rapid emergence of self-help groups in the last two decades, the abundance of recent literature about the self-help movement and the results of the above studies implies that the professional care service system is becoming more aware of self-help groups. As more self-help groups emerge the need for educating, informing and training of professionals concerning the availability and potential uses of the groups as community resources are required. As well, much more research is needed in determining how professionals and their agencies develop and maintain contact with self-help groups.

Although there is information regarding the attitude of self-help groups towards professionals and professional services (discussed elsewhere) a reciprocal pool of data is limited (Shatan, 1973; Hatfield, 1979; Toseland and Hacker, 1982).

Rodolfa's (1982) claim that numerous professionals are convinced of the value of self-help appears to be one of hopeful optimism rather than one based on any significant data. Why professionals refer to self-help groups is a more significant question to ask rather than do professionals refer to self-help groups as a way of collecting attitudinal perceptions. There is

very little in the literature which directs itself to this question.

There are however a number of studies and surveys which indicate that professionals have both positive and negative attitudes toward self-help groups.

Steinman and Traunstein (1976) make the point that professionals are elitists, support the established order, draw membership from the most privileged classes and feel they know more than others. Professionalism perpetuates the attitude that professionals are higher while clients are lower and the nature of the relationship is one of an authoritarian healing kind. Often when clients do not change, they are blamed for the failure (Ryan, 1971).

Steinman and Traunstein's (1971) above description suggests that a major attitude of professionals towards self-help groups is a result of the differences in the makeup and practice of the two systems. If so, then negative attitudes (later in report) would follow. Professional care-givers, like other individuals suffer from insecurity and there may be a fear that a self-help group might be more successful in providing help to a client. Many professionals view self-help groups as competition for clients rather than as a resource to collaberate with in providing needed help.

Other common criticisms by professionals towards

self-help groups include:

1. they are anti-professional
2. they provide a "crutch" for members who then become isolated from the greater community
3. their subjective knowledge (Romeder, 1982) about their problem area and the treatment of these problems and concerns should be more adequately addressed by professional social services (objective knowledge)
4. their effectiveness has not been sufficiently documented (Sidel and Sidel, 1976, pp. 67-69; Kleiman, Mantell and Alexander, 1976, pp. 403-410; and Back and Taylor, 1976, pp. 295-309).

Borkman (1976) raises a final concern that professionals have about self-help groups. Borkman's comments address the methods which self-help groups use in working with their members. Borkman observes that the experiential knowledge possessed by members of self-help groups is quite different than the professional knowledge which is acquired by professional social workers. Borkman states that this may lead to potential conflict between professionals and self-help group leaders as they both attempt to prove the effectiveness of their methods. Borkman concludes that investigations should be conducted to determine under what con-

ditions and how social workers relate to self-help groups and furthermore under what conditions professional knowledge or experiential knowledge may be the best method to serve clients.

Vattano (1972, pp. 7-15) states that despite the concerns identified, social workers support self-help groups as vehicles to empower citizens.

A survey of members of the American Psychiatric Association by Wechsler (1960) revealed the following results with regards to the psychiatrists' attitudes towards Recovery Inc., a post-psychiatric patient organization.

> ...In general psychiatrists felt that Recovery is a helpful and valuable tool because of the group aspects...(Wechsler, 1960, p. 299).

Kline and Robert (1973) proposed that self-help groups be used with Indian Alcoholics due to the Indian culture and reticence to discuss personal difficulties.

Jacques and Patterson (1974) in a review of the literature, conclude that self-help groups are viable and necessary in the rehabilitation service systems.

Guggenheim and O'Hara (1976) conclude that self-help is a valuable service for the medically ill.

Pierce and Schwartz (1978) suggest that self-help groups are cost efficient in providing appropriate services.

Levy (1978) in a national survey reports a gener-

ally favorable evaluation by professionals of the effectiveness of self-help groups and the potential role they play in mental health services.

Hermalin, Melendez, Kamarck, Kievans, Ballen and Gordon (1979) describe a survey of a clinical staff of a large urban community mental health/mental retardation centre concerning their involvement with self-help groups. Results indicate that 88% of the clinicians surveyed endorse their hospital's involvement with self-help groups and 61% indicated a desire to work with them. The researchers conclude that clinicians recognize the valuable contribution made by self-help groups and their desire to participate in joint programs.

Todres (1982) in a study cited earlier indicates that the 308 professional care-givers in Torontothat were surveyed held favourable attitudes towards self-help groups.

Toseland and Hacker's (1983) study provides an interesting discrepancy between professional respondents and those of self-help group leaders. One third of the 247 social work respondents questioned felt that self-help groups had negative attitudes towards collaberation and cooperation with social workers. Another 24% felt that self-help groups had neutral attitudes towards collaberation while 43% believed that self-help

groups had positive attitudes towards professional cooperation. Toseland and Hacker's (1982) study concluded perhaps ironically that self-help group leaders welcomed and encouraged professional involvement to a greater degree felt than the professional social workers of the 1983 (Toseland and Hacker) study.

Katz and Bender (1976a) conclude that professionals view self-help groups as a positive means for members to share common concerns and to develop their own skills and coping mechanisms.

Professional attitudes towards self-help groups range from a position of total rejection to actively endorsing and in helping to set such groups up. There is no question that further conclusive research is required to gain a better understanding about professional attitudes towards self-help groups. The local scene in particular needs to be studied.

The self-help movement has had an ongoing concern about the nature and the extent of professional involvement in the functioning of groups. The 1980's will probably see new models of service delivery incorporating an increasingly strong relationship between professionals and self-help groups. Several investigators (Jertson, 1975, p. 145; Killilea, 1976, pp. 37-93; Borman, 1976, pp. 46-47; Baker, 1977, pp. 139-149; and Gartner & Riessman, 1977, pp. 128-158) have called for

a thorough analysis of the role of professionals in the self-help movement, but, with one notable exception (Lieberman & Borman, 1979) little empirical work has been done.

As noted previously, self-help groups have moved into the helping areas once orginally serviced by professionals. Professional care-givers have had great difficulty and little success in working with and meeting the needs of many hard-to-reach groups of individuals. Because agencies and institutions have too long emphasized the exclusive services by professionals to potential or real clients (Barish, 1971). Many great opportunities have been lost in developing a positive relationship with a network of natural helpers (Collins, 1973). As a result many individuals who have been labelled deviant along with particular indiginous populations have become anti-professional (Barish, 1971) and place little trust in collaberating with professionals (Back & Taylor, 1976).

Antze (1976) warns that,

> Whatever outsiders try to support to cooperate with one of these organizations they run the risk of tampering with its ideology...Sometimes the mere involvement of a professional can weaken the meaning of certain teachings (for example, "Only a drunk can help another drunk."). Matters become worse if the observer should point out that a given belief runs against medical knowledge, or if he counsels changes to increase the group's acceptance in professional circles. If the view developed here has been developed, then meddling of this kind would do real harm to the therapeutic

process. (Antze, 1976, p. 344)

Romeder (1982) states that quite often professionals dominate groups. Gartner and Riessman (1977) feel that professionals cultivate dependence, impose new rules, create or reinforce anti-professionalism rather than harmonizing professional and non-professional approaches in a useful way; and promote the romantic idea that small groups hold the only key to social change. Gartner and Riessman (1977) raise the concern that some professionals may socialize self-help groups to professional norms and leave them as appendages of traditional agencies.

On the other hand Borman (1976, pp. 46-47) states that,

> while self-help groups operate outside professional agencies, many of them have been initiated and supported by professionals behind the scenes.

Parents Anonymous (Haeuser & Meikamp, 1978) an international network with over 8000 members in 800 chapters in the U.S.A. alone, incorporates professionals in a clearly defined and limited role as part of the therapeutic process. Furthermore, they depend on relationships with professionals and public funding in order to maintain organizational growth and chapter development. The consumer-professional mix is in contradiction to Gartner and Riessman's (1977, p. 12) comments that:

implicit in the self-help thrust is a profound critique of professionalism.

Mellor, Rzetelny and Hudis (1981) conclude from their research that self-help is not an alternative to professional social work but that the two forms can be complementary and this partnership is particularly well-suited in planning programs for caregivers and the aged.

Lieberman and Borman's (1979) study of ten self-help groups revealed that all the groups benefited from professional intervention. Six of the ten groups were either started or given an early boost by professionals. Lieberman and Borman (1979) identified nine attributes of the professionals in their supporting of self-help groups.

1. Professionals went beyond conventional theories of human nature and treatment in beginning a self-help group (Dr. Low, Recovery, Inc.).
2. A professional defined more broadly certain afflictions. A.A. recognizes that alcoholism is a combination of mental obsession and physical allergy.
3. A professional went beyond conventional accepted skills and techniques as in the use of "Attack Therapy" by Synanon (Yablonsky, 1965).

4. Some professionals began to focus on neglected stages of conditions such as after-care and rehabilitation.
5. Some professionals became concerned about neglected problems and formed self-help groups (Recovery Inc.).
6. A number of professionals altered their professional role from that of a solo role to a collaborative role with self-help groups as illustrated by Compassionate Friends.
7. Professionals helped or supported self-help groups to form outside the mainstream and to not concern themselves with bureaucratic issues of legality, accountability, etc.
8. Professionals attempted new innovations in the recruitement of potential members for self-help groups by using the media or by word of mouth.
9. Finally, professionals and self-help groups minimized the fees for membership.

A Canadian study (Romeder, 1982) quite clearly does not support the conclusion that professionals are not welcome or at least are with mixed feelings (Borkman, 1976, pp. 445-446; Steinman & Traunstein, 1976; Katz, 1970). Two hundred and sixty-four groups were surveyed across Canada and some of the findings

indicate that 70% of self-help groups received assistance from various professionals.

The relationship or what Baker (1977) refers to as interface between professionals and self-help groups is quite diverse. At one extreme, the literature indicates a hands off relationship while at the other end we have numerous examples of professionally led groups. The final section of this chapter discusses potential roles for professionals with self-help groups.

There are roles that professionals can perform in respect of the wishes of self-help groups. As discussed earlier there is much controversy over the relationship between self-help groups and professionals. In spite of this controversy, there is a long history of professional-self-help involvement (Gartner & Riessman, 1982). We will probably see anincreasingly strong relationship between the two groups in the years to come.

Wollert and Knight (1980) suggest that before a professional becomes involved with a self-help group, (at any phase of its development) the professional would be wise to understand adequately the workings of such groups. This would include the knowledge of self-help group dynamics and how to manage them; the different types of self-help groups; and the awareness that self-help groups do not use the treatment model of

most therapy groups (Hurvitz, 1970). Besides the necessary knowledge base, a level of trust towards the group is a definite requirement. The group or potential group needs to be sure that they can allow the professional to enter their system. There is a real demonstrated danger (Kleiman, Mantell & Alexander, 1976) of professionals who may interfere and impose their own ideas and methods on the structure and operating procedures of self-help groups. The need for the professional to detatch himself from the group at an appropriate organizational stage would be a positive indication in demonstrating professional trust in the group.

The first contribution that a professional might make is in helping to create a group (Baker, 1977).

> One of the controversial roles that has been suggested for social workers is the role of initiation or developer of a self-help group. Unlike the consultant who may serve as a source of expert advice for group members but takes direction from the needs and requests of a pre-established group, a social worker who initiates a self-help group will often have major leadership responsibilities, including that of helping the group to develop its interventive techniques, its use of facilitative dynamics and its relationship with community agencies. To avoid dominance over the group, social workers and other professionals who function as initiators of self-help groups have been cautioned to work in partnership with members of the target population to insure that adequate leadership direction and participation develop from within the group itself. (Gartner & Riessman, 1979, pp. 168-169)

Because the professional is often in a position to

see a number of individuals going through similar difficult or crisis situations, he can suggest that they organize or have him organize a meeting around the issue. The idea of mutual support is born from the pooling of resources to deal with a common problem. This was the manner in which Recovery Inc. was started, (Gartner & Riessman, 1977); Widow-to-Widow Groups, (Gartner & Riessman, 1977); the SHARP (Share-Help-Alcohol Recovery Program), (Stead & Viders, 1979); and a group for bereaved parents formed in Montreal (Harris, 1981). The function of acting as a catalyst or facilitator is a skill that professionals are uniquely equipped to perform in the early stages of self-help groups (Vattano, 1972). Harris (1981) provides a list of ten steps which a professional can follow in properly organizing a self-help group.

The need for professionals to consider seriously in helping to start self-help groups in particular areas is evidenced in the writings of Hess (1976) and Milofsky (1980). The former suggests that professionals should initiate self-help groups for the ageing and to continue to provide continuity to the group(s). The latter stresses the significant function of social workers in helping the disabled to construct groups for their particular disabilities as well as building a network of people to assist disabled group members with

small but necessary tasks. By creating this informal network of support, four activities would become less difficult. This includes: (1) mundane daily tasks, (2) personal hygiene tasks, (3) community support tasks, (4) institutional access tasks. Furthermore, Milofsky states that professionals should also become advocates for the groups in areas such as programs, etc.

Isenberg (1981) addressed the ways in which participation in self-help groups helps the inflicted and members of their family to cope with cancer. The findings suggest that professionals played a major role in the two self-help groups studied and that professionals can enhance the service capacity of self-help groups by developing or participating in them.

A study by Toseland and Hacker (1982) of 44 self-help groups reveals that 56% were begun by professionals. One of the groups in their study was initiated by a social worker. The social worker saw the need for a group to provide social stimulation and mutual support for former mental patients as few services were available otherwise. The social worker contacted other professionals and former patients for referrals and invited them to join her in establishing a self-help group. With joint professional and non-professional involvement, the group found a meeting place and developed a program to serve the social, psychological and

recreational needs of its members.

A second function which professionals can perform is to refer individuals to self-help groups (Baker, 1977; Powell, 1975, 1979; Lieberman & Borman, 1979; Rodolfa & Hungerford, 1982). Powell (1975) provides therapists with four points that they should consider as to how and why individuals come to accept a group. According to Powell's work in the area of reference group theory and research the client will have the following concerns as to whether he wishes to accept a particular group as a point of reference for his conduct:

1. Is it a socially approved thing to do? The professional can demonstrate social approval by how he handles the referral.

2. Will the client find similar people there? The professional needs to explain very precisely the composition of the group so that the client will be able to see some similar characteristics.

3. Does the group have ideas which are compatible with his about the nature of the problem and its resolution? The therapist should present the group's interests as an extension and elaboration of the client's interests.

4. Is the group accessible? The professional worker should make it highly desirable for the client to meet members and get there.

Powell (1975) believes that a professional can enhance the relationship he may have with a client by referring the client to an appropriate self-help group. In discussing social work referrals to Parents Anony-

mous, Powell (1979) concludes that the professional-client relationship was enhanced because the social worker was able to talk to the client about the client's shame of joining the group.

When discussing professional referrals to self-help groups, Lieberman and Borman (1979), note that because of an appropriate referral process, a number of groups that they studied developed excellent linkages with health, mental health and other social service agencies, as well as including a reciprocal referring system.

In recommending that clients join self-help groups, it is assumed that professionals must be aware and have knowledge about particular groups. Unfortunately, this is not always the case as described earlier. A solution to this problem is for professionals to receive some courses in their training about self-help groups. Professionals should inform other professionals of specific self-help groups in the community (Harris, 1981).

Some researchers including Katz (1976a) are prepared to limit professional involvement to initiating a self-help group, contributing resources (a place to meet) and giving technical assistance. Gottlieb takes a stronger stance against a third professional role-consultation. Gottlieb (1982) states that mental

health professionals who act as consultants to self-help groups are engaging in an inappropriate and potentially dangerous form of collaberation. He believes that such consulting roles are inappropriate, given that the social context and the helping processes provided by informal community support systems which include self-help groups, are not well known to professionals and are in contrast to the usual way consultation is carried out in the mental health field.

However, consultation is a third function that a number of writers feel that professionals can perform on behalf of self-help groups (Vattano, 1972; Powell, 1975; Baker, 1977; Wollert, Knight & Levy, 1980; Torjman, 1980; and Toseland & Hacker, 1982). Many consultation models exist and the reader is encouraged to research and study them (Caplan, 1970).

The professional consultant can also lend his expertise by helping the group to evaluate its methods of dealing with problems; build group theory through helping the group to analyze its experiences and by sharing his professional knowledge with the group about problems experienced by group members and helping members to develop skills that would enable them to cope with or change their behavior (Vattano, 1972; Gartner & Riessman, 1977; Toseland & Hacker, 1982).

Wollert, Knight and Levy (1980) caution that pro-

fessional consultants to self-help groups (based on their own study) should only offer consultation when it is desired by the self-help group membership. The consultant should be content to allow the group to use the suggestions as they see fit, and most importantly, the professional has to be willing to work in a collaberative style with the group and not attempt to impose his authority.

The professional might help the group acquire needed material resources (Romeder, 1982). Steinman and Traunstein (1976) report that many self-help groups operate on limited budgets. Providing space for meetings can be a very significant contribution by the professional. The professional can serve as a linkage by connecting traditional services, clients and self-help groups to one another (Haeuser & Meikamp, 1978).

Professionals (Toseland & Hacker, 1982) can also provide a sense of continuity as members leave and new ones join the group. As well, professionals are seen as experts and their relationship can sanction the role of self-help groups as offering aid within the human service network.

Romeder (1982) in his pilot study of self-help groups in Canada compiled a list of suggestions directed at social service agencies and all levels of government in supporting self-help groups.

1. All levels of government should be made aware of the existence and importance of self-help groups in our society.
2. Set up information-dissemination mechanisms with the purpose of making people with certain problems aware of the existence of one or more self-help groups in general (process) so that each person can decide whether a specific group meets his/her needs, particularly with respect to the content peculiar to each group.
3. Directories of self-help groups should be created in every community, updated periodically and distributed appropriately.
4. The various magazines and journals published by government agencies in the social field, as well as professional journals should regularly solicit and publish articles on self-help groups.
5. Develop clearinghouses on self-help groups across Canada in order to collect documentation, publish newsletters and other items, provide training and technical assistance and organize or sponsor periodic regional conferences enabling professionals and group members to learn from one another.

6. Sponsorship of meetings between professionals and members and organizers of self-help groups.
7. The various voluntary agencies and associations which already have some resources and structures should devote a larger share of their efforts to the development of self-help groups, which should be recognized as sources of particularly effective assistance based on voluntary initiative.
8. Encourage local or regional networking of various self-help groups, taking into account their differences and the resistance of some groups to such associations.
9. Priorities should be determined, within existing programs of grants to voluntary organizations which contribute directly to the development of self-help groups.
10. Means of identifying and selecting lay persons able to organize self-help groups should be developed; training having regard for the layperson's abilities and the self-help context should be elaborated. Professionals such as social workers, community organizers or adult educators should offer individualized training.

11. Research with self-help groups should be carried out, as much as possible, from a "participant-research" perspective, enabling the self-help groups to benefit from the results of the research.

In conclusion, the potential for a new synthesis which relates self-help approaches to professional practice is very possible. Self-help groups can enter a relationship with a professional and not worry that they will be co-opted or corrupted. At the very least, a complementary relationship can exist where an individual is involved simultaneously with both a self-help group and professional care.

CHAPTER EIGHT

SELF-HELP GROUPS

HOW TO START A SELF-HELP GROUP

> Mothers who have lost custody of their children can now lend support to each other through a group organized by a Winnipeg woman.
> For information, write: Mothers Without Custody, Box 123, Postal Station A, Winnipeg, R3K 1Z9.
> Winnipeg Sun, July 24, 1983

Self-help is a way of dealing with a particular problem or concern with those who share the problem or concern. A self-help group doesn't start until you find at least one other person with whom to share. Often this may be the most difficult step. Many people are frightened or just lack confidence in getting the ball rolling. However, as soon as you find one other person you can start sharing the organizational burden.

Sharing the Burden: Finding Another Member

Quite often the idea for a self-help group doesn't occur to a person until he or she speaks with someone else who might share the concern.

> Jolly K. had spent many years seeking professional help from ten state and county social service and mental health agencies in order to control her abusive behavior. Frustrated and angry because her abusive behavior continued and at the lack of resources for abusive parents she suggested to her psychiatric social worker, Leonard Lieber, that just being able to talk with other similar mothers would be helpful. With Lieber's encouragement, she began Mothers Anonymous with another abusive mother. (Haeuser, 1978, p. 1)

Other groups which share a similar beginning are Alcoholics Anonymous (Robinson & Henry, 1977, p. 16; Evans, 1979, pp. 149-151) and the Fortune Society, an ex-prisoner group which originated in New York City in 1967, growing out of discussions in the auditorium following performances of Fortune and Men's Eyes, a play about prison life.

Some groups have been organized by patients, victims or concerned citizens (Yablonsky, 1969; Bond, Borman, Bankoff, Daiter, Lieberman & Videka, 1979; and Wollert, Barron & Bob M., 1982, pp. 102-107).

> The Fellowship was founded in 1969 by William Carson, a recovered alcoholic who was "consumed with the idea of sharing the methods and means of his acquired sobriety with others still floundering in hopeless despair with their various alcoholic states." He reasoned, simply, that if he could work his way to sobriety others could do likewise if someone cared enough to show the way and would provide the support over the long road to a fruitful recovery. (Lusky, 1979, p. 114)

Quite often professionals begin self-help groups because they feel it will help in meeting the shared needs of their clients. Harris (1981) discusses how she began two self-help groups in Montreal while Petrillo (1976) explains the genesis of Rap Room which began:

> ...in 1970 at Woodlands High School as an attempt to intervene meaningfully with youthful rebellion and alienation which showed itself in drug abuse, racial alienation, student disaffiliation and an intolerable level of threat about the school. (Petrillo, 1976, p. 54)

Trainor (1982) discusses the beginnings of the United Ostomy Association (UOA):

> The UOA originated through the efforts of a Philadelphia physician who encouraged five ostomates to meet and share their knowledge and experience of ostomy. (Trainor, 1982, p. 416)

From its humble beginnings in the early 1960's, the UOA in 1981 had developed into an organization of 607 chapters throughout the U.S.A. and Canada.

Sometimes self-help groups begin when a professional care-giving agency responds to the requests of the public.

> The concept of this self-help group was originally developed within Mental Health/Ottawa in response to the needs expressed often through telephone calls by the relatives and friends of individuals with a mental illness. (Torjman, 1980, p. 2)

Self-help groups have also developed when a creative professional has asked for funding from government to demonstrate that competence based on experience and wisdom derived from bearing an affliction, a basic tenet of self-help philosophy, could be used as a preventative support with others who are in a similar situation.

> Epilepsy self-help groups were initiated simultaneously in 15 cities in 1976 as a result of a federal grant from the Office of Developmental Disabilities. The proposal was prepared by two professionals, both social psychologists, who were involved in an earlier vocational training program with persons with epilepsy. (Borman, Pasquale & Davies, 1982, p. 113)

When contact has been made with a small core of

interested individuals a number of issues need to be discussed before a larger first group meeting is held. This core group should decide upon the purpose of the group; a place to meet; membership criteria; whether to involve a professional or not if relevant; and how to publicize the group (Evans, 1979; Harris, 1981). These issues will be dealt with later in this chapter.

Three writers, Evans (1979) and in particular, Gartner and Riessman (1980) have published invaluable working guides for organizing self-help groups, while Harris (1981) has described a step-by-step methodology of establishing a self-help group which she started.

Ten Steps to a New Self-Help Group

1. Assess and define the need as expressed (target population).

2. Check out whether such a group, to meet the need, exists in the community.

3. Obtain information from similar groups in other communities.

4. Contact individuals (professionals included) in the community involved with target population to assess their perceptions of the needs, their opinions; solicit cooperation.

5. Discuss with interested individuals possible goals and purpose of proposed group and some strategies for reaching prospective members.

6. Publicize your project through the media, community newsletters, etc. State time, date and place of first meeting, plus phone number for people to call.

7. Speak with prospective members individually (by phone or in person) defining purpose and goals of group. Encourage feedback, discussion, expres-

sion of anxieties, etc.

8. First meeting: Could be led by professional; ground rules discussed and themes for further discussion; tentative planning for frequency of meetings, place, time, name of group discussed.

9. Phone those who came to first meeting and those who didn't come (but had previously expressed interest) for further feedback; discussion and clarification of expectations.

10. Second meeting: Consolidate ideas, plan future meetings, assess, evaluate and negotiate leadership roles; (health groups usually need a professional consultant available at meetings). (Harris, 1981, p. 16)

Another method of learning about how self-help groups work is for the potential organizer to attend open meetings of existing self-help groups such as A.A. (Evans, 1979) and/or E.A. (from E.A. newsletter). Seeing a successful self-help group operate can be a tremendous confidence builder.

Self-help groups have been started in many ways and they work. Fifteen million members in an estimated 500,000 groups operating in the U.S.A. and Canada have found ways to begin to help each other.

Purpose of the Group

The first decision a self-help group makes is to determine and to declare its purpose. For example, the purpose of Emotional Health Anonymous is to practice:

> ...a program of mutual emotional support through sharing problems and personal solutions. (Emotional Health Anonymous pamphlet, "EHA at a Glance", 1983)

The purpose of Reach to Recovery (RTR) is to train volunteer women who have themselves undergone surgical breast removal, to counsel patients in like situations (Ogg, 1978). "On Our Own" is a self-help group for present and former "mental patients" whose purpose is articulated in one sentence: "We advocate on our own--the right to choose, and our legal rights as human beings." (Neufeldt, 1981, p. 4).

The way a group defines itself is its purpose--its reason for existence. The goals of the group, whether short and/or long range will be determined in light of this purpose. Sometimes a group begins to fulfill an immediate singular need (cesarean support groups who feel their needs are not being met by professional helpers) and then realize that by uniting to help each other they can meet a variety of needs under this general purpose:

> Cesarean support groups fulfill five major functions as follows:
>
> 1. Information. The groups provide information on such subjects as types of anaesthesia, medications and incisions; potential complications, the possibilities and risks of vaginal delivery following a cesarean; hospital procedures and local policies; and current research on the effects of cesarean birth on the infant.
>
> 2. Peer emotional support. The groups provide a safe atmosphere of mutual emotional support in which members "permit" each other to express openly a full range of feelings about their cesareans and to give and receive feedback that such feelings are justified and understood. Many women are

convinced that only another woman who has "been there" can truly know how a cesarean mother feels.

3. Reference group and role models. By providing a reference group of "normal-appearing" women who have delivered by cesarean, each group helps women alleviate feelings of stigma, guilt or personal inadequacy. The group also fosters a positive redefinition of cesarean birth, the underlying message being that a cesarean has the potential to be as rewarding as another birth.

4. Helping others. This function reflects what Gartner and Riessman (1977) call the "helper therapy" principle which suggests that those who help others in a similar situation are, themselves, helped as much or more.

5. Increasing consumer consciousness and control. Cesarean groups encourage women to become more knowledgeable and assertive health care consumers. (Lipson, 1982, p. 19)

The purpose of the group does not necessarily have to be predetermined when an organizer first seeks out people who share a similar problem or condition. The purpose of the group could be an excellent topic for discussion in the group's first meeting (Evans, 1979; Gartner & Riessman, 1980). The statement of purpose can serve as a starting point to initiate discussions and a process of helping for a new self-help group.

Membership

Who can and who cannot join the group? The keystone of any group is--the membership. Membership is often defined in light of the group's statement of purpose. In Recovery Inc. (Wechsler, 1960) for example, a self-help group whose purpose is to use an

"acquired specific method of self-help and after-care aimed at the prevention of relapses and chronicity among the mentally ill (Wechsler, 1960, p. 188), is open to those who were and are "mental" patients.

There are a host of questions that need to be considered in defining membership (Evans, 1979). For example, in a health group, should membership be open to those who have the health problem or their families and friends as well? Mended Hearts is a medical self-help group for heart surgery patients and their spouses (Videka, 1979, p. 362). The Parents Auxiliary of Little People of America is a self-help group for families of short-statured children (Ablon, 1982, p. 31). Should there be geographic limitations put on membership (Harris, 1981)? Are potential members expected to pay fees or can this be waived for those unable to pay? How many meetings must someone attend before they are regarded as a member?

Involvement for many people in self-help groups is temporary (Evans, 1979; Romeder, 1983). Members often leave the group after they get what they want. For example, in some groups such as the Compassionate Friends (Harris, 1981) members recover from their bereavement sufficiently that they drop out. However, many members often return at times of stress (dead child's birthday) for a short period of reinforcement.

Unless the group sees its membership as lifetime, the process for leaving should be easy so members do not have to feel guilty.

In conclusion, self-help groups should establish a constitutional statement early about membership so as to avoid being charged with unfairness or arbitrariness as well as having easy access and exits for members.

The Organizational Structure, The Organizer and Leadership

With over 500,000 active self-help groups around it would be a major if not an impossible task to determine which organizational structure is most effective. In reviewing the literature about self-help groups two points seem to emerge with regards to organizational structure. The first point is not to take on more structure than is required. Second, if formal officers are desired it should be because they are needed to help the group run effectively. Some structure, however, is required to hold people in the group and to give them a sense of belonging. Defining membership, (discussed earlier) then, is a key component in organizational building (Evans, 1979; Gartner & Riessman, 1980). Decisions about structure should be considered in light of how it would serve the group's best interest and purpose.

The organizational structure could be as simple as having one member act as a facilitator in a small self-help discussion group (Petrillo, 1976) or as complex as having an executive director along with a board of directors associated with an international self-help network (Bond, Borman, Bankoff, Daiter, Lieberman & Videka, 1979). For example, Mended Hearts was founded in 1951 by four patients recovering from heart surgery and their doctor. By 1955, Mended Hearts was formally incorporated with a constitution and a set of bylaws. New chapters were then developed by the original members in Massachusetts and New York. By 1966, Mended Hearts had expanded with chapters in 26 cities. A national office was established in Boston and in 1975 the first salaried position was instituted. In 1979, Mended Hearts could boast of a membership of approximately 10,000 members in 88 chapters. The national board consists of a president and regional chairmen who are vital in the transmitting of the organizational bylaws, chapter charters, national newsletters and other forms of guidance in supporting fledgling chapters. The local chapters include a president, several vice presidents, a treasurer and recording secretary. Some chapters have as many as 37 officers (Bond, Borman, Bankoff, Daiter, Lieberman & Videka, 1979, pp. 43-66). Mended Hearts is a successful self-help organ-

ization because its structure changed appropriately to meet its expanding purpose and programs.

The "Association for Relatives and Friends of the Mentally Ill" handled its organizational growth in a different fashion (Torjman, 1980). Unable to deal adequately with the heterogeneity of needs expressed in the general meetings a new structure was devised. Three separate self-help groups were formed. The first group provided mutual support and a place to share experiences. The second group dealt specifically with admission, treatment and discharge procedures in hospitals. A third group focused its concern on community services.

There are other discussions about evolving organizational structures in the literature. For example, Omark (1979) discusses the organizational processes and beliefs in Recovery Inc. Norman (1981) deals with the relationship between organizational features and personal change in the context of weight loss self-help groups, while Norris (1970) outlines the origins and structural growth of Alcoholics Anonymous.

In short, there is no single accepted approach when dealing with organizational structure in the self-help setting. Groups cover an enormous range in their styles of origin and growth.

Organizers

Gartner and Riessman (1980) make a distinction between individuals who are organizers and those who are leaders. The organizer and the eventual leader(s) of a self-help group may or may not be the same person. The organizer acts as a catalyst for the group's coming together. Quite often the organizer is a professional. In his article, Self-Help: The Professional, Borman (1976) supports this contention by pointing out that "while self-help groups operate outside professional agencies many of them have been initiated and supported by professionals behind the scenes." (Borman, 1976). The organizer is then playing a dominant role and performs a number of tasks including designating the time and place of meetings, the conducting of meetings, identifying potential group members and assisting members in relating to each other and introducing the concepts of self-help to the membership (Gartner & Riessman, 1980).

It is particularly important in the beginning of the group that the organizer's role be in setting the tone of the meetings and suggesting processes for accomplishing group work. In essence, the organizer attempts to train the members on how to be effective as participants in a self-help group. Group members often model and adopt the behaviors of the organizer. Al-

though the organizer may be perceived as the expert it is more significant for him/her to have the group create a process and eventually have leadership emerge from the membership. In this way the aim of self-help is accomplished as the strength of each member is relied upon (Evans, 1979; Gartner & Riessman, 1980). There are many examples, however, where the organizers have no desire to give up control of leadership (Yablonsky, 1967; Lusky, 1979).

To allow the group to mature, to find its own destiny involves the organizer moving from the role of the catalyst to technical assistant (Gartner & Riessman, 1980). During this transitional period one or more of the group members begin to take over the functions of the organizer. As a technical assistant the organizer observes the group process and provides support in the form of encouragement and suggestions.

Finally, when the organizer's role as a technical assistant is no longer required, he or she may decide to remain involved in the group as a resource member. In this role, the organizer acts as a support person without having the same vested interest as other group members. The significant difference between the organizer's role as a technical assistant and that of a resource member is that he or she only responds to requests rather than volunteering suggestions to the

group and its leaders.

Leadership

Just as there is no single accepted approach in the organizational structure of self-help groups, the same holds true for the kinds and roles of leadership. Self-help groups emphasize peer solidarity rather than hierarchical governance because they are largely self-governing and self-regulating. Essentially, leadership "means a process by which the efforts of individual members are coordinated to enable the group to achieve its desired objectives, purposes and goals." (Gartner & Riessman, 1980, p. 165)

Members of self-help groups view themselves as possessing a number of strengths and weaknesses. In this way all members are urged to contribute to the leadership functions. Often the leadership role is shared by a number of members. Katz and Bender (1976a) describe the leadership of consciousness-raising groups:

> Many groups adopted a system of rotating leadership to overcome problems of dominance by a few. There seems to be a need for some controlling or focusing of the discussion. If one person is responsible at each meeting for timing, keeping people to the topic; this may help prevent bad feelings and keep order. Some groups, however, felt no need for any leader. (Katz & Bender, 1976a, p. 169)

The self-help group setting can facilitate members

in strengthening their skills and confidence and to utilize those skills in the leadership function. For example, Raiff's (1979) study of Recovery Inc. appears to support the idea that within Recovery's hierarchy fewer illness indicators were observed along with more reports of enhanced enjoyment and activity within the self-helper role. It was also concluded that Recovery Inc. leaders also greatly resembled, and in some cases surpassed self-reported measures of satisfaction and happiness reported by large samples of "normal" Americans (Raiff, 1979).

But not all self-help groups have a pattern of shared leadership with different members performing different kinds of leadership functions based on their strengths. The exercise of leadership in self-help groups ranges from the concept of shared leadership to traditional autocratic types. Recovery Inc., for example, has a highly organized structure which trains leaders who are then certified by the national organization. A certified Recovery Inc. leader is one who has learned methods of group leadership as well as becoming entrenched in the Recovery method (Wechsler, 1960; Gartner & Riessman, 1980).

Parents Anonymous has two "leaders" in its local groups: a professional "sponsor" and a chairperson who is elected from the membership of the group. Hamilton

(1981) designed a study to understand those factors crucial to the development of chapters in Parents Anonymous. Three types of leadership were identified in these chapters: autocratic, bureaucratic and democratic. The results of the study give credence to the idea that a variety of leadership styles exist in self-help groups, even within the same national organization.

Meeting Places

Meetings and meeting places are crucial to the self-help group's ability to achieve its goals. Sometimes self-help groups are founded in somebody's living room. Harris (1981) describes the location of the first three meetings of a chapter of Compassionate Friends which she began:

> a first meeting was held in my home on November 14, 1977--six months after I had contacted the first parent to check out my plan. There were fourteen people at the first meeting. The second meeting one month later was held in my home. The third meeting was held at the YM-YWHA and the group continued to meet there monthly until recently. Now the group meets in members' homes. (Harris, 1981, p. 16)

Gartner and Riessman (1980) are somewhat idealistic in what they see as required in the physical settings for self-help group meetings:

> Weight-lighted rooms with comfortable chairs arranged in a circle or around a large table to promote interaction are best. In homes the dining room table will be preferable to the living room. If the meeting facility is not a home, a space

> that is easy to get to (without cumbersome stairs and heavy doors) and close to rest rooms is desirable. Eliminating drafty air currents and providing for people who may have hearing or sight impairment is necessary. (Gartner & Riessman, 1980, p. 165)

Petrillo (1976) in contrast to the above describes the physical setting of the successful Rap Room Group.

> A small room on the second floor of the academic wing of Woodlands High School, Hartsdale, New York, Rap Room is a converted textbook closet. It is appointed with three couches, a divan, folding chairs, a table and a lamp. The walls are covered with colorful but hard-hitting posters whose one-liners address the least productive coping behaviors of humankind. About 12 persons can sit comfortably with room for about eight more on the floor. At peak periods the room holds 30-40 persons. (Petrillo, 1976, p. 54)

Self-help groups meet in private homes, public schools, colleges, service clubs or church halls. One American chapter of Parents Anonymous meets weekly for two hours in a free meeting place--a YMCA or church because it is a "safe setting--this is no authoritarian agency." (Harris, 1979, p. 168). As groups form and grow the membership will need to decide on what their needs are as far as meeting space. Factors such as location, cost if any, size and availability of space need to be addressed in the successful functioning of a self-help group.

The Group Process

The way a group does things is the group process. For example, Alcoholics Anonymous meetings are quite ritualized, usually with a religious underpinning. An opening prayer is followed by the recitation of a series of steps in which members must openly acknowledge their compulsive habits. Following are the 12 steps of A.A.:

1. We admitted we were powerless over alcohol--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. Make a list of all persons we had harmed and became willing to make amends to them all.

9. Make 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 a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Evans, 1979, p. 153)

Accepting the responsibility of the final step, that is, being available to help another alcoholic at anytime, means that the A.A. member must stay sober--you can't be drunk if you are to help a drunk. In the act of helping, the member also gains a certain distance from his or her own problem, and begins to see it more objectively. A.A. provides group support in achieving abstinence one day at a time, through a clearly defined way of life that comes to take the place of former compulsive cravings. Achievers, moreover, have unlimited opportunities to move up into respected positions as "old-timers" in the group (Holmes, 1970; Bean, 1975). This is how one group deals with a particular problem in a particular way based on particular principles. Other self-help groups such as Gamblers Anonymous (Cromer, 1978) Narcotics Anonymous (Nurco & Mackofsy, 1981) and Neurotics Anonymous (Morrow, 1976) have borrowed and modified the A.A. process to their specific problem.

Being a member in a self-help group can be beneficial in a variety of ways; socialization with other members, by giving time to group projects, by being on

committees, etc. However, the core of self-help remains in group discussions--telling your story and listening to the stories of others.

By sharing the "story" with others, a member's problems often become less fearsome. Listening to the stories of other members allows one to feel less alone. Discovering that others have gone through th same problems and the same pain and have worked out some solutions can be very heartening.

> First, it is often only a person in the same situation who can truly understand the feelings of despair, guilt, anger, hostility and shame which characterize the emotional response to mental illness in a relative or close friend. It is helpful, indeed essential in most cases, for a relative to find out that he or she is not alone; that these feelings have been experienced by others over and above the sharing aspect, relatives are also in a position to exchange information on how they dealt with particular behaviors or communication difficulties with hospitals or professionals. (Torjman, 1980, p. 4)

Strongly affiliated with the aspect of mutually sharing in group discussions is the phenomenon Riessman (1976) refers to as the helper-therapy principle. This powerful mechanism operates in self-help groups, and, according to this principle, those who "do the helping" or provide the actual support are helped the most. Whether the group's process is as systematic as A.A. or as unstructured as Rap Room (Petrillo, 1976) the member reinforces his own beliefs when listening and offering advice to others. The helping member not only feels

helpful by playing a helping role, but because they sense the importance of being a model for someone else they gain confidence and self-respect in the process.

The decisions the group makes with regards to discussion, the performing of tasks and problem-solving are the guts of the self-help process. According to one member of a self-help group an individual should get from the position where they say, "I'm alone" to "I can communicate with those in the group" and eventually where they can say, "I can communicate with those on the outside". Groups should not be a place were people can find a "rest" (Anonymous, 1983).

Publicity and Fund Raising

Publicity, of some kind, is needed to get a self-help group started and to keep it growing. Many groups of course still rely on publicity through word of mouth to bring in new referrals (Ogg, 1979).

Powell (1979) studied the various ways in which parents heard about Parents Anonymous. Asked where they first heard about the group, 18 said they heard of it from the media while 1Ø said they heard of it from a personal source. P.A. recruitment was effected upwards after two Phil Donahue national television network shows. Newspaper and magazine articles and local announcements in community publications have also been

effective in obtaining new referrals. Powell (1979) suggests however that when parents heard about P.A. from both the media and a personal contact the impact seemed greater in bringing new members to the self-help group.

"On Our Own", a self-help group for "ex-psychiatric inmates" attracted 150 people to its founding meeting after an article by a friendly newspaper reporter was published in the Toronto Star (Neufeldt, 1981, p. 3). During 1983, a number of self-help groups received publicity through articles in newspapers in Winnipeg including Parents Anonymous (Winnipeg Sun, July 24, 1983, p. 8), Gay Fathers (Winnipeg Free Press, August 3, 1983, p. 14), Overeaters Anonymous (Winnipeg Free Press, August 29, 1983, p. 14) and Emotions Anonymous (Winnipeg Free Press, October 17, 1983, p. 3).

Other forms of publicity are the use of press releases or group brochures. A humerous but effective press release by the National Association to Aid Fat Americans, Inc. (1977) resulted in immediate publicity and membership applications.

For Immediate Release December 9, 1977

Civil Rights Group Knocks Oral Roberts University

> Two national organizations have joined the fight against fat discrimination at Oral Roberts University in Tulsa, Oklahoma. The National Association to Aid Fat Americans (NAAFA), a civil rights/self-help organization based in New York City, has pledged its support to the American Civil Liber-

ties Union, which has recently filed a 75 page complaint against Oral Roberts' program of weight restrictions and compulsory dieting for its students.

Mrs. Lisbeth Fisher, Executive Secretary of NAAFA, herself weighing more than 200 pounds, said that such restrictions are "blatant and misguided discrimination against fat people" and that "NAAFA has offered to help the American Civil Liberties Union in Oklahoma City, as well as any student at Oral Roberts who feels that his or her human rights have been violated."

Mrs. Fisher also pointed out that "weight and ability to perform college level work had no relationship". She stated the "NAAFA stands ready to help in any way that it can, including letter writing campaigns, referral to expert witnesses and other forms of assistance to those who need it". NAAFA has been fighting size discrimination for the past eight years in such areas as schooling, employment, insurance, fashion, social interaction and advertising.

For further information, contact:
Lisbeth Fisher, Executive Secretary
(212) 776-8120

Fund-Raising

The expenses in running a self-help group can vary from needing money for coffee to paying for office space, staff and advertising (Evans, 1979). Therefore fund-raising can vary from passing the plate around to sponsering large events. Some self-help groups such as Make Today Count (Wollert, Knight & Levy, 1980) have solicited external funding. A.A. on the other hand flatly refuses any financial support from non-alcoholics and limits the contributions of alcoholics as well (Jones, 1970). Some groups, such as Parents Anonymous

(Powell, 1979) received a grant from a government department. Self-help groups who rely primarily on this kind of funding may lose some of its effectiveness (Stewart, 1983).

Publicity and raising funds through membership fees, projects, donations or from external sources such as government or corporate grants is an issue which self-help groups must deal with during their existence.

A Final Thought

There is hope, and there is help. There are millions of people around the world who would acknowledge with grateful thanks the opportunity for being in a self-help group. In her foreward to the book, Make Today Count by Orville E. Kelly and Randall Becker (1975), Elizabeth Kubler-Ross gives her reason for joining with others to share.

> The strength, courage and wisdom that evolve from times of pain and suffering cannot come forth when we are left alone and isolated. (Elizabeth Kubler-Ross, 1975)

The final words however are left to Leonard Borman (1979) who sees the future of self-help as:

> The compelling new direction of the self-help movement may represent a revolution. As the flat-world thinkers reached beyond their limited horizons, they discovered a new world; singularly, the self-help movement might discover a new world of human resources and capacities that will rival everything already known. (Evans, 1979, p. 235)

CHAPTER NINE

THE PRACTICUM

Introduction

During the years 1968 to 1978 over 300,000 people were discharged from psychiatric institutions in the United States alone (Sokolovsky, Cohen, Berger & Geiger, 1978). The implications for mental health professionals are obvious. How do we adequately deal with the psycho-social needs of these ex-patients? Frequently, therapeutic interventions are ineffectual. This is often the result of community workers lacking sufficient understanding of the social capabilities and limitations of this population (Shapiro in Sokolovsky, 1971). In the fall of 1980, three social work students set out to meet some of the psycho-social needs of ex-mental patients by offering them the possibility of identifying and utilizing their capabilities within the context of a self-help group.

Post-psychiatric patients have been described in the literature as being socially isolated, shut-in and withdrawn (Sokolovsky, Cohen, Berger & Geiger, 1978). The average person on the street would consider them crazy and dangerous. After all, many an ex-patient talks to him or herself in public, walks aimlessly up

and down hallways, takes lots of medication and is unclean, often hallucinates and is thought to be violent without any provocation (New York Times, 1982). In organizing a group for ex-patients this writer learned that he initially shared much of the above perceptions as did other professional care-givers. In order to organize such a group, the author had to deal with these feelings by relating to ex-patients as people rather than as a collection of symptomatologies. This was achieved not by romanticizing their "crazy" behaviors but by working together to organize a group which would promote individual and collective strengths.

This chapter is divided into various sections which highlight specific aspects of this writer's relationship with the self-help group. Taken all together the chapter describes the process in organizing a self-help group for ex-mental patients. The information that will be shared comes from the observations and notes of the three organizers during their involvement with the group.

Organizing a self-help group requires imagination, creativity and flexibility. It also requires a tremendous investment of commitment and time. The three student organizers spent a major portion of the academic year, 1980-1981, involved in many areas related to

the initiating of a self-help group. Meetings and telephone calls with potential professional allies, peer and supervisory sessions as well as reviewing the literature were all essential requirements in gaining confidence and momentum in the start-up of a self-help group. There is no definite methodology one can follow in the setting-up of a group. The literature that deals specifically with starting a self-help group is case-specific related (Evans, 1979; Harris, 1981). However, this writer did find Gartner and Riessman's (1980) article about organizing self-help groups to be quite helpful. In particular, the writer was able to utilize what Gartner and Riessman refer to as the three evolving roles of the self-help group organizer:

1. the catalyst for the group's coming together;
2. the technical assistant; and
3. the resource person.

The author discusses the first two roles only for the purposes of this report.

Who Needs Self-Help?

The idea for starting a self-help group for former mental patients originated with one of our professor-supervisors in the School of Social Work. Dr. Barry Trute's knowledge about the lack of community supports for discharged patients, the very high rate of

recidivism and the work of other psychiatric self-help groups prompted him to seek out students who would be prepared to organize such a group in Winnipeg.

Getting Started--Initial Preparation

The first meeting of the self-help group was held on November 26, 1980. The organizers however, were actively involved for a couple of months in preparing for the eventual start-up of the group. This included contacting several professional mental health workers, agencies and hospitals to inform them about our project and to solicit their support. The organizers also spent a considerable amount of time reviewing the literature in the area of self-help groups, writing letters to active groups elsewhere in the country and deciding on an eventual meeting place.

The Organizers

Two undergraduate social work students and one Master's student in social work comprised the unit I refer to as the organizers. The organizers viewed themselves as a working unit while they were involved with this project. In respecting this complementary relationship, I have refrained from identifying the nature of the contribution of each organizer. To do so, I believe would undermine the collective support

and encouragement that existed among the three organizers. The strength of the working relationship was due to our collective commitment towards the ideology of mutual aid.

A letter written by the president and vice-president of the self-help group in March of 1981 is evidence of how the organizers were perceived by the group. The reference to money illustrates this point which is cited below. An excerpt of their letter follows:

> A problem arose as to the type of student/s they would send. The question we faced and had to answer was: "Do we take the risk and accept their conditions, with the hope of getting a student or students like the ones who helped form the group and likewise risk getting a student or students who would rather take over the group and run it like an out-patients group or a social services group?" Since the group would have no choice but to either go along with the student/s or lose the money and the odds were against us in terms of getting others the same as Harold, Kathy and Linda. (Anonymous, 1981)

In summary, a project of this nature requires students who share a similar ideology and who have developed an ability to work in a complementary arrangement.

A Place to Meet

A number of considerations were crucial in locating an appropriate place to meet. In order to ensure that referring sources would not be deterred in

sending potential members to us a location had to be secured before the initial meeting of the core group.

The organizers and their supervisors determined that the eventual meeting place would have to offer some definite benefits. The location should be in the central area of the city--preferably downtown. As we gathered information about psychiatric patients, we learned that many of them were quite poor and lived in boarding houses and low cost apartments in the inner city area. Many ex-patients had also settled in this area because it was near the hospital where they had or were receiving treatment. Having a downtown location would remove possible roadblocks such as transportation and inclement weather from preventing people's attendance at meetings.

The eventual meeting place should be free of cost. The organizers' budget was negligible and there were no potential sources of income forthcoming. Since members would not be in a position to help out financially, the organizers agreed that the desired meeting place should be free of any expenses.

The meeting place should be on neutral territory. The organizers did not want the self-help group to be seen as an extension of an existing service such as the hospital or part of some government program. We also anticipated that potential members might have mixed or

even negative feelings towards the hospital or the system because of their past or present experiences as patients. Furthermore, we hoped that the neutrality of the meeting place would enhance the promotion of the self-help concept as a new way of helping.

The organizers recognized the necessity of meeting on a regular basis--same time, same day. This was an important consideration because a change of days and/or times would make it difficult for potential future members to come (they would not know when the meetings would be held). As well, having consistent meeting times would hopefully ensure that the self-help group would be an integral and reliable part of our members' lives. Our desire was to keep things as simple as possible. Unneeded complications would only make the task of starting a group more difficult.

A fifth consideration for a meeting place was the need to have tables and chairs which would suggest to members that this was to be a working as well as a support group.

Six potential locations were considered in order to secure space for the self-help group meetings. All of them however, had some shortcomings. Some of the locations charged rent while others could not guarantee the room on a regular basis. The organizers decided that a seminar room at the University of Winnipeg would

be the appropriate choice. The location of the university is in the downtown area; it was free of charge; it was available on a regular basis; it had tables, chairs and a blackboard; and it was in our estimation a reasonably neutral site.

Initially, the choice of the university seminar room proved to be a good one. However, after the self-help group had been in existence for a few months a number of unanticipated difficulties did evolve.

We discovered that psychiatric patients smoke a great deal. This resulted in the room becoming very stuffy and the need for the door to remain open. Having the door open took away from the sense of privacy as students moved back and forth through the bordering hallway.

Secondly, the organizers often had to track down a security guard to open the door. On some occasions members would be standing outside the locked door unable to relax and use their own meeting room.

Thirdly, the organizers on other occasions had to persuade students to leave the room despite the students' desire to study in the classroom.

Fourthly, as the group expanded in membership, it became evident that there was no room to store anything from one meeting to another. Coffee makers, files and other material necessities had to be carried back and

forth every meeting.

A final potential problem was the organizers' realization that as the group would grow, the room would soon be too small. We did not want the small size of the room to dictate the potential for membership growth.

The organizers came to realize after a few months that the group required its own place; a room where it could hold meetings and activities as often as it desired. A place where the group's identity could be seen and felt. This need was realized by the summer of 1981 and is discussed elsewhere in this report.

Contacting Outside Resources

The purpose of contacting various mental health agencies and individuals was to (a) inform them that we were organizing a self-help group for ex-patients with psychiatric problems; (b) obtain referrals for an initial core group; and (c) learn how professional care-givers perceive the needs of this client group. Several meetings related to the above were held between September and December, 1980. The writer has chosen those meetings which best highlight the results of our various interactions.

An October Meeting

A meeting was held in October, 1980 with the head of the Social Services Department in a major Winnipeg hospital. This individual, Z, proved to be sympathetic to our project and as well he suggested some steps whereby we could obtain referrals. Z was particularly concerned with two aspects of our goals to obtain appropriate membership. He felt, based on his experience with psychiatric patients that the initial core group should not include certain types of ex-patients such as manic- depressives and borderlines. Z explained that manic- depressives would probably be hazardous to the potential of evolving leadership within the group. As for borderline type behaviors, Z felt that they would be unable to develop any lasting relationship with a group or take responsibility of any kind.

Z also cautioned us about including a worker who was an ex-patient. The worker, Y, had approached one of our professors about being involved in a self-help group for patients with psychiatric problems. Z felt that Y's and the other group members' needs would be significantly different in the early stages of group formation. He believed that the early group members would be seeking support and friendship rather than getting themselves involved in areas which demanded

taking advocacy positions.

The group organizers and Z established a preliminary process to obtain referrals which was cognizant of the perceived attitudinal values of the psychiatry department. Z believed that the psychiatric staff would view us with little credibility because we were students and that we were attempting to introduce a system of help which was in opposition to the prevailing medical model. Z agreed to use his position and influence to speak with two key members of the psychiatry department about the proposed self-help group. We all agreed as well that potential referrals should include those individuals who had been released from the hospital in the previous two months and who were receiving very little if any follow-up from hospital personnel. The organizers also agreed to meet with the two key staff members.

The meeting with Z was significant. Z's knowledge of working with the psychiatric population enabled us to understand somewhat more clearly the difficulty in organizing and maintaining a self-help group. Psychiatric patients often have a difficult time in relating to other people. They often have difficulty in making decisions or carrying out actions. The task of getting many of our members to believe in themselves would be a constant concern in developing the potential

of the group. Z also helped us to realize that gaining support for our project would be difficult. Z confirmed the literature's findings that many health care professionals are threatened by the possible introduction of an alternative system of delivering service. The meeting also raised a number of collective anxieties among the organizers. Could we really start and maintain a group? Could we handle people with crazy behaviors? Did we really have a chance of selling our ideas about self-help to the hospitals? the patients? As organizers we were not a confident unit at this point. Our fears outweighed our perceived strengths. I believe that our concerns and fears strengthened our determination and commitment in carrying out this project. It enabled us to use our knowledge and ability to form relationships with professionals and patients.

A Meeting with G & M

In late October, 1980, the organizers met with the two psychiatric social workers who were identified as key people by Z. The organizers had approached this meeting with two purposes. The first purpose was to describe the self-help group concept and to convince the social workers that the eventual group would function differently from that of existing therapy groups in the hospital. The organizers did not want to chal-

lenge or judge the existing system of professional care. Instead, we wanted the self-help group to be seen as a community resource for patients after their discharge from the hospital. We hoped that the hospital would not see us as competition. Our second purpose was to secure about eight to ten potential referrals for the core group.

Both psychiatric social workers agreed with the need for a group of this kind. G described the professional care givers in the hospital as having resigned themselves to a revolving door syndrome for psychiatric patients because of the lack of follow-up in the community. G gave a number of examples of patients who felt overwhelmed and isolated after leaving the hospital. The organizers acknowledged that it was this problem that we saw as the reason for the group. That is, ex-patients supporting ex-patients on a daily basis with the organizers initial input and direction. This declaration of purpose appeared to meet with approval as other areas of concern were then discussed.

The social workers wondered about the commitment the organizers were prepared to make to the group and its members. How long would the organizers be involved? Would we start the group and then eventually leave it to its own devices when the academic year ended? These questions were anticipated by the organizers. We

were aware that before professional helpers would consider trusting and referring clients to us that we needed to show them some long-term commitment.

The organizers explained their commitment in a satisfactory manner. The three students represented part of the School of Social Work and the Psychological Services Centre commitment to the project. The two undergraduate students would be involved until April, 1981, while this writer could participate to the fall of 1981. If further student involvement was required after the fall of 1981, the university would provide the student or students along with the supervision. We made it clear that the long-term goal was to enable the group to become self-sufficient but with links to formal resources readily available if they desired.

G began to offer suggestions which would prove to be very valuable in organizing the group. G stated that getting people to come to the group on a regular basis would be a significant accomplishment. We discussed ways to deal with this challenge such as driving potential group members to the first few meetings as well as greeting members at the University entrance. G also expressed concern over the frequency of meetings. G felt that the target population was quite isolated and that this fact would have to be addressed in a satisfactory manner. One possible solution discussed

would be to meet more frequently during the week. The organizers agreed to look at this solution as a way of dealing with members' social isolation and continuity of contacts.

In contrast to G's enthusiasm and helpful comments, M attempted to legitimize our position by suggesting stronger affiliation with the hospital. M felt that our group would be providing "action therapy" which would result in some positive therapeutic effects. Although we certainly desired the hospital's support in actively endorsing the establishment of a self-help group, we did not want the group seen as an extension of therapy. The organizers did not openly challenge M's comments. We felt that questioning M's ideas might jeopardize possible support and referrals from the hospital. After M's discourse on group therapy, we were invited to attend and observe a structured therapy group that M was leading in the hospital. M felt that this would help us to better understand the functioning level of potential members as well as making us visible to the hospital staff. The organizers attempted to distance themselves from this proposal. We stated again that the initial core group should include individuals aged 20-40 and who were already living and functioning with some success in the community. We felt that it would be some time later that

the group could expand to include lesser-functioning individuals. M reacted to our objections by attempting to get us involved in a discussion about psychiatric labels. The organizers were aware of the potential trappings of being lured into this kind of discussion. We were probably no match for M's familiarity with psychiatric labels. We stated that we were not here to discuss these labels. M responded by saying that our reluctance to talk about the psychiatric labels reflected our lack of knowledge about psychiatric illnesses and the behavior of patients. As a last resort, we explained to M that Z had suggested to exclude manic-depressives or borderlines in the core group. Quoting Z prevented any further discussion about psychiatric labels. In private discussions after the meeting, the organizers expressed astonishment at M's attack and retreat. We concluded that M's position in the hospital hierarchy prevented any further discussion.

M strongly suggested that we attend a management meeting of psychiatric staff to present our proposals. According to M, we might possibly gain some allies at this meeting who in turn would initiate referrals to our group through G and M. We agreed to the invitation despite G's non-enthusiastic support of it.

The organizers and their supervisors discussed the

results of our contact with G and M, the two psychiatric social workers. During supervision we decided to meet only with the social workers of the psychiatric department rather than including other personnel such as psychiatrists and nurses. The decision was attributed to a number of concerns.

Our first concern was that we had originally planned to have informal rather than formal referrals from G and M. We hoped that G or M would suggest to discharged patients that they contact the group. This would place some responsibility on the discharged patient. A formal referral might suggest to the patient that the group was an extension of the hospital.

Secondly, we were worried that formal links with the psychiatric department would create a probable slowdown in potential referrals because of bureaucratic procedures within the hospital.

Third, a meeting with the psychiatrist might lead to further debate over psychiatric labels and patients.

Fourth, we felt that the social work department would be our natural allies because of social work values and practice.

Finally, we were concerned that our presentation would gain support in the meeting but not in actual referrals. This result could lead to a further delay in the startup of the group because we would be forced

to count on the hospital towards formal referrals which might not be forthcoming.

M was not happy with our decision or explanation but reluctantly agreed to participate in a meeting with the social work staff only.

Informational Meeting with the Social Work Staff of the Psychiatry Department

The organizers felt optimistic after their meeting with the social work staff. They agreed that discharged patients could use a self-help group which would provide support and promote their social concerns. The social workers also accepted our rationale for not linking formally with the hospital.

The meeting produced a process for referring discharged patients to the self-help group. The hospital social workers would contact ex-patients to inform them about the self-help group. We would then contact the interested ex-patients after receiving their names.

During our association with the group only a few ex-patients were referred through this referral process. G was responsible for most of them. We learned several months later that G had belonged to a self-help group.

December 18, 1980--A Meeting with Two Social Workers at Another Psychiatric Institution

This encounter proved to be quite frustrating for the organizers. The purpose of the meeting was to inform the hospital social workers of the self-help group and to obtain future referrals from the institution. Present at the meeting were two hospital social workers, the organizers and Y, our worker member.

F, one of the hospital social workers, seemed to be obsessed with Y's being a worker. We assured F that we were not here to evaluate or investigate the institution. The organizers presented F and B with a typewritten handout which had been prepared by the group. The pamphlet was an introduction to the group and to the nature of its purpose. Because of our experiences in previous meetings and F's concern about Y we discussed the group as a means of social support.

At one point during the discussion F appeared to be mocking us. F stated support for our project and asked us if we would accept forensic rapists and murderers. F made it clear that mental patients were incurable.

B, although supportive of our ideas, strongly suggested making a series of formal linkages with other agencies. B felt that there were a number of good resources providing service for ex-patients in Winni-

peg. The organizers believe that B viewed the group as a clearinghouse for referrals to already available resources.

The organizers were never really able to gain a rapport of understanding with B and F. Although they assured us of referrals, none would be forthcoming during our association with the group.

Discussion

The discussion to this point has centered around the efforts to establish linkages with resource persons and community organizations and to obtain input from these sources. In pursuing these contacts we had hoped to gain heightened credibility for the group and an increased probability of obtaining referrals. We felt that the viability of the self-help group would be enhanced if it was supported by a network of community institutions and resources.

The overall results of our contacts with mental health professionals revealed a negative attitude toward the ex-mental patient. The literature suggests two possible explanations that could account for our poor reception.

Studies by Franchia, Canale, Cambria, Sheppard and Merlis (1975) and Pines and Maslach (1978) conclude that negative attitudes by mental health professionals

are a result of too much information, contact and experience with mental patients.

A second study suggests that negative attitudes towards the mental patient are due to the differential effects of the particular professional training models (Morrison and Hanson, 1978; Morrison, 1979).

This writer is not sure which explanation best interprets the results of our contacts with some professional care-givers. What is clear however is a conflicting message conveyed by the mental health professionals. Ex-mental patients were portrayed as suffering from a non-contagious disease and therefore should be treated like anyone recovering from an illness; yet we were told at the same time that the ex-patient is dangerous and very ineffectual.

The thrust of our proposal was to influence mental health professionals that they needed to believe and support the idea that ex-patients need the opportunity to find their potential and use their own strengths in the community. Our observations and interventions suggest that establishing relationships with mental health workers was important as a learning experience for the organizers but an unproductive excercise in obtaining referrals. In retrospect one could postulate that the idea of self-help groups is rather new to the professionals in that they resisted this kind of in-

novation in a rather reactionary manner. This tells us something about the lack of awareness professionals have about innovations being made in their own field.

Development of a Self-Help Group for Ex-Psychiatric Patients

The growth and development of a self-help group for ex-psychiatric patients can be viewed within the heuristic frame provided by Gartner and Riessman's (1980) work on the organizing of self-help groups. In their study, Gartner and Riessman discerned a sequence of strategies or tasks in the roles of the organizers: (1) catalyst, (2) transition from catalyst to technical assistant, (3) technical assistant, (4) transition from technical assistant to resource member, and (5) resource member. As a participant observer, the author discusses only those phases in which he had direct experience with the group. It is useful to view the work done by the organizers in terms of this framework.

Phase One--The Organizer as the Catalyst for the Group's Coming Together

> In this role, the organizer is playing a dominant leadership role performing such tasks as
> --identifying potential group members,
> --setting the time and place of meetings,
> --conducting meetings,
> --introducing members to self-help concepts, and
> --assisting members in getting to know each other.
> (Gartner & Riessman, 1980, p. 163)

Self-help groups operate differently from more traditional groups. The organizer is in effect attempting to train the group to be effective self-help group members. The aim of self-help groups is to rely on the strengths of each member. The organizer tries to accomplish this aim by modeling behaviors and suggesting a process which reflects the principles of self-help.

Statement of Purpose

The first meeting of a self-help group for ex-psychiatric patients occurred at the University of Winnipeg and was held on November 26, 1980. In attendance were three group members and the three organizers. The aims of the group as stated by the organizers at that time were: to offer friendship, understanding and social support to any person who has been a psychiatric patient at one time and to promote the potential for advocacy and change for ex-patients living in the community. Several months later, the group had become incorporated, received a government grant and rented space from a national mental health organization.

Identifying Potential Group Members

During our meetings with various agencies, a profile began to emerge of the ex-patient that we wanted

for the core group. The ex-patient should be between twenty and forty years of age. He or she should be functioning reasonably well in the community. By functioning reasonably well we meant an individual whose mental difficulties would not stand in the way of joining and participating actively in a self-help group.

The organizers were dependent on the contacts we established with the agencies in referring the initial members to form a core group. Some difficulties resulted from this dependency which had a major impact on the relationship between the organizers and the group.

First, many of our contacts did not refer any members. As a result only two or three members attended the meetings for the first few weeks. Because there were as many organizers as members it was difficult to form a group and sell the concept of self-help.

Second, some members who were referred were under the impression that this was to be a therapy rather than a self-help group. Coupled with the low attendance these individuals felt overwhelmed with the expectations inherent within the self-help framework. They generally did not attend group meetings after their initial appearance.

Third, the majority of individuals referred were functioning considerably below the level we felt was

needed in establishing a core group. These members became dependent on the organizers as well as the future leaders of the group. They were often at risk of being rehospitalized. They were heavily medicated with psychiatric drugs and were being seen on a regular outpatient basis. Often during meetings, these members hallucinated, spoke or laughed to themselves, stood up or walked out of the room without any apparent reason, as well as verbally lashing out at other members. They often complained of discomforts and side effects from medication, new medication or because of a lack of medication. Their ability to form supportive relationships and to actively contribute to the group was very limited. They attended meetings in order to meet other ex-patients and for something to do during the week.

Y on the other hand, was an ex-patient who was a professional worker. It was very difficult for Y to identify with most of the other members. His education, appearance, income and interests were far different than the other members. Y had joined the group with the hope of being a participant in an organization which had the ability to deal with the legal, political and social plight of the psychiatric patient. Y, unlike the early members, did not join the group primarily for social reasons. Invariably, Y would relate to the organizers as peers rather than the other members.

Y would always remain outside the relationships developed by other members. This would eventually lead to Y's dropping out of the group. Y would also leave the group because his original goals for joining could not be met within the context of the larger membership.

Eleven members attended meetings between November 26, 1980 and the first few weeks of January, 1981. At no time were there more than six members at any one meeting. This forced the organizers to concentrate their activities towards certain directions. These activities will be discussed shortly.

Setting the Time and Place of Meetings

The core group began to meet every Wednesday evening at the University of Winnipeg. However, by the third month, some group members wanted to socialize more and participate in activities such as visits and outings. These members also had great difficulty in contributing to the meetings because of their personal limitations at that time. To accomodate this emerging need some changes were made to the kind and frequency of meetings.

A second group day was suggested by the organizers despite some concerns expressed by some of the members and the organizers. Wouldn't there be a loss of continuity if some members couldn't attend both days?

Could the organizers commit themselves to attending twice a week?

The issue was resolved after a suggestion by the organizers and a vote by the membership. Wednesdays were to be used for meetings and some socialization while Sundays were to be available for social activities only. The organizers would alternate in their attendance at weekly meetings and outings. Two organizers would always be present if possible.

The organizers discovered early during the group formation that contact with group members would often be on a daily basis. Members would call the organizers at home, sometimes during the middle of the night. Many of our members had difficulty in sleeping. During these phone calls, members discussed their anxieties and fears about other participants in the group. Psychiatric symptoms and problems were described as members sought possible solutions to their discomforts. The organizers believed that some members wanted us to behave as their therapists. We were very uncomfortable in this position. We felt quite manipulated. On one hand we had to respond to the members because (1) they might have been experiencing some real difficulties and (2) we did not want to lose them as members. However, we were aware that our responding and responses were in direct opposition to the concept of self-help. The

more we would respond as therapists-students, the more likely the group would become a therapy group. Eventually, the organizers discussed the nature of our role during group meetings. We stressed the nature of self-help and modeled how members could support other members. A phone list of all members was drawn up and distributed. This appeared to ease the phone calls to the organizers. We realized, however, that our membership was quite dependent on our presence and that it would take a tremendous effort in training members to accept and use self-help concepts.

Conducting Meetings

The organizers facilitated the meetings by encouraging the members to discuss their current situation and what they hoped to gain from being a group member. Our efforts were directed towards the goal of promoting a commonality of concerns among group members rather than through us as group facilitators.

Meetings were held every week for the first few months. A couple of important trends occurred during this period.

First, meetings were quite informal because of the small turnout, irregular attendance and the introduction on a weekly basis of new members. Three positive consequences, however, can be linked to this phenome-

non.

The organizers were able to develop trusting relationships more quickly with members. Second, over the course of a few meetings the organizers helped the members to put together a broad list of individual goals. Third, the organizers were able to model behaviors such as conducting a meeting, more appropriate listening skills and methods of showing encouragement and support for other members.

The organizers were unable to relinquish their leadership roles during the early months as no potential leader had emerged from the group. As a result, we stressed the need for more membership as a means of pursuing group goals.

Discussion

Patience, commitment, and above all, persistence were obviously necessary throughout the course of development, but especially during the first stage.

We attempted to offer the group members a spirit of hope and a bolstering of self-confidence as they attended meetings. We hoped to help them create a sense of community by identifying the group as a strength through numbers and commonalities.

As catalysts in the group's coming together, we attempted to help the members feel comfortable in ex-

pressing their needs and goals. We supported members in encouraging dialogue among themselves and therefore forming relationships. We modeled behaviors which would encourage group leadership in a spirit directed towards the goal of self-help.

Furthermore as organizers we began to feel more comfortable exposing our own vulnerabilities and creating a personal support system among the three of us. As a result, we were able to suspend our expectations of immediate success and to deal more appropriately with where our members were at.

The Transition from Catalyst to Technical Assistant

As catalysts, the organizers helped the group members identify a number of goals, objectives and priorities in the first several meetings. As well, we enabled the members to discuss the reasons for their choices. For example, S wanted better housing for ex-mental patients because it was difficult to feel good about yourself while living in a slum. R, on the other hand, wanted more friends as he was quite lonely and this made him go "crazy".

The next step would be to determine the methods the group could use to accomplish their priorities. This, however, presented a problem for the group and the organizers. The membership was unable to articu-

late any methodology in achieving their goals despite the encouragement given by the organizers. As well, the members blocked any suggestions put forth by the organizers. This was probably due to their lack of confidence, fears and inexperience in risking a new approach to problem solving.

The organizers decided that it would not be in the best interest of the group if we were to lead them in the accomplishing of some goals. We did not want to set up the expectation that we would be the leaders who would solve particular problems. We agreed that leadership needed to come from the group. Until that happened, we were prepared to foster momentum in the group by discussing self-help principles, encouraging the development of relationships among the members, and for members to mention the group to their therapists as a way of recruiting. The discussions and tasks reflected the functioning level of the members and the group as a whole.

The period of transition from catalyst to technical assistant occurred between December 17, 1980 and March 11, 1981. This transition evolved because leadership emerged within the group. As a result, many of the functions performed by the organizers were transferred to some of the group members.

The group met for its regular Wednesday meeting on

December 17, 1980. In attendance for the first time were two new members, X and I. As usual, the organizers helped the older members welcome the two new members to the group. We then asked the new members how they had heard about the self-help group. According to X, a group member, R, had spoken highly about the group to his psychiatrist who in turn suggested that X and I attend our meetings. This statement appeared to encourage some of the other members to discuss their reasons and hopes for joining the group. The organizers encouraged the discussion to continue and as a result everyone learned X and I's reasons for joining the group. With some clarification afforded by the organizers X and I discussed changing the mental health system as their major goal in joining the group. They saw the group as an appropriate vehicle in pressuring the government and public to change "the oppressive mental hospitals".

As the above discussion ended, all the members including X and I asked us about our commitment to the group. The organizers sensed a qualitative difference in the asking of commitment from the previous time. We believe that the group saw X and I as probable leaders who were determined to use the group in a number of risk-taking activities. Our commitment to support rather than lead was a required assurance for the group

to proceed in these endeavors. Our affirmative reply indicated our confidence in the ability for ex-mental health patients to assert themselves in areas pertaining to their own well-being.

The organizers also helped the group to co-ordinate plans for a Christmas party at the December 17th meeting. Responsibilities were delegated to each member depending on their ability to contribute materially and emotionally to such an event. The party was arranged for December 22, 1980.

The Christmas party provided an opportunity for some members to create and be responsible for their own activity. The members appeared to be happy and gain some confidence at the success of the party.

Four meetings were held between January 7 and January 21, 1981. Recognizing that X and I were potential group leaders, the organizers began to help the group to define more clearly its purpose and process of problem solving.

We introduced the idea that group members should alternate in acting as chairperson and secretary for the meetings. Up to this point, the organizers had functioned in this dual responsibility. Even though the group would continue to operate informally the introduction by the organizers of some structural changes would have significant bearing towards the

group's development. As we would become less involved in these positions group members would have to fill the void. We feel that our ability to successfully model the roles of chairperson and secretary allowed the members to successfully perform these duties.

The group priorized its goals as one of the members listed them on paper. The goals included: socializing, public relations, law reform, and better training and treatment of patients.

During the group discussion the organizers pointed out that these goals could only be achieved by a larger membership. We then encouraged the group to discuss ways in which new membership could be developed. X suggested that committees be formed to help publicize the group. X, with the assistance of M, would be in charge of Public Relations. Their initial task was to create a pamphlet which would describe the group's statement of purpose and inform readers of the dates and times for meetings. Another committee was formed whose function would be to distribute the pamphlets to public places. As well, Y the professional worker, was advised by the group to bring information about the steps required in legally incorporating the group. This request stemmed from a discussion about funding and budgets and was put forth by X.

The issue of anonymity was dealt with during this

transitional period. There were divergent opinions as to whether members names could be discussed outside the group. The organizers took this issue as an opportunity to further help the group in learning how to problem solve. We asked the group to brainstorm the possible ramifications of either stance. This generated considerable discussion among the group members. An eventual solution emerged and was voted on by the members. If an individual member wanted to identify him or herself with the group to outsiders that would be acceptable. Otherwise, the names of group members would remain within the boundaries of the group meetings. The organizers were again able to teach a process which helped members to discuss and solve a problem. The group was being exposed gradually to new strategies in problem solving and decision making.

During the meetings of January 21 and January 28, 1981, X began to show more assertiveness around the leadership function. X strongly suggested that the group accept the pamphlet she created with M's help. The group supported her request as well as agreeing to be incorporated.

The January 28, 1981 meeting was also a turning point in the relationship between the group and the organizers. Despite objections and alternative suggestions put forth by the organizers the group decided

that I's telephone number and X's address be used on the pamphlets. The organizers preferred a contact number which was not subject to the possible comings and goings of group members. The membership decided to trust X's and to some extent I's ability to provide leadership. X and I, with the group's endorsement, would gradually begin to take leadership responsibilities away from the organizers. Although the organizers' suggestions would still be welcome in the future, our status as student-professionals no longer would carry the weight it once did in the setting of goals and direction for the group.

Between January 28, 1981 and March 4, 1981 two major trends dominated the group. First, the organizers supported numerous learning experiences for the group including the conducting of meetings, budget preparation and efforts towards outreach and public relations tasks. As a result, group participation became more active. The other major trend was the growing competition between X and I in leading the group. Both of these observations will now be discussed.

The informational posters were printed and ready for distribution. The organizers helped the distribution committee identify locations in the community where the posters could be placed. Some of the members

of the distribution committee were quite anxious and unsure of how to ask for permission to put up posters. Recognizing this problem, the organizers helped the members to simulate such a situation. A number of members were eventually able to then distribute some of the posters.

The organizers introduced the idea of developing a scrapbook for the group. We felt that this would give the group a sense of history, belonging and accomplishment. Photographs, writings, members names and milestones along with other artifacts of group culture would be stored in the book. This proved to be a popular and practical suggestion as members would often contribute to the pages and use the book as a vehicle for welcoming new members.

Another structural change suggested by the organizers and accepted by the group was that a member should be designated whose responsibility would be to telephone and remind the membership about upcoming meetings and activities. The suggestion was also introduced in order to involve D in the group process. D agreed to take on this task with great enthusiasm and commitment. The organizers were finally able to find something that would motivate D to involve himself in the group beyond showing up for meetings.

By mid-February 1981, a number of group members

through the weekly efforts of the organizers began to formally greet and welcome potential new members into the group. A recognizable process of orientation was now in place.

We also observed the growing confidence in group members chairing the meetings. Our role here had moved from one of modeling the behavior of a chairperson to encouraging the membership to indicate confidence in each members ability to chair the meetings. Members began to praise and clap for the chairperson at the end of the meeting.

Although meetings were still often quite chaotic with many members speaking at one time, an identifiable process was evolving. Minutes would be read from the previous meeting, a new agenda would be identified and a discussion would then follow. We observed that X or I generally had the last word in any discussion and that their suggestions or arguments would be the most influential in the group's decision making. The organizers also observed a growing interaction among members during and outside meetings. There was a sense of belonging and a desire to get on with a number of tasks and the consolidation of having more control over group direction. Generally, the members had learned to develop a climate which was reasonably comfortable for members to feel at ease and welcome. All these factors

would manifest themselves in the group electing a president and executive on March 4, 1981.

X and I represented and symbolized the hopes of the group in having an indiginous leader. As well, the organizers saw in X and I the positive opportunity in relinquishing their reluctant positions as leaders and moving towards the role of technical assistants.

I was a charismatic character whose display of emotions and kindness made him a welcomed friend to other members. He was able to get members excited about the group and to give hope for changing their situation in life. He promised to deliver in all of the group's goals but in particular those pertaining to public attitudes and laws towards mental patients. I was defeated in his bid for the presidency of the group. His loss, however, was predictable. I could not deliver on any of his promises during the two months preceding the election. I was a leader without a process, a leader who could not meet the needs of the potential followers. His interaction with the membership was based on seductive promises of hope rather than observable accomplishments.

X, on the other hand, did deliver on her promises. Her contact with a professional friend resulted in the free printing of the group's posters. As head of the public relations committee she made contacts with out-

side organizations and professionals to inform them about the group. She was competent in running a meeting, in making decisions, and was employed part-time. For the group, she symbolized an ex-patient who fought with great courage to recover from her previous difficulties and circulated with some confidence in the community.

It would be X that would confront I on one of his promises. This development had a great effect on the group and its future direction. The group realized that any changes in the plight of the ex-mental patient would only occur through a process of hard work rather than on hope alone. I's credibility was destroyed. Even though he would run for the presidency his membership and activity in the group would wane over the next few months. X, in contrast, would gain more power as the group trusted her competency. X's power would be gained from the group's loss of hope in I, the qualities of leadership exhibited by X and the lessening influence of the organizers.

The group's uniting together around X became evident as it dealt with a possible donation of money from the University of Manitoba. The university was prepared to give a few hundred dollars to the group but with some stipulations. Although the group could have used the money, the organizers view their unanimous

decision against the donation as a sign of strength.

The group had now been together for about four months. A number of friendships had developed among the members. The group had enjoyed some success in completing a number of tasks. They were in the process of being incorporated. They elected a competent member to be president. They viewed the organizers as student-professionals who supported but no longer lead the group. They saw themselves as a viable group with strength, direction and leadership. They perceived the offer by the University as an external threat to their autonomy. Their vote against the offer of financial help was a vote of confidence in themselves.

Discussion

During the transition from catalyst to technical assistant the organizers participated in the strengthening of group autonomy and the teaching of individual and collective skills.

We were able to help the group clarify its goals--its purpose. As well, we assisted the group in establishing short-term objectives and priorities. For example, the organizers recognized the need for an increase in membership. By encouraging the members to distribute public relations posters a new member joined the group on February 17, 1981. She had seen the

group's poster at her church and felt the group could meet some of her needs.

The organizers assisted the members in defining who the potential target population for recruitment should be. Some members wanted more students and/or professionals. The organizers, however, suggested the need for more ex-patients. We directed the group to see professionals as resource people rather than as active group members. The group agreed and restricted its membership to current and ex-patients. Professionals could be invited to group meetings but only by a unanimous group vote.

Gradually, the organizers were able to routinize the meeting process. Members were encouraged and supported in taking on certain roles. Activities were suggested by the organizers which would enable the group to carry out the purpose and the goals of the group. An example of this would be a meeting with a school to investigate a job training program for ex-psychiatric patients. Expectations of group behavior began to develop. For example, members were encouraged to greet new members and to socialize after the meeting.

As well, during this phase, the organizers proposed ideas for recruiting new membership. We were able to introduce a method of informal record keeping

for the group. A member was elected who kept and read the group's minutes on a weekly basis. We assisted the group in a major fund-raising campaign. As a result, the group raised a few hundred dollars during a successful raffle drive.

We helped the group establish a membership fee. Members would not pay any dues but rather, they would donate money to a coffee fund. The organizers offered their expertise in budgeting skills and in helping the group set up a bank account. The money-making ventures strengthened the confidence of the group. The organizers utilized the fund-raising programs as a way of creating tasks which would stress individual and cooperative activities.

The self-help group developed from a collection of unrelated and isolated ex-psychiatric patients to a group with several goals and an assertive leader. The contributions made by the organizers during this phase were directly responsible for the group's maturity. The organizers were effective in moving from the role of catalyst to technical assistants.

CHAPTER TEN

THE PRACTICUM--CONCLUSION OF INTERVENTION

Between May and September of 1981 this writer was the only organizer working with the self-help group. The other two organizers left the group upon completion of their academic year.

> "In the role of technical assistant, the organizer does not actively participate as a group member. Rather, the organizer observes the group process, comments as requested by group members, and provides support in the form of encouragement or suggestions, when needed." (Gartner & Riessman, 1980, p. 163)

As technical assistant, the organizer contributed to the group in two major areas. Through the appropriate use of his knowledge and skills the organizer was able to help the group obtain a major financial grant. The organizer was also able to convince the group of the ongoing need for assistance that would be manifested in the acquiring of a new social work student. In achieving the latter, the organizer was able to share with the incoming social work student the organizer's perceptions about the group and possible strategies that might be utilized in order to support the group.

The year 1981 was designated the "International

Year of Disabled Persons". The term, "disabled person", as defined by the 1975 United Nations Declaration of the Rights of the Disabled, Article One, refers to any person unable to ensure by him or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities.

During the International Year of Disabled Persons the federal government through a Manitoba Organizing Committee offered grants for projects and programs which would promote the full and equal participation of disabled people in society and/or the public awareness of problems of disabled people. As a technical assistant, the organizer suggested that the group consider applying for a $5,000.00 grant. The organizer felt that the group required monies to locate a permanent home for its membership as well as carrying out a number of tasks related to its original goals.

In considering the application, the organizer as technical assistant helped the group discuss the word "disabled" in relation to themselves; formally apply for the grant; and affiliate itself with a professional mental health organization.

The organizer introduced the subject of the grant during the spring of 1981. He was able to do so by

asking permission from the group to place the topic on the group's agenda during a meeting. The initial response from the group was very hostile. The organizer observed the difficulty the members had in accepting themselves as disabled. Sensing the mood of the group, the organizer facilitated a discussion among the group members which allowed members to express their feelings and thoughts about the application. The organizer made sure that every member participated in the discussion by specifically asking everyone for comments. The organizer explained to the group that they were disabled in the sense that the public perceived them as having deficiencies. Collectively, however, their individual deficiencies were diminished and the monies could be used towards changing public attitudes toward psychiatric patients as well as supporting group projects.

The group supported the proposal during a follow-up meeting through a vote. Coincidently, the group, in the estimation of the organizer, required new facilities. The group was in need of its own permanent place that would foster the further development of its growth. The organizer suggested the group approach a professional Agency in order to: (1) sponser the group in its application for the grant and (2) rent space from the Agency.

The group was of course concerned that it might lose its autonomy if it affiliated in some fashion with professionals. The organizer suggested an exploratory meeting with its executive director. The president of the group and two members of the executive along with the organizer eventually met with the executive director.

During the course of the meeting, the organizer was successful in easing the tension by articulating the group's feelings about professionals. This action permitted a frank and open discussion about the nature of a possible relationship between the two organizations.

The group's executive was comfortable with the discussion and suggested to the group to endorse an affiliation with the professional agency. A series of meetings followed between the two organizations in which the organizer assisted in establishing an acceptable working affiliation between the organizations. On September 1, 1981, the self-help group upon receipt of the grant moved into its newly leased facilities.

Between May and September, 1981 over forty people attended at least one meeting of the group. The largest meeting attracted fourteen people. The average meeting involved about eight people. Most of the members were attracted by the group's posters while some

were referred by a sympathetic psychiatrist. Several people attended only once because they thought that this would be a professionally led therapy group. Two individuals also attended only once because they thought that they would be paid for coming to the meetings. I for all intents and purposes left the group while X consolidated her position as president.

X's growing use of power concerned the organizer. During the early stages of the group's formation the organizers controlled the power by virtue of their role as catalysts. Our intent was to transfer that power to the group over a period of time. After X joined the group, she began to achieve an informal sense of power. This was accomplished by her competency in leadership-"type" functions as discussed earlier. When X was elected president she was given formal power by the group. In a sense she took over the roles that the organizers had once held.

X, throughout the summer months, dominated the group. The organizer believes that many of her actions on behalf of the group were fulfilling self-oriented needs. X contacted local politicians, various social service agencies and other self-help groups across the country. X would use the group as a basis of setting up the contacts, however it would be X and not the group who would benefit from these encounters. Al-

though X was becoming quite well-known because of her actions, there was no observable gain for the group.

The group was unable to produce another member who had the strength to question X's motives or the outcome of her actions. Even the other members of the executive did not challenge X's behavior. Despite a viable group process which permitted and stressed questions and answers and checks and balances, X's actions continued. The organizer believes that the group was prepared to allow X to take care of it and be in charge. This situation occured because of X's strengths and the membership's weaknesses. When the organizers had initiated the self-help group we immediately stressed the strengths of shared leadership. Shared leadership involved different members performing various leadership roles according to their own special abilities. For example, one member of the group was good at making coffee, while another member could be counted on to suggest Sunday activities. The organizers modelled the concept of shared leadership every meeting. X, however, by the summer of 1981 was the only member who was proficient in decision-making and the carrying-out of significant public actions.

The organizer attempted a number of strategies to deal with this situation.

The organizer met with X on several occasions

outside the group time. In speaking with X, the organizer stressed the need to develop other leaders within the group so as to help X in her many functions as leader. X would become very defensive during these discussions. She would verbally attack the organizer by saying that he had no confidence in her or ex-psychiatric patients. She also pointed out that the group never objected to her plans when she announced them during the meetings. In the end, these discussions only added to the growing distance between X and the organizer. In retrospect, the separate meetings with X were probably not a good idea. The organizer might have found a way to point out his concerns during a group meeting. In this way, the group could have made a decision around the concerns. X would then have to be accountable to the group if the group was in opposition to her behavior. However during this period of time, the organizer did not see this option as viable or available.

There were three members on the executive besides the president. The organizer met with these members alone on a few occasions. He tried to get the executive to talk about their feelings and perceptions about the group. The organizer gently tried to persuade the executive to bring any concerns to the group meetings. This strategy proved unsuccessful as the three were

either intimidated by X or content in allowing the relationship to continue as it was going.

The organizer attempted to strengthen the linkages between members by meeting with them on a frequent social basis. We would discuss their hopes and roles in the group. This strategy again failed to have any significant impact on the group process.

Members were allowed to bring up new business matters for the group's meetings. Although the organizer had surrendered his various functions to X and the group, he could still suggest some items for discussion. The organizer used this forum to suggest the group redirect its focus to recruitment from that of meeting with other professionals. The strategy was an attempt to redirect X's energy to a direction which would be more beneficial to the group. The organizer was unable to solicit any support from the group however.

A difficult situation faced the organizer. As a team, the organizers had initiated a self-help group with a difficult population. From its inception, the organizers stressed the process of self-help and their faith in the membership. The group matured and a capable leader emerged. The self-help group was presently negotiating its arrangements for affiliation with the professional Mental Health Agency. During the

evolution of the group, the organizer's influence and power diminished appropriately. Despite the lack of success of the other strategies mentioned the organizer was not prepared to openly challenge X's behavior. Such an action would probably result in (a) a prolonged battle with X which would probably result in other members leaving the group, (b) the possibility of X leaving the group or (c) the further loss of the organizer's influence. The organizer was aware from his review of the literature that professionally organized self-help groups often develop difficulties when the professional attempts to place his or her expectations on the group (Kleiman, Mantell & Alexander, 1976). The organizer sensed that he was at a crossroads in his relationship with the group.

The goal of the organizer from his initial involvement was to eventually leave the group. The organizer felt that the group was ready to write its own script without the presence of the original organizer. The presence of the organizer seemed only to deter the required interaction between X and the group. The group rather than the organizer needed to question X's position. As long as the organizer stood between X and the group this would not happen. The organizer needed to convey to the group that he had confidence in their ability to solve problems and plot a future course. At

the same time the organizer felt that the group still required some support. The decision concerning the status of the organizer had to be made for the group's benefit. The organizer knew this and his suggestion to the group reflected his awareness. The organizer decided that he had to leave the group so as not to get in the way of their problem-solving. As well, the organizer felt that a new student was needed to support the group as it continued to develop. The organizer believed that this strategy was appropriate and had potential for success. It would diffuse the obvious tension between X and the organizer. It would probably promote the group and X to work closer together as a way of allowing the group to survive into the future. It would remove the symbolic position of the organizer as the person who started and helped plot out the direction of the group. Finally, it would allow a new student to act more freely as a technical assistant and eventually as a resource person (Gartner & Riessman, 1980).

The organizer introduced his suggestion during August, 1981. He shared with the group that although it had come a long way it could still use the support of a student as it tackled new endeavors. The organizer traced the history of the group from its initial formation. By doing so, the organizer was able to

demonstrate the enormous growth of the group and its membership. As well, the organizer was able to clearly state to the group that it was in a position to dictate its own direction. It was now like a young adult ready to deal with the world with its own strengths and weaknesses. Its support should come from developing new relationships and not from its ties with the organizer. For the organizer to stay in the group, it would be similar to that of a parent disallowing his grown child the opportunity to become independent and develop future self-esteem. The group needed its independence.

The group understood but was hurt by the suggestion from the organizer that he was leaving. They wanted to know if the organizer would still visit. However, the group showed its maturity by deciding that the organizer could suggest a specific student but the group would make the final decision as to the acceptability of the person. The new student was invited to attend a few meetings before a decision would be made.

The group and the organizer parted company in September of 1981. The group bestowed upon the organizer the position of an honorary member. The organizer agreed to be an outside resource to the self-help group. The change in the relationship between the group and the organizer was positive and appropriate.

Discussion

As technical assistant, the organizer appropriately terminated his relationship with the group. The organizer was able to ensure the future potential of the group's growth without his direct intervention. This was achieved by assisting the group in its application for a grant and its affiliation with a professional Mental Health Organization.

The organizer as technical assistant was also sensitive and successful in his perception and understanding that his direct service to the group was no longer required. His participation as an active observer-member was terminated in a manner which was supportive of the membership and its strength as a self-help group.

CHAPTER ELEVEN

SUMMARY, RECOMMENDATIONS AND EVALUATION

Work with Us, Not for Us"--Anonymous, 1980

Summary

In the autumn of 1980 three social work students met for the first time. These students had a similar academic interest--to start a self-help group for ex-psychiatric patients. Their knowledge about psychiatric patients and self-help groups was limited. Their experience in organizing such groups was minimal. They read the literature about self-help groups. They discovered that many self-help groups started because its members felt either neglected or rejected by the professional health care system (Levy,1976). The students wrote letters to other psychiatric self-help groups. The following response expressed an insightful concern which the organizers constantly related to in their work with the self-help group.

> The new interest of professionals in wanting to help facilitate self-help groups is disconcerting to almost everyone in the organized mental patients' movement. In the past, patients' rights groups in Conneticut and New York, to mention only two cases, were set up by ex-inmates themselves to provide mutual emotional support and social activities for the people involved. Professionals stepped in and "helped". The result was that the ex-inmates felt robbed of their efforts. It is very likely, however, that your efforts to organize such a group will backfire. The result may

> simply be that you will have another situation in which ex-patients lean on you--the "together", knowledge people for support. (President of an ex-psychiatric self-help group in San Francisco)

Certainly our goal as organizers was to avoid the above outcome. I believe that we were able to help create a self-help group run by and for ex-mental patients.

The students then met with other professional care-givers. For the most part, we were amazed by the negative attitudes expressed by many of our contacts and the lack of commitment and referrals to the self-help group. We also learned from our meetings with professional health care-givers that only one of them had either organized, participated in or referred to a self-help group. The professional social worker who did have experience with self-help groups was a member of A.A. and fittingly made the initial referrals to the group.

The student organizers as catalysts successfully started a self-help group for ex-psychiatric patients. From the very beginning we understood and experienced the above quoted passage. Our members leaned on us as much as they could. We had to support some of the "lean" because they were individuals who had serious mental difficulties and whose ability to socialize and show assertiveness was severely limited. Although we accepted our members for where they were at, we gently

demanded improvements in their functioning. We spoke about and modelled behaviors which were essential to the success of self-help groups. We asked members to express their goals and to talk with each other. I believe that we were able to help reduce our members' isolation and alienation by enabling them to feel a part of the self-help group. It allowed some of them to feel a sense of community through their active affiliation with the group. Simply put, some members felt accepted by other people for the first time in their lives.

Slowly but surely, the reins of power and leadership were passed over to the group as an indiginous leader emerged. The organizers promoted this transfer of responsibilities in a respectful and sensitive manner. As technical assistant, the organizer helped the group to become incorporated, raise significant monies to support its goals for another year and to locate and have jurisdiction over its own premises. As a final act the organizer terminated his activity based on his positive relationship with the group and his understanding of the literature.

Recommendations

(1) As a participant observer and student of the literature, I see self-help groups as a promising and

viable concept which has the potential for great benefits. It is my belief, based upon an extensive review of the mutual aid literature and a very intensive participation in this group, that self-help groups must be taken into account in any comprehensive analysis of our mental health resources and in planning for their most effective utilization. In my estimation self-help groups provide an access to care to those individuals who are the hardest to reach by professionals.

(2) A city-wide Clearing House should be established for the promotion of self-help groups. This centre would make available the names of existing self-help groups and a library of information about the phenomenon. Professionals could make use of the Centre to learn about self-help groups and to refer clients to an appropriate one. The Centre could actively educate the professional and the public about self-help groups.

(3) Further research and understanding is needed in developing and fine-tuning the relationship between professionals and self-help groups. This can only happen if more professionals are prepared to join an existing group or start their own self-help group.

(4) There is a need for students of the School of Social Work to be exposed to self-help groups in their studies. These students will have to know how to work with these groups as societal problems increase and

change while professional resources remain stagnant or dwindle.

(5) The School of Social Work should consider contracting with existing self-help groups as a potential placement for students. The student, the School, Social work and the self-help group would all benefit from this affiliation.

Evaluation of Learning Experience

This section of the report is an attempt to summarize the learning experiences provided during the course of conducting this practicum.

This report has not discussed the student's other major learning experience during the academic year, 1980 to 1981. This student was involved in a full-time placement at the Psychological Services Centre. From that position, the student read and practiced in the area of network theory and intervention. Along with his responsibilities of participating in the intake process and contributing to his team's discussions and activities, the student became involved with several clients on an ongoing basis. The student showed a significant growth in his understanding and acquisition of skills related to network intervention.

The major growth for this student was in his acquisition of knowledge and skills in developing a

self-help group.

In general, the student was able to combine his activities of reading, clinical intervention and supervision in a meaningful way. In short, he was able to translate the theory into practice and this enabled him to think and plan appropriate and meaningful interventions.

The experience in starting a self-help group was worthwhile and provided an excellent background to further interventions in this area. He has gained tremendous confidence and competence from this experience. At his present position as a professional social worker, he has acted as a consultant to two individuals who wanted to start a self-help group.

I feel that viewing the plight of the ex-mental patient as well as other human problems in the context of self-help groups offers a number of advantages. This became apparent to me as I read the literature and attempted to translate it into practice. Initially, I was not aware of the complexity involved in the convening of such a project.

I feel that the skills acquired during the course of this practicum are transferable to other social work interventions. This realization has become increasingly apparent to me. My knowledge of self-help groups has allowed me to refer clients as part of my interven-

tion. My skills as a social worker have now given me confidence in dealing with the complexity of presenting problems in a rational and planned manner.

The literature review I believe testifies to the enjoyment and understanding which I experienced while reading in the area of self-help groups. Generally speaking, the opportunity to read this material has given me a great deal of insight into the need for self-help groups and the attention and respect that social workers should give it.

The learning experience caused many moments of self-analysis and times of uncertainty. I believe that this was a positive indication of my learning. As a result, I feel that I have increased my professional competency. The learning experience allowed me to achieve the general objectives that I had initially expected as well as additional benefits.

It was a privilege to be associated with such a project.

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