SELF-HELP/MUTUAL AID GROUPS

IN MENTAL HEALTH

Ideology, Helping Mechanisms and Empowerment

A THESIS SUBMITTED
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To the reason of all these, to my truly beloved husband

ABSTRACT

In the last quarter of the twentieth century, self-help/mutual aid groups for mental health issues started to emerge in growing numbers, mainly in Western societies, offering and/or advocating for alternative non-traditional forms of support, and attracted the attention of many researchers and clinicians for their unique characteristics. Among the subjects of interest are typologies of groups, helping mechanisms and benefits from participation. However, there is lack of systematic research in the area and existing studies have been largely confined to the therapeutic value of these groups instead of acknowledging their socio-political meaning and subsequent psychosocial benefits for their members like personal empowerment.

The present study was conducted during the transitional years from a Conservative to a newly elected Labour Government (1996 -1998), with subsequent policy shifts taking place in the welfare sector. The purpose of the study was to explore the potential of self-help groups as part of a broader new social movement, the service user movement, focussing on the English scene. It addressed this issue examining the relevance of a group typology based on political ideology and focus of change. To test the validity of this classification for members, a set of individual characteristics and group mechanisms as well as their change through time were examined. The sample consisted of fourteen mental health self-help/mutual aid groups from London and South East England, with a variety of structural and organisational features. The methodology used was a combination of both quantitative (self-completion questionnaires) and qualitative techniques (analysis of written material, participant observation and interviews). Measurements were repeated after a one-year interval (Time 1 N=67, Time 2 N=56).

Findings showed that, indeed, political ideology of self-help/mutual aid groups provided the basis of a meaningful typology and constitutes a comprehensive way of categorising them. Group ideology was related to specific helping mechanisms and aspects of personal empowerment. Specifically, conservative and combined group members reported more expressive group processes like sharing of feelings and self-disclosure, while radical group members were more empowered and optimistic. Group identification was also associated with specific helping activities and aspects of empowerment in the three group categories. The psychosocial character of group types and the beneficial outcomes for members remained stable through time. In general, prolonged participation was reflected in greater member identification with the group and resulted in improved mental wellbeing, increased social support, companionship and optimism for the future.

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INTRODUCTION

No one will tell our fate, and that is that.
We ourselves will tell the sun's fate, and that is that.

Odysseas Elytis, This Wind that Loiters

(translation by E. Keely and P. Sherrard 1966)

Looking at the larger picture

Since the establishment of mental health services world-wide, users of psychiatric services have mainly been treated as 'patients', merely objects of mental health professionals' interventions and, explicitly or implicitly, are presented in a way which emphasise their pathology (Foucault 1961). Indeed, in their review of the relevant literature, Pilgrim and Rogers (1993) assert that there is "*a disregarding of users' views by researchers when they do not coincide with those of mental health professionals*" (p.162). Another view which is consistent with treating service users as 'patients' is that "*users of mental health services are continually irrational and so incapable of giving a valid view*" (p.162) and even when partial credence is given to their perspective, it must fit in with the expert's view (Pilgrim and Rogers 1993).

An alternative way of thinking about people who use mental health services is as 'consumers' of the services. This approach is based in the ideology of "consumerism", a relatively new concept introduced in British health policy-making at the beginning of the '80s. Conservative British governments have been attracted to market-based approaches to welfare, arguing for greater diversity in provision, more consumer choice and more reliance on personal resources (Davis 1988; Towell 1990). According to Davis (1988), the introduction of consumer perspectives onto the political agenda has also emerged from the influence of the pressure groups and organisations, like the National Association of Mental Health (MIND) and the National Schizophrenia Fellowship (NSF). Over the last decades, these organisations have become part of the mental health scene by promoting consumers' and relatives' views of the mental health services. Another factor that contributed to the emergence of consumer issues in health is the visible increase in the activities of consumer organisations during the 1980s.

The effect of this recent philosophy, according to Pilgrim and Rogers (1993), was a growing acknowledgement of the importance of consumer satisfaction and of the health services being accountable to the patient. Health policy makers, following this new ideology, began

to accept that more credence and authority should be given to a user perspective. This 'consumer' view is, however, seriously restricted by the *'clinical autonomy'* of the medical profession. Many doctors were unwilling to treat patients as consumers, for example by having access to their own records and by having choice in their treatment. Additionally, critics of this view doubt whether users of mental health services are in a position to make informed choice as they do not have the same access to clinical knowledge as the professionals have. They also have objections to the notion of 'consumer' being used specifically in relation to people using psychiatric services as 'consumer' tends to denote a positive choice from a range of alternatives which are not, most of the time, available to these service users.

Viewing users as survivors is the third option that Pilgrim and Rogers (1993) discuss. This view takes into account the position of psychiatric users in a wider social context, that is the mental patient' s identity and social position in everyday life and the structural position of users as a social group within wider society. Thus, it gives emphasis to the individual experience of users and to their collective role as a group within society. Users as survivors question the utility of services and bring to light their dissatisfaction with them. They act collectively and constitute the "mental service user movement" world-wide (Chamberlin 1988, 1990; Pilgrim and Rogers 1993; Rogers et al. 1993). This third view of users as survivors, giving a voice to the users' demands and criticising professional interventions, emphasises that the fundamental needs of users are for rights rather than for specialised services. In contrast, both the 'patient' and the 'consumer' views are professionally defined and they restrict service users' choices to the existing traditional philosophy of mental health services. Most importantly, these views deprive users from re-establishing their social status quo in the society by assigning them the passive identity of someone who 'suffers' from an illness or someone who 'consumes' provided services. In stark contrast, the characterisation of people using mental health services as survivors emphasises their socio-political singularity as citizens and their active involvement in the mental health service reform (Pilgrim and Rogers 1993; Rogers and Pilgrim 1991).

The "mental health service user movement", also known as the "psychiatric system survivor movement" is a recent development with direct implications for the reform of the mental health services (Chamberlin 1990; McIver 1991). It developed first in America and Holland in the early 1970s and both the Dutch and the US movements have long since gained national and state recognition (Rogers and Pilgrim 1991). However, there are variations in

the way that these two national movements initiated and evolved which is closely connected with the structure of health and social welfare.

In Holland, where psychiatric services are part of the public sector and welfare is provided mainly by the state, the movement involved the development of ward based patients' councils. These councils have been supported by managers who want to communicate with users in order to improve service quality and also by government, where members see the movement as an aid in the process of standardising psychiatric hospitals. Legislation has been drawn up which states that each Dutch psychiatric hospital must have a patients' council (McIver 1991).

In the United States, the mental health service user movement has developed in opposition to the government rather than with institutional support as it was the case in Holland. Mental patients' liberation fronts and similar organisations soon developed informal self-help drop-in centres which attracted patients away from the formal conventional psychiatric programmes. At present, there exist many aftercare and support services in the States, run by users and ex-users in an alternative way and receiving public funding (Chamberlin 1990; McLean 1995). The North American user movement has two major goals: to develop self-help alternatives to medically based psychiatric treatment and to secure full citizenship rights for people labelled 'mentally ill'. The movement questions the medical model of "mental illness", and insists that people who have been labelled as 'mentally ill' are able to speak on their own behalf and not be represented by others who claim to speak "for" them (Chamberlin 1990).

From a sociological point of view, the user movement can be perceived as a 'new social movement'. In their analysis, Rogers and Pilgrim (1991) define social movements as

> *certain groups engaged in informal efforts in order to promote their interests in opposition to dominant forms of power and organisation preferred by the state.* (p.130)

The difference between "old" and "new" social movements relies on the fact that the latter go beyond the point of defending existing social and property rights from erosion by the state and they pursue to establish new agendas. "New" social movements have both social and cultural aims and they emerge because traditional political parties fail to represent adequately the interests of certain marginalised groups. These "new" social movements (e.g. feminism, environmentalism, disabled rights movement, gay rights movement etc.) prefer to take a direct social action and are characterised by a collective identity, post-materialist values and a demand for autonomy from interference by the state. These characteristics,

according to Rogers and Pilgrim (1991), seem to be consistent with the nature of the "mental health users' movement".

In Britain, the rise of the service user movement was relatively late. Its beginnings can be traced to the mid-1980s (Rogers and Pilgrim 1991; McIver 1991). Some of the factors which led to the emergence of the British user movement, like the introduction of consumer values in the mental health policy making, are common to the development of the movement in other countries (Rogers and Pilgrim 1991). However, there were elements, characteristic of the British scene, which contributed to this development. Firstly, hospital closure policies facilitated the formation of user groups by ex-patients living outside the hospitals and demanding their civil status. Moreover, the attempt on the part of psychiatry to impose 'iatrogenic' therapeutic strategies in the community care has come to be seen as unacceptable by a significant sector of users and caused greater user dissatisfaction. Finally, the introduction of Mental Health Act 1983, which although has not been regarded as particularly radical or effective, did create a new ethos that patients' rights and opinions could no longer be ignored. Political ideology within the British movement is clearly varied as there is a range of views about traditional mental health services and relationships with professionals, from the pro-medical position of "Voices" to the revolutionary anti-psychiatric stance of "Campaign Against Psychiatric Oppression" (CAPO). However, there is common 'ground' connecting the different factions, namely the issue of individual dignity, the importance of users having a voice, and the fact that the patients and their experience are placed centre stage.

The service user movement has brought a new conception of the 'patient' attempting to replace the notion of an atomised 'mentally ill patient' with a collectivised conception of empowered individuals making social and political demands on the state, statutory services and mental health professionals (Rogers and Pilgrim 1991; Lindow 1994; Campell 1993). The movement contradicts the 'irrational' reputation of the mental patient and restores the social status of the people who experience mental distress by fighting for their civil rights and their freedom to choose their treatment. It is rather premature to make a judgement about the success or not of the service user movement. As any social movement it depends heavily on the degree of involvement of the users and it is known, at the time of writing, that only a small number of users are actively involved in this movement (Campell 1993; Lindow 1994; Chamberlin 1990). However, the user movement has an influence in the design and the implementation of mental health policies. It has been clear for many professionals and managers that greater user involvement is an essential and achievable policy, and efforts are

being made to establish user involvement in all levels of mental health services, administration as well as delivery of services (Croft and Beresford 1990; Towell 1990).

A proof of the change that is taking place in the mental health area is the increasing number of self-help and consciousness-raising groups which are set up across countries, advocating for or/and offering alternative non-traditional forms of support (Ramon with Giannichedda 1988). Mental health self-help/mutual aid groups 'take on board' the notion that people who experience mental health problems can help themselves and others with similar problems by sharing their experiences and seeking knowledge about their condition or problem. Through this mutuality, members of these groups feel more supported and empowered and have the chance to see themselves as valuable, dignified citizens with the power of contributing positively to the solution of their own problems as well as helping others. Participation in these groups has been seen as an important step towards changing the stigmatised identity of the 'mental health patient' by leading members of the user movement (Chamberlin 1990; Lindow 1994). Chamberlin emphasises this point in her account of the American user movement in 1990:

> *By taking on a role other than that of the passive, needy client, self-help group members can change the systems with which they interact, as these systems adjust to respond to clients in their new roles as advocates and service providers.* (p.331)

The academic and professional community has recently turned its interest to the study of self-help/mutual aid groups. The reasons for this interest are not always very clear. Some scholars regard these groups as a 'lay' form of psychotherapeutic professionally led groups and they attempt to analyse them using traditional experimental methods. This approach fails to understand the core character of these groups, that in fact they are peer-led, with little or no professional involvement and the main purpose is to offer mutual support and empathy instead of therapeutic solutions to their common condition/problem. Other researchers, more sensitive to the uniqueness of the phenomenon, seek to comprehend the ways these groups function and, recognising the fact that this is an uncharted territory, they apply alternative methodological paradigms.

My personal experiences

From the beginning of my studies as a mental health worker, I was very concerned about the social stigma attached to people who experience mental health problems. I was especially sceptical of the way that clinical psychologists (my field of speciality) were addressing the issue of 'stigmatised identities' of their clients. From my own experience as a trainee clinical psychologist in Greece, I saw that mental health service users were treated as the

'passive objects' of a psychological therapeutic intervention. Although they were usually expected to comply with the diagnosis and treatment of their therapist, they were not given any real choice or any 'space' to express themselves and take real control of this process. When I got involved with a research programme about the reception of economic refugees from the ex-Soviet Union in my country, I was introduced to the concept of self-help/mutual aid groups and had the chance to witness their great potential for empowering people. In that particular study, my role as a researcher was to present the idea of self help and mutual support to people with a particular problem (e.g. refugees) and to act as facilitator in order to set up self-help/mutual aid groups in city neighbourhoods. Through this experience, I had the opportunity to reflect on issues that I have been preoccupied with since my training days such as the unbalance of power relations between helping professions and the receivers of such 'help', the processes through which people can take back control of their problems, and the ways that mental health professionals can help in these processes. Also, my work with these groups led to a series of questions about their way of operation and beneficial outcomes for their members. The groups I was helping to set up were, contrary to the spontaneous character of the 'natural' self-help groups, initiated by professionals and not by the people themselves. Moreover, they were addressing practical problems (e.g. economic difficulties that refugees encounter after their entry to a foreign country) rather than issues concerning their mental health. Another important issue was the difficulty in obtaining funding in order to continue their work.

Looking at the relevant literature, I realised that this area was quite unexplored by the academia world-wide. The existing research was mainly focused on specific well-established self-help organisations/groups (like the Alcoholics Anonymous), ignoring a great variety of groups that started in more recent years. Also, a lot of researchers were confining themselves to the observation of group meetings with little attempt to explore more systematically crucial factors of the self-help phenomenon such their socio-political attitudes, help-giving activities occurring during meetings and components of personal empowerment.

The socio-political importance of self-help/mutual aid groups was even more relevant to the changes that were taking place in the British welfare system during the period of my doctoral studies, 1995 to 1998. In this period, significant political changes took place, namely the transition from a Conservative to a Labour Government in May 1997. This change subsequently led to a shift in health and social care policies. In general, there was a continuity in the emphasis on consumerism and on client satisfaction. However, The Labour Government expressed a renewed interest in service user involvement in consultation of

service design and improvement as well as an acknowledgement of users' rights as equal citizens (Means and Smith 1998).

Broad scope and overview of the thesis

Motivated by my past experience with self-help/mutual aid groups and my wish to explore in depth their character, I decided to undertake a doctoral research project. The main purpose of the present study was to describe in a systematic way the phenomenon of self-help/mutual aid groups of people who experience mental health problems in terms of political ideology, psychosocial processes and outcomes. Specifically, the aims of the study were:

a) To meet and collaborate with different types of self-help/mutual aid groups of people experiencing mental health problems and to describe their profile.
b) To explore the relationship between the ideological type/focus of change of a self-help group and the psychosocial outcomes for its members.
c) And finally, for the better understanding of the self-help phenomenon, to compare different types of self-help/mutual aid groups and to assess differences in group processes and outcomes for their members through time.

The plan of my thesis follows the different stages of the research project. In Chapter One, I introduce the reader to the main theme of my thesis and discuss the relevant literature about self-help/mutual aid groups. Also, I introduce the issues that I find important and worth investigating in my study. The purpose of Chapter Two is to present the methodological particularities of research in this area and, therefore, the choice of methodologies I used in my project. In this chapter, I outline the specific research objectives and the various stages of the study as well as describing the sample and the research tools used. A detailed account of the participating self-help organisations and groups is given in Chapter Three. Specifically, I present their structural and organisational characteristics based on each organisation's/group's written material, my own field notes from participant observation of group meetings and interviews of group leaders/facilitators/chairpersons. Also, I describe how I categorised the groups according to their political ideology and focus of change. Chapters Four, Five and Six include quantitative findings of the two Phases of the study. In these chapters, I present results from the statistical analysis of the data collected in Phase One and Two of the study and relationships between the factors studied. I also discuss differences between types of self-help/mutual aid groups as well as changes of group members through time. Chapter Seven includes discussion of the findings in relation to previous research and feedback from participating groups. In this last chapter of the thesis I delineate the contributions of the study to the advancement of knowledge about self help and

mutual aid as well as issues that have arisen for future research. Finally, based on my findings, I make recommendations about professional education, mental health service development and social policy issues.

CHAPTER ONE

Self Help and Mutual Aid: An overview of the literature

1.1. Introduction

During the last two decades, there has been a vast expansion in the activities of groups devoted to self help and mutual aid[1] in the Western countries (Katz and Bender 1990; Riessman and Carroll 1995; Kurtz 1997). This development has important political implications as it presents a provocation to the conventions of post-war welfarism as well as to the older traditions of charity and voluntarism. The power of the phenomenon is also evident in the multifarious nature of groups' focal problem/condition/issue. Presently, there are self-help/mutual aid groups for an overwhelming range of social and health issues, covering "a complete life-cycle", as Orford (1992) points out at his account of self help within the realm of community psychology.

Recognising their socio-political singularity, Wann (1995) emphasises that "*self help and mutual aid stress personal responsibility and interdependence, as well as direct, local action. They present an ethos which is empowering and enabling rather than protective, prescriptive or philanthropic*" (p.1). These characteristics of self help, namely mutuality, egalitarianism and empowerment, constitute a major challenge to the power of professional groups and especially in the field of mental health given the fact that statutory services in many countries face a plethora of important financial and organisational problems.

At the moment there is a growing interest on behalf of the researchers and the activists in the self help domain and a range of questions have already arisen concerning the future of this movement (Riessman 1990; Chesler 1991a). Whether these activities should continue to be regarded as marginal or should play a regenerating role to the welfare state for the 21st century, it is a phenomenon which is worth investigating and evaluating.

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1 The terms 'self help' and 'mutual aid' are often used interchangeably in the literature and therefore in the present thesis. Although 'self help' is the term mostly used by the vast majority of people, 'mutual aid' may be more appropriate because, as I discuss later in this chapter, it more clearly delineates the most salient aspect of these groups and organisations. However, for the sake of economy, these groups often will be referred simply as "self-help/mutual aid" ones.

1.2. Literature review of self-help groups

1.2.1. Origins

Although self help activity is probably as old as the history of people living in communities, it has taken different forms and meanings through time. Adams (1990) claims that in Britain it is viewed by many people as a creation of the 1979 Conservative Government, or as an import from the self-help boom in the US, which has developed during the last fifty years. Kurtz (1990), an American self-help scholar, remarks that, according to the researchers who studied the self-help movement in the States during the 1980s, the growth of the movement was a response to industrialisation, the breakdown of family kinship systems, and the decline of the community. However its origins certainly go much further back than the 1980s.

Self help may be a neutral descriptive term which has acquired significance through the historical and social context in which it has become popular. The multifaceted nature of self help can be seen in its contradictory origins reported by the scholars who study this area (Katz and Bender 1976a; Adams 1990; Wann 1995); such are the works of Smiles (1859; reprinted 1883) and Kropotkin (1914; reprinted 1989) as well as the development of Friendly Societies in England (14th-19th century) and the Trade Unions in the United States (beginnings of 20th century).

In the works of Smiles and Kropotkin, one can find the contrasting uses of the term 'self help', which can be seen as a highly individualist act or as a form of collective action. Specifically, Smiles, a writer in mid-Victorian England, conceptualised self-help as an expression of individualism, since it involves activities whereby individuals and small groups deal with their problems. Self help is, according to Smiles, individual effort and self-improvement, and has no relation to the activities of governments and charities. Kropotkin, on the other hand, stressed the importance of collective action. Writing before the Russian Revolution, he described mutual aid as a natural force, which bound people together. Common interest groups transcending kinship or propinquity ties appeared very early and were widespread among ancient societies. The goal, according to Kropotkin, was a nationally healthy community, in order to fulfil the individual and provide insurance against people's loss of control over their own lives by improving their participation in the local community. He agreed with Smiles that self help was irrelevant to governments' activities and philanthropic organisations.

As Katz and Bender (1976b) suggest in their historical review, the first self-help/mutual aid groups were created in England of the late 18th century by working class people who were

trying to cope with the stresses of industrialism, poverty and disablement. These groups were the 'Friendly Societies', the chief mutual-aid organisations served both to deal with the immediate needs of their members but served also to politicise them, that is as a means to "raise their consciousness" in order to achieve social change. There seems to be a great similarity in the ideological and behavioural conformity of both the prototypical British Friendly Society and some contemporary self-help groups. Friendly Societies were locally organised and directed, self-governing and multifunctional; the preambles of these societies emphasised the continual need for mutual assistance and support.

At the beginnings of the 20th century, mutual aid activities started taking place at the United States in the form of Trade Unions, very similar to the Friendly Societies, "*a place of refuge and support during strikes and periods of unemployment*" (Katz and Bender 1976b). These unions were also involved in practical matters such as organising co-operative housing projects and union labour banks, as well as worker (adult) education and representation of ethnic minorities' workers.

Since the 1970s, self help has been influenced by developments in state welfare and policies, namely the turn to "care in the community" and the emphasis on strengthening of community facilities, as well as the evolution of the women's movement and the consciousness-raising groups formed in order to support socially disadvantaged people (Wann 1995). Both movements were committed to enabling individuals and groups to become more powerful and determine their own destinies, to gain confidence and learn new skills, to stand up for their rights and to negotiate with professionals and others in authority. Self help characterised many of the practices of these groups. Together with the disability rights and the gay rights movement, these 'new' social movements provided an important model for present-day self-help advocacy as it is expressed in a large number of advocacy-oriented self-help groups, especially in the mental health area.

Despite their historically radical or social change oriented goals, many modern self-help groups are conservative, reflecting the values of middle-class society, with respect to social change, to the point of being organisationally unaffiliated and concerned only with individual change ("growth") through group support (Emerick 1991). Relevant to this observation is the view presented by Giddens (1998) about the rising importance of individualism in the modern society. According to his analysis, the growing emphasis on individualism by newer generations does not mean that we witness the rise of a 'me' generation, a 'me-first' society where common values and public concerns are destroyed. In contrary, he believes that the new individualism "*is associated with the retreat of tradition*

and custom from our lives...[and] *goes hand in hand with pressures towards greater democratisation*" (p.36-37). In this respect, the growth of individual change self-help groups reflects these societal changes and does not connote destruction of social solidarity.

1.2.2. Definitions

Reviewing the literature, it becomes obvious that there is a lack of consensus in contemporary definitions of self help; a fact that is justified by the multifaceted nature of self-help/mutual aid groups and the wide variety of processes that take place in them. First of all, there is a confusion about which group can be called self-help/mutual aid and, consequently, these misunderstandings have influenced research about self help, as Humphreys and Rappaport (1994) clearly point out at their discussion around methodological issues in self help research. They refer to difficulties in the use of the term self-help group. These arise partly because the term is inaccurate, as it does not explicitly include one important feature of these groups, the mutual supportive atmosphere of groups, suggesting instead an ethos of individualism. Despite this problem, the term self-help group is preferred by group members and remains the one that is well known and mostly used by all concerned parties.

For research purposes, scholars have tried to construct a definition. A widely quoted definition is by Katz and Bender (1976a), reporting self help as group activity. They define self-help groups as:

> *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.* (p. 9)

In their pioneering work, Katz and Bender highlighted some basic characteristics of self help groups. Some of these are: the members' disappointment, or even rejection, of the existing social institutions, the emphasis on face-to-face interactions and the assumption of personal responsibility by members, the provision of material assistance as well as emotional support, and the promotion of an ideology or values through which members can obtain an enhanced sense of personal identity.

All of the above elements are valid for a majority of self-help groups, nonetheless there are still characteristics that can be added to this description and that depend heavily on the fact

that these groups may be very different from each other and that they evolve rapidly through time. According to the German Association of Self Help Supporters (cited in Wann 1995) self-help groups do not want to make a (commercial) profit but they aim to change the personal life situations of their members and often influence their social and political environment; in their meetings they stress authenticity, equality, a common language and mutual aid; the group is a means to counteract outer (social) as well as inner (psychological) isolation; the goals of self help groups focus on their members, and not on outsiders; self-help groups are not led by professional helpers but some consult experts now and again on particular questions.

The above characteristics are contained in other more recent efforts to define these groups, such as this of Kurtz (1997), with the reservation that it is a description of the "ideal type" in its pure form and that rarely represents reality adequately. Actual groups may have some but not all of the characteristics mentioned in the ideal type. According Kurtz this type is:

> *...a supportive, educational, usually change-oriented mutual-aid group that addresses a single life problem or condition shared by all members. Its purpose may be personal or societal change or both, achieved through the use of ideologies for dealing with a situation. Its leadership is indigenous to the group's members; participation and contributions are voluntary ... Professionals rarely have an active role in the group's activities, unless they participate as members. Boundaries include all who qualify for membership by having the problem, the situation, or an identity in common with other members.* (p. 4)

Another way of defining the nature of self-help groups is to consider their differences from other similar kinds of existing groups like support and psychotherapy groups. Although they have many characteristics in common, the three are not the same kind of group. According to Schopler and Galinsky (1995), support groups can be conceptualised as the centre of a continuum of these group interventions, overlapping with self-help groups at one end and psychotherapy (treatment) groups at the other. A major difference between support and self-help groups is that that the former are professionally facilitated, linked to a social agency or a larger, formal organisation, and limited to offering emotional support and education. In contrast, self-help groups are peer-led, not necessarily affiliated to a large organisation, and aiming at effecting change. At the two extreme ends of this continuum, self-help and psychotherapy groups have in common an interest in achieving personal change for their members. However their difference is that the former have a professional therapist to

achieve this change, instead self-help groups rely solely on the knowledge of their members to effect personal or societal change.

A great difficulty concerning the definition of self help is that it is a evolving phenomenon expressed in various forms and there are major controversial issues that need to be addressed in order to define self help in a comprehensive way. As Posner (1989) notes in her account of definitions of self-help groups, in practice, the development of self help activity is taking new forms that cut across previously defined categories and there is need to update existing definitions.

Additionally, it is important to point out that the cultural elements of the self-help phenomenon should not be ignored. Gidron and Chesler (1994), in their discussion of the international nature of self-help, note that nations have differing arrangements for caring for people and these differences are reflected in governments' attitudes towards self-help/mutual aid groups. Therefore, the government may provide support to self-help groups as part of the state's responsibility, as it is the case of Western European countries that have a welfare state orientation. Alternatively, self-help groups may result from an anti-social-welfare and voluntarist ideology that favours independence of government service - as in the case of the United States where the state supports the idea of self-help as an explicit spur tovoluntaristic and private alternatives to state activity and service.

In either case there is an ethos that exists in all forms of self-help, which Riessman and Carroll (1995) define as "*a constellation of norms and sentiments, a series of themes that underlie behavior*" (p. 5). These themes are the 'anti-big', anti-bureaucratic, non-hierarchical character of self-help, the reaffirmation of basic core traditions of community such as neighbourhood, spiritual values, and self-reliance, the empowerment process and the democratisation of everyday life in the sense of demystification of mental and physical illness, 'anti-elitism' and 'anti-expertism'.

Consistent with Riessman and Carroll's self-help ethos, Gidron and Chesler (1994) describe the universal attributes of self-help:

> *The recruitment and mobilization of peers in an informal and non-hierarchical setting, and the sharing of their common experiences, are the basic building blocks for almost all forms of self-help, in all nations and cultures. Under these conditions, all members have an opportunity to see their personal problems in a new light, to collectivize and legitimize their understandings and reactions, and to adopt active and empowered roles in coping with life dilemmas. The opportunity not only to receive help from others, but to provide it*

to others, also is empowering. Thus, self-help reemphasizes the importance and even the indispensability of the human bond among peers as a mechanism of communication around difficult issues, and as a mechanism with healing power. While different groups, and even different forms of self-help, emphasize different aspects of this process, in different ways and degrees, they almost all share this basic paradigm. (p. 3)

In describing self-help groups, we usually refer to certain common activities encountered in them such as (Wann 1995, Kurtz 1997):

- *Emotional support*, provided to members by other members with similar experiences and problems.
- *Information about the condition or problem around which the group is formed*, provided in the form of small resources of literature and audio-visual material, leaflets and booklets in accessible language, talks by professionals with specialist knowledge.
- *Advice and practical help*, based on members' own experience and wider knowledge (e.g. telephone help lines run by the group).
- *Recruiting new members*, enriching in this way the group's store of knowledge and empowering the group.
- *Publicity and education*, in order to attract new members, make themselves known to potential funding bodies and professionals, as well as educate the wider public about their issue of concern.
- *Fund raising*, for enabling the group to continue existing and organise activities.
- *Campaigning*, when a group has identified bad practice or a lack of suitable services.

1.2.3. Typologies

The difficulty of defining self-help groups is also apparent in their categorisation. Self-help groups sometimes have a central focus of activities and can be distinguished but, most of the time, are involved in various activities. Moreover, they evolve through time, they can change their profile, or new kinds of groups may appear (Adams 1990; Riessman 1992).

However, by and large self-help groups can fit in some general types which may be used as an indication of their large variety. One of the first efforts to categorise groups was the typology of Katz and Bender (1976a) based on their survey and personal observations. They classified self-help groups according to their primary or central focus of activity, viz.:

- individual self-fulfilment or personal growth,
- social advocacy,
- creating alternative patterns of living,
- providing refuge (usually residential) for desperate people who are seeking protection from the pressures of life, and
- groups with no single primary focus of activity but in which several important directions of effort or attention coexist.

A similar categorisation of self-help groups was developed by Levy (1976) and was based on a study of six national self-help groups. He identified groups orientated to:

- behavioural control or conduct reorganisation,
- coping with stress and to provide support,
- personal or collective survival,
- personal growth and self-actualisation.

A problem common to the above typologies is that they are not based on a large representative sample of self-help/mutual aid groups, instead the authors admittedly considered selected organisations and groups. Also, in the proposed categories, self-help/mutual aid groups are perceived within the framework of professional human services, that is the authors examine the 'services' these groups may offer to their members without looking more thoroughly into socio-political effects they may inflict in their lives. Moreover, they are limited as their point of reference to the self-help movement in North America.

Another effort to categorise self-help/mutual aid groups was made by Schubert and Borkman in 1991, from an organisational point of view. They propose a typology to classify local-level groups according to the degree of their dependence on a larger organisation. There are two major criteria for this kind of classification: 'resource dependence' and 'authority to make decisions'. Schubert and Borkman argue that groups present a distinct 'pattern of dependency' on external sources and decision-making authority. According to this typology, groups can be categorised as follows:

1. *Unaffiliated groups*. These groups are local and independent, with no relationship with an external source of leadership, funding or policy.

2. *Federated groups*. Groups in this category have a relationship with a larger organisation but they are autonomous; however, they have access to resources provided by the national organisation.

3. *Affiliated groups*. These groups are dependent on higher levels of their national organisation which has the power to impose policy and authorise the groups to act as an affiliate.

4. *Managed groups*. Groups in this category are monitored and controlled by professionals. They employ a combination of self-help and professional techniques and belong to a non-self-help organisation.

5. *Hybrid groups*. These groups are a combination of affiliated and managed groups. They are organised by a higher level of a national organisation, as the affiliated groups, and use professional expertise along with peer experiential knowledge to address members' issues.

Once again, one of the disadvantages of this typology is that having as a point of reference the North American self help scene, it does not consider organisational varieties of self-help organisations/groups that can be found in other parts of the world. In addition, the authors have also included groups that have not a genuine self-help/mutual aid character in the sense that they are not strictly peer-led (e.g. managed and hybrid groups). This point invokes confusion between self-help/mutual aid and other types of groups such as support and therapy groups. Nonetheless, in this categorisation, the authors have moved on from the restrained area of the professional human services and they consider the groups' socio-economic connections thus looking at aspects of their social identity.

From a merely sociological perspective, Emerick (1991) differentiates self-help groups according to their political ideology. He is especially interested in the mental health self-help movement and analyses a national sample of ex-mental patient self-help groups (number of groups: 104) according to four factors: two structural variables called "group affiliation" and "professional evaluation", and two types of interactional support: the level of "organisational interaction" and the level of "institutional interaction". "Group affiliation" refers to both groups' public affiliational identity and their self-help organisational affiliation; "professional evaluation" is a composite dimension based on a group's evaluation of traditional psychiatry. By level of "organisational interaction", Emerick implies the group's level interaction with other self-help groups or organisations, and the level of "institutional interaction" is the group's level of interaction with professionals. These structural and

dynamical variables specify the ideological type of a self-help group and, according to this classification, there are three types of groups:

- *The social movement (radical) groups*, which are politically active and they aim to a) change the mental health system away from its traditional individualistic and biological models, toward social and political ones, b) raise the political consciousness of former mental patients and, c) promote "empowered", positive and non-psychiatric identities through self-help activities. These groups may affiliate loosely with local or developing national movement organisations, are anti-psychiatry and provide their members with opportunities for involvement in political activism, legal advocacy work and other "social change" types of activities.

- *The individual therapy (conservative) groups*, which are politically conservative, pro-psychiatry and formally affiliated with a national self-help organisation that promotes a particular self-help "method". These groups provide their members with some form of "alternative therapy" directed toward individual growth. The notion of "alternative therapy" refers to the adoption of a social support model that is relatively non-threatening to mental health professionals concerned about loss of control to the more independent forms of self-help.

- *The moderate groups*, that stand mid-way between the other two types in terms of both political ideology and such structural factors as organisational affiliation. They are engaged in a broad range of activities and their organisational affiliations reflect their political neutrality.

Emerick's typology offers a very interesting perspective on the way that self-help groups can be conceived and is based on his understanding of the self-help phenomenon as a "new social movement", a claim which was made by others elsewhere (McLean 1995; Humphreys and Rappaport 1994; Everett 1994; Chesler 1991a; Kurtz 1990; Katz 1981). It has provoked a lot of discussion especially among sociologists. The main point for this characterisation is that the developing self-help movement has important political and ideological implications for the health delivery system as its primary actors are the mental health users themselves who become self-activated and attempt to take an energetic role to solve their problems, often criticising the faults of traditional health care systems and even challenging the knowledge of experts with their own experiential knowledge. Thus, there is a potential force in the self-help movement to effect social change via its influence to the recipients of the services and, consequently, to play a role in the renovation of the health care system. This

conceptualisation of the self-help phenomenon is consistent with the main characteristics of a social movement, according to Goldberg's (1991; cited in Everett 1994) definition: "*a social movement is a formally organised group that acts consciously and with some continuity to promote or to resist change through collective action*". The so-called 'new social movements', such as the gay movement, the women's conscious-raising campaign and the ex-patients/consumers/survivors' movement, have become part of the social life. They have common aims and these are to point out the importance of the symbolic change as a first step towards the real change, to make the mechanisms and uses of power visible and to highlight the connection of individual change and collective action, as "the personal is the political" (Everett 1994).

However, not all self-help groups can appropriately be considered as a part of a social movement, as Chesler (1991a) notes at his account of consumer activism in health care. It appears that groups that focus solely on individual's psychological needs rather than aiming on external changes, do not share the characteristics of a social movement. Nevertheless, all these variants have their roots in the same structural conflict underlying user-provider relations in the care of people who experience distress, the implicit challenge to the professional monopoly and ideology of service and, the element of empowerment of their members. Chesler even suggests that the internally focused groups may best be considered quasi-social movement organisations as a lot of them are engaged in social change efforts as part of their regular activities. Overall, he emphasises the importance of the social movement perspective to self-help groups in order to reserve their autonomous alternative identity and to offer a chance to service users of having active and empowered roles and advocating for themselves and others.

Looking from a similar angle, Kurtz suggests categorising self-help groups according to the degree and type of change desired by their members (Kurtz 1997). Following this typology, there are two broad categories of self-help groups:

- *Personal-change groups*, which are primarily interested in their members' individual change.

- *No personal-change groups*, which are mainly educational and supportive, without using behaviour-change ideologies, or/and pursue advocacy objectives.

Kurtz's categorisation, although general, has positive elements as it puts the focus of attention on the criterion of the desired outcome from group participation and allows a variety of different groups to fall into one of the two categories. This distinction is more

clear for the first type of groups, personal-change, as the orientation is obvious from the beginning as in the case of Alcoholics Anonymous, where the person has to decide that he/she wants to change his/her behaviour. However, the latter type is less apparent as there are cases where groups have a supportive/educational or advocative character but at the same time they may have a personal-change orientation.

Both Emerick and Kurtz, in their efforts to conceptualise a typology, consider the socio-political potential of self-help/mutual aid groups, implicitly or explicitly positioning them in the context of a social movement. Members are seen as people who make conscious choices towards their active involvement in altering their lives as well as their peers' lives. So, under this light, the main concern of a categorisation would be the direction of this change. There were previous attempts to categorise groups in a likewise manner. A similar suggestion was made much earlier by Sagarin (1969), who perceived two broad categories of self-help/mutual aid groups: those focusing on helping the individual members to overcome their common problem and those focusing on the change of public attitudes towards the problem/condition/issue that the group was addressing. Although in the same spirit, this suggestion did not consider however important elements mentioned by the other two typologies presented above, namely groups' interactions with professionals and other organisations, evaluations of the existing system, along with the supportive function of these groups. Conclusively, Emerick's and Kurtz's typologies are more comprehensive in the sense that they both ascribe a political meaning to self-help/mutual aid groups, allowing simultaneously the researcher to study a wide range of important psychosocial factors instead of restricting the study of groups in the area of their therapeutic value.

1.2.4. Theoretical approaches to the self help phenomenon

The self help phenomenon has not yet been explained thoroughly by a single theoretical approach. Few efforts have been made by scholars of both the psychological and the sociological fields in order to offer an analysis of the mechanisms of self help. There are a number of reasons for this lack of theory. First of all, the phenomenon is very complex, variant and evolved very rapidly in the past two decades, making it difficult for scholars to keep up with it and understand in detail its dimensions. Secondly, researchers in relevant fields (such as psychology, sociology, anthropology, etc.) only recently have started to show interest in the study of self help as a distinct area that needs theoretical exploration due to its uniqueness. Finally, efforts to present a theoretical framework have been one-sided

explaining partially the multifaceted phenomenon of self-help and consisted of descriptive case-studies, based on clinical observations or anecdotal evidence (Suler 1984; Kurtz 1990; Humphreys and Rappaport 1994).

However, researchers and scholars of the self-help movement have drawn from existing psychological theories and have applied a variety of concepts in their attempt to explain the process, outcomes and therapeutic value of these groups. From a psychological point of view, there are numerous theories about groups dynamics and processes and that can be applied to theoretically explain how groups help their members, as Kurtz (1990) reports in her literature review about the self help movement. A lot of these theories like the social support buffering hypothesis (Cohen and Wills 1985), cognitive-behaviour mechanisms (Bandura 1982), reference group and affiliation theory (Schachter 1959; cited in Baron et al 1992), and self-esteem (Rosenberg 1965), offer elements that help to explain some of the mechanisms of self-help groups. However, as Stewart (1990a) correctly points out, they have important weaknesses due to the fact that they either refer to groups in a generalised way and not to the specific type of self-help groups or they have not been tested methodologically as frameworks in self-help group studies. Thus, their contribution remains speculative. Nevertheless, theoretical understandings of group mechanisms as well as group helping processes offer a basis for the self-help researcher to analyse and conceive the particular frameworks that are able to explain the functional elements of mutual aid groups and their contribution to members' wellbeing.

Empowerment

One of the key themes that the majority of scholars discuss about mutual help is a term that has been widely used for contemporary social issues, the term empowerment. This term has been used with a variety of different meanings depending on the context of reference, such as psychology, politics, sociology, theology and many others. However, in all these views, the main elements of empowerment are the contrast to the traditional existing status quo and the emphasis on the person 's control over his/her life and awareness of his/her positive influence to the community.

Referring to the mental health issues, Rappaport (1985) talks about the "empowerment language" as an alternative terminology which can replace the traditional medical one that has created increasing stress and dependence of service users upon the medical bureaucracy, while reducing individual choice and self care. He argues in favour of a new culture, a new

ethos that will replace the "iatrogenic" model of health professionals who present themselves as "experts" controlling the healing process of people instead of working with them towards their change. The new ethos is well exemplified by mutual help activities where people help others as well as themselves, gaining consciousness of their own healing powers and, ultimately, feeling empowered. This is the reason why empowerment is considered as "*the fundamental ideology underlying the psychiatric consumer movement and the philosophical basis of its alternatives* ... [and] *a generic concept within grass roots movements*" (McLean 1995, p.1053).

In the light of its complexity and multidimensionality, empowerment can be more easily comprehended by its absence. For example, many writers who review the socio-political status quo of mental health services users, like Barham (1993) and McLean (1995), consider that users feel helpless and disempowered as a result of their experiences within the 'old' traditional system of care. Rappaport (1985, 1987) argues that empowerment embodies both psychological and political dimensions because it includes considerations of personal efficacy (i.e. one's sense of control over one's life), issues of social justice, human rights, self worth and human dignity as well as conceptions of one's political efficacy (i.e. one's ability to make a difference in the social status quo). Moreover, many scholars have described empowerment as a life-long process rather than a stable trait of a person, emphasising its dynamic and evolving attributes (Segal et al. 1993;Chanberlin 1997; Rogers et al. 1997).

There are different levels of empowerment, according to the context where the term is used: the individual (or psychological), the group and the community (or organisational) level (McLean 1995; Israel et al. 1994). In her analysis of empowerment, McLean explains that empowerment, at the individual level, refers to interpersonal and organisational processes:

> *It develops when individuals regain faith in the validity of their own perceptions, but may be perceived only as they begin to relate their experiences to others. Confirmation from others who have shared their experiences may provide necessary sources of external validation of their own experiences.* (p.1057)

At this level empowerment refers to the individual's ability to make decisions and have control over his/her personal life. It is similar to other constructs such as self-efficacy (Bandura 1982), self-esteem (Rosenberg 1965) in the point of development of a positive self-concept or personal competence. Additionally, individual (or psychological) empowerment includes the establishment of a critical understanding of the social and political circumstances and the advancement of both individual and collective skills for

social action (Israel et al. 1994). Thus, empowerment at the individual level combines a) personal efficacy and competence, b) a sense of mastery and control, and c) a process of participation to influence institutions and decisions.

Empowering processes may also occur at the group level, through mutual help activities, where individuals are enabled to increase their control within the group, helping each other and legitimating their experiences. A step further is empowerment at the community (or organisational) level where the aim is to effect change in social policy within the community and broader society. These latter two levels of empowerment refer to the "politicisation process", mentioned by Riessman (1985), that occurs to individuals as they move beyond self-awareness to an awareness of larger social issues that influence their condition. Through this process of realisation they are motivated to meaningful political praxis and become engaged to advocacy activities. Thus, the three levels of empowerment must be seen as a continuum where empowered people act towards the change of their environment (Riessman 1985).

With relevance to the concept of empowerment, Riessman (1965) suggested the "helper-therapy principle" is one of the most powerful mechanisms in mutual aid groups. In its simplest form, this principle suggests that in the act of helping another, the member is empowered to help others and simultaneously to help him or herself. Although this may be true of all helpers, whether they are professionals, volunteers, or whatever, it is more sharply true for helpers who have the same problem as the helped. People who have a particular problem may be helped in much more specific ways by providing help to others who have the same specific problem.

The empowering features of this principle may be seen in the mechanisms offered to explain its potential strength, such as Skovholt's explanation (1974; quoted in Gartner and Riessman 1977). The effective helper, according to him, receives as benefits of helping "an increased level of interpersonal competence", "a sense of equality in giving and taking between himself/herself and others", "valuable personalised learning", and "social approval from the people he/she helps". Thus, the helper becomes less dependent, learns about his/her problem from his/her experience of helping others, and obtains a sense of social usefulness and esteem. The helper therapy principle describes quite appropriately the condition of self-help groups as members are both helpers and helped and have the opportunity to become empowered through these roles.

Experiential knowledge - Social learning

Another theoretical framework to conceptualise the function of self-help groups is that of "experiential knowledge", presented by Borkman (1976). According to her analysis, experiential knowledge serves as a primary source of truth in self-help groups and competes with professional knowledge, which is the foundation of expertise in most human service organisations. This type of knowledge distinguishes self-help groups from their professionally based equivalents and is defined by Borkman as:

> ... *truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others ... The two most important elements of experiential knowledge are 1) the type of "information" on which it is based and 2) one's attitude toward that information.* (p. 446)

By type of information Borkman means wisdom and know-how gained from personal experience instead of isolated bits of events and feelings upon which a person has not reflected. This knowledge is concrete, specific, and has to make common sense since it is based on the individual's actual experience which is unique, limited and, by and large, very similar to the experience of others who have the same problem. On the other hand, people have confidence in the validity of such information. Experiences coming from direct participation in a situation constitute a type of knowledge which is more believable by people who face similar situations. Additionally, this kind of information is shared among self-help group members thus reinforcing their belief in it.

Another concept introduced by Borkman is experiential expertise, that is "*the competence or skill in handling or resolving a problem through the use of one's own experience*" (p. 447). This concept refers to the actual application of experiential knowledge towards successful coping and is closely related to the degree of involvement of self-help group members. The longer the member stays at the group, Borkman suggests, the better he/she can integrate the knowledge and use it successfully. Consequently, the old-timer member "*becomes both a role model and a source of hope*" for the others.

In contrast to experiential knowledge and expertise, professional knowledge is claimed by people trained in a specific occupation. It is characterised traditionally by elitism and authority as access to this kind of knowledge is limited to those who meet the criteria of specialised education and formal training, and it tends to be imposed on people as the "sole truth" without questioning. Self-help consist are a non-traditional area where experiential

knowledge is the primary basis of authority and where professionals' expertise is usually challenged. The relationship between these two types of knowledge is a subject of debate due to the fact that it involves a re-examination of professional models in the light of their flexibility to include experiential knowledge as a crucial input for comprehensive approaches to problems.

The usefulness of experiential knowledge derives from the fact that it can be largely shared in environments such as self-help groups by pooling the experiences of a number of people, thus extracting the common elements of a problem and attempts to cope with it. Consequently, the individual realises how his/her problem is both similar to and different from that of others, which drives him/her to utilise the knowledge adjusted to his/her situation.

Borkman's conception of experiential knowledge can be examined in terms of a well-known theoretical framework, the social learning theory developed by Bandura (1982). Social learning theory synthesises cognitive, behavioural, emotional, and environmental explanations of learning and behavioural changes. Specifically, it postulates that personal and situational influences can alter coping behaviour and transactions with the social environment. This is accomplished mainly through role modelling, reinforcement, enhanced self-efficacy, cognitive restructuring and vicarious learning.

Role modelling, a primary concept of social learning theory and an important component of helping relationships, is thought to happen in self-help group meetings as peers with a history of successful coping serve as role models to others and enhance experiential knowledge. This knowledge is thus reinforced among self-help group members. As a result, new information and new perspectives on difficult situations stimulate cognitive re-framing and new vocabularies with which to understand one's condition. Learning can occur by mutual exchange of first-hand experiences, that is experiential knowledge, as well as observation and comparison with others (Stewart 1990a). This learning constitutes an important basis for self-knowledge about personal efficacy, thus altering positively perceived self-efficacy, the way that individuals think about themselves and improving their well-being.

Stewart (1990), attempting to propose new theoretical settings for the study of self-help groups, refers to Katz' s (1985, quoted in Stewart 1990a) remark that "*though Borkman does not use their terminology, her descriptions parallel the concepts of role modelling and reinforcement advanced by ... social learning theorists*" (p. 59). She points out, however, that there is a lack of studies about self-help groups using social learning theories.

Nevertheless, the claim that self-help groups offer opportunities for social learning has been made by some scholars (Kurtz and Powell 1987; Kurtz 1990), especially in relevance to Twelve Steps groups where there is a structured programme with instructions to follow, veteran members serving as role models, and reinforcements of new behaviours as well as extinction of dysfunctional habits.

Social support

A common and obvious remark that can be made about the usefulness of self-help groups is that they serve as extended social networks and offer social support to their members (Pilisuk 1985; Maton 1988; Stewart 1990a). This becomes important if one considers that often the set of social relationships available to people in distress proves incapable of providing the necessary support.

Indeed, there is a considerable amount of evidence that social networks influence health and the general wellbeing of people. The most common explanation for an association between health and social networks states that social ties provide a buffering effect from stress, thereby reducing the vulnerability of an individual to stress-related illnesses (Cobb 1976; Thoits 1986; Heller et al. 1986). Other theories have emphasised the consequences of the absence of social ties such as the finding that people who are socially isolated and whose social ties have been recently disrupted are at increased risk for health breakdown and even for death (Cohen and Wills 1985; McColl et al 1995).

Support systems are multifaceted and, as Caplan (1974, quoted in Killilea 1976) states, many professions and formal community institutions as well as natural systems (such as the family, non-professional and informal social units, mutual help organisations) are potentially elements of support systems:

> *Support systems are attachments among individuals or between individuals and groups that serve to improve adaptive competence in dealing with short-term crises and life transitions as well as long-term challenges, stresses and privations through a) promoting emotional mastery, b) offering guidance regarding the field of relevant forces involved in expectable problems and methods of dealing with them, and c) providing feedback about an individual's behaviour that validates his* [sic] *conception of his* [sic] *own identity and fosters improved performance based on adequate self-evaluation.* (p. 2)

Following Caplan's definition of support systems, supportive social ties appear to be an essential preventive medicine. Thus, self-help groups become a valuable asset to an individual's social life as they may contribute not only to the combating of loneliness and the building of communication, but also to the prevention of illness and to recovery from disease (Pilisuk 1985).

As an extension of social support theories, Stewart (1990a) comments that there is a body of studies influenced by medical models that can prove useful to the understanding of the potential relationship of social support and immunity to disease. A new term is introduced in these studies, psychoneuroimmunology, and it is concerned with the complex bi-directional interactions between the central nervous system and the immune system (Stewart 1990a). Through psychosocial influences, such as social support, the disease-fighting ability of the immune system is strengthened. The psychoneuroimmunological empirical studies which have particular significance for self-help groups, according to Stewart, are those that focus on the physiological and immunological changes associated with bereavement, loneliness, and social isolation. Self-help groups can offer compensatory social ties through counteracting feelings of isolation and solitary by creating a sense of community and socially supporting their members.

It has been frequently pointed out by authors in the field (among them Katz and Bender 1976a; Gartner and Riessman 1977; Kurtz 1990; Wann 1995) that self-help groups have emerged through a crisis, or as a supplement to, helping natural support systems such as the family and kinship networks. The fact that they can be a prevalent and significant source of social support indicates their capacity of maximising the competence, both psychological and physiological, of people undergoing stressful life events. Although this link of social support and immunology offers a dynamic perspective to the health care field, only few empirical studies are based on this theoretical framework of self help (Vachon et al. 1980).

Ideology of the group

A common element of self-help groups is the existence of a set of beliefs or ideologies about their shared problem (or status). This is presented to group members as a means to help them understand their problem and/or cope with the situation that causes them distress.

Antze (1976) was one of the first theorists of self help who wrote about the role of ideologies in these groups. He mentions that a *"group's teachings are its very essence ... Participants absorb group ideas, not just as a creed, but as a living reality that is*

reconfirmed in each day's experience" (p. 273-274). These teachings are tailored to the specific group and its members and they can be more influential in their lives than any other of the group's processes.

With evident influence from cognitive-behaviour theories, mainly considering organisations with a formatted ideological framework such as Alcoholics Anonymous, Antze proposes that ideologies serve as cognitive antidotes to the basic condition that the participant wishes to change and these antidotes prevent the participant from relapsing to his/her previous problematic situation. A lot of researchers have shared Antze's opinion about the importance of ideology and there is a growing number of studies that report evidence of the influence of group ideology in members' lives (Rappaport et al. 1985; Rappaport 1993; Humphreys and Kaskutas 1995; Kennedy and Humphreys 1995).

Like Antze, Suler (1984) proposes that the ideology of self-help groups can offer a conceptual framework for understanding their therapeutic potential. He remarks that this ideology may be implicit or explicit, but in all cases it sets up the intended aims of the group and structures the self-help process. The power of the ideology relies on the core philosophical position of self help/mutual aid. This term connotes

> *egalitarianism, grass-roots decision making, and the ability to change oneself by one's own efforts - an aprofessional philosophy that opposes the more authoritarian therapeutic model that is typical of traditional human-service institutions. The therapeutic potential of the self-help ideology is its ability to encourage people to overcome powerlessness, to feel and use their own strength to resolve problems.* (p.30)

In his analysis of the parameters of ideology, Suler examines some basic issues that should be addressed in order to construct a typology of belief systems. These are:

a) the issue of the group making internal or external attributions about its members' problems,

b) the issue of members' identity management, including coping with stigmatised identities and transitions to new identities,

c) the issue of emphasis on social and expressive interactions within the group and

d) the issue of isolation or integration of the group in relevance to the outside world.

However, he acknowledges that the specificity and clarity of a self-help group's ideology may vary a lot in parallel to the specificity and clarity of the problem that this group has in common. Thereby, even though all groups may uphold, at least implicitly, the philosophical

basis of self help as their core belief, not all groups maintain a detailed belief system, such that of Alcoholics Anonymous.

It is interesting at this point to reflect on Suler's assertion that all groups have as their core ideological basis the same understanding of the self help ethos. For example, researchers of the Alcoholics Anonymous organisation and other twelve-step programmes, report that there is reference to a "universal order", that is recognition of some form of power greater that the self (Kurtz 1997). This belief is not compatible with the sense of empowerment that Suler considers as the strongest therapeutic influence of self-help groups. Moreover, the "aprofessional philosophy" as opposite to the authoritarian traditional models is not always shared by self-help groups; instead there are groups that support or even reinforce belief in professional authority among their members and they retain close relationships with them (Emerick 1991). Despite variations on the implementation of the self help philosophy, Suler's argument about a core belief that exists among all self-help groups may still hold. This belief is that experience must be appreciated and that experiential knowledge must be used for learning and changing the existing problematic situation. Differences in the way that groups direct their efforts for change, make them interestingly unique and shape their own ideology.

Consistent with Antze (1976) and Suler (1984), Kennedy and Humphreys (1994) emphasise the importance of beliefs that a self-help group holds and teaches to its members. They name these beliefs 'worldview' or 'assumptive world', a term used by Frank (1973, quoted in Kennedy and Humphreys 1994) to denote *"a highly structured, complex, interacting set of values, expectations and images of oneself and others, ... which are closely related to his[/her] emotional states and his[/her] feelings and well-being"* (p. 27). The term is similar to the notion of ideology but, according to the authors, it is more accurate to describe the entity of one's beliefs, attitudes and ways of thinking.

Changes in people's worldviews can occur in self-help group settings. There are three main reasons, according to Kennedy and Humphreys, for the importance of these changes among members. First, self-help groups constitute a community of belief and as such they adopt a particular set of beliefs which constitute an approach to life. The worldview of a group develops over time and is often recorded in the group's developing written material. Secondly, worldview changes have a role in psychological healing. A number of psychological theories (for example Kelly's (1955) personal construct theory) recognise that people are interactive interpreters of their environments and that the structure of an individual's interpretive world has strong influence on his/her psychological functioning. A

group's worldview can have the effect of decreasing anxiety and uncertainty for its members by offering them alternate interpretations of their experiences and guides in recovering and living. This point is taken by Suler (1984) as well, who emphasises the important role that self-help groups may play in people's lives: *"For those people experiencing a problem for which no help or information is offered by formal institutions, a self-help group may provide a cognitive structure that creates meaning and purpose"* (p. 30). The third reason for examining worldviews is that changes in beliefs are often accompanied by behavioural changes. This argument is supported by cognitive change theories such as Meichenbaum's (1975) which suggests that changes in attitudes, perceptions, attributions and interference processes result in changes in emotions and behaviour. Thus, internal processes that take place in self-help groups such as worldview transformation can be very helpful for their members' life improvement.

Kennedy and Humphreys (1994), based on their studies of American twelve-step programmes, suggested four life domains where changes in a group member's worldview can be assessed: a) experience of self as a result of the member's problem, b) beliefs about the existence of a universal order/Higher Power, c) relationships with others under the influence of the member's problem and d) understanding of the problem that brings the group together. However, they recognise the fact that this analysis is limited to organisations like Alcoholics Anonymous with articulated and well-documented worldviews and teachings and with an orientation to "ameliorator" groups that aim for individual change in their members. Discussing the generalisability of their conceptual framework of worldview transformation, they accept that in order to describe phenomenological changes in "redefiner" groups that aim to social change, there is need to include other domains such as political worldviews.

A different perspective on the process of identity transformation in self help was suggested by Rappaport (1993). A narrative framework views mutual help organisations as one of a number of potential communities of membership available to people, with narratives about themselves and their individual members. In this sense, the self-help group is a normative structure in social experience, similar to families, religious organisations, political parties, labour unions or other voluntary organisations. The members are not clients getting services and thus somehow different from other people. Moreover, according to this approach, people who elect to join mutual help groups are not necessarily deciding to obtain a "treatment", so much as making a choice that helps them to answer identity questions. In fact, Rappaport claims that the way that a self-help group provides its members with an

identity is through the narrative it tells about the community of membership, about how members change, and this narrative serves as a basis for change in one's personal identity story.

As community narrative Rappaport means *"a story repeatedly told among members of a setting [that] ... can be told directly, as in face-to-face interaction, or indirectly by means of written material, rituals, implicit expectations, shared events, and non-verbal behaviours"* (p. 247). On the other hand, a personal story *"is more private and more idiosyncratic. It serves the purposes of individual identity development, maintenance and change"* (p. 248). Self-help organisations can be viewed as a special class of communities in which an alternative identity is provided and those members who become highly involved do so by transforming their personal life stories so that they can conform to the community narrative. The emphasis on the power of the community narrative to change its members' life stories is consistent with the self-help ethos of empowerment (Riessman 1985). It highlights the influence that a self-help community can have on its members and the view that self-help groups are normative settings and not necessarily alternative treatments.

1.2.5. Helping factors and change mechanisms in self-help groups

The main purpose of self-help groups is to help and sometimes change their members. In this point, there is a lot of confusion among theorists and researchers as the ways of helping in self-help groups are both similar to and different from psychotherapy groups (Lieberman 1990). A major similarity between self-help and psychotherapy groups is that both help members to achieve change; the basic difference is that the former are self-managed whereas the latter are controlled by a professional therapist.

Lieberman (1990) offers a useful analytic framework for comparing the internal processes in self-help and psychotherapy groups. He presents five dimensions:

- *the group's technological complexity/simplicity*
- *a view of the group as a "social microcosm"*
- *the degree of differentiation among members*
- *the specificity-generality of helping methods*
- *the psychological distance between helper and helped*

The first point refers to the fact that group psychotherapy relies on complex technologies introduced by the group therapist. By *technological complexity*, Lieberman implies therapeutic methods based on theories about human behaviour and professional skills applied by the therapist in the group. In self-help groups there are non-professional leaders who represent specific group ideologies *"that define the problem and direct specific interventions"* (p. 266).

Lieberman explains that by *social microcosm*, he means that *"underneath activities in therapy groups lies the assumption that cure or change is based on the exploration and reworking of relationships in the group"* (p. 265). That is, the psychotherapy group serves as a microcosm of the society in which members have the opportunity to examine dysfunctional ways relating to the world. On the other hand, self-help groups de-emphasise transactions among members and do not give therapeutic value on these.

On the third point, Lieberman points out that psychotherapy group members usually deal with a variety of problems, are generally "differentiated" (different from each other) and their uniqueness is reinforced in the group meetings. Instead, self-help groups exist because their members share a common core issue and they emphasise this fact consistently.

On the issue of specificity of helping methods, professional therapists in psychotherapy groups are more specific on the way they help their clients than the generalised support offered by friends and family. However, the help offered in self-help groups is highly specified to the nature of their members' particular problem and, for this reason, is in general more specific than the methods used in psychotherapy groups.

The final point that Lieberman presents to contrast psychotherapy and self-help groups is the issue of the psychological distance between helper and helped. As a part of their specialised training professionals are taught to refrain from bringing their own problems to the group, limit contacts between themselves and group members, and emphasise their role as experts. In self-help groups, on the other hand, there is great psychological parity between the helper and those being helped as helpers share similar experiences of the condition. Moreover, peer control of the self-help group/organisation erases psychological distance among them as all members work as equals to solve their problems and there are no formal distinctions of helpers and clients.

In addition to the above points, Kurtz (1997) reports three more:

- *open versus closed boundaries*, referring to the fact that self-help groups admit anyone who qualifies for membership whereas therapy groups do not,

- *the charging of fees*, that is professional psychotherapists may charge fees for their services in the group (e.g. in the United States) whereas self-help groups rarely charge a fee and they are supported by small donations, and
- *dependence on extra-organisational support,* meaning that self-help groups rarely depend on outside support apart from their own national organisations and psychotherapy groups rely on social and mental agencies and facilities.

Differences between self-help and psychotherapy groups (Lieberman 1990; Kurtz 1997)

	SELF-HELP GROUPS	PSYCHOTHERAPY GROUPS
Technological complexity	LOW	HIGH
Group as social microcosm	LOW	HIGH
Differentiation of members	LOW	HIGH
Specificity of helping methods	HIGH	MODERATE
Psychological distance of helper/helped	LOW	HIGH
Boundaries of group membership	OPEN	CLOSED
Charging of fees for services	NO	YES
Extra-organisational support	NO	YES

Having examined the differences that exist between these two types of groups, psychotherapy and self-help, it is useful to consider the helping factors and change mechanisms of self-help groups. It has been pointed out by several theorists and researchers (Wollert et al. 1982; Lieberman 1990; Yalom 1995; Kurtz 1997) that some of the therapeutic factors identified in psychotherapy groups are also manifested in self-help groups in addition to others that are uniquely presented in the latter type of groups. Reviewing relevant studies, Kurtz (1997) reports some therapeutic factors known from the study of psychotherapy groups (Yalom 1995) and frequently encountered in self-help groups as well:

- *group cohesiveness*, the degree to which members feel trust and closeness to another,
- *instillation of hope*, the belief of members that they will be helped in the group, and
- *universality*, the realisation of members that others in the group are "in the same boat", have similar experiences with them.

In addition, Kurtz (1997) concludes from her review of research on group processes and change mechanisms that there are five helping processes observed in self-help groups:

- *giving support*, the benefit most often mentioned by members when asked what they have gained from membership (Kurtz 1988; Maton 1988),

- *imparting information*, another of the most important characteristics of the participation in self-help groups, which takes place during formal meetings (through discussion among members, presentations by invited speakers, distribution of bibliography and other relevant written material) and in informal socialising after the meeting,

- *conveying a sense of belonging*, through affiliation with the group that offers a new social network and support system for its member, thus becoming a normative structure similar to the family, or a religious organisation, or any other voluntary association (Rappaport 1993),

- *communicating experiential knowledge*, the specialised information and perspective that people obtain when they experience a condition and which is different from expert or lay knowledge in respect of its power to influence greatly self-help group members (Borkman 1990), and

- *teaching coping methods*, new methods for group members to cope with their problems, drawing on both expertise and experience and developing the ability to communicate in beneficial ways for improved relationships.

Examining the change mechanisms that are reported by self-help group members in various studies, Kurtz (1997) mentions that although it is rare for a group to manifest a whole set of diverse mechanisms, there are five change-oriented skills, most commonly reported by researchers, that help members to alter their life conditions:

- *Identity transformation*. The reconstruction of a positive identity in self-help groups has been acknowledged by early scholars (Katz and Bender 1976a) as the major contribution of a self-help group to people with deviant labels. Shared experience is the means of identification of new group members with the veteran ones who model new ways of coping and being. However, there is the controversial issue of accepting the diagnostic label as part of the member's identity, which was heavily criticised as a source of stigma and discrimination (Goffman 1963). In the light of the alternative function of self-help groups, this acceptance can help members to conceptualise their experiences of a condition within a framework in order to make sense and protect themselves from further identity damage. This can be achieved through group discussions about causes,

responsibility, correctness of the mental illness label and plausible explanations for members' difficulties (Kurtz 1997).

- *Empowerment.* This occurs when members become able to take action for themselves and on behalf of others due to their increased perceived self-efficacy and self-esteem, as a result of their participation in the self-help group. Empowerment is closely related to the community aspect of a self-help group being a place with indigenous leadership and peer governance where experiences become validated and members can mobilise resources in pursuit of their needs and interests (Gidron and Chesler 1994). Empowerment can be achieved in all types of self-help groups regardless of their focus on personal or social change (Kurtz 1997).

- *Insight.* The non-threatening atmosphere of self-help groups facilitates members to gain insight more easily than in formal therapy where denial and avoidance can often be an obstruction (Kurtz 1997). In self-help groups detailed self-disclosure is not a prerequisite, there is less scepticism since members share the same condition and when personal disclosures happen other group members respond with empathetic understanding and expressions of identification.

- *Re-framing.* Self-help groups offer new perspectives to their members through cognitive re-definitions, new language to construct explanations and coping strategies for their problems (Kurtz 1997). In this process, the self-help group's ideology can serve as a framework or as a "cognitive antidote" as Antze (1976) called it, for its members to re-examine their experiences and find alternative ways of improving their lives.

- *Formation of a new way of life.* Self-help groups have the potential to become "normative narrative communities" as Rappaport (1993) characterised them, namely their ability to offer their members a new community to live in a different and more positive way. Of course, this is not the case for all self-help groups nor for all their members (Kurtz 1997).

1.2.6. Relationships with professionals

As Katz (1992) points out explicitly, the self-help movement has grown up by and large without professional guidance and help; it is a grassroots movement that has created its own culture, traditions, ways of doing things, mostly independently of professionals. Due to its rapid expansion and the realisation that self-help groups can be a valuable resource for help, it has attracted the interest of professionals.

Collaboration between self help groups and professionals occupies a central theme in the literature of self help because the relationship is both vital and problematic (Katz 1981; Jacobs and Goodman 1989; Adams 1990; Wann 1995). Many controversial issues are implicitly or explicitly raised by this broad relationship - e.g. the nature of helping; similarities and differences between the two forms of aid; their role in welfare state.

Although self-help groups share the same goal in promoting the wellbeing of their members as do health professionals and the human service agencies in securing the wellbeing of their clients, there are a lot of differences between them in various levels as structure, resources, organisation, source of knowledge and ideology (Wilson 1995, quoted in Wann 1995). These differences often become barriers to a constructive relationship between them and lead to questions about whether such a relationship is feasible.

Some of the most radical self-help groups are opposed to any kind of "institutional interaction" believing that liaisons with conservative status quo oriented community and professional mental health organisations, have a negative effect on self-help goals (Emerick 1991). In fact, according to Emerick (1990) one of the major historical obstacles to the development of partnerships between self-help groups and health care professionals in the North America is the natural antithesis between the philosophies of self help and professional health care. Katz and Bender (1976a), in their account of the American self-help movement, report that one of the major functions of early self-help groups had been to politicise their members, to urge them to view their problems collectively in a broad socio-political and economic context. Acknowledging the influence that professionals can have in a self-help group, Chamberlin (1978) classifies groups based on how they deal with the problem of whether or not to include psychiatrists and other mental health professionals in their membership or leadership cohorts. Thus there are three categories of groups: a) the most radical (anti-psychiatrist) "separatist", that reject professionals within their membership in any capacity, b) the moderate (psychiatrically neutral) "supportive", that allow professionals in auxiliary roles, and c) the most conservative (pro-psychiatric) "partnership" ones, that promote a kind of sharing in leadership responsibilities between professionals and members-as-partners.

On the other hand, professionals often question the effectiveness and eligibility of self-help groups; they perceive them a threat to their status, or damaging for their clients (Katz 1981; Jacobs and Goodman 1989; Stewart 1990b; Wann 1995). Their reserve lies in the paucity of knowledge about self help included in professional education and literature and in the

continuing dilemmas, conflicts and disagreements about how professionals, agencies and self-help groups should relate to each other (Katz et al. 1992).

However, some researchers consider that self-help groups and professionals can help each other to be more effective in meeting the needs of people with health and social problems (Katz 1981; Kurtz and Powell 1987; Wann 1995). The role most often mentioned in surveys of professionals and self-help members is the one of linker (or "referral agent") (Katz 1992; Borman 1992). In order to achieve the best possible co-operation, Kurtz (1990, 1997) refers to the balance theory of co-ordination. This suggests that optimal collaboration between entities occurs when there is neither under-involvement nor over-involvement by the professional, but rather a balanced involvement that may include consultation, initiation of groups, speaking to members, sponsoring groups or merely attending meetings as an observer or member. Stewart (1990) suggests that such involvement can also support and strengthen the group.

1.2.7. Differences between self help and other related activities

Self help can be seen as part of a wider spectrum of lay activity in health and social issues (Katz 1981; Adams 1990; Wann 1995). Some of the related activities mostly known are:

Self-care. It has some elements that distinguish it from self-help. The most important of these is that medical self-care can be practised by individuals alone, or in a intimate setting such as the family, but does not require participation in a more formally or purposefully organised group.

The support system. Broader than that of self-help groups since it includes both "natural systems" (e.g. the family, and work-connected and friendship networks) and the kind of "created" social units represented by self-help organisations. Thus, self-help groups comprise a particular and important kind of support system.

Social networks. Self-help and other "created" groups may be significant components of an individual's or family's "save network", that is a person's/family's supportive resources.

Other forms of activities which are frequently confused with self help and mutual aid activities are voluntary and community groups/organisations. Burns and Taylor (1998), discussing this issue, present the 'territory' within which self help and mutual aid develop. They examine the broader area of non-profit organisations, according to four organisational characteristics: a) their degree of 'professionalisation' (run by paid workers or volunteers),

b) their legal status (formal or no formal relationship to the state), c) the type of governance (representative or direct decision making) and d) the form of organisation (formal organisational or network structure). By reference to these criteria, there are five categories of organisations: *the state, the voluntary/non-profit sector, the community sector, the sphere of informal mutual aid* and *the sphere of personal and family activity*. Although they admit that these categories are not 'perfect' and that this area is more of a "*dynamic spectrum of activity*" with the organisations moving up and down the categories, the authors state that self help and mutual aid activities fall roughly into the three latter categories of their typology. Groups/organisations in these categories share some common characteristics, that is they are mainly run by the interested parties, they have an informal constitution or just some rules, they are characterised by direct decision-making and they present an informal network structure. The sphere of 'personal activity', as its name states, is characterised by individual and family self-help and the sphere of 'mutual aid' as well as a part of the community sector refer to mutual aid groups/organisations.

1.2.8. Research about self-help groups

The early body of research (up to the 1970s) on self-help groups included descriptive case-histories, many based on anecdotal evidence, particularly groups of former alcoholics and drug abusers (Katz 1981; Kurtz 1990; Emerick 1995). Lieberman and Borman (1979) presented the first large-scale review of research on self-help, discussing mainly the situation in the United States where the vast majority of reported studies took place. Their edited work contains reports of quasi-experimental outcome studies, observations of group processes and ideologies, and descriptions of many community self-help organisations. An early example of case-studies was Antze's (1976) presentation of three large and known organisations in the United States at the time of his study, Alcoholics Anonymous[2], Recovery Inc.[3] and

[2] Alcoholics Anonymous is probably the oldest (founded in 1935) and largest mutual-help fellowship in the world (over 1.500.000 members are reported in the United States and Canada alone and over 500.000 in other parts of the world, Kurtz 1997). It has been the prototype for other organisations that deal with different problems or conditions but follow AA's model.

[3] Recovery, Inc. is an old self-help organisation (founded in 1937) whose purpose is "to help prevent relapses in former mental patients and to forestall chronicity in nervous patients" (Recovery, Inc. 1995, quoted in Kurtz 1997), currently with 777 groups throughout North America, Great Britain and Israel (Recovery, Inc. as above).

Synanon[4], in an effort to discuss their ideological and cognitive approach in dealing with members' problems. The description of these organisations is based on the author's personal observations and knowledge obtained from discussions with related persons.

In the 1980s, self-help research, still largely conducted in North America, started focusing on the relationship between professionals and self-help organisations, the definition and classification of helping processes in such groups and the evaluation of the effect that self-help groups have on their members (Kurtz 1990). More specifically, findings of these studies were concentrated on the following:

- Organisational aspects:

Structure. Although limited, the research done in this area indicates that structures are determined primarily by the shared problems and experiences of the members, who function simultaneously as givers and recipients of help (Kurtz 1990; Maton 1988). Structural and functional characteristics that distinguish self-help groups from conventional types of social agencies are: horizontal communication, required personal involvement, solidarity and autonomy of members, group decision-making, informal democratic processes, focus on members' learning and changing in the process of (and in part because of) the undertaking of concrete tasks (Katz and Bender 1976; Katz 1981).

Ideology and group processes. Levy (1976) hypothesised, from his own observations, seven "cognitively-oriented processes" that operate in self-help groups such as: demystification of the members' experience, information exchange, expansion of alternative perceptions, consensual validation, elaboration of a substitute culture through which identity changes can occur. There are some indications of greater membership stability in the more ideological groups but this has not been rigorously tested (Emerick 1991). However, few comparative studies of different self-help groups (Kurtz and Chambon 1985) suggest that different ideological characteristics of groups appeal to different types of people.

- Relations with professionals:

The role of professionals in initiating self-help groups (in their agency/institutional capacity, or in a purely personal one). Leadership or facilitation of meetings is a role that independent self-help associations usually designate for peers. Some studies suggest that when groups are professionally-led they do not progress as well as the peer-led ones (Yoak and Chesler 1985; Kurtz and Chambon 1987; Toro et al. 1988). However, there is evidence that a collaborative

[4] Synanon was the prototype of an alternative community programme for hard drug addicts, founded in 1958 and mainly developed in the United States (now defunct, Kurtz 1997).

perspective on the part of professionals can prove useful for the groups (Yoak and Chesler 1985; Kurtz 1988)

The attitudes of professionals toward self help. Surveys examining professionals' attitudes toward self-help groups found them receptive to the idea of self help but uninformed about the specific nature of their work (Kurtz et al. 1987).

- Helping processes:

Supportive processes. Researchers in several studies report that various forms of support take place within a self-help group: acceptance, empathy, affirmation, cohesion (Toro et al. 1988; Maton 1988) and emotional support is ranked by members as the main benefit received from their participation in the group (Kurtz 1988).

Information and education. Information sharing, cognitive instruction and experiential knowledge were processes found in almost all groups studied (Levy 1976; Maton 1988; Kurtz 1988).

Identity Formation. Reconstruction of a positive identity is a process that was proposed by scholars of self help as a major contribution to the members (Katz and Bender 1976a) and ethnographic studies of AA describe such a process occurring in a group (E.Kurtz 1982; Denzin 1987).

Affiliation and community. Studies found that belonging in a self-help group provides its members with an enhanced sense of security, companionship, and well-being (Maton 1988). Also it has been reported that groups can offer to their members an entire social network or "normative community" (Salem et al. 1988).

Personal transformation. Personal change is a goal for a lot of groups and researchers recorded several processes of personal change to take place in group meetings such as: insight, opportunities for goal setting, identification with veterans who have made a successful transformation, spiritual growth (Wollert et al. 1982; Kurtz and Powell 1987; Toro et al. 1987).

Advocacy and empowerment. The advocacy function of self-help groups empowers their members and encourages them to get involved in social action towards changes of governmental policies and promotion of public education (Gartner and Riessman 1977; Kurtz 1988; Emerick 1989). However, researchers have only described this effect of group participation in anecdotal accounts.

- Outcomes of self-help groups:

Despite the above elements of helping processes described by researchers, outcome studies have not been able to confirm that membership in self-help groups for mental health leads to psychiatric symptom removal as measured by standardised instruments. Some would reject this as a goal of research anyway. However, some evaluations suggest that "*more involved members report greater life satisfaction, shorter hospital stays, less dependence on professionals, raised self-esteem, and improved attitudes*" (Kurtz 1990).

From a methodological point of view, evaluations of outcome usually have viewed self-help groups as alternative treatment services and researchers have employed cross-sectional designs with convenience samples. In some more extensive evaluations there were methodologies such as before-after measurements, comparison groups, and time-series designs (Kurtz 1997).

Experimentally controlled evaluations of self-help groups are difficult to design due to groups' open boundaries, independence from professionals and lack of record keeping (Levy 1984; Kurtz 1990; Humphreys and Rappaport 1994). Although most of the recent research on psychiatric self help continues to be done by clinical scientists investigating the effects of single groups on individuals (Emerick 1991), the paradigm of research in professional human services has been criticised by contemporary self-help researchers as unsuitable for the understanding of this particular phenomenon and even violating to the ethos and uniqueness of the self-help movement. Thus, Humphreys and Rappaport (1994), in their criticism of previous self-help research, point out that elements such as the two-way role relationship of helper and helped and the dominance of peers in all aspects of self-help organisations, differentiate the mutual help activities from any other forms of human service provision. Therefore, they conclude that:

> *Studies that employ high researcher control over "self-help groups" through random assignment to conditions or leadership of groups destroy some of the qualities of self-help groups, such as context and self-direction ... Thus, controlled outcome studies have an inherent weakness in that they invariably impose a major change on the phenomena they purport to understand, specifically making it more a study of professional-controlled paraprofessionals rather than of self-help groups.* (p.221)

In addition to the above argument, they claim to identify "professional centrism", that is the a priori belief of professionals that their help is better than any other form of help and that greater professional involvement in a helping group ensures its greater effectiveness.

Professional centrism, they argue, may influence the design and interpretation of data in order to favour professional intervention.

An interesting point about the status of self-help research is made by the American sociologist Emerick (1996). In his opinion it is dominated by psychologists who treat self help in a narrow individual perspective ignoring its socio-political character:

> *I propose that we need more self-help group and self-help movement research that reflects the philosophy of social realism, emphasizing the importance of social and cultural context, and adopting the biases of an overtly political and social systemic orientation.* (p.156)

He calls for a broad collaboration of social scientists in the study of the phenomenon in order to understand its social movement dimensions.

In the 90's, research continues to focus on helping processes and group outcomes but is increasingly recognised by researchers that self-help is not a treatment and that experimental evaluations and clinical trials are probably a misuse of research resources (Borkman and Schubert 1995; Kennedy and Humphreys 1995; Kurtz 1997). Investigations about self-help groups have moved to a more detailed inquiry of organisational variables (Maton 1994), worldviews and ideologies (Kennedy and Humphreys 1995; Humphreys and Rappaport 1994), minority participation (Snowden and Lieberman 1994) along with international and multicultural aspects of self help and mutual aid (Gidron and Chesler 1994).

1.2.9. Self-help groups and government policies

Self-help/mutual aid groups exist primarily in the voluntary sector. However, activities of self help and mutual aid has started to attract the attention of policy makers and governmental agencies. The main reasons for this interest are outlined by Burns and Taylor (1998), in their report about the possibilities of self help and mutual aid as coping strategies for excluded communities:

> *Self-help and mutual aid are seen to offer solutions to a number of problems faced by policy makers today. Firstly, in the face of rising demands on the welfare budget, support networks have the potential to take the load off formal caring systems. Secondly, they are seen as a counterbalance to an apparent breakdown in social cohesion and as a way of re-establishing moral and social responsibilities eroded, first by dependency on the state and then by the individualism of the market.* (p. 1)

Self-help groups are characterised mainly by autonomy and independence from statutory services but they have often to solve practical problems in order to continue their work. It is probable, then, that their autonomy and effectiveness may depend on receiving support from outside. Existing support is either local and general or national and specialist (Wann 1995).

In Britain, there were only few recent national initiatives for the support of self help (Humble 1989). Two of them were independent of government: the National Self Help Support Centre (first funded 1985-86), financed by private trusts to provide support, information and training at a national and local level; and the Self Help Workers Support Network (1984) organised by locally employed workers for the purposes of meeting and discussing on a regular basis. The Self Help Alliance, a central government funded programme, was a pilot scheme run by the Department of Health in 1986 which set up 18 projects to support self help in different parts of the country, as part of government's policy on community care; the funding was for three years only and none of the projects has survived intact. Withdrawal of funding was the main reason for their termination (Wann 1995).

However, mental health service users' groups such as *user forums* are increasingly asked to take part in consultation processes to help identify needs and plan delivery of services (Wann 1995). Their contribution is likely to be greater than that of individual service users. John Simmons, Head of Operations in Derbyshire Social Services (1993; quoted in Wann 1995) makes a special reference at the importance of a close collaboration between the statutory services and self-help groups in order to improve the welfare system:

> *The Community Care Act demands that individual service users are involved in the planning of services and in the day to day management of those services and in the care planning activity that is undertaken. It is not always easy, though ... I think there is an important role there for self help groups in advocating and supporting the individual, in feeling able to communicate with large organisations such as social services, health authorities and GPs... Therefore, it is important that, through groups ... and umbrella organisations within the county, and national umbrella organisations, we develop representative voices that can play a part in that communications process about evaluating what we are doing now, and also looking to future developments.* (p.66)

As Wann (1995) recommends, for the development of self help activities, government policy should acknowledge the scope and scale of these activities. Public funds should be invested in local organisations which offer support to self -help groups and in training programmes for professionals and local government officials (Unell 1987). The need to support

"mediating organisations in the community and the creation of a benign environment", rather than the self-help groups themselves, is recognised by Burns and Taylor (1998) as well. They caution about the inherent danger of applying a strategy of their incorporation into the statutory sphere and they recommend further research in order to find ways of supporting them: "*...Policy interventions are extremely difficult in this area. Mutual aid can be easily destroyed by attempts to incorporate...For the future, we need to find ways of mapping the extent of mutual activities and explore how links are built from the sphere of mutual aid up through more formal organisations to the state and back in order not to control them but to understand how the diversity which they represent can be accommodated in a way which plays to their strengths.*" (p. 30)

1.3. Self-help groups and other mental health group formats

The use of groups for therapy purposes is an issue that has attracted a lot of attention during the last decades in the mental health field (Yalom 1995). Bond and De Graaf-Kaser (1990) note that, in the United States, the development of comprehensive approaches to the treatment and rehabilitation of people with severe mental health problems has influenced the conceptualisation and practice of group approaches. Groups in the mental health area started be recognised by professionals because: a) they can help clients to improve their interpersonal skills, b) intensive dyadic approaches are either unproductive or counterproductive for persons with severe mental problems, c) groups are cost-effective by maximising therapist contact time, and d) medications do not remedy clients' psychosocial problems (Bond and De Graaf-Kaser 1990; Lieberman 1990).

In presenting their typology of group formats that reflect current mental health practice, Bond and De Graaf-Kaser (1990) include self-help groups and mutual aid societies as "experiential in vivo" formats. Specifically, they classify them along with psychosocial rehabilitation and drop-in centres having as common elements the fact that they develop in natural environments and have an experiential character. They consider that self-help groups have weaknesses in that members are self-selective and that, according to some surveys, the large majority of active members in traditional mutual aid organisations would not meet the criteria for chronic mental illness. As a main strength of these groups they report their potential *"to provide an "ecological niche" for clients who otherwise would not fit into the mental health system"* (p. 30).

The very fact that Bond and De Graaf-Kaser (1990) attempted to include self-help groups in a typology of group formats in mental health presents a special interest for the self-help researcher as it positions them in a broader perspective. It is however a typical example of the manner that self-help groups have been studied to date. Indeed, their discussion about self-help groups leaves no doubt that they, as other professionals, consider self-help groups with "professional centrism", a term which we mentioned earlier in our presentation of research about self-help groups (introduced by Humphreys and Rappaport 1994, see section 1.2.8). The implications of such an attitude is that these authors, along with many mental health professionals, strive to fit self-help/mutual aid groups according to the traditional criteria of therapy groups, in other words to incorporate them in the bulk of pre-existing knowledge, instead of approaching them as unique entities and learning from them new ways to improve services for mental health users.

Nonetheless, there is a growing number of self-help groups with people who experience mental health problems in most western countries and a majority of their members are mental health service users or ex-users (Wann 1995; Kurtz 1997). Furthermore, there is an encouraging number of workers and researchers in the mental health area who have begun to realise that self-help groups have the potential to enrich if not change the existing means that people with mental health problems get helped. Research is needed to determine the way that these groups affect people's mental difficulties.

1.4. Concluding comments

Self help and mutual aid activities nowadays play an important role in many people's lives as growing demands within the welfare sector and insufficient response from statutory services in most countries, even the more developed ones, drive those in need to search for ways to help themselves (Unell 1989). Self help has a lot in common with voluntarism and charity; however, it has essential differences as it is about self-determination and co-operation. Although a number of self-help/mutual aid groups or organisations, specifically the radical ones, criticise strongly existing mental health services and, sometimes, advocate for profound changes, these activities do not aim to reject overall existing statutory services; rather to ameliorate their standards and the quality of help they offer to mental health service users.

As discussed in this chapter, previous research suggests that self-help groups present some unique features such as helping group processes occurring in natural environments. These

groups are a safe place where people find support and understanding. Members acknowledge and exchange experiential knowledge towards successful coping with their common problems, and empowerment is an important outcome of participation in such groups. Although promising, these findings about processes and outcomes of self-help groups are usually not specific to the different types of self-help/mutual aid groups, thus presenting only a part of the phenomenon. Moreover, in order to explore possible variations of these groups, it is important to depart from the narrow psychotherapeutic perspective and recognise the socio-political potential of self help and mutual aid to assist mental health service users regaining control over their lives and actively coping with their problems.

There are important issues that must be addressed in order to properly study self help activities. Firstly, methodological issues such as appropriate techniques of evaluating self-help groups, sample definition, design of suitable research procedures must be addressed. Further, there is need for development of specific theoretical frameworks as well as alternative models to traditional ones used in the professional services research (Rapp et al. 1993; Kauffman 1993; Lieberman and Snowden 1993; Meissen and Warren 1993; Powell 1993).

In the light of the literature review, the present thesis has as a main purpose the examination of English mental health self-help groups in a systematic way with consideration of their particularities and variance. This task has an original character because, on one hand, previous literature about European self-help groups is practically non-existent and, on the other hand, there is no systematic examination of members' characteristics in respect of a specific group typology. Acknowledging the fact that groups vary greatly and consequently have differences in the way they function and help their members, this thesis will investigate self-help groups' processes and outcomes according to their political ideological type and focus of change as well as assess changes in members' characteristics over time.

Finally, there must be pointed out that this study does not take the thesis that self-help is an answer to all people's problems. It is rather one more way of managing with problems and it does not work for all (Wann 1995). As Powell (1993) accurately points out *"self help should not be thought as a "poor person's psychotherapy" or, perhaps more aptly, as "uninsured person's psychotherapy". Nonetheless, ... it is a policy that might be especially appropriate for people in particular circumstances - for example, people who are recovering or are coping with long-term conditions or need to implement or maintain lifestyle changes to manage their conditions effectively"* (p. 163).

CHAPTER TWO

Methodology and Research Design of the Study

Following up the discussion about the nature of self-help/mutual aid groups and particular issues concerning this phenomenon, I now turn to the presentation of the methodology and the research design of the study.

2.1. Orienting points of the study

Based on the existing literature reviewed, the design of this project was guided and formulated by a number of research questions, some of them already tested in the United States, which were been explored in the English context, acknowledging the socio-cultural particularities of a different environment. These questions were related to the three following broad areas:

a. Group Typology. From the overview of the literature, I was very interested in the area of group categorisation because of its importance and its relevance to the way self-help/mutual aid groups were perceived. Past attempts to systematically examine these groups often led researchers to confusion and misunderstandings as their efforts were restricted by pre-existing therapy and health service delivery frameworks. In fact, the phenomenon of self-help and mutual aid, being a part of a new social movement, can be best viewed from a sociological perspective. A review of suggested group typologies, presented in the previous Chapter (section 1.2.3), led me to he conclusion that a categorisation of groups according to political ideology and focus of change offered a comprehensive way of examining this phenomenon. Very similar in their essence, both these typologies allow the researcher to evaluate group outcomes in a socio-political context and permit to look at the social as well as the psychological implications from participation. From this point of view, major benefits of membership are individual empowerment and attainment of a new positive social identity. However, these typologies have not been used before in order to systematically study self-help groups. Therefore, based on these typologies, this study embarked to explore the question whether different types of self-help/mutual aid groups were related to the their members' individual characteristics and specific group processes occurring during meetings. The expectation was that different helping processes would take place in different ideological types of self-help groups and members would report different levels of empowerment as a result of the focus of change; that is, groups focussed on individual

change would report a greater number of supportive and expressive processes occurring in their meetings whereas social change group members would feel more empowered as a result of their social activities.

b. Length of Membership and Group Identification. The beneficial nature of self-help groups for their members was one of the major issues of discussion about them; thus, the majority of studies mainly focussed on exploring beneficial outcomes. Previous research indicated that group members reported that they benefited from their participation in several ways, e.g. became empowered, received more social support. Also, researchers in the field suggested different mechanisms taking place during group meetings, for example, the sharing of a positive social identity, the exchange of experiential knowledge and the mutual helping. On the other hand, there was some evidence that the degree to which members benefited from their participation was relevant to the level of commitment to their group, i.e. length and intensity of attendance, identification with the group. Therefore, in the light of these findings, an interesting topic of research was to explore whether length of membership would be related to levels of personal empowerment, social support and wellbeing. Based on previous findings, the expectation is that long-term members and members who identify with their group will report increased levels of empowerment, social support and psychological wellbeing.

c. The Effect of Time. A third question which stemmed from the reading of relevant literature was about the effect of time on the phenomenon of self help and mutual aid as well as on their specific group types. Due to the particular nature of these groups, previous attempts to record characteristics and processes through time were inconclusive. However, the issues about the durability of beneficial outcomes and the consistency of self-help group attributes presented an intriguing area of study which would also compliment the knowledge obtained about group categorisation. Therefore the study would additionally examine whether psychosocial characteristics of self-help group members as well as group processes and beneficial outcomes would remain stable through time; similarly, if the differences between ideological group types would be repeated in time.

2.2. Methodological considerations

Systematic research on self-help/mutual aid interventions has unique and complex elements difficult to conceive and study with existing tools and traditional methods (Goldklang 1991; Tebes & Kraemer 1991; Humphreys and Rappaport 1994). There is surprisingly little

substantial research on self-help groups despite years of clinical and policy interest. In 1989, the National Institute of Mental Health (NIMH) held a research workshop in the United States, on the methodological issues in evaluating mutual support interventions, as an effort to stimulate high-quality research. Goldklang (1991), in his report from that workshop, notes that participants agreed research on naturally occurring self-help groups is at a rudimentary stage and as such it presents a similar picture as psychotherapy outcome research in the 1950s. Specifically, global questions about effectiveness instead of specific ones are being asked and the nature of self-help interventions is ill defined. Further, participants noted a distinctive feature of research in self help:

> ***researchers are guests** in naturally occurring self-help groups **and not hosts** ...* [they] *need to be responsive to the needs of self-help groups ...* [so] *the outcomes measured must include variables of interest to the participants.* (p. 791)

They pointed out a number of methodological problems in the research to that date. Some of the major issues in the field are the lack of consensus on the "criterial attributes or components" which define self-help groups, the lack of consistency in the use of terms "self-help" and "mutual support", and the lack of agreement on what constitutes membership, that is minimum number of meetings necessary to attend and the issue of attendance and active participation. Furthermore, the participants of the workshop agreed that the requirements of a research design that are imposed on self-help groups can potentially distort some of their critical elements and may change their very nature. Another important barrier for the application of a more "traditional" methodological design in order to evaluate outcomes is the difficulty of obtaining an appropriate comparison or control group. The main reason for this is the fact that membership of self-help groups is largely self-defined and that self-help groups have more satisfied members than other groups as those who are not benefiting usually drop out. A final point about applying existing methods is that there are discrepancies between members' and researchers' evaluation of the effectiveness of self-help groups as they are based on different criteria.

Consistent with the above observations about self help research, Tebes and Kraemer (1991) discuss the inherent complexity that professionals and researchers face if trying to study mutual support quantitatively, that is using traditional research methods such as experimental designs, comparisons of self-help with control groups, pre-post intervention measurements. They identify three critical issues, which contribute to this complexity and impede 'scientific' knowledge of mutual support phenomena:

- the lack of researcher control over the intervention, due to the peer-led character of self-help groups and the peripheral role of professionals in them,
- the "perspectival discrepancy" , that is *"the difference in perspective between the self-helper and the researcher about the nature of the group process and what constitutes outcome"* (p. 742), and
- the lack of uniformity among investigators about how to conduct scientific research on mutual support.

The authors argue that, in order to overcome the above mentioned difficulties, it is important to re-examine the scientific methods used in the study of social phenomena such as self-help/mutual aid groups. Although they acknowledge the usefulness of experimental and quasi-experimental designs for the understanding of human and social phenomena, they criticise such designs, as currently implemented, considering that they fail to capture the richness and complexity of these phenomena. Tebes and Kraemer (1991) point out that in order to study self-help/mutual aid interventions there is need for an alternative approach, that is integration of qualitative and quantitative methods. The incorporation of qualitative knowing into quantitative designs allows investigators to monitor closely the "local conditions", the specific and unique characteristics of the local setting which provide the context for a study, thus permitting them to address the difficulties described above.

Qualitative knowing employs methods that share a number of characteristics: naturalistic inquiry, inductive analysis, fieldwork, and adoption of a holistic/ecological viewpoint (Tebes and Kraemer, 1991). Some of the qualitative approaches that Tebes and Kraemer (1991) suggest as appropriate to research on mutual support are case study, participant observation, process evaluation and adversary hearing.

The case study involves the in-depth observation analysis and description of "*an individual, a group, an organisation, a community or a collectivity of groups, organisations, or communities over time*" (Tebes and Kraemer 1991). Characteristics of the case study are that the focus is on a small number of participants, that the phenomenon is studied in a naturalistic context, that hypotheses are constructed during the collection of data, and that the researcher inductively generalises from the particulars of the case to wider application areas. The case study providing rich in-depth qualitative information can prove very useful in assisting clarification of quantitative results. This is the method that has most extensively been used to study in detail self-help organisations and local groups by researchers who were aware of the complexities of this specific field (Humphreys and Rappaport 1994).

Participant observation is a type of direct observation by the researcher of an activity, process, behaviour, organisation, relationship, or network of which the researcher is a part. Important elements of this type of observation are that the researcher can experience the phenomenon in its totality as a participant and that the participants are viewed as informants and research collaborators rather than objects of study (Tebes and Kraemer 1991; Bogdewic 1992).

The process evaluation aims to describe the specific events in the implementation of an intervention, programme or group, such as its context, activities and ideology. The researcher uses a combination of quantitative and qualitative methods such as in-depth interviews, direct observation, and analysis of relevant documents, as well as assessment of variables such as characteristics of the participants, the group's organisational features and interactions between participants. Ideally, process evaluation is conducted in conjunction with an outcome evaluation as it can contribute to a comprehensive understanding of the phenomenon being studied (Tebes and Kraemer 1991).

Finally, adversary hearing refers to a procedure in which the participants of the study meet with the researcher to judge whether findings are consistent with their experiences. This procedure enables participants to serve as 'critics' of the findings and the extent to which participants confirm these findings provides evidence for their validity. With this method the experiential knowledge of the participants (Borkman 1976) can be used to cross-validate findings.

Chesler (1991b), reinforcing the view about the appropriateness of alternative methods for the research of self-help groups, applied the model of participatory action research as an alternative research paradigm. He argued that

> *The alternative approach of participatory action research (PAR) is quite congenial with the highly participatory and experiential culture and goals of self-help* ... [because] *it employs technologies of data collection and analysis that are congruent with the reliance on local wisdom and lay leadership that runs through the self-help movement* ... [and] *the ways in which participatory action research generally utilizes research findings is more consistent with the organizational structures and action needs, as well as empowerment potentialities, of self-help groups.* (p.758).

Central features of this alternative research paradigm are that the researcher is committed to personal activism and that there is a high degree of co-operation and involvement between researcher and participants with constant feedback processes. Most important, the goal of

participatory action research is the implementation of the findings in order to improve social issues (Banister et al. 1994; Chesler 1991b; Rogers and Palmer-Erbs 1994).

In the field of self-help groups, an important and striking difference between the above two research paradigms, the conventional and the participatory model, relates to the research agenda. The conventional research model usually poses a specific and detailed agenda prior to entering the field, typically based on theories of personal and group processes and primarily aiming to answer whether self-help groups work equally or better than professional service systems (Jabocs and Goodman 1989). However, participatory action research studies evolve from interactions with members and groups in the field and, thus, are more oriented in practical issues that concern self-help groups themselves such as problems of group functioning (leadership, recruitment, attendance of members, funding). In this way, findings can generate information useful for the continuation of groups and their future improvement (Chesler 1991b).

Chesler (1991b) points out some of the advantages that this alternative type of research may have for the self-help researcher. First of all, its flexibility may help the researcher to adequately tap or be relevant to real-life heterogeneity of self-help groups. In addition, with collaboration and active participation researchers may improve their access to the groups and have first-hand experience of them. Moreover, the empowering character of this methodology is consistent with the personal and collective empowerment issues that are crucial for self-help groups. Finally, the shared control of participatory research between researcher and participants is very helpful to overcome the reserve that a lot of groups have towards researchers, even towards the most 'sensitive' ones (Rappaport et al. 1985).

2.3. Choice of methodology

Considering the methodological issues and complexities presented, my choice of methodologies in the present study ought to be flexible in order to reflect the particularities of the self-help/mutual aid field. My first concern was to be able to establish good relationships with the groups I approached, in order to be able to co-operate with them in the research project. Following the principles of participatory action research, there was constant communication between the researcher (myself) and the participants (group members), in the form of participant observation and the adversary hearing process. More specifically, from the beginning of the study, I introduced myself to the groups and made clear that my research intention was to learn from the groups and understand their ways of functioning. I

also stated that I perceived myself as a mental health worker and a researcher; however, the purpose of my presence at group meetings was to have a first-hand experience of these groups, and not to 'intrude' and enforce an 'expert' s opinion to the groups. My frequent contact with the groups gave the members a chance to ask their questions about the project and discuss any issues they felt were important to clarify with me. For instance, during a group meeting of the Fellowship of Depressives Anonymous, a member who had doubts about my attendance put forward the issue in the group and this was a good opportunity to discuss members' feelings towards me. In that particular case, the group argued that they were feeling positive about me participating in their meetings and that they wished more professionals were willing to hear their views. Moreover, I kept an 'open communication line' with the groups during and after the end of the study. I went back and visited a number of them, getting their feedback about the results.

As the main purpose of the study was to record systematically psycho-social characteristics of self-help/mutual aid group members such as empowerment, social support and networks, helping processes and group identification, I wanted to include quantitative measurements as a way to explore a set of relevant variables. My effort was to keep them as 'user friendly' as possible, keep them as short as possible and avoid any scales written in professional jargon. For that matter, I also 'tested' the selected set of questionnaires in a pilot study with mental health service users attending a Day Centre.

The combination of qualitative and quantitative methods is used more frequently nowadays by social scientists who realise that a single methodology is not adequate to capture the complexity of social phenomena (Rabinowitz and Weseen 1997). My methodological design was an effort to tackle the difficulties mentioned by previous self-help researchers. For a more comprehensive approach, I adopted sociological as well as psychological perspectives of self-help groups in my analysis of their processes and outcomes. Thus, the typology of political ideology I followed has a strong sociological influence whereas among the variables I chose to examine in order to evaluate differences between groups are psychological concepts such as mental wellbeing and helping group processes and broader psychosocial factors like empowerment and social support and networks.

2.4. Specific aims and objectives

The main purpose of this study was to describe in a systematic way the phenomenon of self-help/mutual aid groups in terms of operation, structure and outcomes, and discuss their role in the mental health area. Specifically, the aims of the study were:

- To locate and collaborate with different types of self-help/mutual aid groups of people experiencing mental health problems (according to Emerick's (1991) and Kurtz's (1997) typology) and to represent their profile.
- To explore the relationship between the type of a self-help group and the psycho-social outcomes for group members, as there is evidence in the literature that groups oriented towards individual change of their members differ from groups oriented towards social change (e.g. Emerick 1991). Moreover, outcome studies suggest that self-help groups can be beneficial for their members through experiential knowledge (Borkman 1976), social support (Paine et al. 1992; Wollert et al. 1982), adaptation of effective coping strategies (Humphreys et al. 1994), and empowerment (Rappaport 1985).
- To compare ideological types of self-help/mutual aid groups in order to assess differences in group processes and outcomes for their members.
- And, finally, to assess possible changes through time in the psychosocial characteristics of self-help group members, overall and within the ideological group types.

In order to achieve the above aims, the research objectives were to:

(a) Locate various types of self-help/mutual aid groups of people experiencing mental health problems (e.g. individual-change, social-change oriented or combined, structured or unstructured, etc.)

(b) Provide descriptive information regarding the profile of the participating groups and their organisations (wherever appropriate).

(c) Describe the characteristics of people experiencing mental health problems who attend these self-help/mutual aid groups, that is sex, age, education level, marital status, occupation, contact with mental health services, reasons for attending, perceived benefits from the group, satisfaction with the group.

(d) Describe the ideology of groups according to Emerick's (1991) classification, which is based upon the assessment of group affiliation, professional evaluation, levels of organisational and institutional interaction.

(e) Assess psychosocial variables of group members both at individual (empowerment, social network and support, mental wellbeing) and at group (group identification, helping processes) level.

(f) Explore the relationship between ideological type of group and psychosocial individual as well as group characteristics of members.

(g) Compare self-help/mutual aid groups in relevance to their members' characteristics at individual and group level, focusing on the ways that people benefit from participation.

(h) Assess possible changes in self-help/mutual aid groups through time (repeated measures in a 12-month period).

2.5. Sample of the study

The sample for the study consisted of a range of self-help groups in order to reflect the typology which I chose to follow in their analysis (Emerick's typology of political ideology). Specifically, the self-help organisations/groups that agreed to participate in the study were[1]:

1. *Fellowship of Depressives Anonymous (FDA) - London group:* meets weekly in a private flat, is open and unstructured, and its usual attendance is 10 to 15 members. Its focus problem is depression and there is emphasis on anonymity and low profile. It is a local group of the FDA organisation.

2. *Voices Heard Group (VOICES) - Canterbury group:* meets weekly in a day centre, is open and unstructured and its usual attendance is 4 to 5 members. Its focus problem is the experience of hearing voices and it was initiated by social services although it is peer-led.

3. *Voices Heard Group (VOICES) - Whitstable group:* meets weekly in a day centre, is open and unstructured and its usual attendance is 3 to 4 members. Its focus problem is the experience of hearing voices and it was initiated by social services although it is peer-led.

4. *Overeaters Anonymous (OA) - Maidstone group:* meets weekly in the day centre of a clinic, is a closed (although holds open meetings once a month) and highly structured (follows the Alcoholics Anonymous structure) group and its attendance is 7 to 10

[1] A more detailed description of the groups and the national organisations they belong to as well as the method of their categorisation is presented in Chapter Three.

members. Its focus problem is compulsive overeating and it is a local group of the OA organisation.

5. *Depression Alliance (DA) - London morning group:* meets monthly in the organisation's offices, is open and unstructured and its attendance is 4 to 5 members. Its focus problem is depression and it is quite stable in its membership. It is local group of the DA organisation.

6. *Depression Alliance (DA) – London afternoon group:* meets monthly in the organisation's offices, is open and unstructured and its attendance is 4 to 8 members. Its focus problem is depression and it is local group of the DA organisation.

7. *Depression Alliance (DA) - St. Albans group:* meets monthly in a church hall, is open and fairly structured and its attendance is 15 to 20 members. Its focus problem is depression and it is local group of the DA organisation.

8. *Manic Depression Fellowship (MDF) - Wandsworth group:* meets monthly in a church hall, is open and unstructured and its attendance is 7 to 10 members. Its focus problem is bipolar depression and it is local group of the MDF organisation. It is jointly led by a user and a relative.

9. *Manic Depression Fellowship (MDF) - Crystal Palace and Anerley group:* meets monthly in a voluntary organisation's offices, is open and unstructured and its attendance is 15 to 20 members. Its focus problem is bipolar depression and it is local group of the MDF organisation.

10. *Eating Disorders Association (EDA) - Maidstone group:* meets weekly in a day centre of a clinic, is open and unstructured and its attendance is 5 to 10 members. Its focus problem is eating disorders and it is local group of the EDA organisation.

11. *Eating Disorders Association (EDA) - Southend group:* meets fortnightly in day centre of the Mental Health Services, is open and unstructured and its attendance is 4 to 6 members. Its focus problem is eating disorders and it is local group of the EDA organisation.

12. *Shepway Mental Health User Forum (SWOF) - Folkestone:* meets fortnightly in a day centre of a hospital, is closed and semi-structured and its attendance is 5 to 6 members. Its focus is the representation of service users' views at the mental health authorities and, specifically, the creation of a clubhouse as a means of helping long-term service users

back to employment. It was initiated by social services and it is partly supported by them (in practical issues).

13. *Havering, Barking and Brentwood Mental Health Users Group (HUBB) - Romford:* meets monthly in a church hall, is open and structured and its usual attendance is 10 to 20 members. Its focus is the representation of users' views at the mental health authorities, the reform of the existing 'traditional' services and advocacy. It was initiated by social services and it is partly supported by them (in practical issues).

14. *Lewisham User Forum (LUF) - Lewisham:* meets monthly in the offices of the Community Council, is open and structured and its attendance is 5 to 9 members. Its focus is the representation of service users in the planning and provision of mental health services.

Table 2.1: *Sample of the study*

NAME OF ORGANISATION/GROUP	FOCUS PROBLEM	NUMBER OF PARTCIPATING GROUPS
Depressives Anonymous (FDA)	Depression	1
Depression Alliance (DA)	Depression	3
Manic Depression Fellowship (MDF)	Manic-depression	2
Eating Disorders Association (EDA)	Eating disorders	2
Overeaters Anonymous (OA)	Eating disorders	2
Voices Heard Group (VOICES)	Hearing Voices	1
Shepway User Forum (SWOF)	Advocacy	1
Havering User Group (HUBB)	Advocacy	1
Lewisham User Forum	Advocacy	1
TOTAL*		**14**

*Total number of members who responded: Time 1= 67, Time 2=56

2.6. Research procedure

Due to the lack of a central information point about self-help/mutual aid groups/organisations in the United Kingdom, and specifically in the Kent and London area, the research was conducted in the following stages:

a. Locate self-help/mutual aid groups/organisations:

Initial information about groups in Kent and London Area was gathered through various sources. One way of looking for information about these groups was to search at existing resources such as the Directory of the Council for Voluntary Services, the Mental Health Resources Directory and the Yellow Pages. Moreover, as a preliminary exploration of the

area and another way of gathering information, I conducted key informant interviews with people involved in self-help organisations/groups or/and the service user movement. Having compiled a rather comprehensive list of organisations and groups, I sent an informative letter to all of them about the purpose and aims of the study (see Appendix A). In this initial letter, I asked groups to contact me if willing to know more about the project and eventually participate in it. Further action was needed to find different types of groups in order to satisfy the research aims. I made contact with mental health voluntary organisations (e.g. MIND, UKAN, Good Practices in Mental Health) in order to advertise my project and find additional groups. Finally, I made use of the information that participating groups gave me about the existence of other self-help organisations and local groups.

b. Agreement for participation:

Groups that responded to my initial letter contacted me by phone or mail. I asked each group's representative for permission to attend a group meeting and present the project details to the group in order to request their participation. I visited the groups that agreed to my presence at a group meeting (from the fourteen groups which responded to my initial invitation, all accepted my request to visit them). I introduced myself and explained about the research project and what would be the involvement of the group. Then I asked for groups' permission to attend meetings and for groups' consent to participate in the research. At this point, I reassured group members that I was not there as a professional aiming to undermine their work in any way but as a researcher willing to work with and learn from them about self-help groups. I also explained to them about confidentiality and anonymity issues. Specifically, all information about the group and individual members as well as the content of group discussions was confidential and anonymity would be kept for all individual participants (including interviews with group leaders/facilitators/chairpersons). The issue of naming the participating groups in consequent reports and presentations was also discussed and all groups gave the consent to use the name of their group, as long as they could not be identified individually. Finally, I attended group meetings in order to gather information about the group through participant observation (for 3-4 meetings of each group) and collection of written informative material.

c. Pilot Study:

I conducted a pilot study with mental health users (N=8) attending a Day Centre (Mustard Seed, Canterbury) in order to have users' feedback about clarity and suitability of the set of questionnaires that I had chosen to use in the study.

d. Collection of data:

Group members who volunteered completed a set of questionnaires regarding individual and group characteristics. Additionally, I conducted semi-structured interviews with group leaders/facilitators/chairpersons in order to have additional information about group functioning and leadership. Repeated measures took place in a 12-month interval. Finally, I gave feedback to participating groups in a form of short report (see Appendix F) and discussed with some of them the findings of the research.

Table 2.2: *Stages of the study*

STAGES OF THE STUDY
1. Contact groups and invite them to participate at the study.
2. Participant observation of groups (for 4-5 meetings) and collection of written material about the group.
3. Pilot study to test the questionnaires to be used.
4. Distribution of questionnaires to participating groups (TIME 1).
5. Interviews with group leaders/facilitators/chairpersons.
6. Repetition of measurements after twelve months (TIME 2).
7. Analysis of data from measurements, interviews, observation and written material.
8. Give feedback to all participating groups in an easy-to-read form report.

2.7. Ethical issues and confidentiality

Ethical issues of the study were addressed from the early stages of its design. Thus, the Research Ethics Committee of the university department, where I studied for my degree (Tizard Centre, University of Kent at Canterbury), evaluated an initial proposal of the research project. The feedback of the Committee was positive. This process was valuable for the actual implementation of the project as it gave me the opportunity to consider in detail important issues such as consent of participants, confidentiality and anonymity, and usefulness of the study for the participants.

As I mentioned in the section about the research procedure, there was an explicit commitment from my part to group members (as well as respondents of the pilot study) that all information about them was strictly confidential and anonymous. For this purpose, all data were kept safely with my responsibility and protected with secure means. Also, there was complete anonymity of the respondents because, although I was usually present in the administration of questionnaires, I was not aware of the identity of group members who

decided to complete the scales. Participants were only giving their date of birth in order to identify the people who participated at both times of the study[2]. Thus, it was impossible even for the researcher to identify them by name. Additionally, anonymity was kept for all group leaders/facilitators/chairpersons who were interviewed and no other information apart from the fact that they belong to a specific group was revealed publicly. Confidentiality was also guaranteed by the researcher about the content of the groups meetings she attended during the study. The issue of anonymity for the participating groups was discussed with each group separately and all of them decided that the name of the group could be used in public presentation of the study, as long as individual members were anonymous. Therefore, consent of groups and their members was given to the researcher prior the conduct of the project. It was also discussed and made clear that individual participants and groups retained the right to withdraw their consent at any time during the study and to decide what kind of verbal or written information the researcher should have about their activities. There were no problems of co-operation throughout the study and whenever there was an issue, e.g. when a group decided to decline participation at the second phase (see Chapter Three, section 3.2.1), reasons for this decision were discussed and clarified between researcher and participants.

Another important point for the conduct of the study was that, in the case of a group being part of a bigger organisation, there was need to obtain initial permission from the organisation in order to contact their local groups. Indeed, this was the case for all the organisations whose local groups eventually took part in the research. This procedure was also necessary because, when applicable, the only way to access local groups was to go through their national organisations.

Issues concerning the clarity of the research procedure and of the measurement tools as well as usefulness of the research findings and feedback about results to groups were addressed accordingly. Specifically, information about the study was given to the participants from the beginning in the format of a letter and of verbal presentation. Respondents had also opportunity to discuss with me further issues about the project. Additionally, the scales of the study were tested in a pilot study in order to assure comprehensiveness and appropriateness. Although payment of participants was not feasible due to lack of funding, the benefit of participating groups was both direct, by using findings as a feedback for their work, and indirect, by employing the produced knowledge to argue publicly about the important role of self-help groups in the mental health field. Finally, feedback about results

[2] Participants of the pilot study were given the option to disclose their personal details if they wished to discuss further with the researcher the structure of the questionnaires. Such meetings took place in strict confidentiality.

of the study was given to participating groups through my active interaction with them during the study and at the end in the format of an easy-to-read brief report (see Appendix F).

2.8. Description of measurement tools

In order to meet the objectives of the study and take into consideration the particular characteristics of self-help groups along with the methodological particularities of research in this area, I chose to use a combination of quantitative and qualitative methods. Following the principles of alternative research paradigms discussed previously, the methods I used in this study were participant observation, process evaluation and adversary hearing. Specifically, I used participant observation in order to witness in person the way groups operated, to build relationships with participating groups and to collect written material about groups. Process evaluation was being conducted through quantitative assessment of various psychosocial variables related to individual and group factors. Finally, I followed the method of adversary hearing when I met at the end of the study with groups, presented my findings to them and had their feedback which assisted me in their evaluation.

Quantitative data that was collected included both individual and group variables. The choice of the specific variables followed the research orienting points presented at the beginning of this Chapter. Specifically, the selected scales assessed members' individual psychosocial resources such as social support and networks, psychological wellbeing and personal empowerment. Moreover, there were questions about group characteristics such as beliefs about the group, expectations and benefits from it, as well as helping group processes occurring during group meetings and members' identification with their group.

Selection of the scales was based on methodological and practical criteria. My intention was to include self-reported questionnaires in order to give the freedom of choice to members to respond on a voluntary basis and at their own pace. Therefore, they should be short yet comprehensive. On the other hand, I wanted to avoid scales written in the 'traditional' professional jargon but instead preferred scales written in a clear and understandable manner. As a result, the questionnaire of the study was a combination of 'standard' and 'new' scales, some of which have not been used before in an English population. Some of them were designed by mental health service users (e.g. Empowerment scale) or they were created after direct experience with self-help groups (e.g. Helping Group Processes scale). Others were standard widely used scales (e.g. General Health Questionnaire, Group

Identification Scale), or they had been based on pre-existing scales (e.g. Social Support Questionnaire for Transactions, Lubben Social Networks Scale) (see Appendix B).

At the individual level, the following questionnaires were included:

Demographic information about individual characteristics of group members. This part included information about sex, age, educational level, marital and employment status, as well as contact with mental health services. Contact with mental health services included past and present experience with mental health professionals, length of contact, experience of hospitalisation and sectioning (under the Mental Health Act 1983).

Empowerment Scale (Sciarappa et al. 1994). This was an American 28-item user-constructed scale to measure the personal level of empowerment as defined by 'consumers' of mental health services. Answers were rated on a four-point Likert scale ranging from strongly disagree (1) to strongly agree (4) and the total score range is 28 to 112; higher scores indicated higher levels of empowerment. This scale was the result of a study designed and conducted by a consumer research advisory board, according to the principles of the participatory action research (PAR) paradigm. The board based the construction of the scale on a definition of psychological empowerment and agreed upon fifteen attributes of empowerment (for a detailed list of attributes, see Appendix B). However, they emphasised that personal empowerment is a process, therefore it is not necessary for a person to show all these attributes to be empowered. A factor analysis applied by the scale's constructors revealed five dimensions. These dimensions can be seen within a framework for the concept of personal empowerment. Rogers et al. (1997) argue *that "using a tripod metaphor, there are three legs or supports of empowerment"* (p.1045). The first one includes two of the dimensions: self-esteem/self-efficacy: (9 questions, e.g. I have a positive attitude toward myself), and optimism/control over the future (3 questions, e.g. I can pretty much determine what will happen in my life). The second 'leg' of empowerment are the feelings of actual power of the person (7 questions, e.g. Most of the misfortunes in my life were due to bad luck). The third part of empowerment refers to *the "ability and willingness to harness anger into action and a socio-political component of empowerment"* (p.1045). It includes the two dimensions: righteous anger (3 questions, e.g. Getting angry about something is often the first step toward changing it), and community activism (6 questions, e.g. People working together can have an effect on their community). An examination of the questionnaire's reliability revealed that, in the present study, the internal consistency of the scale was quite satisfactory and at similar levels with the constructors' findings (Alpha = .82, constructors' Alpha = .86).

Social Support Questionnaire for Transactions (Suurmeijer et al. 1995). This scale consisted of 23 items measuring actual supportive interactions or exchanges of resources. Answers were rated from 1 (seldom/never) to 4 (often) and the total score range was 23 to 92. In the present study, the internal consistency of the questionnaire's items was very satisfactory (Alpha = .93). According to its constructors, social support is conceptualised as "*an actual transaction or exchange of resources between at least one recipient and one provider of these resources, intended to enhance the wellbeing of the recipients*" (Suurmeijer et al. 1995, p.1221). The scale takes into consideration two main distinctions concerning social support: a 'social-emotional' type (e.g. affection, sympathy or companionship) vs. an 'instrumental' type of social support (e.g. advice, practical help or financial aid) and a 'crisis' or 'problem oriented' type vs. an 'everyday' or 'daily' type of social support. Thus, the questionnaire measures five basic types of social support:

Daily (everyday) emotional support (5 items, e.g. Are people friendly to you?),
Problem-oriented (crisis) emotional support (6 items, e.g. Do people tell you not to lose courage?),
Social companionship (5 items, e.g. Do people just call you up or just chat to you?),
Daily (everyday) practical support (4 items, e.g. Do people help you to do odd jobs?), and
Problem-oriented (crisis) practical support (3 items, e.g. If necessary, do people help you if you call upon them to do so unexpectedly?).

General Health Questionnaire-12 (Goldberg 1979). This was the short 12-item version of a frequently used questionnaire about mental wellbeing. It consisted of six positively worded and six negatively worded items that described recent feelings or activities about general mental health matters. Answers were rated on a four-point Likert scale from 0 to 3; however, scores were transformed in a standard version 0 or 1, where 0 indicated good wellbeing and 1 indicated poor wellbeing. The total standard score had range from 0 to 12 and a threshold at 2/3 (Goldberg 1979); scores above this threshold indicated a poor mental wellbeing. The high levels of internal consistency of the scale in the present study confirmed that this was a highly reliable tool (Alpha = .94).

Lubben Social Network Scale (Lubben 1988). This scale consisted of 9 items, each of which ranged in value from 0 (no social networks) to 5 (a large number of social networks), having a total score from 0 to 45. The consistency of the scale in the present study confirmed that items are satisfactory inter-correlated (Alpha = .76). The questionnaire provides information on the level of an individual's connection and interaction with relatives and friends. Lubben (1988), the constructor of the scale, views social networks as distinctively different from

social support. Social networks include "*all of an individual's social contacts*" and can be "*described along structural and interactional dimensions including size, source of ties, member homogeneity, frequency of contacts, and opportunity for reciprocal exchange of support*" (Ell 1984:134, quoted in Lubben 1988, p.45). Specifically, the scale consists of four parts: family networks, friends networks, confiding relationships, and living arrangements. These four parts examine the following information:

Family networks	**Friends networks**	**Interdependent Social supports**
Number seen monthly	Number feels "close to"	Has a confidant
Frequency of social contact	Number seen monthly	Is a confidant
Number feels "close to"	Frequency of social contact	Living arrangements

At the group level, the questionnaires included were the following:

Demographic information about participation of group members. This part included information about group members' attendance, involvement, expectations, and satisfaction with the group.

Group Identification Scale (Brown et al. 1986). This was a 10-item inventory, which measured the level at which a member was identified with his/her group through statements of both affirmation and denial. Answers were given in a five-point scale (from 1= never to 5=very often) and the total score range was 10 to 50. The internal consistency of the scale in the present study was .82 and it was similarly high as the constructors' s reported consistency, Alpha = .71. Group identification is examined within the framework of social identity theory (Tajfel 1978). According to this theory, group memberships play an important role in the formation of people's social identities and these identities are sustained mainly through intergroup comparisons. Social identity is defined as "*that part of an individual's self-concept which derives from his [or her] knowledge of his [or her] membership of a social group (or groups) together with the value and emotional significance attached to that membership*" (Tajfel 1978, p.63, quoted in Brown et al. 1986, p.275). This scale of group (social) identification attempts to tap the three aspects of social identity, as defined by Tajfel: awareness of group membership (2 items), evaluation of this social identity (4 items) and affect attached to group membership (4 items).

Helping Processes (Wollert, Levy and Knight 1982). This scale consisted of 28 items. Each item was rated on a five-point scale from 1 (never happens in a group meeting) to 5 (frequently happens in a group meeting). The total score range was 28 to 140. Internal consistency of the questionnaire was quite satisfactory (Alpha = .87). The scale was especially designed to study group processes after observation of self-help groups and refers to help-giving activities that take place in these groups such as: behaviour-oriented, group cohesiveness, support, expression, confrontation, and insight-oriented. However, each of the 28 items describes a specific helping-giving activity that might take place in a self-help group. These processes were drawn either from studies of various psychotherapy techniques or were developed from the constructors' observations of self-help groups. According to the constructors of the scale, these processes belong to the broader categories as follows:

HELPING PROCESSES

Behaviour-oriented	Supportive	Expressive	Confrontational
Behavioural prescription	Reassurance of competence	Self-disclosure	Confrontation
Behavioural proscription	Justification	Sharing	Requesting
Behavioural Rehearsal	Mutual affirmation	Encouragement of sharing	Offering feedback
Positive reinforcement	Empathy	Reflection	Group Cohesiveness
Punishment	Normalisation	Catharsis	Group goal setting
Extinction	Instillation of hope	Insight-oriented	Assertion of group norms
Modelling		Functional analysis	Consensual validation
Personal goal setting		Discrimination training	
		Explanation	

In order to obtain qualitative data about the structural, organisational and ideological characteristics of the groups and to categorise them according their political ideology and focus of change, three approaches were followed:

Interviews with group leaders/facilitators/chairpersons. Semi-structured interviews with each group's leaders/facilitators/chairpersons were conducted. The interview schedule (see Appendix A) had the following axes:

- General information about the group: history of the group about longevity, frequency and place of meetings, practical responsibilities, composition and numbers of membership.
- Ideology of the group: aims and principles of the group, affiliations with other self-help and/or other-type organisations and attitudes towards mental health professionals according to Emerick's (1991) suggested factors of political group typology (discussed in Chapter 1, section 1.2.3).
- Structure/operation of the group: code of conduct, groundrules, ways of functioning, sources of funding.
- Leadership: style of leadership, leader's attitudes towards other members and the group as a whole.

Collection of group written material. Written information about the groups, provided by themselves, was collected. This included publicity material, constitutions and information about the common problem/condition/issue given to members.

Participant observations of group meetings. In order to triangulate data about the groups' profile and to establish a relationship with participant members, I attended three or four meetings of each group.

2.9. Analysis of the results

For the statistical analysis of the collected quantitative data, I used the Statistical Package for the Social Sciences (SPSS), Version 7.5. The analysis was conducted in several stages. First, I explored the data using descriptive statistics (frequencies and percentages) for responses from the First and Second Phase of the study. At this level, I also tested the internal consistency of the scales used in the questionnaire, examining Cronbach's coefficient alpha (Kline 1993). Secondly, I examined the relationships of variables with each other using Pearson correlation and chi-square tests. To determine the variances between the three ideological types of groups, I used one-way analysis of variance (ANOVA) or equivalent non-parametric tests like the Kruskal-Wallis H test (where the data were not homogeneous and did not have normal distributions, e.g. in the Second Phase of the study). Finally, I compared data from the two Phases of the study with independent samples t-tests or equivalent two independent samples non-parametric tests like the Ranks Sum (Mann-Whitney U) test. For the testing of changes within the same sub-sample of respondents who

participated at both times of the study, I conducted paired samples t-tests or equivalent two dependent samples non-parametric tests like the Wilcoxon Matched-pairs Signed-ranks T test.

Analysis of qualitative data such as open questions, interviews, written material of participating groups and field notes from participant observations were analysed using the technique of content analysis (Heiman 1998). In the case of open-ended questions, participants' answers were scored by counting specified types of responses and descriptive statistics were produced (e.g. questions about expectations and benefits from group participation). Interviews, written material and field notes were analysed more 'freely', that is the purpose of the analysis was not to produce quantitative statistics but to report important structural and organisational characteristics of participating groups and, subsequently, to attempt categorising them according their political ideology and focus of change. Therefore, following the axes of the interview, presented in the previous section, data were employed in order to outline self-help/mutual aid groups' profile.

A final note concerning the analysis of data is about the issues of reliability, validity, representativeness and generalisability. The present study is of descriptive nature and is conducted in naturally occurring settings. Therefore, there are limitations to the extent of control the researcher can exercise to extraneous variables of the study such as the environment where it is conducted (e.g. wherever self-help groups hold their meetings) or the participants (e.g. number of people attending each meeting). Despite these restrictions, the design of the study allowed the researcher to assure aspects of reliability and validity.

Specifically, reliability of the measurements tools was examined in two ways: assessing the internal consistency of the scales (Cronbach's Alpha) and checking their test-retest reliability. Internal consistency of a scale shows how relevant with each other the items of the scales are, that is if all items measure the same variable. Test-retest reliability indicates that participants tend to obtain the same score when tested at different times. Both techniques were used in the study in order to determine the degree to which measurements were consistent and reproducible. The number of respondents allowed me to conduct internal consistency tests and the longitudinal character of the project gave the opportunity to examine test-retest reliability tests. The results of these tests were satisfactory. Details of the internal consistency tests were presented earlier on in this Chapter, in the section 2.8; results concerning test-retest reliability will be presented in Chapter Six.

In addition, convergent validity of the measurement was possible to be determined for several of the scales I used. This type of validity refers to the extent to which scores

produced from one scale are positively correlated with scores obtained from another relevant scale. For example, in the present study, scales of social networks and social support were highly correlated with each other. Moreover, It could be argued that there was evidence of internal and external validity due to the longitudinal character of the study. Internal validity refers to the degree to which we can draw the correct inferences about the relationships occurring within a study. Indeed, results of the two phases indicated that there were a number of relationships that were repeatedly present, showing that relationships remained stable through time. External validity is the degree to which the results accurately generalise to other individuals and other conditions. In the present study, although the selection of samples was not intended to be representative, effort was made to select groups which present a variety of organisational and structural characteristics. Therefore, it could be argued that at some degree findings of the study were potentially typical of the general population. This argument is reinforced if we consider the fact that, despite the fact that participants at the two phases of the study were in their majority different, a lot of the findings were repeated.

Finally, in order to ensure the of reliability and validity of measurement tools used in the study, as well as to assess the efficiency, understanding and clarity of questionnaires employed I conducted a pilot study with a small number of service users who attended a local day centre. Feedback from the pilot study is presented in detail in Chapter Four, section 4.1.

CHAPTER THREE

Profile of Participating Groups

Each self-help/mutual aid group is unique in its character and, although they may share common attributes with other self-help/mutual aid groups or they are part of a bigger self-help organisation, they have a distinct profile which is due to the particular conditions and composition of membership. It is, therefore, necessary to introduce in detail each one of the participating groups of the study in order to understand how these groups work and in which ways the findings are related to them. In this Chapter, I will also present the arguments for the categorisation of the groups, based on the qualitative data I collected during the study.

3.1. Collection of qualitative data about organisations and local groups

As already stated in previous chapters, the main aim of this study was examine the relevance of a group typology of self-help/mutual aid groups based on political ideology and focus of change. Therefore one of the major tasks in the project entailed the categorisation of participating groups according to the chosen typological criteria. To achieve this aim I chose to employ qualitative methodological approaches, as I mentioned in Methodology (Chapter Two). Information about participating groups and the organisations they belonged to was gathered through:

a. Relevant literature about groups and organisations like publicity leaflets, booklets, newsletters, press releases, mission statements and constitutions (usually given to me by the groups themselves) (for a detailed list of literature from participating groups see References).

b. Semi-structured interviews conducted with group leaders/facilitators/chairpersons (description of the interview's main themes is given in Chapter Two, section 2.8).

c. Participant observations of group meetings (three or four for each group).

All qualitative data were studied using the content analysis technique, as I mentioned in the Methodology chapter (section 2.9). Interviews were taped with the interviewee's permission and were fully transcribed. These interviews took place, for most of the cases, where the group was meeting, outside the usual meeting times. The people who decided to talk to me about their group were usually these members who were responsible for facilitating group meetings or who were clearly characterised as leaders of the group or, in some cases, the members who

were acting as chairpersons or secretaries for the group (this was the case for user forums). There was also one case where it was decided that the interview would be given by the whole group, as I discuss in later sections of this Chapter. All interviewees were keen on giving as much information as possible about their groups. However, in some cases, people were showing signs of exhaustion from trying to keep their group alive and running and talked about their disappointment of not having more support for this effort from public funding sources. They were all eager for me to record their history and do research on self-help/mutual aid groups because hey thought it would be beneficial for them and it might help with recruiting new members. The interview axes served as the themes of the subsequent content analysis. Both interviews and literature from organisations and groups were analysed 'freely', that is the purpose of analysis was to learn about their most important structural and organisational characteristics. Consequently, there was a selective use of material in order to compose their profiles and to be able to categorise participating groups.

Participant observations of group meetings had a twofold purpose: to enable the researcher to approach groups and establish a rapport with their members and to compliment information from literature and interviews. Being a "participant observer", I was confronted with the reality of these groups and got the chance to better understand their empowering character. I witnessed members' transformations from passive and helpless 'sufferers' of a mental health problem to self-assured active members of a dynamic community group. I empathised with them by listening to their discussions about their everyday struggle to cope with loneliness and isolation from family and friends, drugs' side effects and contradicting therapeutic approaches, desperation and sense of uselessness. I also had the unique chance to share experiences from my professional life and academic research with group members and listen to their enlightening views. Some of the challenges of this type of observation, as discussed in qualitative methodology books (e.g. Crabtree and Miller 1992; Banister et al. 1994), are the influence of the observer's identity on the way s/he observes the phenomenon and the impact of the observer on the observed situation. In this case, observation was not the main source of information but it was one of the methods used to collect data. Therefore, field notes were mostly used for triangulation purposes, to validate information gathered by interviews and written material. Nonetheless, a great amount of data was collected by all three approaches which is not fully explored in the present thesis and it could serve as the basis for further elaboration and publication.

3.2. Description of participating self-help/mutual aid organisations and groups

Variety is the key word for describing the structural and organisational characteristics of the groups participating in this study. There are groups that belong to a national-wide self-help/mutual aid organisation and groups that stand by themselves. There are groups with a very formal way of operating and there are groups with a very loose character. There are groups with a large membership and groups with few consistent members. There are groups that welcome professionals and/or relatives in their meetings and groups that operate on an "only-users" basis.

All the above differences between groups denote the multifaceted character of self-help/mutual aid groups and compose the unique profile of each separate group. Members base their choice of group on this profile and outcomes from group participation are influenced by these unique attributes. Despite their singularity, groups share common elements with others and, thus, can be categorised in relation to specific traits.

Consequently, it is essential to examine in depth the profile of our participating groups, describing also the broader organisations to which some of them belong. The aim is to get familiar with them as well as explore similarities and differences between them. Also, the presentation of the groups' profile will lead to the arguments about their categorisation according to their political stance.

3.2.1. The Depression Alliance (DA)

The Organisation

"Depression Alliance" is one of the biggest self-help organisations in United Kingdom for people experiencing clinical depression, according to one of its recent press releases. It came to existence under this name in January 1995. However, its history as an organisation dates back to 1973 when a nurse who also "*had first-hand experience of depression*" decided to set up the "Depressives Anonymous". This original group was at that time based in the founder's house and it consisted mainly of the founder providing help to fellow sufferers[1] on a personal basis via correspondence. Some years later, due to the opinion of the founder that the condition of anonymity should be abolished, the organisation split and she started the "Depressives Associated". The new group (Depressives Associated) obtained the status of charity in 1979

[1] The term 'sufferer' as well as other terms such as 'patient', 'consumer', 'service user' or 'user', refers to the people who have a mental health problem and have received professional treatment; these are used in this chapter as appropriate, according to each organisation's or group's terminology. The existence of different terms denotes a more general view of groups about the social identity of people who have mental health problems.

and it was still operating in the format of correspondence with fellow sufferers and the publication of a newsletter.

By mid 80s, Depressives Associated had grown considerably and its membership was around 600 people, a figure that doubled in the last four years of the decade. It went on producing information about depression, self help and advice for carers and medication. According to a relevant press release of the present organisation concerning its history, "*gradually Depressives Associated began to attract more publicity and its value to sufferers and carers was recognised by the medical profession*" (Press release - Depression Alliance 1996). At the beginning of the 90s, the organisation rented an office staffed by voluntary helpers. It also started to develop relationships with the Royal College of Psychiatrists, joining them in a campaign about depression run by the College, the "Defeat Depression Campaign". Additionally it promoted its work at Charity Fairs throughout the country. This increasing publicity led to the expansion of the organisation by moving to a larger accommodation and involving its members to a large number of activities such as interviews to the media and participation in medical conferences both within UK and abroad.

On January 1995, the Association changed its name to Depression Alliance because its members felt that the previous name "*portrayed a somewhat unsatisfactory image and the connotation was wrong*" (Press Release - Depression Alliance 1996). The launch of its new name was made at a formal reception held at the House of Commons with "*a number of Peers, MPs and notable figures in the medical field and celebrities*" taking part. In the beginning of 1996 the membership of Depression Alliance had grown of 1500 people, "*but considerably more sufferers of depression were helped as membership has never been a prerequisite for assistance and support*" (Press release – Depression Alliance 1996). Moreover, the organisation maintains that "*despite the growth in membership the emphasis remains on a caring personal approach*" (Interview with DA's Director 1996). The new organisation has a Constitution and is run by an Executive Committee, which is elected annually. Nominations for the Committee are invited from all full-time members and must be supported by two full-time members of the organisation. At present, the Committee consists of sufferers, carers and some professionals. There is also a 'Finance and General Purposes Committee' as well as an 'Advisory Panel' with the same kind of composition. In the hierarchy of the Alliance, there are paid staff such as the Director, the London Groups Co-ordinator and the National Groups Co-ordinator. However, a lot of the people who work at the organisation's offices are volunteers. Funding for running expenses as well as special events comes from various sources such as membership fees (which in 1996 was 7 pounds per year), grants (e.g. Lottery grants or funding from the Department of Health or Local Health Teams) and sponsorship from pharmaceutical

companies. In 1996, the Director reported at the Annual General Meeting that the organisation's income had raised to more than 250.000 pounds.

The organisation's membership has risen dramatically since its launch. In a recent fact file published by Depression Alliance in 1997, it is mentioned that "*the organisation currently has 3000 members* [and] ... *has responded to over 16000 requests for help and advice*". At an issue of their newsletter called "*A Single Step*", in 1996, it is reported that 72% of members are women and 28% are men, while the majority falls into the 36-55 age group, with the second largest group being the 26-35s. Moreover, according to the DA fact file (1997), the organisation is "*staffed by people who have a thorough understanding of depression*", either from personal experience or as carers. The organisation states clearly, in the same source of information, that its main activities are focused on:

1. *educating people about depression, its causes and how to cope with its difficulties,*
2. *helping the establishment of small, personal-contact self-help groups for sufferers who need them,*
3. *co-ordinating a pen friend scheme for members in isolated areas, and*
4. *becoming actively involved in research into the causes of and treatments for depression and the dissemination of such results.* (DA Fact file 1997)

The present organisation has still close relationships with the medical professionals, through its involvement with the Defeat Depression Campaign and the Long Term Medical Conditions Alliance. As a consequence, it collaborates with Health Authorities and Commissioning Teams in various projects concerning the specific mental health problem. The Alliance positions itself next to the professionals, claiming that there is need for co-operation with them in order to succeed an effective treatment of depression. According to the Director's words: "*Depression Alliance's role is to operate alongside members of primary and secondary care teams to enhance the treatment available for sufferers and their prospects of recovery.... Our work complements that of doctors and the primary and secondary health care teams in general*".

The attitude of the organisation towards the illness of depression is that it is a long-term "illness" which must be accepted by the sufferer before he/she starts to cope with it. Depression Alliance emphasises there is no instant remedy for depression. The organisation believes that each person with this illness must follow a combination of medical and psychological treatments. These treatments may have the form *of "medication, psychotherapy,*

counselling and self help" (Interview with DA's Director 1996); however, the view is that a combination of two or more usually is providing to be most effective.

Among the organisation's information for the public, there is a special booklet about self help and its various forms (Depression Alliance 1996). It is explained that there are two forms of self help: 'individual' and 'mutual support'. Mutual support is, according to this booklet, "*provided by members of small groups of sufferers who meet to share encouragement, understanding and a listening ear*". Furthermore, a distinction is made between self help and medical treatment. It is strongly emphasised that self help is not an alternative to professional advice and treatment and people are encouraged to seek firstly for this kind of help, consulting their GP or more specialised professionals like psychiatrists or psychotherapists. Self help is referred as a 'back up' to this help. Talking more specifically about the self-help groups, a list of benefits is given in order to promote their usefulness. These are mainly concentrated in the elements of mutual support, non-judgemental environment, reassurance of not being alone, and shared information about 'symptoms'. A description of group structure is also presented in this booklet and it points out the role of the 'group contact', that is the person who sets up and runs the group. The group structure is described as 'small', 'informal', 'free', with each group having a 'slightly' different character "*according to its members' requirements which often change from week to week*".

The Local Groups

The Lambeth Morning and Afternoon Group

These two groups are based in the offices of the Depression Alliance in London. They were both first set up at the beginning of 1995 by a sufferer who was also a member of the Committee as a National Groups Co-ordinator. There were a number of members, about thirty, who wanted to have a morning and an afternoon meeting. When the organisation hired a London Groups Co-ordinator in 1996, she took over the two groups and encouraged their members to come forward as facilitators. This happened a while after and at the time of the study there were new group facilitators[2], two 'old' group members who volunteered.

The Lambeth Morning Group is small with four or five regular members. It meets monthly and its main focus, according to its group facilitator, is "*mutual support*", "*a kind of a society where people can unwind in a non-threatening way and in a non-threatening environment*", "*an environment where they* [members] *know that they can feel valuable and understood*". The

[2] The terms 'group facilitator', 'group leader', and 'group co-ordinator' are used interchangeably in this chapter and denote the person who is responsible of arranging practical matters for the group as well as facilitate the discussion during the meetings. The reason for the use of these different terms is that these people chose to refer to themselves as such in the course of the interviews I contacted with them.

structure of the group is liberal, with free-floating conversation, "*keep the group as relaxed and laid back as possible*". In order to join the group, people have to go through the Alliance; they get in touch with the organisation and then their details are forwarded to the group facilitator. He, then, responds to them with information about the meetings and invites them to join the group. Members do not have to pay fees or subscribe to the Alliance. So, the group is publicised only through the Alliance's newsletter.

The group has no sources of funding as it does not have any expenses, like paying for the place of meeting or for publicity material. These are provided by the organisation. Group members only pay voluntarily for coffee and biscuits. The group is open to sufferers and carers alike. Professionals do not have any part in the group. However, according to its group facilitator, members would not mind to have them joining the group as invited speakers from time to time. Themes of group discussions include everyday coping with depression, how the illness affects members' relationships and sharing of information about alternative therapies. There is also a 'library', a collection of self-help books about depression, which the Morning group shares with the Afternoon group and from which members can borrow.

During the research project, and specifically when I was about to start the Second Phase of the study, I contacted all participating groups in order to arrange with them the administration of questionnaires to members. The group facilitator of the Lambeth morning group replied that, due to changes in the group's operation, the group decided to operate in a 'closed' (members only) manner, i.e. not to accept any outsiders in future meetings. This decision had an effect on our collaboration because I was no longer able to attend their meetings and therefore I could not ask for their participation in the second phase of the study. When I pursued the matter with the group facilitator, he explained to me that the group's decision was the result of operation problems they were facing in the past months, i.e. leadership difficulties, conflict in members' opinions about the character of the group. He reassured me that their decline to continue to participate in the study did not have to do with how they were feeling about the project but it was influenced by their internal problems and consequent changes that took place. After discussing it with the other members, he informed me that the group, despite their refusal to participate in the second phase was very happy to be included in the first phase of the study and any reports resulted from it.

The Lambeth Afternoon Group also meets once a month and has a core of three or four regular members with a few more joining occasionally. The organisation puts in touch people who want to join the group with its group facilitator; however, members do not have to belong to the Depression Alliance in order to participate in the group. The aim of the group is "*to provide support, reassurance and understanding in a relaxed atmosphere*" as well as "*to share*

experiences of depression and learn coping strategies". The group's basic principles are, according to the group facilitator, "*confidentiality, respect and equality*". He mentions that, although the group has no formal structure, these ground rules represent 'values' upon which their meetings should be conducted.

The group is mainly consisted of sufferers but is open to carers as well. It does not have any contacts with professionals as such but, nonetheless, it does not object to their presence as invited speakers at some occasions. The group facilitator states clearly that their group is not "*a political group*", "*it's neither pro or anti-psychiatry*". The focus of discussion, most of the times, in the meetings is about "*what people have in mind, what seems to be trivial concerns, ... it is talking about things they are worried about, and it's listening about these worries*". Practical matters like funding are covered by the fact that the national organisation provides the place of meetings as well as informative material for members. The group facilitator also express the opinion that the group does not "*always fulfil its potential, members have different views about its usefulness, some really enjoy it and some go away disappointed. It's trying to cater for everybody, this can be difficult. But it's really a group of people sitting in a room and chatting about things they matter to them without hiding away their feelings*".

The St. Albans Group

This group has started nine years ago in 1989 at the Day Hospital at St. Albans, meeting mainly for lunch. A year later, the group facilitator, who started the group, took the initiative to continue the meetings at her own house. It went on evolving to a large group and in 1995 the place of meetings changed to a Church Hall. People can join the group through the national organisation. However, the group gets referrals through the local mental health services or the St. Albans Council of Voluntary Services (C.V.S.). Group members can also recommend people who are interested in joining. The group facilitator emphasises the fact that she is very careful with the issue of who joins the group. She prefers that the group accept new people who are recommended only from the above sources. For this reason, she also meets the potential new members, before they join the group for the first time, and discuss with them what they expect from the group, "*to see if they would fit into the group*". The criterion for joining is to suffer from depression as the primary problem, so the group facilitator encourages people who have depression "*as a secondary illness*" to join a different group and provides information about this. She claims that "*if they are not in the correct group, then I can direct them to one*".

This group has usually fifteen to twenty people at each meeting, with a core group of eight to ten regular members. The majority of the membership is sufferers and there are a few carers.

Actually, the group has two group facilitators, a sufferer and her husband who is a carer. He runs a separate group at their house for carers only. The meetings were once a month but, due to the increasing number of members at each meeting, in 1997 the group decided to start meeting twice a month. The focus of each meeting is different. One meeting is mainly for invited speakers and "*a bit of self help*", that is discussing about personal issues and the other meeting is devoted solely to self help. The topics of the talks cover a wide variety; some are about professional services that are provided in the local area, as well as alternative therapies, the work of other charity organisations, or about something not relevant with depression like a hobby. In the self-help meetings, members discuss medication and side-effects, living on your own with depression, different ways of coping and the effect of the illness in personal relationships. Usually, in these meetings the group splits to smaller groups with an 'old' member as co-ordinator and members can decide their theme of discussion. At the end of the meeting, members return to the larger group and give feedback from the discussions that took place. Some members like to get together after the meetings in a pub and develop friendships.

The purpose of the group is "*to support one another because we are all suffering from depression, ... there are certain things we all have in common*". They also organise social outings and they are involved in various community activities such as giving talks to the local mental health teams and informing the GPs about the group and the needs of people who suffer from depression. Recently, the group got funding from the mental health services to set up a help line for the members of the group. The group has to cover expenses like paying rent for the place of meetings or expenses for social outings. It has a variety of sources for funding such as the local mental health services, mental health organisations like MIND or other charity organisations like local churches. Depression Alliance helps them by providing relevant literature but does not fund them. Members contribute a small amount of money for coffee and biscuits.

The group's attitudes towards professionals are described by its group facilitator as diverse: "*often the old psychiatric hospital wards are criticised but there again we praise things that are good*". The group has a lot of contact with mental health professionals either by inviting them as speakers to their meetings and getting referrals from them, or talking to them about issues that matter to the sufferers and changes they would like to see from the professionals.

3.2.2. The Fellowship of Depressives Anonymous (FDA)

The Organisation

The "Fellowship of Depressives Anonymous" has started in 1973 as I already have mentioned in the description of the Depression Alliance (this Chapter, section 3.1.1.). It was founded by a psychiatric nurse who was also a sufferer from depression, but in 1979 the organisation split and another one, the "Depressives Associated", was started by the initial founder. The Fellowship continued to exist with the same character and aims. The focus of the organisation is people who suffer from depression and its main purpose to *"help ourselves and anyone, anywhere, who has felt the need of our support"* (FDA Newsletter 1996). However, the organisation believes that it has also a *"long-term role in helping to educate the public about the true nature of depression"*. It characterises itself as a "national self-help organisation" and consists of a network of self-help groups throughout the country. Other aspects of the organisation are a pen friend scheme with a *"large number of individuals in touch by post with at least one other helper-sufferer"* and the publication of a newsletter which gives information about the organisation's activities and publishes sufferers' personal stories along with articles and book reviews on aspects of depression. The Fellowship organises also Open Days about depression several times a year in various parts of this country.

The organisation has charity status and its central offices are in North Humberside. There is an elected Committee and they hold an Annual General Meeting. The Committee is entirely composed of present or past sufferers because the fundamental belief is that *"depressives can help themselves and each other by the very fact of their shared affliction"* (FDA Newsletter 1996). There is no specified hierarchy within the organisation but, in contrary, everyone is equal as its members believe that *"there is no room in FDA for an attitude of 'them' and 'us' with some individuals laying down the law to others"* (FDA Leaflet). They also emphasise the fact that the organisation is *"in favour of strict confidentiality"* and for this reason it includes the anonymity element in its name. Its position towards professionals is a positive one, stating that it believes in *"working alongside the medical and caring professions"* and that *"some of us have been helped by psychiatry, drugs or ECT"*. In fact, in the organisation's introductory leaflet, it is mentioned that *"it should be strongly emphasised that the Fellowship's offer of mutual self-help is in no way opposed to the professional treatment of depression"* and that it encourages members *"to seek, or continue to seek, all possible help of a conventional kind"*. The view of the organisation about its relationship with professionals is that they should collaborate and professionals should refer their patients to FDA groups. According to this view, groups can offer help *"not only when other methods seem to be failing, but also as a way in which 'recovered' patients can follow up whatever form of therapy had enabled them to face the world again"*.

The Fellowship supports financially itself almost solely through the membership fees which are seven pounds a year. Subsequently its funds are limited and this can be seen in the absence of expensive publications about depression and related issues, unlike its 'sister' organisation, Depression Alliance which has access to a wide variety of funding. Most of the activities are organised by volunteer members.

In reference to self-help groups, the organisation states that "*not everyone chooses to attend a group, even if there is one nearby, but many do, some travelling considerable distances because they find it a vital aid to better living and a real help to recovery*". It is also noted that FDA groups vary enormously and that every local group is autonomous in the way that it will operate. Their common point is "*a genuine interest in the welfare of each person who comes to the group, and a willingness to listen to them, thus fostering an atmosphere in which members can find out for themselves how best they can cope and improve*".

The Local Group

The Central London Group

The group started nine years ago, in 1989, by a sufferer who thought it could help her with her depression to meet others who have similar experiences. At the beginning they were meeting at a local day centre run by the social services but very soon they moved to the group leader's flat as it was convenient for most of the members as well as for the group leader who had health problems and couldn't move easily. The group was small at the start with three or four people attending each meeting but it became larger during the time because, according to its group leader, it is one of the few self-help groups for depression based in Central London. At the time of the study, the meetings are weekly and the attendance of a meeting is usually ten to fifteen members, most of them being regular ones.

The group leader mentions that she has some help from the national organisation in the form of advice how to run the group and some information material. However, she says that the group is quite independent and members do not have to be members of FDA. In fact, most of them are not subscribed to the organisation. The group does not get any funding but it does not have running expenses like paying rent. Also, the group leader feels it "*uncomfortable to ask people for donations*". People can find out about the group mainly through the national organisation but there is information about the group in the local MIND office and social services.

The structure of the meeting is quite loose. At the beginning, the group leader asks members to tell the name and how they are doing and then they move on discussing whatever they want. She only intervenes when someone talks for along time and she tries to give the chance to other people to talk as well about their experiences. The topics of discussion are usually

members' experiences with depression, ways of coping, alternative therapies, medication and side effects. The meetings are not open to carers or professionals but the group does not oppose relationships with professionals. In fact, it has a positive attitude towards them and it collaborates with them when its help is asked for research purposes or for announcing clinical drug trials to its members.

3.2.3. The Eating Disorders Association (EDA)

The Organisation

"Eating Disorders Association" is a national charity formed in 1989. It was formed through the merger of three small charities, "Anorexic Aid", "Anorexic Family Aid" and "Society for the Advancement for Research into Anorexia", which were set up by individuals who had experienced "*the difficulties and frustrations of trying to get help and treatment for eating disorders*". It is "*the only major national charity which offers help to all those involved with anorexia and bulimia nervosa*", according to one of the organisation's fact files (EDA's Fact file, 1996). The charity is governed by an elected Council which includes people who have had eating disorders, carers and professionals. The head office is in Norwich and there are no regional offices but the organisation has a national network of self-help and support groups for sufferers/carers only or for both. The 'mission statement', which is presented in their 1996 Annual Report, is the following:

"*Eating Disorders Association is a national charity offering help, support and information to people whose lives are affected by eating disorders, in particular, anorexia and bulimia nervosa. It aims to campaign to improve standards of treatment and care and to raise awareness of eating disorders and related issues*".

Specifically, the key objectives that are presented in the above mentioned report, have a support/education as well as social action focus, stating that the organisation aims:

1. *to offer services which provide support and information for people with anorexia or bulimia nervosa, and their families and friends,*

2. *to campaign for better treatment and care for people with anorexia or bulimia nervosa,*

3. *to raise awareness of anorexia or bulimia nervosa through research, training and education, and*

4. *to secure funding to achieve these objectives.*

It is important to note that the sort of campaigning action that the organisation wishes to undertake, concerns collaboration with the mental health professionals who are already responsible for the provision of existing services. So, professionals are very much involved in the Association as members of the Executive Council or as advisors in various projects that the organisation initiates, as well as active members being involved in the preparation of information material for sufferers and service providers. Indeed, it is characteristic of the organisation's attitude towards professionals the fact that there is a special professional membership category which also includes subscription to a professional journal, *the "European Eating Disorders Review"*.

The Association is well-organised, having a series of clearly written leaflets to inform people about eating disorders and the consequences in the sufferers' lives and their families. It also publishes a bi-monthly newsletter, called *"Signpost"*, which presents relevant articles written by professionals as well as by suffers and carers and news about the organisation's activities. Other services that the Association provides to its members are:

- Telephone helplines.
- A network of locally based groups and individual volunteers who offer support by telephone and mail correspondence.
- Training courses for school nurses and matrons.
- Support for research through (limited) funding and a volunteer database.
- Guidelines on service specifications for the treatment of eating disorders.

The organisation covers its running expenses (e.g. renting offices, paid secretarial staff, publishing information material, organising fundraising events and commissioning research) from a wide variety of sources. Some of these are income from membership, sale of books and information packs, grants like a National Lottery grant and the Department of Health grant, donations from various business and bank or charity organisations as well as from ex-sufferers and their families.

At the beginning of 1996, the organisation commissioned a market research agency to conduct a survey about the members' views of the self-help groups and the organisation as a whole. From this research (cited in EDA's Annual Report, 1996), it is reported that the majority of the

EDA's membership is young women: "*21% are under 19, about 26% are students and 51% are working full or part-time.* ". There is also a point of confusion about the problem that the organisation has as a focus. According to the survey "*a significant minority* [of members] *classify themselves as compulsive eaters*", which contradicts the specific focus of the Association in anorexia and bulimia nervosa. The organisation, responding to this confusion, insists that the focus cannot be changed due to the high demand that would cause; however, they are networking with other organisations like the Overeaters Anonymous in order to develop complimentary services with them and help people with different eating problems. In the same report, it was mentioned that most people (67%) who contact the organisation are sufferers themselves. Moreover, the membership fees (£20 per year) were reported to be a restraining factor for potential members. As a result, the organisation reduced the annual fees to fifteen pounds and there is an option of free membership to anyone who cannot afford to pay.

The survey about the EDA's self-help and support groups showed that these are important to many members but not all of them would attend. It was also reported that all groups are very different and there was no 'typical' EDA group. People attending groups were not necessarily EDA members and did not know about the national organisation's work. However, the group co-ordinators were very positive about the organisation. The Association's attitude to the groups is to support them, finding ways to expand their number by assigning a Groups' Co-ordinator to organise this effort. There is also a plan aimed at "*setting up pilot regional offices to offer better support to local groups and to provide better links between people with eating disorders and the professionals working in the area*" (EDA Annual Report 1996).

The organisation's views about eating disorders, referring specifically to anorexia and bulimia nervosa, is that they "*are the outward expression of deep psychological and emotional turmoil*" and that "*sufferers turn to food and eating as a means of expressing their difficulties*". It also acknowledges the impact of social influences relevant to self-image and the different ways that women and men respond to these social factors. The Association refers to the variety of treatments for eating disorders, emphasising the need for 'talking therapies' and the prerequisite of professionals having '*an understanding of the condition*' in order to provide effective services. It also recognises the fact that "*neither anorexia nor bulimia can be cured overnight*" and that "*recovery is a long hard process*".

The Local Groups

The Maidstone Group

This local EDA group was started in 1986 by a carer who was a member of one of the older organisations from which the Eating Disorders Association was formed. The group was set up out of the need to help sufferers in the specific area where there was nothing on offer for eating disorders. At the start, the group was for sufferers only; however, it changed to a mixed group for both sufferers and carers because the group leader had the opinion that it would be beneficial for the group to have both kinds of members. Moreover, whereas the meetings were monthly at the beginning, later due to member demands they became weekly. The only requirement for joining the group is to have experience with eating disorders either as a sufferer or as a carer. It is not obligatory to become an EDA member and members don't pay any fees for participation, but they contribute voluntarily for coffee and biscuits. The group does not have any running expenses as it does not pay rent for the meeting place, which is a room in a Day Clinic run by the mental health services. People can find out about the group through their GPs who have information about EDA and its groups, other organisations like the Samaritans, directories about mental health services, and via friends and fellow sufferers. The group does not promote its work in other ways.

The number of members is usually five to ten, with a core of three or four regulars. It varies significantly from meeting to meeting due to the fact that the group leader has an 'open' attitude about attendance. She states that "*people can come and go when they need to, perhaps some don't come very often but this must be their choice*". When asked if there are any cases where parents bring their children who suffer without their consent, she answered that she suggests to the parent to come alone in a meeting and then to tell her/his child about it. In this way the sufferer has the chance to decide for him/herself. She also mentions that in a lot of cases both the parent and the sufferer decide to participate in the group because they feel it helps them. She believes that it is better to have this combination of sufferers and carers and that it is more helpful than having separate meetings because it gives both sides a chance to see how the other is feeling and to learn from this.

The group meetings follow a loose structure according to which the group leader introduces newcomers and they go in a circle saying their names and, if they want to, describe how they are doing. The group leader gives 'space' to anyone to express themselves: "*People may be emotional in the group. That's OK. We laugh, we cry. But that's OK*". She lets members talk as much or as little they like, "*as deep as they feel able to go. If they start to talk about details, then I say it's OK, it's their chance*". Due to the lack of other similar organisations locally, the group does not have contacts with other organisations. The group leader is personally involved

with other mental health organisations and talks to professionals, "from time to time", promoting the needs of people who suffer from eating disorders. Her opinion about self-help groups is that these are not effective for everybody and that possibly different types of groups are the right ones for different people. She believes that "*one of the important things to think about is that the group leaders should at least have some training in counselling and counselling skills*" in order to run a self-help group more efficiently. Nonetheless, she emphasises that it does make a big difference to '*go in as one of us*', to have the same experiences and be a fellow sufferer.

The Southend Group (SEEDS)

The group started in 1991 by a local community psychiatric nurse (CPN) in a Day Centre run by the mental health services. From the start it was under the umbrella of the Eating Disorders Association, and it was operating as a support group, with staff from the services as group leaders. Two years later, it became a user-led group and the present group leader took over. In 1996, it got charity status with the name of South Essex Eating Disorders Support (SEEDS) and there is an Elected Committee and a Constitution. However, the group is still affiliated to the national organisation and gets support in the form of advice with the organisational matters of the group as well as participating in training days for group leaders and members about various issues.

The group has four regular members and a number of members who attend less regularly. There is no restriction for joining the group and the only requirement is to have eating disorders. Although the group is for sufferers only, they do accept carers into their meetings from time to time. The aim of the group is, according to its group leader, '*to help and support people with eating disorders and to promote issues and educate about eating disorders*'. The form of help that the group can offer is "*to get members to talk, to give them a place to go to and talk so as they don't feel they are alone... To be there as a backup... And to help and educate the carers as well as we can*". The group is also involved in community activities like organising talks to promote public awareness of eating disorders, giving interviews about the problem in the local and national media, and running its own local helpline for people who suffer from eating disorders and would like to talk to someone and get some information about it. For the financial support of some of these activities, the group decided to obtain the charity status so that it can be eligible to apply for grants. At the time of the study, the group had applied for a National Lottery grant and had obtained funding from the local mental health services to set up the helpline.

The group's attitude towards professionals is positive and they get referrals from them, as well as referring people to the services. There is also a 'medical advisor', the CPN who actually

started the group and remained as advisor when there are worries about a member or they need to have some information about a specific issue or service. However, members accept professionals' presence only as invited speakers or as collaborators in a specific project like informing the local community. They would not like them being in the actual group meetings. As for the group's opinion about the traditional mental health services, members have their own personal experiences but it is not a topic for discussion and they do not express an opinion as a group. Moreover, the group is affiliated with an American organisation for eating disorders, called the National Association of Anorexia Nervosa and Associated Disorders (ANAD), similar to the Eating Disorders Association. They are also members of the local Council for Voluntary Services (C.V.S.).

3.2.4. The Overeaters Anonymous (OA)

The Organisation

"Overeaters Anonymous" in Britain is part of a bigger American organisation with the same name which began in 1960. There are thousands of groups in the United States, Canada and Europe. The organisation follows the principles and structure of the Alcoholics Anonymous, the oldest and biggest self-help organisation world-wide. According to information given by a Public Information Officer of the London and South-East Region Intergroup, it is "*a fellowship of individuals who through shared experience, strength and hope work towards overcoming the problem of compulsive eating*". The only requirement for OA membership is a desire to stop eating compulsively. However, they do not limit the membership to a single form of eating disorders but they state that their meetings are "*for people who suffer from all types of eating disorder: anorexia, bulimia, severe binge eating*" (OA Leaflet about the organisation 1992). They also emphasise, in their literature, that the organisation is not a diet club and does not offer advice on food and weight because "*food and weight are only symptoms of our problem*". In contrary, they state that "*a diet ... often intensifies the compulsion to overeat*". The sole activity of the organisation is to meet with each other and offer support during their recovery from the 'illness'. The main aim of the organisation is to offer "*identification, acceptance, anonymity and most important, a programme of recovery for the physical, emotional and spiritual parts of the illness, based on the 12 step programme of Alcoholics Anonymous*" (OA Leaflet about the organisation 1992). In the OA's introductory leaflet for health care professionals, there is a statement of the organisation's attitude towards eating disorders as a form of addiction: "*OA believes that compulsive overeating is a threefold disease: physical, emotional and spiritual, which, like alcoholism and drug abuse, can be arrested but not cured*". (OA Leaflet for Health Care Professionals 1988)

The Overeaters Anonymous is a highly structured organisation, with strong characteristics like the element of strict anonymity and an ideology about compulsive overeating along with a specified strategy of coping with it. Anonymity, according to the information leaflet of the organisation, "*allows the fellowship to govern itself through principles rather than personalities*". The members share the common identity of compulsive overeater and "*social and economic status has no relevance in OA*". For this reason, anonymity is kept in every contact with the organisation, during the meetings and in any communication with public media like press, radio, television and other. This is quite apparent from the first contact with the organisation. There is a national phone number that people who are interested can call, which is usually listed in Yellow Pages, newspapers, or any other public source of information. When someone calls, there is a recorded message with details of meetings as well as first names of contact people in regions with their phone numbers to call. Meetings are weekly and for sufferers only; however groups have usually an 'open' day each month for people who'd like to find out about the organisation, either because they want to join or because they are relatives of sufferers or professionals and want to know more about the meetings.

The ideology that OA offers to its members is a set of principles and beliefs, which they call 'Twelve Steps', and a more extended set of guidelines, the 'Twelve Traditions', which sets the organisational structure of the fellowship and its mode of conduct. More specifically, the 'Twelve Steps' contain statements about the members' acceptance of losing control over their problem and their dedication to overcome it through 'spiritual awakening', with the help of a Power which is referred to as 'God'. Despite the reference to God, the organisation states clearly that: "*Overeaters Anonymous has no religious requirement, affiliation, or orientation. The twelve-step program of recovery is considered 'spiritual' because it deals with inner change. OA has members of many different religious beliefs as well as some atheists and agnostics*". The 'Twelve Steps' of Overeaters Anonymous are as follows:

1. *We admitted we were powerless over food – 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 ask Him to remove our shortcomings.*

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

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

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

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

12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practise these principles in all our affairs* (Overeaters Anonymous 1993)

The above steps are an exact copy of the Twelve Steps of Alcoholics Anonymous, except of the adaptation made for the case of overeaters. These and any other material of the organisation is based in the very same material of Alcoholics Anonymous, "*patterned after the AA program*", as the OA organisation states. The reasoning behind the Steps is that they are offering to members a cognitive framework in order to start the 'recovery process': "*The concept of abstinence is the basis of OA's program of recovery. By admitting inability to control compulsive overeating in the past, and abandoning the idea that all one needs to be able to eat normally is 'a little willpower', it becomes possible to abstain from overeating – one day at a time*" (Overeaters Anonymous 1993). This is as well the motto of their meetings that members should *take "one step at a time*", instead of pushing themselves to move along.

The meetings of all OA groups are weekly and there is a specific structure that members follow every time. There are no fees for membership; groups are entirely self-supporting through members' voluntary contributions. OA does not solicit or accept outside contributions. During the meetings, members take the role of the group co-ordinator alternately and follow the basic points of the 'Twelve Traditions', using as reference the Steps. They sit in a circle and each member greets the group with the statement: "*My name is X and I am a compulsive overeater*". He/she then continues talking about their week and how they are getting on with their personal recovery process. At the rest of the meeting, the group has a

discussion theme in each meeting, chosen by the OA programme, and the members express their personal thoughts about it. At the end, the meeting closes with the OA prayer which is read by all members, holding their hands with each other. The last thing that the OA members do is to hug each other with the saying "*Keep coming*". The ground rules of the meetings as well as the organisation itself are set by the 'Twelve Traditions':

1. *Our common welfare should come first; personal recovery depends upon OA unity.*

2. *For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.*

3. *The only requirement for OA membership is a desire to stop eating compulsively.*

4. *Each group should be autonomous except in matters affecting other groups or OA as a whole.*

5. *Each group has but one primary purpose – to carry its message to the compulsive overeater who still suffers.*

6. *An OA group ought never endorse, finance or lend the OA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.*

7. *Every OA group ought to be fully self-supporting, declining outside contributions.*

8. *Overeaters Anonymous should remain forever non-professional, but our service centers may employ special workers.*

9. *OA, as such, ought never be organised; but we may create service boards or committees, directly responsible to those they serve.*

10. *Overeaters Anonymous has no opinion on outside issues; hence the OA name ought never be drawn into public controversy.*

11. *Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, television, and other public media of communication.*

12. *Anonymity is the spiritual foundation of all these traditions, ever reminding us to place principles before personalities.* (Overeaters Anonymous 1993)

In the OA organisation, newcomers have a 'sponsor', that is an old member who succeed to recover or is well familiar with the philosophy of the fellowship. The 'sponsor' will help the new member to understand and apply the 'Twelve Steps'; he/she will offer his/her personal experience as an encouraging message for the new member to continue following the programme.

The Local Group

The Maidstone Group

This local OA group started in 1988, due to lack of groups for eating disorders in the area. The people who set it up were already attending OA meetings in a different area. The person who talked to me about the group is not the group leader, as there is no single leader in OA groups, but an old member through whom I contacted the group in the first instance, following the recommendation of the Regional Groups' Co-ordinator. The practical responsibilities of the group are shared among the members. The venue of the meeting is a room in a Day Centre and the group does not pay rent but they give voluntarily a small donation. People can find out about this group through the national phone number of the organisation.

The group does not keep any records about its membership. The usual attendance of each meeting is about seven to ten people, most of them regular members. They tend to have an increased number of people at the 'open' day of the group. However, this is happening when they have a request from someone who wants to attend the group without joining. In this special meeting, the member who co-ordinates the group states that it is an 'open' meeting so that the others will know that there are non-members attending as well.

The opinion of the group member I talked to about the Steps and the Traditions is that '*they were written down ... to make things easy for us so we don't have to worry about all this*'. Apart from the brief history of how the group started, she hesitates to discuss any other aspects of the group and refers me to the material of the organisation as well as to a Public Information Officer of the region in order to provide the 'official' views of the organisation. However, it is clear that there is a standard pattern in which the OA groups operate and in that sense this group is similar with others in other parts of Britain.

3.2.5. The Manic Depression Fellowship (MDF)

The Organisation

The "Manic Depression Fellowship" is a national voluntary sector organisation established in 1983 for "*people whose lives are affected by manic depression*". The stated aims of the Fellowship, according to one of the fact sheets in their web page (http://www.mdf.u-net.com), are to:

1. *help people with manic depression, their relatives, friends and others who care,*
2. *educate the public and caring professions about manic depression, and*
3. *encourage research for better methods of treatment for manic depression.*

The organisation claims that it is "*the largest user led self help organisation in the field of mental health in the UK*" (MDF Fact Sheet 1997). It is run by a national Council of Management which is elected and composed mainly by members. The offices of the organisation are staffed by nine full-time and three part-time paid staff and a number of volunteers. Apart from its central offices in Surrey, the Fellowship has also regional offices in Scotland, Wales and Greater London. Its main activities include the development and support of a network of self-help groups, the publication of a quarterly journal called "*Pendulum*" and a professional advisory panel of experts on manic depression, which provides information and advice on relevant issues and publishes literature on various subjects concerning the condition. Additionally, among the services that the organisation states that can offer to its members are:

- "*representation*" on national mental health forums, parliamentary working parties and the Media Watch project,
- "*democracy*" within a user-led organisation with no internal barriers,
- "*support from people with similar experiences*" through a nation-wide network of self-help groups,
- conferences and workshops around the country,
- training in self-management of manic depression,
- an employment advice telephone line to offer information and guidance on work-related issues and

- a parliamentary liaison officer, to represent the views of people who have manic depression to the centres of power.

The Fellowship has various sources of funding such as membership fees (at present ten pounds for a year), income from selling the Fellowship's publications as well as from fundraising events, grants from the public services (e.g. the Department of Health) and National Lottery grants. It collaborates closely with mental health professionals in research and education about manic depression. This is evident from the very fact that it has formed a professional advisory panel for this purpose and that two of the three MDF patrons are psychiatrists. However, the focus of this relationship is to promote improved treatments for the condition such as talking therapies, self-management, and development of support networks e.g. self-help groups. As it is emphasised in a leaflet about manic depression: "*For effective treatment of manic depression, the right combination of medication, support and self-management is essential. By participating in self-help and self-management, members can regain autonomy, well-being and self-esteem*" (MDF Leaflet).

The view of the organisation about the condition of manic depression is that it is "*a serious mental health problem involving extreme swings of mood (highs and lows)* [and]... *is episodic (occurs in phases). It is possible to remain well for long periods and many people can and do lead useful and creative lives*" (MDF Leaflet). It supports equally medication and self-management as means to cope with manic depression and, as mentioned above, it notes particularly the value of better support systems. As for the causes of the condition, it is mentioned that there are medical as well as social factors that play an important role in the appearance of mania or depression. There is also reference to inherence of a 'vulnerability' to developing manic depression.

Self-help groups are seen by the Fellowship as a means to "*offer members the opportunity to meet other people who have been through similar experiences. MDF groups can lessen the sense of isolation and provide a safe space*" (MDF Leaflet). The organisation encourages the development of self-help groups and has an appointed Group Development Officer. There is also a newsletter called "*MDF Group News*", where regional news and information about groups and meetings are published. Groups are quite independent on the way they operate. Help is given from the national organisation in the form of support and advice, open days for group co-ordinators and written material about the running of a group and information about the condition itself.

The Local Groups

The Wandsworth Group

The group started in 1995 by the MDF Greater London Director. At the second meeting, two members volunteered to take over the running of the group, a person who has manic depression and a carer. The venue of the meetings is at a church hall and they meet in a monthly basis. The group is open to both people who have manic depression and carers and there are usually seven to ten people in every meeting. People can find out about the group mainly through the national organisation but members have also put posters about the group in local hospitals, libraries and their doctors' surgeries.

According to one of the group's co-ordinators, the aim of the group is "*to provide a safe place which is confidential ... where people can find out information about the illness from other people who have it, where people who care after people with the illness can talk to each other about the techniques the use and can talk to the sufferers, perhaps a new way as to what kind of care is required*". The group also invites professionals as speakers to its meetings and encourages members to access the services for treatment. Moreover, the group co-ordinator mentions a link with the professionals through a local council organisation called Voices and Views, which "*feeds back the views from people who use the mental health services to people who provide them*". A council officer discusses with the group their views about the plans of the local mental health services and informs them about any progress. However, the group does not get involved with community activities because, according to the group co-ordinator, there is lack of "*continuity to have an active group and promoting manic depression and educating the general public*" and members find difficult publicly to discuss their personal circumstances.

The group is funded by charities and the local authorities in order to pay for the rent of the place they meet as well as everyday expenses such as coffee and biscuits. Members do not have to pay any fees or to be members of the national organisation. The structure of the meetings is rather loose and informal. Members can discuss whatever they want to and the group co-ordinators try to give everyone the chance to talk. The topics of discussion are varied but they are mainly focused around self-management and ways of coping with the condition, relevant articles and books, employment issues and how the condition affects people's lives.

The Crystal Palace and Anerley Group

The group started in 1985 by a user who was a member of Manic Depression Fellowship. The venue of meetings was a church hall in Croydon, "*very tiny and inconvenient*", according to the present group co-ordinator. In 1990, the group decided to change its place of meetings in

order to get some funding from the local authorities of the Bromley borough. So, they moved to another church hall in Bromley and at the same time the present co-ordinator took over from the initial one. However, the new place was again not very satisfactory, without heating and basic facilities. In a short period of time, the group had a suggestion from the Bromley Users' Group (B.U.G.) to use its offices and they moved again to that place where they have met since.

People can find out about the group through the national organisation; however, they get also referrals from the local and neighbouring mental health services. The meetings are monthly and there are usually fifteen to twenty people in each meeting. However, the group co-ordinator keeps an on-going list of members and reports that they are over thirty at the time of study. She sends them regularly a reminder about the meetings along with the agenda and invites them to join the group. In cases where people have not turned out for a long time, she writes them to check if they still want to be in the group and asks them to contact her. If there is no response, she stops sending them letters about the meetings. However, the group is open to all people who have manic depression or related experiences; it does not require members to attend regularly. Moreover, there are members from ethnic minorities, unlike other self-help/mutual aid groups in the study. The group co-ordinator claims that this is because the borough of Bromley where the group meets has "*a diverse profile of mental health users*". Carers are also welcome but the group co-ordinator notes that there are very few carers joining the group and "*if there are carers, they come only for one time and then it's the user who stays, the one who doesn't feel very well ... we are very much a users' group*". Her opinion is the carers "*must feel kind of outsiders ... because their aims are different from ours, from users*". The aim of the group, according to its co-ordinator, is "*self help, 'rubbing off' each other, ... we are all saying: I know exactly what you mean by that because it's happened to me like this and we can relate to each other, ... we share things together*". Moreover, they are involved through Bromley User Group (BUG), described bellow, in educating the general public about mental health issues. For this purpose, members participate in open days about mental health issues and give talks about manic depression in community settings as well as professionals' institutions. Also, the group supports members who are in hospital during crisis and organises social outings like day trips to the countryside, visiting local festivals and going to the theatre.

The group invites professionals as speakers to its meetings but apart from this it does not have relationships with them. Nonetheless, there are group members – including the group co-ordinator – who are also involved in the Bromley Users' Group which is a "*pressure group that aims to improve voluntary, private and statutory services offered to the* [Bromley] *Borough*". In fact, the group is affiliated to the Bromley Users' Group and it is expected to

participate through a representative to its Council. The group co-ordinator acts also as a Chair in the BUG Council. Due to this affiliation, the group is also informed regularly about BUG's activities and issues that are relevant to mental health service users. Moreover, there are group members who are involved in other user organisations and groups and they inform the group about activities in other local areas. The group does not have to pay rent for the place of meeting and members contribute voluntarily towards coffee and biscuits and other running expenses like photocopying and posting.

The structure of the meetings is loose and the co-ordinator runs the group informally. Members share different responsibilities from the practical things like making coffee and tea in the meetings and helping with the mail, to the way of operation like welcoming new members and finding guest speakers.

3.2.6. The Voices Heard Group

History

The Voices Heard group started in 1996 on the initiative of two social workers from the Day Services in Herne Bay, Kent. The focus of the group was to bring together people who experience hearing voices or seeing visions and to share these experiences with each other. The social workers that set up the group were inspired by their contact with the Hearing Voices Network, a self-help organisation for people who hear voices or have visions. This is an established network of groups, mainly operating at the north of England, which aims to bring together people with this kind of experiences and to promote public awareness about this issue, as well as to fight prejudice. People who have such experiences are usually diagnosed by the mental health professionals as schizophrenic and are characterised by the public as dangerous to society. The Hearing Voices Network is trying to fight these misconceptions and organises conferences and public meetings, involving allies such as professionals and public figures, in order to inform about this phenomenon.

The social workers who started the Voices Heard group participated in a conference the Network organised in 1996, along with service users from the Day Services, who had similar experiences and were interested to join a group. On their return, the two workers started the group with the support of the services. The meeting place was a Day Centre in Herne Bay. The group was meeting weekly with six or seven people attending in every meeting, most of them in a regular basis. The stated aim of the group was to "*share experiences and problems in a supportive way*" and also to "*try and develop a better relationship with professionals and voice hearers*" (Voices Heard Leaflet). The way to achieve the group's aims was "*to listen to each*

other in order to develop and grow with acceptance and life satisfaction'. However, the group did not hold a specific set of beliefs about hearing voices, like the Hearing Voices Network does.

Shortly after the group was founded, a member became group facilitator and the social workers stopped running the group; however, they remained actively involved, supporting the group facilitator, getting funding for the group from social services and promoting the group within the services. They also helped the members to publish a monthly newsletter called '*Voices Heard*', where members could write about their experiences and give information about relevant issues. The group was open to all people with relevant experiences; however, all members were service users who were diagnosed with a mental health problem, mostly with schizophrenia, and were attending the mental health day services.

In 1997, the group members decided to move to another nearby town, Whitstable, and change the venue because it was "*too formal and too medical*". At the same time, a group member who was living in a neighbouring town, Canterbury, decided to set up another group there. These groups no longer had the active support of the social workers but were run by users. Although the social workers tried to keep an affiliation with the Hearing Voices Network, the two subsequent groups did not have any connection with the organisation, only some group members were also members of the Network. Moreover, the groups did not have any similarities or relations with each other and they operated in a different way. The Canterbury group ceased to meet a year after it started but the Whitstable group continues to operate to date.

The Groups

The Canterbury Group

The Voices Heard group in Canterbury, as mentioned above, started in 1997. The group facilitator was a member of the Herne Bay group from the beginning. In his effort to set up the group, he had the help of the deputy manager of a Day Centre called Mustard Seed, which was the group's meeting place as well. The deputy manager publicised the group within the Centre and in other mental health services and public places the local library, the town hall and the university. He also supported the group practically, helping them to produce advertising posters and giving them relevant information.

The meetings were weekly and there were four or five members attending regularly. The topics of discussion were mostly members' experiences with hearing voices and seeing visions, the effect of these experiences on their lives, difficulties of communicating these experiences with their relatives and friends, ways of coping with the voices. Moreover, they were discussing

their experiences of the mental health services and problems they had with medication and other "traditional" therapies such as ECT, as well as the prejudice they were facing from professionals and the society in general. There was no specific structure of the meetings and the group facilitator was giving every member "*the chance to speak freely, without being judged from others about their experiences*". The aim of the group was to "*support each other in a safe environment and to talk about unique experiences with people who understand about it*".

Despite the efforts to advertise its presence, the group did not have any success in getting new members. For this reason, when the group facilitator started working full-time and stopped coming to the group, the other members did not take responsibility for the group and, after a while, it ceased to exist. The efforts of the deputy manager of the Day Centre, who was interested to encourage people to join the group, were unsuccessful and as he mentioned "*there was no real interest from people to join such a group*".

The Whitstable Group

The Voices Heard group in Whitstable started in 1997 by a group member of the Herne Bay group. The meetings take place in the coffee area of a local centre called Whitstable Umbrella. Although it started as a group for people who hear voices, it is open to everyone who "*has a mental health problem and needs the support*". The purpose of the group is "*friendship and mutual support for people who have a rough time with mental health and the mental health services*". The group facilitator mentions also that there is "*exchange of information about services and treatments, ways of coping and any other relevant issues*".

The meetings are weekly and the number of members is small, three or four people attending regularly. There are no membership fees and the group does not have any running expenses. Every member pays for his/her coffee/tea. There is no specific structure of group meetings. The facilitator lets members talk freely about what interests them. The topics of discussion are everyday coping with mental health problems, relationships with relatives and friends, problems with the mental health services. The group does not have any relationships with professionals and does not express any views about them.

The main problem that the group faces at the moment, according to its facilitator, is small membership. However, members have not been making any effort to advertise the group apart from putting posters in the notice boards of the Umbrella centre. The group facilitator, who is very committed to the group, states that she will "*promote the group in the local community and recruit more members*".

3.2.7. The Havering Users Barking and Brentwood Forum (HUBB)

The Havering Users Barking and Brentwood Forum was set up in 1991 and was the result of a joint effort of several local Health Authorities' and Social Services' managers, service users and people from local voluntary agencies. The first step for the setting up of the Forum was to form a special group called the "Mental Health Users Enabling Group". According to one of the Forum's fact files about its history, the task of this initial group was '*to help set up an independent self-advocacy group to service the whole Barking, Havering and Brentwood ared*' (HUBB Fact file, May 1995). For this purpose, a part-time worker funded by the Health Authority started to act as 'User Liaison and Advocacy Worker'. This worker helped initiate advocacy and self-advocacy projects supporting users and carers in order to take up issues within the local Health Authority. She also held meetings at Warley Hospital "for patients and carers" to discuss the formation of a user forum.

In August of 1991, the new forum, then called the "Mental Health Users Group", had its first meeting at a church hall with approximately 50 service users and carers attending. During its first year, the Forum had the financial support of the local Health Authority for initial expenses. At that year, members of HUBB set up a Steering Committee and produced a monthly newsletter, which circulates to date, drew a draft constitution and started fundraising. The Forum became involved in many projects and committees such as the Warley Hospital closure and the Mental Health Development Project Steering Group, the Health Authority and Social Services Joint Planning Team. The Forum has also a very active and important role at the Warley Hospital Patients Council, which started in 1992. The Council is chaired by HUBB and "*the needs and complaints of the patients are taken by a user and an advocate/HUBB staff member to the User Views Meeting, where issues are passed on to the Senior Managers and any results are fed back to the next Council meeting*" (HUBB fact file, May 1995).

In an article which was published about HUBB when it first begun ("H.U.B.B. stands for Hope", Update Magazine 1992), it is stated that the general aims of the group are:

> "*to improve the quality of life and status of all users of public, private or voluntary mental health services within the District, including their carers* ... [and] ... *to advance the education of the public by providing easily available information and act as an advice resource on mental health services in the area of benefit*".

Among the objectives of HUBB mentioned in this article as well as theHUBB's leaflet about its history are:

- Improvement of the provision of mental health services: more out-of-hours' services, such as drop-ins, setting-up an emergency crisis line/referral services, more half-way houses, greater access to Community Psychiatric Nurses, GPs to give more time and show appropriate attitudes towards those with mental health problems.

- Change of the 'traditional way' that services operate: to alter bias by increasing use of 'talking treatments', such as psychotherapy, and reducing drug-based 'cures', to raise the status of mental health users in general and to provide users with feedback to service providers and other relevant parties, to provide a focal point to which service providers can go and gain users' feedback.

- Fighting discrimination and prejudice against service users: to educate service providers, employers, the police etc, with the aims of reducing discrimination against mental health users and getting a fairer deal.

- Support and advice to users and carers: to provide a setting where they can share their experiences and reduce feelings of isolation, to provide information and advice on the availability of services and related matters, to assist users and carers in making complaints and in the improvement of their general quality of life, information on drugs, their efficacy and side effects, and advice on possible alternatives.

Due to the successful involvement of HUBB across the Barking, Havering and Brentwood Health Authority area, funding was approved and in 1993 HUBB employed three workers ad set up its office in Romford, Essex. This change of the group from *"a volunteer user group to employers of paid staff"* was difficult for the members, especially when the Health Authority decided to stop the funding for the User Liaison and Advocacy Worker, who was supporting considerably the members in their work. In 1995, the Chair of HUBB and other Committee members resigned *"as the level of work done as volunteers was resulting in health problems"*. Another Committee was elected and the Forum decided to split the full-time posts in order to employ an advocacy worker to support the HUBB staff in their work. At the same time, the group obtained registered charity status.

Currently the organisation has a well-established membership and its composition is as follows: 43 users, 23 carers/interested people, and 10 organisations (HUBB Newsletter 1997). There are membership fees (50 pence for users, £1 for carers/interested individuals and £5 for organisations); however, the Forum's main financial sources are funding from the local health authorities and social services, consultancy provided to health trusts, as well as National Lottery grants and donations from the private sector. Their relationship with professionals has

the form of collaboration with the emphasis on promoting users' views, advocating for their rights within the existing services and actively contributing to the design of improved services. Specifically, as the Chair of the Forum explains: "*Members of HUBB are involved in the Health and Social Services Joint Planning team meetings to find out what new mental health service developments are being planned and to contribute their ideas about what is needed. We have produced workshops to student nurses to help professionals see mental health issues from a 'consumer' point of view, e.g. what it's like to be an in-patient in a psychiatric hospital. We are visiting regularly in-patients at Warley Hospital and we are very involved with the Patients' Council in there. HUBB has also put together a directory on all available mental health services in the area and makes every effort to keep up to date with other advocacy projects and in general user involvement.*". The Forum is also affiliated and involved with the United Kingdom Advocacy Network (UKAN), one of the major English mental health service user organisations, and with various other user-led groups such as the South Essex Advocacy Alliance and Barking and Dagenham Care Forum.

As a group, the Forum meets monthly and has an attendance of twenty to twenty members, most of them regular, in each meeting. The meetings follow a specific structure; at the first twenty minutes or so, members sit in the refectory area, having their coffee/tea and have the opportunity to meet others before the meeting starts. After that, the group sits together in another area and a member of the Committee opens the meeting, welcoming the members. Usually there is an invited speaker who talks for about twenty minutes. The topics of these talks are generally issues about the work of local services, statutory or voluntary, alternative treatments, information about benefits, work schemes, service users' rights and other relevant matters. When the speaker finishes, the group discusses the agenda of the meeting. This includes update on the Forum's activities, recent developments, issues that members want to raise and future work that the Forum is planning to undertake. Among the activities that the Forum is organising are surveys and research of the users' views about the quality and the efficiency of the local services. An example of such work is the publication of a report called "*Working towards a better future: 3 years on, a survey of the reprovision of mental health services in Barking and Dagenham*". This piece of research was conducted and reported in 1996 by HUBB. It is concerned with the progress on the reprovision of services by the Barking and Havering Health Authorities which had started three years ago, in 1993. The participants were both users and professionals who were interviewed about how they were feeling about the whole project and the progress that had been made.

3.2.8. The Shepway Work Orientation Forum (SWOF)

The Shepway Work Orientation Forum was set up in 1995, as a result of a work study project carried out by the Head Occupational Therapist of the Day Services in Folkestone, Kent. The project was entitled: "Involving service users when defining need and developing prevocational services for people with long-term mental health problems". A major finding of this project was that service users were supporting the idea of developing prevocational services in their area:

> *The results suggested that the participants highly valued and aspired to be in the worker role. The majority perceived the need for opportunities to develop prevocational skills e.g. building work habits through assessment, skills' rehearsal and graded activity. Results pointed to a need for a transitional programme which combined social support, positive expectations and job opportunities which allowed time and continuity whilst recognising the continuum of rehabilitation. Most important were opportunities which facilitated empowerment and dignity.* (History of SWOF, March 1997)

Based on the participants' opinions, workers of the Day Services encouraged the setting up of a user forum, originally called "Shepway Work Opportunities Forum" (SWOF). A year after its foundation, due to members' view that "*the word Opportunities suggested we provided work for our members*" (History of SWOF, March 1997), the Forum changed its name to "Shepway Work Orientation Forum", denoting its intention to explore ways of helping service users to return back to employment. Over time, the Forum has concluded, "*through its own explorations, visits, meetings with managers and other service users*", that the best way to meet the employment needs of the users in Shepway is the Clubhouse approach to prevocational rehabilitation. Therefore, the group's priority is "*getting a Clubhouse established in the* [Folkestone] *area*".

The group meets fortnightly in a Day Centre and there are five or six members who attend regularly from the beginning. There is no group facilitator/chairperson; instead, all group members have their turn in co-ordinating the meetings and keep minutes as well. There is a group member who acts as a liaison between the group and the Day services which support the Forum. The services' support extends to the point of providing them with a place to meet and giving information about issues that interest the group. Professionals participate in meetings only as guest speakers. Apart from that, the group collaborates with them in order to promote the creation of a Clubhouse, the main objective of the Forum:

"*Our Forum has organised and attended many meetings on various scales with professionals from the Health and Social Services, with a view to meeting the needs of users and realising the objective of a Clubhouse for our area*" (interview with the group).

For the same purpose, group members have visited various Clubhouses set up in the South East area. However, the Clubhouse is not the only aim of the Forum as it is stated in their publicity poster:

"*The main aims of the Forum are: to influence change and development within the Mental Health Service, to help others gain awareness of the needs of people with mental health problems and to assist members to gain confidence and plan their next move.*".

So, the Forum is also involved in other projects such as consulting the Day Services about a compilation of a Drugs' Directory for service users, participating in a Joint Planning Meeting along with other local statutory and voluntary organisations for the promotion of users' views, working with local educational institutions for the setting up of courses designed to help service users back to work. The group is open to all users and ex-users and, although it was set up with the specific purpose of employment for service users, it is operating in a friendly and supportive way. As the group members emphasise in the interview I had with them about SWOF: "*our group offers support, friendship, understanding and information to sufferers of mental health problems*". The Forum is also affiliated with other user organisations and local user groups such as the United Kingdom Advocacy Network (UKAN), the Kent Users Forum, the Ashford User Forum and others.

Members of SWOF do not have to pay any membership fees. They contribute voluntarily for coffee/tea and biscuits. The group does not have any running expenses because there is no rent for the place of meeting and group members use their own equipment for typewriting and printing written material such as the minutes of the meetings or advertising leaflets. There is also some funding available to the Forum from the social services to cover expenses like visiting other Clubhouses in the South East area. The Forum has also put forward an application to the East Kent Health Authority (EKHA) for funding the development of a Clubhouse in Shepway.

Recent developments concerning the Forum's efforts are that the local Health Authority approved its application for the Clubhouse and they proceed towards this direction. The Folkestone Clubhouse "The Squirrels" opened on January 1999.

3.2.9. The Lewisham Users Forum (LUF)

The Lewisham Users Forum started in 1987 on the initiative of a mental health voluntary organisation called "Good Practices in Mental Health". This organisation invited mental health service users and ex-users of the Lewisham area to set up a user group. At the beginning, the group had the help of a support worker, funded by a mental health organisation, "Good Practices in Mental Health", to organise them *"until we were on our feet"* (interview with LUF's secretary). The support worker left as soon as the group elected a Committee and formed a Constitution. According to its Constitution, the Forum has the following objectives:

- *"To empower mental health service users by giving them a real voice in the planning and provision of services by both the statutory and voluntary services.*
- *To educate professionals working in mental health by participating in their training.*
- *To provide mutual support for service users.*
- *To advocate on behalf of members and other service users in the Borough of Lewisham where their treatment is unsatisfactory or inadequate.*
- *To promote good practices in mental health."* (LUF Constitution, 1987)

Membership is only open to mental health service users or ex-users living in the Borough of Lewisham and those who used to live in that Borough and are still interested to remain members of the Forum, *"provided they are not members of a similar organisation elsewhere"* (LUF Constitution 1987). The Forum defines as 'similar organisation' a local user group and not a national organisation such as MIND, UKAN or others. To be considered as members and have the right to vote and be elected, users/ex-users must fulfil the above conditions and have attended at least 3 meetings within 18 months. However, all users/ex-users, whether from Lewisham or other areas, can join the Forum's meetings. Professionals and carers cannot attend group meetings *"except when they are invited as guest speakers, or when they themselves are users or ex-users"*. The ethos behind this restriction is that *"people feel more comfortable if they are with other users. If we have carers or professionals, they may have their own agenda, people might not feel free to speak and be as they want to be. We've got to feel free and know that people understand."* (interview with LUF's secretary). The Forum has a collaborative relationship with professionals in the sense that it provides consultancy and training to them about users' views and gets new members referred from them occasionally. Moreover, the group is funded primarily by the local health authority which favours user

representation and involvement. Despite this relationship, the Forum's attitude towards professionals, especially the 'traditional' ones, is "absolutely negative":

> *We do complain about side effects of medication, we do feel that managers are emasculated and the psychiatrists, the medical profession are still on the old ways of being very superior and giving a lot of medication and not listening too much. So we feel we have to complain to the doctors and get them to understand how very distressing the medication is. For example, we disapprove of ECT, most of us feel we don't want to have that treatment. So we feel that the Trust managers are very much on our side but not the doctors.* (interview with LUF's secretary).

Their meetings are held in a community health centre and are monthly. In each meeting, there are usually five to nine members, most of them attending regularly. The topics of discussion are mainly about activities that the Forum plans to or presently undertakes such as consultancy, training, representation in various planning meetings of the Health and Social Services, and advocacy. The Forum also organises and funds social outings for its members and, according to the group's secretary, "*there are people that come along to social events but they don't come to our meetings, they're on our mailing list and they get notice of the meetings and the minutes*". The mailing list of members contains up to forty people and it is an informal way to keep records of membership. Additionally, the group is renting an office in a Community Centre, different from the place of meetings. There are no paid workers and it is staffed by volunteer members. The office offers a basis for the group to organise its activities, prepare the paperwork as well as meet with service users who look for information about advocacy issues and their rights. Among the projects the Forum got involved in the past are: the production of a booklet and a video for sectioned patients to inform them of their rights, the provision of training for Lewisham Social Services, and the Joint Consultation Forum with the Lewisham and Guy's Mental Health Trust on User Empowerment.

3.3. Categorisation of participating groups

All the presented participating groups have their unique profile which is composed by the specific conditions, structure and membership. Despite their particularities, they all share some common characteristics such as they are peer-led groups, with a common focal problem/condition, and the general purpose of their members is to help themselves and each other. Based on these characteristics, I identified them as self-help/mutual aid groups. Nonetheless, beyond this common overall label, these groups share some more specific differences and similarities with each other. For their systematic study there is need for a

typology, according to which we can categorise them and systematically study them. Previous efforts made by self-help researchers have taken into account several criteria such as the primary or central focus of activity (Katz and Bender 1976; Levy 1976) or the organisational characteristics of the group (Schubert and Borkman 1991) (for a detailed discussion of typologies see Chapter One, section 1.2.3). As for the first method of typology, it is clear that nowadays there are self-help/mutual aid groups for a wide variety of problems/conditions which get involved in a range of activities and this kind of typology can extend to a rather long list. Moreover, the primary activity of the group does not necessarily indicate that groups belonging to a category share similar characteristics in their way of functioning and their appeal to members. The second method of typology allows a better categorisation of groups because it examines their structure, affiliation or not with a larger organisation, and operational features. However, this typology is one-sided as it does not take into account the ideological characteristics which are very important for a self-help/mutual aid group. Additionally, this kind of typology is concerned with the external characteristics of these groups and leaves unexamined the effect they have on their members.

Other suggested ways of studying self-help/mutual aid groups is the focus of change (Kurtz 1997) and their political ideology (Emerick 1991). These two typologies turn us back to the originality of these groups and the very essence of self help and mutual aid. They both address the important issue of what the group has to offer to its members and why the group member chooses to join a specific group. Although there is a variety of explanations offered by a self-help/mutual aid group to its members about their common problem/condition, the group holds a distinct position about the focus of desired change as well as a socio-political attitude towards ways of achieving this change. The first type of categorisation (according to focus of change) gives the advantage to examine very diverse groups in the light of their activities and the effect they can have on members, regardless of their structure or focal problem/condition. The benefit of the other one (according to political ideology) is that it looks at the organisational elements of the groups and their affiliations with professionals and other user organisations, putting the groups in a broader socio-political perspective.

In the present study, I followed a combination of the two latter typologies taking into account both the focus of desired change groups wished to achieve and the socio-political ideology which underlies behind this orientation. This method of typology is quite broad and general as it should be in order to allow the examination of diverse self-help/mutual aid groups but in the same time it is a comprehensive one because it offers the chance to explore the self-help/mutual aid groups within the framework of a new social movement. Therefore, the criteria for the categorisation of groups were the following:

1. The focus of desired change: personal or social change or a combination of both.
2. Professional evaluation: pro-psychiatric or anti-psychiatric or neutral attitudes towards mental health professionals.
3. Level of organisational interaction: none/low, moderate, high interaction with other self-help/mutual aid groups/organisations.
4. Level of institutional interaction: none/low, moderate, high interaction with mental health professionals.

Based on these criteria, I classified the groups of the sample into three categories: the individual-change (conservative) groups, the social-change (radical) groups and the individual and social change (combined) groups. The characteristics of the groups in each category are as follows:

Type of group	Focus of change	Professional evaluation	Organisational interaction	Institutional interaction
Individual change (Conservative)	Personal	Pro-psychiatric or Neutral	None/low interactions	Moderate/high interactions
Individual & Social change (Combined)	Personal & Social	Pro-psychiatric or Neutral	Low/moderate interactions	Low/moderate interactions
Social change (Radical)	Social	Anti-psychiatric	Moderate/high interactions	None/low interactions

Although the levels of organisational and institutional interaction seemed to vary and overlap between the three types, there was a consistency in the way that the groups presented themselves according to the other two criteria. Also, in cases where the group was affiliated with a bigger national self-help organisation, I considered in addition the characteristics of this organisation for the categorisation of the local group. Nonetheless, I did not characterise groups based solely on the profile of the national organisation. On the contrary, there were cases where I differentiated groups which belonged to the same organisation, for example local groups of the Manic Depressive Fellowship, where one of them was clearly focussed on individual change whereas the other one was trying to achieve both individual and social change.

In this exercise, I made an effort to consider information collected from various sources and based on groups' own views; however, it should be said that I had the main responsibility for

categorising the groups and although, I took the opportunity to discuss this issue with group members in several occasions, this effort was limited by the fact that it was done by the researcher alone.

So, the fourteen groups of the sample belonged to one of the three types:

Individual change (conservative)

1. Depression Alliance – Lambeth Morning
2. Depression Alliance – Lambeth Afternoon
3. Eating Disorders Association – Maidstone
4. Overeaters Anonymous – Maidstone
5. Fellowship of Depressives Anonymous – Central London
6. Manic Depressive Fellowship – Wandsworth
7. Voices Heard – Canterbury
8. Voices Heard – Whitstable

Individual & social change (combined)

1. Depression Alliance-St. Albans
2. Eating Disorders Association-Southend
3. Manic Depressive Fellowship-Crystal Palace

Social change (radical)

1. Havering Users Barking and Brentwood Forum (HUBB)
2. Shepway Work Orientation Forum (SWOF)
3. Lewisham Users Forum (LUF)

Finally, I need to emphasise that the typology I followed in this study is by no means an arbitrary way of looking at self-help/mutual aid groups. The categorisation of the groups is a useful way to examine them in a meaningful manner but it is not the purpose of this research project to develop a definite typology. The indication of each group's political attitude and change orientation is useful in the analysis of the psycho-social characteristics of group members and puts in perspective the differences and similarities that will be reported in the following chapters. It is important to keep in mind that the aim of the study was to explore mental health self-help/mutual aid groups in general as well as in relation to their socio-political attitudes.

CHAPTER FOUR

Findings from the First Phase of the study

In the following there will be a discussion of findings from the pilot study and results from the First Phase of the study. Findings will be presented according to the research design, discussing overall individual and group characteristics and their relationships as well as differences and similarities between the three ideological group types.

4.1. Pilot study

The aim of the pilot study was to test the set of questionnaires and instruments chosen for the research project, for format and language, clarity and comprehensiveness, and appropriateness for mental health service users, especially users who are group members. This was especially important, as all but one questionnaire had not been administered before to an English population.

The pilot study took place during November 1996 and January 1997 at Mustard Seed, a day centre for mental health service users at Canterbury, Kent. In order to approach volunteers to participate in the study without disturbing the everyday operation of the centre, I asked for the help of the Deputy Co-ordinator of the centre who agreed to inform the people who were regularly attending activities of the centre and give questionnaires to anyone interested. Additionally, I approached the Canterbury Mental Health Service User Forum which is based at Mustard Seed and invited their members to participate.

All information was anonymous and confidential. However, for a further discussion of participants' comments, I asked for a name and a contact number if they were willing to meet with me and talk in person or at group meetings if feasible. Such meetings took place with those who responded.

Eight participants volunteered to complete the questionnaires, four women and four men, aged between 31 and 68 years. They were all white and long-term mental health service users. Seven of them were participating in groups within the centre (not self-help groups); one was not.

Overall, participants' feedback about the set of questionnaires was positive. The majority found the questions asked in a acceptable format (e.g. "I particularly like the touch of appreciation given"), in a clear and comprehensive manner (e.g. "simply put"), in jargon-free language and relevant to users' experiences (e.g. "understand how mental health works", "straight forward guide"). There were some comments about specific scales. Regarding the empowerment scale (Rogers et al., 1997) which requires a 'forced choice' of answers, they would have preferred to have had a fifth option of "I am not sure" instead of being 'forced' to answer either positively or negatively. They also commented on the format of an answer ("<monthly") on social networks which was a bit confusing and they suggested a change ("less than monthly").

Moreover, respondents in the pilot study advised me about the presentation of questionnaires. Specifically, they suggested numbering the pages so that it can be easy to follow through. Also, they commented on individual demographics. For example, in the question about ethnic origin, they suggested that "Irish" not to be included because they thought it might offend people who did not consider "Irish" as an ethnic group. Also, in the part of contact with mental health services, they proposed to add a question about previous hospitalisation because it concerns another aspect of experience with the services; and in the question about the educational level, to add the choice of "other" in order to give respondents the chance to offer an alternative answer. The time of questionnaire completion was approximately twenty to thirty minutes, which was acceptable to the respondents.

According to feedback from participants in the pilot study, I made changes suggested by the respondents in the section on individual demographic information (omit the "Irish" category but include "Other" as an additional option, add a question about previous hospitalisations, add a choice of "Other" in the education section) and the social networks scale (change the answer "<monthly" to "less than monthly"). I also improved the presentation of questionnaires. I did not change the answers in the empowerment scale because, in this way, results could be comparable with the scores reported from the constructors of the scale.

4.2. First phase of the study

At the beginning of the study (Spring 1996), I made an initial contact with self-help/mutual aid groups that were interested to participate in the research project (see Chapter Three: Profile of the Participating Groups). When they agreed to participate, I started visiting them in a regular basis and participated at their meetings (Summer 1996 - Winter 1997). In total, I

followed up four or five group meetings of each group. The aim of these participant observations was to familiarise myself with the way that the group was functioning and collect informative written material, as well as to interact with members and discuss the study.

At the first phase of the study (March - May 1997), I administered questionnaires during a group meeting to all members who volunteered to complete them. Participants were asked to return the questionnaires by post. From a total of 114 questionnaires administered, there were 67 returns (response rate 59%). The response rate of returned questionnaires by group is as follows:

Table 4.1: *Response rate of returned questionnaires by group (Time 1)*

Name of Group	Type of Group	Members*	Respondents	Response Rate
DA-London 1 (a.m.)	Individual change (Conservative)	5	3	60%
DA-London 2 (p.m.)		7	3	43%
EDA-Maidstone		6	3	50%
FDA-London		10	6	60%
OA-Maidstone		10	7	70%
VOICES-Whitstable		3	2	67%
VOICES-Canterbury		5	2	40%
MDF-Wandsworth		10	6	60%
DA-St. Albans	Individual & Social change (Combined)	10	8	80%
EDA-Southend		8	4	50%
MDF-Bromley		15	11	73%
HUBB-Romford	Social change (Radical)	15	6	40%
SWOF-Folkestone		5	4	80%
LUF-Lewisham		5	2	40%
TOTAL		**114**	**67**	**59%**

* Present at the meeting in which I administered the questionnaires

The number of respondents in each group reflects both the informal character of self-help/mutual aid groups and the restrictions of the data collection method. Self-help/mutual aid groups are open and the number of group members in a meeting is changeable. Moreover, participants of the study had the choice whether and when to complete the questionnaire. Taking also into consideration that it was a lengthy questionnaire (18 pages) and had a large variety of topics the response rate was quite encouraging. The representation of each group varies (Table 4.1); however it is above 40% for all groups.

4.2.1. Demographics of group members

The sample in the first phase of the study consisted of 14 mental health self-help/mutual aid groups from London and Southeast England (total number of participants = 67). They represented all three types of political ideology (as discussed in Chapter Three), with a variety of structure and organisational features. Overall, the majority of the sample were women (63%), young adults (19-44 years old, 57%), well educated (87%), single (46%), all but one white, unemployed (66%), and with a long-term experience with the mental health services (84%) (Table 4.2).

The lack of group members from minority ethnic communities in the sample reflected the membership of the organisations and groups that participated in the study. It was also characteristic of the situation in self-help/mutual aid groups in England. The issue of non-participation in self-help/mutual aid groups of people from ethnic minorities has become a research topic in the recent American literature (Kurtz 1997), but there is no evidence about this in Europe.

Looking at specific types of groups, there were equal numbers of women and men in the radical groups, a larger number of members were of older age (58-77 years old), had no formal educational qualifications or at a secondary level and all but one were unemployed. Conservative and combined groups had a majority of women, a high number of their members had higher or professional education and a large number of them were employed.

Table 4.2: *Demographic characteristics of the sample (Time 1)*

	Total sample	Type of group		
		Conservative	Combined	Radical
GENDER				
Women	42 (62.7%)	21 (65.6%)	15 (65.2%)	6 (50%)
Men	25 (37.3%)	11 (34.4%)	8 (34.8%)	6 (50%)
AGE				
19-29 years	10 (14.9%)	5 (15.6%)	4 (17.4%)	1 (8.3%)
30-44years	28 (41.8%)	14 (43.8%)	9 (39.1%)	5 (41.7%)
45-57 years	17 (25.4%)	9 (28.1%)	6 (26.1%)	2 (16.7%)
58-77 years	12 (17.9%)	4 (12.5%)	4 (17.4%)	4 (33.3%)
EDUCATION				
No formal qualifications	6 (9.4%)	3 (9.4%)	-	3 (30%)
Secondary/Further education	19 (29.7%)	12 (37.5%)	4 (18.2%)	3 (30%)
Higher education	17 (26.6%)	6 (18.7%)	11 (50%)	-
Professional education	22 (34.4%)	11 (34.4%)	7 (31.8%)	4 (40%)

MARITAL STATUS				
Single/Never married	31 (46.3%)	15 (46.9%)	11 (47.8%)	5 (41.7%)
Married/With partner	15 (22.4%)	8 (25%)	6 (26.1%)	1 (8.3%)
Divorced/Separated	16 (23.9%)	7 (21.9%)	5 (21.7%)	4 (33.3%)
Widow/Widower	5 (7.5%)	2 (6.3%)	1 (4.3%)	2 (16.7%)
ETHNIC ORIGIN				
White	66 (98.5%)	31 (98.5%)	23 (100%)	12 (100%)
Black/African	1 (1.5%)	1 (1.5%)	-	-
OCCUPATIONAL STATUS				
Employed	23 (34.3%)	15 (46.9%)	7 (30.4%)	1 (8.3%)
Unemployed	44 (65.7%)	17 (53.1%)	16 (69.6%)	11 (91.7%)

Almost all group members had contact with mental health services (98.5%), 34% had seen 4 or more professionals, half of them have been admitted to a psychiatric unit (47%), of whom some have been sectioned under the Mental Health Act (27%). At the time of the study however, more than a quarter (27%) of the respondents were not seeing any mental health professional (Table 4.3).

Specifically, it is interesting to mention that there was a distinct and statistically significant difference (χ^2 (1,16) = 25.06, $p < .05$) in the use of mental health services by self-help group members between the past and present time. All members reported lesser use of services at present, especially conservative group members who used to have contact with one or two mental health professionals (56%) and, at the time of study, had no contact (44%) or with only one mental health professional (31%). We should note that this change might reflect a variety of reasons such as change in mental health policy, that is the turn to community care at recent years. However, this might be an indication of the beneficial character of self-help and it is worthy of further investigation.

Additionally, comparing the three types of groups, there were a higher percentage of radical group members (71%) who had been sectioned under the Mental Health Act. This experience may be related to their interest in social change and reform of the existing mental health services.

Table 4.3: *Contact with mental health services by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Contact with mental health services				
1 month -2 years	9 (16.1%)	4 (14.8%)	4 (20%)	1 (11.1%)
3 - 14 years	26 (46.4%)	15 (55.6%)	6 (30%)	5 (55.6%)
15 - 26 years	13 (23.2%)	4 (14.8%)	7 (35%)	2 (22.2%)
27 - 50 years	8 (14.3%)	4 (14.8%)	3 (15%)	1 (11.1%)
Have you ever seen any of the following?				
A mental health professional*	7 (10.4%)	4 (12.5%)	3 (13%)	-
Two of the above	20 (29.9%)	14 (43.8%)	3 (13%)	3 (25%)
Three of the above	16 (23.9%)	5 (15.6%)	6 (26.1%)	5 (41.7%)
Four or more of the above	23 (34.3%)	8 (25%)	11 (47.8%)	4 (33.3%)
None of the above	1 (1.5%)	1 (3.1%)	-	-
Have ever been admitted to a psychiatric unit?				
Yes	37 (56.1%)	16 (50%)	14 (63.6%)	7 (58.3%)
No	29 (43.9%)	16 (50%)	8 (36.4%)	5 (41.7%)
If yes, was it under a section of Mental Health Act?				
Yes	13 (35.1%)	2 (12.5%)	6 (42.8%)	5 (71.4%)
No	24 (64.9%)	14 (87.5%)	8 (57.1%)	2 (28.6%)
How old were you at first contact with professionals?				
13 - 18 years old	16 (23.9%)	10 (37%)	6 (30%)	-
19 - 29 years old	16 (23.9%)	5 (18.5%)	8 (40%)	3 (33.3%)
30 - 40 years old	16 (23.9%)	6 (22.2%)	6 (30%)	4 (44.4%)
41 - 56 years old	8 (11.9%)	6 (22.2%)	-	2 (22.2%)
Are you seeing any of the following?				
A mental health professional*	22 (32.8%)	10 (31.3%)	9 (39.1%)	3 (25%)
Two of the above	17 (25.4%)	7 (21.9%)	5 (21.7%)	5 (41.7%)
Three of the above	8 (11.9%)	1 (3.1%)	4 (17.4%)	3 (25%)
Four or more of the above	2 (3%)	-	2 (8.7%)	-
None of the above	18 (26.9%)	14 (43.8%)	3 (13%)	1 (8.3%)

* Psychiatrist, CPN, Counsellor/Psychotherapist, Psychologist, Social Worker, or Other

4.2.2. General characteristics of self-help/mutual aid group members

Generally, group members who responded to the questionnaires, had a limited number of social networks, low levels of social support and the level of their psychological wellbeing just above the threshold, that is, marginally well (Table 4.4). This profile was consistent with the relevant literature about the effects of chronic mental health problems on the social life of people (Goldberg and Huxley 1980). Despite this low psychosocial profile, participants

reported high levels of personal empowerment. These individual characteristics were common in all three types of groups.

Table 4.4: *Mean scores (and standard deviations) of individual characteristics of self-help/mutual aid group members*

	Total sample	Type of group		
		Conservative	Combined	Radical
Social Networks (Range = 0-45)	23.41 (7.63)	23.36 (7.90)	24.15 (8.14)	22.14 (6.21)
Social Support (Range = 23-92)	50.79 (10.89)	50.42 (11.62)	51.73 (11.76)	49.98 (7.20)
Mental Wellbeing (Threshold = 2/3)	3.27 (3.82)	3.28 (3.95)	2.96 (3.74)	3.83 (3.86)
Empowerment (Range = 1-4)	2.80 (.25)	2.74 (.22)	2.86 (.26)	2.85 (.31)

Moreover, the above characteristics differentiated among members according to the length of participation in their groups (Table 4.5). If we compare short-term with long-term members, we observe differences in variables. Although the number of helping processes taking place in meetings remained the same for both types of members, a Mann-Whitney U test analysis showed that long-term members became more identified with their group ($U = 383$, $n_1=28$, $n_2=39$, $p<.05$). Social networks did not differ between the two groups; however, there were marginal differences in mental wellbeing ($U = 413$, $n_1=28$, $n_2=39$, $p<.10$) and social support ($U = 409.70$, $n_1=28$, $n_2=39$, $p<.09$). Specifically, mental wellbeing of long-term members was below the threshold of the scale, indicating that they were psychologically better, and they reported higher scores of social support in comparison with short-term members. Also, empowerment mean scores were similarly high for both short-term and long-term members.

A further exploration of the responses of short-term and long-term members revealed that these two groups differed in optimism ($t(65)=-1.96$, $p<.05$), a sub-factor of empowerment, and social companionship ($t(65)=-2.16$, $p<.05$), a sub-factor of social support (for detailed tables see Appendix C). In both cases, long-term members reported higher scores.

Table 4.5: *Mean scores (and standard deviations) of processes and outcomes of participation by time of membership*

	Short-term members (N=28)	Long-term members (N=39)
PROCESSES		
Helping processes (Range = 28-140)	90.39 (17.93)	90.59 (13.04)
Group identification (Range=10-50)	**40.35 (4.39)***	**43.10 (5.69)***
OUTCOMES		
Empowerment (Range = 1-4)	2.76 (.28)	2.83 (.23)
Social Networks (Range = 0-45)	22.57 (7.78)	24.02 (7.56)
Social Support (Range = 23-92)	**48.86 (11.19)†**	**52.18 (10.59)†**
Mental Wellbeing (Threshold = 2/3)	**3.89 (4.33)†**	**2.82 (3.38)†**

*Means difference significant at .05 level (Mann-Whitney U test)
†Means difference significant at .10 level (Mann-Whitney U test)

4.2.3. Typology of self-help/mutual aid groups

Self-help/mutual aid groups of the sample were categorised according to their political ideology and focus of change (Emerick 1991; Kurtz 1997; see Chapter Three: Profile of the Participating Groups). However, not all groups within a category were identical and presented the same psychosocial profile. In contrast, if we compare mean scores of individual and group variables between groups, we observe differences among them, even statistically significant ones. These differences reflect the variety of structural and organisational characteristics of self-help/mutual aid groups. Nevertheless, these groups shared common aims and focus of change and, as a consequence, offered a specific ideology to their members. The common ideological elements that were shared by groups are the basis to differentiate from another ideological type.

In the "individual change" category, significant differences were observed in individual characteristics such as social networks, social support and psychological wellbeing (Table 4.6). Specifically, members of the Depression Alliance group (London-afternoon) and the Fellowship of Depressives Anonymous group (London) had far fewer social networks than other members in this category and differed significantly from the Overeaters Anonymous group. Moreover, members of the Overeaters Anonymous group reported more social support that the Fellowship of Depressives Anonymous group (London). Finally, only three of the eight "individual change" groups (EDA-Maidstone, OA-Maidstone and FDA-London) scored

above the threshold of psychological wellbeing, namely they reported poor psychological wellbeing. The remaining five groups appeared to have no "ill" members.

Despite their differences, all these group members were empowered and identified quite strongly with their group.

Table 4.6: *Mean scores of individual and group variables in individual change groups*

	INDIVIDUAL CHANGE GROUPS								
	DA-Lon.1 (N=3)	DA-Lon.2 (N=3)	EDA-Maid. (N=3)	OA-Maid. (N=7)	FDA-Lon. (N=6)	MDF-Wands. (N=6)	Voices-Cant. (N=2)	Voices-Whit. (N=2)	Total (N=32)
Empowerment (R=1-4)	2.64	2.84	2.59	2.70	2.69	2.89	2.95	2.67	2.74
Social networks (R=0-45)	19.67	14.50 *	29.00	31.57 *	18.33 *	24.00	24.50	17.00	23.36
Social support (R=23-92)	42.33	45.00	58.33	62.14 *	43.67 *	49.58	50.00	41.00	50.42
Wellbeing (Thr.=2/3)	.67 *	1.00	8.33 *	3.43	5.83	2.33	1.00	.00	3.28
Group identification (R=10-50)	40.33	39.50	42.00	45.86	43.00	41.67	41.00	39.00	41.95
Helping processes (R=28-140)	93.00	76.00	96.33	87.78	93.54	88.87	105.00	86.50	90.25

*Mean difference significant at .05 level (Tukey HSD test)

In the "combined" category, groups differed in some individual characteristics such as social networks and support and in a group variable, namely helping processes. Specifically, the Depression Alliance group (St. Albans) presented fewer social networks, less social support and fewer helping processes that the Eating Disorders Association group (Southend) (Table 4.7). The difference in helping processes between the two groups may be understood if we consider their way of functioning. As I already described in Chapter Three, the St. Albans' group had usually a larger number of people in its meetings than the Southend one and an increased number of helping processes was easier to take place in a smaller group. Moreover, the Southend group gave a lot of emphasis on its members' personal problems, whereas the St. Albans' one had a strong interest on social activities. All combined group members reported high personal empowerment scores and strong group identification.

Table 4.7: *Mean scores of individual and group variables in combined groups*

	COMBINED GROUPS			
	DA-St. Albans (N=8)	MDF-Bromley (N=11)	EDA-Southend (N=4)	Total (N=23)
Empowerment (Range=1-4)	2.72	2.92	2.96	2.86
Social networks (Range=0-45)	18.34*	26.34	29.75*	24.15
Social support (Range=23-92)	44.37*	54.02	60.12*	51.73
Wellbeing (Threshold=2/3)	1.25	4.73	1.50	2.96
Group identification (Range=10-50)	40.34	42.16	46.69	42.31
Helping processes (Range=28-140)	84.59*	90.36	105.69*	91.02

*Means difference significant at .05 level (Tukey HSD test)

Table 4.8: *Mean scores of individual and group variables in social change groups*

	SOCIAL CHANGE GROUPS			
	HUBB-Romford (N=6)	SWOF-Folkestone (N=4)	LUF-Lewisham (N=2)	Total (N=12)
Empowerment (Range=1-4)	2.67	2.98	3.14	2.85
Social networks (Range=0-45)	20.12	25.25	22.00	22.14
Social support (Range=23-92)	47.29	50.25	57.50	49.98
Wellbeing (Threshold=2/3)	4.50	3.50	2.50	3.83
Group identification (Range=10-50)	35.17*	45.75*	44.50	40.25
Helping processes (Range=28-140)	84.75	95.75	95.50	90.21

*Means difference significant at .05 level (Tukey HSD test)

In the "social change" category, we observe statistical differences only in a group variable, group identification. Members of the SWOF group (Folkestone) were more identified with their group than members of the HUBB group (Romford). This difference may be explained by the different composition of those groups. The SWOF group was smaller and its members had close relationships in comparison with the HUBB one; therefore, SWOF's members had probably more opportunities to feel closer to their group (Table 4.8). However, all groups were highly empowered.

4.2.4. Individual characteristics

Empowerment

Overall, the mean score of personal empowerment was 2.80 (range 2.19 to 3.54), which means that participants scored above the middle range of the scale (Table 4.9). The same observation could be made for the mean scores of sub-factors of empowerment which were also above the middle of the scale. One of the sub-factors which was distinct from all the others was community activism, where participants had the highest mean score, 3.19 (range 2.50 to 4.00).

Table 4.9: *Mean scores (and standard deviations) of empowerment and sub-scales by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Empowerment	2.80 (.25)	2.74 (.22)	2.86 (.26)	2.85 (.31)
Sub-scales				
Optimism	2.61 (.44)	**2.49 (.39)***	2.65 (.38)	**2.86 (.57)***
Power	2.65 (.35)	**2.55 (.31)***	**2.78 (.37)***	2.64 (.35)
Self-esteem	2.76 (.36)	2.69 (.35)	2.83 (.36)	2.83 (.36)
Community Activism	3.19 (.33)	3.16 (.28)	3.22 (.33)	3.21 (.45)
Righteous Anger	2.70 (.49)	2.78 (.33)	2.59 (.65)	2.69 (.46)

*Means difference significant at .05 level (Tukey HSD test)

It was interesting to note that self-help group members' overall empowerment scores were significantly higher than reported scores of a sample of users (N=260, from four districts of England), aged 18-65 years, living in the community and in contact with mental health services on the Care Programme Approach ($t(325)=13.37$, $p<.01$) (Carpenter et al. 1999). Strong statistical differences between self-help group members and service users existed also in three of the five sub-factors, namely optimism ($t(325)=4.25$, $p<.01$), self-esteem ($t(325)=8.27$, $p<.01$) and community activism ($t(325)=28.73$, $p<.01$).

There were no overall statistically significant differences between groups in overall personal empowerment, but there were some differences in its sub-factors (Table 4.9). Radical group members reported more optimism/control over the future than conservative ones ($F(2, 66) = 3.43$, $p<.05$). Also, combined group members reported more feelings of actual power than conservative ones ($F(2, 66) = 3.00$, $p<.05$).

Relationship between empowerment and individual characteristics of group members

If we examine the relationship of personal empowerment with psychosocial characteristics of group members across different types of self-help groups, we see that mental wellbeing was the characteristic that was significantly correlated with empowerment in the total sample (r=-

.31, p<.05) (Table 4.10). This relationship indicates that personal empowerment reflects on good psychological wellbeing. There was also a marginal relationship of empowerment with social support (r=.22, p<.08) and a more significant relationship with a specific type of support, social companionship (r=.36, p<.01) (for a detailed table of sub-factors see Appendix C). However, this was not the case for all three types of groups. The relationship with mental wellbeing was mainly true for conservative groups (r=-.44, p<.05), and marginally for radical ones (r=-.52, p<.08). In combined groups empowerment was related to social networks (r=.52, p<.05) and social companionship (r=.41, p<.05).

Table 4.10: *Correlation of empowerment with psychosocial characteristics by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
	EMPOWERMENT			
Mental Wellbeing	**-.31***	**-.38***	.10	**-.52†**
Social Networks	.21	.05	**.52***	.22
Social Support	**.22†**	.09	.35	.35

†p<.08, *p<.05, **p<.01

Social Networks

Consistent with the psychosocial profile of long-term mental health service users, self-help members of the study presented poor social networks. Looking in detail, respondents reported an absence of strong family relationships. Only half (45%) of the total sample reported that they had contact at least once per month with three or four family members (Table 4.11). Additionally, there was a significant number of respondents who had no monthly contact with a family member (12%). Finally, the vast majority (67%) had none or only one family member they felt close to. The different types of groups presented the same picture as the overall sample.

Table 4.11: *Family Network by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Number of family members in contact monthly				
None	8 (12%)	3 (9%)	3 (13%)	2 (17%)
One or two	16 (24%)	7 (22%)	5 (22%)	4 (33%)
Three or four	30 (45%)	15 (47%)	12 (52%)	3 (25%)
Five to eight	11 (16%)	6 (19%)	3 (13%)	2 (17%)
Nine or more	2 (3%)	1 (3%)	-	1 (8%)

Frequency of contact per month				
More than monthly	5 (8%)	2 (6%)	1 (5%)	2 (18%)
Monthly	4 (7%)	1 (3%)	-	3 (27%)
A few times a month	8 (13%)	4 (13%)	4 (20%)	-
Weekly	17 (27%)	9 (29%)	6 (30%)	2 (18%)
A few times a week	13 (21%)	7 (23%)	4 (20%)	2 (18%)
Daily	15 (24%)	8 (26%)	5 (25%)	2 (18%)
Number of family members feel close to				
None	9 (13%)	4 (12.5%)	4 (17%)	1 (8%)
One or two	36 (54%)	19 (59%)	10 (43%)	7 (58%)
Three or four	14 (21%)	5 (16%)	5 (22%)	4 (33%)
Five to eight	8 (12%)	4 (12.5%)	4 (17%)	-

Supportive relationships were mainly based on friends. Almost half of the total sample reported that they had one or two close friends and they had contact with them at least once a month. Moreover, a large number (73%) of respondents reported that they had frequent (weekly or more often) contact with their closest friend. The three types of groups did not differ in relevance to their friendship networks. However, there were more conservative group members isolated with no close friends at all (5 out of 32) (Table 4.12).

Table 4.12: *Friends Network by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Number of close friends				
None	6 (9%)	5 (16%)	1 (4%)	-
One or two	28 (42%)	11 (34%)	8 (35%)	9 (75%)
Three or four	18 (27%)	8 (25%)	7 (30%)	3 (25%)
Five to eight	13 (19%)	7 (22%)	6 (26%)	-
Nine or more	2 (3%)	1 (3%)	1 (4%)	-
Number of friends in contact per month				
None	6 (9%)	4 (13%)	2 (9%)	-
One or two	30 (45%)	11 (36%)	10 (44%)	9 (75%)
Three or four	19 (29%)	10 (32%)	6 (26%)	3 (25%)
Five to eight	9 (14%)	5 (16%)	4 (17%)	-
Nine or more	2 (3%)	1 (3%)	1 (4%)	-
Frequency of contacts per month				
More than monthly	3 (5%)	3 (10%)	-	-
Monthly	3 (9%)	4 (13%)	-	2 (17%)
A few times a month	8 (13%)	5 (17%)	1 (5%)	2 (17%)
Weekly	16 (25%)	5 (17%)	7 (33%)	4 (33%)
A few times a week	17 (27%)	7 (23%)	7 (33%)	3 (25%)
Daily	13 (21%)	6 (20%)	6 (29%)	1 (8%)

The majority of the sample had confiding relationships with others, that is someone to discuss important issues with (often, very often or always, 63%). The vast majority of radical group members appeared to have this type of relationship (often, very often or always, 83%) whereas, both conservative and combined group members reported a lack of such a relation (never, seldom, or sometimes, 40.5% and 44% respectively). On the other hand, other people infrequently talked to group members about important decisions (never, seldom or sometimes, 61%). Findings were similar for all three group types (Table 4.13).

Table 4.13: *Confiding Relationships by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Having someone to discuss with important decisions				
Never	2 (3%)	-	2 (9%)	-
Seldom	5 (7%)	4 (12.5%)	-	1 (8%)
Sometimes	18 (27%)	9 (28%)	8 (35%)	1 (8%)
Often	8 (12%)	4 (12.5%)	1 (4%)	3 (25%)
Very often	18 (27%)	6 (19%)	9 (39%)	3 (25%)
Always	16 (24%)	9 (28%)	3 (13%)	4 (33%)
Others will discuss with you important decisions				
Never	2 (3%)	1 (3%)	1 (4%)	-
Seldom	7 (10%)	4 (12%)	3 (13%)	-
Sometimes	32 (48%)	16 (50%)	9 (39%)	7 (58%)
Often	12 (18%)	5 (16%)	4 (17%)	3 (25%)
Very often	10 (15%)	5 (16%)	4 (17%)	1 (8%)
Always	4 (6%)	1 (3%)	2 (9%)	1 (8%)

Almost half of the overall sample (29 out of 67 people, 43%) lived alone or with unrelated individuals (Table 4.14). There were similar numbers of people in all three group types. The rest of the sample lived either with their family (25%) or spouse/partner (22%) and fewer people lived with friends (9%). The picture was similar for conservative and combined group members. However, radical group members lived mostly with their family (6 out of 12) but only one with a spouse/partner.

Table 4.14: *Living arrangements by type of group*

	Total sample	TYPE OF GROUP		
		Conservative	Combined	Radical
Live alone	27 (40%)	11 (34%)	11 (48%)	5 (42%)
Live with unrelated individuals	2 (3%)	1 (3%)	1 (4%)	-
Live with friends	6 (9%)	4 (12.5%)	2 (9%)	-
Live with family	17 (25%)	9 (28%)	2 (9%)	6 (50%)
Live with spouse/partner	15 (22%)	7 (22%)	7 (30%)	1 (8%)

A closer look at the social networks of the self-help/mutual aid group members, revealed that groups differed in relations with relatives or friends but the overall picture was that there was a significant number of members with none or very few social relationships. The main source of support was friends rather than relatives. Furthermore, a significant number of participants lived alone (almost half in all three types of groups). Poor social networks justify the fact that the vast majority of members gave as the main reason for attending self-help/mutual aid groups the support and empathy that they received from other members.

Social Support

Overall, self-help/mutual aid group members of the study reported low levels of social support (mean=2.21, score range=1-4) (Table 4.15). Particular types of support like practical support (e.g. advice, practical help) seemed to have even lower mean scores than emotional (e.g. affection, sympathy) support and social companionship. The highest mean scores could be observed in daily emotional support in the overall sample and separately in all three types of groups. The increased numbers in this particular type of support could be an indication of the benefits from participation in self-help/mutual aid groups. In fact, examining social support by length of membership, we noted that long-term members had higher mean scores in overall support and especially in the emotional-type of support. Moreover, they differed significantly from short-term members in social companionship ($t(65)=-2.16$, $p<.05$) (see Table 6, Appendix C).

Table 4.15: *Social support by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Social support (total score)	2.21 (.47)	2.19 (.50)	2.25 (.51)	2.17 (.31)
Types of support				
Daily Practical	1.73 (.44)	1.74 (.48)	1.73 (.49)	1.71 (.23)
Problem-oriented Practical	1.90 (.58)	1.91 (.59)	1.88 (.65)	1.91 (.37)
Daily Emotional	2.63 (.60)	2.70 (.66)	2.63 (.58)	2.48 (.49)
Problem-oriented Emotional	2.34 (.61)	2.31 (.64)	2.37 (.60)	2.35 (.59)
Social Companionship	2.19 (.59)	2.07 (.64)	2.36 (.55)	2.18 (.52)

Mental Wellbeing

More than half of the sample (57%) reported scores below the threshold of the General Health Questionnaire (GHQ), which means that they felt psychologically well (Table 4.16). However,

there were a significant (29 out of 67) number of members who scored at or above the threshold and this was an indication that they did not feel very well. The different types of groups presented similar scores of mental wellbeing except of radical groups which had more members (7 out of 12, 58%) reporting poor mental wellbeing (≥ threshold).

Table 4.16: *Mental Wellbeing by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
0	18 (26.9%)	9 (28.1%)	6 (26.1%)	3 (25%)
1	15 (22.4%)	8 (25%)	7 (30.4%)	-
2	5 (7.5%)	2 (6.3%)	1 (4.3%)	2 (16.7%)
3 (Threshold)	8 (11.9%)	3 (9.4%)	2 (8.7%)	3 (25%)
4 or above	21 (31.5%)	10 (31.2%)	7 (30.4%)	4 (33.2%)

Relationship between mental wellbeing, helping processes and empowerment

Mental wellbeing was not particularly correlated with the total amount of helping processes that were reported as occurring by group members. However, it was highly correlated with a specific type of helping processes, behaviour-oriented, in the total sample ($r = -.36$, $p<.01$) as well as in conservative ($r = -.38$, $p<.05$) and radical groups ($r = -.58$, $p<.05$) (Table 4.17). This relationship suggests that the increase of behaviour-oriented processes that occur in meetings reflects on good psychological wellbeing, a finding which is expected if we consider that this kind of processes refer to ways of coping with the focal problem/condition of the self-help group members.

Table 4.17: *Correlation of mental wellbeing with helping group processes and their sub-scales by type of group*

	Mental Wellbeing			
		Type of group		
	Total sample	Conservative	Combined	Radical
Helping Processes	-.23	-.26	-.21	.22
Sub-scales				
Behaviour-oriented	**-.36****	**-.38***	-.23	**-.58***
Expressive	-.11	-.14	-.01	-.35
Supportive	.09	-.18	-.02	.08
Group cohesiveness	-.15	-.14	**-.48***	-.37
Confrontational	-.15	.02	-.28	.33
Insight-oriented	-.03	.07	-.01	-.11

* $p<.05$, ** $p<.01$

Also, as I mentioned earlier, there was an interesting relationship of mental wellbeing with personal empowerment and its sub-factors (Table 4.18). Overall, members who felt psychologically well reported higher levels of empowerment ($r = -.31$, $p<.05$), and more

specifically they reported more optimism (r = -.24, p<.05), feelings of actual power (r = -.26, p<.05) and self-esteem (r = -.24, p<.05). This finding is expected because psychological wellbeing is based on positive feelings towards oneself and others.

From the three ideological group types, it was the conservative groups that presented a significant negative relationship of mental wellbeing with overall empowerment (r = -.38, p<.05), and with feelings of actual power (r = -.35, p<.05) whilst manifesting a marginal correlation with self-esteem (r = -.30, p<.08). Radical groups showed as well a marginal relationship of wellbeing with empowerment (r=-.52, p<.08) and optimism (r=-.51, p<.08) as well as a stronger relationship with self-esteem (r = -.60, p<.05). Finally, combined groups did not show any significant relationship between wellbeing with empowerment and its sub-factors.

Table 4.18: *Correlation of mental wellbeing with empowerment and its sub-scales by type of group*

	Mental Wellbeing			
		Type of group		
	Total sample	Conservative	Combined	Radical
Empowerment	**-.31***	**-.38***	-.10	-.52†
Sub-scales				
Optimism	**-.24***	-.20	-.17	-.51†
Power	**-.26***	**-.35***	-.03	-.46
Self-esteem	**-.24***	-.30†	.02	**-.60***
Community Activism	-.20	-.16	-.09	-.39
Righteous Anger	-.04	-.13	-.17	.33

† p<.08, * p<.05, ** p<.01

4.2.5. Group characteristics

Member attendance and length of membership

Examining the frequency of member attendance and length of membership, we observed that the vast majority of members in the total sample were frequent attenders (attending all or most of the meetings, 81%) and long-term members (thirteen months to nine years, 58%). The same picture was shown for the three types of groups separately (Table 4.19). There were no significant differences between types of groups.

In addition, the relationship of member attendance with the length of membership was very strong (r=.50, p<.01) in the overall sample. This means that members who attended group meetings for longer became regular attenders. However, this relationship differed in the three

types of groups. In both conservative and combined groups it was still significant (r=.39, p<.05 and r=.70, p<.01 respectively) but not in radical groups.

Also, the length of participation at group meetings was related significantly with some of the variables of the study. Specifically, membership length was positively correlated with group identification (r=.29, p<.05). It had also a marginal relationship with social support (r=.23, p=.06) but stronger relationships with two specific types of support: daily emotional support (r=.26, p<.05) and social companionship (r=.34, p<.01).

Table 4.19: *Member attendance and length of membership by type of self-help/mutual aid group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Member attendance				
Beginners	8 (11.9%)	3 (9.4%)	4 (17.4%)	1 (8.3%)
Irregular attenders	5 (7.5%)	3 (9.4%)	-	2 (16.7%)
Regular attenders	54 (80.6%)	26 (81.3%)	19 (82.6%)	9 (75%)
Length of membership				
0-1 month	10 (14.9%)	5 (15.6%)	4 (17.4%)	1 (8.3%)
Up to 1 year	18 (26.9%)	11 (34.1%)	5 (21.7%)	2 (16.7%)
1 to 2 years	19 (28.4%)	7 (21.9%)	5 (21.7%)	7 (58.3%)
3 to 4 years	12 (17.9%)	4 (12.5%)	7 (30.4%)	1 (8.3%)
4 to 9 years	8 (11.9%)	5 (15.6%)	2 (8.7%)	1 (8.3%)

Participation in self-help/mutual aid groups

Group members answered a series of open-ended questions about their participation in the group[1]. Half of the members in the total sample characterised their group *as "self-help"*, while almost one third described it as *"support/mutual support"*. The rest of the answers were consistent with the various characteristics attributed in the relevant literature to self-help/mutual aid groups. Respondents referred to their group as been *informal/open, user-led, advocacy/campaigning, providing help/information*, and *discussion* (Table 4.20).

However, differences appeared in the answers of the three types of groups. Conservative and combined group members emphasised mostly the self-help character of their group (55% and 61% respectively), whereas radical group members believed that their group was mostly user-led (36%) and promoted advocacy and campaigning on mental health issues (27%). Combined

[1] Results of the content analysis of members' answers to open-ended questions are presented at this sub-section. Reported numbers represent the frequency that each member reported a specific answer; therefore, percentages refer to the total number of respondents. The number of people who did not respond at all is presented as well.

group members believed that another important characteristic of their group was support/mutual support (43%).

Table 4.20: *What kind of group is your group?*

	Total sample (N=65)	Type of group		
		Conservative (N= 31)	Combined (N=23)	Radical (N=11)
Self-help	32 (49.2%)	17 (54.8%)	14 (60.9%)	1 (9.1%)
Support/Mutual support	18 (27.7%)	6 (19.3%)	10 (43.5%)	2 (18.2%)
Help/Information	7 (10.8%)	5 (16.1%)	1 (4.3%)	1 (9.1%)
Informal/Open	6 (9.2%)	3 (9.7%)	3 (13%)	1 (9.1%)
User-led	5 (7.7%)	-	1 (4.3%)	4 (36.4%)
Advocacy/ Campaigning	4 (6.1%)	-	1 (4.3%)	3 (27.3%)
Discussion	4 (6.1%)	3 (9.7%)	1 (4.3%)	-
Mental health	2 (3.1%)	-	1 (4.3%)	1 (9.1%)
No answer	2 (3%)	1 (3.1%)	-	1 (8.3%)

The main reason given for joining the group was to *help oneself and others* (31%). Nonetheless, there were other reasons that seemed to be also quite important such as: *meeting others with the same experience and sharing with them* (18%), *suffering a mental health problem* (15%), *company and socialising* (14%), *information and understanding of the problem* (14%), or a *referral or recommendation* (11%) (Table 4.21). The most common reason given by radical group members was *company and socialising* (36%) followed by *information and understanding of the problem* (27%).

Table 4.21: *Reasons for joining a self-help/mutual aid group*

	Total sample (N=65)	Type of group		
		Conservative (N=32)	Combined (N=22)	Radical (N=11)
To help myself and others	20 (30.8%)	12 (37.5%)	6 (27.3%)	2 (18.2%)
To meet others with same experience/ to talk & share feelings with them	12 (18.5%)	8 (25%)	4 (18.2%)	-
I had a mental health problem	10 (15.4%)	5 (15.6%)	4 (18.2%)	1 (9.1%)
For company/socialising	9 (13.8%)	3 (9.4%)	2 (9.1%)	4 (36.4%)
For information/learn more/understand the problem	9 (13.8%)	3 (9.4%)	3 (13.6%)	3 (27.3%)
I was referred/recommend	7 (10.8%)	2 (6.2%)	3 (13.6%)	2 (18.2%)
To see there were others out there coping	2 (3.1%)	1 (3.1%)	1 (4.5%)	-
Previous group ceased to exist	2 (3.1%)	-	2 (9.1%)	-
Not satisfied with treatment	1 (1.5%)	-	-	1 (9.1%)
No answer	2 (3%)	-	1 (4.3%)	1 (8.3%)

The expectation of members from their group was mainly of *support and understanding of their feelings* (51%). They also expected *help from others' experiences* (17%), *exchange of information and advice* (13%), and *social contact* (11%). Although expectations were similar to all three types of groups, three of the twelve radical group members stated *campaigning for better treatment and change of the system* (Table 4.22).

Table 4.22: *Expectations from the group*

	Total sample (N=63)	Type of group		
		Conservative (N=31)	Combined (N=21)	Radical (N=11)
Support/Empathy/Understanding	32 (50.8%)	16 (51.6%)	12 (57.1%)	4 (36.4%)
Help from others' experiences	11 (17.5%)	6 (19.3%)	2 (9.5%)	3 (27.3%)
Exchange of information/Advice	8 (12.7%)	2 (6.4%)	4 (19%)	2 (18.2%)
Social contact/Friendship	7 (11.1%)	2 (6.4%)	4 (19%)	1 (9.1%)
Insight/Understanding of condition	4 (6.3%)	4 (12.9%)	-	-
Meet others with same problem	4 (6.3%)	1 (3.2%)	2 (9.5%)	1 (9.1%)
Campaigning for better treatment/change of system	3 (4.8%)	-	-	3 (27.3%)
Feel useful/valuable	2 (3.2%)	-	1 (4.8%)	1 (9.1%)
No expectations	2 (3.2%)	2 (6.4%)	-	-
Expected more "therapy-like" structure	1 (1.6%)	1 (3.2%)	-	-
Don't know/Not sure	2 (3.2%)	1 (3.2%)	1 (4.8%)	-
No answer	4 (6%)	1 (3.1%)	2 (8.7%)	1 (8.3%)

Table 4.23: *What do you think the group can offer to you?*

	Total sample (N=61)	TYPE OF GROUP		
		Conservative (N=30)	Combined (N=21)	Radical (N=10)
Friendship/A listening ear	19 (31.1%)	8 (26.7%)	9 (42.8%)	2 (20%)
Support/Mutual support	15 (24.6%)	9 (30%)	5 (23.8%)	1 (10%)
Insight/Understanding of problem/Personal experiences	15 (24.6%)	9 (30%)	6 (28.6%)	-
Confidence/Reassurance/ Encouragement	7 (11.5%)	3 (10%)	2 (9.5%)	2 (20%)
Information/Advice/Self-educ	6 (9.8%)	1 (3.3%)	3 (14.3%)	2 (20%)
Help	2 (3.3%)	1 (3.3%)	1 (4.8%)	-
Freedom of choice	2 (3.3%)	-	1 (4.8%)	1 (10%)
Hope	2 (3.3%)	1 (3.3%)	-	1 (10%)
A base to work from	1 (1.6%)	-	-	1 (10%)
Don't know/Not certain yet	3 (4.9%)	2 (6.7%)	1 (4.8%)	-
No answer	6 (8.9%)	2 (6.2%)	2 (8.7%)	2 (16.7%)

Members believed that their group could offer them what they were expecting, that is mainly *friendship* (*"a listening ear"*) (31%), *support/mutual support* (25%), *insight and personal experiences* (25%), plus *confidence, reassurance and encouragement* (11%) (Table 4.23). This was the case for all three ideological types with the exception of radical group members who did not report "insight" and "personal experiences" as did members of the other two types. Radical group members considered that the group could offer *freedom of choice, hope* and *a base to work from*. These differences were consistent with the "social-change" character of this ideological type of self-help/mutual aid group.

Half of the group members believed that they could offer to their group *personal experiences* and *support*. They also mentioned *friendship* (15%), *practical help and ways of thinking* (13%) and *information* (11%). In addition, conservative group members reported *sharing of feelings* (four members), whereas radical group members reported *ability to work for better conditions and skills* (two members) and *trust, loyalty and commitment* (one member) (Table 4.24). Again, these differences denote the groups' ideological character, namely their personal or societal orientation.

Table 4.24: *What do you think you can offer to the group?*

	Total sample (N=61)	Type of group		
		Conservative (N=31)	Combined (N=20)	Radical (N=10)
My personal experiences/story	23 (37.7%)	12 (38.7%)	9 (45%)	2 (20%)
Support	12 (19.7%)	6 (19.3%)	6 (30%)	-
Friendship/A listening ear	9 (14.7%)	6 (19.3%)	2 (10%)	1 (10%)
Help others/Practical help/Ways of thinking	8 (13.1%)	5 (16.1%)	-	3 (30%)
Information	7 (11.5%)	4 (12.9%)	2 (10%)	1 (10%)
Ability to work for better conditions/Skills	6 (9.8%)	1 (3.2%)	3 (15%)	2 (20%)
Sharing of feelings	5 (8.2%)	4 (12.9%)	-	1 (10%)
Trust/Loyalty/ Commitment	2 (3.3%)	1 (3.2%)	-	1 (10%)
Don't know	1 (1.6%)	-	1 (5%)	-
No answer	6 (8.9%)	1 (3.1%)	3 (13%)	2 (16.7%)

Finally, members reported their degree of satisfaction from the progress of the group as well as from their chance to discuss issues that mattered to them during the meetings (Table 4.25). Overall, respondents answered that they were quite satisfied from their group (94%) and they felt that they had sufficient chance to discuss issues they mattered to them (89%). There were no differences between the three ideological types of groups.

Table 4.25: *Do you feel comfortable with the group and how it is progressing?*

	Total sample	Type of group		
		Conservative	Combined	Radical
Do you feel comfortable with the group and how it is progressing?				
Yes, always	15 (23.8%)	6 (20%)	7 (31.8%)	2 (18.2%)
Yes, most of the times	44 (69.8%)	22 (73.3%)	14 (63.3%)	8 (72.7%)
Not often	4 (6.3%)	2 (6.7%)	1 (4.5%)	1 (9.1%)
Never	-	-	-	-
Do you get sufficient chance to discuss issues important to you?				
Yes, always	16 (25.4%)	6 (19.4%)	6 (28.6%)	4 (36.4%)
Yes, most of the times	40 (63.5%)	22 (71%)	13 (61.9%)	5 (45.5%)
Not often	6 (9.5%)	3 (9.7%)	2 (9.5%)	1 (9.1%)
Never	1 (1.6%)	-	-	1 (9.1%)

In summary, members of the English mental health self-help/mutual aid groups that participated in the study were regular attenders with long-term membership. They characterised their group as *self-help* or *support/mutual support* one and the main reason for joining was *to help themselves and others*. Mainly, they expected from their group *support* and *understanding of their feelings*, and they believed that the group could offer them *friendship*, a "*listening ear*", *support* and *insight to their personal experiences*. They also believed that they could offer to other members their *personal experiences* and *support*.

Helping Processes

Self-help group members who participated in this study reported a large number of helping processes occurring during group meetings. More specifically, expression, support and insight were the processes *mostly reported* (mean score>3), as measured by the Helping Processes Questionnaire (Table 4.26). Confrontational, group cohesiveness and behaviour-oriented processes were less frequent (mean score<3). There was no significant difference among the three types of groups in the overall mean score. However, if we examine the different types of processes, we see that group cohesiveness (such as establishing group goals) was reported more frequently from radical group members than the conservative ones ($F(2, 66) = 3.57$, $p<05$). Also, processes having a therapeutic character like expression of feelings (e.g. self-disclosure, sharing, reflection) (marginal difference, $F(2, 64)=2.35$, $p<.10$) were reported more from the conservative group members than radical ones.

Looking in more detail at the 28 helping group processes assessed by the scale (detailed presentation in Chapter Two: Methodology), all participants reported as occurring "frequently" (≤4) the following: sharing, mutual affirmation, empathy and behavioural prescription (Table 4.27). These four processes are characteristic of the self-help ideology

and are consistent with evidence from previous research, as mentioned above (see Chapter One, section 1.2.5). However, there were some significant differences between the groups in the most frequent processes and these were in line with their ideological type and the orienting points of the study. Specifically, conservative groups reported more self-disclosure ($F(2,66) = 2.67$, $p<.05$) than the radical ones. Also, both conservative and combined groups reported more sharing ($F(2,66) = 8.29$, $p<.01$) and catharsis ($F(2,66) = 4.25$, $p<.02$) than the radical ones. Finally, radical groups reported more establishing of group goals ($F(2,66) = 5.56$, $p<.01$) than the other two group types.

Table 4.26: *Mean scores (and standard deviations) of helping group processes• and sub-scales by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Helping Processes	3.23 (.54)	3.22 (.55)	3.25 (.47)	3.22 (.67)
Sub-scales				
Behaviour-oriented	2.82 (.65)	2.77 (.67)	2.73 (.51)	3.09 (.82)
Expressive	3.76 (.73)	**3.91 (.57) †**	3.75 (.76)	**3.38 (.97) †**
Supportive	3.98 (.78)	4.00 (.92)	4.01 (.69)	3.90 (.54)
Group cohesiveness	2.55 (.83)	**2.33 (.85)***	2.60 (.65)	**3.06 (.95)***
Confrontational	2.40 (1.03)	2.38 (1.05)	2.57 (1.04)	2.17 (1.02)
Insight-oriented	3.46 (.92)	3.46 (.89)	3.61 (.76)	3.17 (1.28)

•The range of answers is from 1=never happens to 5=happens frequently
† Means difference at .10 level (Tukey HSD test)
* Means difference significant at .05 level (Tukey HSD test)

Table 4.27: *Mean scores of helping processes reported most frequently by type of group*

HELPING PROCESSES REPORTED MOST FREQUENTLY•				
PROCESSES	Total sample	TYPE OF GROUP		
		Conservative	Combined	Radical
Behavioural prescription	**4.14**	**4.16**	**4.04**	**4.29**
Behavioural proscription	3.31	3.42	3.11	3.37
Positive reinforcement	-	-	-	3.46
Modelling	3.09	3.25	-	-
Self-disclosure	3.82	**4.12[1]**	3.68	3.27[1]
Sharing	**4.55**	**4.81[2]**	**4.52[2]**	3.92[2]
Confrontation	-	-	3.12	-
Encouragement of sharing	3.70	3.65	3.85	3.52
Reflection	3.15	3.09	3.06	3.50
Reassurance of competence	3.73	3.81	3.74	3.52
Justification	3.92	3.87	**4.03**	3.83
Mutual affirmation	**4.31**	**4.21**	**4.35**	**4.46**
Empathy	**4.42**	**4.53**	**4.35**	**4.27**
Normalisation	3.67	3.81	3.66	3.29
Instillation of hope	3.86	3.75	3.92	**4.04**
Personal goal setting	3.01	3.06	3.02	-

Establishing group goals	-	-	-	3.96[3]
Consensual validation	-	-	3.36	-
Functional analysis	3.29	3.31	3.36	3.08
Discrimination training	3.20	3.03	3.54	3.02
Explanation	3.89	**4.03**	3.93	3.42
Catharsis	3.56	3.84†	3.61†	-

• Means ≥ 3.00 (processes occurring sometimes/frequently)
In bold, means = 4 or higher
[1] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad
[2] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
[3] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad

Among the helping processes reported as occurring never or rarely (≥2) were punishment, assertion of group norms and behavioural rehearsal (Table 4.28), a finding which is consistent with the general orientation of self-help groups toward safety and simplicity (Wollert et at. 1982). However, this was not the case for all three types of groups. Conservative groups reported punishment more rarely than the radical ones ($F(2,66) = 4.06$, $p<.05$), whereas assertion of group norms ($F(2,66) = 2.87$, $p<.05$) was reported as occurring a little more by radical groups than both the other two groups.

Table 4.28: *Mean scores of helping processes reported less frequently by type of group*

HELPING PROCESSES REPORTED LESS FREQUENTLY•				
PROCESSES	Total sample	TYPE OF GROUP		
		Conservative	Combined	Radical
Behavioural rehearsal	**1.83**	**1.66**	**1.72**	2.50
Positive reinforcement	2.80	2.59	2.74	-
Punishment	**1.80**	**1.44***	**2.01**	2.35*
Extinction	2.57	2.64	2.28	2.92
Modelling	-	-	2.95	2.96
Confrontation	2.81	2.71	-	2.46
Requesting	2.14	2.15	2.04	2.29
Offering feedback	2.26	2.25	2.54	**1.75**
Personal goal setting	-	-	-	2.85
Establishing group goals	2.90	2.47[3]	2.96[3]	-
Assertion of group norms	**1.81**	**1.78****	**1.49****	2.48**
Consensual validation	2.95	2.75	-	2.73
Catharsis	-	-	-	2.69†

• Means <3.00 (processes occurring rarely/never)
In bold, means = 2 or lower
* Means difference significant at 05 level (Tukey HSD test) – Conserv-Rad
[3] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
** Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad

Group Identification

Overall, members reported high overall scores at group identification (mean = 41.95, std.=5.33, score range = 10-50). Similarly high scores were reported in its three facets: awareness of group membership (mean = 4.10, std.=.67, range=1-5), evaluation of the group (mean = 4.19, std.=.72, range=1-5) and affect from it (mean = 4.24, std.=.59, range=1-5). Similar high scores were presented in the three ideological types of groups. Also, members became more identified with their group in time, that is long-term members reported higher group identification than short-term ones (as presented earlier). Frequency of attendance did not seem to differentiate group identification significantly.

Relationship of group identification with helping processes and empowerment

The relationship of group identification with the occurrence of helping processes at group meetings was consistent with the self-help ethos (Table 4.29). In the total sample, group identification was highly correlated with a specific type of helping processes, the supportive ones ($r = .33$, $p<.01$). This finding suggests that members became more identified with their group when they got more support from them. Specifically, in combined groups, group identification was significantly correlated with the overall score of helping processes taking place at group meetings ($r = .42$, $p<.05$) and with the supportive ones ($r = .49$, $p<.05$). However, in conservative groups group identification related negatively with the confrontational processes ($r = -.39$, $p<.05$), indicating that their members felt closer to their group when there was no confrontation in the meetings. Finally, in radical groups group identification was not related to helping processes occurring in meetings.

Aspects of group identification presented similar interesting relationships with helping processes (for detailed tables see Appendix C). So, we observe that, in the total sample, affect about the group was negatively associated with confrontation (-.25, $p<.05$) and positively related with supportive processes (.37, $p<.01$). There was also a positive relationship of awareness with expressive processes (.28, $p<.05$) and supportive ones (.43, $p<.01$). Looking these relationships in the three ideological group types, we note that in combined groups awareness and evaluation of group membership were associated with overall helping processes (.54 and .42, $p<.05$) and especially with supportive ones (.51 and .34, $p<.05$).

There was a stronger positive correlation between group identification and overall empowerment scores ($r=.34$, $p<.01$) in the total sample (Table 4.30). This suggests that group members who feel closer to their group, are more empowered. Factors of empowerment such as optimism ($r=.25$, $p<.05$), perceptions of actual power ($r=.28$, $p<.05$) and community activism ($r=.32$, $p<.01$) were also correlated positively with group identification. Overall

empowerment (r=.43, p<.05) and one of its factors, optimism (r=.47, p<.01) were particularly connected with group identification in combined groups. However, righteous anger was the only sub-factor related with group identification in conservative groups (r=.43, p<.05) although there was no relation of this factor in other groups or the total sample. This relation suggests that members in conservative groups felt closer to their group when they started feeling angry about their problems. There was also a very strong relation of power with group identification in radical groups (r=.83, p<.01), which implies that perceptions of actual power reinforced members' identification with the group when this group was orientated towards social change.

Table 4.29: *Correlation of group identification with helping group processes and their sub-scales*

	Group identification			
	Total sample	Type of group		
		Conservative	Combined	Radical
Helping Processes	.16	.12	**.42***	-.11
Sub-scales				
Behaviour-oriented	.05	.24	.19	-.23
Expressive	.19	.09	.36	-.05
Supportive	**.33****	**.36***	**.49***	.07
Group cohesiveness	.02	.01	.18	.01
Confrontational	-.15	**-.39***	.17	-.47
Insight-oriented	.12	-.13	.23	.24

*p<.05, **p<.01

Looking at the aspects of identification, we note that there were some similarly interesting relationships with empowerment and its components (for detailed tables see Appendix C). So, overall empowerment was significantly correlated with all three aspects of identification, namely awareness, evaluation and affect (.30, .30, and .29 respectively, p<.05). Also, awareness, evaluation and affect were related with both community activism (.35, p<.01, .21 p<.08 and .30, p<.05 respectively) and feelings of actual power (.22, p<.07, .22, p<.07 and .27, p<.05 respectively). Examining these associations within the three ideological group types, we observe that in radical groups awareness of membership and affect attached to it were strongly associated with feelings of actual power (.83 and .78, p<.01).

Table 4.30: *Correlation of group identification with empowerment and its sub-scales*

	Group identification			
		Type of group		
	Total sample	Conservative	Combined	Radical
Empowerment	**.34****	.18	**.43***	.50
Sub-scales				
Optimism	**.25***	.27	**.47****	.17
Power	**.28***	-.15	.36	**.83****
Self-esteem	.21	.06	.37	.29
Community Activism	**.32****	.30	.29	.41
Righteous Anger	.06	**.43***	-.07	-.03

*p<.05, **p<.01

4.2.6. Political ideology and longevity of group participation

People who have been members of a group for a longer period of time and on a regular basis might be assumed to embody the values and modes of operation more strongly. They are sometimes referred to as the "culture carriers" (Luke et al. 1991). In order to estimate possible differences between groups according to their political ideology, regular long-term members of all groups were examined more closely. These particular group members presented significant differences (Table 4.31).

The first significant observation was that radical group members were more empowered in comparison with conservative ones ($F(2,36) = 3.11$ $p<.05$). This finding confirmed my expectation about the relationship between personal empowerment levels and political ideology. Radical group members appeared to be also more optimistic than the conservative ones (marginal difference, $F(2, 34)=2.51$, $p<.10$). Also, combined group members reported more feelings of actual power ($F(2,36) = 4.14$, $p<.05$) and self-esteem ($F(2,36) = 4.67$, $p<.05$) than conservative ones. This may be an indication that groups that combine personal and social change are better able to help their members to increase their self-confidence and feel more in power. Another interesting finding was that conservative group members showed more righteous anger ($F(2,36) = 2.99$, $p<.05$) than combined ones. Righteous anger, according to the constructors of the empowerment scale (Rogers et al. 1997), is the first step towards community activism and social change. So, this difference may be an indication that long-term conservative group members were becoming aware of the need for social change as well as personal in order to cope with their problems.

Table 4.31: *Mean scores (and standard deviations) of empowerment and sub-scales for regular long-term members by type of group*

	Type of group		
	Conservative (N=16)	Combined (N=14)	Radical (N=7)
Empowerment	**2.73 (.17)***	2.90 (.26)	**2.94 (.26)***
Sub-scales			
Optimism	**2.58 (.35) †**	2.73 (.39)	**2.91 (.46) †**
Power	**2.50 (.32)***	**2.87 (.42)***	2.80 (.34)
Self-esteem	**2.64 (.34)***	**3.00 (.31)***	2.87 (.28)
Community Activism	3.18 (.27)	3.17 (.26)	3.36 (.42)
Righteous Anger	**2.83 (.32)***	**2.38 (.62)***	2.71 (.62)

† Means difference significant at .10 level (Tukey test)
* Means difference significant at .05 level (Tukey test)

Long-term regular group members reported similar mean scores of help-giving processes with the overall sample (Table 4.32). Likewise, supportive, expressive and insight-oriented were the helping processes reported most frequently (mean score>3) by this special sub-group of members, as in the overall sample. This was expected due to the fact that the operation of self-help/mutual aid groups remained the same for all members; therefore it was unlikely that there would be differences with the overall sample. Additionally, we observed similar variations between the three ideological group types. Radical group members still reported higher mean scores of group cohesiveness (marginal difference $F(2, 34)=2.12$, $p<.10$) than the conservative ones whereas processes with a therapeutic character like supportive ones were reported more from conservative and combined group members.

Table 4.32: *Mean scores (and standard deviations) of helping processes• and sub-scales for regular long-term members by type of group*

	Type of group		
	Conservative (N=16)	Combined (N=14)	Radical (N=7)
Helping Processes	3.22 (.45)	3.29 (42)	3.26 (.50)
Sub-scales			
Behaviour-oriented	2.67 (.66)	2.62 (.49)	3.15 (.47)
Expressive	3.86 (.51)	3.96 (.70)	3.54 (.70)
Supportive	4.17 (.71)	4.07 (.68)	3.90 (.50)
Group cohesiveness	**2.35 (.87)†**	2.57 (.68)	**3.10 (.81)†**
Confrontational	2.23 (.09)	2.76 (1.09)	1.86 (.63)
Insight-oriented	3.58 (1.09)	3.69 (.79)	3.39 (1.16)

• The range of answers is from 1=never happens to 5=happens frequently
† Means difference significant at .10 level (Tukey test)

The three ideological types of groups presented similar mean scores in the remaining individual and group characteristics. Additionally, long-term regular members had similarly

low mean scores with the total sample in individual characteristics such as social networks (mean = 24.21, total sample mean = 23.41) and social support (mean = 51.96, total sample mean = 50.79). Although not statistically different, mental wellbeing of long-term regular members was below the threshold of the scale indicating that they were feeling psychologically better in comparison with the total sample (mean = 2.65, total sample mean = 3.27). They also presented similarly high levels of group identification (mean = 43.38, total sample mean = 41.95).

The similarity of this sub-group with the total population in the above characteristics indicates that longevity of participation differentiates ideological group types mainly in levels of personal empowerment and some of its factors such as optimism, self-esteem, power, and righteous anger.

4.2.7. Summary of findings from the First Phase

Findings from the First Phase of the study provided answers to some of my research questions concerning both the general characteristics of English mental health self-help/mutual aid groups and the specific traits of the ideological group types which were explored in this study. In general, the overall majority of the members participating in the research were well-educated unemployed single young white women. However, radical groups presented a somehow different picture where there were equal numbers of men and women, a larger number of members were of older age (55-77 years old), had with no formal or basic educational qualifications and all but one were unemployed. Also, the majority of members had long-term contact with the mental health services, half of them had been admitted to a psychiatric unit, of whom one third had been sectioned under the Mental Health Act. Again, radical groups differed from the other group types having two thirds of their members been subjected to the experience of involuntary hospitalisation, in stark contrast with conservative group members who almost all were admitted with their own will.

An interesting finding about the use of mental health services was that there was a shift between past and present use reported by self-help/mutual aid group members. Whereas their vast majority used to have contact with more than two mental health professionals in the past, at the time of the study almost one third of group members were having no contact with professionals. This change was more evident in the conservative groups with nearly half of their members not seeing any professionals at the time of study.

The psycho-social profile of group members was typical of people who have long-term experience of mental health problems, that is they had a limited number of social networks, report low levels of social support and marginal psychological wellbeing. Feelings of isolation were common for all self-help/mutual aid group members when they reported an absence of family networks, a limited number of friends, and the fact that in their majority they were living alone. This lack of support justifies the finding that the main reason for people to attend the self-help/mutual aid group was the support and empathy they received from fellow members.

Despite this lack of individual psychosocial resources, self-help group members reported quite high levels of personal empowerment, especially community activism. This was also confirmed by comparing their scores with a sample of English mental health service users where self-help members showed consistently higher scores in overall empowerment, optimism, self-esteem and community activism. Furthermore, there were significant differences between ideological group types, that is radical group members showed more optimism than the conservative ones and combined group members manifested more feelings of actual power that the conservative ones. These particularities were more evident at the sub-group of regular long-term group members. Specifically, radical group members were generally more empowered than the conservative ones as well as more optimistic. On the other hand, combined group members had better self-esteem than the conservative ones as well as having more feelings of actual power. Finally, conservative members showed more righteous anger than the combined ones.

Looking at group characteristics, we observe that the majority of members of the sample attended most of the meetings over a long period of time. Time of membership was positively associated with psychological wellbeing, social support and especially daily emotional support and social companionship as well as with group identification. These relationships denote the significant influence of long-term participation in the improvement of self-help group members' wellbeing, levels of support and of closeness to their group.

Moreover, members characterised their group as a self-help or support/mutual support one and their main reason for joining is to help themselves and others. As we mentioned above, they expected to find support and empathy in their group and they believed that their fellow members could offer them friendship, a "listening ear" - as most of them said, along with support and insight to their experiences. In return, they were ready to offer mutually their experiences and their support.

At the group level, participants reported a large number of helping processes occurring during group meetings. Specifically, the types of processes having the highest mean scores were supportive, expressive and insight-oriented. Although there were no significant differences among the three ideological types in the overall score of helping processes, we observe some differences in the various types of helping processes. Group cohesiveness, which refers to the functioning of the group, was reported more frequently by radical group members that conservative ones whereas expressive processes, which imply a therapeutic character, were reported more frequently by conservative group members than radical ones.

Additionally, an analysis of the specific processes examined revealed that the most frequently occurring ones were sharing, mutual affirmation, empathy and behavioural prescription. However, groups showed their different ideological type by reporting processes consistent with it. So, conservative and combined groups reported more sharing and catharsis than the radical ones whereas radical groups reported more establishing of group goals than both the other two group types. The processes reported to occur more rarely in meetings were punishment, behavioural rehearsal and assertion of group norms. However, again groups differed between them. Conservative groups reported even less punishment than the radical ones whereas assertion of group norms was reported a little more from radical groups than both the other two. When examining the special sub-group of regular long-term members, the picture remained similar with the one we described in the total sample and this was expected as the operation of groups was the same for all members.

Furthermore, self-help/mutual aid group members were highly identified with their group, especially after a long period of participation, and there were no differences between the three ideological types. Group identification appeared to be related to supportive helping processes occurring in a group meeting and this relationship was mainly present in combined groups. On the other hand conservative groups became more identified with their group when less confrontational processes occurred in its meetings. There was also an interesting positive relationship of group identification with overall empowerment as well as with optimism, perceptions of actual power and community activism. Overall empowerment and optimism were particularly correlated with group identification in combined groups whereas in conservative groups righteous anger was the sub-factor of empowerment uniquely correlated with group identification. Radical groups presented a rather expected relationship of power with group identification.

There were also some interesting relationships between aspects of identification and variables of the study. Specifically, awareness of being member of a self-help group, evaluation of such

a social identification and affect from this identity presented strong relationships with overall empowerment as well as with community activism and feelings of actual power. Also, awareness was associated with the amount of overall helping processes taking place in meetings, especially expressive and supportive processes. Finally, the affect attached to group membership was influenced negatively from confrontation occurring during meetings and positively from supportive help-giving activities. The relationship of awareness and affect with power was mainly true in radical groups whereas association of awareness and evaluation with supportive processes was observed basically in combined groups.

CHAPTER FIVE

Findings from the Second Phase of the study

The Second Phase of the study took place one year after the First one (March - May 1998). I visited the participating groups again and administered the same set of questionnaires to members who were willing to complete it. In this phase, respondents were not all the same as those who had responded at the First Phase. In the intervening period some members had left and new ones had joined. At this Chapter, I will present results of the Second Phase discussing similarities and differences with the First Phase.

5.1. Second Phase of the study

In the second phase of the study, there were some changes of the original sample. Specifically, one of the self-help groups stopped meeting (Voices-Canterbury) and another one chose not to participate due to changes in its way of operation (Depression Alliance – London, morning).

These two cases are examples of possible developments that can occur in a self-help/mutual aid group. In the first case, the Voices (Canterbury) group had had problems in its operation from the beginning. The group was set up by a worker from the Mustard Seed Day Centre and, later on, became user-led (see Chapter Three: Profile of the Participating Groups, section 3.1.6). Nonetheless, it continued to exist due to the enthusiasm of its leader/facilitator but when he left from the group, it collapsed. In the second case, the Depression Alliance (London, morning) group had a few problems of operation in the past, i.e. leadership difficulties, conflict in members' opinions about the character of the group (see Chapter Three: Profile of the Participating Groups, section 3.1.1). After a crisis with a 'difficult' member, the group decided to operate in a 'closed' (members only) manner, i.e. not to accept any outsiders in future meetings. As a result, they declined to participate in the Second Phase of the study.

So, from the initial fourteen groups, only twelve participated in Time 2. From 95 questionnaires administered to group members, there were 56 returns (response rate 59%) (Table 5.1).

Table 5.1: *Response rate of returned questionnaires by group (Time 2)*

Name of group	Type of group	Members*	Respondents	Response Rate
DA-London 2 (p.m.)	Individual change (Conservative)	6	3	50%
EDA-Maidstone		6	3	50%
FDA-London		8	4	50%
OA-Maidstone		9	5	55.5%
VOICES-Whitstable		3	3	100%
MDF-Wandsworth		10	4	40%
DA-St. Albans	Individual & Social change (Combined)	10	5	50%
EDA-Southend		8	4	50%
MDF-Bromley		15	13	87%
HUBB-Romford	Social change (Radical)	10	4	40%
SWOF-Folkestone		5	4	80%
LUF-Lewisham		5	4	80%
TOTAL		95	56	59%

* Present at the meeting in which I administered the questionnaires

The response rate of some groups (i.e. FDA-London, DA-St. Albans) dropped from the First Phase of the study. However, this is expected in repeated measurements. Overall, the total response rate was the same as in Phase One, and it was above 40% for all groups.

At this point it is necessary for the discussion of the findings to comment on the fact that there is a decreased number of participants in Time 2 (11 people, 16.4%). Although a drop in numbers of respondents is expected in a longitudinal study, taking into consideration that the sample of the study in Time 1 is a small one, any drop in the repetitive measurements in Time 2 could effect the statistical analyses carried out, in the manner that any observed differences between sub-groups would have to be quite large in order to be evaluated as such (Heiman 1998, page 378). Therefore, whenever there are interesting findings I will try to compensate for this phenomenon and additionally explore them with the help of descriptive statistics.

5.1.1. Demographics of group members (Time 2)

The demographic characteristics of respondents in Second Phase were very similar to those at Phase One. The majority of the sample were women (66%), young adults (19-44 years old, 54%), educated (86%), single (50%), all but two white, and unemployed (65%). All three types of groups present a similar profile (Table 5.2). The fact that the profile of the sample in both phases is so similar, supports the case for making a comparison between Time 1 and Time 2.

Table 5.2: *Demographic characteristics of the sample (Time 2)*

	Total sample (N=56)	Type of group		
		Conservative (N=22)	Combined (N=22)	Radical (N=12)
Gender				
Women	37 (66.1%)	14 (64%)	15 (68%)	8 (67%)
Men	19 (33.9%)	8 (36%)	7 (32%)	4 (33%)
Age				
19-29 years	10 (17.9%)	2 (9.1%)	6 (27.3%)	2 (16.7%)
30-44years	20 (35.7%)	12 (54.5%)	7 (31.8%)	1 (8.3%)
45-57 years	20 (35.7%)	6 (27.3%)	8 (36.4%)	6 (50%)
58-77 years	6 (10.7%)	2 (9.1%)	1 (4.5%)	3 (25%)
Education				
No formal qualifications	8 (14.3%)	4 (18.2%)	2 (9.1%)	2 (25%)
Secondary/Further education	23 (41.1%)	8 (36.4%)	8 (36.4%)	7 (58.3%)
Higher education	12 (21.4%)	7 (31.8%)	4 (18.2%)	1 (8.3%)
Professional education	13 (23.2%)	3 (13.6%)	8 (36.4%)	2 (16.7%)
Marital status				
Single/Never married	28 (50%)	9 (40.9%)	14 (63.6%)	5 (41.7%)
Married/With partner	8 (14.3%)	5 (22.7%)	2 (9.1%)	1 (8.3%)
Divorced/Separated	15 (26.8%)	7 (31.8%)	5 (22.7%)	3 (25%)
Widow/Widower	5 (8.9%)	1 (4.5%)	1 (4.5%)	3 (25%)
Ethnic origin				
White	54 (96.4%)	22 (100%)	20 (91%)	13 (100%)
Black/Caribbean	2 (3.6%)	-	2 (9%)	-
Occupational status				
Employed	20 (35.7%)	8 (36.4%)	9 (40.9%)	3 (25%)
Unemployed	36 (64.7%)	14 (63.6%)	13 (59.1%)	9 (75%)

Once again, contact with the mental health services was characteristic for respondents in the Second Phase as it was in the First one. Almost all group members had contact with mental health professionals (98%), 37.5% had seen four or more professionals, more than half have been admitted to a psychiatric unit (57%), of whom the majority had been sectioned under the Mental Health Act (58%). At the time of the study however, a quarter of the sample were not seeing any mental health professional. This was also true for the specific types of groups (Table 5.3). This interesting difference between the past and present use of the mental health services was statistically significant (χ^2 (1,16) = 28.10, $p<.05$), similarly with our findings in the First Phase.

Table 5.3: *Contact with mental health services (Time 2)*

	Total sample	Type of group		
		Conservative	Combined	Radical
Contact with mental health services				
1 month - 2 years	6 (12%)	2 (10%)	3 (14.3%)	1 (11.1%)
3 - 14 years	19 (38%)	9 (45%)	7 (33.3%)	3 (33.3%)
15 – 26 years	13 (26%)	6 (30%)	4 (19%)	3 (33.3%)
27 – 50 years	12 (24%)	3 (15%)	7 (33.3%)	2 (22.2%)

Have you ever seen any of the following?				
A mental health professional*	6 (10.7 %)	4 (18.2%)	2 (9.1%)	-
Two of the above	12 (21.4%)	3 (13.6%)	5 (22.7%)	4 (33.3%)
Three of the above	14 (25%)	5 (22.7%)	6 (27.3%)	3 (25%)
Four or more of the above	23 (41.1%)	9 (40.9%)	9 (40.9%)	5 (41.7%)
None of the above	1 (1.8%)	1 (4.5%)	-	-
If yes, how old were you at first contact?				
13 - 18 years old	14 (28%)	5 (25%)	8 (38.1%)	1 (11.1%)
19 - 29 years old	19 (38%)	8 (40%)	7 (33.3%)	4 (44.4%)
30 - 40 years old	14 (28%)	5 (25%)	6 (28.6%)	3 (33.3%)
41 - 56 years old	3 (6%)	2 (10%)	-	1 (11.1%)
Have ever been admitted to a psychiatric unit?				
Yes	32 (57.1%)	9 (40.9%)	14 (63.6%)	9 (75%)
No	24 (42.9%)	13 (59.1%)	8 (36.4%)	3 (25%)
If yes, was it under a section of Mental Health Act?				
Yes	18 (56.3%)	2 (22.2%)	9 (64.3%)	7 (77.8%)
No	14 (43.7%)	7 (77.8%)	5 (35.7%)	2 (22.2%)
Are you seeing any of the following?				
A mental health professional*	24 (42.9%)	12 (54.5%)	10 (45.5%)	2 (16.7%)
Two of the above	10 (17.9%)	2 (9.1%)	4 (18.2%)	4 (33.3%)
Three of the above	5 (8.9%)	1 (4.5%)	1 (4.5%)	3 (25%)
Four or more of the above	3 (5.4%)	-	3 (13.6%)	-
None of the above	14 (25%)	7 (31.8%)	4 (18.2%)	3 (25%)

* Psychiatrist, CPN, Counsellor/Psychotherapist, Psychologist, Social Worker, or Other

5.1.2.General characteristics of group members

Group members, in the second Phase of the study, presented the same profile as in First one, namely low mean scores in social networks and social support as well as poor wellbeing (Table 5.4). This picture was the same for all types of groups except of radical group members who seemed to be psychologically better than both the other two types and especially conservative group members ($F(2,55) = 3.15$, $p<.05$).

Table 5.4: *Mean scores (and standard deviations) of individual characteristics of self-help/mutual aid group members*

	Total sample	Type of group		
		Conservative	Combined	Radical
Social Networks (Range = 0-45)	22.82 (7.44)	22.27 (7.95)	22.86 (6.78)	23.75 (8.18)
Social Support (Range = 23-92)	52.51 (12.66)	52.50 (14.33)	52.86 (12.86)	51.90 (9.64)
Mental Wellbeing (Threshold = 2/3)	4.09 (4.10)	5.45* (4.24)	3.91 (4.09)	1.92* (2.97)
Empowerment (Range = 1-4)	2.84 (.34)	2.81 (.37)	2.83 (.30)	2.92 (.36)

*Means difference significant at .05 level (Tukey HSD test)

Length of membership was found to differentiate group members in the Second Phase as in the First one (Table 5.5). Specifically, although the number of helping processes taking place in group meetings remained the same, comparisons between the two sub-groups, using non-parametric Mann-Whitney U tests, showed that long-term members reported far better psychological wellbeing ($U=222$, $n_1=26$ $n_2=30$, $p<.001$) as well as better social networks ($U=284.50$, $n_1=26$ $n_2=30$, $p<.09$) and more social support ($U=287.50$, $n_1=26$ $n_2=30$, $p<.09$). Overall scores of group identification and empowerment did not differentiate statistically between the two sub-groups of membership. However, we can observe that long-term members reported consistently higher mean scores in all variables studied. Furthermore, an examination of variables' sub-factors confirmed differences we found at Time 1 between these two sub-groups in optimism (marginal, $U=286.50$, $n_1=26$ $n_2=30$, $p<.08$) and social companionship ($U=269.50$, $n_1=26$ $n_2=30$, $p<.05$) and also revealed differences in two other factors, self-esteem ($U=267.50$, $n_1=26$ $n_2=30$, $p<.05$) and daily emotional support (marginal, $U=281.50$, $n_1=26$ $n_2=30$, $p<.08$) (for detailed tables see Appendix D). In these sub-factors of empowerment and social support, as it was the case at the First Phase, long-term members reported higher scores than the short-term ones.

Table 5.5: *Mean scores (and standard deviations) of processes and outcomes of participation by length of membership*

	Short-term members (N=26)	Long-term members (N=30)
PROCESSES		
Helping processes (Range = 28-140)	93.61 (8.69)	90.83 (18.44)
Group identification (Range=10-50)	40.41 (8.82)	43.16 (5.00)
OUTCOMES		
Empowerment (Range = 1-4)	2.77 (.33)	2.90 (.34)
Social Networks (Range = 0-45)	**21.11 (7.19)†**	**24.30 (7.45)†**
Social Support (Range = 23-92)	**49.85 (13.46)†**	**54.82 (11.64)†**
Mental Wellbeing (Threshold = 2/3)	**5.88 (4.09)***	**2.53 (3.47)***

†Means difference significant at .09 level (Mann-Whitney U test)
*Means difference significant at p<.001 (Mann-Whitney U test)

5.1.3. Typology of self-help/mutual aid groups

As discussed in Chapter Four, despite the fact that participating groups with common ideological characteristics were categorised in three broad types, they had their own profiles and differences. Groups that participated in the Second Phase of the study, still presented

some differences between them and these seemed to be consistent with the ones found in First Phase.

Specifically, in the "individual change" category, one-way analysis of variance (ANOVA) revealed that members of the Depression Alliance (London, afternoon) group had fewer social networks and less social support than members of other group and differed significantly from the Overeaters Anonymous and the Eating Disorders Association (Maidstone) group (Table 5.6). All groups in this category had poor psychological wellbeing (mean = 5.45, well above the threshold). Despite their differences, all members were feeling empowered, were highly identified with their group and reported a high number of helping processes occurring in their meetings.

Table 5.6: *Mean scores of individual and group variables in individual change groups*

	INDIVIDUAL CHANGE GROUPS						
	DA-Lon.2 (N=3)	EDA-Maid. (N=3)	OA-Maid. (N=5)	FDA-Lon. (N=4)	MDF-Wands. (N=4)	Voices-Whit. (N=3)	Total (N=22)
Empowerment (R=1-4)	2.94	2.71	2.82	2.89	2.75	2.71	2.81
Social networks (R=0-45)	9.67*	28.00*	29.20*	22.75*	22.25	17.00*	22.27
Social support (R=23-92)	33.00*	70.00*	60.60*	48.00	50.25	50.00	52.50
Wellbeing (Thr.=2/3)	4.67	7.33	5.80	5.00	4.25	6.00	5.45
Group identification (R=10-50)	45.67	39.83	47.40	39.50	38.00	42.67	42.34
Helping processes (R=28-140)	98.00	88.67	83.85	93.00	96.75	77.33	89.50

*Mean difference significant at .05 level (Tukey HSD test)

In the "combined" category, although there were no statistically significant differences, we observe that members of the Depression Alliance (St. Albans) group reported fewer social networks and less social support than the other two groups, as in the First Phase (Table 5.7). Also, they reported much poorer psychological wellbeing (mean = 6.40, well above the threshold) than the other two groups, the Manic Depressive Fellowship (Bromley) and the Eating Disorders Association (Southend) group (means = 3.23 and 3.00 respectively, both at or just above the threshold). Furthermore, all three groups showed high empowerment and group identification as well as reporting a large number of helping processes.

Table 5.7: *Mean scores of individual and group variables in combined groups*

	COMBINED GROUPS			
	DA-St. Albans (N=5)	MDF-Bromley (N=13)	EDA-Southend (N=4)	Total (N=22)
Empowerment (Range=1-4)	2.66	2.87	2.95	2.83
Social networks (Range=0-45)	19.20	23.15	26.50	22.86
Social support (Range=23-92)	50.40	51.54	60.25	52.86
Wellbeing (Threshold=2/3)	6.40	3.23	3.00	3.91
Group identification (Range=10-50)	43.25	40.90	39.19	41.12
Helping processes (Range=28-140)	102.00	96.46	102.75	98.86

In the "social change" category, the SWOF (Folkestone) group reported more helping processes than the other two groups and differed significantly from the LUF group (Table 5.8). There were no significant differences in the other variables. However, we observe that SWOF members had higher means scores of group identification, social networks and social support. On the other hand, the LUF group reported higher levels of empowerment than the other two. Moreover, all three groups reported good mental wellbeing (mean =1.92, below threshold) and they differed from the other two ideological group types in this respect.

Table 5.8: *Mean scores of individual and group variables in social change groups*

	SOCIAL CHANGE GROUPS			
	HUBB-Romford (N=4)	SWOF-Folkestone (N=4)	LUF-Lewisham (N=4)	Total (N=12)
Empowerment (Range=1-4)	2.71	2.87	3.18	2.92
Social networks (Range=0-45)	23.50	26.75	21.00	23.75
Social support (Range=23-92)	49.75	53.50	52.44	51.89
Wellbeing (Threshold=2/3)	2.25	1.50	2.00	1.92
Group identification (Range=10-50)	40.75	44.31	42.25	42.44
Helping processes (Range=28-140)	87.25	96.25*	70.25*	84.58

*Means difference significant at .05 level (Tukey HSD test)

5.1.4. Individual characteristics

Empowerment

Personal empowerment of respondents remained in the same high levels as in the First Phase. The overall mean score of personal empowerment was 2.84 (range 2.14 to 3.61), that is above the middle of the scale (Table 5.9). We also observe similar high mean scores for the sub-factors of empowerment. Community activism continues to present the highest scores (mean = 3.28, range 2.67 to 4.00) of all five sub-factors. Self-help/mutual aid group members in the Second Phase had similar differences as in Time 1 with a sample of mental health service users participating in the Care Programme Approach, reported in the study of Carpenter et al. (1999) (see Chapter Four, section 4.2.4). Self-help group members consistently reported higher overall empowerment (U=-9.21, p<.01), optimism (U=-4.46, p<.01), self-esteem (U=-6.66, p<.01) and community activism (Mann-Whitney U=-11.87, p<.01) than service users living in the community.

Similarly with Phase One, non-parametric Kruskal-Wallis H tests revealed that there were statistically significant differences between the three types of groups in some of empowerment' s sub-factors. Specifically, radical group members reported better self-esteem than conservative ones (H=4.10, p<.10) whereas conservative group members reported more righteous anger than the combined ones (H=4.00, p<.10).

Table 5.9: *Mean scores (and standard deviations) of empowerment and sub-scales by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Empowerment	2.84 (.34)	2.81 (.37)	2.84 (.30)	2.92 (.36)
Sub-scales				
Optimism	2.69 (.53)	2.65 (.50)	2.67 (.64)	2.80 (.39)
Power	2.68 (.44)	2.70 (.47)	2.66 (.42)	2.69 (.46)
Self-esteem	2.79 (.49)	**2.67 (.56)†**	2.82 (.44)	**2.94 (.44)†**
Community Activism	3.28 (.36)	3.23 (.38)	3.30 (.30)	3.33 (.46)
Righteous Anger	2.65 (.57)	**2.79 (.43)†**	**2.51 (.63)†**	2.67 (.65)

†Means difference significant at .10 level (Mann-Whitney U test)

Relationship of empowerment with psychosocial characteristics of group members

Relationships between personal empowerment and other individual psychosocial characteristics of the study remained stable. Thus, empowerment was once again highly correlated with mental wellbeing (r=-.41, p<.01) in the overall sample (Table 5.10). At this Phase, the relationship existed in all three types of groups, although it was stronger in conservative groups (r=-.44, p<.01), as observed in Phase One, and marginal in combined (r=-.40, p<.10) as well as radical groups (r=-.52, p<.10). Also, there was a marginal

relationship of empowerment with overall social support (r=.21, p<.10) and a specific type of support, social companionship (r=..28, p<.05), as found also in Time 1. Combined groups showed once more significant relationships between empowerment and social networks as well as social companionship (.43 and .51 respectively, p<.05). Additionally this time, there existed a correlation with overall social support (.49, p<.05).

Table 5.10: *Correlation of empowerment with psychosocial characteristics by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
		EMPOWERMENT		
Mental Wellbeing	-.41**	-.44**	-.40†	-.52†
Social Networks	.18	.07	.43*	.32
Social Support	.21†	.14	.49*	.18

† p<.10, * p<.05, ** p<.01

Social Networks

As we observed in the First Phase, social networks of self-help/mutual aid group members were limited. Specifically, barely half of group members (48%) reported that they were in monthly contact with at least one or two family members and only a quarter of respondents had contact with three or four family members (Table 5.11). However, there was a significant number of participants (11%) who had no monthly contact with family members. Also, the majority of respondents (68%) had either none or only one family member they were feeling close to. The three types of groups presented similar family networks.

Table 5.11: *Family Network by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Number of family members in contact monthly				
None	6 (11%)	2 (9%)	3 (14%)	1 (8%)
One or two	27 (48%)	10 (45.5%)	11 (50%)	6 (50%)
Three or four	14 (25%)	5 (23%)	6 (27%)	3 (25%)
Five to eight	7 (12%)	4 (18%)	2 (9%)	1 (8%)
Nine or more	2 (4%)	1 (4.5%)	-	1 (8%)
Frequency of contact per month				
More than monthly	9 (16%)	3 (14%)	4 (18%)	2 (17%)
Monthly	8 (14%)	3 (14%)	4 (18%)	1 (8%)
A few times a month	6 (11%)	3 (14%)	2 (9%)	1 (8%)
Weekly	10 (18%)	4 (18%)	3 (14%)	3 (25%)
A few times a week	11 (20%)	4 (18%)	5 (23%)	2 (17%)
Daily	12 (21%)	5 (22%)	4 (18%)	3 (25%)

Number of family members feel close to				
None	11 (20%)	5 (23%)	4 (18%)	2 (17%)
One or two	27 (48%)	10 (45.5%)	11 (50%)	6 (50%)
Three or four	15 (27%)	5 (23%)	6 (27%)	4 (33%)
Five to eight	3 (5%)	2 (8.5%)	1 (4.5%)	-

Table 5.12: *Friends Network by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Number of close friends				
None	2 (4%)	2 (9%)	-	-
One or two	24 (43%)	10 (45.5%)	8 (36%)	6 (50%)
Three or four	21 (37.5%)	6 (27%)	11 (50%)	4 (33%)
Five to eight	7 (12.5%)	4 (18%)	2 (9%)	1 (8%)
Nine or more	2 (4%)	-	1 (4.5%)	1 (8%)
Number of friends in contact per month				
None	5 (9%)	3 (14%)	1 (4.5%)	1 (8%)
One or two	20 (36%)	8 (36%)	7 (32%)	5 (42%)
Three or four	21 (37.5%)	6 (27%)	11 (50%)	4 (33%)
Five to eight	7 (12.5%)	4 (18%)	2 (9%)	1 (8%)
Nine or more	3 (5%)	1 (4.5%)	1 (4.5%)	1 (8%)
Frequency of contacts per month				
More than monthly	6 (11%)	3 (14%)	3 (14%)	-
Monthly	2 (4%)	-	2 (9%)	-
A few times a month	9 (16%)	4 (18%)	2 (9%)	3 (25%)
Weekly	17 (30%)	8 (36%)	6 (27%)	3 (25%)
A few times a week	13 (23%)	5 (23%)	6 (27%)	2 (17%)
Daily	9 (16%)	2 (9%)	3 (14%)	4 (33%)

Table 5.13: *Confiding Relationships by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Having someone to discuss with important decisions				
Never	1 (2%)	-	-	1 (8%)
Seldom	5 (9%)	3 (14%)	2 (9%)	-
Sometimes	13 (23%)	5 (23%)	6 (27%)	2 (17%)
Often	7 (12.5%)	4 (18%)	2 (9%)	1 (8%)
Very often	11 (20%)	4 (18%)	6 (27%)	1 (8%)
Always	19 (34%)	6 (27%)	6 (27%)	7 (58%)
Others will discuss with you important decisions				
Never	1 (2%)	-	1 (5%)	-
Seldom	6 (11%)	4 (18%)	1 (5%)	1 (8%)
Sometimes	25 (45.5%)	10 (45.5%)	9 (42%)	6 (50%)
Often	7 (12.5%)	2 (9%)	4 (19%)	1 (8%)
Very often	13 (24%)	6 (27%)	3 (14%)	4 (33%)
Always	3 (5%)	-	3 (14%)	-

Networks of friends were stronger than the relatives' networks. Almost half of the sample (43%) reported that they had one or two close friends and they had contact with them at least once a month (Table 5.12). Additionally, the majority of respondents (69%) had frequent (weekly or more) contact with their closest friend(s). The three types of groups did not show any differences in their friendship networks.

The majority of respondents had confiding relationships with others, that is someone to discuss important issues with (often, very often or always, 66.5%) (Table 5.13). However, other people infrequently discussed important issues with them (sometimes, seldom or never, 58.5%). Findings for all groups were similar.

Half of respondents were living alone (27 out of 56 people, 48%) or with unrelated individuals (Table 5.14). The other half of them were living either with their family (34%) or with their spouse/partner (14%) or with friends (4%). Living arrangements were similar for conservative and combined groups whereas in radical groups it was the majority who lived alone or with unrelated individuals (8 out of 12, 67%).

Table 5.14: *Living arrangements by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Live alone	23 (41%)	8 (36%)	9 (41%)	6 (50%)
Live with unrelated individuals	4 (7%)	1 (4.5%)	1 (4.5%)	2 (17%)
Live with friends	2 (4%)	1 (4.5%)	1 (4.5%)	-
Live with family	19 (34%)	8 (36%)	8 (36%)	3 (25%)
Live with spouse/partner	8 (14%)	4 (18%)	3 (14%)	1 (8%)

Overall, social networks of members were reported to be similarly poor with members in the First Phase. There was a particular absence of strong family relationships, whereas friends were the main source of support for respondents. Also, members were living mainly alone or with unrelated individuals. Thus, there seems to be the same need for support that basically motivates them to take part in self-help/mutual aid groups.

Social Support

Similarly with the First Phase, self-help/mutual aid groups in the Second Phase reported low scores in social support (mean = 2.28, score range = 1-4) (Table 5.15). There were particular types of support like practical support (e.g. advice, practical help) that seemed to have far lower mean scores than others like emotional support (e.g. affection, sympathy) and companionship. Again, daily emotional support was mostly reported in the overall sample as well as in the three types of groups. There were no significant differences between the three types.

Table 5.15: *Social support by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Social support (total score)	2.28 (.55)	2.28 (.62)	2.30 (.56)	2.26 (.42)
Types of support				
Daily Practical	1.92 (.57)	1.89 (.62)	1.98 (.62)	1.87 (.43)
Problem-oriented Practical	2.02 (.69)	2.04 (.75)	2.03 (.72)	1.94 (.50)
Daily Emotional	2.60 (.65)	2.74 (.77)	2.50 (.63)	2.53 (.38)
Problem-oriented Emotional	2.43 (.73)	2.46 (.85)	2.45 (.66)	2.34 (.69)
Social Companionship	2.24 (.68)	2.06 (.70)	2.34 (.70)	2.37 (.54)

Mental Wellbeing

Almost half of the overall sample (47.5%) reported scores below the threshold of the General Health Questionnaire (GHQ), indicating that they were feeling psychologically well (Table 5.16). Similarly with Time 1, there was a significant number of respondents (29 out of 56, 52.7%) who reported scores at or above the threshold of the scale.

The three types of groups presented a different picture. Although combined and radical groups had fewer members reporting poor psychological wellbeing (above threshold, 36% and 25% respectively), the majority (64%) of conservative group members scored above the threshold of the scale, thus showing that they did not feel very well.

Table 5.16: *Mental Wellbeing by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
0	17 (30%)	4 (18%)	6 (27%)	7 (58%)
1	3 (5%)	1 (4.5%)	1 (4.5%)	1 (8%)
2	7 (12.5%)	2 (9%)	4 (18%)	1 (8%)
3 (Threshold)	4 (7%)	1 (4.5%)	3 (14%)	-
4 or above	25 (45.5%)	14 (64%)	8 (36.4%)	3 (25%)

Relationship between mental wellbeing, helping processes and empowerment

Similarly with Phase One, mental wellbeing was not particularly correlated with the total amount of helping processes that were reported as occurring by group members. However at this phase it was highly correlated with another type of helping processes, group cohesiveness, in the total sample as well as in the three different group types (Table 5.17). Specifically, we observe that group members who were feeling psychologically well reported more processes concerning group behaviour ($r=-.45$, $p<.01$). This remark was mainly true for conservative ($r=-.49$, $p<.05$) and radical group members ($r=-.65$, $p<.05$).

Table 5.17: *Correlation of mental wellbeing with helping processes and their sub-scales by type of group*

	Wellbeing			
		Type of group		
	Total sample	Conservative	Combined	Radical
Helping Processes	-.01	-.05	-.07	.06
Sub-scales				
Behaviour-oriented	-.05	-.05	-.26	.19
Expressive	.12	-.03	.09	-.01
Supportive	.03	.07	-.12	-.37
Group cohesiveness	**-.45****	**-.49***	-.30	**-.65***
Confrontational	-.11	.09	-.37	.30
Insight-oriented	.01	-.24	.21	.02

* p<.05, ** p<.01

Once again, there was an interesting relationship of mental wellbeing with empowerment and its sub-scales (Table 5.18). Overall, members who were feeling well reported higher levels of empowerment (r=-.41, p<.01), as well as more optimism (r=-.38, p<.01), feelings of actual power (r=-.43, p<.01) and self-esteem (r = -.49, p<.01). These relationships confirm that mental wellbeing is strongly connected with positive feelings about oneself and others, positive thinking about the future and perceptions of control over one's life.

From the three ideological group types, conservative members were the ones that mostly presented this strong relationship of mental wellbeing with empowerment (r = -.44, p<.05), and especially with self-esteem (r = -.63, p<.01). On the other hand, radical group members showed a marginal relationship with overall empowerment (r=-.52, p<.10) and a strong relationship with feelings of actual power (r = -.78, p<.01). Both group types manifested an interesting correlation of wellbeing with righteous anger (-.45 and -.64 respectively, p<.05). Finally, in combined groups there was a significant relationship of wellbeing with optimism (r=-.50, p<.05).

Table 5.18: *Correlation of mental wellbeing with empowerment and its sub-scales by type of group*

	Wellbeing			
		Type of group		
	Total sample	Conservative	Combined	Radical
Empowerment	**-.41****	**-.44***	-.29	**-.52†**
Sub-scales				
Optimism	**-.38****	-.31	**-.50***	-.18
Power	**-.43****	-.40	-.39	**-.78****
Self-esteem	**-.49****	**-.63****	-.25	-.46
Community Activism	-.03	-.06	.24	-.08
Righteous Anger	.18	**-.45***	.29	**-.64***

† p<.10, * p<.05, ** p<.01

5.1.5.Group characteristics

Member attendance and length of membership

Group members in the Second Phase had the same characteristics as in the First one with regard to their attendance of group meetings and length of membership. The majority of members were regular attenders (attending most or all of the meetings, 77%) and long-term members (thirteen months to nine years, 55%) (Table 5.19). Although all three types of groups were regular attenders, they differed among them in length of membership. Combined and radical group members had similar patterns of membership with the overall sample (54.5% and 75% respectively). However, conservative groups reported more short-term (13 out of 22, 59%) than long-term members.

The relationship of member attendance with length of membership was once again very strong in the overall sample ($r=.57$, $p<.01$). As described in the First Phase, this relation existed in both conservative ($r=.55$, $p<.01$) and combined ($r=.68$, $p<.01$) groups; however, it did not appear in radical groups.

Of special interest were the relationships between membership length and some of the variables of the study. As in Phase One, there was a positive relationship, although a marginal one this time, with group identification ($r=.23$, $p<.09$) and stronger relationships with perceived social support ($r=.28$, $p<.05$), and especially two types of support: daily emotional support ($r=.30$, $p<.05$) and social companionship ($r=.37$, $p<.01$). Additionally, at this Phase the time of membership was also correlated with factors of empowerment such as optimism (.30, $p<.05$) and self-esteem (.23, $p<.09$), with mental wellbeing (-.33, $p<.05$) and social networks (.30, $p<.05$).

Table 5.19: *Member attendance and length of membership by type of self-help/mutual aid group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Member attendance				
Beginners	8 (14.3%)	3 (13.6%)	5 (22.7%)	-
Irregular attenders	4 (7.9%)	1 (4.5%)	2 (9.1%)	2 (16.7%)
Regular attenders	43 (76.8%)	18 (81.8%)	15 (68.2%)	10 (83.3%)
Length of membership				
0-1 month	8 (14.5%)	3 (13.6%)	5 (22.7%)	-
Up to 1 year	17 (30.9%)	10 (45.5%)	5 (22.7%)	3 (25%)
1 to 2 years	9 (16.4%)	3 (13.6%)	2 (9.1%)	4 (33.3%)
3 to 4 years	9 (16.4%)	2 (9.1%)	5 (22.7%)	2 (16.7%)
4 to 9 years	12 (21.8%)	4 (18.2%)	5 (22.7%)	3 (25%)

Participation in self-help/mutual aid groups

Members' answers about their experiences in self-help/mutual aid groups were similar to responses in the First Phase. Almost half of respondents characterised their group as "*self-help*", with about one third saying "*support/mutual support*". Also respondents referred to their group as been "*mental health*", "*advocacy/campaigning*", "*informal/open*", providing "*help/information*" and "*discussion*" (Table 5.20).

Once again, differences appeared in the answers of the three types of groups. Conservative and combined group members referred mostly to the self-help (68% and 41% respectively) and support (32% and 27% respectively) character of their group, while radical group members emphasised that their group promoted advocacy and campaigning on mental health issues (36%). Both combined and radical group members also reported that their group was about mental health (23% and 27% respectively).

Table 5.20: *What kind of group is your group?*

	Total sample (N=55)	Type of group		
		Conservative (N= 22)	Combined (N=22)	Radical (N=11)
Self-help	25 (45.4%)	15 (68.2%)	9 (40.9%)	1 (9.1%)
Support/Mutual support	15 (27.3%)	7 (31.8%)	6 (27.3%)	2 (18.2%)
Mental health	9 (16.4%)	1 (4.5%)	5 (22.7%)	3 (27.3%)
Advocacy/ Campaigning	4 (7.3%)	-	-	4 (36.4%)
Informal/Open	4 (7.3%)	2 (9.1%)	2 (9.1%)	-
Help/Information	3 (5.4%)	-	2 (9.1%)	1 (9.1%)
Discussion	2 (3.6%)	1 (4.5%)	1 (4.5%)	-
User-led	1 (1.8%)	-	-	1 (9.1%)
No answer	1 (1.8%)	-	-	1 (8.3%)

As in the First Phase, members emphasised that their main reason for joining the group was the element of mutuality and sharing (Table 5.21). This time the first reason they gave was *meeting others with the same experience and sharing feelings with them* (39%).

Other important reasons were: *help oneself and others* (18.5%), *suffering a mental health problem* (17%), *referral or recommendation* (13%), *or information and understanding of the problem* (11%). Radical group members gave additional reasons such as "a voice for the mentally ill" (2 out of 10) and dissatisfaction with treatment received (1 out of 10).

Table 5.21: *Reasons for joining a self-help/mutual aid group*

	Total sample (N=54)	Type of group		
		Conservative (N=22)	Combined (N=22)	Radical (N=10)
To meet others with same experience/ to talk and share feelings with them	21 (38.9%)	9 (40.9%)	10 (45.4%)	2 (20%)
To help myself and others	10 (18.5%)	6 (27.3%)	1 (4.5%)	3 (30%)
I had a mental health problem	9 (16.7%)	5 (22.7%)	4 (18.2%)	-
I was referred/ recommended	7 (13%)	2 (9.1%)	4 (18.2%)	1 (10%)
For information/learn more/understand the problem	6 (11.1%)	2 (9.1%)	2 (9.1%)	2 (20%)
For company/socialising	2 (3.7%)	-	2 (9.1%)	-
To see there were others out there coping	1 (1.8%)	1 (4.5%)	-	-
Not satisfied with treatment received	1 (1.8%)	-	-	1 (10%)
A voice for the mentally ill	2 (3.7%)	-	-	2 (20%)
No answer	2 (3.6%)	-	-	2 (16.7%)

Table 5.22: *Expectations from the group*

	Total sample (N=54)	Type of group		
		Conservative (N=22)	Combined (N=21)	Radical (N=11)
Support/Sympathy/ Empathy/Understanding	25 (46.3%)	13 (59.1%)	11 (52.4%)	1 (9.1%)
Help from others' experiences	8 (14.8%)	4 (18.2%)	1 (4.8%)	3 (27.3%)
Social contact/Friendship	5 (9.2%)	1 (4.5%)	2 (9.5%)	2 (18.2%)
Exchange of information/Advice	4 (7.4%)	1 (4.5%)	1 (4.8%)	2 (18.2%)
No expectations	4 (7.4%)	1 (4.5%)	3 (14.3%)	-
Insight/Understanding of condition	3 (5.5%)	2 (9.1%)	1 (4.8%)	-
Campaigning for better treatment/change of system	3 (5.5%)	-	-	3 (27.3%)
Meet others with the same problem	2 (3.7%)	-	2 (9.5%)	-
A chance to talk about my problems	1 (1.8%)	1 (4.5%)	-	-
Don't know/Not sure	1 (1.8%)	1 (4.5%)	-	-
No answer	2 (3.6%)	-	1 (4.5%)	1 (8%)

Similarly to the First Phase, the expectation of members from their group in the Second Phase was mainly *support and understanding of their feelings* (46%). Other expectations were *help from others' experiences* (15%), *social contact* (9%), *and exchange of information/advice* (7%).

Expectations of members presented some differences in radical groups. Their members expected mostly help from others' experiences (27%) and campaigning for better treatment and change of the system (27%) (Table 5.22).

Table 5.23: *What do you think the group can offer to you?*

	Total sample (N=53)	Type of group		
		Conservative (N=21)	Combined (N=21)	Radical (N=11)
Support/Mutual support	21 (39.6%)	12 (57.1%)	8 (38.1%)	1 (9.1%)
Friendship/A listening ear	20 (37.7%)	7 (33.3%)	9 (42.8%)	4 (36.4%)
Insight/Understanding of problem/Personal experiences	8 (15.1%)	2 (9.5%)	6 (28.6%)	-
Help with problems	7 (13.2%)	2 (9.5%)	2 (9.5%)	3 (27.3%)
Information/Advice/Self-education	6 (11.3%)	3 (14.3%)	3 (14.3%)	-
Confidence/Reassurance/ Encouragement	5 (9.4%)	2 (9.5%)	2 (9.5%)	1 (9.1%)
A base to work from/A joint voice	3 (5.7%)	-	-	3 (27.3%)
Freedom of choice	1 (1.9%)	1 (4.8%)	-	-
Don't know/Not certain yet	1 (1.9%)	1 (4.8%)	-	-
No answer	3 (5%)	1 (4.5%)	1 (4.5%)	1 (8%)

Table 5.24: *What do you think you can offer to the group?*

	Total sample (N=53)	Type of group		
		Conservative (N=21)	Combined (N=21)	Radical (N=11)
Support	21 (39.6%)	8 (38.1%)	12 (57.1%)	1 (9.1%)
My personal experiences/story	13 (24.5%)	5 (23.8%)	7 (33.3%)	1 (9.1%)
Friendship/A listening ear	12 (22.6%)	6 (28.6%)	6 (28.6%)	-
Help others/Practical help/Ways of thinking	8 (15.1%)	2 (9.5%)	3 (14.3%)	3 (27.3%)
Information/Knowledge	5 (9.4%)	2 (9.5%)	3 (14.3%)	-
Ability to work for better conditions/Skills	5 (9.4%)	1 (4.8%)	-	4 (36.4%)
Trust/Loyalty/ Commitment	3 (5.7%)	1 (4.8%)	-	2 (18.2%)
Sharing of feelings	3 (5.7%)	1 (4.8%)	2 (9.5%)	-
No answer	3 (5%)	1 (4.5%)	1 (4.5%)	1 (8%)

Most members believed that their group could offer them what they were expecting, that is *support/mutual support* (40%), and *friendship* ("*a listening ear*") (38%) (Table 5.23). They also reported *insight and personal experiences* (15%), *help with their problems* (13%), and *information/advice* (11%). All members prioritised support and friendship as the main things their group could offer them. However, different group types gave distinctively different

additional responses. Conservative and combined group members emphasised information and advice as well as insight and personal experiences, whereas radical group members mentioned especially help with problems and "a base to work from", "a joint voice" for mental health issues.

The majority of respondents believed that they could offer to their group *support* (40%), *personal experiences* (24.5%), *friendship* (23%), and *practical help and ways of thinking* (15%). In addition, radical group members reported ability to work for better conditions and skills (36%) and trust, loyalty and commitment (18%) (Table 5.24).

Overall, members were quite satisfied with the progress of their group and were feeling comfortable with it (most of the time or always, 92%). They also believed that they had sufficient chances to discuss issues important to them (most of the time or always, 89%). There were no differences between the three types of groups (Table 5.25).

Table 5.25: *Do you feel comfortable with the group and how it is progressing?*

	Total sample	Type of group		
		Conservative	Combined	Radical
Do you feel comfortable with the group and how it is progressing?				
Yes, always	17 (33%)	8 (36%)	4 (22%)	5 (45.5%)
Yes, most of the times	30 (59%)	11 (50%)	13 (72%)	6 (54.5%)
Not often	4 (8%)	3 (14%)	1 (6%)	-
Never	-	-	-	-
No answer	5 (8.9%)	-	4 (18.2%)	1 (8.3%)
Do you get sufficient chance to discuss issues important to you?				
Yes, always	14 (27%)	7 (32%)	1 (5%)	6 (54.5%)
Yes, most of the times	30 (58%)	11 (50%)	14 (74%)	5 (45.5%)
Not often	8 (15%)	4 (18%)	4 (21%)	-
Never	-	-	-	-
No answer	4 (7.1%)	-	3 (13.6%)	1 (8.3%)

Generally, self-help/mutual aid group members who participated in the present study presented consistent opinions about their group and its characteristics over time. Answers of respondents remained similar in the First and the Second Phase of the study and they reflected the elements of self help and mutual aid as they were been described in the relevant literature (see Chapter One, section 1.2.2).

Helping Group Processes

Consistent with the First Phase, respondents in the Second Phase reported a large number of helping processes taking place during group meetings (Table 5.26). Expression, support and insight were the processes most frequently reported (means score>3), as measured by the

Helping Processes Scale. Confrontational, group cohesiveness and behaviour-oriented processes were less frequent.

At this Phase, we observe some statistical differences between the three ideological group types. Specifically, combined group members reported more helping processes that the other two group types and differed statistically from radical group members who reported fewer processes ($F(2, 55)=4.84$, $p<.05$). As for the specific types of helping processes, we observe once again that expression of feelings (e.g. self-disclosure, sharing, reflection) was reported more frequently by both conservative and combined groups and they both differed significantly from radical groups ($F(2, 55)=6.95$, $p<.01$). Also, although confrontation was low in group meetings, conservative groups reported even less confrontation than the other two group types and especially combined groups ($F(2, 55)=7.43$, $p<.01$). Finally, combined groups reported more behaviour-oriented processes and differed significantly than both the other two group types ($F(2, 55)=3.52$, $p<.05$).

Table 5.26: *Mean scores (and standard deviations) of helping group processes• and sub-scales by type of group*

	Total sample	Type of group		
		Conservative	Combined	Radical
Helping Processes	3.30 (.52)	3.20 (.51)	**3.53* (.40)**	**3.02* (.58)**
Sub-scales				
Behaviour-oriented	2.92 (.64)	2.78 † (.73)	3.18 † (.43)	2.72 † (.65)
Expressive	3.93 (.65)	**3.99* (.58)**	**4.17* (.45)**	**3.38* (.82)**
Supportive	4.03 (.67)	4.10 (.69)	4.16 (.60)	3.69 (.66)
Group cohesiveness	2.76 (.53)	2.64 (.62)	2.86 (.48)	2.81 (.44)
Confrontational	2.34 (.97)	**1.84* (.59)**	**2.86* (.97)**	2.32 (1.09)
Insight-oriented	3.41 (.87)	3.44 (.89)	3.53 (.78)	3.15 (.87)

•The range of answers is from 1=never happens to 5=happens frequently
†Means difference significant at .08 level (Tukey HSD test)
* Means difference significant at .01 level (Tukey HSD test)

Similarly with the First Phase of the study, all participants in the Second Phase reported as occurring frequently the following group processes assessed by the scale: sharing, mutual affirmation, empathy, installation of hope and behavioural prescription. (Table 5.27). All these common processes reflect the self-help ethos of these groups that is mentioned in the relevant literature (Kurtz 1997). However, we still see some differences between the three group types. Specifically, conservative and combined group members reported more self-disclosure ($F(2,55) = 6.67$, $p<.01$), sharing ($F(2,55) = 5.10$, $p<.01$) and personal goal setting ($F(2,55) = 4.28$, $p<.05$) than radical ones. Also, conservative group members reported more normalisation ($F(2,55) = 3.97$, $p<.05$) than the radical ones. Finally, radical group members reported more group goal setting ($F(2,55) = 4.56$, $p<.05$) than conservative ones.

Table 5.27: *Mean scores of helping processes reported most frequently by type of group*

HELPING PROCESSES REPORTED MOST FREQUENTLY•				
HELPING PROCESSES	Total sample	Type of group		
		Conservative	Combined	Radical
Behavioural prescription	**4.14**	3.91	**4.23**	**4.42**
Behavioural proscription	3.40	3.04[1]	3.86[1]	3.17
Positive reinforcement	3.19	-	3.63	-
Modelling	3.20	-	3.72	-
Self-disclosure	3.88	**4.23**[2]	**4.09**[2]	-
Sharing	**4.63**	**4.82**[3]	**4.68**[3]	**4.17**[3]
Encouragement of sharing	3.81	3.41	**4.41**	3.25
Reflection	3.44	3.32	3.82	-
Reassurance of competence	3.75	3.36	**4.00**	3.83
Justification	3.95	3.91	**4.18**	3.50
Mutual affirmation	**4.29**	**4.36**	**4.27**	**4.08**
Empathy	**4.33**	**4.54**	**4.41**	3.83
Offering feedback	-	-	3.32	-
Normalisation	3.71	**4.09††**	3.68	-
Instillation of hope	**4.17**	**4.27**	**4.27**	3.75
Personal goal setting	3.02	3.18†	3.23†	-
Group goal setting	3.07	-	3.18	**3.75†††**
Consensual validation	3.01	-	3.50	-
Functional analysis	3.06	3.00	3.32	-
Discrimination training	3.19	3.18	3.14	3.17
Explanation	3.98	**4.09**	**4.00**	3.58
Catharsis	3.90	**4.18**	3.77	3.50

• Mean ≥ 3.00 (processes occurring sometimes/frequently)
In bold, means = 4 or higher
[1] Means difference significant at .05 level (Tukey HSD test) – Conserv-Comb
[2] Means difference significant at .01 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
[3] Means difference significant at .01 level (Tukey HSD test) - Conserv-Rad, Comb-Rad
†† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad
† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
††† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad

Once again, among the processes that members reported as occurring never or rarely were behavioural rehearsal, punishment, and assertion of group norms (Table 5.28), confirming that self-help/mutual aid groups favour safety and simplicity. Also, the three types of groups differed in some processes. Conservative groups reported punishment less frequently than radical ones ($F(2,55) = 3.61$, $p<.05$). They also reported less requesting than both the other two group types and especially the combined ones ($F(2,55) = 5.60$, $p<.01$).

Table 5.28: *Mean scores of helping processes reported less frequently by type of group*

HELPING PROCESSES REPORTED LESS FREQUENTLY•				
HELPING PROCESSES	Total sample	Type of group		
		Conservative	Combined	Radical
Behavioural rehearsal	**1.99**	**1.91**[1]	2.32	**1.58**[1]
Positive reinforcement	-	2.95	-	2.83
Self-disclosure	-	-	-	2.92[2]
Punishment	**1.69**	**1.32**[3]	**1.82**	2.25[3]

Extinction	2.74	2.95	2.73	2.50
Modelling	-	2.95	-	2.67
Confrontation	2.39	2.14	2.68	2.42
Reflection	-	-	-	2.92
Requesting	2.12	**1.68***	2.68	**2.00***
Offering feedback	2.52	**1.73**	-	2.50
Personal goal setting	-	-	-	2.25†
Normalisation	-	-	-	2.92††
Group goal setting	-	2.54†††	-	-
Assertion of group norms	**1.72**	**1.50**	**1.91**	**1.83**
Consensual validation	-	2.91	-	2.33
Functional analysis	-	-	-	2.67
Positive reinforcement	-	2.95	-	2.83

• Means <3.00 (processes occurring rarely/never)
In bold, means = 2 or lower
[1] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad
[2] Means difference significant at .01 level (Tukey HSD test) - Conserv-Rad, Comb-Rad
[3] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad
* Means difference significant at .01 level (Tukey HSD test) - Conserv-Rad
† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad, Comb-Rad
†† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad
††† Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad

Group Identification

Members in the Second Phase, as in the First one, had high scores at group identification (mean = 41.88, std.=7.11, range = 10-50) as well as at its three aspects: awareness of group membership (mean=4.04, std.=.85, range=1-5), evaluation of this identity (mean=4.18, std.=.80, range=1-5) and affect attached to membership (mean=4.27, std.=.72, range=1-5). Scores were similarly high in all three types of groups. Length of membership was a variable which, similarly with Time 1, was statistically associated with group identification (as presented earlier).

Relationship of group identification with helping processes and empowerment

In the Second Phase of the study, there were no significant relationships between group identification and overall helping processes occurring at meetings in the total sample or separately in the three group types. However, there was a marginal relationship of group identification with a specific type of helping processes, group cohesiveness ($r=.22$, $p<.10$), a finding which was expected if we consider that processes concerning group cohesiveness help enhancing members' identification with their group.

From the three ideological types, radical groups presented a significant relationship of group identification with group cohesiveness ($r=.67$, $p<.05$) and a marginal one with supportive processes ($r=.48$, $p<.10$) (Table 5.29). These correlations suggested that group cohesiveness and support were important processes for radical group members in order to feel closer to their group.

There were some relationships between aspects of identification and specific types of helping processes which were repeated in the Second Phase (for detailed tables see Appendix D). Specifically, awareness of membership was correlated once again with supportive processes (.23, p<.08) whereas affect attached to membership was associated negatively with confrontation (.-.21, p<.09) and positively with supportive processes (.21, p<.09). The association of awareness with supportive group processes was mainly true once again in the combined groups (.46, p<.05).

Table 5.29: *Correlation of group identification with helping group processes and their sub-scales*

	Group identification			
	Total sample	Type of group		
		Conservative	Combined	Radical
Helping Processes	.04	.14	.01	.01
Sub-scales				
Behaviour-oriented	-.03	.02	.07	-.13
Expressive	.03	.14	.25	.18
Supportive	.18	.22	.09	**.48†**
Group cohesiveness	**.22†**	.16	.09	**.67***
Confrontational	-.16	-.28	-.19	-.38
Insight-oriented	.10	.20	.03	.01

† p<.10, * p<.05

At this Phase, we did not observe significant relationships of group identification with overall empowerment and its sub-factors. The three group types presented the same picture except of the marginal relationship of group identification with feelings of actual power (r=.53, p<.07) observed in radical groups, a correlation we also found in Phase One (Table 5.30). This finding suggests that feelings of actual power reflect on the way that radical group members think about their group.

Despite the lack of consistency in the relationships of group identification with empowerment observed in the First Phase with those in the Second Phase, we see that associations of aspects of identification with empowerment and its components were repeated in the Second Phase (for detailed tables see Appendix D). Thus, awareness of group identity and affect attached to this identity were once again correlated with overall empowerment (.30, p<.05 and .22, p<.07) as well as with feelings of actual power (.26, p<.05 and .24, p<.06). The association of awareness and affect with feelings of power was repeated in radical groups (.56 and .62, p<.05).

Table 5.30: *Correlation of group identification with empowerment and their sub-scales*

	Group identification			
		Type of group		
	Total sample	Conservative	Combined	Radical
Empowerment	.19	.21	.17	.17
Sub-scales				
Optimism	.06	.12	.14	.24
Power	.17	.10	.09	**.53†**
Self-esteem	.11	.17	.08	.02
Community Activism	.15	.30	.19	.13
Righteous Anger	.19	.08	.26	.29

† p<.07

5.1.6. Political ideology and longevity of group participation

At the Second Phase of the study, assessment of regular long-term group participants revealed a clearer picture than the one we observed in the overall sample regarding differences between the three ideological group types. Specifically, my expectation about the relationship between political ideology and empowerment was confirmed, that is radical group members reported significantly higher scores of personal empowerment (H=4.09, p<.08) than conservative ones. They also differed from them in some of the components of empowerment such as self-esteem (H=3.99, p<.07) and community activism (H=4.14, p<.10) (Table 5.31).

Table 5.31: *Mean scores (and standard deviations) of empowerment for regular long-term members by type of group*

	Type of group		
	Conservative (N=9)	Combined (N=11)	Radical (N=8)
Empowerment	**2.80 (.34)†**	2.87 (.36)	**2.99 (.27)†**
Sub-scales			
Optimism	2.74 (.43)	2.79 (.70)	2.83 (.36)
Power	2.66 (.44)	2.71 (.49)	2.76 (.42)
Self-esteem	**2.78 (.43)†**	2.87 (.46)	**3.01 (.38)†**
Community activism	**3.15 (.40)†**	3.27 (.27)	**3.44 (.42)†**
Righteous Anger	2.55 (.33)	2.48 (.62)	2.75 (.50)

†Means difference significant at .10 level (Mann-Whitney U test)

On the other hand, helping processes taking place at group meetings were similarly highly reported by this special sub-group of regular long-term members (Table 5.32), as it was the case for the overall sample. Likewise, support, expression and insight were the processes mostly reported by members of this sub-group. Differences between the three ideological types were also confirmed in the group of regular long-term members. Specifically, we see that combined groups reported a greater number of overall helping processes than radical

group members (F(2, 27)=3.97, p<.05), as well as more processes with a therapeutic character like behaviour-oriented (F(2,27)=3.94, p<.05) and expressive ones (F(2,27)=4.61, p<.05). Also conservative groups reported far less confrontational processes taking place at their meetings than both the other two group types (F(2,27)=15.94, p<.01).

Table 5.32: *Mean scores (and standard deviations) of helping processes• for regular long-term members by type of group*

	Type of group		
	Conservative (N=9)	Combined (N=11)	Radical (N=8)
Helping Processes	3.09 (.72)	**3.58 (.48)***	**2.83 (.59)***
Sub-scales			
Behaviour-oriented	2.64 (.88)	**3.27 (.31)***	**2.50 (.71)***
Expressive	3.76 (.76)	**4.13 (.52)***	**3.16 (.80)***
Supportive	3.92 (.86)	4.31 (.70)	3.64 (.53)
Group cohesiveness	2.72 (.51)	2.98 (.56)	2.87 (.43)
Confrontational	**1.56 (.67)****	**3.49 (.65)****	**2.00 (1.10)****
Insight-oriented	3.56 (.84)	3.36 (.98)	2.79 (1.08)

•The range of answers is from 1=never happens to 5=happens frequently
* Means difference significant at .05 level (Tukey HSD test)
** Means difference significant at .01 level (Tukey HSD test)

As in the First Phase of the study, the three ideological group types did not present any differences in the remaining individual and group characteristics. Also, long-term regular members presented the same psychosocial profile as the general sample. Thus, they had low mean scores in individual characteristics such as social networks (mean=23.57, total sample mean=22.82), social support (mean=54.17, total sample mean=52.51). In addition, mental wellbeing was a lot better for regular long-term members in comparison with the general sample (mean=2.71, total sample mean=4.09). Finally, they presented similar high mean scores of group identification as the total sample (mean = 43.31, total mean sample = 41.88).

Generally, this sub-group of members was similar in its individual and group characteristics with the general sample. Longevity of membership enhances differences among groups according to their political ideology in terms of personal empowerment and some of its components like self-esteem and community activism. We also see differences between the groups in overall helping processes as well as in specific types like expressive, confrontational and behaviour-oriented ones.

5.1.7. Summary of findings from the Second Phase

At the Second Phase of the study, findings confirmed a large number of my previous observations about self-help/mutual aid groups. Nonetheless, there were some differences in

associations and relationships observed at Time 1. In general, self-help/mutual aid group members presented a similar demographic profile as the one described at Time 1. Thus, the majority of them were women aged between 19 and 44 years, well-educated, single, unemployed and white. Once again, there were some differences in the profile of the ideological group types. Radical groups had a greater number of middle-aged or older people and more members with no formal educational qualifications or at a secondary level. On the other hand, almost half of combined group members were employed in contrast with the other two groups. Another area where respondents gave similar answers was contact with mental health services. The majority of self-help members were long-term users of the services, more than half of them had been admitted to a psychiatric unit, of whom the majority had been sectioned under the Mental Health Act. Again, the vast majority of radical group members experienced involuntary psychiatric hospitalisation whereas conservative group members were admitted with their own will. The interesting difference observed in Phase one between reported past and present use of mental health services was also evident in the Second Phase. So, members who used to see more than two mental health professionals in the past, at the time of study were seeing no or just one professional.

Overall, there is a consistent profile of individual psychosocial characteristics which is repeated at the Second Phase of the study. So, group members reported a limited number of social networks, low social support and marginal mental wellbeing. However, this time ideological group types differed between them in levels of mental wellbeing. Radical group members were feeling psychologically better than the other two types and differed significantly from conservative group members. Despite the lack of psychosocial resources, members showed once again high levels of personal empowerment, especially community activism. Self-help/mutual aid group members' scores were still significantly higher compared with these from a national representative sample of mental health service users; specifically, in overall empowerment, optimism, self-esteem and community activism. Furthermore, ideological group types showed once again differences in sub-factors of empowerment, that is radical group members showed more self-esteem than the conservative ones whereas conservative group members reported more anger than the combined ones. Differences between radical and conservative groups were also evident in the sub-group of regular long-term members. Radical group members were generally more empowered and reported better self-esteem and community activism than conservative ones.

At this Phase of the study, members shared similar group characteristics as in the First Phase. Thus, the majority of them attended meetings regularly over a long period of time. Once more, length of membership was positively correlated with social support and especially daily emotional support and social companionship as well as with group identification.

Moreover, members gave similar answers about reasons of joining a self-help/mutual aid group, expectations from their group and what they could offer to their group. Also, they reported a consistently large number of helping group processes taking place during their meetings. The most frequently reported types of processes were, similarly with Time 1, supportive, expressive and insight-oriented ones. There were differences between the three ideological types in overall helping processes as well as specific types of processes. So, combined group members reported more helping processes and especially expressive ones than the other two group types and differed significantly from radical group members. On the other hand confrontation was reported less frequently from conservative group members than combined ones.

An analysis of the specific helping processes examined revealed that once again sharing, mutual affirmation, empathy, instillation of hope and behavioural prescription were the processes occurring more frequently during meetings. However, groups differed between each other revealing their ideological type. Thus, conservative and combined groups reported more self-disclosure, sharing and personal goal setting whereas radical groups reported more group goal setting. The least reported processes were punishment, assertion of group norms and behavioural rehearsal, as it was reported in the First Phase. Again, groups differed between them and we observe that conservative groups reported less punishment than the radical ones.

As helping processes are very relevant to the way groups operate, it is interesting to observe that there were some significant differences within each group type over time. These differences mainly concerned operational changes that had happened in groups during the intervening period between the two times of the study. For example, conservative groups reported less confrontation in the Second Phase than in the First one ($t(52) = 2.14, p<.05$). This is mostly true for the Depression Alliance (London, afternoon) group that changed its way of operation during that period of time (see Chapter Three). Also, combined groups appeared to report more helping processes ($t(43) = -2.14$, $p<.05$), and especially behavioural ($t(43) = -3.14$, $p<.01$) and expressive ($t(43) = -2.27$, $p<.05$) ones in the Second Phase of the study. These differences can be traced in the Depression Alliance (St. Albans) group which altered its way of functioning (see Chapter Three). Finally, radical groups did not report any changes during time and this can also be observed when groups belonging to this category are examined individually.

Finally, self-help/mutual aid group members were still highly identified with their group and especially after a long period of participation. There were no differences between the three ideological group types. Group identification was related to a specific type of helping processes, group cohesiveness and this relationship was mainly true for radical group

members. There was also an interesting relationship of group identification with feelings of actual power in radical groups, a finding which was observed at Time 1 as well. Another interesting observation was that aspects of identification remained significantly correlated with empowerment and helping processes. Specifically, awareness of self-help group membership and affect from such a membership were once more associated with overall empowerment and feelings of actual power. These aspects were also correlated with supportive helping processes reported by members. In addition, affect from group membership was negatively related to confrontation occurring during group meetings. Looking at the three ideological types, we observe that awareness and evaluation were associated with supportive processes in combined groups whereas the relationship of awareness and affect with feelings of actual power was mainly true for radical group members.

CHAPTER SIX

Stability and Reliability of Findings

One of the research aims of the study was to assess the effect of time on individual and group characteristics of self-help/mutual aid groups and their ideological type. I have already discussed in Chapter Five that participants' responses were quite similar at both times of the study. While the majority of participants were different at Time 1 and Time 2, there were a number of members who responded at both times of the project. An examination of their responses provides an additional evaluation of changes through time as well as a testimony of the study findings' reliability. In this Chapter, I present results from this sub-group of respondents arguing about the stability of views in time and the subsequent verification of reliability of the measurements.

6.1. Changes in groups through time: repeated measurements

Respondents in this study participated in a volunteer basis thus it was not always possible to ensure that same members would respond in both phases of the study. Moreover, due to the unrestricted type of participation characteristic in self-help groups, composition of groups was not stable and there was a constant move of members at each meeting (old members not attending every meeting and new members joining the group). Despite these practical difficulties, there was a sub-group of respondents who participated in both times. This sub-group consisted of 17 people, 6 men and 11 women (same proportion as the total sample), and shared common demographic characteristics with the total sample, that is the majority were educated (88%), unemployed (59% at Time 1 and 53% at Time 2), and all white (Table 6.1).

There were some differences in age and marital status. While, in both times of the study, the majority of respondents were young adults (19 to 44 years old), in this sub-group most of the respondents were middle aged or older (45 to 77 years old, 59%). Similarly, in this sub-group there was a higher number of people who were married/with partner, although the majority (76%) were still either single or divorced or widowed.

Respondents belonged to all three types of groups: seven (7) of them to a conservative group, five (5) to a combined one and five (5) to a radical one. Proportionately, there was a

higher percentage of radical group members (29.4%) in this sub-group than in the samples of Time 1 (18%) and Time 2 (21.4%). Also, there were more radical group members who participated in both Times (42% at T1 and T2) than conservative (22% at T1 and 32% at T2) or combined (22% at T1 and 23% at T2) group members.

Table 6.1: *Demographics of members responding in Time 1 and Time 2*

Gender	Women Men	11 (64.7%) 6 (35.3%)
Age	19-29 years 30-44years 45-57 years 58-77 years	3 (17.6%) 4 (23.5%) 5 (29.4%) 5 (29.4%)
Education	No formal qualifications Secondary/Further education Higher education Professional education	2 (11.8%) 4 (23.5%) 2 (11.8%) 9 (52.9%)
Marital status	Single/Never married Married/With partner Divorced/Separated Widow/Widower	5 (29.4%) 4 (23.5%) 5 (29.4%) 3 (17.6%)
Ethnic origin	White	17 (100%)
Occupational status (T1)	Employed Unemployed	7 (41.2%) 10 (58.8%)
Occupational status (T2)	Employed Unemployed	8 (47.1%) 9 (52.9%)

Contact with mental health services was similar with the total sample (Table 6.2). Specifically, respondents had long-term experience with professionals (three years or more, 87%), from an early age (13-29 years old, 60%), half of them had been admitted to a psychiatric unit of whom almost half had been sectioned under the Mental Health Act. All but one of the respondents had seen at least a mental health professional with the vast majority having seen two or more professionals (82%).

Table 6.2: *Contact with mental health services*

Length of contact with mental health services (N=15)	1 month - 2 years 3 - 14 years 15 - 26 years 27 - 50 years	2 (13.3%) 7 (46.7%) 4 (26.7%) 2 (13.3%)
Have you ever seen any of the following? (N=17) * Psychiatrist, CPN, Counsellor/ Psychotherapist, Psychologist, Social Worker, or Other	A mental health professional* Two of the above Three of the above Four or more of the above None of the above	2 (11.8%) 6 (35.3%) 3 (17.6%) 5 (29.4%) 1 (5.9%)

How old were you at your first contact with the services? (N=15)	13 - 18 years old 19 - 29 years old 30 - 40 years old 41 - 56 years old	5 (33.3%) 4 (26.7%) 2 (13.3%) 4 (26.7%)
Have ever been admitted to a psychiatric unit? (N=17)	Yes No	9 (52.9%) 8 (47.1%)
If yes, was it under a section of Mental Health Act? (N=9)	Yes No	4 (44.4%) 5 (55.6%)

Also, findings from this sub-group confirmed the reliability of evidence about reported decrease of service use by self-help group members, which was discussed in earlier chapters (Table 6.3). In fact, a comparison in the present use of services between the First and Second Phase confirmed that it differed statistically and that there was an increased number of members who did not see any mental health professionals at the second phase of study (seven in T1, nine in T2) (Cramér's phi (ϕ_c)= .72. p<.01).

Table 6.3: *Use of mental health services by self-help members over time*

	TIME 1	TIME 2
Are you seeing any of the following?		
A mental health professional*	6 (35.3%)	4 (23.5%)
Two of the above	2 (11.8%)	1 (5.9%)
Three of the above	2 (11.8%)	3 (17.6%)
Four or more of the above	-	-
None of the above	7 (41.2%)	9 (52.9%)

* Psychiatrist, CPN, Counsellor/Psychotherapist, Psychologist, Social Worker, or Other

6.1.1. General characteristics of group members

Group members who responded at both times of the study shared the same psychosocial profile as the general sample, that is they had limited social networks, low social support and marginal psychological well-being. However, they still reported high scores of personal empowerment (Table 6.4). These characteristics did not change through time. Differences between the three ideological group types were observed only in personal empowerment at both times of the study. Specifically, radical group members consistently reported higher mean scores than both the other two group types and differed significantly from conservative group members in Time 1 (H=4.37, p<.10) as well as in Time 2 (H=4.65, p<.10). Individual characteristics of members within each group type remained stable over time.

Table 6.4: *Means of individual characteristics of group members at Time 1 and Time 2 by type of group*

	Total (N=17)		Type of group					
			Conservative (N = 7)		Combined (N = 5)		Radical (N = 5)	
	T1	T2	T1	T2	T1	T2	T1	T2
Social Networks	24.62	24.18	23.93	21.43	26.40	25.40	23.80	26.80
Social Support	53.65	53.35	51.43	49.14	56.20	57.40	54.20	55.20
Mental Wellbeing	3.00	3.47	3.43	4.14	2.80	4.40	2.60	1.60
Empowerment	2.84	2.84	**2.76†**	**2.72††**	2.80	2.79	**3.01†**	**3.05††**

†Mean difference significant at .10 level (Mann-Whitney U test) – Conservative-Radical T1
††Mean difference significant at .10 level (Mann-Whitney U test) – Conservative-Radical T2

In this sub-group, it was once again found that length of membership was a factor that differentiated self-help/mutual aid group members; these findings reinforce the reliability of results in the general sample of both times of study. Thus, long-term members were more identified with their group that their short-term counterparts ($U=17.50$, $n_1=6$ $n_2=11$, $p<.10$), reported better social networks ($U=12.50$, $n_1=6$ $n_2=11$, $p<.05$) and more social support ($U=16.40$, $n_1=6$ $n_2=11$, $p<.10$). These differences were not statistically significant in Time 2 as the small number of short-term members (N=2) did not allow a valid comparison with long-term ones (N=15). However, long-term members still reported consistently higher mean scores than short-term ones in group identification, social networks and social support (Table 6.5).

Table 6.5: *Mean scores (and standard deviations) of processes and outcomes of participation by length of membership for both times of measurement*

	TIME 1		TIME 2	
	Short-term (N=6)	Long-term (N=11)	Short-term (N=2)	Long-term (N=15)
	PROCESSES			
Helping processes (Range = 28-140)	91.46 (21.43)	92.00 (14.26)	102.50 (6.36)	89.13 (18.28)
Group identification (Range=10-50)	**42.71†** **(2.85)**	**45.74†** **(5.04)**	39.87 (10.07)	42.80 (6.38)
	OUTCOMES			
Empowerment (Range = 1-4)	2.83 (.21)	2.85 (.25)	2.90 (.19)	2.83 (.27)
Social Networks (Range = 0-45)	**19.08*** **(8.34)**	**27.64*** **(5.27)**	19.50 (9.19)	24.80 (6.89)
Social Support (Range = 23-92)	**49.00†** **(13.59)**	**56.18†** **(6.43)**	50.00 (19.79)	53.80 (8.62)
Mental Wellbeing (Threshold = 2/3)	2.50 (3.27)	3.27 (3.63)	3.50 (.71)	3.47 (4.03)

† Means difference significant at p<.10 (Mann-Whitney U test)
* Means difference significant at p<.05 (Mann-Whitney U test)

6.1.2. Individual characteristics

Empowerment

Repeated measurements of personal empowerment and its sub-factors showed no changes over time. Thus, community activism was once again the sub-factor with the highest reported mean score at both times of measurement (T1 mean=3.23, T2 mean=3.27). This was also the case for the three ideological types of groups.

Moreover, differences in empowerment and sub-factors between group types were confirmed by results of this sub-group (Table 6.6). Specifically, as already mentioned, radical group members reported higher empowerment scores than the other two types at both times, showing a significant difference from conservative group members. Also, they reported higher scores and differed significantly from conservative members in feelings of actual power ($H=6.84$, $p<.05$) at Time 1 as well as in self-esteem ($H=4.00$, $p<.10$) and in community activism ($H=4.07$, $p<.10$) at Time 2. Finally conservative group members reported more righteous anger than combined ones at Time 1 ($H=4.01$, $p<.10$).

These differences between the three ideological types confirmed and established the reliability of my findings in both times of the study that political ideology affected levels of personal empowerment and its sub-factors. Also the fact that empowerment did not present any changes over time within each group type reinforced my observation that ideological differences remained stable in time.

Table 6.6: *Mean scores (and standard deviations) of empowerment and sub-scales by time and type of group*

	Total (N=17)		Type of group					
			Conservative (N = 7)		Combined (N = 5)		Radical (N = 5)	
	T1	T2	T1	T2	T1	T2	T1	T2
Empowerment	2.84 (.23)	2.84 (.26)	**2.76†** **(.16)**	**2.72††** **(.24)**	2.80 (.23)	2.79 (.24)	**3.01†** **(.26)**	**3.05††** **(.22)**
Sub-scales								
Optimism	2.76 (.40)	2.76 (.33)	2.67 (.33)	2.71 (.30)	2.67 (.41)	2.67 (.47)	3.00 (.47)	2.93 (.15)
Power	2.65 (.34)	2.62 (.35)	**2.41*** **(.29)**	2.52 (.32)	2.71 (.30)	2.54 (.27)	**2.91*** **(.22)**	2.82 (.44)
Self-esteem	2.84 (.34)	2.84 (.30)	2.71 (.39)	**2.67**** **(.34)**	2.84 (.30)	2.90 (.22)	3.02 (.29)	**3.02**** **(.21)**
Community activism	3.23 (.33)	3.27 (.37)	3.24 (.29)	**3.12[1]** **(.34)**	3.13 (.32)	3.17 (.26)	3.33 (.42)	**3.57[1]** **(.38)**
Righteous anger	2.61 (.46)	2.57 (.57)	**2.86[2]** **(.32)**	2.57 (.42)	**2.33[2]** **(.47)**	2.40 (.76)	2.53 (.50)	2.73 (.64)

†Mean difference significant at .10 level (Mann-Whitney U test) – Conserv-Rad T1
†† Mean difference significant at .10 level (Mann-Whitney U test) – Conserv-Rad T2
*Mean difference significant at .05 level (Mann-Whitney U test) – Conserv-Rad T1
** Mean difference significant at .05 level (Mann-Whitney U test) - Conserv-Rad T2

[1] Mean difference significant at .10 level (Mann-Whitney U test) – Conserv-Rad T2
[2] Mean difference significant at .10 level (Mann-Whitney U test) – Conserv-Comb T1

Relationship of empowerment with individual characteristics of group members

An examination of relationships of empowerment with other individual characteristics revealed that, in this sub-group, although there were some significant correlations at each time of the study, e.g. with mental wellbeing, these relations were not repeated through time (see Table 1, Appendix E). This lack of stability may be attributed to the small number of cases. Looking at the different group types, correlations although significant were also not repeated.

Social Networks

Group members who responded at both times of the study had similarly poor social networks as the total samples. Social networks did not change during the one-year interval of the study. Thus, half of the respondents had contact at least once a month with only three or four relatives at Time 1 (53%) or one to two relatives at Time 2 (53%). Also, half of the respondents (53%) had none or only one family member they felt close to (see Table 2, Appendix E).

Friends were a source of support for this sub-group of respondents. Almost half of respondents answered that they had one or two close friends and they had contact with them at least once a month (see Table 3, Appendix E). Moreover, a large number of members (59% at T1, 65% at T2) had frequent contact (weekly or more often) with their closest friend(s). Friends' networks remained the same over time and they did not present significant differences between the three ideological types. However, there were conservative group members (2 at T1 and 1 at T2 out of 7) who were more isolated than the rest of members having no close friends at all.

Twelve out of seventeen respondents in this sub-group had confiding relationships with others at both times of the study, that is someone to discuss important issues with (very often or always, 71%) (see Table 4, Appendix E). However, they answered that other people did not confide as much to them about important decisions (often, very often or always 59% at T1, 47% at T2). There were no significant differences between ideological group types or changes through time.

Although there was almost one third of respondents who lived alone (29% at T1, 35% at T2), the majority of them lived either with their family (35% at T1, 41% at T2) or with their spouse/partner (29% at T1, 23.5% at T2) (see Table 5, Appendix E). This was mainly true

for conservative group members, whereas there was a higher percentage of combined and radical group members who lived alone (40% and 40% at T1, 60% at T2 respectively).

Social Support

Generally, respondents reported low scores of social support (T1 mean = 2.33, T2 mean = 2.32) and there were no changes over time. Like I observed in the two phases of the study, specific types of support like practical support had lower mean scores than emotional support (Table 6.7). Thus, the highest mean scores could be observed in daily and crisis (problem-oriented) emotional support in the overall sample.

Unlike what we had already seen in the two Phases of the study, in this sub-group social companionship did not present high overall mean scores; the type of support, which had the highest scores, was daily emotional support. However, this was due to the fact that conservative group members reported very low mean scores in this particular type of support (T1:1.83, T2: 1.94) and differed significantly from the other two types (T1: $F(2,16)=3.00$, $p<.08$, T2: $F(2,16)=2.58$, $p<.10$). The three ideological types did not present any changes through time in levels of social support.

Table 6.7: *Social support by type of group and time*

		Total sample	Type of group		
			Conservative	Combined	Radical
Social support (total score)	T1	2.33 (.42)	2.24 (.58)	2.44 (.36)	2.36 (.25)
	T2	2.32 (.41)	2.14 (.49)	2.50 (.32)	2.40 (.34)
Type of support					
Daily Practical	T1	1.76 (.38)	1.71 (.42)	2.05 (.33)	1.55 (.21)
	T2	1.79 (.44)	1.61 (.38)	1.85 (.49)	2.00 (.47)
Problem-oriented Practical	T1	2.11 (.41)	2.05 (.49)	2.27 (.43)	2.07 (.28)
	T2	2.00 (.47)	1.76 (.42)	2.27 (.36)	2.07 (.55)
Daily Emotional	T1	2.78 (.66)	2.83 (.93)	2.60 (.44)	2.88 (.44)
	T2	2.75 (.47)	2.66 (.70)	2.88 (.23)	2.76 (.26)
Problem-oriented Emotional	T1	2.55 (.71)	2.52 (.94)	2.50 (.58)	2.63 (.58)
	T2	2.50 (.69)	2.40 (.90)	2.73 (.52)	2.40 (.56)
Social Companionship	T1	2.21 (.65)	**1.83 (.66)†**	**2.64 (.43)†**	2.32 (.58)
	T2	2.28 (.59)	**1.94 (.58)†**	2.48 (.56)	**2.56 (.46)†**

†Means difference significant at .10 level (Tukey HSD test)

Mental Wellbeing

Half of the respondents in this sub-group scored below the threshold of the General Health Questionnaire (GHQ), indicating that they were feeling psychologically well (Table 6.8). These scores were quite similar with the ones reported in the total samples confirming once again the reliability of measurements. Mental wellbeing remained stable over time in the

overall sample. Looking at the three ideological types, there were some changes in the combined groups with members reporting lower wellbeing at Time 2.

Table 6.8: *Mental Wellbeing by type of group and time*

	Total sample		Type of group					
			Conservative		Combined		Radical	
	T1	T2	T1	T2	T1	T2	T1	T2
0	5 (29.4%)	7 (41.7%)	3 (43%)	2 (29%)	1 (20%)	1 (20%)	1 (20%)	4 (80%)
1	3 (17.6%)	-	-	-	3 (60%)	-	-	-
2	1 (5.9%)	1 (5.9%)	-	1 (14%)	-	-	1 (20%)	-
3 (Threshold)	3 (17.6%)	2 (11.8%)	1 (14%)	1 (14%)	-	1 (20%)	2 (40%)	-
4 or above	5 (29.4%)	7 (41.7%)	3 (43%)	3 (43%)	1 (20%)	3 (60%)	1 (20%)	1 (20%)

Relationship between mental wellbeing, helping processes and empowerment

There were significant correlations of mental wellbeing with variables of the study, as we already saw in the two Phases. In this sub-group of respondents we still observed these relationships; however, they were not necessarily repeated over time at the same statistical significance probably due to the fact that the number of cases was very small. So, although there existed significant correlations of wellbeing with overall helping processes (-.52, $p<.05$) as well as specific types like behaviour-oriented (-.54, $p<.05$), expressive (-.42, $p<.10$), supportive (-.47, $p<.05$) and insight-oriented (-.42, $p<.10$) at Time 1, these relations were not repeated at Time 2, except of the relationship of mental wellbeing with supportive processes (-.47, $p<.05$). Looking at the three ideological group types, it could be also observed that, similarly, existing relationships of wellbeing with overall helping processes and specific processes did not emerge at both times of the study (see Table 6, Appendix E).

As already discussed above, personal empowerment was significantly correlated with mental wellbeing (-.53, $p<.05$ at Time 2); however, this relationship was not repeated through time. There were also significant relationships of mental wellbeing with sub-factors of empowerment like self-esteem, optimism and feelings of actual power. From these relations, only the correlation of wellbeing with power was present at both times (-.37, $p<.10$, at T1 and -.78, $p<.01$ at T2). The picture was similar in the ideological group types. The only consistent relationship we observed was the one of wellbeing and power (-.93 at T1 and -.91 at T2, $p<.05$) in radical group members (Table 7, see Appendix E).

6.1.3.Group characteristics

Member attendance and length of membership

The seventeen group members who participated at both times of the study were mostly regular long-term members. Specifically, only 3 out of the 17 respondents were beginners in Time 1 and these became regular attenders in Time 2. Also, from the six people with short-term membership in Time 1, only two remained at this category in Time 2 (Table 6.9).

The length of participation at group meetings, as we already noted at both Phases of the study, was correlated with some of the variables we examined. Thus, in this sub-group of respondents, membership length was once again positively correlated with group identification (.40, p<.10 at T1 and .41, p<.09 at T2), social networks (.53, p<.05 at T1 and .43, p<.08 at T2) and social support (.42 at T1 and .41 at T2, p<.09). Additionally, there was a consistent relationship of membership length with a particular type of support, social companionship (.45, p<.07 at T1 and .41, p<.09 at T2), as it was the case in the total samples.

Table 6.9: *Member attendance and length of membership by type of self-help/mutual aid group and time*

	TIME 1	TIME 2
Member attendance		
Beginners	3 (17.6%)	-
Regular attenders	14 (82.4%)	17 (100%)
Length of membership		
0-1 month	3 (17.6%)	-
Up to 1 year	3 (17.6%)	2 (11.8%)
1 to 2 years	6 (35.3%)	6 (35.3%)
3 to 4 years	2 (11.8%)	4 (23.5%)
4 to 9 years	3 (17.6%)	5 (29.4%)

Helping Processes

Respondents in this sub-group reported a large number of helping processes occurring during group meetings. It was confirmed that the processes most frequently reported were supportive, expressive and insight-oriented whereas confrontation, group cohesiveness and behaviour-oriented processes were the processes least reported by group members (Table 6.10). There were no changes over time in the number of helping processes reported by group members. However, we observed that the three ideological group types presented similar differences between them at both times of the study. Specifically, conservative group members reported fewer confrontational processes taking place at their meetings than both the other types and especially combined group members (H=3.90, p<.09 at T1 and H=6.85,

p<.05 at T2). Also, they reported more supportive processes than radical group members (H=3.78, p<.10 at T1and H=4.34, p<.10 at T2).

Table 6.10: *Mean scores of helping group processes• and sub-scales by type of group and time*

	Total (N=17)		Type of group					
			Conservative (N = 7)		Combined (N = 5)		Radical (N = 5)	
	T1	T2	T1	T2	T1	T2	T1	T2
Helping Processes	3.24	3.24	3.09	3.17	3.48	3.53	3.35	3.05
Sub-scales								
Behaviour-oriented	2.89	2.96	2.75	2.75	2.81	3.22	3.15	3.01
Expressive	3.88	3.69	3.80	3.69	4.10	4.08	3.76	3.32
Supportive	4.06	3.97	**4.00†**	**4.26††**	4.27	4.07	**3.73†**	**3.48††**
Group cohesiveness	2.49	2.73	2.09	2.55	2.62	3.00	2.93	2.73
Confrontational	2.33	2.16	**1.86***	**1.43****	**3.15***	**3.13****	2.20	2.20
Insight-oriented	3.48	3.40	3.19	3.57	3.78	3.37	3.60	3.20

•The range of answers is from 1=never happens to 5=happens frequently
† Means difference significant at .10 level (Kruskal-Wallis test) – Conserv-Rad T1
†† Means difference significant at .10 level (Kruskal-Wallis test) – Conserv-Rad T2
* Means difference significant at .05 level (Kruskal-Wallis test) – Conserv-Comb T1
** Means difference significant at .05 level (Kruskal-Wallis test) – Conserv-Comb T2

From the 28 helping processes assessed by the scale, all respondents reported as occurring frequently (≥4) the following: sharing, mutual affirmation, empathy and installation of hope (see Table 8, Appendix E). These processes, found at both Phases of the study, were highly relevant with the self-help ideology that groups shared and confirmed their ethos. Reported helping processes did not change over time.

Despite these common characteristics, ideological group types differed between them at each time of the study in specific processes. These differences, already observed in the total samples, were consistent with their focus of change. So, at both times of the study, conservative group members reported more self-disclosure that the radical ones (F(2,16)=2.47, p<.10 at T1 and F(2,16)=3.10, p<.07 at T2) whereas radical group members reported more group goal setting than the conservative ones (F(2,16)=5.30, p<.05 at T1 and F(2,16)=2.70, p<.10).

Similarly with our findings from the two Phases of the study, in this sub-group of respondents, among the helping processes reported as occurring never or rarely (≤2) were punishment, behavioural rehearsal and assertion of group norms (see Table 9, Appendix E). This finding remained stable at both times and confirmed the orientation of self-help/mutual aid groups towards safety and simplicity.

However, there were some characteristic differences between group types which could be observed at both times of the study. Specifically, conservative group members reported less punishment than the radical ones ($F(2,16)=3.07$, $p<.07$ at T1 and $F(2,16)=6.46$, $p<.01$ at T2) and less confrontation than the combined ones ($F(2,16)=3.02$, $p<.09$ at T1 and $F(2,16)=3.07$, $p<.07$ at T2).

Group Identification

Respondents in this sub-group reported high levels of group identification at both times of the study (mean = 44.60 at T1 and mean = 42.55 at T2) and these scores did not differ significantly over time. There were no differences between the three ideological group types. As already mentioned above, there was a relationship of group identification with the length of membership (.40, $p<.10$ at T1 and .41, $p<.09$ at T2).

Relationship of group identification with helping processes and empowerment

Although group identification was not correlated with overall helping processes in this sub-group of respondents, it presented a significant relationship with a specific type of processes, confrontation, at both times of the study (-.58 at T1 and -.53 at T2, $p<.05$) (see Table 10, Appendix E). This relation suggested that group members became more identified with their group when they did not experience confrontation during group meetings. Relationships in the separate group types were not repeated through time, thus offering a less clear picture.

In this sub-group of respondents, group identification was not particularly correlated with personal empowerment or its sub-factors. This lack of relationships could be seen at both times of the study. However, there were some interesting relationships within the separate ideological group types which occurred at both phases, like the relationship of group identification with righteous anger in combined groups (.71 at both times, $p<.10$) as well as the relation of group identification with feelings of actual power in radical groups (.76 at both times, $p<.10$) (see Table 11, Appendix E).

6.1.4. Summary of findings from comparison of repeated measurements

The sub-group of seventeen self-help/mutual aid group members who participated at both times of the study shared a similar demographic profile with the samples in Phase One and Two. So, the majority of them were women, educated, unemployed and all white. There were some differences in age and marital status. In this sub-group, the majority was middle-

aged or older and although most of them were single, divorced or widowed – as it was the case in the samples of the two phases - there is a higher number of people who were married/with partner.

The most important characteristic of the findings from this sub-group was that it was possible to confirm observations made in the total samples of the study. Respondents presented a similar picture in the use of mental health services, that is they were long-term service users, half of them had been admitted to a psychiatric unit of whom more than half had been sectioned under the Mental Health Act. Also, we continued to find a significant difference between past and present use of mental services; members who were seeing two or more professionals in the past, were not seeing any professionals at the time of the study. Moreover, the reported present use of the services dropped significantly from Time 1 to Time 2.

The profile of members in terms of individual and group characteristics remained the same through time. So, self-help/mutual aid group members had limited social networks, low social support and marginal mental wellbeing. However, they reported quite high scores of personal empowerment. And a great number of helping processes occurring during meetings. Members also reported high levels of group identification. Length of membership was confirmed to be a critical factor that differentiated members and these differences were evident in group identification, social networks, social support and especially social companionship, where long-term members reported consistently higher scores than short-term ones.

Although sample numbers did not permit to verify the stability of ideological variations through time, nonetheless there were differences between group types which remained stable. Specifically, radical group members reported consistently higher mean scores in overall empowerment than the conservative ones at both times of the study. Also, looking at the different types of helping processes occurring during meetings we saw that at both times of the study conservative group members reported less confrontation than combined group members and more support than radical group members. Likewise, examining processes in detail, we observed that differences between groups were consistent with their ideological profile. Thus, conservative group members reported more self-disclosure and less punishment than the radical ones whereas radical group members reported more group goal setting than conservative ones.

Finally, the examination of relationships of group identification with empowerment and helping processes revealed some interesting findings. At both times of the study, members became more identified with their group when they did not experience confrontation during

group meetings. Also, there was a repeated association of group identification with righteous anger in combined groups and a relationship of identification with feelings of actual power in radical groups.

CHAPTER SEVEN

Conclusions and Recommendations

The study presented in this thesis has as a main theme the exploration of mental health self-help/mutual aid groups in the English context. One of the critical issues in this inquiry was to establish whether groups' political ideology and focus of change present a meaningful and comprehensive way of categorising them. In order to test the validity of this classification for group members, I chose to examine a set of individual characteristics and factors related to group processes and outcomes. The other important element of the study was its longitudinal character, a methodological choice that would allow me to assess possible changes through a period of time in self-help/mutual aid groups. In a general perspective, the very fact I was doing research in an 'uncharted terrain', the self-help/mutual aid area in England posed a broader aim: to give an account of these groups' profile and their members' characteristics.

A review of the study findings highlights its innovative aspects and contributions to the self-help area. The first important finding is that, indeed, political ideology and focus of change of self-help/mutual aid groups provide the basis of a meaningful typology and constitute a comprehensive way of classifying them. This approach allows the systematic examination of individual along with group psychosocial characteristics of members. It also permits the evaluation of outcomes from group participation in socio-political terms rather than in restricted 'psychotherapeutic' ones. Secondly, group ideology is further confirmed with the longitudinal exploration of these aspects, which reveals that the political ideological character of self-help/mutual aid groups and their particular beneficial outcomes for members remain stable through time. Finally, in this study it was made possible to investigate and verify in a quantitative manner previous anecdotal observations about beneficial outcomes from self-help/mutual aid group participation. Namely, self help and mutual aid activities contribute to members' individual empowerment while prolonged participation in these groups is reflected in greater group identification and results in improved wellbeing, increased social support and companionship, and increased optimism over future.

The findings make an original contribution to the advancement of knowledge about this naturally occurring phenomenon and their influence in the mental health area. Firstly, by looking at a large spectrum of self-help/mutual aid groups - in terms of structural and organisational characteristics -, it becomes evident that self-help/mutual aid groups have

distinctive common properties while they offer a wide range of choice through their different types to people who experience mental health problems. Also, through the systematic examination of members' characteristics, group processes and outcomes in relation to a specific typology and the effect of time on these factors, the present research shows that self-help/mutual aid groups present features consistent with their political ideology and focus of change. Additionally, as an original research work, these results provide a much-needed methodological background and suggest directions for further investigations. Specifically, the experience reported here shows that a combination of methodologies can prove to be a suitable choice in order to record thoroughly and comprehensively the multifaceted elements of self-help groups.

In this last Chapter, I review some of the interesting points of this project arguing about specific methodological and theoretical issues. Also, I discuss in detail the findings of the study looking at the general characteristics of English mental health self-help/mutual aid groups, the specific traits of the different group types, and the changes observed through time. Finally, I conclude by presenting my suggestions about further research along with recommendations for professional mental health education, service development and social policy issues.

Issues of interest

Methodological choices

As I discussed in Chapter Two, the particularities and unique features of the self-help/mutual aid area urge the researcher to break from the traditional experimental designs, widely used in the field of psychology. There is need to have an open mind to a combination of research methods, quantitative and qualitative, in order to remain reflexive to the natural and spontaneous character of self-help/mutual aid groups. However, this choice presents difficulties as it can lead to contradictions. For example, my intention to study a set of individual and group variables in a quantitative manner led me to the use of self-completion questionnaires. The drawback of this choice was the fact that most self-help/mutual aid group members were reserved towards professionals and their traditional methods of questioning and I had to address their hesitation in completing the scales. On the other hand, my decision to collect information about the groups through participant observation led me to the process of asking permission from groups to attend their meetings. In order to do so, I often had to 'defend' my project and my research intentions to members' criticisms and to overcome their distrust of professionals.

To address the above dilemmas, I tried to be as flexible as possible, given the limitations of time and resources. The selection of questionnaires was made according to certain requirements such as simplicity, jargon-free language and relevance to the issues in question. Then, I validated this selection in a pilot study where I had feedback from mental health service users and made changes to the questionnaires accordingly. Before administering the questionnaires to self-help group members, I spent considerable time presenting the content of the scales, explaining about the questions asked and justifying their choice. During this discussion, there was opportunity to answer people's queries and address their doubts and objections. In any case, participation was voluntary. Finally, in order to be aware of respondents' opinions, there was a last part of the questionnaires asking for participants' feedback about them. The vast majority of respondents made positive comments about the selection of scales in relation to their clarity, understanding and relevance to the research questions.

My contact with self-help/mutual aid groups became a valuable learning experience as I had the opportunity to reflect upon and re-consider my research questions in the light of the discussions I had with members. Specifically, in order to establish their co-operation, I presented the project to them in detail, explaining the purpose of the study and asking for their help. This was an interactive process during which I, the researcher, shared theoretical knowledge about self help and my research questions with group members and they, the participants, shared their experiential knowledge and ideas about the study with me. The result of this process, which evolved throughout the project, was a relationship of collaboration based on mutual trust.

Furthermore, the fact that research on self-help/mutual aid groups is still in its early stages generated additional challenges, for example there is a lack of research tools designed exclusively for this study. It is not always easy to compensate for this shortage by 'borrowing' tools from other related areas of research. Existing tools used by self-help researchers have usually been created to examine only specific types of groups, e.g. Alcoholics Anonymous. They may not be so adaptable. An example of this difficulty is the questionnaire I used for the assessment of help-giving group processes. Although it was judged very relevant by group members, it is nonetheless heavily influenced by the theoretical assumptions concerning the functioning of psychotherapy groups. It is therefore better able to depict processes aimed at personal, as opposed to social, change. Despite this weakness, all respondents reported a high number of helping processes occurring during meetings, and especially certain types like supportive and expressive ones. These findings show that the scale relates to the self-help experience, but that possibly there is need for a

refinement of its items in order to assess processes emphasised in social change groups such as community activism and advocacy.

From the above examples, it is evident that research in the self help area calls for inventiveness and flexibility in methodology. The researcher cannot rely on 'traditional' one-sided approaches; instead, as Humphreys and Rappaport (1994) put it very graphically, "*self-help researchers can take many roads (research paradigms) on a common journey (knowledge about the phenomenon of self-help groups)*" (p. 217). Being rather 'young' as a research field, it presents the advantage of being yet 'boundless' in the scientific approaches used by scholars, hence constituting an intriguing area for alternative research paradigms.

Theoretical considerations

Another interesting issue in this study is the theoretical significance of self-help groups' political ideology. The decision to use this criterion to test a typology of groups was greatly influenced by the nature of these groups. As I argued in the literature review (Chapter One, section 1.2.3), the view that I adopt in this study about self-help/mutual aid groups is that they are part of a new social movement, the user movement, thus embodying the potential to exercise a significant socio-political influence on the mental health reform, a development which is anticipated by many scholars in the self-help area (Powell 1993). This is true for all self-help/mutual aid groups, regardless of their focus of change, because they all espouse the principles of mutuality and solidarity and put forward self-activation and experiential knowledge of fellow users as essential elements of the change they pursue. From this perspective, a categorisation of self-help groups is more relevant if it focuses in the way these groups position themselves within the social process than in circumstantial characteristics, like the common problem/condition/issue groups address or their organisational features.

Moreover, the term political ideology used by Emerick (1991), who first introduced this typology, connotes a fundamental sociological value, namely the notion of the person being a citizen ('political' comes from the Greek word "πολιτης", meaning a citizen), thus having a role to play in the making of the society. The political ideology that relies upon the formation of a self-help/mutual aid group has to do with the citizen taking action to confront his/her problem/condition/issue. This is achieved through personal interaction with fellow members who have the same experience and by mutual helping. Whether this action aims to personal or social change, it is none the less a *political* action in the sense that the person gets actively involved in coping, instead of depending passively on the formal help delivery

systems. So, the term 'political' is used in the present study with its broad sociological sense and does not imply connections with particular contemporary political parties or factions.

I will now turn to the wider implications of conceptualising self-help/mutual aid groups as part of the user movement. It is important to recognise a significant change which begun to take place within Western democratic societies, namely an apparent crisis of traditional political parties and an increase of power of non-governmental organisations (NGOs). Giddens (1998) argues that during the 80s and 90s while the orthodox political parties were unable to present an effective ideological framework, new social movements put forward and started to campaign about issues "*that fell outside traditional social democratic politics*". These included ecology, consumers' rights and so forth. Giddens foresees that these new groups and non-governmental organisations are going to be an inherent part of the political scene world-wide: "*Social movements, single-issue groups, NGOs and other associations of citizens surely will play a part in politics on a continuing basis – from a local through to a world level.*" (p.53). In fact, in his discussion of the 'third way of politics', which is a "*deepening and widening of democracy*", he suggests that the government should act in partnership with such civil agencies in order to achieve community development. Within this framework, self-help/mutual aid groups are particularly prominent as they demonstrate direct civic engagement and elements of society's self-organisation.

Overall findings of the study

In the present study, I have found that self-help/mutual aid groups for people experiencing mental health problems have distinct psychosocial profiles, presenting characteristics consistent with those described in the North American self help literature, reviewed in Chapter One. To begin with, there is a majority in groups' demographic composition of well-educated, single, young, unemployed women. It should be noted that this profile refers to the variety of local groups represented within the study sample, in contrast with previous research which was mainly concentrated in group composition of particular big organisations such as Alcoholics Anonymous (AA) (Kurtz 1997). Characteristics such as gender and age of members vary among studies, depending on the sample of the study; therefore, it is not possible to confirm similarities or differences with previous studies. Nonetheless, educational level, employment and marital status are among the attributes which fit the typical profile of a self-help group participants reported by researchers in a limited number of nation wide surveys of American groups (Lieberman and Snowden 1993). Interestingly, a common characteristic of North American and English samples is that there is under-representation of ethnic minority people in self-help groups. This imbalance, which I noted

in the presentation of findings (Chapter Four, section 4.2.1), has attracted the attention of researchers in recent years and there are some hypotheses about its causes, such as an ideal concept called "racial fit" or "person-group fit" (Kurtz 1997). According to this concept, people feel more comfortable in groups where they share racial or other ethnic characteristics with most of the other members. There are a few studies supporting this assumption (Humphreys and Woods 1993) but the phenomenon is largely unexplored, especially in Europe. In their discussion of the emergence of the survivor movement, Sassoon and Lindow (1995) point out that in England there are few user-led groups where both white and black mental health service users co-exist. Nonetheless, they also observe that "*there is an understanding in some quarters that joining a mainly White group may not be attractive to Black survivors, and although many* [White] *members wish to be part of a multiracial organisation, they respect the wishes of Black survivors who may prefer to explore issues related to the psychiatric system with other Black people*" (p.97). Also, the two authors comment on the danger of introducing ethnic minority people in white-dominated user groups in a tokenistic way. Instead they propose alternative solutions such as white survivors to assist in campaigns led by ethnic minority users, to adopt in their agenda issues of racism, and to undertake anti-racism training.

Irrespective of the focal problem/condition/issue of the self-help/mutual aid group, respondents of the study consistently reported long-term experience with mental health professionals and psychiatric hospitalisations, including compulsory detention. Also, they reported fewer contacts with mental health professionals than previously. This interesting change, although undoubtedly influenced by the reforms that took place in the mental health area during recent years, is also in agreement with findings from previous studies about reduced use of professional services by self-help groups members (Kurtz 1990). Whether participation in the groups was indeed a major factor which contributed to this shift or not is a matter of future more systematic research.

Social networks are small and perceived social support is low. People report an absence of family ties and small although more intense friendship networks. The fact that most of them live alone confirms their need for companionship. This may be an important reason for their participation in self-help/mutual aid groups. Supportive interactions are also limited, especially practical support offered by others, either in everyday life or in a crisis. This contrasts with their reported higher scores in emotional support and social companionship. The finding that members report more emotional support and companionship than instrumental support, concurs with previous research findings and relevant literature about self-help/mutual aid groups (Levine 1988; Maton 1988). Moreover, members' low levels of psychological wellbeing corroborate this picture of social isolation.

In contrast with this lack of psychosocial resources, participants show quite high levels of individual empowerment, notably community activism. In support of this finding, a comparison with a sample of English mental health service users, living in the community and in contact with mental health services on the Care Programme Approach (Carpenter et al. 1999), shows that self-help group members score consistently higher in individual empowerment and some of its components like optimism, self-esteem and community activism than people using professional mental health services. Considering the above remark about scarcity of social buttresses, a recurrent characteristic of people experiencing long-term mental health problems, this important difference suggests that participation in self-help/mutual aid groups may be the empowering experience which differentiates their members from other people having mental health problems and receiving professional help. This also coincides with findings from previous research in the United States where empowerment is reported as a main outcome from self-help group participation (Katz and Hermalin 1987; Kurtz 1990). However, findings of previous studies were based on qualitative data such as field observations. The present study provides quantitative evidence that group participation is associated with empowerment.

Personal empowerment of participants is associated with many of the characteristics studied in the project, namely mental wellbeing, social support and a specific type of support, social companionship. These relationships point out the significance of mental health and perceived support in the process of becoming empowered. The fact that empowerment is considered by scholars as a process evolving throughout one's life, gives a broader perspective in the interpretation of these associations. Thus it is more likely that they are two-directional relations where empowerment is a resource and an outcome of successful coping. Also, as Rogers et al. (1996) reported from the United States, empowerment was not found to be influenced by demographic characteristics of group members like gender, age, educational level, marital and occupational status or from the amount of past and present contact with mental health professionals.

Members' experiences within their group give a testimony in favour of the self-help ethos described by Riessman and Carroll (1995). Indeed, this ethos is evident in their answers about reasons for joining the group, expectations from it and contributions from and to fellow members. Hence, people joined a self-help/mutual aid group in order to *help themselves and others* as well as to *meet others with the same experience and share feelings with them.* They expected to find *support* and *empathy* in the group and this is exactly what they believe the group offers to them, namely *mutual support* and *friendship* – "a listening ear", as most of them emphatically say. Their own contribution to the group mainly consists of *sharing personal experiences* and *mutually supporting their peers.*

In agreement with these beliefs about attributes of a self-help group, members report a large number of helping processes and specifically of certain types like *supportive*, *expressive* and *insight-oriented* processes, taking place during their meetings. This picture is very similar to that described in the North American literature, mainly reported in qualitative observational studies (Kurtz 1988; Maton 1988) but also quantitatively by the constructors of the helping processes questionnaire used in the present study (Wollert et al. 1982). Thus, helping occurs mostly in the format of sharing, mutual affirmation, empathy, instillation of hope and suggestions of experiential coping strategies (behavioural prescription). What is unlikely to happen during group meetings is threatening activities or 'professionally simulated techniques' (referred as such by Wollert 1986) like punishment, behaviour rehearsal or assertion of group norms. The latter finding is especially interesting if we consider that in the sample there are groups with a highly structured character, e.g. anonymous-type groups such as Overeaters Anonymous or user forums which function as a Committee, having highly structured meetings, such as the Havering, Barking and Brentwood Users Group (HUBB). It could be expected that these groups would report more group processes involving control over their group members. Nonetheless, in agreement with previous research (Wollert et al. 1982), all members of self-help groups emphasise positive and helpful group activities whereas they delineate less frequently threatening and repressive activities that will make them feel uncomfortable within the group. Consequently, even when a group has a highly structured character, the emphasis is given in the securing of a relaxed and non-threatening atmosphere among members. The structure in these cases serves merely as a guide for a more fruitful conduct of meetings.

Many self-help/mutual aid group members participating in the study attended most of the meetings over a long period of time. This allows us to examine more closely the effect of intense and long-term membership to the individual and group variables. There is a consistent difference at both times of the project between long-term participants and their short-term counterparts in terms of group identification, psychological wellbeing and social support. Specifically, people who are long-term self-help/mutual aid group participants report better psychological wellbeing and social support as well as becoming more identified with their group. In addition, at both times of the study, a further exploration reveals similar differences in a component of empowerment, optimism, and a specific type of support, social companionship. These findings confirm previous research showing that prolonged participation in self-help groups contributes to better outcomes for their members, such as reduced psychiatric symptomatology, increased life satisfaction and social support (Kurtz 1990). In the present study, members with long-term involvement have improved wellbeing,

increased support and companionship, increased optimism over future and they feel more connected to their group.

Group members reported high levels of group identification. There are interesting relationships of group identification with empowerment and helping processes which, however, are not repeated with the same statistical significance at both times of the study. Nevertheless, a closer examination of aspects of identification reveals a different picture. Specifically, awareness of group membership which "*contributes to self-definition*", according to the scale's constructors (Brown et al. 1986), is repeatedly positively associated with members' personal empowerment and feelings of actual power. Considering the fact that one of the major elements of personal empowerment is self-esteem and self-efficacy, this finding can be interpreted according to the social identity theory (Brown 1988). The main idea of this theory is that groups are a source of social identity for people. Group memberships contribute in a major way to our sense of who we are and of our place in the world. In defining themselves as a member of a particular group, people also associate themselves with the various common attributes and norms which they see as being part of that group. In this case, the independent and pro-active character of self-help/mutual aid groups prompts their members to feel better about themselves, more confident and in control. The result of this process is that greater consciousness of this identity will lead to increase of personal empowerment and feelings of actual power.

On the other hand, supportive processes occurring during a group meeting also reinforce this social identity's awareness and affect. This is also expected if we consider that participants' main anticipation from the group was peer support. As consequence, the frequency of supportive helping processes during meetings is possible to lead to greater identification of members with their group and to increase their affect coming from this identity. Another type of process which influences the emotional significance stemming from identification as a self-help group member is the amount of confrontation that takes place in meetings. This time it is a negative relation, namely lack of confrontation brings members closer to their group. The association of these two types of helping processes with the affect of the self-help group member identity concurs with the aforementioned observations about the most and least reported helping processes. It also indicates that the occurrence of specific helping processes may be characteristic of members' preferences to favour or avoid them instead of others.

Generally, the findings about the overall character of self-help/mutual aid groups support the initial hypotheses. Thus, personal empowerment, help-giving activities and group identification are very important factors in the description of the processes taking place in

self-help/mutual aid groups. High levels of identification with the group are strongly associated with increased numbers of help-giving activities and members' personal empowerment. Moreover, long-term participation is beneficial for the majority of their members and positive outcomes are related to better mental wellbeing, increased social support and feelings of personal empowerment.

Group typology of mental health self-help/mutual aid groups

The results of the study about differences between groups in terms of political ideology confirm that self-help/mutual aid groups can be distinguished in terms of their orientation towards personal or/and social change, their affiliations to other organisations and their attitudes to professionals. However, the English scene presents some significant differences from the North American one, and there are some unique features worth mentioning. In the sample here, "radical" groups are not necessarily *against* the traditional mental health system in the sense that they wish to abolish the existing services altogether and replace them with user-led alternative ones, as often happens with the American radical groups. The welfare state in England is still the main provider in the mental health area. As a result, users depend heavily on the system and users' groups (user forums) are frequently initiated within the mental health services in an effort to involve users in service design and improvement. However, these groups can become quite independent and act as consultants for changes in the system. So, these groups, although they have a social-change orientation, are not necessarily dismissive of the existing services.

Moreover, combined groups (those that espouse both goals) are not always so balanced in their "individual/social change" character and, sometimes, one side may overcome the other. So, there are combined groups which are involved more with the personal change of their members and other groups are very active toward social change. This point is consequently reflected in the differences between the three ideological group types.

Following the above observations, as I already argued in Chapter Three, section 3.2, the typology adopted in this study puts self-help/mutual aid groups within the framework of a new social movement; it does not represent an arbitrary way to examine members' individual characteristics as well as group processes and outcomes. Indeed, the definition of self-help groups according to this categorisation presents 'ideal' types of groups. However, actual groups may have some but not all the characteristics found in the ideal type. It remains, nonetheless, a meaningful way to evaluate fundamental differences of self-help/mutual aid groups and organisations, showing that each group can be, in its own way, a natural helping resource for people who have to cope with mental health problems.

The groups I encountered in the study seemed to reflect the picture presented by Levy (1982) in his survey of English mutual support groups, the only available survey about self-help groups in England up to date. The proportional representation of the three ideological group types in the sample of this study is consistent with his findings. So, it appears that there are more self-help/mutual aid organisations and groups oriented towards individual than social change. However, there are 'conservative' self-help/mutual aid organisations which are also involved in various activities aimed to raise social awareness about their members' common problem/condition/issue, thus taking up action that influences their socio-political environment. These would be characterised according to the typology of political ideology suggested by Emerick as 'combined' organisations; nonetheless, their local groups do not necessarily have a 'combined' character. This tendency of 'personal-change oriented' organisations/groups to be involved in social activity is also reflected, as I will discuss, in some of the findings.

Elements of the groups' political ideology are evident in a variety of their aspects. To begin with, we note that 'radical' groups have a different demographic profile from the other two group types. Their members appear to have a lower social-economical status and have been subjected to the experience of involuntary hospitalisation, in contrast with 'conservative' group members who were all admitted for psychiatric treatment with their own will. This difference of experiences with mental health services is possibly one of the reasons for radical group members' interest in changing the existing system. On the other hand, almost half of 'conservative' group members, in spite of their past heavy use of services, were not seeing at the time of the study any mental health professionals, whereas members of the other group types reported that they were still seeing one or two professionals. The focus of 'conservative' groups on individual change could be a probable explanation of such a considerable variance. Indeed, conservative group members are mainly preoccupied with their personal change through mutual support and exchange of information and coping strategies. It is thus expected that their efforts would be mostly evident in the frequency of their use of professional help and that this would be more apparent in this type of groups than in the other two types. Namely, the support and help they receive in their group could result in a decrease of the need for professional intervention. This does not necessarily mean that this type of groups is more 'suitable' to act as a replacement of the services. However, as they focus on personal change, they may be particularly helpful in individual coping with mental health problems thus having a complementary role to the existing statutory welfare.

The individual psychosocial profile of members does not differ between the three group types. Thus, all self-help/mutual aid group participants share feelings of isolation, having limited social networks and the need for social support. Their mental wellbeing is at

marginal levels, which indicates that they do not feel psychologically very well. However, they show differences in levels of personal empowerment and its components, according to my initial hypotheses. Specifically, radical group members are more empowered, optimistic and self-confident than their conservative counterparts. On the other hand, conservative group members show more anger than combined ones. Differences between ideological categories remain the same and become more evident when we examine especially members with intense and prolonged participation. However, variations of 'combined' group members in terms of empowerment and its components do not present a consistent picture at both times of the study. Whereas they have better self-esteem and show more feelings of actual power than conservative group members at the First Phase of the study, these differences are not repeated at the same significant level the second time. This unstable picture could be attributed to the characteristic I commented on earlier, that is personal and social orientations are not equivalent parts in these groups and their combination could be in favour of one side or the other. Thus, their characteristics are not presented in a clear-cut manner.

For the evaluation of the differences between the ideological group types in relation to personal empowerment and its components, it is useful to reflect upon the meaning of empowerment, as it is examined in the present study. The construction of the specific scale was based on a working definition of empowerment (Chamberlin 1997) where it is evident that the term is viewed from a socio-political perspective. According to this definition, empowerment is a process with distinctive qualities and entails assertion of basic human rights such as decision-making power and freedom of choice, along with active behaviour like critical thinking and effecting personal and community change. Thus, the empowering process connotes pro-active attitudes. A consequence of such a definition is that people who are involved in socially oriented activities, like radical group members, would be more empowered than others. And this is the case in the present study. The difference of conservative and combined group members in levels of righteous anger is an intriguing one. Righteous anger is a factor which, according the constructors of the scale, implies "*the ability and willingness to harness anger into action and a socio-political component*" (Rogers et al. 1997, p.1045). So, this difference may be an indication that although conservative group members are not socially active as their peers in combined groups, and indeed because of that, they may feel more intense anger. Undertaking social action might 'ease' these strong feelings, as it is possible to happen in 'combined' groups.

The socio-political attributes of the different group categories can also be assessed in the responses of members about reasons for joining the group, expectations from it and contributions from and to fellow members. Hence, the emphasis of the group's character is placed by both conservative and combined group members on its self-help and mutual

support aspects whilst radical group members stress the elements of peer control and self-advocacy. Moreover, whereas mutual help and sharing of experiences and feelings is the primary motive for joining a self-help/mutual aid group given by conservative and combined group participants, radical group members are prompted by their need for company and socialising as well as for information and comprehension of their problem/condition/issue. Expectations of support and empathy from fellow members are common for all three ideological types; however, there are a number of members clearly stating that they expected "*campaigning for better treatment and change of the system*". Likewise, answers of members about group's contributions differ according to their political ideology. Conservative and combined groups emphasise more therapeutic-like benefits such as insight and their peers' personal experiences of their common problem/condition/issue whilst radical group members refer to the freedom of choice, hope and encouragement that their group offers them. Finally, responses about members' own contribution to the group are consistent with this socio-political ideological distinction. While conservative and combined groups members share in their personal stories and feelings, radical group participants prioritise practical help and personal skills as a more important way of contributing to their group.

The outline of the three ideological group types, as described through members' own words about their experience with the group, discloses that they share a lot of similar features, which are essential prerequisites for their characterisation as self-help/mutual aid groups. The emphasis on different aspects of their organising and functioning looks more like a variation of shades of a continuum rather than a polarisation of antithetical factions. The quest for mutual support and helping is what brings people in these groups; it is the manner in which they pursue to accomplish this shared task that differs and brings about the groups' variant character. We should not however consider that there is a 'good' and 'bad' group type as all groups help in their own way their members to cope with their common problem/condition/issue and most importantly offer them a change of self-activation, in contrast with the passive roles which are assigned to them by traditional professional helpers. It is this encouragement of self-respect which is the most significant gain for self-help group members.

The other area where I expected to observe consistent differences between the three ideological categories of self-help/mutual aid groups is the nature of helping processes occurring during meetings. Indeed, although I found that there is a great amount of help-giving activities taking place in all groups, there are more expressive processes reported by conservative and combined group members than their radical counterparts. Furthermore, a detailed examination of the particular processes assessed in the study is enlightening in relation to these differences. Thus, conservative and combined group participants describe a

therapeutic-oriented atmosphere where more processes like sharing of feelings and self-disclosure, personal goal setting and catharsis are emphasised whereas confrontational processes like punishment are avoided. On the other hand, radical group members show their group's socially active character by reporting more group goal setting than the other two ideological types.

These results about helping processes suggest possible mechanisms through which the different group types promote and achieve change. Where personal change is the primary focus, expression and sharing of experiential knowledge serves as a vehicle for learning and subsequent behavioural change, in accordance with the explanations offered by the social learning theory (Borkman 1976; Bandura 1982). Expressive processes which are frequently reported by conservative and combined group members can lead to mechanisms like cognitive restructuring and vicarious learning which are considered as important by social learning theorists for altering coping behaviour. On the other hand, the emphasis of radical group members in the setting of group goals may indicate the significance of the group to the re-formation of their social identity. Belonging to this group and working towards the success of the common goals may give radical group members a 'new' identity, which they are proud of. This 'new' positive social identity leads to self-empowerment and confidence (Brown 1988).

The final point where we can detect important differences between the three ideological group types is the relationship of group identification with the other two important variables of the study, empowerment and helping activities. These associations are of special value as they provide us with indications of possible influences shaping the identity of a self-help group member. Looking at the relationship of group identification with empowerment in the particular group types we observe interestingly that there are different elements of empowerment associated with the identification process. In combined groups, identification is associated with overall personal empowerment and optimism whilst in conservative groups there is a relationship of identification with feelings of righteous anger. Although these intriguing relations are not repeated in the same statistical strength at the Second Phase of the study, they indicate however that there may be specific aspects of personal empowerment connected with the particular socio-political identity of these two group categories. There is one consistent relationship of group identification observed at the same statistical significance in radical groups at both times of the study. It is the association of identification with feelings of actual power.

Examining these connections under the prism of the social identity theory (which is the theoretical basis of the examination of group identification in the present study), we can

suggest some possible explanations for this differentiation between the groups. The choice to join a self-help group is a voluntary one and, as I have argued previously, shows the person's willingness to take some control over the problem/condition/issue he/she faces by self-activation and mutual helping. So, the person who joins such a group lends a positive value to this decision and this group affiliation contributes to a positive self-concept. On the other hand, personal empowerment is a complex concept that refers to an evolving process of self-evaluation, as I have also discussed earlier. The 'new' identity as a self-help group member adopted by people who experience mental health problems is very empowering and this was confirmed in the general findings of the study discussed previously. The variations of this relationship observed in the different group types suggest that group membership affects members' empowerment in a different way.

Thus, in the case of the personal-change oriented (conservative) groups, the expression of anger about injustices that happen in their lives is the empowerment element associated with the identification process. This may be so because, although oriented towards individual change, members of these groups nonetheless face the same social stigma and prejudice as all people with mental health problems. Being with their peers who have similar experiences helps them to release these feelings of oppression. And, as Chamberlin (1997) explains characteristically, "*clients need opportunities to learn about anger, to express it safely and to recognise its limits*" (p.45). This realisation and expression of anger, a crucial factor for members' individual empowerment, may be the basis where the new social identity as a conservative self-help group member is formed and sustained. Furthermore, in the case of combined groups, their dual character may be a possible explanation for the connection of identification with overall personal empowerment and optimism. Indeed, the combination of activities for personal and social change can lead to a holistic sense of empowerment and being identified with such a group where both changes can be achieved helps members to feel more optimistic about their future. Finally, the persistent association of identification with perceptions of actual power in radical groups is in agreement with the political ideology of this group type. Their community activism contributes to an enhanced sense of actual power because they see things happening in their close or wider social environment as a result of their efforts (e.g. specific improvements in the delivery of local mental health services or successful completion of an undertaken project). These perceptions of actual power consolidate people's social identity as members of a radical self-help/mutual aid group.

Group identification appears also to be positively related to a specific type of helping processes, the supportive ones, in combined groups and negatively related to confrontational processes in conservative groups. Again, although these associations are not repeated

through time, they give us an insight into the elements that could bring members of different group types closer to their group. These findings suggests that in a combined self-help group the identification process is facilitated by the frequency of supportive activities occurring during meetings whereas the formation of an identity as a conservative self-help group member is prompted by the existence of a non-threatening safe environment. Therefore, although similar helping process may occur in these group types, the emphasis may be given in different group processes.

In order to explore in more detail the above relationships I looked at the different aspects of group identification and the possible connections with empowerment and helping processes. So, it was found that in radical groups it is the awareness of a group identity and the emotional significance attached to it that are connected with perceptions of actual power. On the other hand, in combined groups, supportive group processes were connected with members' awareness and evaluation of their group identity. In other words, there is a great complexity in the process of becoming socially identified as a self-help/mutual aid group member and more specifically of being identified with a particular ideological self-help group type. Thus, it is possible that the definition of such an identity is based on the actual power members perceive they have, as it happened in radical groups, or on the amount of support the group offers, as it was the case in combined groups. The relationships found in the present study are only an indication of possible directions in the exploration of the mechanisms involved. The thing that becomes apparent from the findings is that, as Brown (1988) illustrates in his analysis of group process, "*one of the first consequences of becoming a member of a group is a change in the way we see ourselves. Joining a group often requires us to redefine who we are.*" (p.20).

Changes through time

The longitudinal design of this study had a twofold purpose. First, to assess the effect of time on associations and differences observed in the First Phase of the study between the variables, either looking at the sample as a whole or comparing the three ideological group types. Secondly, to record possible changes in individual and group characteristics of members through time. I have already discussed the particular characteristics of self-help/mutual aid groups as well as relationships among these characteristics and their variation according to political ideology. I also commented on the consistencies of findings of the First and the Second Phase. At this point I turn my attention at the special group of members who participated at both times of the study. An overall observation is that my hypothesis about the stability through time of psychosocial attributes of self-help group members as well as group processes and beneficial outcomes was confirmed by the findings.

Also, differences between ideological group types remain similarly stable through time, as I have predicted.

This sub-group of group members shares a similar demographic profile with the other two samples of the project. Ideological group types are also represented in the same proportions. Most of these members have a record of frequent and prolonged group participation. Also, it is interesting to note that apart from the significant difference between past and present use of mental health services by self-help group members, which I have already discussed, reported present contact with professionals has decreased significantly over the intervening period of twelve months between the two phases of the study. This finding is a further indication that self-help group participation may be an important source of support for people who experience mental health problems and in that respect it may facilitate people to cope thus they become less dependent on professional help.

Individual and group characteristics of members remain stable through time. Thus, in spite of their limited psychosocial resources, self-help group members remain quite empowered, report a large amount of helping processes occurring during meetings and feel identified with their group. It is important to remember that these members had been involved with the group a long time before the Time 1 observations. It is possible that increases in benefits from group participation would be most evident in the first few years of membership. When a member becomes a regular long-term participant, differences in outcomes over time would be less expected. Thus, one hypothesis we could make about the lack of change during time is that effects from group participation tend to remain stable and do not increase over time in long-term group participants. The other possibility, which does not contradict the first one, is that benefits from self-help group membership such as high levels of personal empowerment do not diminish with the passage of time.

Length of membership remains a critical factor for variations in levels of group identification, social networks and social support, especially a specific type of support, social companionship. Hence, at both times of the study long-term members report large social networks, receive more social support and especially social companionship, and become more identified with the group than their short-term counterparts. These findings confirm the observation made earlier that prolonged self-help group participation is beneficial for members.

The distinctive characters of the three ideological group types appear to be quite stable over a period of time, as we do not see any changes in the differences observed between groups. Specifically, radical group members report consistently higher scores in overall empowerment in comparison with the conservative group members. Also, conservative

group members repeatedly report less confrontation than combined ones and more support than radical ones. Likewise, there are stable significant differences in the specific help-giving activities reported by the three ideological group types. Conservative group members favour self-disclosure and avoid punishment in comparison with their radical counterparts. On the other hand, radical group members report more group goal setting than the conservative ones. The stability of characteristics of the ideological group types suggests that these respondents are "culture carriers" for their groups, namely there is a specific profile for each ideological type. Thus, radical group members can be distinguished from the conservative counterparts in terms of personal empowerment and group cohesiveness. On the other hand, conservative groups emphasise the importance of support and safety, thus being distinctively different from the radical ones. The pursuit of both goals, personal and social change, may be a significant reason for the unclear picture of the combined self-help/mutual aid groups.

Finally, although we observe once more associations of group identification with empowerment and its components as well as with helping group processes, these relationships do not show the same statistical strength at both times of measurement. Nonetheless, there is a consistent negative relationship of group identification with confrontational group processes. Also, in combined groups group identification is repeatedly connected with righteous anger and in radical groups there is a stable association of group identification with feelings of actual power.

In conclusion, we found that there are no significant changes in members' individual characteristics as well as self-help/mutual aid group processes over the period of twelve months. Instead, group processes and outcomes as well as variations between groups in terms of political ideology appear to be stable during time. This endurance may be attributed to the fact that these groups, unlike others, are driven by a concrete view about their group and their expectations from it as well as contributions to it, as I commented earlier. In other words, members know exactly what they want from the group and what they can offer to it and these strong opinions may reflect on the stability of mechanisms and outcomes.

Further research and Recommendations

Findings of the present study make an original contribution to the advancement of knowledge about this naturally occurring phenomenon and its influence in the mental health area. These results provide a much-needed background and call for further investigations in the field. Specifically, this experience shows that, in order to record systematically and comprehensively the multifaceted elements of self-help groups, there is need for a combination of methodologies. Future research could have as a focus the construction of

customised quantitative tools, like scales designed especially to measure self-help group variables and based on members' input and collaboration (e.g. Rogers et al. constructed scale of empowerment). It would also be valuable to conduct large-scale studies testing the typology of political ideology and focus of change in order to validate these findings in a representative population.

Moreover, the observations about cultural differences in the way that political ideology of self-help groups is manifested show the need for cross-cultural comparisons world wide, and especially in Europe where there is a dearth of research on self help and mutual aid in mental health. In addition, the existence of a vast number of self-help groups which vary in structure and ideology, poses another imperative research goal. In future projects, there is need to include different types of groups and assess them in a holistic manner. In this project, I followed one way of group categorisation which proved to be consistent and comprehensive. I believe there is still space for improvement of this typology through a further refinement and specification of its categories. Notwithstanding these suggestions, the foremost element of any future research projects concerning self-help/mutual aid groups is for researchers to share control over the study with group members by either collaborating closely with them in the process or assisting them to conduct their own projects in order to explore issues that are meaningful to participants.

Of course, apart from further research which is crucial for our deeper understanding of self-help and mutual aid, findings of the study give rise to recommendations for professionals, policy-makers and people involved in self-help/mutual aid groups. The obvious implication of the finding that political ideology can be a distinctive characteristic in order to explore these groups is that they are socio-political entities rather than another form of therapy. This approach could have a profound effect on the attitudes of mental health professionals.

First of all, professionals should be more aware and better informed about self-help/mutual aid groups in order to incorporate this knowledge in their everyday practice. Groups are a living proof that people who experience mental health problems wish to be actively involved in their own recovery, they value experiential knowledge and peer support and they have specific views on the focus of desired change. Thus, self-help groups constitute a valuable learning field for professional education and there is need for a close co-operation with self-help/mutual aid organisations. This relationship should be characterised by equality and give new professionals the chance to be educated by self-help/mutual aid group members. An example of such collaboration could be that self-help group members take part in the training of professionals, giving them the opportunity to present their perspective and needs to future therapists and thus enriching their skills. This could also have practical benefits for groups in

the sense that payment for teaching would present a regular source of funding, something which is a common problem for many groups.

Another form of collaboration could be the dissemination to their clients and colleagues of information about local and national self-help organisations and groups by mental health professionals. This could prove to be a great boost for the existing network of welfare services which are inadequate at present to cope with the growing demands of people experiencing mental health problems. The presence of self-help groups in the mental health area contributes to the support systems available to service users and fills the gaps of professional helping. So, instead of being antagonistic to self-help groups, professionals should be more open, recognise their beneficial effects for their clients and establish a mutual working relation with them in order to improve the mental health of the community.

The role of self-help/mutual aid groups in the mental health area should be acknowledged also by social policy makers. The findings suggest that prolonged participation proves to be beneficial for people's mental wellbeing and that self-help group members make a lesser use of mental health services. Although these are initial observations that have to be explored in more depth, they are none the less indications of the potential that these groups have in order to efficiently support their members. However, relevant literature (Lieberman and Snowden 1993) shows that one of the main reasons that self-help groups are short-lived is the lack of consistent and long-term funding and practical support. It is thus evident that the provision of better resources and funding of the existing self-help organisations and local groups could reinforce the social welfare system in the long run by building up grassroots natural support networks. This should not be at the expense of groups' autonomy and peer-led character. Instead, policy makers should be aware of the sensitive nature of these groups and make an effort to support them without controlling them.

Another action that policy makers need to take in order to promote self help and mutual aid is to encourage the birth of new organisations and groups by promoting knowledge about them within the health and social services, informing professionals and service users alike. It has been argued by people involved in self-help and mutual aid that a close connection with the established public welfare domain would be destructive. The fact that the vast majority of self-help group members participating in this research were also continuing to use the existing services shows that these groups may have a complimentary role in the area of mental health and their co-existence with the services can prove mutually beneficial.

Finally and most importantly, the findings have implications for people who participate in mental health self-help/mutual aid groups. The significance of political ideology in the categorisation of groups and its effects in member characteristics and group outcomes is also

useful knowledge in the promotion of these groups' work. Specifically, the emphasis on personal or societal change or both could be used for the promotion of groups' work in order to attract new members and inform the larger community. In this case, findings about the effects of such an ideology would help prospective participants to decide which type of self-help/mutual aid group is more suitable for them. On the other hand, the finding that beneficial outcomes are associated with long-term participation would be an encouraging message for existing members. Moreover, the knowledge that people who experience mental health problems and participate in self-help/mutual aid group are more empowered than others who do not take part in such groups, verifies their beneficial character and confronts people's scepticism against them.

A pressing need that emerged from this research is that, for the development and continuation of self-help/mutual aid groups, it is important that groups acknowledge their variety by starting to collaborate with each other. This becomes more important if we consider the fact that in England there exists no central point of information about these groups. There is no agency like the North-American clearinghouses which are sustained by governmental funding (Wollert 1987; Meissen and Warren 1993). It is therefore up to the groups themselves to form an alliance and make an effort to raise public awareness about them. This task would help to clarify misunderstandings that confuse and avert people with mental health problems from joining self-help groups but more significantly it would allow people to access information which is difficult to be found via the existing services.

Conclusively, self-help/mutual aid groups in the mental health area constitute an interesting challenge for both professionals and people who experience mental distress. As the contemporary welfare state of most Western countries is in a critical phase and the consequences of this crisis are experienced in our everyday lives, it is more imperative than ever to look for alternative routes. Grassroots responses in the form of self help and mutual aid activities flag new ways to cope with personal and social issues, a new era for societal organisation. It is maybe time to remember the old Greek saying: "Συν Αθηνά *και χείρα κίνει*", that expert care and self-activation are both necessary and interdependent conditions for the preservation of our wellbeing. Understanding of the socio-political and psychological attributes of self-help/mutual aid groups will lead to the realisation of their true potential. This study produced encouraging results about the role of groups' political ideology in the manifestation of particular beneficial outcomes for their members. Future research should be focused on plausible causal explanations of those relationships.

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APPENDIX A

- Letter of information about the research project
- Interview of group leader/facilitator/chairperson
- Questionnaire of the study

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RESEARCH ON SELF-HELP/MUTUAL AID GROUPS IN MENTAL HEALTH

During the last years, there is a growing number of users' groups in mental health area, usually known as self-help groups, advocacy groups, users' forums, or else. These groups can vary a lot in their profile, their way of functioning, their aims and influence, and their activities. Members of these groups may be interested in the treatment of specific mental health problems, or in the social consequences of having mental health problems, or in improving mental health services. Thus, users' groups may act in various ways at an individual or collective level. Limited studies of these groups confirm that they can offer a lot of help to service users and, generally, to the improvement of mental health services.

As this area, although very promising, is still largely unexplored, this research project aims to study the various types of users' groups in UK, and especially in Kent area. Specifically, my interest as a researcher is to explore more thoroughly the different kinds of groups, their structure and ways of functioning, their aims and outcomes, their role in the mental health area. The main question is whether these groups are useful to people who have mental health problems, and if yes, in which ways they help people. Furthermore, if these groups have a place in the future of mental health and if they can contribute to the improvement of the services.

In order to be able to set up my research, I would like to discuss these issues with people who were or are involved in users' groups of any kind. My name is Eleni Hatzidimitriadou and you can contact me in the above address and phone number.

Thank you for your time.

GROUP LEADER INTERVIEW

INFORMATION ABOUT THE GROUP (organisational elements)

- **Longevity:**

1. How long has the group existed?

- **History:**

2. How did the group start?

- **Meetings:**

3. Where do the meetings take place? Have you always met in the same place? Why?

- **Practical responsibilities:**

4. Who is responsible for letting the members in?
5. What about arrangements for tea, coffee etc.?

- **Membership:**

6. Who can join the group? What are the requirements?
7. Who refers people to the group? (If applicable)
8. Is there a regular attendance? (any limits?)
9. How many members does the group have? Do you keep records of membership?

IDEOLOGY OF THE GROUP (aims, principles, affiliations - Emerick's typology)

- **Aims:**

1. What are the aims of the group?

- **Principles:**

2. What are the group's principles?
3. Attitudes towards ethnic minority people. Efforts of involvement?

- **Affiliations:**

4. How can someone find out about the group?
5. Does the group has any affiliations with other self-help groups or organisations?
6. Name other self-help organisations with which you have regular contacts.
7. Does the group has any affiliations with statutory services or mental health professionals?
8. How do you characterise your `evaluation of traditional psychiatry`?

Very positive ❑ *Positive* ❑ *Neutral* ❑ *Negative* ❑ *Very negative* ❑

9. Do you have any relationships with traditional mental health professionals (psychiatrists, psychologists, social workers)?

❑ *Never / Aware of each other*
❑ *Occasionally associate with them*
❑ *Some collaboration / Referrals to/from*
❑ *Extensive interaction*

STRUCTURE/OPERATION OF THE GROUP - LEADERSHIP

- **Functioning:**

18. How does the group function? (leader(s), rules, choice of discussion topics, ways of discussion, members' participation, difficult members, handling crisis during the meeting)?

- **Funding:**

19. How is the group financially supported?
20. Do the members have to pay for participation? If not, who is responsible for funding the group?

- **Type of leadership:**

21. How did you become involved with the group? When?
22. What is your role within the group? What are your responsibilities?

GROUPS IN MENTAL HEALTH

★Important information★

Hello!

Thank you for agreeing to take part in this study of groups for people with mental health problems. Surprisingly, not much is known about these groups. It would be useful to know who goes and why. Also how these groups work and what kind of help people can get from them.

In this questionnaire, there are questions about you and the group you have joined. Please answer as clearly as you can. The questionnaire should take you about 20-35 minutes to complete. Feel free to ask if anything is unclear. All information you give me is strictly confidential and anonymous. Remember that you can refuse to answer anything you feel uncomfortable with and to withdraw your consent at any time.

All questions are important so please try to fill them all in. Afterwards you can ask me anything you like about these questions and, of course, you can have access to any information concerning you.

I APPRECIATE YOUR VALUABLE HELP.
I THANK YOU VERY MUCH FOR YOUR CO-OPERATION.

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❀❀❀❀❀❀❀❀

ABOUT YOU

DATE:

Sex: ○ Male ○ Female

Date of Birth: ____ / _____ / _____
date month year

Educational Level: (Please tick ✓ a box)

❑ No formal qualifications
❑ GCSE / 'O' Levels
❑ 'A' Levels
❑ Degree (University/College)
❑ Professional qualifications (e.g. law, engineering)
❑ Other (please specify) _____

Marital status: (Please tick ✓ a box)

❑ Single / Never married
❑ Married/ With partner
❑ Divorced / Separated
❑ Widow / Widower

Ethnic origin: (Please tick ✓ a box)

❑ White
❑ Black/Caribbean
❑ Black/African
❑ Black/Other (please specify) _____
❑ Indian
❑ Pakistani
❑ Bangladeshi
❑ Chinese
❑ Other (please specify) _____

Occupation:

Are you currently employed? ❑ YES ❑ NO

How you would classify your current or most recent job? (Please tick ✓ a box)
❑ Professional
❑ Managerial
❑ Clerical
❑ Skilled manual
❑ Semiskilled / Unskilled manual
❑ Other (please specify) _____

Contact with mental health services:

Have you ever seen any of the following? (Please tick ✓ as many as appropriate)

❑ Psychiatrist
❑ Psychiatric nurse (CPN)
❑ Counsellor / Psychotherapist
❑ Psychologist
❑ Social worker
❑ Other (please specify) _____

If YES, how old were you at your first contact with the services? _____

Are you now seeing any of the following? (Please tick ✓ as many as appropriate)

❑ Psychiatrist
❑ Psychiatric nurse (CPN)
❑ Counsellor / Psychotherapist
❑ Psychologist
❑ Social worker
❑ Other (please specify) _____

Have you ever been admitted to a psychiatric unit? ❑ YES ❑ NO
If YES, how many times? _____

Was it under a section of "Mental Health Act"? ❑ YES ❑ NO
If YES, how many times have you been "sectioned"? _____

MAKING DECISIONS

Below are several statements relating to one's perspective on life and with having to make decisions. Please tick (✓) the answer that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

PLEASE ANSWER ALL QUESTIONS
BY TICKING THE ANSWER THAT BEST DESCRIBES HOW YOU FEEL
PLEASE TICK ONLY ONE

1. I can usually determine what will happen in my life.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

2. People are only limited by what they think is possible.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

3. People have more power if they join together as a group.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

4. Getting angry about something never helps.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

5. I have a positive attitude toward myself.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

6. I am usually confident about the decisions I make.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

7. People have no right to get angry just because they don't like something.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

8. Most of the misfortunes in my life were due to bad luck.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

9. I see myself as a capable person.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

10. "Making waves" never gets you anywhere.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

11. People working together can have an effect on their community.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

12. I am often able to overcome barriers.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

13. I am generally optimistic about the future.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

14. When I make plans, I am almost certain to make them work.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

15. Getting angry about something is often the first step toward changing it.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

16. Usually I feel alone.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

17. Experts are in the best position to decide what people should do or learn.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

18. I am able to do things as well as most other people.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

19. I generally accomplish what I set out to do.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

20. People should try to live their lives the way they want to.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

21. You can't fight the council or the government.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

22. I feel powerless most of the time.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

23. When I am unsure about something, I usually go along with the rest of the group.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

24. I feel I am a person of worth, at least on an equal basis with others.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

25. People have the right to make their own decisions, even if they are bad ones.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

26. I feel I have a number of good qualities.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

27. Very often a problem can be solved by taking action.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

28. Working with others in my community can help to change things for the better.

❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

RELATIONSHIPS - PART 1

Below there are questions concerning your relationships with relatives and friends. Please read each question and tick (✓) the answer that is closest to how things are.

1. How many relatives do you see or hear from at least once a month? (NOTE: Include in-laws with relatives)

- ❑ zero
- ❑ one
- ❑ two
- ❑ three or four
- ❑ five to eight
- ❑ nine or more

2. Think about the relative with whom you have the most contact. How often do you see or hear from that person?

- ❑ more than monthly
- ❑ monthly
- ❑ a few times a month
- ❑ weekly
- ❑ a few times a week
- ❑ daily

3. How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help?

- ❑ zero
- ❑ one
- ❑ two
- ❑ three or four
- ❑ five to eight
- ❑ nine or more

4. Do you have any close friends? That is, do you have any friends with whom you feel at ease, can talk to about private matters, or can call for help? If so, how many?

- ❑ zero
- ❑ one
- ❑ two
- ❑ three or four
- ❑ five to eight
- ❑ nine or more

5. How many of these friends do you see or hear from at least once a month?

- ❑ zero
- ❑ one
- ❑ two
- ❑ three or four
- ❑ five to eight
- ❑ nine or more

6. Think about the friend with whom you have the most contact. How often do you see or hear from that person?

- ❑ more than monthly
- ❑ monthly
- ❑ a few times a month
- ❑ weekly
- ❑ a few times a week
- ❑ daily

7. When you have an important decision to make, do you have someone you can talk to about it?

❑ Always ❑ Very often ❑ Often ❑ Sometimes ❑ Seldom ❑ Never

8. When other people you know have an important decision to make, do they talk to you about it?

❑ Always ❑ Very often ❑ Often ❑ Sometimes ❑ Seldom ❑ Never

9. Do you live alone or with other people? (NOTE: Include in-laws with relatives)

- ❑ Live with spouse/husband/wife/partner only
- ❑ Live with family (parents, siblings, offspring)
- ❑ Live with other relatives
- ❑ Live with friends
- ❑ Live with other unrelated individuals (e.g., paid help)
- ❑ Live alone

RELATIONSHIPS - PART 2

Below you will find questions about some of the ways that you feel that people have helped you or tried to make life more pleasant for you. Please read each one of them and tick (✓) the answer that shows how often these things happen to you.

1. Are people warm and affectionate towards you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

2. Are people friendly to you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

3. Do people sympathize with you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

4. Do people show their understanding for you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

5. Are people willing to lend you a friendly ear?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

6. Do people make you feel at ease?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

7. Do people give you a nudge in the right direction, as it were?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

8. Do people perk you up or cheer you up?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

9. Do people reassure you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

10. Do people tell you not to lose courage?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

11. Can you rely on other people?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

12. Do people drop in for a (pleasant) visit?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

13. Do people just call you up or just chat to you?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

14. Do you things like shopping, walking, going to the movies or sports, etc., together with other people?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

15. Do people ask you to join in?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

16. Do you go out for the day with other people just for the enjoyment of it?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

17. Do people help you to do odd jobs?

❑ Seldom or Never ❑ Now and then ❑ Regularly ❑ Often

18. Do people lend you small things like, for example, sugar or a screwdriver or something like that?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

19. Do people lend you small amounts of money?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

20. Do people give you information or advice?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

21. If necessary, do people help you if you call upon them to do so, unexpectedly?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

22. If necessary, do people lend you valuable things?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

23. If necessary, do people help you, for example, when you are sick, when you have transport problems or when you need them to accompany you somewhere?

❑	❑	❑	❑
Seldom or Never	Now and then	Regularly	Often

GENERAL WELL-BEING

Below there are statements about any medical complaints and your health in general OVER THE PAST FEW WEEKS. Please answer the questions on this page simply by circling the answer you think most nearly applies to you. Remember that you should refer to present and recent complaints, not those you had in the past.

HAVE YOU RECENTLY:

1. Been able to concentrate on whatever you're doing?

Better than usual	**Same as usual**	**Less than usual**	**Much less than usual**

2. Lost much sleep over worry?

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

3. Felt that you are playing a useful part in things?

More so than usual	**Same as usual**	**Less useful than usual**	**Much less useful**

4. Felt capable of making decisions about things?

More so than usual	**Same as usual**	**Less so than usual**	**Much less capable**

5. Felt constantly under strain?

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

6. Felt you couldn't overcome your difficulties?

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

7. Been able to enjoy your normal day-to-day activities?

More so than usual	**Same as usual**	**Less so than usual**	**Much less than usual**

8. Been able to face up to your problems?

More so than usual	**Same as usual**	**Less so than usual**	**Much less able**

9. Been feeling unhappy and depressed?

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

10. Been losing confidence in yourself?

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

11. Been thinking of yourself as a worthless person?

Not at all	No more than usual	Rather more than usual	Much more than usual

12. Been feeling reasonably happy, all things considered?

More so than usual	About same as usual	Less so than usual	Much less than usual

ABOUT YOUR GROUP

1. What is the name of your group?

_____

2. What kind of group would you say it is?

_____

3. How long have you been a member of this group?

_____

4. How many groups meetings have you attended?

All of them	Most of them	Only a few	Only one or two

5. Why did you join?

_____

7. What did you expect from the group?

_____

8. What do you think the group can offer to you?

_____

9. What can you offer to the group?

_____

10. Do you feel comfortable with the group and how it is progressing ?

Yes, always	Yes, most of the times	Not often	Never

Any comments?

_____

_____

11. Is the date/time/place of meeting satisfactory?

(Date) **YES** **NO**
(Time) **YES** **NO**
(Place) **YES** **NO**

12. Do you get sufficient chance to discuss issues important to you?

Yes, always	Yes, most of the times	Not often	Never

Any comments?

_____

_____

Below you will find statements about how you feel towards your group. Please tick (✓) the answer you find more appropriate for you.

1. I am a person who identifies with this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

2. I am a person who considers this group important.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

3. I am a person who makes excuses for belonging to this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

4. I am a person who feels held back by this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

5. I am a person who feels strong ties with this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

6. I am a person who criticises this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

7. I am a person who is glad to belong to this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

8. I am a person who sees myself as belonging to this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

9. I am a person who is annoyed to say I'm a member of this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

10. I am a person who tries to hide belonging to this group.

❑	❑	❑	❑	❑
Never	Seldom	Sometimes	Often	Very often

During a group meeting a lot of things might happen. In the following you will find descriptions of some of these things. Please indicate (by ticking ✓one of the boxes) HOW OFTEN they take place at your group meetings .

1. Group members suggest things another member might do to overcome a problem.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

2. Group members identify actions they believe another member should not take.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

3. Group members suggest how another member might act to handle a problem, and then ask the person to practice this behaviour in the presence of the group.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

4. The group applauds or rewards desirable behaviour.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

5. The group criticises or punishes members for undesirable behaviour.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

6. The group ignores undesirable behaviour.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

7. Group members explain how they would go about handling a problem brought up by another member, and demonstrate how they would react if they were faced with this person's problem.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

8. Group members disclose to other members experiences, fantasies, thoughts or emotions which are very personal and which they normally would not tell other people.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

9. Group members share everyday experiences, thoughts or feelings with other members.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

10. Group members challenge one another to explain themselves or account for their behaviour.

☐	☐	☐	☐	☐
Never	Rarely	Not sure	Sometimes	Frequently

11. When a group member brings up a personal problem, other members ask the person for additional information or explanation about this problem, but do so in a way which is not challenging.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

12. In order to clarify how a group member thinks or feels about something, other members put in other words what they believe the person has said.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

13. A group member asks other group members how he/she impresses them, and how they feel about him/her.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

14. Group members disclose their feelings and impressions about one another in "face to face" interactions.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

15. Members assure one another that they are capable of handling their problems.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

16. Members let other members know that they were justified in feeling or acting as they did in response to some situation.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

17. Members assure one another that they are worthwhile, valuable people.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

18. When a person expresses his/her emotions in the group, other group members let that person know that they understand and share his/her feelings.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

19. When a person describes his/her actions or emotions as somehow strange or abnormal, other group members assure him/her that his/her behaviour is normal.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

20. Group members reassure other members that their problems will be worked out positively.

Never	Rarely	Not sure	Sometimes	Frequently
☐	☐	☐	☐	☐

21. A group member sets his/her own goals, and checks the progress he/she makes towards these goals.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

22. Group members discuss goals they believe should be adopted by the group.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

23. The group has rules as to how members should feel, think and act. Members refer to these rules in group meetings.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

24. Members use the group to determine if their personal view of the world is accurate.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

25. Group members try to understand a problem by breaking it down and determining such things as what went on before the problem situation arose, how the person reacted, and what happened after the difficulty arose.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

26. When a group member describes a presently happening situation as similar to past situations, other members point out how these situations differ.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

27. Members provide explanation which help other group members to better understand themselves or their reaction to a situation.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

28. The group facilitates the release of emotions.

❒	❒	❒	❒	❒
Never	Rarely	Not sure	Sometimes	Frequently

RESPONDENT'S COMMENTS

NOW THAT YOU HAVE FINISHED COMPLETING THE QUESTIONNAIRES, I WOULD APPRECIATE IF YOU COMMENT ON THEM:

1. Did you find the questions easy to understand? **YES** **NO**
Why (explain)?

_____

_____

2. Did you find the questions easy to answer? **YES** **NO**
Why (explain)?

_____

_____

3. Do you think that these questions are appropriate for group members (that is relevant to their experiences)? **YES** **NO**
Why (explain)?

_____

_____

Is there anything else you want to comment about these questionnaires?

_____

_____

_____

_____

_____

_____

I HOPE THAT THE EXPERIENCE OF PARTICIPATING IN THIS STUDY WAS GOOD AND THAT YOU DIDN'T HAVE A HARD TIME DOING IT.
I LIKE TO THANK ALL OF YOU WHO KINDLY ENOUGH TOOK TIME TO COMPLETE THE QUESTIONNAIRE.
I BELIEVE THAT THE INFORMATION YOU GAVE IS VERY HELPFUL FOR THE BETTER UNDERSTANDING OF MENTAL HEALTH SERVICE USERS' MATTERS. I ALSO BELIEVE THAT THIS STUDY WILL CONTRIBUTE TO THE IMPROVEMENT OF THEIR LIVES.

THANK YOU FOR YOUR HELP

APPENDIX B

- List of attributes of Empowerment (Rogers et al. 1997)
- Summary definitions of Helping Processes (Wollert et al. 1982)

Attributes of Empowerment developed by an advisory board of leaders of the self-help movement:

- Having decision-making power
- Having access to information and resources
- Having a range of options from which to make choices (not just yes-no and either-or)
- Assertiveness
- A feeling that one can make a difference (being hopeful)
- Learning to think critically; unlearning the conditioning; seeing things differently. For example, learning to redefine what one can do, and learning to redefine one's relationships to institutionalised power
- Learning about and expressing anger
- Not feeling alone; feeling part of a group
- Understanding that a person has rights
- Effecting change in one's life and one's community
- Learning skills (for example, communication) that one defines as important
- Changing others' perceptions of one's competence and capacity to act
- Coming out of the closet
- Growth and change that is never-ending and self-initiated
- Increasing one's positive self-image and overcoming stigma

From: Rogers, Chamberlin, Langer-Ellison and Crean (1997) *A Consumer-Constructed Scale to Measure Empowerment among Users of Mental Health Services*, Psychiatric Services, 48(8), p.1043.

SUMMARY DEFINITIONS OF HELPING PROCESSES EVALUATED BY SELF-HELP GROUP MEMBERS

Type of process	Process name	Summary Definition
BEHAVIOR	1. Behavioral prescription	Group members suggest things another member might do to overcome a problem.
	2. Behavioral proscription	Group members identify actions they believe another member should not take.
	3. Behavioral rehearsal	Group members suggest how another member might act to handle a problem, and then ask the person to practice this behavior in the presence of the group.
	4. Positive reinforcement	The group applauds or rewards desirable behavior.
	5. Punishment	The group criticizes or punishes members for undesirable behavior.
	6. Extinction	The group ignores undesirable behavior.
	7. Modeling	Group members explain how they would go about handling a problem brought up by another member, and demonstrate how they would react if they were faced with this person's problem.
	21. Personal goal setting	A group member sets his own goals, and checks the progress he makes towards these goals.
EXPRESSION	8. Self-disclosure	Group members disclose to other members experiences, fantasies, thoughts or emotions which are very personal and which they normally would not tell other people.
	9. Sharing	Group members share everyday experiences, thoughts or feelings with other members.
	11. Encouragement of sharing	When a group member brings up a personal problem, other members ask the person for additional information or explanation about this problem, but do so in a way which is not challenging.
	12. Reflection	In order to clarify how a group member thinks or feels about something, other members put in other words what they believe the person has said.
	28. Catharsis	The group facilitates the release of emotions.
CONFRONT	10. Confrontation	Group members challenge one another to explain themselves or account for their behavior.
	13. Requesting	A group member asks other group members how he impresses them, and how they feel about him.
	14. Offering feedback	Group members disclose their feelings and impressions about one another in "face to face" interactions.
SUPPORT	15. Reassurance of competence	Members assure one another that they are capable of handling their problems.
	16. Justification	Members let other members know that they were justified in feeling or acting as they did in response to some situation.
	17. Mutual affirmation	Members assure one another that they are worthwhile, valuable people.
	18. Empathy	When a person expresses his emotions in the group, other group members let that person know that they understand and share his feelings.
	19. Normalization	When a person describes his actions or emotions as somehow strange or abnormal, other group members assure him that his behavior is normal.
	20. Instillation of hope	Group members reassure other members that their problems will be worked out positively.

GROUP COHESIVENESS	22. Group goal setting	Group members discuss goals they believe should be adopted by the group.
	23. Assertion of group norms	The group has rules as to how members should feel, think and act. Members refer to these rules in group meetings
	24. Consensual validation	Members use the group to determine if their personal view of the world is accurate.
INSIGHT	25. Functional analysis	Group members try to understand a problem by breaking it down and determining such things as what went on before the problem situation arose, how the person reacted, and what happened after the difficulty arose.
	26. Discrimination training	When a group member describes a presently happening situation as similar to past situations, other members point out how these situations differ.
	27. Explanation	Members provide explanation which help other group members to better understand themselves or their reaction to a situation.

**5-point scale:
1=an inaccurate description (this process Never occurs, is not something the group emphasizes, and is a misleading characterization of the group), and
5=a very accurate description (this process occurs frequently, is something which the group emphasizes, and gives a good idea of what the group is like)

From: Wollert R.W., Levy L.H. and Knight B.G. (1982). *Help-giving in behavioral control and stress coping self-help groups.* Small Group Behavior, **13(2)**, pp. 204-218.

APPENDIX C

- Additional Tables of results from Chapter Four

Table 1: Mean scores (and standard deviations) of Empowerment and its sub-factors by length of membership

Table 2: Mean scores (and standard deviations) of Helping Group Processes and its sub-factors by length of membership

Table 3: Mean scores (and standard deviations) of Social Support Questionnaire for Transactions and its sub-factors by length of membership

Table 4: Correlation of aspects of group identification with helping group processes and their sub-scales

Table 5: Correlation of aspects of group identification with empowerment and its sub-scales

Table 1: Mean scores (and standard deviations) of Empowerment and its sub-factors by length of membership

	Short-term members (N=28)	Long-term members (N=39)
Empowerment	2.76 (.28)	2.83 (.23)
Sub-scales		
Optimism	**2.49 (.49)***	**2.70 (.39)***
Power	2.59 (.30)	2.69 (.38)
Self-esteem	2.70 (.38)	2.81(.34)
Community Activism	3.19 (.37)	3.19 (.31)
Righteous Anger	2.79 (.42)	2.64 (.53)

* Means difference significant at $p<.05$ (t-test)

Table 2: Mean scores (and standard deviations) of Helping Group Processes and its sub-factors by length of membership

	Short-term members (N=29)	Long-term members (N=39)
Helping Group Processes	3.23 (.64)	3.23 (.46)
Sub-scales		
Behaviour	2.93 (.68)	2.74 (.62)
Expression	3.74 (.77)	3.77 (.71)
Support	3.87 (.93)	4.07 (.64)
Group Cohesiveness	2.48 (.88)	2.61 (.81)
Confrontation	2.47 (1.00)	2.36 (1.07)
Insight	3.38 (.84)	3.52 (.98)

Table 3: Mean scores (and standard deviations) of Social Support Questionnaire for Transactions and its sub-factors by length of membership

	Short-term members (N=26)	Long-term members (N=30)
Social Support	2.12 (.48)	2.27 (.46)
Type of support		
Daily Practical	1.74 (.46)	1.72 (.43)
Problem-oriented Practical	1.92 (.55)	1.89 (.60)
Daily Emotional	2.51 (.56)	2.72 (.63)
Problem-oriented Emotional	2.26 (.60)	2.40 (.62)
Social Companionship	**2.01 (.59)***	**2.32 (.57)***

* Means difference significant at p<.05 (t-test)

Table 4: Correlation of aspects of group identification with helping group processes and their sub-scales

	Group identification		
	Awareness	Evaluation	Affect
Helping Processes	**.33****	.02	.15
Sub-scales			
Behaviour-oriented	.18	.07	.02
Expressive	**.28***	.09	.18
Supportive	**.43****	.16	**.37****
Group cohesiveness	.18	.11	.04
Confrontational	-.01	-.12	**-.25***
Insight-oriented	.18	.01	.17

*p<.05, **p<.01

Table 5: Correlation of aspects of group identification with empowerment and its sub-scales

	Group identification		
	Awareness	Evaluation	Affect
Empowerment	**.30***	**.29***	**.30***
Sub-scales			
Optimism	**.21†**	**.23†**	**.20†**
Power	**.22†**	**.22†**	**.27***
Self-esteem	.16	**.23†**	.15
Community Activism	**.35****	**.21†**	**.30***
Righteous Anger	.06	.03	.06

†p<.10, *p<.05, **p<.01

APPENDIX D

- Additional tables of results from Chapter Five

Table 1: Mean scores (and standard deviations) of Empowerment and its sub-factors by length of membership

Table 2: Mean scores (and standard deviations) of Helping Group Processes and its sub-factors by length of membership

Table 3: Mean scores (and standard deviations) of Social Support Questionnaire for Transactions and its sub-factors by length of membership

Table 4: Correlation of empowerment with social support and its sub-scales by type of group

Table 5: Correlation of aspects of group identification with helping group processes and their sub-scales

Table 6: Correlation of aspects of group identification with empowerment and its sub-scales

Table 1: Mean scores (and standard deviations) of Empowerment and its sub-factors by length of membership

	Short-term members (N=26)	Long-term members (N=30)
Empowerment	2.77 (.33)	2.90 (.34)
Sub-scales		
Optimism	2.55 (.53)†	2.81 (.51)†
Power	2.62 (.43)	2.74 (.44)
Self-esteem	2.66 (.55)†	2.90 (.42)†
Community Activism	3.27 (.36)	3.29 (.37)
Righteous Anger	2.69 (.62)	2.62 (.52)

† Means difference significant at p<.07 (t-test)

Table 2: Mean scores (and standard deviations) of Helping Group Processes and its sub-factors by length of membership

	Short-term members (N=26)	Long-term members (N=30)
Helping Group Processes	3.34 (.31)	3.24 (.66)
Sub-scales		
Behaviour	2.93 (.50)	2.91 (.74)
Expression	4.15 (.38)†	3.74 (.78)†
Support	4.11 (.61)	3.97 (.72)
Group Cohesiveness	2.63 (.56)††	2.87 (.49)††
Confrontation	2.22 (.74)	2.45 (1.14)
Insight	3.51 (.75)	3.32 (.98)

† Means difference significant at p<.08 (Mann-Whitney U test)
†† Means difference significant at p<.09 (t-test)

Table 3: Mean scores (and standard deviations) of Social Support Questionnaire for Transactions and its sub-factors by length of membership

	Short-term members (N=26)	Long-term members (N=30)
Social Support	2.17 (.58)†	2.38 (.50)†
Type of support		
Daily Practical	1.92 (.57)	1.92 (.59)
Problem-oriented Practical	1.93 (.74)	2.09 (.65)
Daily Emotional	2.43 (.65)†	2.75 (.62)†
Problem-oriented Emotional	2.33 (.80)	2.51 (.68)
Social Companionship	2.04 (.69)*	2.41 (.62)*

† Means difference significant at p<.06 (t-test)
* Means difference significant at p<.05 (t-test)

Table 4: Correlation of empowerment with social support and its sub-scales by type of group

	Total sample	Type of group		
		Conservative	Combined	Radical
Social support	.21†	.14	.49*	.18
Type of support				
Daily Practical	.30*	.37†	.54**	.38
Problem-oriented Practical	.19	.16	.39	.11
Daily Emotional	.23†	.25	.30	.18
Problem-oriented Emotional	-.04	-.06	.32	.49
Social Companionship	.28*	.02	.51*	.43

†p<.10, *p<.05, **p<.01

Table 5: Correlation of aspects of group identification with helping group processes and their sub-scales

	Group identification		
	Awareness	Evaluation	Affect
Helping Processes	.07	.04	.01
Sub-scales			
Behaviour-oriented	.01	.01	.09
Expressive	.06	.01	.03
Supportive	.23†	.08	.21†
Group cohesiveness	.31*	.06	.29*
Confrontational	-.19	-.07	-.21†
Insight-oriented	.13	.07	.08

†p<.10, *p<.05, **p<.01

Table 6: Correlation of aspects of group identification with empowerment and its sub-scales

	Group identification		
	Awareness	Evaluation	Affect
Empowerment	.33*	.04	.22†
Sub-scales			
Optimism	.18	.05	.01
Power	.26*	.02	.24†
Self-esteem	.27*	.03	.14
Community Activism	.17	.11	.16
Righteous Anger	.25†	.07	.24†

†p<.10, *p<.05, **p<.01

APPENDIX E

- Additional tables of results from Chapter Six

Table 1: Correlations of empowerment with psychosocial characteristics by type of group for both times of measurement

Table 2: Family Network by type of group and time

Table 3: Friends Network by type of group and time

Table 4: Confiding Relationships by type of group and time

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Table 6: Correlation of mental wellbeing with helping processes and their sub-scales by type of group for both times of measurement

Table 7: Correlation of mental wellbeing with empowerment and its sub-scales by type of group for both times of measurement

Table 8: Mean scores of helping processes reported most frequently by type of group and time

Table 9: Mean scores of helping processes reported less frequently by type of group and time

Table 10: Correlation of group identification with helping group processes and their sub-scales by type of group for both times of measurement

Table 11: Correlation of group identification with empowerment and their sub-scales by type of group for both times of measurement

Table 1: Correlations of empowerment with psychosocial characteristics by type of group for both times of measurement

	Total sample		Type of group					
			Conservative		Combined		Radical	
	T1	T2	T1	T2	T1	T2	T1	T2
Mental Wellbeing	-.24	**-.53***	-.50	**-.70†**	**-.75†**	-.24	-.14	-.48
Social Networks	.19	.11	.45	**.59†**	.52	.30	.49	**.70†**
Social Support	.01	.06	**.57†**	.48	**.75†**	.38	.01	.22

†p<.10, *p<.05

Table 2: Family Network by type of group and time

		Total sample	Type of group		
			Conservative	Combined	Radical
Number of family members in contact monthly					
None	T1	1 (5.9%)	1 (14.3%)	-	-
	T2	-	-	-	-
One	T1	2 (11.8%)	1 (14.3%)	-	1 (20%)
	T2	5 (29.4%)	2 (28.6%)	2 (40%)	1 (20%)
Two	T1	2 (11.8%)	-	1 (20%)	1 (20%)
	T2	4 (23.4%)	1 (14.3%)	2 (40%)	1 (20%)
Three or four	T1	9 (52.9%)	4 (57.1%)	4 (80%)	1 (20%)
	T2	5 (29.4%)	2 (28.6%)	1 (20%)	2 (40%)
Five to eight	T1	2 (11.8%)	1 (14.3%)	-	1 (20%)
	T2	1 (5.9%)	1 (14.3%)	-	-
Nine or more	T1	1 (5.9%)	-	-	1 (20%)
	T2	2 (11.8%)	1 (14.3%)	-	1 (20%)
Frequency of contact per month					-
More than monthly	T1	1 (5.9%)	-	-	1 (20%)
	T2	1 (5.9%)	1 (14.3%)	-	-
Monthly	T1	1 (5.9%)	-	-	1 (20%)
	T2	3 (17.6%)	1 (14.3%)	2 (40%)	-
A few times a month	T1	4 (23.5%)	2 (28.6%)	2 (40%)	-
	T2	2 (11.8%)	1 (14.3%)	-	1 (20%)
Weekly	T1	3 (17.6%)	1 (14.3%)	2 (40%)	-
	T2	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
A few times a week	T1	3 (17.6%)	1 (14.3%)	-	2 (40%)
	T2	2 (11.8%)	1 (14.3%)	-	1 (20%)
Daily	T1	5 (29.4%)	3 (42.9%)	1 (20%)	1 (20%)
	T2	6 (35.3%)	2 (28.6%)	2 (40%)	2 (40%)
Number of family members feel close					
None	T1	3 (17.6%)	2 (28.6%)	1 (20%)	-
	T2	3 (17.6%)	2 (28.6%)	1 (20%)	-
One	T1	6 (35.3%)	3 (42.9%)	1 (20%)	2 (40%)
	T2	6 (35.3%)	4 (57.2%)	1 (20%)	1 (20%)

Two	T1	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
	T2	4 (23.5%)	1 (14.3%)	1 (20%)	2 (40%)
Three or four	T1	4 (23.5%)	1 (14.3%)	1 (20%)	2 (40%)
	T2	3 (17.6%)	-	1 (20%)	2 (40%)
Five to eight	T1	1 (5.9%)	-	1 (20%)	-
	T2	1 (5.9%)	-	1 (20%)	-

Table 3: Friends Network by type of group and time

		Total sample	Type of group		
			Conservative	Combined	Radical
Number of close friends					
None	T1	2 (11.8%)	2 (28.6%)	-	-
	T2	1 (5.9%)	1 (14.3%)	-	-
One	T1	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
	T2	3 (17.6%)	3 (42.9%)	-	-
Two	T1	4 (23.5%)	1 (14.3%)	1 (20%)	2 (40%)
	T2	6 (35.3%)	1 (14.3%)	1 (20%)	4 (80%)
Three or four	T1	6 (35.3%)	2 (28.6%)	2 (40%)	2 (40%)
	T2	6 (35.3%)	2 (28.6%)	4 (80%)	-
Five to eight	T1	2 (11.8%)	1 (14.3%)	1 (20%)	-
	T2	1 (5.9%)	-	-	1 (20%)
Number of friends in contact per month					
None	T1	1 (5.9%)	1 (14.3%)	-	-
	T2	1 (5.9%)	1 (14.3%)	-	-
One	T1	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
	T2	3 (17.6%)	3 (42.9%)	-	-
Two	T1	5 (29.4%)	1 (14.3%)	2 (40%)	2 (40%)
	T2	5 (29.4%)	-	1 (20%)	4 (80%)
Three or four	T1	7 (41.2%)	3 (42.9%)	2 (40%)	2 (40%)
	T2	6 (35.3%)	2 (28.6%)	3 (60%)	1 (20%)
Five to eight	T1	1 (5.9%)	1 (14.3%)	-	-
	T2	-	-	-	-
Nine or more	T1	-	-	-	-
	T2	2 (11.8%)	1 (14.3%)	1 (20%)	-
Frequency of contacts per month					
More than monthly	T1	-	-	-	-
	T2	2 (11.8%)	1 (14.3%)	1 (20%)	-
Monthly	T1	3 (17.6%)	2 (28.6%)	-	1 (20%)
	T2	-	-	-	-
A few times a month	T1	4 (23.5%)	2 (28.6%)	-	2 (40%)
	T2	4 (23.5%)	3 (42.9%)	-	1 (20%)
Weekly	T1	3 (17.6%)	2 (28.6%)	-	1 (20%)
	T2	5 (29.4%)	2 (28.6%)	2 (40%)	1 (20%)
A few times a week	T1	3 (17.6%)	1 (14.3%)	2 (40%)	-
	T2	3 (17.6%)	-	2 (40%)	1 (20%)
Daily	T1	4 (23.5%)	-	3 (60%)	1 (20%)
	T2	3 (17.6%)	1 (14.3%)	-	2 (40%)

Table 4: Confiding Relationships by type of group and time

		Total sample	Type of group		
			Conservative	Combined	Radical
Having someone to discuss with important decisions					
Seldom	T1	2 (11.8%)	1 (14.3%)	-	1 (20%)
	T2	1 (5.9%)	1 (14.3%)	-	-
Sometimes	T1	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
	T2	4 (23.5%)	3 (42.9%)	1 (20%)	-
Very often	T1	6 (35.3%)	2 (28.6%)	4 (80%)	-
	T2	3 (17.6%)	1 (14.3%)	2 (40%)	-
Always	T1	6 (35.3%)	3 (42.9%)	-	3 (60%)
	T2	9 (52.9%)	2 (28.6%)	2 (40%)	5 (100%)
Others will discuss with you important decisions					
Never	T1	1 (5.9%)	1 (14.3%)	-	-
	T2	-	-	-	-
Seldom	T1	2 (11.8%)	1 (14.3%)	1 (20%)	-
	T2	2 (11.8%)	2 (28.6%)	-	-
Sometimes	T1	4 (23.5%)	2 (28.6%)	-	2 (40%)
	T2	7 (41.2%)	3 (42.9%)	2 (40%)	2 (40%)
Often	T1	3 (17.6%)	-	1 (20%)	2 (40%)
	T2	3 (17.6%)	1 (14.3%)	1 (20%)	1 (20%)
Very often	T1	5 (29.4%)	2 (28.6%)	2 (40%)	1 (20%)
	T2	4 (23.5%)	1 (14.3%)	1 (20%)	2 (40%)
Always	T1	2 (11.8%)	1 (14.3%)	1 (20%)	-
	T2	1 (5.9%)	-	1 (20%)	-

Table 5: Living arrangements by type of group and time

		Total sample	Type of group		
			Conservative	Combined	Radical
Live alone	T1	5 (29.4%)	1 (14.3%)	2 (40%)	2 (40%)
	T2	6 (35.3%)	1 (14.3%)	2 (40%)	3 (60%)
Live with friends	T1	1 (5.9%)	-	1 (20%)	-
	T2	-	-	-	-
Live with family	T1	6 (35.3%)	3 (42.9%)	1 (20%)	2 (40%)
	T2	7 (41.2%)	3 (42.9%)	2 (40%)	2 (40%)
Live with spouse/partner	T1	5 (29.4%)	3 (42.9%)	1 (20%)	1 (20%)
	T2	4 (23.5%)	3 (42.9%)	1 (20%)	-

Table 6: Correlation of mental wellbeing with helping processes and their sub-scales by type of group for both times of measurement

		Wellbeing			
			Type of group		
		Total sample	Conservative	Combined	Radical
Helping Processes	T1	**-.52***	-.58	-.62	**-.95***
	T2	-.35	.08	**-.87***	-.08
Sub-scales					
Behaviour-oriented	T1	**-.54***	-.51	-.67	**-.95***
	T2	.01	-.19	**-.87***	-.10
Expressive	T1	**-.42†**	-.28	-.45	**-.93***
	T2	.20	-.09	**-.80†**	-.33
Supportive	T1	**-.47***	-.38	-.45	**-.86***
	T2	**-.47***	-.44	**-.81†**	-.36
Group cohesiveness	T1	-.24	.09	-.69	-.73
	T2	**-.59***	**-.86***	-.47	**-.80†**
Confrontational	T1	.18	-.16	-.66	-.71
	T2	.10	-.53	-.43	**-.79†**
Insight-oriented	T1	**-.42†**	**-.67†**	-.26	**-.90***
	T2	.12	-.04	**-.76†**	-.21

†p<.10, *p<.05

Table 7: Correlation of mental wellbeing with empowerment and its sub-scales by type of group for both times of measurement

		Wellbeing			
			Type of group		
		Total sample	Conservative	Combined	Radical
Empowerment	T1	-.24	-.50	**-.75†**	-.14
	T2	**-.53***	**-.70†**	-.24	-.48
Sub-scales					
Optimism	T1	-.18	-.39	-.45	-.13
	T2	**-.39†**	-.30	**-.78†**	-.25
Power	T1	**-.37†**	-.37	-.62	**-.93***
	T2	**-.78****	**-.77***	-.59	**-.91***
Self-esteem	T1	-.14	-.37	-.63	-.29
	T2	**-.66****	**-.89****	-.27	-.23
Community Activism	T1	-.13	-.42	-.30	-.32
	T2	-.23	-.29	.44	-.63
Righteous Anger	T1	-.08	-.48	-.49	-.71
	T2	-.03	**-.66†**	-.12	-.69

†p<.10, *p<.05, **p<.01

Table 8: Mean scores of helping processes reported most frequently by type of group and time

HELPING PROCESSES REPORTED MOST FREQUENTLY✦								
PROCESSES	Total sample		Type of group					
			Conservative		Combined		Radical	
	T1	T2	T1	T2	T1	T2	T1	T2
Behavioural prescription	4.18	3.82	4.43	3.29	3.60	4.20	4.40	4.20
Behavioural proscription	3.29	3.41	3.29	-	3.20	4.20	3.40	3.40
Positive reinforcement	3.19	3.47	-	3.00	3.65	4.20	3.80	3.40
Modelling	-	3.06	-	3.00	-	3.40	-	-
Self-disclosure	4.10	3.65	4.57*	4.14**	4.15	4.20	3.40*	-
Sharing	**4.51**	**4.71**	**4.86**	**4.86**	**4.55**	**4.80**	**4.00**	**4.40**
Confrontation	-	-	-	-	3.75	3.00	-	-
Encouragement of sharing	3.57	3.35	3.00	-	3.95	4.40	4.00	3.40
Reflection	3.57	3.00	3.00	-	3.95	3.60	4.00	-
Reassurance of competence	3.96	3.65	3.86	3.57	4.05	3.80	4.00	3.60
Justification	3.91	3.82	3.86	4.00	4.30	4.00	3.60	3.40
Mutual affirmation	**4.40**	**4.47**	**4.14**	**4.86**	**4.75**	**4.40**	**4.40**	**4.00**
Empathy	**4.40**	**4.35**	**4.43**	**4.71**	**4.55**	**4.40**	**4.20**	3.80
Normalisation	3.56	3.47	3.71	4.14	3.90	3.60	3.00	-
Instillation of hope	**4.15**	**4.06**	**4.00**	**4.29**	**4.10**	**4.20**	**4.40**	3.60
Personal goal setting	3.25	3.23	3.43	3.43	-	3.60	3.40	-
Group goal setting	3.37	3.29	-	-	3.25	3.40	4.80[1]	4.00[2]
Consensual validation	-	3.18	-	3.43	3.40	3.40	-	-
Functional analysis	3.59	3.12	3.43	2.86	3.60	3.40	3.80	3.20
Extinction	-	-	3.29	3.71	-	-	-	-
Punishment	-	-	-	-	-	-	-	3.20[3]
Discrimination training	3.16	3.12	-	3.29	3.95	-	3.60	3.20
Explanation	3.71	3.94	3.86	4.57	3.80	3.80	3.40	3.20
Catharsis	3.62	3.76	3.57	4.14	3.90	3.40	3.40	3.60

✦ Means ≥ 3.00 (processes occurring sometimes/frequently)

* Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T1

** Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2

[1] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T1

[2] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2

[3] Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2

Table 9: Mean scores of helping processes reported less frequently by type of group and time

HELPING PROCESSES REPORTED LESS FREQUENTLY✦								
	Total sample		Type of group					
			Conservative		Combined		Radical	
PROCESSES	T1	T2	T1	T2	T1	T2	T1	T2
Behavioural rehearsal	**1.76**	**1.88**	**1.14**	**1.71**	2.20	2.40	2.20	**1.60**
Punishment	**2.00**	**2.00**	**1.14***	**1.00³**	2.40	2.20	2.80*	-
Behavioural proscription	-	-	-	2.86	-	-	-	-
Extinction	2.69	2.82	-	-	1.75	1.60	2.80	2.80
Encouragement of sharing	-	-	-	2.57	-	-	-	-
Self-disclosure	-	-	-	-	-	-	-	2.40**
Reflection	-	-	-	2.71	-	-	-	2.80
Normalisation	-	-	-	-	-	-	-	2.40
Positive reinforcement	-	-	2.43	-	-	-	-	-
Modelling	2.73	-	2.86	-	2.90	-	2.40	2.80
Confrontation	2.69	2.00	2.00	1.29	-	-	2.60	2.00
Requesting	2.40	1.82	2.00	1.57	2.95	2.40	2.40	1.60
Offering feedback	1.93	2.65	1.57	1.43	2.75	4.00	1.60	3.00
Personal goal setting	-	-	-	-	2.85	-	-	2.60
Group goal setting	-	-	2.43¹	2.71²	-	-	-	-
Assertion of group norm	**1.65**	**1.59**	**1.71**	**1.57**	**1.20**	**2.00**	**2.00**	**1.20**
Consensual validation	2.47	-	2.14	-	-	-	2.00	2.60
Discrimination training	-	-	2.29	-	-	2.80	-	-

✦ Means >3.00 (processes occurring rarely/never)
* Means difference significant at 05 level (Tukey test) – Conserv-Rad T1
** Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2
¹ Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T1
² Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2
³ Means difference significant at .05 level (Tukey HSD test) – Conserv-Rad T2

Table 10: Correlation of group identification with helping group processes and their sub-scales by type of group for both times of measurement

		Total sample	Type of group		
			Conservative	Combined	Radical
Helping Processes	T1	.33	.36	.09	**.83†**
	T2	.17	.02	.26	.12
Sub-scales					
Behaviour-oriented	T1	.13	.34	.06	**.75†**
	T2	.23	-.01	.38	.09
Confrontational	T1	**-.58***	**-.67†**	-.28	-.59
	T2	**-.53***	-.11	-.04	-.63
Expressive	T1	**.41†**	-.15	.06	**.96****
	T2	.02	.17	.32	.27
Group cohesiveness	T1	.28	.15	.55	.58
	T2	.10	-.45	**.90***	.55
Insight-oriented	T1	.34	.12	.13	.63
	T2	.02	.11	.15	.01

Supportive	T1	.11	.78*	.29	.85†
	T2	.04	.08	.25	.06

†p<.10, *p<.05, **p<.01

Table 11: Correlation of group identification with empowerment and their sub-scales by type of group for both times of measurement

		Total sample	Type of group		
			Conservative	Combined	Radical
Empowerment	T1	.09	.04	.19	.45
	T2	.04	.16	.71†	.05
Sub-scales					
Optimism	T1	.07	.72†	.39	.37
	T2	.15	.31	.49	.42
Power	T1	.24	.81*	.08	.76†
	T2	.30	.38	.53	.76†
Self-esteem	T1	.22	.18	.05	.54
	T2	.25	.33	.66	.50
Community Activism	T1	.15	.77*	.39	.60
	T2	.31	.14	.01	.67
Righteous Anger	T1	.30	.45	.71†	.66
	T2	.43†	.19	.71†	.38

†p<.10, *p<.05, **p<.01

APPENDIX F

- Example of Feedback Report to Participating Self-Help/Mutual Aid Groups

RESULTS FROM RESEARCH ON SELF-HELP GROUPS

MENTAL HEALTH SERVICE USERS (SWOF) FOLKESTONE

A GENERAL NOTE

Researchers have suggested that self-help/mutual aid groups can be categorised in different types according to the focus of change they are trying to achieve and their attitudes towards their common problem, e.g. mental health difficulties. So, it is suggested that groups can have an individual or a social change orientation or they may try to achieve both individual and social change.

Groups which focus on individual (personal) change, discuss mainly issues about coping with the common problem/condition/issue of members and do not get involved in social activities or be concerned with wider social issues. Members in these groups are more interested in finding ways to achieve personal change.

Groups which focus on social change, are mainly concerned with the wider social circumstances of their common problem/condition/issue and members believe that they can solve their problem by achieving social change.

Groups which combine both ways of change, personal and social, are interested in personal change but are also involved in social activities.

After participating in a number of your group meetings and studying your written stated aims and history, I have concluded that this group belongs to the social change category. Below, I give you a brief feedback of the findings of the research which refer to your group.

(SPRING 1997 - SPRING 1998)

- MEMBERS WHO RESPONDED:
  - Four people.
  - All of them were unemployed. After a year, one of the members got a job.

- Most of them had more than 3 years experience with the mental health services.

- ATTENDANCE:
  - Members were attending most of group meetings
  - They thought that the date, place and time of meetings are satisfactory, felt comfortable with the group and how it was progressing and they were able to discuss issues important to them.
- ABOUT THEMSELVES:
  - Members were feeling quite empowered, optimistic about the future, self-confident, and community-active.
  - They were feeling psychologically well and reported a high level of social support.
- ABOUT THE GROUP:
  - They expected to find "understanding, help, friendship" and to "grow, be better organised, change the local mental health system for the better".
  - They thought that the group can offer: "mutual support, confidence to speak with a group of people, friendship, knowledge about current events in mental health, and a link with mental health services after discharge".
  - They believed that they could offer to the group: "experience, be there for others, loyalty and being reliable".
  - They were highly identified with their group.
  - They reported a lot of helping-giving activities occurring in their group meetings, that is they felt that they were helping and been helped a lot during meetings.

After a comparison of your group and others like yours with the other two types of self-help/mutual aid groups, I found that social change group members feel more empowered than the other two group types due to their community activism. On the other hand, members in individual change groups describe more supportive and expressive activities taking place in their meetings. However, all self-help groups help their members to feel better and more empowered and it seems that these benefits are more evident in those members who participate for a longer period of time in a group.

I would like to thank all of you for your help and interest in my project. I hope that this brief report will be the start of discussions between your group and other interested parties like other self-help groups, researchers like myself and professionals in the mental health area.