Professional Psychology: Research and Practice
1992, Vol. 23, No. 6, 515-520

0735-7028/92/$3.00

A Comparison of Espoused Theories of Self- and Mutual Help: Implications for Mental Health Professionals

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Nonprofessional helping organizations, known as self- or mutual-help groups, are viewed as homogeneous, varying primarily in the problem addressed. However, there is great diversity in their methods, even among groups addressing similar problems, which has important implications for referring clinicians. Results of this study, which is a content analysis of the literature of 2 internationally known organizations for the mentally ill, suggest nonprofessional helping organizations are not homogeneous. Techniques of self-help based on authority, as opposed to mutual-help based on interpersonal and spiritual growth, characterize some of the differences. Groups also differ in problems addressed and help strategies offered. This study discusses the implications of these differences for mental health professionals.

In recent decades numerous nonprofessional, peer-run helping groups have organized for members to assist each other in coping with, confronting, or eradicating a common psychological or medical problem (Department of Health and Human Services Public Health Service, 1988; Gartner & Riessman, 1984; Katz & Bender, 1990; Powell, 1990). At present, nonprofessional groups, often generically referred to as "self-help groups," exist for almost every known health or mental health disorder. Jacobs and Goodman (1989) have defined self-help groups as those that "have a common problem, meet for the purpose of exchanging psychological support, charge minimal or no fees, and [are] essentially member-governed, even if the members use professional consultation" (p. 536). Many groups are local (i.e., unaffiliated with any national organization). Others, such as Alcoholics Anonymous, are part of a state, national, or even international organization. Using a variety of empirical sources, Jacobs and Goodman (1989) have estimated that the number of people currently in a self-help group rivals the number of psychotherapy clients, and they predict that not only will such groups continue to flourish in the foreseeable future, but they increasingly will be seen as legitimate and economical.

Because they are all primarily nonprofessional, these groups are frequently referred to as a homogeneous entity. Levy (1984) observed that nonprofessional groups vary on a number of dimensions, including their structure, manner of conducting meetings, the quality of their social interaction, and their longevity (see also, Maton, Leventhal, Madera, & Julien, 1989). Similarly, Killilea (1976) recognized the diversity of these groups in her request for research that would classify them along several pertinent parameters, including degree of cognitive or affective emphasis. To further illustrate the diversity among these groups, Levy (1984) noted that even within the same national organization there is significant variability in the manner in which local meetings are conducted.

Luke, Rappaport, and Seidman (1991), using observer-recorded behavioral observations, found that within the same organization a variety of group process differences could be found across individual groups. In addition to differing in a number of obvious ways, such as type of problems addressed or use of a standard program for the conduct of meetings, they also appear to differ on more subtle dimensions. Often the terms *self-help* and *mutual help* are used interchangeably to describe them, although it is possible to distinguish clear differences. In self-help, emphasis is placed on the members' own ability to use an expert's or program's advice that is offered in an easily accessible format (analogous to "do-it-yourself" programs). In mutual help, emphasis is placed on shared interpersonal support and interaction among members.

Significant heterogeneity among these nonprofessional groups could have important implications for clinicians. Jacobs and Goodman (1989) predict that professionals will have

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THIS RESEARCH WAS SUPPORTED in part by a grant from the National Institute of Mental Health (MH37390) to Julian Rappaport and Edward Seidman.

WE GRATEFULLY ACKNOWLEDGE the assistance of the undergraduate coders, Alberto Segre for his technical assistance, and three anonymous reviewers for their comments on a draft of this article.

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greater involvement with such groups. Referring clients, both while still in professional care and as a form of aftercare, is one of the important ways mental health professionals can assist their clientele (Department of Health and Human Services Public Health Service, 1988). Indeed, it is likely that increasing numbers of clients will ask mental health professionals to assist them in finding an appropriate group. Particularly for long-term mental patients, membership in a peer-run group can serve to provide some of the daily life supports that professionals do not have the time to offer (Salem, Seidman, & Rappaport, 1988). Given the heterogeneity, choosing an appropriate group for referral may require knowing more than the type of problem a group addresses or the target population they seek to attract. If differences among groups with similar emphases are significant, clinicians may also want to understand these differences to ensure a good match between clients' problems and groups' goals, as well as a match between the professional care and the group's methods. Although group heterogeneity generally has been observed (Levy, 1984), there has been little empirical study focused on comparing the methods of various organizations. Thus, the significance of the observed differences remains unclear. This question is salient for clinicians and is the focus of the present study.

Antze (1979) noted that a group's espoused theories (i.e., what they believe about their afflictions and the means by which they help) can be gleaned from a group's literature. This relatively easily accessed information is one method by which professionals can become better informed. Both Levy (1984) and Killilea (1976) have recommended textual analysis, comparable to that used in the analysis of literary criticism, to analyze what the group purports to be their emphases and goals. Extending their suggestions, a comparative textual analysis would enable the direct comparison of the emphases and goals of two or more nonprofessional groups. As a means to illustrate how mental patient groups run by nonprofessional peers can be understood through their written material, the literature of two well-known organizations, GROW and Recovery, Inc., were selected as examples of the many groups that have the common goal of helping people who have a history of psychiatric hospitalization for serious mental illness.

GROW was founded in Australia in 1957 by a group of recovering former mental hospital patients, among them a priest who became the organization's leader. The organization now has over 500 groups worldwide and an extensive written literature designed to help members cope with daily problems. Beyond its literature, written by the members themselves, it has two other program components: (a) weekly group meetings with a structured format and (b) what GROW refers to as the "sharing and caring community" (Rappaport et al., 1985).

Recovery, Inc., was founded in 1938 by the late Abraham Low, a psychiatrist. The program is published in a widely distributed text, *Mental Health Through Will Training* (Low, 1971). The organization reports some 800 groups worldwide (Barter & Berning, 1991). Recovery members meet weekly in a structured group format in which trained leaders provide the program's responses to members' problems. These trained leaders are typically members who have been in the program for a long time and have made significant progress. To discourage digression from the prescribed program, participant contact between meetings is restricted to one 10-min telephone call (for further details, see Weschler, 1960).

To examine and compare the espoused theories of GROW and Recovery, their respective literatures were content analyzed on six dimensions. The first three dimensions were chosen because of their obvious interest for clinicians wanting to ensure a good fit between the type of mental health problems addressed in the group and the client's difficulties. These dimensions include (a) type of problems discussed, (b) whether spirituality is an integral part of the program, and (c) whether the group focuses solely on problems or whether growth issues are also discussed. The next two dimensions are of interest to clinicians who refer clients to groups as an adjunct to treatment and want to determine whether different organizations are compatible with their own therapy techniques. These dimensions include (d) type of help given and (e) whether help is given in an authoritative or nonauthoritative manner. The final dimension, (f) memorizability, is an attempt to capture the ease with which the organization's advice is likely to be recalled by members. An a priori scanning of the literature indicated that some portion of it was written in an easy-to-remember form. Content analysis enabled an accurate assessment of this facet of the program.

Method

GROW and Recovery, Inc., Literature

The content of the two primary texts of GROW (*The Program of Growth to Maturity*, GROW, 1982, and *Readings for Mental Health*, Keogh, 1975) and the text for Recovery, Inc. (*Mental Health Through Will Training*, Low, 1971) were analyzed. These books, which are intended to be read by all members, contain the groups' philosophies and methodologies. In each book problems related to mental illness are described and suggestions of how to overcome these problems are made.

GROW's *The Program of Growth to Maturity* is a pocket-sized pamphlet of readings; the length of each varies from a single line to a few short paragraphs. This book, with a total of 84 excerpts and numerous one-line phrases, serves as a handy reference to the GROW philosophy during meetings and outside the group context. Many members attempt to memorize these short passages as a means of integrating the GROW philosophy into their lives and coping with daily life stresses. For example, the following excerpt, entitled "The Overall Key to Mental Health" is designed to help members keep a balanced perspective: "Settle for disorder in lesser things for the sake of order in greater things; and therefore be content to be discontent in many things" (GROW, 1982, p. 9). A second example is "Keep your temper. If you're in the right, you can afford to keep it. If you're in the wrong, you can't afford to lose it" (GROW, 1982, p. 45).

GROW's *Readings for Mental Health* (Keogh, 1975) contains 60 short pieces organized according to the program's "12 steps of personal growth." The 12 steps are similar to those of the Alcoholics Anonymous program. For each step there are five readings of three to four pages in length that are designed to help the GROW member reflect on important issues of that step. For example, group members working on the second step, "cooperating with help," are provided a reading that describes commonly adopted resistance attitudes that the client uses to sabotage a professional's help or to place barriers between the client and the helpgiver. Some of these attitudes include being silent or talking too much, admitting to needing help but saying "you're not the one to help me," saying "I don't care," twisting the meaning of helpers' advice, or giving a clever display of arguments. Those working on the

sixth step, "we endured until cured" are provided with a reading on why it takes time to recover. The following excerpt of this reading captures its general meaning: "All great changes in us take time. The greater the change, the longer it takes. Since we got sick over a long period, we cannot expect the reverse process to be instantaneous" (Keogh, 1975, p. 103).

Recovery, Inc.'s *Mental Health Through Will Training* is divided into four parts: (a) panel discussions with extensive quotations, (b) panel discussions with abbreviated quotations, (c) the principle methods of sabotage, and (d) group psychotherapy interviews. There are a total of 61 excerpts, three to four pages in length, in which problem behaviors are addressed through the Recovery philosophy.

After each of the panel discussions, which are scripts of group meetings, Dr. Low provides readers with his analysis of the problem and how the problem should have been handled. For example, in one of the panel discussions the group leader announces the topic of "indecisiveness." A group member describes an occasion when she was shopping for her daughter and had difficulty deciding between two pairs of socks. She describes her symptoms and how the symptoms subsided when her daughter resolved the problem by deciding for her. Other group members also present their examples of being indecisive. In Low's comments he notes that the woman cheated herself by allowing her daughter to decide for her. He discusses how easy it is for patients to allow others to assume their responsibility, but how relinquishing responsibility robs the person of self-esteem.

The second part of the Recovery text focuses on behaviors patients use to sabotage their mental health. Some of the topics discussed in this section include those that result from ignoring or discrediting initial improvement, disparaging the competence or method of the physician, challenging the physician's diagnosis, failing to recognize emotionalism and sentimentalism, and failing to exercise self-discipline (Low, 1971). The following excerpt from one of these readings illustrates failure to exercise self-discipline: "The patient says he suffers from fatigue. The fact is, however, that he thinks his muscles are exhausted and fears or neglects to use them for the purposes of walking or working. 'Fatigue' then thwarts proper muscular behavior" (Low, 1971, p. 304).

Coding System

The coding unit is defined as a single, complete excerpt that is structurally apparent and meaningful. This coding unit occurs naturally and contains a single message or lesson for the reader. Smaller coding units (e.g., sentences or words) would have been artificial and meaningless when presented to coders out of context.

Each excerpt was categorized separately on six dimensions: type of problems discussed, type of help given, problem versus growth focus, whether help was given in an authoritative versus nonauthoritative manner, memorizability of excerpt, and whether reference was made to some aspect of spirituality. The categories for each dimension were rationally generated. Specifically, type of problem and helping response categories were delineated on the basis of the content of the three texts and the problem and helping categories commonly discussed in the psychological literature. These general categories represent the major domains that might reasonably be expected to be addressed in psychiatric self- and mutual-help groups.

The problem categories include affective, behavioral, interpersonal, cognitive, sexual, general mental health or illness discussion, general professional mental health system discussions, the program itself, and spirituality. These categories are supplemented by a list of rationally generated subcategories. For example, depression, anxiety, anger, guilt, mania, anhedonia, and unhappiness are some of the subcategories listed under the general category of affective problems. The helping-responses categories include affective, interpersonal, cognitive, and behavioral strategies, as well as reassurance, recommendation of professional help, and appeal to spiritual help or the group program.

A third dimension on which excerpts were categorized is whether a problem or growth focus was taken. A *problem focus* is defined as a discussion of a specific problem, whereas a *growth focus* is represented by a discussion of enhancement issues, for example, a reading on how to be a good friend. Authoritative versus nonauthoritative manner, the fourth coding task, is defined by the manner in which the help is offered. An *authoritative* excerpt conveys the feeling of an expert talking to a layperson. *Nonauthoritative* help, in contrast, conveys equality or focuses on the issue.

The last two dimensions, amount of spiritual or religious reference and memorizability of an excerpt, were dichotomously coded (yes, no). Examples of a spiritual reference were listed to help coders decide whether the excerpt contained such a reference. Similarly, features of an easy-to-remember excerpt were delineated. The procedures for doing each of the six coding tasks as well as the list of categories, subcategories, their definitions, and extensive examples, are described in the coding manual.[1]

Coding Procedures

Coders. The coders were 10 undergraduates unfamiliar with GROW and Recovery literature. They were each assigned to one of two groups (A and B); each group was trained to do three of the six coding tasks. Group A coded excerpts with respect to type of problem, problem versus growth enhancement, and religious reference. Group B coded the excerpts according to helping response, authoritative versus nonauthoritative helping style, and memorizability of the excerpt. The rationale for training different coders to do specific tasks was to maximize independence of ratings.

Training. After studying the manual, the coders met with Lisa McFadden to review the procedures and practice the coding tasks. Coders were then tested on the definitions of the categories. Once they demonstrated familiarity and comprehension of the categories, the coders categorized practice excerpts. Excerpts from earlier editions of the GROW and Recovery literature, as well as the literature of similar groups, were used as practice material. For each task, an excerpt was placed into one mutually exclusive category. Coders' individual categorizations were compared with the established criterion, and instructive feedback was provided. The Kappa statistic, κ, was used to determine coder-criterion reliabilities (Cohen, 1960). During this training phase, all coders were required to reach $\kappa = .70$ on each categorization task.

After demonstrating familiarity and reliability with the coding system, each coder categorized four sets of excerpts from the most recent editions of the texts. These training excerpts were selected with a stratified sampling procedure. Each set comprised a mixture of GROW and Recovery excerpts. The purpose of this training phase was to ensure that the system worked on the actual excerpts. Each excerpt was categorized by five coders on each of the six categorization tasks. To determine reliability, each excerpt needed to be represented by only one code for each task. A consensus categorization was established when at least three of five coders agreed on the categorization of each excerpt on a particular task. When agreement was not reached by three of the five coders, the excerpt was considered uncodable for that particular task and was excluded from analysis. To determine the reliability of the consensus categorization, it was compared with Lisa McFadden's criterion judgment. Values of κ ranged from .66 to 1.00, with a median of .87.

Coding. Coders read and categorized the GROW and Recovery lit-

[1] The coding manual is available from Lisa McFadden on request.

erature.[2] Again, a consensus categorization was obtained for each excerpt on each task. Almost all excerpts were codable for memorizability, spiritual reference, and authoritative versus nonauthoritative helping. Approximately one fifth of the excerpts for type of problem and helping response were uncodable, but there was no significant difference in the percentage uncodable by organization. Problem versus growth focus were codable for approximately 90% of the GROW excerpts, whereas 100% of Recovery excerpts were codable.

The subsample of excerpts categorized immediately following training were categorized again during the course of categorizing all of the material. A comparison of the two categorizations of the same excerpts provides an index of coder drift. These test–retest reliabilities (κ: range = .64 to 1.00, *Mdn* = .90) indicate that coders continued to reliably use the categorization scheme.

Results

For each of the six dimensions, the categorizations of GROW and Recovery excerpts were compared. This comparison was accomplished using the G-square statistic, G^2, which is the log-linear equivalent of chi-square and is used with the analysis of categorical data (Feinberg, 1980). Like chi-square, G-square provides an overall index of the difference between two distributions and also orders the categories in terms of their contribution to an overall significant difference.

For the type of problems presented, the overall distribution of the GROW and Recovery literature, presented in Table 1, differed significantly, $G^2(8, N = 165) = 118.2$, $p < 01$. Recovery differs dramatically from GROW, with an almost exclusive emphasis on affective problems, such as depression and anxiety, and secondarily on professional–client mental health issues, such as use of medication. In contrast, the types of problems discussed in the GROW literature are more widely distributed, with high proportions being categorized as mental health/illness, interpersonal, and spiritually oriented problems. Both organizations have a similar and substantial emphasis on cognitive problems, such as psychotic thoughts, obsessions, and indecisiveness.

The distribution of helping responses between GROW and Recovery, presented in Table 2, also differed significantly, $G^2(8, N = 158) = 74.39$, $p < .01$. Both organizations emphasize cognitive coping techniques, and Recovery does so almost to the exclusion of everything else, with some attention to behavior change. In addition to cognitive coping strategies, GROW was distinguished by a higher proportion of excerpts categorized as advocating the use of the GROW program, spirituality, and interpersonal sources of help. A substantial proportion of the GROW excerpts offered no specific help strategy.

The results for problem versus growth focus again show a significant difference between the GROW and Recovery distributions, $G^2(2, N = 181) = 39.52$, $p < .01$. The Recovery literature is almost exclusively focused on presentations of problematic situations (98%). GROW distinguishes itself from Recovery by having 25% of its excerpts focused on encouraging individuals to strive to their fullest potential, without reference to any specific problem.

With regard to authoritative versus nonauthoritative helping style, the results indicate that in approximately half of the Recovery excerpts, help was judged to be given in an authoritative manner, whereas in over 96% of GROW excerpts, help was judged to be given in a nonauthoritative manner, $G^2(4, N = 187) = 141.2$, $p < .01$. A large proportion of the Recovery excerpts judged to be authoritative were those in which Dr. Low directly addresses the reader. Spirituality is an important dimension of the GROW literature. Of the GROW excerpts, 42.7% contained spiritual references, whereas no such references were made in the Recovery literature, $G^2(1, N = 203) = 80.25$, $p < .01$.

Table 1
Theme Categories (%) for GROW and Recovery, Inc., Literature

Themes	GROW	Recovery
Affective	9.6	60.0
Mental health/Illness	24.3	2.0
Interpersonal	21.7	4.0
Spirituality	16.5	0.0
Professional mental health	1.7	14.0
Program	4.3	0.0
Behavioral	3.5	0.0
Cognitive	16.5	20.0
Sexual	1.7	0.0

Note. Categories are listed in order of their overall contribution to G^2.

The results indicate that 23.2% of the GROW literature contains short, easily memorized excerpts that members can quickly call on to help them during difficult daily interactions. The Recovery literature does not contain such short excerpts but is written in short-story form, $G^2(1, N = 203) = 35.22$, $p < .01$.

Discussion

In the context of this study, GROW and Recovery represent two examples of well-established nonprofessional helping organizations for persons with a history of serious mental illness, often including psychiatric hospitalization. Both organizations are well known for the availability of their peer-led groups. If not informed, the professional community might assume that these two organizations are quite similar, given their common goal of helping the same types of people. As observed by Levy (1984), and empirically confirmed in this study, even two seemingly similar groups may have very different emphases and goals. These results illustrate that nonprofessional peer helping groups are not homogeneous entities. These two organizations, both focused on people with a history of serious emotional difficulties, were found to differ on all six dimensions of interest. Descriptively, the results indicate that Recovery, as repre-

[2] GROW and Recovery excerpts were presented in sequential order rather than randomly. Given this procedure, order effects could potentially explain the obtained differences. Coders may have unintentionally used Recovery excerpts as a reference point to make categorizations rather than using the criteria listed in the manual. To test this alternative explanation, the subsample of excerpts rated immediately following training, which were presented in a quasi-counterbalanced order and thus not subject to order effects, were compared with the ratings of the entire sample on each task. These comparisons revealed that order effects did not influence categorizations of Recovery material (G^2 ranged from .13 to .90, all *ns*).

Table 2
Helping Response Categories (%) in GROW and Recovery, Inc., Literature

Helping responses	GROW	Recovery
Spirituality	12.0	0.0
Program	10.2	0.0
Interpersonal change	9.3	0.0
Behavior change	3.7	12.0
Affective change	2.8	6.0
Cognitive change	40.0	78.0
Professional help	0.0	0.0
Reassurance	0.0	0.0
No help given	21.3	4.0

Note. Categories are listed in order of their overall contribution to G^2.

sented in its literature, focuses on helping people with affective-related problems through the use of cognitive-change techniques. The idea of a psychiatrist or mental health professional as the expert is reinforced, and spirituality or religion is not a part of the program. These emphases are closely aligned with traditional psychotherapeutic approaches in which problems are conceptualized and a focused range of coping techniques are prescribed by an expert. Given that Recovery was founded by a psychiatrist, it is not surprising to find close alignment with traditional therapeutic approaches.

GROW, in contrast, addresses a wider range of problems, including issues related to personal enhancement. Similarly, it advocates a wide range of methods of coping, including appealing to spirituality. The help given is delivered in an issue-focused, nonauthoritarian manner rather than by appeal to the authority of a professional as expert. GROW's grassroots history perhaps explains its somewhat broader, less traditional therapeutic focus.

Recovery and GROW differ as nonprofessional help organizations, not only in terms of the specific themes described above but also in terms of their interpretations of the process of help. Recovery appears to be a self-help program in the sense of individuals learning to practice what is prescribed to them by the psychiatrist who founded the organization (a top-down model of self-help). Their literature has put professional help techniques into layperson terms and a tightly structured program that can be "safely" used by nonprofessionals. GROW, in contrast, is a mutual-help program in the sense of people helping each other by sharing common experiences (Borkman, 1990). Two examples illustrate these differences. First, GROW emphasizes the importance of friendship among its members, whereas Recovery strictly limits interpersonal interaction between members to one 10-min telephone call each week. The rationale for limiting contact is that members need to adhere to the program because informal contacts might lead to digression from the structured program. Second, the Recovery group method is very structured, and individual input into the group process is limited. At meetings members carefully recite the Recovery literature. Although references are made to the literature in GROW's problem-solving process, individuals are also encouraged to use their own experiences as sources of help.

Knowledge of these differences may be helpful to clinicians, who are increasingly likely to be called on to advise both their clients and the general public concerning contact with such groups. These results regarding the diverse goals and emphases of the group cannot, however, provide a "cookbook" formula of how to enhance compatibility between client, group, and mental health professional. Rather, this information illustrates the more general point of a need to obtain information about such nonprofessional organizations, at least in terms of types of problems addressed and the range of helping behaviors used, before making referrals. Concretely, the fact that Recovery emphasizes affective-related problems and uses primarily cognitive-change techniques does not necessarily mean that all depressed people should be be referred to Recovery. Neither does it imply that cognitively oriented clinicians should refer all their clients who might benefit from self-help to this organization. Rather, the clinician would need to consider all the client's needs in terms of the information he or she has gathered regarding the appropriate organizations. For example, clients who require more authoritative structure may be more appropriately referred to Recovery. The needs of other clients, such as socially isolated individuals who need to build a supportive social network, may be better met by GROW. Similarly, the GROW organization may be more appropriate for people who feel comfortable with a spiritual as opposed to more exclusively cognitive orientation, whereas Recovery may make more sense for clients who already have a supportive social network.

In addition, if the clinician is still working with the client, he or she might want to consider the compatibility of his or her own helping techniques with that of the group. Thus, these findings do not imply specific recommendations regarding referrals as much as they highlight the need for mental health professionals to become aware of nonprofessional group heterogeneity. This study also illustrates some dimensions that professionals might want to consider in evaluating groups (i.e., types of problems addressed and types of help given). However, there may be other dimensions that are personally relevant to individual clinicians.

The heterogeneity in emphases and goals found in this study is probably not limited to these two organizations. Rather than blindly referring on the basis of the problem addressed by the nonprofessional group, or on the basis of general reputation, clinicians might want to make an effort to get to know local groups. One effective way to do so would be to carefully read the local groups' literature. Visiting these groups and talking to their leaders and members can also be an invaluable source of information. Given the likelihood of continued growth and use of such organizations, professionals may want to consider gathering such information to be a part of their continuing education. It may even be advisable to invite self- and mutual-help group leaders to conduct workshops and information exchanges with professional agencies and groups.

The results of this study also have implications for the members of nonprofessional groups. Given their diversity, such organizations might be encouraged by local mental health associations to disseminate information about their own emphases and goals to local clinicians, either by mailing out their literature or by presenting their program at professional meetings. These organizations are typically not in the business of advertising; rather, their central purpose is reaching others in need of

their help. To this end, disseminating information about their group would be helpful.

In summary, nonprofessional helping groups are not homogeneous entities whose emphases can be readily understood simply by noting the type of problem addressed. As seen in this study, even organizations that help individuals who have a history of previous hospitalization may have very different emphases that should be taken into account by professionals who wish to make sensible use of the services offered by such groups.

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Received December 6, 1990
Revision received May 11, 1992
Accepted May 11, 1992 ■

Acknowledgment of Ad Hoc Reviewers, 1992

Albert A. Agresti
Philip Ash
Janet W. Borden
M. Michele Burnette
Joan C. Chrisler
Kathleen Chwalisz
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Mary F. Ruzicka
Daniel Sanders
Lawrence Schneider
Lynn Singer
Dan Somberg
Howard Carlton Stevenson
Garnett S. Stokes
Timothy C. Thomason
Derek Truscott
Georgiana Shick Tryon
Leon D. VandeCreek
C. Edward Watkins, Jr.
Martha M. Woods
Luis H. Zayas