

SERVICE PROVIDERS' VIEWS OF PSYCHIATRIC MUTUAL SUPPORT GROUPS

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Despite evidence that mutual support groups can be beneficial for those with serious mental illnesses, professionals have been reluctant to utilize this resource. We surveyed over 400 providers across several disciplines and settings within the state of Connecticut's public mental health system to assess their attitudes and practices regarding the use of mutual support groups for their patients. We found that being a rehabilitation worker and possessing more advanced training, greater numbers of years in their setting and discipline, and personal experience with psychiatric disorders or mutual support were associated with more favorable attitudes and behaviors toward mutual support. In addition, traditional 12-step groups (e.g., Alcoholics Anonymous) were viewed more favorably than psychiatric mutual support groups. Implications for educational efforts about the benefits of mutual support for those with serious mental illnesses are discussed. © 2002 Wiley Periodicals, Inc.

It has been shown that mutual support groups can be helpful for those with serious mental illnesses. Given the central role in their patients' lives, the attitudes and behaviors of mental health service providers are key factors determining whether those with serious mental illnesses make use of these groups. In this article, we provide a brief background of mutual support for those with psychiatric disorders and then

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present the findings of our own study. In the study, we examine the attitudes and behaviors of mental health providers in a state-wide system toward psychiatric mutual support groups to learn ways to design educational strategies to increase the utilization of these groups.

BACKGROUND

What Is Mutual Support and How Is It Helpful?

Mutual support refers to people who have similar problems in living providing assistance to one another in the context of a reciprocal relationship. This phenomenon is increasingly gaining acceptance as a helpful intervention across a variety of behavioral and physical health issues. For example, in 1997, about 7% of adults in the United States participated in some sort of mutual support group within the past year and 18% had participated in mutual support within their lifetime (Kessler, Michelson, & Zhao, 1997). Nationwide, there are more than 800 mutual support organizations addressing most social problems and health issues (McGinnis & Foege, 1993; White & Madara, 1998). In the state of Connecticut alone, there are more than 1,250 mutual support groups addressing a variety of concerns ranging from bereavement, health, mental health, social issues, and advocacy (Connecticut Self-Help Network, 2000).

Unlike naturally occurring social support, mutual support is an intentional process that includes regular procedures, routines, and prescriptions for addressing problems and issues of everyday life (Levine & Perkins, 1987; Levy, 2000). The "prescription" is simple and standardized: each group meeting, participants present their problems and the other members empathize and give suggestions based on their own experiences with similar problems. This process is thought to provide new information and perspectives, training, skills, and exposure to successful role models, while allowing for vicarious learning, modeling, and an enhancement of problem-solving skills (Gartner & Reissman, 1982; Kaufmann, Freund & Wilson, 1989; Kurtz, 1990; Kurtz & Powell, 1987; Levy, 1976; Rootes & Aanes, 1992; Stewart, 1990).

A primary example of mutual support has been the mutual support group. The group format often involves anywhere from 5–20 persons coming together on a regular basis to share their experiences and help each other cope with the stated problem. Although these groups may be organized in different formats, in this paper we focus on the types of groups that meet Levy's (1976, 1978) five criteria of mutual support groups. These groups (1) are organized for the sole purpose of helping its participants (*purpose*); (2) are created by the members (*origin*); (3) utilize the members primarily for the assistance offered in the group (*source of help*); (4) are made of people who share a common problem in living (*composition*); and (5) are controlled and governed by the members (*control*). Mutual support groups can be affiliated with national or international organizations (e.g., Alcoholics Anonymous, Take Pounds Off Sensibly) or they can be locally organized around a common problem. Research has shown that these groups can be helpful for individuals with a wide variety of disorders (e.g., Trojan, 1989).

Relevance of Mutual Support for Those with Serious Psychiatric Disabilities

Along with the expansion of mutual support for a range of behavioral and physical health issues, there has been a proliferation of mutual support groups for those with

serious psychiatric disabilities. Groups such as Recovery, Inc., Schizophrenics Anonymous, and GROW are international mutual support organizations that have hundreds of groups operating across the world for individuals with psychiatric disabilities. There also are groups for people with psychiatric disabilities that are created and maintained locally, through mental health centers or psychosocial clubhouses. Similar to other mutual support groups, these local groups involve persons with psychiatric disabilities meeting on a regular basis to discuss a wide range of issues including how they are coping with their disorders, symptoms, medications, interpersonal issues, stigma, social relationships, and employment.

These groups grew out of the mental health consumer movement, which, consistent with the mutual support agenda, emphasizes consumer self-help, empowerment, and advocacy (Chamberlin, 1990). Although the roots of the consumer movement can be traced back to the early 20th century, the formal organization of consumer advocacy groups began in the early 1970s. Psychiatric mutual support groups that were initially developed and led by mental health professionals, such as Recovery, Inc., began transforming into a self-help format in the early 1950s. Through this movement, mental health consumers have become more influential over the years in all aspects of planning, providing, and evaluating mental health services (Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999). Underlying all of these efforts is the mutual support philosophy: that consumers are able to help themselves and each other to achieve better outcomes in their treatment and in their lives.

Although more work is needed, research on the utility of mutual support groups for those with serious psychiatric disabilities such as schizophrenia or bipolar disorder is encouraging. Specifically, participation in mutual support groups is related to lower hospitalization rates and fewer days spent in the hospital (Galanter, 1988; Kennedy, 1989; Rappaport, 1993), less substance use and more positive social functioning (Moos, Schaefer, Andrassy, & Moos, 2001), reduced symptomatology (Levine and Perkins, 1987), and enhanced social networks (Rappaport et al., 1985; Carpinello, Knight, & Janis, 1991; van Uchelen, 1989).

12-Step Groups as a Specific Type of Mutual Support

Specific mention should be made of 12-step groups as a specific type of mutual support. These groups such as Alcoholics Anonymous and Narcotics Anonymous have a detailed prescriptive philosophy that members are encouraged to adopt and use in their everyday lives as a means of addressing their difficulties. In addition to utilizing the members for support (as stated in Levy's third criteria above), members of AA, for instance, use the 12-step process to achieve sobriety. Many psychiatric mutual support groups that are not based on the 12-step model do not possess as prescriptive of a philosophy. Both types of groups, however, share all of the other characteristics of mutual support groups described above.

Compared to psychiatric mutual support groups not based on the 12-step approach, the 12-step model is older and appears to be more established and more prevalent. For example, AA has grown tremendously in the last 60 years, from about 100 members in 1940, to 476,000 members in 1980, to 653,000 members in 1983, and to 979,000 members in 1990 (General Services Organization, 1980, 1983; Room & Greenfield, 1993). The 12-step model, especially for substance abuse, has become increasingly integrated into professional treatment. A survey in 1979 showed that about 40% of men and 60% of women who reported having received any assistance for alcohol-

ism had gone to AA, while these figures grew to 60% for men and 80% for women in 1990 (Weisner, Greenfield, & Room, 1995). According to the authors of this report: "There . . . appears to be more of an overlap between use of AA and treatment agencies than in the past. It is becoming rare to find people in the formal treatment system who do not also have some experience with AA" (Weisner, Greenfield, & Room, 1995).

Interface with Professional Treatment System

Although the essence of mutual support groups is that they consist of persons who share similar problems in living, they often are dependent on professionals for referrals of new members. Given the utility of mutual support for those with serious psychiatric disabilities, and with behavioral healthcare dollars becoming more tightly controlled, mutual support offers extra services that can complement professional treatment without much additional cost. For example, integrating mutual support groups into treatment regimens has shown advantages over using professional treatment alone in smoking cessation (Jason, Gruder, Martino, Flay, Warnecke, & Thomas, 1987), parenting of premature infants (Minde, Shosenberg, Marton, Thompson, Ripley, & Burns, 1980), and preventing and reducing hospitalization among recently discharged psychiatric inpatients (Gordon, Edmunson, Bedell, & Goldstein, 1979). To take full advantage of this collaboration, linkages between mutual support and professional treatment should be better understood and, as a result, better coordinated.

Problems with the Interface

As mentioned above, linkages between substance abuse 12-step groups and the professional substance treatment community are well developed and clear. The 12-step approach has been in existence for many years, is well accepted as a compliment to professional substance abuse treatment, and has even been used as a model for the development of many professional-led interventions (e.g., substance abuse residential treatment facilities that sponsor their own AA and NA groups that residents are required to attend).

The relationship between psychiatric mutual support groups and the professional mental health treatment system is less developed. Despite the potential benefits, research has shown consistently that few professionals refer their clients to mutual support groups. For example, of individuals who were attending Recovery Inc. groups, professional referral rates have been found to range from 2 to 39% (Galanter, 1990; Grosz, 1973; Lee, 1993; Raiff, 1978). In a study of almost 750 mental health administrators, less than half made frequent or occasional referrals to psychiatric mutual support groups (Levy, 1978). In another study of over 900 mental health professionals, Salzer, Rappaport, and Serge (2001) found that over a third never referred clients to mutual support groups, and over half referred only occasionally. It appears that most mutual support participants learn about groups through being a patient in a setting that has active mutual support groups or through family, friends, or other persons with similar psychiatric disorders.

There may be several reasons for the low rate of referrals to these groups among mental health professionals. For instance, the lack of referrals to psychiatric mutual support groups by professionals may be due to limited knowledge of available groups

(Black & Drachman, 1985; Kurtz, Mann, & Chambon, 1987). It also may reflect attitudes that mutual support is not useful or even damaging. For example, Chesler (1990) found that professionals (e.g., 63 nurses, social workers, and physicians) who work with mutual support groups made up of parents of cancer patients believed that mutual support was a danger to both the parents (e.g., increased risk of creating emotional problems, spreading misinformation, and learning too much so that parents would act like professionals), and professionals (e.g., parents may challenge authority, take over professionals' job, switch doctors, question professional judgment, or make emotional attacks). Salzer, McFadden, and Rappaport (1994) found that among different mental health professionals in community mental health centers, state hospitals and private psychiatric hospitals, professionally led groups were seen as more helpful than mutual support groups, regardless of setting or type of profession.

These findings support the idea of "professional-centrism" or "professional preciousness" (Sarason, Levine, Goldenberg, Cherlin, & Bennet, 1966), which suggests that professionals view the problems they address as amenable only to professional intervention. Salzer et al. (2001) investigated this notion further and found that mental health professionals had higher levels of professional-centrism when they had an advanced degree or had never referred a patient to a psychiatric mutual support group before (versus professionals who had).

The lack of collaboration may also have to do with professionals' views of patients themselves. For example, clinicians have been found to underestimate patients' ability and willingness to participate in their own treatment (Chinman, Allende, Weingarten, Steiner, Tworowski, & Davidson, 1999). Certainly not all mental health professionals view mutual support groups negatively, and in fact, many see them as beneficial (Levy, 1978; Todres, 1982; Toseland & Hacker, 1985). For example, in the early days of the contemporary self-help movement, Hermalin et al. (1979) found that community mental health center clinicians wanted their facilities to become involved with self-help groups.

THE CURRENT STUDY

The literature on mutual support provides evidence that, despite some professional endorsement, referrals to psychiatric mutual support groups remains limited. Attitudes that treaters have toward psychiatric mutual support groups will undoubtedly affect their utilization. Much of the previous work examining professional attitudes towards mutual support has either focused on a global "harmful/helpful" dimension of professional attitudes, or has been limited to sampling one profession, setting, or city (Salzer et al., 1994). To build on the previous work, we attempt to assess the views and reported use of mutual support across a number of professional disciplines, settings, and areas within the context of a state-wide system of care. The study also makes three unique contributions to the literature. First, we investigate similarity and differences in providers' attitudes regarding 12 step mutual support groups and non 12 step mental health groups. Second, by virtue of embedding this study in a state-wide system of care, we include the attitudes and referring behavior of psychiatric rehabilitation providers (e.g., social, vocational, residential). Finally, we investigate whether providers' personal experiences with psychiatric treatment or mutual support participation are related to their attitudes and pattern of referrals. We organize our inquiry into five hypotheses, stated below, and provide justification for the relevance of each.

First, we examine the differences in attitudes toward traditional 12-step groups and psychiatric mutual support groups. Twelve-step groups (i.e., Alcoholics Anonymous) are an example of mutual support that has generally been accepted by the mainstream substance treatment community as a viable intervention, and therefore, makes an excellent group from which to compare psychiatric mutual support groups. Given the established nature of 12-step groups in U.S. society, we hypothesize that mental health providers would view them more favorably than mutual support groups for psychiatric disorders.

Second, we will compare the views of professionals who work in one of three settings: (a) formal treatment settings (e.g., community mental health centers and the state hospital); (b) rehabilitation settings; and case management programs (e.g., ACT teams and other case management programs). Treatment for those with psychiatric disabilities in community mental health centers and state hospitals typically involve direct clinical services emphasizing the stabilization of symptoms and medication management. The field of psychiatric rehabilitation involves teaching persons with psychiatric disabilities skills (such as vocational, social, and residential) needed for independent community living and developing the environment (local social networks, community resources) to support their functioning. Although ranging in service intensity, case management with those who have psychiatric disabilities involves providing links to other needed services and supports, ongoing monitoring to assess progress, advocacy, assistance with basic needs and entitlements, and in more intensive forms, outreach, the direct provision of clinical services, and crisis intervention. We expect that rehabilitation and case management providers will have more favorable attitudes toward mutual support, due to a greater focus on recovery and use of consumers as providers in their programs.

Third, we will examine whether providers' level of training is correlated with more or less favorable views of mutual support. Given the potential presence of "professionalism," we, therefore, hypothesize that those with more advanced training (i.e., psychiatrists, psychologists, nurses, social workers) will have less favorable attitudes toward mutual support than those with less training (i.e., mental health workers with bachelor's degrees).

Fourth, we will also examine whether personal experiences have an effect on attitudes towards mutual support. Specifically, we assess whether history of personal psychiatric treatment, having a family member who was treated or hospitalized for psychiatric reasons, or personal experience with participating in mutual support affects attitudes towards mutual support. Riessman and Carroll (1995) stated that having professionals attend a mutual support group would be a way to improve their support for this approach, and we directly test that notion here. We hypothesize that these personal experiences would be associated with more favorable attitudes toward mutual support.

Finally, we investigate whether there is a relationship between the length of time spent at the current job setting and in a professional discipline and attitudes toward mutual support. We hypothesize that greater lengths of time will be associated with more favorable attitudes resulting from more opportunities to be exposed to the benefits of mutual support.

METHODS

Procedures

A survey was created as part of the Consumer and Family Network Development Project, a grant funded by the Community Support Program of the Center for Mental

Health Services, Substance Abuse and Mental Health Services Administration (#SM51916, PI, K. Kangas). The purpose of the grant was to further develop consumer and family mutual support groups in Connecticut and the survey was used to assess providers' (who are key referral agents) beliefs about these groups. The instrument was piloted with five mental health providers at a community mental health center within the state and minor revisions were made based on their feedback. After piloting the survey, a total of 93 separate facilities serving 61,205 patients across the state were identified as sites for data collection. Providers at the state hospital, seven community mental health centers, and 85 private not-for-profit agencies that serve individuals with serious mental illnesses were invited to participate in the study. To reach as many community mental health centers and private not-for-profit agencies as possible that could be accommodated by the grant's budget, we sampled one provider for every 50 patients within each of the 93 facilities. Facilities serving less than 50 patients at the time of the survey received a minimum of three provider surveys.

A total of 1275 surveys were mailed to mental health providers (i.e., psychiatrists, psychologists, nurses, social workers, mental health workers, and program administrators) across the state. Samples within each facility were chosen by sending facility directors blank survey packets accompanied by a letter asking them to distribute the survey packets (which included surveys, cover letters, and self-addressed and stamped return envelopes) to direct service providers with a last name that began with the letter "D." In the event that there were fewer providers than there were surveys packets sent to them, directors were asked to then distribute the remaining surveys to providers with a last name that began with the letter "E," then "F," then "G," etc., until all the packets were distributed.

Participants

We received 421 surveys (individual response rate of 33%) from 84 (90%) of the facilities. At least three providers from most of the private not-for-profit facilities (91%), the state hospital, and all but one of the community mental health centers responded. Table 1 shows the demographic information of this group. Almost 80% of the mental health service providers in the sample were between the ages of 20 and 50. There were more White (87.9%) and male (66.5%) providers than female or persons from other ethnic groups. There was a wide representation of professional disciplines, although nearly half the sample fell into the Mental Health Worker category. There was also a wide range of settings, although nearly 40% were located at CMHCs. Participants in the study had, on average, worked at their setting for 5.4 years ($SD = 4.7$) and had been in their profession for 11.3 years ($SD = 8.2$). About 17% had been hospitalized for psychiatric reasons themselves, over one-third (38%) had a family member who was hospitalized for psychiatric reasons, and about 14% participated in some type of mutual support at the time of the survey.

Measures

The survey of professional attitudes of mutual support groups consists of several items borrowed from Salzer et al. (1994) and several new items. The new items were created based on discussions with providers, patients, and administrators throughout the state and our own clinical experiences. The new survey not only assessed the "harmful/helpful" dimension examined in Salzer et al. (1994), but also included familiarity,

Table 1. Demographic Information and Characteristics of the Mental Health Service Provider Sample

<i>Demographics</i>	<i>Frequency (%)</i>	
Age ranges	20–35	144 (34.2%)
	36–50	190 (45.1%)
	51–65	79 (10.0%)
	66+	2 (.5%)
	Missing	6 (1.7%)
Race/ethnicity	Asian American	3 (.7%)
	African American	18 (4.3%)
	Native American	3 (.7%)
	Hispanic	6 (1.4%)
	White	370 (87.9%)
	Other	6 (1.4%)
	Missing	15 (3.6%)
Gender	Male	280 (66.5%)
	Female	135 (32.1%)
	Missing	6 (1.4%)
Discipline	Psychologist	18 (4.3%)
	Psychiatrist	15 (3.6%)
	Nurse	50 (11.9%)
	Social worker	119 (28.3%)
	Mental health worker	171 (42.6%)
	Administrator	20 (4.8%)
	Masters clinician	15 (3.6%)
	Other	1 (.2%)
	Missing	10 (2.4%)
Years in discipline	$M = 11.3, SD = 8.2$	
Setting	Community Mental Health Ctr.	165 (39.2%)
	State hospital	12 (2.9%)
	Psychiatric rehabilitation	94 (22.3%)
	ACT team	46 (10.9%)
	Case management program	49 (11.6%)
	Partial hospital program	24 (5.7%)
	Missing/other	32 (7.3%)
Years in setting	$M = 5.4, SD = 4.7$	
Self hospitalized	No	347 (82.4%)
	Yes	71 (16.9%)
	Missing	3 (0.7%)
Family member hospitalized	No	258 (61.3%)
	Yes	159 (37.8%)
	Missing	4 (1.0%)
Participate in mutual support	No	358 (85.0%)
	Yes	58 (13.9%)
	Missing	5 (1.2%)

referral frequency, degree to which mutual support is viewed as a valuable addition to traditional treatment, and the degree to which mutual support is thought to interfere with treatment.

The primary dependent variables of the study came from five items that assessed attitudes and behaviors regarding both mutual support groups for psychiatric disorders and 12-step groups. For both group types, providers were asked the following questions: (1) *Familiarity*: “How familiar are you with each of these groups (1 = Not At All Familiar to 5 = Very Familiar)?”; (2) *Helpfulness*: “In your professional judgment, how helpful/harmful is each group (1 = Very Harmful to 5 = Very Helpful)?”; (3) *Referral Frequency*: “How frequently do you now refer clients to each group (1 = Never to 5 = Often)?”; (4) *Interference with Treatment*: “How much does each group interfere with or disrupt your delivery of mental health services (1 = Interferes a Lot to 5 = Does Not Interfere)?”; (5) *Value*: “How valuable is each group in offering your client the resources and supports you cannot provide yourself (1 = Not At All Valuable to 5 = Very Valuable)?” In addition, participants were asked about their gender, age range, ethnic background, type of program for which they worked, number of years they worked for their program, and number of years they spent in their professional discipline. Participants were also asked if they had ever been hospitalized or treated for a psychiatric condition, if they had a family member hospitalized or treated for a psychiatric condition, and whether they regularly participated in any peer support/self-help themselves (all yes/no responses).

Analyses

To assess the attitudes and behaviors regarding both psychiatric mutual support groups and 12-step groups, we conducted a series of 2 (Training: advanced versus mental health worker) \times 3 (Setting: Treatment versus Rehabilitation versus Case Management) \times 2 (Group Type: psychiatric mutual support versus 12-step) mixed-model ANOVAs, one for each of the five dependent variable items. The Training and Setting effects were between groups factors and the Group Type was a within groups factor (i.e., the same participants responded to the same questions about both psychiatric mutual support and 12-step groups). “Advanced” in the Training variable ($n = 237$) was defined as anyone who was a psychiatrist (3.6%), psychologist (4.3), nurse (11.9%), social worker (28.3%), masters level clinician (3.6%), or an administrator (4.8%). Mental health workers ($n = 171$) are staff that usually have bachelors degrees. The Setting variable’s three levels were *treatment* (made of CMHCs, partial hospitals, and the state hospital, $n = 209$); *rehabilitation* (made of social, vocational, and residential rehabilitation programs, $n = 97$); and *case management* (made of case management and ACT programs, $n = 95$). Scheffe post hoc analyses were conducted to assess how the three levels of the Setting effect differed from each other. We also conducted bivariate correlations between the five items for both mutual support and 12-step groups and the two duration items (years in profession and years in setting). Finally, using the five variables, we conducted mean comparisons (*t*-tests) between those who had been hospitalized and those who had not, those who had family members who had been hospitalized and those who did not, and those who currently participated in mutual support and those who did not.

RESULTS

Mixed Model ANOVAs on Professional Attitudes

Group Type. Mixed-model ANOVAs yielded four significant main effects for the within subjects factor of Group Type. Respondents, regardless of setting and training, were

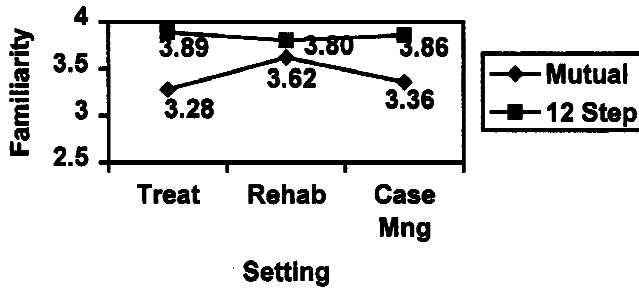


Figure 1. Mean familiarity by group type and setting.

less familiar with psychiatric mutual support groups than 12-step groups, $F(1,381) = 38.83, p = .0001$ (see Fig. 1); viewed 12-step groups as more helpful than psychiatric mutual support groups, $F(1,353) = 16.38, p = .0001$ (see Figs. 2 and 3); and referred to 12-step groups more than psychiatric mutual support groups, $F(1,344) = 11.39, p = .001$ (see Fig. 4). Also, regardless of setting and training, 12-step groups ($M = 4.30, SD = 1.7$) were viewed as more valuable than psychiatric mutual support groups ($M = 4.05, SD = 2.1$) in providing resources and supports not available through traditional treatment, $F(1,342) = 20.79, p = .0001$. There were no significant effects in the ANOVA on *Interference with Treatment*. Significant interactions involving Group Type are presented under Setting and Training.

Setting. The mixed model ANOVAs revealed no significant main effects for Setting; however, there were significant interactions between Group Type and Setting. Staff in rehabilitation settings appeared to be more familiar with psychiatric mutual support groups than those in treatment and case management programs, but were less familiar with 12 step groups than those in treatment and case management programs, $F(2,381) = 3.56, p = .029$ (see the plot of means in Fig. 1), although the Scheffe post hoc analysis was not significant. Staff in rehabilitation settings also appeared to view psychiatric mutual support groups as more helpful than those in treatment and case management programs, but viewed 12 step groups as less helpful than those in treatment and case management programs, $F(2,353) = 4.06, p = .018$ (see the plot of means in Fig. 3), although the Scheffe post hoc analysis was not significant. In the analysis of *Referral Frequency*, Scheffe post hoc analyses indicated that staff in the treatment and rehabilitation settings differed from each other ($p = .002$), with those in rehabilitation

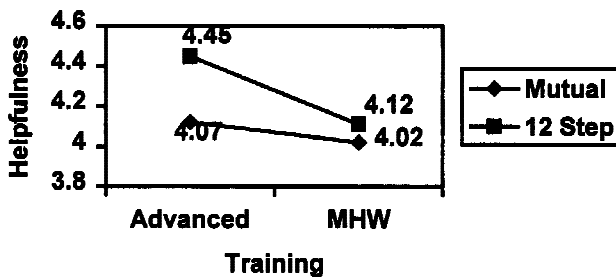


Figure 2. Mean helpfulness by group type and training.

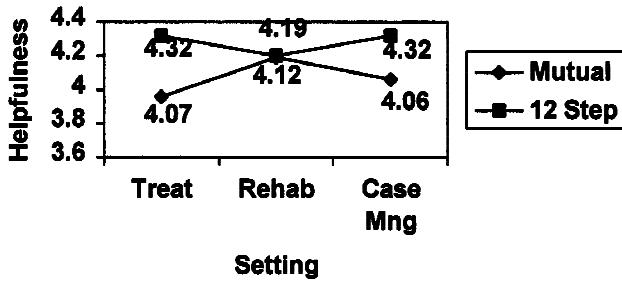


Figure 3. Mean helpfulness by group type and setting.

settings referring more to psychiatric mutual support groups and less to 12 step groups than those in treatment settings, $F(2,344) = 17.68$, $p = .0001$ (see Fig. 4).

Training. There were significant main effects in the mixed-model ANOVAs on Training for familiarity and helpfulness. Respondents indicated that, regardless of setting, staff with advanced training were more familiar with both types of groups, $F(1,381) = 4.68$, $p = .031$, and viewed both as more helpful, $F(1,353) = 8.11$, $p = .005$, than those with less training. Furthermore, for the Helpfulness variable, the Group Type \times Training interaction was significant, $F(2,353) = 5.22$, $p = .023$. Those with advanced training view 12-step groups as more helpful than those with less training, whereas the difference between the two training level groups is much smaller for psychiatric mutual support groups (see Fig. 2).

Personal Experience Comparisons

Providers who had been treated/hospitalized for psychiatric reasons were significantly more familiar with psychiatric mutual support groups, $t(414) = -2.37$, $p = .02$, and viewed them as more valuable, $t(379) = -2.44$, $p = .02$, than providers who had not had psychiatric treatment. Providers who had a family member that was treated/hospitalized for psychiatric reasons were significantly more familiar with psychiatric mutual support groups, $t(413) = -2.11$, $p = .04$, and referred to them with greater frequency, $t(380) = -2.53$, $p = .01$, compared to providers who did not have a family member with psychiatric treatment history. Finally, providers who participated in psychiatric mutual support at the time of the survey were more familiar with them

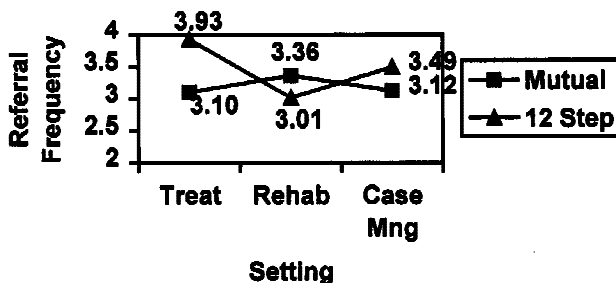


Figure 4. Mean referral frequency by group type and setting.

compared to providers not participating in mutual support groups, $t(412) = -2.01$, $p = .05$ (see Table 2).

Length of Experience Correlations

Table 3 shows the correlations between the number of years respondents spent in their current setting and in their profession and the five items applied to both 12-step and psychiatric mutual support groups (i.e., 10 correlations). Number of years in the current setting, and in a particular profession, were similarly related to familiarity with both 12-step and psychiatric mutual support groups. The more years respondents spent in their setting and in their profession, the more they were familiar with, and referred to, both 12-step and psychiatric mutual support groups. Finally, the more years respondents spent in their setting and in their profession, the less they believed that psychiatric mutual support groups interfered with their treatment.

DISCUSSION

This study generated a number of findings that have implications for how to structure collaboration with, and the training of, mental health professionals regarding psychiatric mutual support groups. First, as hypothesized, professionals surveyed were more familiar with 12-step groups than with psychiatric mutual support groups, referred their patients more often to 12-step groups, and viewed 12-step groups as more helpful and valuable regardless of other factors. Findings about referral frequency are similar to those found in previous work (e.g., Kurtz et al., 1987). These findings could be due to the fact that 12-step groups, in particular substance abuse-related groups, have been in existence longer, have a longer tradition of providing assistance to its members, and are consistent with the use of former addicts as professional counselors. In contrast, given the pervasiveness of the common stereotype that those with serious

Table 2. Means (Standard Deviations) of Attitudinal Items by Personal Experience Characteristics

<i>Attitudinal Items</i>	<i>Y/N</i>	<i>Participate in Mutual Support? (14% = yes)</i>		<i>Have You Been Treated/Hospitalized? (17% = yes)</i>		<i>Family Been Treated/Hospitalized? (38% = yes)</i>	
		<i>N</i>	<i>M (SD)</i>	<i>N</i>	<i>M (SD)</i>	<i>N</i>	<i>M (SD)</i>
Familiarity	No	356	3.34 (1.04)	345	3.32 (1.06)	257	3.30 (1.06)
	Yes	58	3.64 (1.09) ¹	71	3.65 (0.97) ¹	158	3.52 (1.02) ¹
Helpfulness	No	334	4.02 (0.80)	322	4.01 (0.79)	238	3.98 (0.79)
	Yes	54	4.17 (0.75)	68	4.21 (0.80) ¹	151	4.14 (0.80)
Referral freq.	No	327	3.15 (1.21)	315	3.16 (1.18)	233	3.06 (1.15)
	Yes	54	3.35 (1.20)	68	3.29 (1.34)	149	3.38 (1.27) ¹
Interference	No	326	4.40 (0.86)	314	4.37 (0.89)	233	4.39 (0.89)
	Yes	54	4.19 (1.03)	68	4.32 (0.97)	148	4.32 (0.92)
Value	No	326	4.04 (0.86)	316	3.97 (0.89)	234	3.96 (0.88)
	Yes	54	3.91 (1.07)	65	4.26 (0.89) ¹	146	4.12 (0.91)

¹The "Yes" group is significantly more than the "No" group, $p < .05$.

Table 3. Correlations Between Years in Setting and Profession with Attitudinal Items

Items	Group Type	Correlations	
		Years in this setting	Years in profession
Familiarity with	12 Step	.108*	.121*
	Mutual support	.148**	.136**
Helpfulness of	12 Step	.029	.066
	Mutual support	-.059	-.078
Referral frequency to	12 Step	.113*	.151*
	Mutual support	.020	.025
Interference from	12 Step	-.079	-.040
	Mutual support	-.175**	-.130*
Value of	12 Step	.037	.056
	Mutual support	-.022	-.008

*Correlation is significant at the 0.05 level (two-tailed).

**Correlation is significant at the 0.01 level (two-tailed).

psychiatric disorders are consumed by their symptoms, the treatment community has been slow to accept that mental health consumers are capable enough to provide assistance to others with their types of disorders in the context of mutual support groups (Davidson, Hoge, Godleski, Rakfeldt, & Griffith, 1999).

Second, as hypothesized, staff in rehabilitation settings seem to be more familiar with psychiatric mutual support groups, view them as more helpful, and refer to them more often than those in case management or treatment settings, whereas the opposite appears to be true for 12-step groups. Rehabilitation programs have historically adopted mental health consumer-friendly concepts such as “recovery,” which acknowledges that persons can and do recover from having a serious mental illness. According to the Center for Psychiatric Rehabilitation, recovery “is rooted in consumers’ experiences and their articulation of what has helped them to heal . . . [and] . . . a process of empowering individuals with hope and self-esteem to find new meaning and purpose in their lives. Recovery does not imply curing the mental illness, but learning to work within and beyond the limits of the disability so that individuals’ personal rights of friendships, homes, families, satisfying jobs, access to education, and decent pay can become realities.” These concepts overlap a great deal with the strengths-based and pragmatic approach of mutual support and explicitly acknowledge that consumers can play a valuable role in helping one another. In contrast, staff in treatment and case management settings may be more likely to subscribe to the notion that most individuals with serious mental illness tend to deteriorate over time, become engulfed by their symptoms, and therefore, cannot recover or help one another.

Third, in contrast to our hypotheses and the evidence of professional-centrism in the literature (e.g., Salzer, Rappaport, & Segre, 2001) more advanced training was associated with greater familiarity with both types of groups and with perceptions that these groups are helpful. However, this main effect is somewhat muddled by mixing both types of groups, and in fact, what seems to be driving the helpfulness main effect is that advanced professionals view 12 step groups as more helpful than psychiatric mutual support groups much more than the mental health workers do (see Fig. 2). Again, this attests to the widespread acceptance of groups like AA and NA as viable treatment options that professionals can utilize with their patients. Aside from that,

staff with advanced degrees and mental health workers both view psychiatric mutual support groups equally as helpful.

Fourth, personal experience with psychiatric disorders or mutual support is associated with more familiarity with psychiatric mutual support groups. Also, professionals with mental illnesses themselves view psychiatric mutual support groups as more helpful than those without mental illnesses while those with family members who have been treated for a mental illness are more likely to refer to psychiatric mutual support groups than those who do not have such a family member. These findings were consistent with our hypotheses. However, although actual participation in mutual support leads to greater familiarity and is consistent with previous training recommendations (Riessman & Carroll, 1995), it was actual experience with mental illness that seemed more linked to favorable attitudes (i.e., helpfulness) and behaviors (i.e., referring) toward psychiatric mutual support groups. It is conceivable that the mutual support in which the professionals participated was not *psychiatric*-based, and it was their experience with mental illness (whether in themselves or their family) that led them to positively experience psychiatric mutual support groups.

Finally, consistent with our hypotheses, the greater number of years spent in one's discipline and in one's setting is associated with greater familiarity with both 12-step and psychiatric mutual support groups. It seems that professionals with greater experience had more opportunity to become acquainted with both 12-step and psychiatric mutual support groups. Further, greater experience in one's discipline and setting was associated with beliefs that mutual support groups were less of an interference. Perhaps staff with greater longevity have had more time to experience the benefits of mutual support groups, have experienced a greater degree of professional burnout and therefore see mutual support as a way to share responsibility for their patients, or have been able to appreciate how mutual support can maximize the "person-environment fit" beyond the sole use of the professional model.

Limitations and Future Research

There are certain limitations of this study that should be noted. First, although this was a large sample of mental health professionals, it was not a randomized control trial. The study was a naturalistic assessment of a statewide mental health system, and therefore, unmeasured staff characteristics could have biased the results. The overall response rate for the survey was low, which also may have biased the results; however, there was excellent representation across all the facilities surveyed. Also, environmental factors, such as availability of various types of mutual support groups and their quality were not taken into account here, and could have affected the professionals' attitudes in this sample. Finally, the large number of significance tests used here inflated the type I error rate, and may have led to an instance where the conclusion of significance was made when in truth there was none. However, given that empirically based training recommendations are rare in this area, we believed it was important to examine the data to the fullest extent possible in order to devise training recommendations that could later be assessed with more precise and judicious use of significance testing. As with all research, replication of findings is needed to build a solid empirical knowledge base.

With the accumulating research on professional attitudes toward mutual support, more research is needed to assess specific ways in which mutual support can be encouraged in real-world settings. For example, the authors (MC) are involved in an

evaluation of a 3-year randomized controlled trial of an intervention that provides intensive education to clinicians, managers, and seriously mentally ill patients regarding empowerment, rehabilitation, and recovery, and offers technical assistance to patients to facilitate new mutual support groups. This project will assess whether the attitudes and behaviors of mental health professionals can be improved, psychiatric mutual support groups can be created and maintained, and whether these changes translate into improved patient outcomes. Research like this is needed not only to assess the effects of the groups on patients, but to assess whether groups can be created, utilized, and remain viable given the current attitudes and practices of mental health professionals.

IMPLICATIONS FOR INCREASING UTILIZATION OF MUTUAL SUPPORT

Looking across the means of the five main dependent variables, professionals in this sample were the highest (generally over 4 on a five-point scale) on the three items that deal with the positive/negative perceptions of these groups (helpfulness, value, degree of interference); means on the awareness item were in the mid to upper 3 range (out of 5); and means on the one measure of behavior (i.e., referral frequency) was in the low to mid 3 range. These findings, in which attitudes about mutual support are rated more favorably than actual behaviors, are consistent with other studies (e.g., Levy, 1978) and demonstrate that while some support exists for this intervention, more needs to be done to change professional behavior.

Clearly, increasing the awareness of the existence of specific mutual support groups immediately available to their patients and the knowledge of their benefits could lead to greater utilization of this resource. This is especially so given that other studies have found a lack of awareness and knowledge of existing groups to be an important barrier to greater utilization (Black & Drachman, 1985; Kurtz et al., 1987). According to the current study, more junior staff, those with less formal training, and staff in treatment and case management settings could be targeted for this education as members of these groups appear to be less aware of, and have less favorable attitudes toward, psychiatric mutual support groups. In addition, there seems to be empirical support for Riessman's and Carroll's (1995) training recommendation to have professionals attend self-help groups as we found that personal experiences with psychiatric disorders and psychiatric mutual support groups were associated with more favorable attitudes toward these groups. Also, studies have demonstrated that the viability of novel interventions often benefit from having a "program champion," or a powerful individual who is passionate about the intervention, continue to advocate for the program (O'Loughlin, Renaud, Richard, Gomez, Paradis, 1998; Smith, Redican, Olsen, 1992). This study suggests that staff with greater professional experience and training could serve in that role given their seniority and their more favorable attitudes and knowledge of psychiatric mutual support groups.

In considering efforts to impact behavior of professionals regarding the utilization of psychiatric mutual support, we would like to address two additional points. First, it is important that professionals not be given a skewed view of mutual support as a panacea, but that they must be engaged in a dialogue about the realities of the potential benefits and conflicts (i.e., what to do when a mutual support group gives a patient a suggestion contrary to the advice of their professional treater). Second, educational strategies suggested above may need to be augmented with changes in the

relationship between the treatment system and mutual support groups. For example, more formal structures could be put in place to encourage referrals, provide direct links between professionals and various groups, and to give group participants and their umbrella organizations (e.g., Recovery, Inc.) more of a voice in the policies and administration of professional treatment systems.

Mutual support groups of all types have come to play an important role in the health care system as a whole. For those with psychiatric disabilities, they offer a wide range of potential benefits that appear to supplement the treatment received from professionals. Therefore, using the findings of this and related studies, collaborations and other linkages between mental health professionals and psychiatric mutual support groups can be improved with little additional costs.

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