Self-Help and Mental Health

By Alan Gartner

THE ANONYMOUS GROUPS.
In many ways it is appropriate to begin a description of self-help groups with Alcoholics Anonymous (AA). Founded in 1935, AA is the oldest of groups currently in existence (1). It is also the largest self-help organization - one study estimated 18,612 AA groups in 1972 and AA itself reported 26,967 groups in 1975 (2); and it is the group most written about - in 1973, a 63-page annotated bibliography on AA was issued (3). Further, it has been both the model of self-help for many and the spawning ground for at least a dozen other groups, e.g., Gamblers Anonymous, Narcotics Anonymous, Neurotics Anonymous, Parents Anonymous, the newly founded (1976) Prison Families Anonymous, as well as AA auxiliary groups such as Al-Anon and Alateen.

And it is the most vivid expression of one set of characteristics of self-help groups: the focus upon behavior, the attention to symptoms, the importance of the role of the group and the value of the knowledge and experience of the "old-timers," and the viewing of the problem of alcoholism as chronic, with the alcoholic never being cured. Although its distinguishing features are by no means common to all self-help groups, AA does share with many of them an additional set of characteristics including a high degree of authoritarianism (4), a form of blaming the victim, acceptance of societal stigmatization (5) and of the need for behavior reform by the individual, and "acceptance of the prevailing, dominant cultural and social values" (6). In the past few years, while maintaining its basic position, AA seems to be reaching out more to the broader community, as illustrated by the publication of pamphlets such as AA: A Community Resource for Coping with a National Health Problem, with a 1975 print run of 100,000; If You Are a Professional, AA Wants to Work with You, with a 1973 print run of 150,000; and Alcoholism Is a Management Problem, with a 1974 print run of 125,000.

Speaking of a variety of self-help groups, including AA, Caplan notes that they are explicitly authoritarian. Members are expected to adhere to a strict code of conduct, centring of course on drug abstinence. They are kept under careful surveillance and they are severely judged for backsliding, which is punished by public condemnation and shaming.

To me, they also resemble religious orders in their social
structure and controls. All of these institutions have in common a well-defined mission to train members and support them in a disciplined new style of life. They combine an authoritarian hierarchy with an open-ended mobility system that balances punitive sanctions for nonconformity with the very tangible rewards of unlimited promotion for merit (7).

The growth of AA is a tribute to its effectiveness. One observer noted a rise in membership between 1939 and 1947 from 100 members to more than 40,000 (8). Since 1947, the number of AA groups has increased by about 3 per cent a year, growing from 1,664 groups to the 1975 total of 26,967 with 578,007 members.

The AA format has remained stable over its 40-plus years. The individual, whose anonymity is preserved, is held responsible for his (75 per cent of the members are men) conduct, while he invests faith in the group's power to help achieve day-by-day abstinence. The Twelve Steps of AA (see box) provide a guideline for individual behavior, maintaining that "although the individual is powerless over alcohol, he can overcome his problem through self-appraisal, disclosure and responsible behavior" (9).

Not surprisingly, AA has been the self-help group most critically examined. Its members are sensitive to the various charges that have been levelled against it, as is illustrated by the following presentation made by an AA leader at a self-help conference.

I would like to comment on what Alcoholics Anonymous is not. It does not go in the bars to get people to join AA. It doesn't keep membership records or case histories. It doesn't engage in sponsored research. It doesn't offer spiritual or religious services. There is no attempt to control its members. It does not engage in education or propaganda about alcohol. It does not provide housing, food, clothing, jobs, money, or other social services. It does not accept any money for its services or any contributions from non-AA sources. They don't ask you to sign anything when you first come in. They don't ask you what social position you have. They don't ask what intellectual ability you have. They just stretch out their hand and say, "Please come back." Thank You (10).

In a sense, three pairs of seeming contradictions characterize AA. First, the participant is told that he is helpless to overcome alcoholism; yet he must take responsibility for his actions. Second, the individual is told that he is free; yet the Twelve Steps prescribe a philosophy and a set of behavior. And, third, while responsibility is focused upon the individual, it is the group which provides the central vehicle for AA's work. Perhaps this combination of allowing the individual to see himself as helpless while at the same time seeing AA as having the way to energize him to cope with his alcoholism is a feature which makes AA effective.

A quite similar set of procedures is part of Gamblers Anonymous, established in 1957 by AA members. Here, too, the group plays an important role, anonymity is preserved, there is an official credo with a delineation of a member's responsibility for his gambling (again the bulk of the members
are men), and a variant of the AA Twelve Steps. As with AA meetings, those of Gamblers Anonymous follow a simple and generally unvarying format. The credo is read aloud and members comment on it; each member is called upon to give what is called a "weather report"; there is a brief prayer; and the formal meeting ends, often followed by an informal discussion session. It is the weather report which provides the most distinctive feature of the meeting. An example follows:

I'm Jack R., compulsive gambler. I'm a compulsive loser too, but I don't lose no more because I don't gamble no more. I want to tell you that six months ago when I first walked through that door, I had reached the depths of degradation. To give you an example of how low I was, my wife was in the hospital having a baby, and I was holed up in some stinkin' petty larceny joint over in Emeryville playing low-ball. I was in hock up to my ears, I had lost all my self-respect, I couldn't look anybody in the face, I was the kind of guy that if you had a sawbuck to your name, I'd figure a way of conning you out of $9.98. I was always trying for the big score, and later I was trying just to get even and the harder I tried, the more I kept getting in deeper and deeper. And what the hell was this big score anyway? I made it a couple of times, so what did I do with the money? I blew it, I had to blow it, it wasn't real money, it was Mexican money, strictly counterfeit. My wife never got a dress or a pair of shoes out of it. I mean, I was in bad shape. I was writing lousy checks, thank God I was able to cover them in time, but for the Grace of God, I'd be in durance vile right now. But you know the routine as well as I do, we're all the same, we've all gone the same route. But things are different now since I've joined GA. I'm not out of hock yet, but I can see that silver lining up there in all those clouds. I don't know what it is, maybe it's just coming to these meetings, maybe it's some higher power, but I'm getting serenity, some peace of mind now. Like Harry G. says, "Progress is our most important product," and I'm progressing all the time. Just lately, after an absence of many, many years, my wife and I rejoined the church of our faith. When I joined GA, I didn't even come on my own, I had to square a beef with my wife, I admit it, but I decided she was right. I looked in the mirror one morning and I said to myself, "Schmuck, what are you doing with your life?" I know I'm still a compulsive gambler, if I start staying away from here, I'll be right back where I started from. But I take it one day at a time, I haven't gambled in the last 24 hours and tomorrow's another day. That's my weather report" (11).

Many of the features of the weather report are common to all of the anonymous groups (12): the participant having hit bottom, the self-degradation, the lack of alternatives, the value of the group and its "way" being both affirmed for the speaker and other old-timers as well as for the benefit of newcomers, the inability of the individual to behave adequately without the group. These commonalities are no accident, for Gamblers Anonymous, and Neurotics Anonymous were all founded by AA members and have adopted the Twelve Steps and the Twelve Traditions (13). Indeed, the first lines of the Neurotics Anonymous basic brochure states, "Neurotics Anonymous does for the mentally and emotionally disturbed
individual (neurotic) what Alcoholics Anonymous does for the alcoholic. It operates exactly as does AA" (14).

Although it shares the anonymous name with AA and incorporates some of its notions, Parents Anonymous is in many ways different from the other anonymous groups. It was launched in 1969 when Jolly K., then a 29 year old mother of two who was receiving mental health counseling from Leonard L. Lieber, met with another abusing parent from Leiber's caseload (15). Slowly this group grew, and by 1970 it had 70 chapters. Then, in June 1974, PA received a grant from the Office of Child Development (OCD), Department of Health, Education and Welfare. Two years later there were 450 chapters with over 4,000 parents attending weekly meetings (16). With the support of the OCD grant some 10,000 letters were answered, a 24-hour toll-free WATS line installed, an impressive newsletter (Frontiers) published with a mailing list of over 18,000, additional pamphlets and brochures produced, public service promotion spots developed. And like other organizations which have been funded externally, PA is now looking "to new funding sources, including corporations, foundations and individuals...Small donors, big donors, donors of special projects..." (17). Here, of course, is one of the major differences between AA and PA: AA refuses any support from nonalcoholics (and limits the contributions of alcoholics, as well).

Another difference is the role of professionals. Leiber, a psychiatric social worker, was a cofounder (with Jolly K.) of PA and is now national administrator. Four of the 10 officers and members of the board of directors are doctors or social workers, and there is a 13 person advisory council, all but one of whom is an M.D. or Ph.D.; the lone nondoctor is a member of the family which initially funded PA and is one of only two women on the council.

Beyond their leadership role at the national level, professionals are intimately involved in the local PA groups. According to PS's elaborately precise and directive Chapter Development Manual, each chapter must have a sponsor who "should be a professional person in the mental health field who has a profound respect for the self-help concept" (18).

Making a careful distinction, the Manual notes a preference for licensed social workers over those who hold MSWs (Masters' of Social Work) only. Sponsors attend the weekly PA meeting, advise the chairperson (who is a member of PA; the Manual (p.5) describes the relationship between chairperson and sponsor as that of "an active parent-with-a-supportive grandparent...") and advise members during the meetings and through phone contact between meetings.

Like the other anonymous groups, PA members acknowledge the presence of the child-abuse problem and the need for help; plan to take one step, one day at a time; agree not to divulge the names of other members; and take responsibility for their own behavior (19).

Parents Anonymous, then, may be considered a "mixed"
organization in that it combines many of the features of the other anonymous groups with characteristics abhorrent to them - namely, outside funding and integral involvement of professionals. It will be interesting to observe PA's progress after June 1977 when its OCD grant expires to see whether its momentum and, more importantly, its apparent success continue.

SYNANON AND ITS OFFSHOOTS

Many of the characteristics of the anonymous groups also typify several of the drug addiction programs. Caplan describes some of these shared features:

Organizations that help their members break a noxious habit - alcoholism, drug abuse, smoking, or overeating - offer not only individual and group counselling in dealing with the problems involved and particularly anticipatory guidance from old-timers in preparing for expectable difficulties, but they also extend individual ego strength by group sharing of the miseries and discomforts of withdrawal symptoms. In addition, they provide a community in which friendships can develop to provide a new meaning to life; also, social and recreational activities can take place that offer a distraction from unsatisfied cravings (20).

Just as AA is the prototypical anonymous organization, so Synanon is the prototype of the alternative community program in the drug field. It is not large - presently there are some 1,500 residents at five California locations - but it is the most written about of such organizations, and the most controversial (21).

Founded in 1958 by Charles Dederich, an ex-alcoholic who while an AA member rejected its God-directed basis, Synanon incorporates many features of AA. Here, again, the participants have reached bottom, they can expect no cure, they must take responsibility for their own behavior, the group (and here the whole Synanon community) offers the way to acceptable behavior. The use of taped speeches by Dederich and other oldtimers serves much the same purpose as the recital of AA's Twelve Steps, while the Synanon game builds upon GA's weather report. The game, however, is a group exercise. Characterized by wuthering personal confrontations designed to force all participants to be totally honest about their previous behavior and, thus, to take responsibility for their present and future actions, the game serves the same purpose as the self-declarations of the anonymous groups. Even more than the anonymous groups, synanon with its organized communities has found continuing roles for old-timers. The emphasis is on continued involvement, which provides not only successful role models for newcomers, but also continuing reinforcement for the old-timers (22). Indeed, Synanon now views itself as a "secular religion" where ongoing participation is appropriate. Killilea compares it to such intentional communities as the Bruderhof (23).

Although AA's founder, Bill W., was much revered and his ideas treated as gospel, the role of Dederich is even
more central to Synanon. In part, this is a function of its smaller size and geographic cohesiveness. But Dederich's role goes beyond the Synanon centres themselves. For example, Daytop Village, a New York City drug program which can be considered Synanon's East Coast counterpart, was established in 1963 after its founders paid a visit to Dederich's Santa Monica centre (24).

Daytop rejects treating the addict as a sick person needing medical treatment or as a criminal needing jail or as a victim needing sympathy. Rather, according to the Daytop philosophy, the "addict is an adult acting like a baby: childish, immature, full of demands, empty of offerings" (25). In essence the addict is seen as a psychopathic personality, always taking, unable to give, and refusing to take responsibility for his/her actions or to recognize that the fault is his/hers. Taking the posture that the addict is both a reluctant enrollee (who views therapy and change as only a lesser evil than jail or continuing on the street) and a con artist. Daytop's initial attitude is both standoffish and questioning. The addict must prove his/her desire to be in the program, and must do so in the face of severe questioning from old-timers. For the moment the addict must behave as if (s)he were responsible, "must act as if you understand, act as if you are a man, act as if you want to do the right thing, act as if you care about people, act as if you are a mature human being" (26). The addict is asked to play a new role without requiring that (s)he necessarily understand it. This focus upon learning how to behave in a new role characterizes all of the self-help groups described here. Indeed, role theory is a central explanatory factor in understanding the effect of self-help groups.

Following Synanon's game, the thrice weekly encounter session is Daytop's key group therapeutic technique. David Deitch, Daytop's director (and a Synanon graduate) describes the encounter as "a gut-level teaching device that speeds up personality alteration, just as a pressure cooker speeds up the preparation of food" (27). Speaking of the decision to expand Daytop Village from its initial group of 30 men, Deitch said, "The junkie needs new faces on whom to try out his recently acquired skills. It is necessary to create a community of men, women, and children who live and work and love together if our people are to grow into mature responsible citizens" (28). While the newcomers provide the opportunity for the old-timers to try out their newly acquired skills (a good illustration of the helper-therapy principle, according to which the helper benefits most from the helping process), the old timers provide peer models for the newer members. Participants are supposed to be responsible for both their own behavior and that of the others members in the group. Here, in a total living situation, the peer-based method "powerfully reinforces more adaptive behavior" (29). Another offshoot of Synanon is San Francisco's Delancy Street (30). Like Charles Dederich, who had found the constraints of AA too binding and thus
founded Synanon, John Maher, a former drug user, objected to certain features of Synanon and founded Delancey Street in 1968.

Maher incorporated those concepts which had worked for Synanon: no drugs or violence, the game, the need to locate in rich neighbourhoods, a return to the early American work ethic to end the individual's dependence on welfare, federal grants, corporate and foundation funds. He rejected the ideas of Synanon that he felt were proven failures: Synanon had withdrawn to an isolated, utopian community that had no contact with current social movements...Synanon took no part in politics; Delancey Street's political clubs would get out the vote for supportive candidates and would lobby to change laws. Synanon discouraged its people from leaving the commune to live and work on the outside; Delancy Street would aim to put the ex-addict back with society as a productive member with strong economic and emotional ties to the community (31).

Also borrowing heavily from Synanone is a "peer confrontation" program at Palo Alto (California) Veterans Administration Hospital. The participants are male in-patients on an open psychiatric ward "seeking help with alcoholism, drug dependence, gambling, sexual deviation, repeated conflicts with the law, and other self-defeating life styles" (32). The key characteristics of the program are:

An individualized negotiated treatment contract between each potential participant member and his peers; a 24-hour-a-day live-in setting...a supportive drug and medication-free environment oriented toward personal growth and learning; a highly authoritain, member controlled social structure constantly evolving from within the membership; and periodic group confrontation sessions with strict rules including energetic verbal confrontation of each member regarding self-destructive behavior admixed with warmth and empathy of a "super-family." These five characteristics, working together, appear specifically to counteract and contain the severe authority conflicts, dependency, underlying hostility, and profound narcissism with certain patients classified as having character defects (33).

A follow up of some 200 graduates found that about half of those who entered the program were significantly benefited (34).

RECOVERY AND OTHER EX-PATIENT GROUPS

The groups described in the article can be thought of as aligned along a continuum. (Actually, a broad-band spectrum may be a more appropriate metaphor, in that there is a set of characteristics around which we can cluster the groups; but for now let us look at the continuum.) The groups at one end, such as AA and the other anonymous groups, Synanon and Daytop, see their participants as persons with chronic conditions who have hit bottom and are incapable of helping themselves; the activities of the program, whether or not it is residential, becomes central to the participants and "the way" of the group is viewed as the only solution for the individual; and the groups are entirely led by lay people (except Parents Anonymous and
Daytop, which was founded by professionals. Groups which will be discussed later in this article, such as the Widow-to-Widow program in Boston and the national Parents Without Partners, have participants whose conditions are not chronic (although they may continue for a long period) and who are not viewed (nor do they view themselves) as having hit bottom or being helpless (although, of course, they need help). Further, while the latter group are important to their members, they are not the locus of the individual's life, nor do they have a formal philosophy and exegesis which are to be religiously followed. Often, professionals are involved on an ongoing basis; and there is no glorification of a leader or founder.

Recovery, Inc. and the other groups to which I will turn now fall somewhere in the middle between these two sets of groups. Described by its executive director, Robert Farwell, as "a lay run, self-help, after-care, group meeting organization designed by a Chicago psychiatrist to prevent relapses in former mental patients and chronic symptoms in nervous patients," (35) Recovery views its members as in need of long-term participation, but recognizes that one can (eventually) get better. The group is important to its members, but it is neither residential (like Synanon and Daytop) nor are meetings as frequent as those of AA. If the participants have hit bottom, that level of the problem was dealt with while the individual was hospitalized and, thus, when participants arrive at Recovery they are capable of helping themselves.

In addition, two studies, a decade apart, found that about half of Recovery's members have not been hospitalized, and a quarter have not had any psychiatric treatment (36). There is a Recovery "way," a text, a revered leader, although none of these features apply to some of the other ex-patient groups. And Recovery, but not some of the other ex-patient groups, was professionally founded and sees itself as an adjunct to professional care.

The largest of the ex-patient groups, a 1973 study reported 850 Recovery groups with 15,000 members. All other ex-patient organizations combined were reported to have fewer than 400 groups and less than 3,000 members (37). In 1975, the executive director of Recovery reported 1,045 groups in the United States, Canada, and Puerto Rico (38).

Founded in 1937 by Chicago Psychiatric Dr. Abraham A Low, Recovery was "designed to encourage his patients to carry out a self-help program that would permit them to control their symptoms." It operates on the principle that while patients returning from psychiatric hospitals are greatly improved, they still have "residual symptoms" (39). Dr. Low described the returning patients as "mostly afraid of...terrifying sensations, threatening impulses, obsessing thoughts and depressing feelings, that is, their own inner experience" (40).

In sharp contrast to the groups described earlier, Recovery members' close working relationships with professionals were a central feature from the outset. Since 1969, a session on Recovery has
been included in the convention program of the American Psychiatric Association, and in 1975, the Psychiatric Speciality Boards included a question about Recovery (41). However, like the other groups, the weekly meetings are rigidly structured. They begin with an introduction of members by their first names (as in AA), followed by readings from Dr. Low's book, Mental Health Through Will Training. (Akin to AA and GA readings of their Twelve Steps and like Synanon's use of tapes by Dederich, some recovery groups use recordings of Dr. Low's comments.) Then members present examples of their behavior and "spot" on the examples. The central Recovery technique of spotting requires that members identify particular aspects to Recovery's concepts for maintaining mental health (42). (This is similar to AA's personal testimonials and GA's weather reports, but there is no formal group interaction to match Synanon's game.) Unlike the other groups described, Recovery meetings close with a free-will offering of money, and questions from newcomers are answered. Group socializing is not encouraged, nor is extensive out-of-meeting contact. In addition to spotting on behavior, Recovery participants are trained in "self-endorsement," which means that they must give themselves praise every time they make an effort to use Recovery methods. Although spotting and self-endorsement are methods to be used outside of the group, the Recovery participant learns them and tries them out in a group setting. Such discussions are conducted using a special Recovery lingo, with psychiatric terms forbidden. The reason given for this is that it keeps inexperienced people from straying into areas about which they are ignorant, "but it also serves to keep the group's attention on those things they can do to exercise the self-help concept" (43). Of course, it also serves to build the sense of the group as special with its own unique language.

By providing understanding and support, the group serves as an instrument for combatting loneliness and isolation felt by the ex-patient. In addition, the Recovery group provides an advantageous element of competition. Patients consciously or unconsciously compete with one another to see who can improve most completely and quickly and thereby win the approval of the rest of the group. In turn, the actual demonstration of objective improvement from week to week is a source of great encouragement and inspiration to the others. Part of the program for each is the support and reclamation of other patients. The spirit of working together toward a common goal cannot be overemphasized. In union there is strength. Helping others is one of the surest ways to help one's self. These truths have been known through the ages. In Recovery they are brought into sharp focus where patients can actually observe them in practice (44).

This mix of both cooperativeness and competition is not the only dualism in the Recovery design. There is also the tension between whether the patients will truly get better or whether they will always continue in the ex-patient role. Further, there is a
question of the extent to which the patients' efforts are sufficient or whether Dr. Low's dicta are the essential factor. Recovery's official brochure states:

The Recovery method consists of (1) studying Dr. Low's book, Mental Health Through Will Training and other literature, plus records by Dr. Low; (2) regular attendance at Recovery meetings; and (3) the practice of Recovery principles in one's daily life (45).

Another important aspect of Recovery, in addition to the group's role and Recovery's "way," is how it delegates the leadership function:

Groups are led by former patients who have been members for six months or longer of Recovery, who have been trained in the regular Recovery meetings and at monthly area leader meetings and who are authorized from year to year as group leader (46).

The leaders are responsible for two things: the leadership of the weekly meetings (unlike AA and GA where leadership rotates among the lay members), and, as Executive Director Farwell states, "to follow the proscription that we do not advise, consult, diagnose, or treat." As he puts it,

It is lay run. We deal in what we refer to as trivialities. We do not, if possible interfere with but rather cooperate with medical and psychiatric and other counseling that a person may be getting simultaneously or before (47).

While Recovery's "ideal referral comes from a physician or psychiatrist," if the need arises it will accept members who, for economic or other reasons, are not currently under psychiatric care (48). But according to Dr. Stanley R. Dean, who proclaims himself "the first psychiatrist to promulgate" the Recovery program after Dr. Low (49),

Does that (acceptance of patients not presently under psychiatric care) pose a threat to private practice? Not at all. The present author can affirm that a physician who refers selected patients to Recovery will find that it is like bread cast upon the waters - in terms of cross-referrals, therapeutic progress, prestige, and self-esteem (50).

This is a far cry from AA's aggressive assertion that nobody makes money from AA. However, at least one report finds Recovery much like AA, calling it "a kind of cult, with highly ritualized and formalized behavior, with a charismatic leader who expounds the Word, and with a dogma and exegesis" (51).

A study looked at Recovery not as a form of self-help but as a type of voluntary community organization. Finding that "the members of this specialized group showed many of the personal characteristics attributed to members of voluntary community organizations," Wechsler concluded:

The members of the self-help organizations were found to differ from other residents in their home communities in a number of ways which would be expected to exist between joiners and the general population. In addition, despite the fact that the members were either former mental patients or persons who were encountering psychiatric difficulties, they were found to be relatively active in other voluntary
community organizations besides the self-help group. A comparison of the self-help organization members who were inactive, moderately active, and very active revealed the same type of relationships between extent of participation and selected personal characteristics that had been obtained in general studies of voluntary community organizations (52).

Wechsler's study is unique in the field but perhaps because it was pathbreaking it is also limited, not considering factors such as the self-help organization's members in comparison with those of voluntary community organizations, nor of the nature of the involvement and participation of the Recovery members in the other organizations to which they belong. However, it is clear that one of the facets of the self-help organizations which requires more attention is its group function.

Emphasis on the role of the group is also found in Mowrer's "integrity groups" concept (53). Responding to the growing sense of alienation as traditional primary groups weaken, Mowrer, a psychologist, sees "the new small group movement (as representing) an attempt to create, not just a kind of 'therapy,' but actually a new primary social group, or institution, which will compensate for these basic human loses" (54).

Beginning in 1961, the integrity groups grew out of Mowrer's efforts to find a way to establish a warmer relationship with clients in his clinical practice. Indeed, one of the unique features of integrity groups is that professionals are involved as coequal members rather than as leaders or therapists.

Special responsibilities, such as Group Chairman or Council Representative, revolve and the obligation to give as well as receive help is widely diffused. Every therapist is also a patient (if one wishes to use these terms), every student a teacher (55).

However, Mowrer does see a special role for professionals in starting non-professional mutual-help groups; indeed, he has run graduate seminars at the University of Illinois to train such persons. Mowrer distinguishes between the AA-type peer group, in which all the persons have the same problem and there is no status distinction, and the integrity group peer group which includes persons of diverse background who are "equals, without status or rank, except as special functions may be temporarily assigned to them — or in terms of informally recognized group experience or competence" (56). Thus, while the professional may also give as well as get, (s)he does have a special role to play in integrity groups.

Mowrer also suggests a broadening of the self-help concept to emphasize mutual help "which implies give and take." This combination of self-reliance and mutual support is expressed in the integrity group motto: We alone can do it, but we cannot do it alone (57).

Mowrer goes so far as to propose that everyone ought to be in a mutual-help or peer group "(for the bearing and sharing of 'one another's burdens') not as 'therapy' but as a way of life..." (58). The
characteristics of such groups, no doubt, would closely resemble the present integrity groups which feature:
1. A well-defined structure.
2. Goals that focus on each member's responsibility for changing him/herself.
3. Group intake, with modelling procedures, demonstrated by experienced members.
4. A contractual agreement to embrace the core values of honesty, responsibility, and involvement.
5. A commitment to move beyond self-disclosure by translating words into deeds.
6. Leadership shared by participants.

Finally, the integrity group concept includes:

Rapid movement into self-disclosure, confrontation, and support - all aimed at behavioral change. Participants develop a strong fellowship and are available for emergency meetings if a member is in need. Although the emphasis is on encouraging responsibility for one's own behavior, Integrity groups also help members overcome their alienation by developing authentic interpersonal relationships with others (59).

While not properly labelled an ex-patient group, Neurotics Anonymous (NA) does include many ex-patients; indeed, its founder, Grover, was both an alcoholic and undergoing psychiatric treatment. NA follows "the AA Recovery Program as adapted for neurotics" (60). As such, while not hostile toward the professional mental health community, NA can be best described as distanced from it.

There are a considerable number and wide variety of other ex-patient groups. Some are run entirely by participants (20 per cent according to a 1957 survey (61), such as a club for former patients at Massachusetts Mental Health Center (62), while others are professionally run (63). Some simply provide a place for ex-patients to go and be, such as the Massachusetts group, while others, following Recovery, offer therapeutic activities. And in England, professionally led followup groups for discharged patients are part of an integrated mental health service system (64).

"Halfway houses" and some "day hospitals" also share characteristics of self-help. A notable case is the Lodge Program organized by a California state mental hospital where male patients who were ready to be discharged volunteered to live in a building in the community, organized a janitorial business (and later a gardening service), managed and conducted it as well as the affairs of the lodge (65). Professional services were not provided by the hospital, although a rarely used veto power was held over decisions. "Compared to their matched control, a significantly greater proportion of the individuals in the lodge situation were able to remain out of the hospital and resume employment" (66).

Regarding ex-patient groups, the converse of Wechsler's point that those who join REcovery are much like joiners of other community voluntary organizations is that those who are less likely to be joiners in general will be less
likely to join an ex-patient group. In addition, there is the stigma still associated with mental illness and patients' desire to forget about their hospitalization (67). Joining such a group means, in effect, accepting the ex-patient role and, thus, differentiating oneself from the general community. Many may wish to "pass" as having never been a patient (68). Moreover, the absence of clear termination procedures (and the implication that one's condition is chronic, as seems to be the case with REcovery) may lead to continued dependency. It is possible that Mowrer's notion of universal participation in mutual-help groups might serve to destigmatize it. On the other hand, similar to the process described by Parsons as "socialization into the patient role," (69) these groups may socialize ex-patients into a well role (70).

"LIVING WITH" GROUPS

All the groups described thus far deal with people who, depending upon one's classification system and prior assumptions, are sick or patients or seem to be inadequate in some way. The groups to be described in this section do not fit into these categories. While these group members have problems, the source of the problem is someone with whom they live: spouse, child, parent. Essentially, the thrust of these efforts is to inform the relative of the nature of the problem faced by his or her family member and to aid the relative both in coping with the problem and providing understanding and support to the afflicted person.

When the afflicted person is an adult, auxiliary groups for spouses (e.g., Al-Anon and Gam-Anon) and children (Alateen) have been established, or spouses are welcomed to at least some of the activities of the self-help group itself (e.g., Gamblers Anonymous, Recovery Inc., Mended Hearts, Prison Families Anonymous, Huntington's Disease). When the afflicted person is a child, the family members, particularly parents, are required to play a more active role. Gussow and Tracy have grouped self-help organizations into two categories: Type I includes those which provide "direct services to individuals and relatives in the form of education, skills, encouragement, and other forms of support" (71), while Type II organizations are "more foundation-oriented, promoting research, fund-raising, public and professional education and legislative and lobbying activities" (72). Caplan, however, notes that "by campaigning politically for improvement of the community's handling of the needs of people like themselves," they are in fact developing "cohesion and some sense of mastery over cruel fate..."(73). In other words, the activities of what Gussow and Tracy call Type II organizations have Type I effects upon the participants. The range of such groups covers nearly all of the afflictions from which children suffer: there are groups for parents of twins and multiple births, retarded children, emotionally disturbed, physically handicapped children, those who
face hospitalization, those with leukaemia, cystic fibrosis, congenital heart disorders, Down's Syndrome, rubella, spinal bifida, Tay-Sachs, cleft palate and/or lip, cerebral palsy, hemophilia, brain injury, those who are blind or deaf, as well as a group for parents whose child has died (74).

The specific activities of the individual group, of course, vary depending upon the nature of the affliction. But the general functions and activities are quite similar. Some were organized as a service activity of a large organization (e.g., United Cerebral Palsy), and others by the parents themselves (particularly those related to retarded children). Many were organized by hospitals either as part of their program or as a response to parents' desires to get together with persons like themselves. Other groups simply grew out of parents being together in a waiting room of a special clinic serving their children. Several examples may serve to illustrate this type of self-help activity.

For parents of children with Down's Syndrome (and other similar diseases) what had been anticipated as a joyful occasion becomes the opposite. The medical staff often handle their own disappointment by suggesting institutionalization of the child, by exhortations to the parents to love the child, or by avoiding the parents. The parents, for their part, often react with an unwillingness to develop attachments to the child; friends and relatives are encouraged not to visit (or do not on their own); birth announcements are not made. The parents lack knowledge of what the child will look like, what (s)he can do and will need to have done for her/him. And, very likely not knowing anyone with such a child, their grief is compounded by isolation. At group meetings, new members tell about how they learned about their child's illness and how they responded, while old members tell of their own experiences and changes over time. Members practice (role-play) how to tell others and how to respond to them. Information is shared on how to deal with children on a day-to-day basis, what to expect, and what to do (75).

The group mitigates feelings of isolation and depression. Members could see how other children appeared and acted. The discovery that other parents had similar feelings and fears reassured them of their own adequacy and sanity. Some parents served as role models to illustrate that it is possible to survive such an event (76).

For parents of children with cystic fibrosis, the group performed a similar set of functions.

group meeting provided a sounding board for parents to learn, to devise, to consider, and to test new methods of coping as well as to receive reinforcement for prior satisfactory adjustments. Parents repeatedly expressed a sense of comfort in learning that their grief, pain and everyday difficulties were not unlike those of others (77).

Parents of children who are dying of leukaemia go through a process of anticipatory mourning following stages not unlike those of
Down's Syndrome parents: first, denial — including shopping around for alternative diagnoses, then anger, bargaining, depression, and finally, acceptance (78). Groups for these parents deal with issues such as disciplinary problems with the patient and siblings' and peers' reactions to physical changes in the patient, the patient's own questions and fears, the relationship between the parents and their children.

In evaluating the experience of the group, parents emphasize the value of realizing that they were not alone, that there was a place where they could express their actual feelings (at times not wanting to be with the child, being angry with him/her for being ill) without feeling guilty, that they could anticipate and learn how to deal with problems and try out solutions, and for some parents the group became the vehicle which enabled them to talk to each other about their child's illness (79).

Talking about their feelings with someone who has shared similar ones is an overwhelming need for parents whose young children have died, particularly those who are victims of Sudden Infant Death Syndrome (SIDS), formerly called "crib death." As one mother said: "Whenever I get it on my mind and I can't seem to function, I call someone in the Foundation (for Sudden Infant Death). 'Am I nuts? Am I going crazy?' It's comforting to her say, 'No, I've been through this too. Everybody gets these feelings. It's part of the natural grieving process (80)." Founded in 1962 by a Connecticut couple whose baby had died, the foundation now has 43 chapters, while the International Council for Infant Survival, started in 1964 by a couple whose 2-month-old daughter died, has 23 affiliates.

With parents of children whose problem is serious but not life threatening, a different set of activities takes place. For example, the Greater Omaha Association for Retarded Citizens not only organizes groups of parents of retarded children, but pairs parents new to the groups with long-time members (similar to the AA and GA buddy system) to provide emotional support from someone who has "already been there," facts about mental retardation, information about services available, tips about ways to arrange things, and introductions to other parents of retarded children (81). A Yugoslav program for physically handicapped children involves parents in discussion groups about the children and their problems, as well as engaging them in helping with the Children's therapy (82). This is similar to the various programs in which parents learn to provide early stimulation for their retarded children (83).

Although not precisely a self-help activity as I have been using the concept, it is worth noting the increasing number of programs that train parents as therapists to work with their own children (84). The Kendall Center (Chapel Hill, N.C.) incorporates into its program of training parents as therapists a parents' mutual-help group where they are able to share both their experiences as parents of retarded children and as
therapists in training. Of particular value is the opportunity for "older" parents to report to the "newer" parents on changes in their children as a result of their own role as therapists (85).

PEOPLE ALONE

Discussing various types of mutual-help community support groups, Caplan distinguishes between those organizations designed to help their members break a noxious habit, such as alcoholism, drug abuse, smoking, or overeating, and others which emphasize the formation of a new community in which members can immerse themselves. Falling into the second category are parent groups such as those just discussed and "people alone" groups such as Parents Without Partners and widows associations, to which I will turn in this section.

Most of these self-help groups have two-phase programs. The old-timers help the newcomers to master the trauma of the acute crisis of the bereavement, the loss of bodily integrity, or the disappointment of parental hopes, by means of individual and group counselling and by emotional support in expressing and mastering the shock and pain, as well as guidance in accepting and coming to terms with the catastrophe. But the characteristic feature of these organizations is their second-phase provision of long-term social contacts which serve as kind of psychosocial replacement for what has been lost. This never really works - no amount of friendliness in meetings of Parents Without Partners can replace the intimacy of a marital relationship, nor can collaborating with other parents in bettering the lot of the mentally retarded make up for the life-long feeling of emptiness caused by having a child who will never develop to continue the chain of one's life. But at least the association with others in the same situation combats the social isolation that would otherwise be the lot of those who feel themselves, and are perceived by others, to be deviant in ordinary society (86).

Both the parent and "people alone" groups not only provide emotional and social support "but they usually provide detailed information and specific guidance in increasing their members' understanding of the issues involved in their predicament and of practical ways of dealing with the expectable day-to-day and long-term problems" (87).

Founded in 1957, Parents Without Partners (PWP) is the largest group of single parents, with more than 200 chapters and some 30,000 members, about three-quarters of whom are women (88). Unlike the anonymous and ex-patient groups, membership in PWP is subject to considerable turnover: during its first 10 years over 100,000 persons had been members (89).

Weiss makes a point similar to Caplan's, noting that for some PWP members, "the organization was responsive to the marital loss itself" and for others it was "responsive to the defects of life as a single parent." for the first group, more likely divorced (or separated) than widowed, the organization met individuals' need "to be able to talk to understanding and sympathetic listeners about their feelings, their concerns, and their plans." For the second group, already having made the
transition from marriage to life on their own, PWP met their "relational deficits, i.e., distressing absences of important relational provisions. "Weiss points to four "continuing sources of stress" to which PWP responds: (1) the absence of a sustaining community; (2) the absence of similarly placed friends; (3) the absence of support for a sense of worth; and (4) the absence of emotional attachment (90). While it is this last factor that is addressed by the charge that PWP is simply a dating service, the leaders of PWP play it down both because they wish to avoid the pejorative implications of that charge (and its attendant loss of attraction of "nice people") and because they see their work as having a broader scope, as indeed it does.

But this broader scope, expressed in the characterization of PWP by a professional adviser to its national headquarters as "an educational therapeutic advisory organization," (91) presupposes an initial acceptance of the stigma of an inferior position; the belief is that "'parents with partners' - in keeping with the prevailing social norm - are better" (92). Indeed, PWP's recognition of this may be seen in the current discussion within PWP to change its name to Single Parents, International (93). A different type of stigma is faced by divorced Catholics given the doctrinal belief that a valid marriage is indissoluble in the eyes of God. It is no surprise, then, that more than 150 groups of formerly married Catholics have sprung up in the past five years. Most have 100 to 150 members with one (Nassau County, N.Y.) having over 7,000 members. Many of the groups are part of the new North American Conference of Separated and Divorced Catholics, although each club is autonomous (94).

The same issue of stigma arises in widow programs.

Many women see widowhood as a social stigma. They see themselves as marked women, different from everyone else, even carrying this so far as seeing themselves as defective, that something must be wrong with them if they lost their husbands (95).

This sense of stigma felt by many of those involved in the groups I have discussed can be mitigated by the help of someone with the same condition. The stigmatized individual needs to feel that he (or she) is human and essentially normal in spite of appearances and in spite of his own self-doubts...The first set of sympathetic others is of course those who share his stigma. Knowing from their own experience what it is like to have this particular stigma, some of them can provide the individual with instructions in the tricks of the trade and with a circle of lament to which he can withdraw for normal support and for the comfort of feeling at home, at ease, accepted as a person who really is like any other normal person (96).

This is precisely the function played by the widow aide in the Widow-to-Widow program established in 1967 by the Laboratory of Community Psychiatry, Harvard Medical School (97). Both the formal auspices of this program and the use of a paid worker (who, in addition, shares widowhood with those served) make this
program different from those discussed earlier. However, the activities of the program are fully in the mode of self-help as it has been described here. The program was begun as an experiment in preventing emotional problems in a bereaved group. "It was hypothesized that if another widow reached out to the new widow, she would be accepted as a friend because she was someone who understood, since she had been there herself" (98). As one widow put it,

Since you are a widow too, when you said you understand I know you meant it and that was so important. I can't stand sympathy and that's all anyone else could give me (99).

While there are group meetings, most of the work of the Harvard program is done through one-to-one contacts between widow aides and the widowed. Here,

the aide is using her own experience as a human being and as a widow to guide her encounter with the new widow; she appreciates the real need that exists but she never takes the widow's initiative away from her (100).

Beyond proving aid in coping with the trauma of becoming a widow - and, as Silverman points out, this upset is not eased by an institutionalized rite de passage as engagement eases the transition to marriage - the widow aides help the widow adapt to the widow role, which means accepting that the spouse is dead and that new life patterns must be developed. The widow must now learn to make decisions without help and guidance from a husband, to learn to be alone, and to recognize and act upon the need to make new friends and be out among people (101). The widow aides, using their own experience, help the widows both to face the fact of widowhood and then to learn how to manage their own lives. There are a large number of programs for widows, perhaps not as carefully organized as the Harvard program, but which involve other widows as caregivers and recognize the benefit gained by the caregiver as well (102). The extent of these programs is not surprising given the large numbers of widowed persons - 10 million in 1970, 85 per cent of whom were women (103). Indeed, such groups sprout up quite independently - for example, in New Haven, Houston, and Westchester County (N.Y.) (104). Some programs focus on crisis intervention by therapists, while others are more self-help oriented; all see in the experience of the widowed a resource for helping others like them.

Indeed, this may be the single most important common denominator of the various types of self-help groups I have looked at here - namely, that the role of the person who has already lived through the experience is critical for helping others. For not only does that person know what the experience is like, but (s)he has learned how to play the required new role: the alcoholic who has stopped drinking or the mental patient who is now well or the person whose spouse has died and now accepts the state of widowhood. And to the extent that the condition continues (the person remains a widow, for example), the caregiver, too, is a
beneficiary via the helper-therapy principle.

NOTES


2 Zachary Gussow and George S. Tracy, "The Role of Self-Help Clubs in Adaptation to Chronic Illness and Disability." n.d., Table I.


4 For an example of the disagreement created by lumping together self-help groups of differing value orientations, see Alfred H. Katz, "Self-Help Groups," Social Work XVII, 6 (November 1972), pp. 120-121.


19 "Guidelines for Achievement:" I Am a Parents Anonymous Parent, op cit., p. 21 ff.

20 Caplan, op cit., pp.21-22.


24 Following their 1961 visit to Synanon at Santa Monica, Alexander Bassin, Herbert Bloch, Daniel Casriel, and Joseph A. Shelly (then chief probation officer of the Brooklyn Supreme Court), made application to NIMH for a study program under the aegis of the court. A five-year NIMH study grant was received in April 1963. The application for such funds would have been counter to AA policy, while Synanon itself has failed in its efforts to receive NIMH funding.

25 Alexander Bassin, "Daytop Village," Psychology Today II (December 1968), p. 48. (The author was one of the founders of Daytop.)

26 Ibid., p. 51, (emphasis in original).

27 Ibid., p. 52.

28 Ibid., p. 68.

29 Vattano, op cit., p. 10.


33 Ibid., p. 587.

34 Ibid., p. 588.

35 Borman, op cit., p. 53.


37 Gussow and Tracy, "Interim Status Report: Voluntary Self-Help Organizations," op cit., Table III. Recovery has dominated the field for the past 20 years. A 1957 study by the Joint Commission of Mental Illness and Health reported approximately 5,000 members in 42 organizations of mental patients, with an estimated 4,000 of them in 250 Recovery groups (Wechsler, op cit., p. 50.

38 Borman, op cit., p. 53.

39 Donald T. Lee, "Therapeutic Type: Recovery Inc.,” in Katz and Bender, op cit., p. 43.

40 A.A. Low. Mental Health Through Will Training (Boston: The Christopher Publishing House, 1950.)

41 "Recovery Comes of Age," Roche Reports: Frontiers of Psychiatry V, 16 (October 1, 1975).


43 Lee, in Katz and Bender, op cit., pp. 44-45.

44 Dean, op cit., p. 76.


46 Borman, op cit., p. 53.

47 Ibid., p. 54.

48 Dean, op cit., pp. 77, 74.

49 Indeed, he offers as evidence a letter from Dr. Low to that effect, ibid., p. 78, fn. 15. Apparently, Dr. Dean documents this fact in each article he writes: see "The Role of Self-Conducted Group Therapy in Psychorehabilitation: A Look at Recovery Inc.,” American Journal of Psychiatry CXXVII, 7 (January 1971), p. 937, fn. 4.


David H. Sanders, "Patients-75; Professional-0: The Lodge Program in Community Rehabilitation," in Katz and Bender, op cit., p. 176-187.

Talcott Parsons, The Social System (Glencoe, Ill.: Free Press, 1951), pp. 428-473; see also, Katz, op cit., p. 70.


Ibid.

Caplan, op cit., p. 23.

Each one of these groups operates in Massachusetts. See "A Directory of Mutual Help Organizations in Massachusetts" (Boston: Blue Cross and Blue Shield of Massachusetts, 1974).


Ibid., p. 119.


Ibid., p. 74.


Stabler et al., op cit., p. 399.

Caplan, op cit., pp. 21-22.

Ibid., p. 23.

Katz and Bender, op cit., p. 69. Regarding the founding of PWP, see James Egelson and Janet Frank Egelson, Parents Without Partners (New York: E.P. Dutton, 1961).


Weiss, op cit., p. 322. For a more expansive treatment of these types of relationships, see Robert S. Weiss, "The Fund of Sociability," Trans-action (July-August 1969), pp. 36-43.

Gould, op cit., p. 666.

Katz and Bender, op cit.

Ibid., p. 69, fn. 3.


96 Goffman, op cit.

97 Silverman, op cit., pp. 540-547.

98 Ibid., p. 540.

99 Cited in ibid., p. 542.

100 Ibid., pp. 542-543.


102 For an extensive analysis of the benefits to those who staffed the Widow Service Line (a telephone hotline) see Ruby B. Abrahams, "Mutual Helping: Styles of Caregiving in a Mutual Aid Program," in Caplan and Killilea, op cit.
