

**A QUALITATIVE STUDY OF THE
PERCEPTIONS OF THE MEANING OF SELF-HELP,
SELF-HELP GROUP PROCESSES AND OUTCOMES**

BY Self-Help Group Leaders, Members, and Significant Others

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EXECUTIVE SUMMARY

PURPOSE

This study examined the meanings of self-help, the processes that occur in self-help groups, and the outcomes of self-help group membership. The research focused on primary mental health self-help groups which were defined as groups that chiefly included members who had been diagnosed as having a mental illness and were recipients of mental health services.

BACKGROUND

Primary mental health self-help groups are beginning to be organized by individuals with specific mental health conditions (for example, depression, manic depression, neuroses, and schizophrenia), to meet the various mental health needs of special populations (for example, chemical abusers, aged, and the physically disabled), to foster advocacy and empowerment, to reach minorities, and to provide services (for example food and housing). The sampling procedure for this study identified at least 48 primary self-help groups in New York State. This number is already multiplying.

As self-help groups continue to grow at the local, state and national levels, there is also an emerging recognition of these groups as potential adjuncts to current mental health system approaches to care. The sense of a new direction that gives recognition to the concept of self-help in mental health is also reflected in the increasing number of unpublished reports, journal articles, call for conference papers, funding for research and evaluation activities.

Although there is evidence of increased interest in self-help, report of favorable attitudes of self-help groups by professionals, and documentation of positive outcomes, there are *few* investigations directly related to the study of *primary mental health self-help groups*.

One of the major problems identified in past studies is the difference in both the meaning of self-help and self-help groups and the conflict over who is most expert to formulate these definitions (Borkman, 1976; Powell, 1987).

METHODOLOGY

The perspective for this study combined elements of qualitative research methods through the use of focus group interviews and key informant interviews. Each of the views voiced in focus groups or reported in informant interviews were considered part of the *emic* data set--the *insider's* view--rather than the *etic*--the *outsider's*--view. Our ultimate definition and analysis of self-help, its processes, and outcomes emerged from these multiple perspectives. By eliciting contrasting views within focus groups, clarifying and raising new questions between groups, and combining the findings from focus groups with those from key informant interviews, a forum for negotiations was established.

The results and inferences drawn from this study are related to the the meaning of the common bond, professional involvements, significant other impressions, group typology, why self-help works, and the effect of self-help group membership. These inferences are intended to provide working hypotheses to frame future self-help research. The design of this study brings with it typical caveats associated with qualitative research methodology; conventional issues of reliability and validity. The findings of this study are intended to be examined within a qualitative framework. That is, the findings of this study are adequately represented and credible to the participants interviewed, the findings are reliable, confirmable, and factual, and the findings are transferable but may not be generalizable.

RESULTS

Self-Help Group Typology. Participants indicated that their groups served to achieve multiple group functions. Although these purposes reflected three key areas of support, advocacy, and service provision, these results do not support these areas as three distinct categories for self-help groups. For example, participants from advocacy groups that were already established drop-in centers, identified advocacy and support as primary purposes. These results do not support the two specific categories of the service provision component of Emerick's Primary Service Model (1989): 1) groups as social change services (advocacy-legal; educational/technical; information referral) or 2) individual growth services (drop-in center; group support; alternative therapy). Groups serve as both social change agents and to foster individual growth.

Self-help defined. The meaning of self-help contained seven elements: 1) the *common bond*; 2) *helping one's self and other people*: a mutual process; 3) *voluntary* and not mandated, forced, or charity. 4) *trusting, open, supportive* environment; 5) ability to *reach out, share experiences and learn*; 6) *no dichotomy* between the helper and helpee; and 7) *decision making* rests in group members' hands. The common bond is the chief element that distinguishes these groups as primary mental health groups. It is defined as both the: a) collective experience related to being diagnosed as having a mental illness and receiving services from the mental health system; and b) individual experience(s) associated with having survived this process.

Professionals: "How Do They Fit"? Participants clearly indicated that professionals could best serve self-help groups in *supportive roles*. Supportive roles allow professionals in the membership only in an auxiliary or advisory capacity. Partnership roles, which theoretically promote a kind of sharing of leadership responsibilities between professionals and patients-as-partners, were recognized to be only feasible when there was no other person (recipient) to get the group off the ground. Although most participants felt that professionals could be used in supportive ways, doubts about this use still surfaced. Participants expressed three fears: 1) loss of autonomy; 2) co-optation; and 3) lack of professional regard.

Effects Of Self-Help Group Membership. Participants declared: "*Self-help has given my whole life meaning...it has normalized my life*". Recipients characterized their progression from states of dependency, self-destruction, or hopelessness to one of positive social identity. As participants gathered in focus groups and key informants talked about what self-help had done for them in their lives common themes emerged:

positive perceptions of self; personal well-being; autonomous decision making; improved social functioning; pursuit of educational goals and employment opportunities; sobriety, and decreased recidivism. These common themes gave positive testament to the perceived efficacy of self-help group membership by the participants in this study.

CONCLUSIONS

A Genre For Self-Help Groups: The Common Bond. The element related to having a diagnosis of mental illness has been implied in the past to be a common bond. The element of survival, as an identified component of the common bond in this study, is much more discriminating than diagnosis alone. Finding meaning for this new genre can provide a significant link to the positive outcomes of group membership. Moreover, we conclude that the common bond was the key to why a shared sense of the meaning of self-help emerged.

Professional Involvement. We speculate that over time professionals will serve all self-help groups in supportive ways either as consultants, advisors, or coaches. As some self-help groups move from partnership to supportive relationships with professionals, and as independent groups, who fear co-optation by professionals are faced with real needs, both self-help group members and professionals will need to exercise a mutual regard attitude. Professionals and self-help group members will need to learn new roles. Who will be teacher and who will be learner is yet to be decided.

Significant Others. Although family members witnessed the positive effects of self-help in their loved ones they did express doubts about a continuing membership in these groups. We do not interpret this expression as a direct reflection of the self-help group or people in the group but more of a strong indication of the families' desire for them to normalize their lives to the fullest extent possible.

What is and what is Not a Self-Help Group. We suggest the dilemma about what is or what is not a self-help group should rest with the participating members of the group. We predict that efforts to categorize self-help groups will soon prove fruitless. An examination of the data indicated that although there were three primary groups identified, support, advocacy, and service provider groups, these groups had multiple secondary functions that were of a supportive, advocacy and service nature.

Why Self-Help Works. Participants attested to the fact that they felt that self-help works. That is, they attributed positive outcomes (for example: pursuit of education; sobriety) to membership in their self-help group. If we conclude that positive changes occurred in the participants' lives the natural question to follow would be to ask why they occurred or why self-help works. We suggest that there were five human and contextual variables that offered an explanation for why self-help works: These working variables included: 1) formation of a social network; 2) change in role, ie. helper to helpee; 3) sharing of coping behaviors; 4) presence of a role model; and 5) existing meaningful group structure.

Intervening Variables: Self-Efficacy and Coping. Although we hypothesized the reasons why self-help works, we also recognized that a simple cause/effect explanation was insufficient. First, the working variables do not address what occurred over time to individual members to lead to the outcomes identified in this study. Secondly, we like other researchers, have begun to hypothesize that other factors including coping

processes and self-efficacy are related to empowerment (Gutierrez, 1987; Rappaport, 1987). We speculate that coping functions are mediating processes that occur within the theoretical framework of Bandura's social learning theory, self efficacy.

The Collective Meaning of Positive Outcomes: Empowerment. An empowered image of self-help group members was reflected in the results and earlier conclusions drawn from this study. If one examined each effect of self-help group membership in isolation and attempted to make conclusions, one's inferences might be different. It is the idea of empowerment which supports it as a multidimensional concept. Four domains identified in the data set support other explanations of the idea of empowerment (Clay, 1990; Rappaport, 1981, 1985; Rose & Black, 1985) These included personal, social, knowledge, and civil domains.

IMPLICATIONS

The need for future research, theory and practice is recommended. This includes:

0 Developing instruments to measure the outcomes of self-help group membership within four domains of the idea of empowerment. These domains include: 1) personal; 2) social; 3) knowledge; and 4) civil.

0 Designing studies to measure identified outcomes.

0 Assessing the relationship of antecedent, working, and process variables on hypothesized outcomes.

0 Mapping growth and organizational characteristics of primary mental health self-help groups.

0 Testing theory of self-efficacy as it relates to coping functions.

0 Assessing feasibility of self-help as an alternative to current rehabilitation practices as a coping function.

0 Designing studies that include not only traditional experimental methods but also qualitative methods.

0 Educating mental health professionals, other recipients, significant others, and our community at large about the efficacy of primary self-help groups.

0 Planning for dissemination and use of findings.

CONTENTS

PAGE		i
LIST OF FIGURES		ii
LIST OF TABLES		
SECTIONS		
I.	INTRODUCTION	1
	PURPOSE OF STUDY	1
	JUSTIFICATION	2
II.	STUDY DESIGN	4
III.	METHODOLOGY	8
	Population and Sample	8
	Sampling	9
	Group Sampling	13
	Participant Sampling	15
	Confidentiality	15
	Instrumentation	16
	Procedure	17
	Phase One: Orientation	17
	Phase Two: Focused Investigation	17
	Phase Three: Member Checks and Negotiated Outcomes	17
	Data Analysis	18
IV.	RESULTS	21
	Self-Help Group Typology	21
	Meaning of Self-Help	23
	Self-help defined	23
	Role of Professionals	27
	Effects of Membership	31
V.	CONCLUSIONS and IMPLICATIONS	
	The Common Bond	37
	Professional Involvement	38
	Significant Others	39
	What is and What is Not a Self-Help Group	39
	Why Self-Help Works	40
	Self-Efficacy and Coping	
	Intervening Variables	43
	The Collective Meaning: Empowerment	49
	Summary of Conclusions	52
	Implications for Research	54
	Implications for Theory	55
	Implications for Practice	55
VI.	REFERENCES	57
VII.	APPENDICES	61

LIST OF FIGURES

		PAGE
Figure 1	Design Overview	5
Figure 2	Group Sampling Procedure	10
Figure 3	Mapping of Primary Mental Health Self-Help Groups by New York State Counties	12
Figure 4	Four Interrelated Variables in Model of Empowerment	51
Figure 5	Empowerment Model	53

LIST OF TABLES

		PAGE
Table 1	Cross Referencing of Primary Self-Help Groups	14
Table 2	Summary of Responses About Primary Purpose of Self-Help Group	22

SECTION ONE

INTRODUCTION

The essence of the meaning of self-help lies in the power of the individual to aid themselves and to reach out and help others. Self-help groups of all types, including mental health, are presently proliferating faster than any other national human service (Borman, 1982; Jacobs & Goodman, 1989). Within mental health, self-help groups are beginning to be organized by individuals with specific mental health conditions (for example, depression, manic depression, neuroses, and schizophrenia), to meet the various mental health needs of special populations (for example, chemical abusers, aged, and the physically disabled), to foster advocacy and empowerment, to reach minorities, and to provide services (for example food and housing).

As self-help groups continue to grow at the local, state and national levels, there is also an emerging recognition of these groups as potential alternatives to current mental health system approaches to care. The sense of a new direction that gives recognition to the concept of self-help in mental health is also reflected in the increasing number of unpublished reports, journal articles, call for conference papers, funding for research and evaluation activities (Carpinello, 1990a).

Purpose

The purpose of this study was to identify the meanings of self-help, the processes that occur in self-help groups, and the outcomes of self-help group membership. This research focused on primary mental health self-help groups which were defined as groups that chiefly included members who had been diagnosed as having a mental illness and were

recipients¹ of mental health services.

Four primary questions guided this qualitative study. They included: 1) What are the perceptions of the meaning of self-help as expressed by self-help group leaders, members, and significant others? 2) Are there differences in the perceptions of the meaning of self-help by either group role or significant other role? 3) What are the idiographic perceptions of the efficacy of self-help group membership? and 4) What processes/activities occur in self-help groups?

Justification

Although there is evidence of increased interest in self-help, report of favorable attitudes of self-help groups by professionals, and documentation of positive outcomes, there are few investigations directly related to the study of *primary mental health self-help groups*. Additionally, most of these studies were designed to answer questions about specific self-help groups: Grow, International; Recovery, Inc.; Manic Depressive and Depressive Association; and Emotions Anonymous.

Further, the analysis of past studies in self-help have identified a number of problems. These problems include methodological issues which threaten reliability, validity and the generalizability of findings (Gartner & Riessman, 1984; Levy, 1984; Lieberman & Bond, 1978), differences in both the meaning of self-help and self-help groups, and conflict over who is most expert to formulate these definitions (Borkman, 1976; Powell, 1987).

With so many diverse opinions on "what self help is" or "what self help is not", a

¹ We recognize individual preferences for use of words that denote a person who has been diagnosed as having a mental illness and who may be receiving mental health services. This may include the words consumer, psychiatric survivor, or recipient. For purposes of this report we will use the word recipient.

more inductive and phenomenological examination of the meaning of self-help to members of primary mental health self-help groups was needed. In the past, the notion of using experiential knowledge or "truth based on personal experience with a phenomena" as a mechanism for redefining self-help groups and ultimately differentiating their characteristics from other forms of human service was called for (Borkman, 1976; Powell, 1987).

The study of self-help groups also assumes that meaningful outcomes have been identified. But outcomes, implicit in the self-help process, are multiply constructed, depending on both context and who is defining them. There is no reason, for example, to assume that self-help members' viewpoints are identical to one another or to those of professionals, family members, or others (Lieberman & Bond, 1978). Identifying meaningful outcomes, also required an ideographic approach to identify what persons believed they were gaining from their self-help group.

SECTION TWO

DESIGN

The perspective for this study combined elements of qualitative research methods (Basch, 1987; Krueger, 1988; Morgan, 1988), naturalistic inquiry (Lincoln & Guba, 1985) and fourth generation evaluation (Guba & Lincoln, 1990). Conventional (experimental or quasi-experimental) evaluation designs normally present the plan, structure, and strategy of the proposed investigation so as to acquire the answers to predetermined research questions and, to the degree possible, to control variance. In contrast, as other researchers designing qualitative investigations, we were faced with the paradox of presenting a design which had a focused starting point but needed to allow for emerging elements that would be contrary to the customary blueprint. This study emerged from the inquiry and was guided by the following key elements within time and resource constraints:

- o **human-as-instrument: researcher**
- o **qualitative methods: focus group and key informant interviews**
- o **purposive sampling**
- o **inductive data analysis**
- o **member checks/negotiated outcomes**
- o **tests for trustworthiness**
- o **report (see Figure 1)**

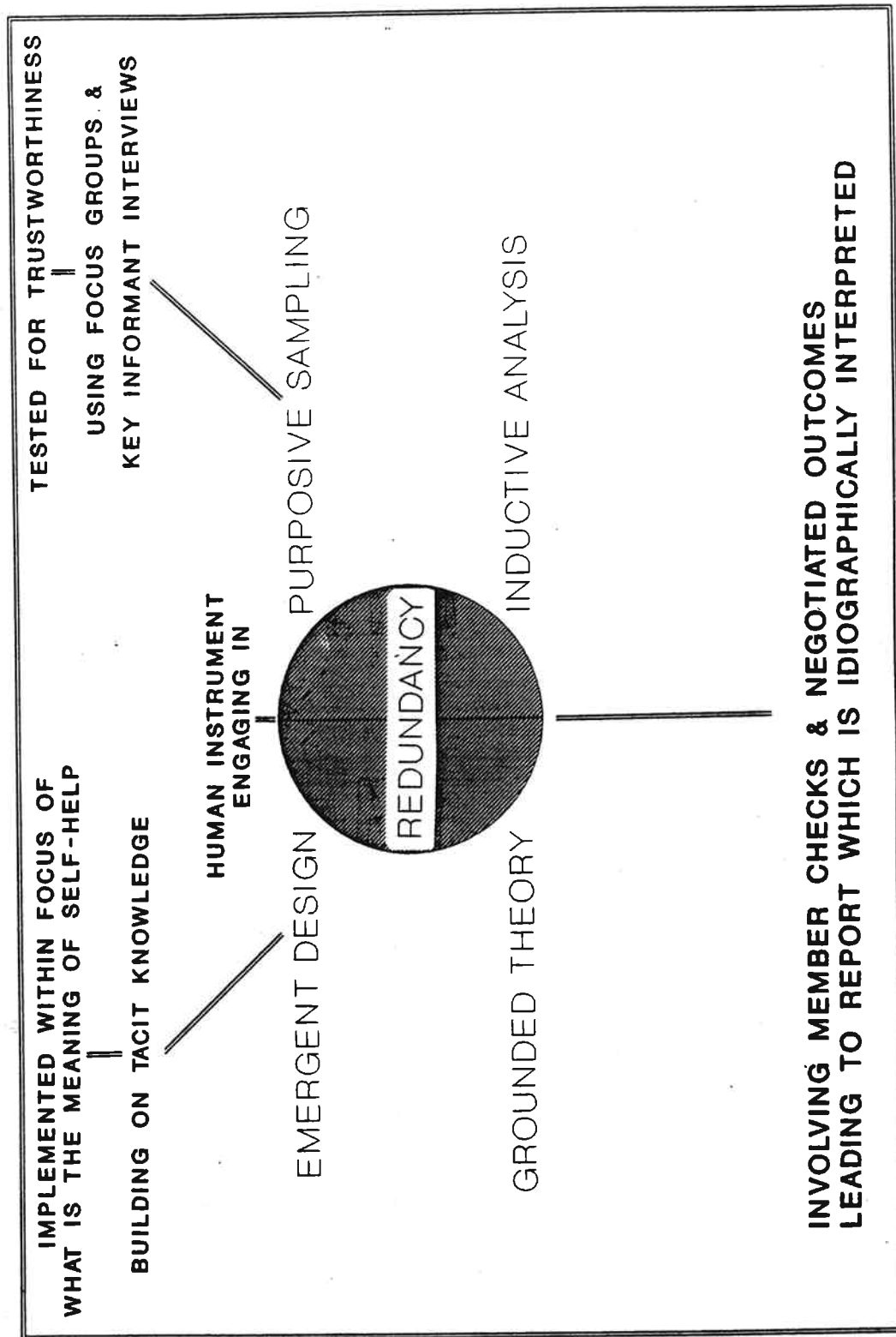
Characteristics of Design

It was hypothesized that participants in primary mental health self-help groups, as well as their significant others, would each have their own perspective on what is self-help. The basis for this hypothesis was Kleinman's Explanatory Model (Kleinman, 1980), or the different ways in which clinicians, patients, and their entourage (family/friends) perceive the nature and course of a disorder and foresee improvement, as well as the therapeutic

Figure 1: Design Overview

Adaptation of Naturalistic Inquiry Flow

(Lincoln & Guba, 1985)



interventions and coping mechanisms they believe to be effective. As the primary method of qualitative research, focus group interviews were used. Focused group interviews elicited contrasting views and experiences within planned group discussions for self-help group leaders, self-help group members, and family members.

Focus groups have been successfully used in the health field, specifically in education, clinical, research and evaluation settings (Basch, 1987; Maddy & Carpinello, 1990). In this study, the human instrument was the researcher (group moderator), who asked a series of open-ended questions designed specifically to elicit participant responses and perceptions of self-help. For example, the moderator asked the group participants:

"When I say the word self-help what do you see or what do you think of?"

and

"What has self-help done for you in your life?"

Key informant interviews were used as the second qualitative method of research. A key informant is defined as having the most information about specific situations (Brinkerhoff et.al., 1983) but as an accepted member of a group is also willing to talk with researchers (Lincoln & Guba, 1985). Interviews with key informants provided researchers with an insiders perspective of the processes and culture that characterized self-help groups.

The findings from the focus groups were triangulated with other methods and/or data. The technique of triangulation, along with other procedures (for example, peer debriefing, member checking, and a thick description of the data) was used as a mode to improve the probability that the findings would be found credible, dependable, and confirmable. The outcomes of focus group interviews coupled with key informant interviews were used to determine the meaning of self-help which was experientially grounded.

Each of the views voiced in focus groups or reported in informant interviews were considered part of the *emic* data set--the *insider's* view--rather than the *etic*--the *outsider's*--view. Our ultimate definition and analysis of self-help, its processes, and outcomes emerged from these multiple perspectives. By eliciting contrasting views within focus groups, clarifying and raising new questions between groups, and combining the findings from the focus groups with those from the key informant interviews, a forum for negotiations was established. Negotiations served to resolve or reduce differences in perceptions, claims, or issues from the stakeholders' perspective. This report is synthesized from this *emic* perspective.

SECTION THREE

METHODOLOGY

The purpose of this study was to identify the meanings of self-help, the processes that occur in self-help groups, and the outcomes of self-help group membership. The focus of this study evolved primarily from guided discussions and face-to-face contact with three types of focus groups: one composed of self-help group members; another comprised of self-help group leaders; and the last made up of significant others. This section describes the methods employed in conducting this qualitative study; information is presented about the sampling selection, instrumentation, procedures, and data analysis.

Population and Sample

New York State has an adult population of approximately 14 million people; over 185,000² of these individuals have been estimated to be severely and persistently mentally ill. It is presently unknown how many of these individuals are actually involved in primary self-help groups because there has not been a systematic study to map existing self-help groups and to evaluate the socio-demographic make-up of these groups.

Sampling

Sampling was purposeful and included a multistage serial selection of both self-help groups and participants to achieve the broadest scope of information. Maximum variation in both groups and participants also allowed for documentation of the range of variations connected to different contexts and situations. Purposive sampling groups was conducted for each of the three separate focus groups; self-help leaders, self-help members,

² Prevalence of Mental Illness Among Adults in New York State. Needs Assessment Unit. Bureau of Planning Assistance and Coordination. N. Y. S. Office of Mental Health (Grosser, R. & Mort, K. 1988).

and significant others.

Group Sampling Procedure

The group sampling procedure involved four initial stages directed at identifying and classifying primary mental health self-help groups: 1) identification of the universe of New York State mental health self-help groups; 2) selection of groups meeting the criteria of primary mental health self-help group; 3) creation of a group typology; and 4) assignment of groups to the classification scheme (see Figure 2).

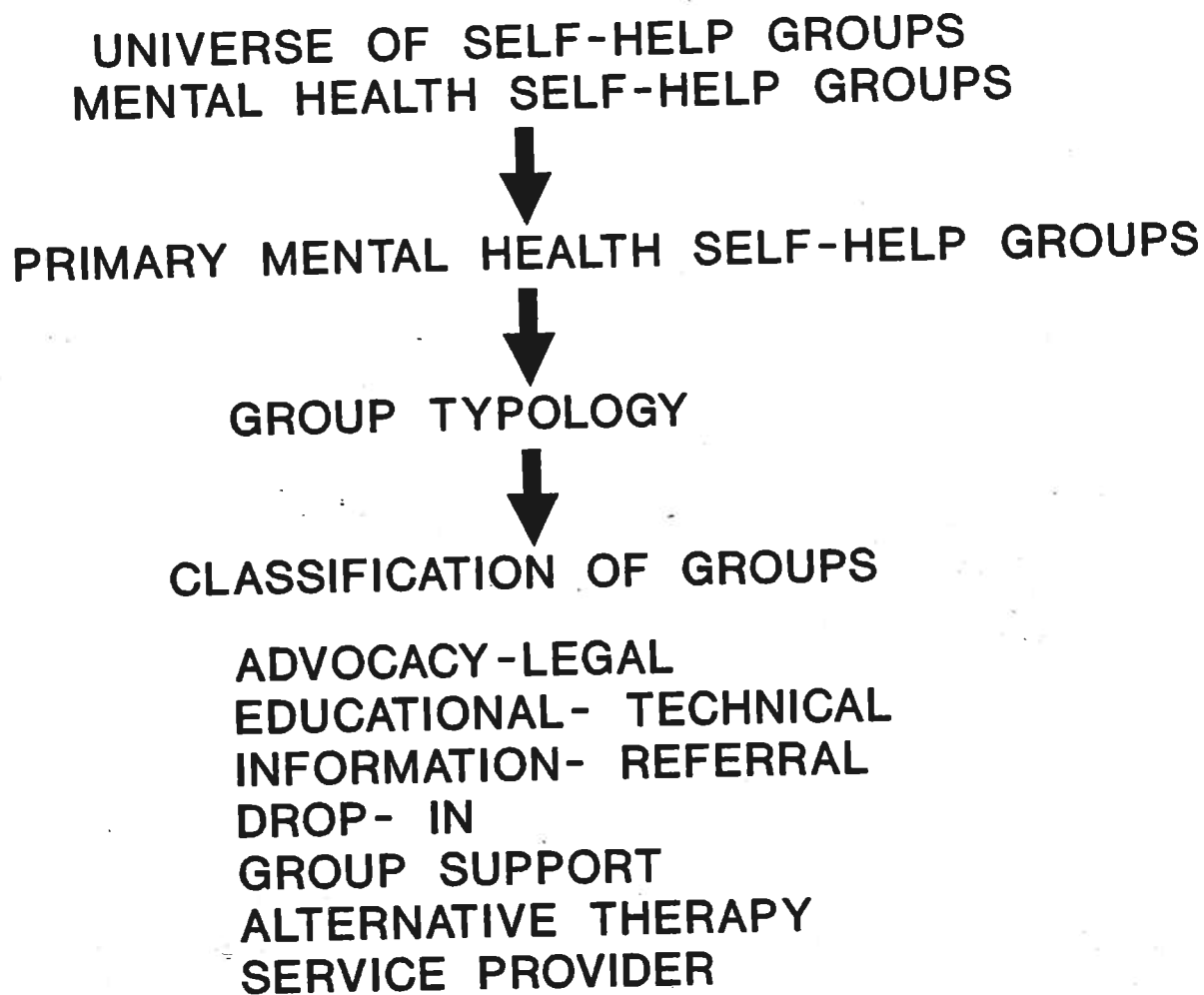
Universe of Mental Health Self-Help Groups. A collective listing of all mental health self-help groups in the state did not exist. To establish a sampling frame, information was gathered from multiple sources in 62 New York State counties. These sources included:

- a) directors/coordinators of 37 self-help county clearinghouses;
- b) directors of mental health associations;
- c) self-help group leaders, members and other key informants;
- d) professionals in supportive and/or partnership roles; and
- e) data from the Consumer Preference Survey (New York State Office of Mental Health Bureau of Evaluation and Services Research, 1990).
- f) recipient newsletters, pamphlets and other publications

A descriptive listing of 116 self-help groups with a mental health focus was generated. This first sampling frame was organized by New York State counties to allow for later geographical sampling considerations.

Primary Mental Health Self-Help Groups. The universe of mental health groups was reviewed by key informants to determine which groups met the definition of primary mental health self-help group. The result of this review was a list of 48 groups.

Figure 2 Group Sampling Procedure



These 48 groups were represented in 20 New York State Counties (see Figure 3).

Group Typology. A typology reflecting two self-help models was created. This typology included a) the Intra-Group Dynamic Service Component of Emerick's Primary Service Model (1989a; 1989b) and b) Knight's Producer Model (1990).

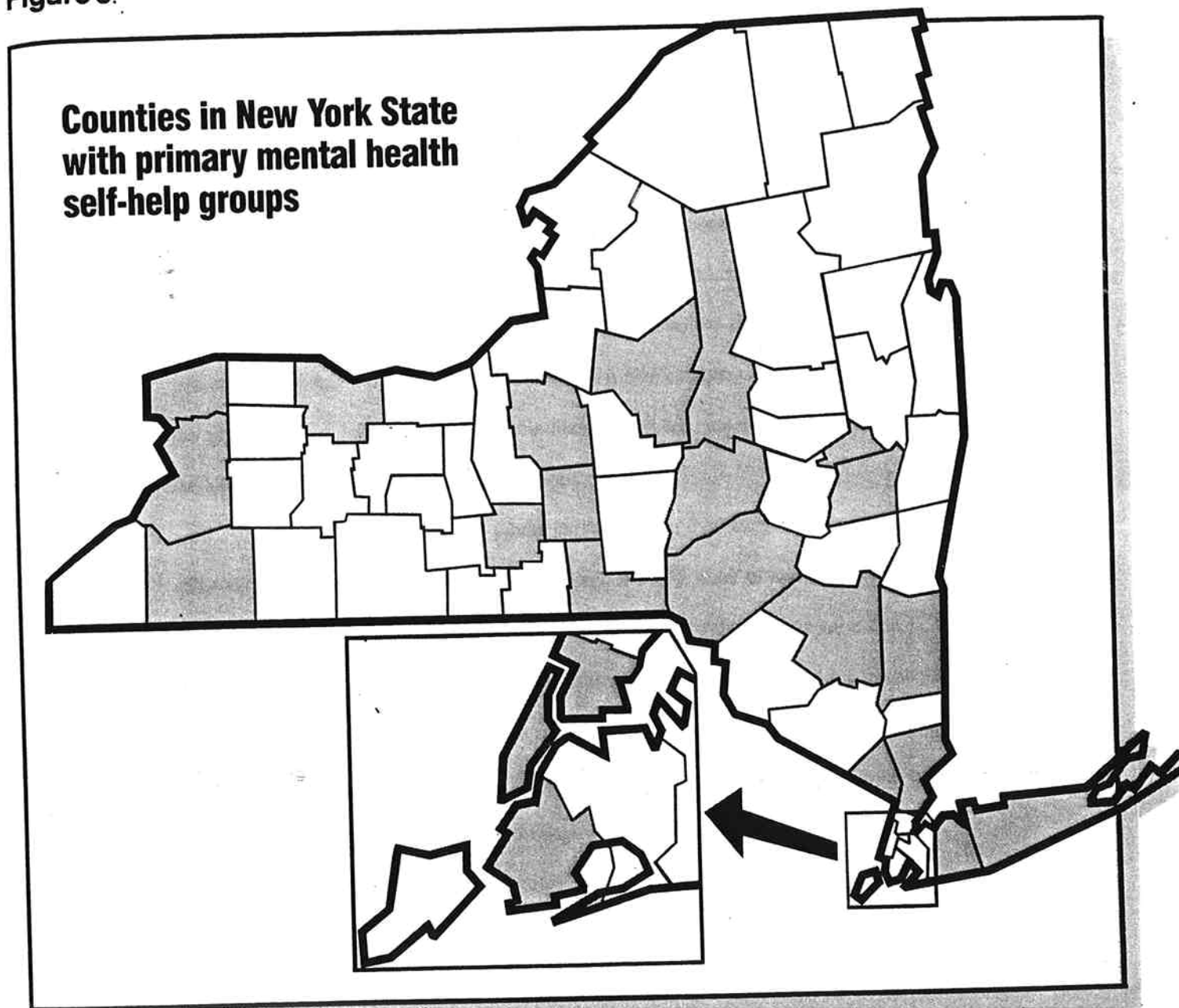
The Primary Service Model explains what groups do, the services provided, and the group structure. Emerick (1989a; 1989b) hypothesized that the service component represented an intra-group dynamic measure of six categories of services. These include three social change services: 1) advocacy-legal; 2) educational-technical assistance; 3) information-referral; and three individual growth services: 4) drop-in centers; 5) group support; and 6) alternative therapy.

Knights (1990) Producer Model is based on the premise that individuals and groups are their own decision makers; they are no longer recipients but producers. Production takes place at three levels including: 1) mutual support groups consisting of people in small groups or sometimes large networks; 2) advocacy groups consisting of people advocating for themselves around issues they define; and 3) service delivery groups which deliver services that they decide are needed.

The categories of mutual support and advocacy were reflected in both models. However, the category of service delivery was distinctly related to Knight's classification. The combined categories reflected seven classes of self-help groups.

Classification of Groups. Researchers and key informants attempted to classify the 48 primary groups into seven categories. We discovered that this was an impossible task; the seven classes were not mutually exclusive. All of the groups cross referenced with at least two other classes; some group support self-help groups cross referenced in all six other

Figure 3.



- existing groups
- no existing groups

classes; some advocacy-legal self-help groups cross referenced with five other classes. The cross referencing of all groups is illustrated in Table 1. Cross referencing of groups was given consideration in the purposive sampling scheme.

Participant Sampling Procedure

The sampling procedure for participants relied on identifying human variables considered to be critical by the researchers and the emergent element of this design. These included: 1) divergent social demographic characteristics; 2) history and/or experience in self-help groups, and thereafter 3) sampling dependent on the characteristics of the preceding elements and emerging outcomes. Purposive sampling was conducted for each of the three separate focus groups (self-help leaders, self-help members and significant others), for key informant interviews and negotiations.

Participants. A total of 25 adults participated in this study. Primary mental health self-help group members (n = 21) ranged in age from 29 years of age to 51 years of age. Self-help group members were further defined according to their group role; that is, as leaders (n = 10) or members (11). Four parents of self-help group members participated.

Self-Help Group Leaders. The self-help group leaders (n = 10) were contacted by telephone and asked to participate. Leaders were identified from the information listed in the clearinghouse directories and/or through key informants. Participants had served in leadership roles from 6 months to 13 years. Two participants were leaders for more than one self-help group. Self-help group leaders represented groups from all seven classes.

Self-Help Group Members. Self-help group members (n = 11) were contacted through self-help group leaders. A cover letter was sent to self-help group leaders stating the purpose of the study and asking that a sign-up list for volunteer participants be

Table 1

Cross Referencing Of Primary Self-Help Groups By Primary Service Model: Intra-Group Dynamic Component (Emerick, 1989) and Producer Model (Knight, 1990) for Sampling.

Primary Self-Help Group	CROSS REFERENCED ¹						
	AL	ET	IR	DI	GS	AT	SP
AL		X	X	X	X		X
ET	X		X		X		X
IR		X			X	X	
DI	X				X		
GS	X	X	X	X		X	
AT					X		X
SP					X	X	

¹ Advocacy-Legal= AL; Educational-Technical=ET; Informational-Referral=IR; Drop-In= DI; Group Support=GS; Alternative Therapy=AT; and Service Provider=SP.

disseminated to group members. Potential participants were contacted and asked a series of questions to determine their eligibility. Self-help group members represented groups from all seven classes.

Significant Others. Participating group leaders and members were asked to invite a family member and/or close friend to also attend a separate focused group discussion. Four parents represented the significant other category and were interviewed in a third focused discussion.

Confidentiality

All participants were volunteers who gave their verbal consent to participate. Introductory remarks at each focus group addressed issues of confidentiality. Confidentiality of responses was guaranteed. Participants were guaranteed that no reference would be made in written or oral communication that included names or any other identifying information. Participants were informed that the group session would be audiotaped and a person would function as a note taker. All audio-tapes and process recordings, participant names, addresses and telephone numbers will be destroyed.

Instrumentation

The major data-gathering instruments were the researchers themselves. In naturalistic inquiry, the quality or adequacy of the data, which corresponds roughly to internal and external validity and objectivity in positivist research, is assured through trustworthiness. Trustworthiness establishes the confidence in the truth of the findings (Lincoln & Guba, 1985, p. 290; Guba & Lincoln, 1990, p. 234). That is, to say, the credibility of the findings were enhanced during the phases of this study when the findings were found to corresponded to the views of the of the participants. Where such correspondence (for

example, in the case of unresolved issues or questions) did not exist, the researchers searched for an understanding through negotiation efforts. Researchers-as-human-instruments established trustworthiness³ through focused interviews, peer debriefings, member checks, and negotiation activities.

A moderator guide was developed for the focused interviews. This guide consisted of three sections including: 1) groundrules; 2) an icebreaker question; and 3) potential open-ended, general and contextually framed questions (see Appendix A). As researchers interacted during interviews and interpreted the data, natural revisions were made in the guide. The very nature of an emergent design, in which succeeding steps rely upon the interpretative results of steps already pursued, made these revisions a necessary step.

Procedure

This study was implemented in three phases. It began with the mapping of self-help groups and recruitment of participants and progressed from the actual implementation of focused interviews with collection of data to the validation of this data through the processes of member checking and negotiation. The conclusion of these phases is this report that adequately represents the participants in this study and is one in which the stakeholders have become empowered to participate. The three phases included: 1) orientation; 2) focused investigation and peer debriefing; and 3) member checks and negotiated outcomes. These phases focused the study. They did not always occur in a consecutive manner but often occurred simultaneously and within the process of data analysis.

³ For a full description of trustworthiness criteria refer to Guba & Lincoln (1985).

Phase One: Orientation/Overview

During Phase One, the researchers obtained information from key informants and began to recruit and identify members for the first focus group. The characteristics of each participant were checked against the sampling plan before another participant was selected. At this time the focus group questions were crystallized. Logistical arrangements for conducting the focus group interviews were finalized; for example, selecting the site, sending directions to participants, and collecting recording equipment.

Phase Two: Focused Investigation

Phase Two, was used to collect information through focused group interviews and key informant interviews. This data provided a thick description of participants' views. The focus group interviews were managed by several principal people. These included a group moderator, co-moderator and notetaker/audio-tape manager. Discussions with key informants were conducted in face-to-face interviews.

The notetaker/audio manager detailed a sociogram and recorded nonverbal communications. Additionally, this person provided an oral summary of the proceedings for debriefing sessions with participants and researchers. Researchers guiding and recording the focus groups also engaged in closed peer-debriefing sessions. Debriefing sessions served multiple purposes by exploring the perceptions of the meanings of the group proceedings, testing working hypotheses, proposing succeeding steps, and allowing for the ventilation of feelings.

Phase Three: Member Checks and Negotiated Outcomes

Member checking is the most critical activity to establish credibility (Guba & Lincoln, 1990). In this study, member checks served the function of giving participants the

chance to correct errors of fact or errors of interpretation and add additional information. Additionally, participants had a chance to judge the overall adequacy of the interview and confirm individual data items. To achieve these purposes, participants reviewed transcripts, interpretations made by researchers (for example, self-help definition(s) and other representations). Three-quarters (12) of the participants in focused group discussions returned transcripts with minor edits.

Member checking allowed for negotiated outcomes between the participants or individuals like them. Three negotiation sessions were conducted with self-help group members (n=7) via teleconference. This method did not allow for the audio-taping of responses. However, a notetaker was on line to record these sessions. Issues that had been labeled as unresolved and of minority opinion were used to formulate questions that guided these sessions. These sessions were critical for establishing the credibility of the outcomes of this study and encouraging the use of the findings.

Data Analysis

Researchers consistently agree that there is no special formula to apply in doing qualitative data analysis. Instead, recommendations are made for a wide variety of techniques incorporating both human efforts and computer aided coding (Higginbotham & Cox, 1979; Krueger, 1988; Morgan, 1988; Miles, 1983; Pfeiffer, Pruzek & Sherry, 1975; Weber, 1985). We employed a systematic plan combining human and technical assistance. The Text-Base Alpha (Tesch, 1990) computer analysis software program was used to assist in the management of data. This program was complemented by individual hand coding by the researchers. Analysis began at the group level and progressed to subsequent groups, to informants, and to individual responses within each group. The specific procedure for

analysis is presented in the following paragraphs.

Handling of Data and Coding

The actual procedure of data analysis consisted of first transcribing the raw data from audio-tapes into written process recordings. These preliminary transcriptions were then reviewed by participants during the member checking phase. Final transcripts were prepared after all editing was completed. A general read through was completed for all transcripts by the researchers.

Initially, the principal researcher organized all focus group proceedings by examining the responses to the research questions guiding this study. This process not only helped to reduce the data but also allowed for immediate decisions to be made about the steps to take in subsequent interviews. For example, what groups and individuals to sample, what new questions needed to be asked, where consensus was reached, and where points of conflict existed. This allowed for later triangulation of data.

A more critical examination of the data, that was content focused, followed this initial review. This examination used a combination of systematic pattern coding by content and ethnographic summary. A coding key was developed by the principal researcher from the first focused group interview. This original coding key was subsequently modified. Data from the leader interview was organized into a pre-structured coding mode for use with the Text-Base Alpha Computer software program. A word occurrence frequency count assisted in identifying coding constructs. The contextual component of this process included a careful consideration to including actual quotes from study participants referenced in the actual framework or set of circumstances in which the citations were made. In most instances, this included one of three conditions: 1) answers to questions posed by the researchers; 2)

response to statements made by other research participants; and c) pure reflection on the part of the participant.

Intercoder reliability considerations were addressed early in the study. Intercoder reliability is defined as the extent to which coding classifications produce the same results when the text is coded by more than one coder (Weber, 1985, p.17.) All three researchers coded all focus group interview transcripts and negotiation transcripts. The principal researcher coded key informant transcripts. Each coded transcript was reviewed by two researchers to identify conflicts in coding. Early conflicts arose in coding the first transcript. These problems were primarily due to differences in conceptual perceptions, personal bias, and the need to refine our coding scheme. We were able to resolve these initial problems but continued with subsequent coding to identify, discuss, and resolve differences.

Although not addressed in relation to interrater reliability, we feel that the personal attributes of the researchers involved in this investigation combined with the naturalistic design of the study contributed to the theoretically sensitive interpretation of this data set⁴. The sources of theoretical sensitivity in this study were in the literature, professional experience, and personal realm. Both research studies and nontechnical literature reviews (eg. clearinghouse directories; key informant interviews; pamphlets) were written in a review prior to the onset of this study (Carpinello, 1990a). This source of information coupled with the mapping procedure of mental health self-help groups in State of New York added to the knowledge base of the researchers. Additionally, the professional and personal experiences of the researchers brought unique perspectives to this analysis.

⁴ For a full discussion on theoretical sensitivity refer to Glaser, B. (1978); Glaser, B. & Strauss, (1967); and Strauss, A. & Corbin, J. (1990).

SECTION FOUR

RESULTS

This section presents the analysis of a qualitative study on the perceptions of the meaning of self-help as expressed by self-help group leaders, members and significant others. The results will be organized around four primary questions that helped to guide this study and emerged from focused interviews: 1) How should primary self-help groups be classified? 2) What are the perceptions of the meaning of self-help? 3) What roles do professionals have in self-help groups? and 4) What are the outcomes of group membership?

Self-Help Group Typology

The problems of overlap that were presented in the methodology section in attempting to classify New York State primary self-help groups by seven levels of service were also reflected in an examination of the data. Participants were asked to respond to questions about the primary purpose of their self-help group(s). Table 2, illustrates a summary of participants responses to these questions. In most cases the participants indicated that their groups served to achieve multiple group functions. These purposes reflected three key areas of support, advocacy, and service provision. For example, participants in groups such as educational/technical and/or information/referral, that were cross referenced with support groups, all reported support as a primary purpose; participants from drop-in centers indicated support, service provision, and advocacy as chief purposes; participants from advocacy groups that were already established drop-in centers, identified advocacy and support as primary purposes.

These results do not support the two specific categories of the service provision

Table 2

Summary of Responses About Primary Purpose of Self-Help Group.

- 0 To help other folks with a psychiatric disability find suitable housing.
- 0 To share problems and small victories relating to illness; keeping abreast of developments with various medications; and a large and enthusiastic social life (both with families and members only).
- 0 To give mutual support to each other, to provide a place for mentally ill persons living in the community to enjoy company, counseling, and food.
- 0 To help each other to achieve more independence and greater self-reliance. Also to have meals.
- 0 To help people with a "primary psychiatric diagnosis" find decent, secure, and affordable housing.
- 0 Information and support.
- 0 To empower the psychiatrically labeled.
- 0 Self-help and advocacy; motto is to "help ourselves and other psychiatrically labeled persons.
- 0 Peer support for the psychiatrically disabled.
- 0 To maintain support and continue to focus on alcoholism and drug addiction.
- 0 Self-help and advocacy.
- 0 Self-help support group; education; support; rap session; professional speakers.
- 0 To empower and organize the psychiatrically labeled persons through peer support, peer advocacy, systems advocacy, public education, training, and consumer-run alternatives.
- 0 Self-help for any nervous condition. Self-discipline of the method learned in structured meetings providing framework for managing symptoms as they arise.
- 0 Self-help support group for those diagnosed as schizophrenic or schizophrenic disorder. Providing a safe environment for discussing delusions and hallucinations; Helping each other overcome the apathy and demoralization following hospitalization. Encourage each other to develop more enthusiasm for life and become empowered in relation to their illness and life in society.
- 0 Helping adult home people; provide a drop-in center.
- 0 Peer support, community awareness, and advocacy.
- 0 Socialization and relaxation.