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Involvement in mental health self-help groups and recovery

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Introduction

Self-help groups for mental health problems are the most prevalent form of self-help. There are several thousand groups in Australia, the U.K., and the U.S. In the U.S, they are utilized by over 2 million adults annually (Goldstrom et al., 2006; Substance Abuse and Mental Health Services Administration, 2009).¹ While qualitative research points to beneficial effects, quantitative studies examining psychiatric outcomes show mixed effects, with about half of studies showing favorable effects on symptoms and social functioning (Pistrang, Barker, & Humphreys 2008, 2010). However, the processes by which involvement in self-help impacts recovery are not fully understood, in part due to the atheoretical nature of research (Brown and Lucksted, 2010; Pistrang, Baker, & Humphreys, 2010; Lloyd-Evans et al., 2014). Studies that examine factors that mediate the effects of involvement on outcomes are limited to cross-sectional designs, precluding firm inferences about causal direction. Moreover, studies examine outcomes in isolation, without considering processes that link them together. By theoretically organizing recovery-oriented processes, the potential effects of involvement in self-help can be better understood.

In this study, we first review how recovery is believed to be facilitated by self-help groups for persons with severe mental illness, emphasizing relationships among key components. Next, we discuss qualitative and quantitative research on self-help and its limitations. Applying empowerment, stigma, and social selection perspectives, we formulate and test a model of the relationships between involvement in self-help (level of participation and interaction with other members), empowerment (self-esteem, mental health confidence, and stigma reduction), symptoms, and quality of life. Then, we examine the reciprocal relationships between beliefs in the efficacy of self-help and involvement. Finally, we report results regarding why some respondents never attended self-help group meetings, why those who continue to attend do so, and why others stop attending.

Self-help and recovery

Over the last few decades, mental health consumer advocates, service researchers, and providers have argued for an approach to recovery from mental illness that places emphasis

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¹Some distinguish between *mental health mutual support groups* (members share common experiences and support), *mental health self-help organizations* (education and advocacy), and *consumer-operated services* (programs and businesses). All these groups are organized and run by persons with mental illness. We use the term *mental health self-help groups* to refer to our main analytic focus on *mental health mutual support groups*.

not only on the symptoms of a disorder, but on the ‘life-context’ of persons (Anthony, 1993; Ralph & Corrigan, 2005). They maintain that, in addition to medication-based symptom management, ‘empowerment,’ increased self-esteem and self-efficacy, along with meaningful relationships, work and improved quality of life, are key interrelated components of recovery. Recovery is therefore conceptualized not as some endpoint, but rather, as an ongoing, eminently *social-psychological* process in which these elements covary over time (Markowitz, 2005).

Self-help organizations (e.g. Recovery, Inc., Schizophrenics Anonymous) have proliferated over the past several decades, as advocacy groups, alternatives, and supplements to conventional services, often in the spirit of helping foster empowerment and recovery (Goldstrom, et al. 2006; Katz, 1993). One advantage to self-help groups is thought to be cost-effectiveness, particularly in the climate of fiscal constraints on therapy (Brown 2009). Although mental health self-help groups vary in their focus and dynamics, they are member-governed, and emphasize self-advocacy and taking an active role in treatment decisions. These groups are believed to provide social support and knowledge gained by interaction with ‘peers,’ those who also have a diagnosis of mental illness—in Goffman’s (1963) terms, the ‘own,’ so that stigmatized individuals find acceptance, a vital step in making cognitive changes that lead to improved functioning and quality of life (Jacobs & Goodman, 1989). This is consistent with self-attribution theories that indicate when persons with mental illness are embedded in meaningful groups and engaged in productive activity, their sense of self is enhanced (Markowitz, 2001). Moreover, self-help is believed to combat stigma by demonstrating that persons with a mental illness can manage their own lives and programs (Powell & Knight, 1995).

Advocacy-oriented qualitative research on the effects of participation focuses on particular groups, but suggests processes that operate across groups. These studies do not measure change in outcomes or estimate the relationships between outcomes, but point to pathways through which involvement facilitates recovery. Research using interviews with members of particular groups highlights the importance of reducing symptoms and increasing self-esteem in recovery (Brown, 2009; Corrigan et al., 2005; Weaver & Salem, 2005). Members also point to a supportive network of others with common experiences as facilitating recovery—a community of ‘sharing and caring’ (Corrigan et al., 2005; Finn, Bishop, & Sparrow 2009). Moreover, self-efficacy may be increased by role changes from ‘one who is helped’ to ‘one who helps others,’ and by providing successful role models (Carpinello & Knight, 1991; Weaver & Salem, 2005).

Critically, this research is limited to those currently involved (self-select) in groups, omitting persons who drop out or decrease participation, for whom benefits may not be evident. To confirm these findings, it is important for longitudinal studies to include those who no longer participate, capturing variation in involvement and outcomes. This also allows for examination of reciprocal relationships between involvement and perceived benefits. Those who perceive participation as helpful may continue to be involved, while involvement, in turn, leads to an increase in perceived benefits, consistent with models of the relationship between attitudes and behavior (Liska, Chamlin, & Baccaglini, 1984), possibilities considered below.

Quantitative studies of self-help focus mostly on psychiatric outcomes (e.g., symptoms, functioning, and treatment adherence). Reviews of the effectiveness of self-help groups indicate that studies using a variety of methods (cross-sectional, longitudinal, randomized) and measures produce mixed findings—only about half show involvement lowers symptoms, or improves social adjustment or treatment adherence (Pistrang, Baker, & Humphreys, 2008, 2010). There is also no evidence that the effectiveness of participation varies by the types of problems that groups focus on. Meta-analysis of randomized studies indicates little effect of groups on symptoms or other outcomes (Lloyd-Evans et al., 2014). While these studies examine the broad ‘effectiveness’ of self-help groups on outcomes, they are largely atheoretical and leave causal mechanisms unspecified. Cross-sectional studies—like their qualitative counterparts—do not account for attrition from groups that may bias effects, leading to possible overestimation of benefits.

While qualitative studies focus on ‘empowerment’ and quantitative studies focus on ‘psychiatric’ outcomes, they do not link the two types of outcomes in an integrated model, leaving causal processes by which self-help might affect outcomes unspecified, especially the extent to which involvement in self-help affects symptoms and quality of life through empowerment variables. Moreover, quantitative studies consider participation as a dichotomy (participant or not), rather than as a continuum (e.g., none to frequent), taking into account forms of involvement, such as attending meetings and getting together with members (Davidson et al., 2006).

While there has been much sociological theory-based research on stigma and mental health outcomes (Link & Phelan, 2013; Markowitz, 2014), there has been little sociological work on recovery, with the exceptions of Markowitz’s (2001, 2005) efforts at formulating a model of recovery processes, and Jacobson (2004), McCraine (2010), Pilgrim & McCraine (2013), and Watson, McCranie, & Wright (2014), who focus primarily on the construction and implications of the concept of recovery for mental health services and consumers. Similarly, sociological research on self-help has been limited to focusing on groups as part of a social movement, as alternatives to traditional treatment (Emerick, 1991; Katz, 1993), or processes of socialization in particular groups (Karp, 1992). In contrast to services-oriented research, there is little sociological theory-based research on the effects of involvement in self-help groups on stigma and recovery.

Participation may have several stigma-related consequences. On one hand, consistent with an ‘empowerment’ approach, it may foster rejection of stereotypes and offer strategies for managing experienced stigma (Corrigan et al., 2005). Participation in groups of people with stigmatized identities—like mental health self-help groups—may be self-enhancing because it helps align a problematic social identity with valued personal identities (Kaplan & Liu, 2000). That is, participation helps create new identities, taking the place of problematic ones, enhancing self-worth. Members may also serve as a favorable comparison group to reference one’s level of self-worth and functioning (Corrigan & Watson, 2002).

Alternatively, similar to the way treatment improves symptoms and quality of life, yet increases stigma and constricts normative networks, involvement in self-help may have similar countervailing effects—improving social support and coping, while cultivating

identity and internalized stigma (i.e., expectations of rejection) and limiting normative networks (Estroff et al., 1997; Link et al., 1989, 1997; Rosenfeld, 1997). Identity theory suggests that involvement in a given social position, relative to other positions occupied, results in stronger identity centrality (Stryker & Serpe, 1994). Sharing stories of stigma might also reinforce notions of ‘us vs. them,’ highlighting stereotypes held by the public (Pescosolido et al., 2010). Consequently, gains in self-esteem and quality of life may be modest. A cross-sectional study of a mental health support group found that although identification with the group was correlated with increased support and stigma resistance, consistent with symbolic interactionist theory, group identification was associated with lowered self-esteem (Crabtree, Haslam, & Postmes, 2010). However, it was not possible to determine the direction of effect without longitudinal data and variability in participation. Moreover, organizational goals of maintaining membership without clear-cut end-points may discourage members from ‘graduating’ out of groups (Omark, 1979).

Social selection

The concept of ‘social selection’ traditionally referred to how persons with mental illnesses are ‘selected’ (or drift downward) into lower socio-economic status (Miech et al., 1999). It has also been applied to how symptoms reduce primary and secondary ties, including involvement in voluntary organizations, as persons with greater symptoms likely face difficulties in forming and maintaining these social ties (Johnson, 1999; Perry, 2014). Self-help groups lie along the continuum between ‘formal’ and ‘informal’ associations, and involve friendship ties (Davidson et al., 2006). Thus, it is possible that persons who are worse off psychologically and socially (e.g., lower quality of life and higher symptoms) are less able to become involved in self-help. Among those involved, persons worse off are less likely to continue involvement, thus ‘self-selecting’ out of groups. Conversely, persons who are better off join and continue participation, or ‘select into’ groups providing interpersonal resources, enhancing their ‘social capital’ (Folgheraiter & Pasini, 2009; Thoits & Hewitt, 2001).

Randomized studies permit estimation of the effects of involvement in self-help on outcomes, eliminating selection effects. However, longitudinal survey studies allow for the estimation of baseline levels of outcomes on participation while isolating possible effects over time. Finding that initial levels of symptoms and quality of life are related to participation provides evidence of selection effects and prevents over-estimation of the effects of self-help.

Present study

Drawing from the above perspectives, we examine the effects of involvement in self-help (meeting attendance and interaction with group members) on recovery-oriented outcomes. Our model is presented in Figure 1. Following previous research, we focus on self-evaluation, stigma, symptoms, and quality of life (Anthony, 1993; Markowitz, 2001, 2005; Watson, 2012). The model proposes first, that initial levels of symptoms and quality of life affect changes in involvement in self-help, controlling for prior levels of self-help involvement. If symptoms are negatively associated with involvement, and quality of life is

positively associated with involvement, this suggests selection effects are operating. Second, from an empowerment approach, involvement is predicted to increase mental health confidence, self-esteem, and reduce internalized stigma. Third, empowerment variables, in turn, are predicted to reduce symptoms and improve quality of life, controlling for their prior levels. Thus, the model indicates that part of the effect of self-help on outcomes is due to empowerment. Alternatively, no effects of self-help indicates that stability or change in outcomes due to underlying illness is what matters most in recovery, consistent with a more medical-psychiatric approach.²

In addition to the main recovery model, in order to better understand trajectories of participation, we examine reciprocal effects between participation and beliefs about the effectiveness of self-help to test whether involvement influences, or is influenced by perceived helpfulness (not shown in figure). Finally, we report responses to open-ended questions indicating why respondents never attended a self-help group, why some continue to attend, and why others stop attending.

Methods

Sample

Utilizing data from a longitudinal survey of persons with serious mental illness in (1) consumer-run self-help groups and (2) outpatient service settings, we are able to capture variation in self-help and recovery outcomes over time. The first wave of data was obtained by asking leaders of mental-health self-help groups from several small and mid-size cities throughout a large, Northeastern U.S. state where self-help groups were known to operate, if they would distribute questionnaires, to be returned by postage paid mail. Ninety-five percent agreed to do so. Concurrently, two outpatient clinics from one mid-size city in the same state, associated with a multi-service community mental health center were asked to distribute surveys over a one-week period. The combined response rate for the two samples was 65% in the first wave (66% for the self-help sample and 57% for the outpatient sample), comparable to response rates of mailed surveys of persons with other medical conditions (Kelly, Frazee, & Hornik, 2010). In the second wave, the 84% of the initial respondents from both samples who agreed to give their names and addresses were mailed a follow-up survey 18 months later. Overall, the wave 2 response rate was 61% (n = 553).³ Preliminary tests indicated that, while those in the self-help sample were slightly older and more likely to be married, the results of multiple-group analyses testing for equivalence of coefficients, there were no differences between the two sample groups in the coefficients from the series of models presented, therefore, findings from the combined sample are presented. The characteristics of the combined sample are similar to those found among persons with

²We are not presently focused on the relationships between symptoms and quality of life examined in other studies (e.g., Markowitz, 2001).

³To determine whether those retained in the second wave of the study differed from those who were not, the log odds of remaining in the sample was regressed on outcome and control variables measured in the first wave (Menard, 2002). The only difference was that respondents not retained were more likely to be residing in group-type settings with higher turnover (7% of the respondents were unable to be contacted in the second wave due to the lack of forwarding address). There were no other differences in outcome variables at wave 1 between those who remained in the study and those who were unable to be contacted in the second wave.

mental illnesses in general epidemiological studies (Kessler et al., 2005), in terms of gender, marital, and employment status.

Measures

Rather than treating involvement in self-help groups as a dichotomy or in number of meetings attended (Yeaton 1994), we conceptualize involvement in two ways. *Meeting attendance* was measured by the question, “In the last 12 months, how active are you in the self-help group that is most helpful?” Responses were coded 0 = “not currently active” (or “did not attend a self-help group”); 1 = “I go to less than 50% of the scheduled meetings;” 2 = “I go to about 50% of the scheduled meetings;” 3 = “I go to more than 50% of the scheduled meetings;” 4 = “I go to all of the scheduled meetings.” Also, since persons in groups often form relationships with members that extend beyond meetings (Davidson et al., 2006), interaction with group members—*talking to/seeing members*, was measured by asking: “About how often do you talk to or see members from the self-help group you are most active in?” (0 = “not at all/not currently active;” 1 = “one or two times a year;” 2 = “three or four times a year;” 3 = “one or two times a month;” 4 = “once a week;” 5 = “more than once a week.”).

Symptoms were measured using the Colorado Symptom Index (Coen, Shern, & Bartsch, 1989), a 14-item self-report scale, including depression, anxiety, and psychosis in the last month. Each of the items were coded from 0 to 4 (“not at all;” to “at least every day”) (Cronbach's alpha reliability = .80). *Quality of life* was measured by five items from the scale developed by Lehmann (1988), asking: “Overall, how do you feel about: the amount of time you spend with your family; the amount of time you spend with your friends; your job status; the amount of money you have to live on each month; and where you live?” Responses were coded on a scale of 1 to 5 (“unhappy” to “pleased”) (alpha = .75). *Self-esteem* is measured by the 10-item Rosenberg Self-Esteem Scale (1965). Each of the items was coded from 1 to 4 (“strongly agree” to “strongly disagree”) so that higher scores indicate higher self-esteem (alpha = .90). *Mental health self-confidence* was measured by the 16-item Mental Health Confidence Scale, designed to measure how confident respondents are in their ability to deal with circumstances related to mental illness (e.g., setting goals, getting support, dealing with symptoms, self-advocacy) (Carpinello et al., 2000). Items were coded from 1 to 6 (“very unconfident” to “very confident”) (alpha = .94). Each set of multi-item scales were summed and divided by the respective number of items.

In the first wave, the measure of *stigma* was a dichotomous response question asking respondents, “In the past 6 months, have you felt stigmatized or discriminated against because of your mental illness diagnosis?” In the second wave, internalized stigma was measured using the average score on a set of items from Link's (1987) devaluation-discrimination beliefs scale that measures internalized stigma. Responses are coded from 1 to 4, where greater scores indicate greater internalized expectations of devaluation and discrimination (alpha = .78).

Belief about self-help effectiveness was measured by the question, “Overall, how helpful has talking to or seeing other self-help group members been for you?” Responses were coded on a scale from 1 (“made my problems worse”) to 5 (“made my problems much better”).

Analysis Plan

We estimate a series of OLS regression equations corresponding to the model. First, we examine the effects of initial symptoms and quality of life on involvement in self-help at time 2, controlling for time 1 involvement. To the extent that initial level of symptoms has a negative effect on involvement, and quality of life has a positive effect, this provides evidence of selection processes. Next, we estimate equations for the effects of involvement in self-help on empowerment (mental health confidence, self-esteem, and stigma), and then for the effects of involvement in self-help and empowerment on symptoms and quality of life, including the lagged dependent variables. This allows us to control for the effects of unmeasured variables and isolate the causal effects on the changes in outcomes (Finkel, 2002). To the extent that involvement in self-help is associated with increased self-esteem and mental health self-efficacy, and lower stigma over time, this provides evidence of empowerment processes. Since the model indicates that the effects of participation in self-help on symptoms and quality of life are mediated by empowerment variables, we first estimate the equations for the effects of self-help involvement on symptoms and quality of life without self-esteem, efficacy, and stigma, and then add them to the equations. We then examine how beliefs and behavior regarding self-help effectiveness influence each other. Lastly, we present the results of open-ended questions regarding reasons for involvement and non-involvement in self-help groups, coding responses that cluster into emergent and distinctive themes (Fowler, 2014).

Results

Descriptive statistics for the main study variables are presented in Table 1. The sample is 40% male, 88% white, the mean age is 44.6 years, has, on average, a high school level of education, is mostly unmarried (76%), and unemployed (67%). In terms of disorders represented, 26% report having been diagnosed with schizophrenia, 54% depression or bipolar disorder, 37% anxiety disorder, and 31% substance disorder, although these are not mutually exclusive due to comorbidity (Kessler et al., 2005).

Repeated-measures t-tests indicate a slight decline in symptoms over time ($p < .05$), but the outcome variables remain, on average, the same. In the first wave, 87% of respondents report involvement in self-help at some point, and 64% attended a meeting within the last year (including general recovery-oriented or disorder specific groups). On average, respondents were members of self-help groups for 1 to 2 years. There was a statistically significant decline in attendance between the two waves—from going to slightly over 50% of scheduled meetings to less than 50% of meetings ($p < .05$). Also, the frequency of seeing or talking to group members declined, from 1 or 2 times per month to just over 1 or 2 times per year ($p < .05$).

Self-Help and Recovery Model

In Table 2, equations 1 and 2, two dimensions of involvement in self-help at time 2 (meeting attendance and interaction with other members) were regressed on initial levels of symptoms and quality of life, controlling for time 1 levels of involvement.⁴ The stability in self-help involvement is modest across the 18-month interval ($r = .35$ for meeting attendance and $r = .$

34 for seeing group members), indicating quite a bit of change in involvement over time. In equation 1, symptoms are associated with a slight reduction in frequency of attendance (standardized beta = $-.060$, $p < .05$) and, in equation 2, a reduction in seeing/talking to members (standardized beta = $-.072$, $p < .05$). Initial levels of subjective quality of life are associated with small, but statistically significant increases in attendance in equation 1 (standardized beta = $.084$, $p < .05$), and seeing/talking to members in equation 2 (standardized beta = $.054$, $p < .05$).

In Table 3, empowerment variables (mental health confidence, self-esteem, and stigma) were regressed on involvement in self-help, controlling for prior levels of confidence, esteem, and stigma. There is a small, but statistically significant effect of attendance on self-esteem in equation 2 (standardized beta = $.053$, $p < .05$). There is, however, strong stability in confidence and self-esteem (bivariate correlations over $.70$), thus leaving a modest amount of change in each variable to be explained. In equation 3, controlling for prior discriminatory experiences, meeting attendance is associated with increased devaluation-discrimination beliefs (standardized beta = $.26$, $p < .01$).

Next (Table 4), symptoms and subjective quality of life were regressed on involvement, without and with the empowerment variables to examine their mediating effects. In equation 1, we find no effect of involvement on symptoms, but, in equation 2, we find effects of mental health confidence and self-esteem on symptom reduction (betas = $-.13$ and $-.24$, respectively, $p < .05$). In equation 3, only the effect of meeting attendance is significant (standardized beta = $.06$, $p < .05$). In equation 4, when the empowerment variables are added, they all have statistically significant effects on the change in quality of life—confidence and self-esteem increase subjective quality of life (standardized beta = $.13$ and $.12$, $p < .05$, respectively), while internalized stigma expectations reduce it (standardized beta = $-.08$, $p < .05$). The effect of meeting attendance on quality of life is slightly reduced and no longer statistically significant. When considered with the results in Table 3, this suggests that self-help may affect quality of life directly and indirectly through self-esteem.⁵

Relationship between effectiveness beliefs and participation

Given that self-help involvement shows only modest effects on the outcomes considered, and that some choose to remain involved, while others drop out for various reasons (see below), we examined the cross-lagged reciprocal relationship between involvement in self-help and beliefs about its effectiveness among those who were still involved.⁶ Results indicated that, on average, persons involved in self-help consider it quite helpful (mean = 4.22 , s.d. = $.77$). Further, the more persons believe self-help is beneficial, the more frequently they participate—their time 1 attitudes predict their time 2 behavior (standardized beta = $.13$, $p < .01$) and there is the comparable effect of time 1 involvement on time 2 effectiveness beliefs

⁴With the exception of married persons being slightly more active in groups ($p < .05$), and that married and employed persons report slightly higher quality of life ($p < .05$), we find no significant effects of background variables (age, sex, race, education, and diagnosis) on the outcomes. Including these variables did not substantively change the main coefficients. For the sake of parsimony, we present the results of the models with just the main variables.

⁵Sobel tests for the significance of indirect effects were performed to confirm the interpretation of mediating effects.

⁶Here, we treat the involvement variable as a weighted factor score derived from principal components analysis of the frequency of attendance and 'seeing/talking to other members.'

(standardized beta = .14, $p < .01$). Thus, among persons involved in self-help, there is mutual influence between their attitudes and behavior.

Open-ended questions about involvement

To provide insight as to why some people do not participate in self-help groups, in the second wave of the study, those who never went to groups (from the service provider sample) were asked to “Describe why you never went to a self-help group.” Among the most frequent responses were that respondents (30%) were not aware of such groups (e.g., “No one suggested it”), 22% were not interested (e.g., “I didn’t feel the need to”), 11% preferred other services, 8% felt more comfortable alone (e.g., “I’m not comfortable around others”), 4% felt it wouldn’t help, and 19% mentioned other, miscellaneous reasons (e.g., lack of transportation, time conflicts).

To better understand the fair degree of inconsistency in the extent to which persons remain involved in self-help across the 18-month period, those who no longer attended were asked to “describe why they stopped going.” Responses included the roughly equal proportion of respondents feeling better (12%) or feeling that it was not helping (12%). Other reasons included that the group was no longer meeting (13%), negativity (14%) (e.g., “members were self-absorbed,” “depressing,” “too much complaining,” “people seemed worse than my problems”) or they didn’t like the way the group was run (4%), preferring to be alone (3%), time conflicts (10%), and transportation problems (5%). Consistent with the negative effect of symptoms on participation reported above, others mentioned becoming too ill, or being hospitalized (25%).

Those who were still going to group meetings were asked to “describe why you continue going.” In line with qualitative research (e.g., Corrigan et al., 2005; Finn et al., 2009), the most frequent responses centered on benefitting from coping and support (39%). Others (21%) mentioned the need to affiliate with others (e.g., “meet others,” “not alone”), that it helps improve or maintain their mental health (17%), that it provides hope (12%), or that they can help others (5%).

Discussion

We examined whether involvement in mental health self-help groups affected recovery outcomes within an integrated, sociologically-informed framework. Like many of the randomized studies, we find that self-help does not dramatically affect outcomes as advocates suggest. There were, however, several effects consistent with the model. First, supporting a selection perspective, we found initial symptoms and quality of life predicted group involvement. Those who are better off socially and symptomatically may be more able and motivated to join groups and maintain involvement, while those worse off may be less likely to access these sources of support. This is perhaps one of the many ways in which the socially-isolating symptoms of mental illness result in further disadvantage.

At the same time, involvement in self-help had some positive effects on self-esteem and quality of life, supporting the notion that self-help facilitates recovery. Involvement, when perceived as meaningful activity may be self-enhancing, in the manner suggested by Kaplan

and Liu (2000). While symptoms and quality of life were found to have fairly strong stability over the 18-month interval, mental health self-confidence and self-esteem were related to improvements in these outcomes. Therefore, involvement in self-help may have some direct and indirect benefits on quality of life and symptom reduction, through its effect on self-concept. Attending self-help groups may also be somewhat effective in enhancing social networks that provide social support (Rosenfield & Wenzel, 1997). However, we did not have more explicit measures of different types of social networks accessed (e.g., ‘normative vs. peers’).

While advocates of self-help promote the idea that it combats stigma, we find that, controlling for prior discriminatory experiences, greater involvement is associated with an increase in beliefs that persons with mental illness will be devaluated and discriminated against. By hearing about (and sharing) difficulties’ faced because of a mental illness diagnosis, those involved in self-help groups may become more aware of stigma perpetuated by the general public and others in the lives of persons with mental illness (Pescosolido et al., 2010). However, since we did not have more systematic measures of the types and sources of stigmatization and possible coping strategies (e.g., educating others, selective disclosure), we are unable to precisely determine the ways in which involvement might better enable persons to manage, or resist internalizing stigma (Link et al., 1991; Ritsher, Ottingam, & Grajales 2003; Thoits, 2011). Some may internalize stigma inhibiting their recovery, while others reject certain stereotypes and deflect stigmatizing experiences and are not necessarily harmed by them—the so-called “paradox of self-stigma” (Corrigan & Watson, 2002). The effects of involvement in self-help groups may also depend on the relative influence of stigmatized and non-stigmatized others as sources of social support, comparisons, or ‘reflected appraisals’ (Markowitz, Angell, & Greenberg, 2011; Rosenfield & Wenzel, 1997). Many of these processes, as they apply to persons in self-help groups remain to be examined.

Our results also indicated that persons who perceive greater benefit from the group are more likely to continue participation, while at the same time, those who continue to be involved are more likely to believe that they are benefitting. This is in line with findings that participation in Recovery, Inc. (one of the largest self-help groups for mental health problems, focusing on cognitive coping skills) appeared more likely to improve symptoms of depression and anxiety when members felt attached and committed to the group (Galanter, 1988). It is also consistent with evidence that, among family support group members, longer-term participants were more likely to perceive benefits (Citron, Solomon, & Draine, 1999).

Our data indicate a lack of consistency in participation in self-help across an 18-month period. Analysis of open-ended questions finds that, in addition to illness severity, not wanting to be around others with a mental illness, the negativity of group members, and perception that involvement was not helping, are among the reasons for non-participation. For some, being around others and hearing their problems provides comfort. For others, it is a turn-off to participation. This suggests the need to more systematically examine the experiences persons have in self-help (e.g., positive vs. negative experiences, social support), as well as measures of changes in stigmatized identity and mental illness centrality, to

provide detailed analyses of *what* participants are getting out of self-help groups and how it affects specific outcomes. Research examining participation experience in detail is limited to cross-sectional study of current members (Brown et al. 2008).

In terms of outcomes, while we utilized measures of self-reported symptoms and subjective quality of life, we did not have objective measures of well-being (e.g., Global Assessment of Functioning scale), as some persons with low symptoms or inflated perceived quality of life may still have considerable difficulty in normative social functioning. However, higher symptoms are likely associated with greater social impairment (Fulforda et al., 2013). On average, clients in the study are somewhat older, compared to those earlier in their treatment history, and the sample contains a substantial portion of persons with schizophrenia. Older persons' quality of life, especially those with schizophrenia, may be more 'established,' compared to younger persons, subject to greater variability in quality of life. Moreover, since the sample is not perfectly representative of persons with serious mental illness, it may be, for example, that while those who go untreated are somewhat worse off, the covariation found among key recovery variables is similar.

In sum, despite limitations, we have theoretically specified and estimated a sociologically-informed model of the pathways through which involvement in self-help groups for persons with a serious mental illness might be affected by and affect well-being. Capturing ongoing processes, although within a limited timeframe, compliments qualitative and experimental approaches, and overcomes some limitations of previous research. While perhaps not as dramatic as advocates suggest, self-help may have modest beneficial effects on recovery-oriented outcomes, the experience of which may be somewhat idiosyncratic, and engaged by those who are doing comparatively better to begin with. These processes certainly warrant further analysis.

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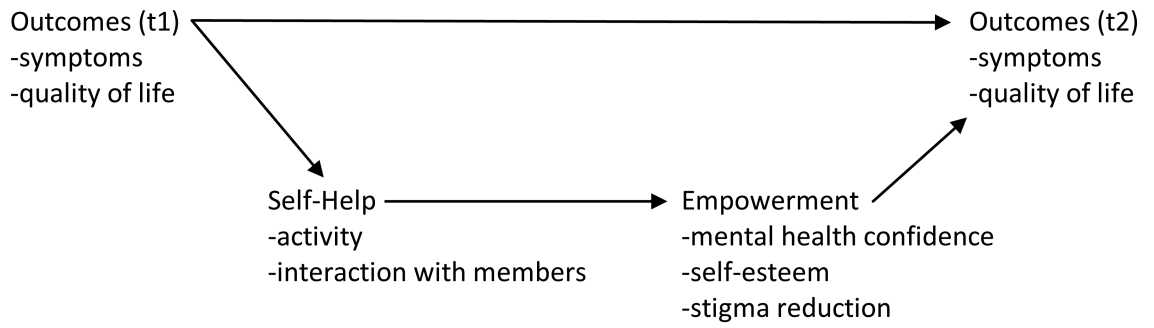
References

- Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*. 1993; 16:11–23.
- Brown LD. How people can benefit from mental health consumer-run organizations. *American Journal of Community Psychology*. 2009; 43:177–188. [PubMed: 19308724]
- Brown, LD.; Lucksted, A. Theoretical foundations of mental health self-help.. In: Brown, L.; Wituk, S., editors. *Mental Health Self-Help*. Springer; New York: 2010. p. 19-38.
- Brown LD, Shepherd MD, Merkle EC, Wituk SA, Meissen G. Understanding how participation in a consumer-run organization relates to recovery. *American Journal of Community Psychology*. 2008; 42:167–178. [PubMed: 18597169]
- Carpinello, SE.; Knight, EL. A qualitative study of the perceptions of the meaning of self-help, self-help group processes and outcomes. New York State Office of Mental Health; Albany, NY: 1991.
- Carpinello SE, Knight EL, Markowitz FE, Pease Elizabeth L. The development of the mental health confidence scale: A measure of self-efficacy in individuals diagnosed with mental disorders." *Psychiatric Rehabilitation Journal*. 2000; 23:236–243.

- Citron M, Solomon P, Draine J. Self-help groups for families of persons with mental illness: Perceived benefits of helpfulness. *Community Mental Health Journal*. 1999; 35:15–30. [PubMed: 10094507]
- Coen, AS.; Wilson, NZ.; Shern, DL.; Bartsch, DA. Innovative programs and types of chronically mentally ill individuals: A treatment outcome study.”. Colorado Division of Mental Health; Denver, CO: 1989.
- Corrigan PW, Slopen N, Garcia G, Phelan S, Keogh CB, Keck Lorraine. Some recovery processes in mutual-help groups for persons with mental illness; II: qualitative analysis of participant interviews. *Community Mental Health Journal*. 2005; 41:721–735. [PubMed: 16328585]
- Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*. 2002; 9:35–53.
- Crabtree JW, Haslam SA, Postmes T. Mental health support groups, stigma, and self-esteem: Positive and negative implications of group identification. *Journal of Social Issues*. 2010; 66:553–569.
- Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*. 2006; 42:443–450.
- Emerick RE. The politics of psychiatric self-help: Political pactions, interactional support, and group longevity in a social movement. *Social Science and Medicine*. 1991; 32:1121–1128. [PubMed: 2068595]
- Estroff SE, Patrick DL, Zimmer C, Lachicotte W. Pathways to disability income among persons with severe, persistent psychiatric disorders.”. *Milbank Quarterly*. 1997; 75:495–532. [PubMed: 9415090]
- Finn LD, Bishop BJ, Sparrow N. Capturing dynamic processes of change in GROW mutual help groups for mental health. *American Journal of Community Psychology*. 2009; 44:203–215.
- Finkel, S. Causal analysis with panel data. Sage; Thousand Oaks, CA: 1995.
- Folgheraiter F, Pasini A. Self-help groups and social capital: New directions in welfare policies? *Social Work Education*. 2009; 28:253–267.
- Fowler, FJ. Survey research methods. 5th Edition.. Sage; Thousand Oaks, CA: 2014.
- Fulforda D, Niendamb TA, Floyd EG, Carter CS, Mathalona DH, Vinogradova S, Stuarda SK, Loewy RL. Symptom dimensions and functional impairment in early psychosis: More to the story than just negative symptoms. *Schizophrenia Research*. 2013; 147:125–131. [PubMed: 23587696]
- Galanter M. Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery, Inc. *American Journal of Psychiatry*. 1988; 145:1248–1272. [PubMed: 3421346]
- Goffman, E. Stigma: Notes on the management of spoiled identity. Prentice-Hall; Englewood Cliffs, NJ: 1963.
- Goldstrom ID, Campbell J, Rogers A, Lambert DB, Blacklow B, Henderson MJ, Manderscheid RW. National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*. 2006; 33:92–103. [PubMed: 16240075]
- Jacobs MK, Goodman G. Psychology and self-help groups. *American Psychologist*. 1989; 44:536–545. [PubMed: 2930056]
- Jacobson, N. In *Recovery: The making of mental health policy*. Vanderbilt University Press; Nashville, TN: 2004.
- Johnson TP. Mental health, social relations, and social selection: A longitudinal analysis.”. *Journal of Health and Social Behavior*. 1991; 32:408–423. [PubMed: 1765630]
- Kaplan, HB.; Liu, X. Social movements and collective coping with spoiled personal identities: Intimations from a panel study of changes in the life course between Adolescence and Adulthood.. In: Stryker, S.; Owens, TJ.; White, RW., editors. *Self, identity, and social movements*. University of Minnesota Press; Minneapolis: 2000. p. 215-238.
- Karp DA. Illness ambiguity and the search for meaning: A case study of a self-help group for affective disorders. *Journal of Contemporary Ethnography*. 1992; 21:139–170.
- Katz, AH. *Self-help in America: A Social movement perspective*. Twayne Publishers; New York: 1993.
- Kelly BJ, Frazee TK, Hornik RC. Response rates to a mailed survey of a representative sample of cancer patients randomly drawn from the Pennsylvania Cancer Registry: a randomized trial of

- incentive and length effects.”. *BMC Medical Research Methodology*. 2010; 10:65. [PubMed: 20630101]
- Kessler RC, Wai CT, Delmer O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*. 2005; 62:617–27. [PubMed: 15939839]
- Lehmann AF. A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning*. 1988; 11:51–62.
- Link BG. Understanding labeling effects in the area of mental disorders: An empirical assessment of the effects of expectations of rejection. *American Sociological Review*. 1987; 52:96–112.
- Link BG, Cullen FT, Struening E, Shroud PE, Dohrenwend BP. A Modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*. 1989; 54:400–423.
- Link BG, Mirotznik J, Cullen FT. The effectiveness of stigma coping orientations: Can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior*. 1991; 32:302–320. [PubMed: 1940212]
- Link, BG.; Phelan, JC. Labeling and stigma.. In: Scheid, TL.; Brown, N., TN., editors. *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems*, 2nd. Cambridge; New York: 2013. p. 571-587.
- Link BG, Struening EL, Rahav M, Phelan JC, Nuttbrock L. On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*. 1997; 38:177–90. [PubMed: 9212538]
- Liska A, Felson RB, Chamlin M, Baccaglini W. Estimating attitude-behavior reciprocal effects within a theoretical specification. *Social Psychology Quarterly*. 1984; 47:15–23.
- Lloyd-Evans B, Mayo-Wilson EH, Bronwyn I, Brown HE, Pilling S, Johnson S, Kendall T. A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*. 2014; 14:39. [PubMed: 24528545]
- Markowitz FE. Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-Concept. *Journal of Health and Social Behavior*. 2001; 42:64–79. [PubMed: 11357719]
- Markowitz, FE. Sociological models of recovery.. In: Ralph, RO.; Corrigan, PW., editors. *Recovery and mental illness: Consumer visions and research paradigms*. American Psychological Association; Washington, DC: 2005. p. 85-100.
- Markowitz, FE. Labeling theory and mental illness.”. In: Farrington, DP.; Murray, J., editors. *Advances in Criminological Theory*. Vol. 18. Transaction Publishers; New Brunswick, NJ: 2014. p. 45-62.
- Markowitz FE, Angell B, Greenberg JS. Stigma, reflected appraisals, and recovery processes in mental illness. *Social Psychology Quarterly*. 2011; 74:144–165.
- McCranie, A. Recovery in mental illness: The roots, meanings, and implementation of a “new” services movement.. In: Pilgrim, D.; Rogers, A.; Pescosolido, B. A., BA., editors. *The SAGE Handbook of Mental Health and Illness*. Sage Publications; London: 2010. p. 471-489.
- Menard, S. *Longitudinal Research*. Sage; Thousand Oaks, CA: 2002.
- Miech RA, Caspi A, Moffitt TE, Entner-Wright BR, Silva PA. Low socioeconomic status and mental disorders: A longitudinal study of selection and causation during young adulthood. *American Journal of Sociology*. 1999; 104:1096–1131.
- Omark RC. The dilemma of membership in recovery, Inc., a self-help ex-mental patients' organization. *Psychological Reports*. 1979; 44:1119–25. [PubMed: 538144]
- Perry BL. Symptoms, stigma, or secondary social disruption: Three mechanisms of network dynamics in severe mental illness. *Journal of Social and Personal Relationships*. 2014; 31:32–53.
- Pescosolido BA, Martin JA, Long J, Tait R, Medina J, Phelan JC, Link BG. A disease like any other? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*. 2010; 167:1321–1330. [PubMed: 20843872]
- Pilgrim, D.; McCranie, A. *Recovery from mental disorder: A critical sociological account*. Palgrave UK.; London: 2013.
- Pistrang N, Baker C, Humphreys K. Mutual help groups for mental health problems: A review of effectiveness studies. *American Journal of Community Psychology*. 2008; 42:110–1121. [PubMed: 18679792]

- Pistrang, N.; Baker, C.; Humphreys, K. The contributions of mutual help groups for mental health problems to psychological well-being: A systematic review.. In: Brown, LD.; Wituk, S., editors. *Mental health self-help: Consumer and family initiatives*. Springer; New York: 2010. p. 61-85.
- Powell, I.; Knight, EL. Empowering the disempowered.. In: Troxel, JP., editor. *Government works: Profiles of people making a difference*. Miles River Press; Alexandria, VA: 1995. p. 425-445.
- Ralph, RO.; Corrigan, PW. *Recovery and mental illness: Consumer visions and research paradigms*. American Psychological Association; Washington, DC: 2005.
- Ritsher JB, Otilingam PG, Grajales M. Internalized stigma of mental illness: Psychometric Properties of a New Measure. *Psychiatry Research*. 2003; 121:31–49. [PubMed: 14572622]
- Rosenberg, M. *Society and the adolescent self-Image*. Princeton University Press; Princeton, NJ: 1965.
- Rosenfield S. Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*. 1997; 62:660–72.
- Rosenfield S, Wenzel S. Social networks and chronic mental illness: A test of four perspectives. *Social Problems*. 1997; 44:200–216.
- Stryker S, Serpe RT. Identity salience and psychological centrality: Equivalent, overlapping, or complementary concepts? *Social Psychology Quarterly*. 1994; 57:16–35.
- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The NSDUH report: Mental health support and self-help groups (October)*. Rockville, MD.: 2009.
- Thoits PA. Resisting the stigma of mental illness. *Social Psychology Quarterly*. 2011; 74:6–28.
- Thoits PA, Hewitt LN. Volunteer work and well-being. *Journal of Health and Social Behavior*. 2001; 42:115–131. [PubMed: 11467248]
- Watson DP. The evolving understanding of recovery: What the sociology of mental health has to offer. *Humanity and Society*. 2012; 36:290–308. [PubMed: 23483849]
- Watson, DP.; McCranie, A.; Wright, E. Everything old is new again: Recovery and serious mental illness.. In: Johnson, RJ.; Turner, RJ.; Link, BG., editors. *Sociology of mental health: Selected topics from forty years*. Springer; New York: 2014. 1970s-2010s. p. 125-139.
- Weaver, RK.; Salem, DA. Mutual-help groups and recovery: The influence of settings on participants' experience of recovery.. In: Ralph, RO.; Corrigan, PW., editors. *Recovery and mental illness: Consumer visions and research paradigms*. American Psychological Association; Washington, DC: 2005. p. 173-205.
- Yeaton WH. The development and assessment of valid measures of service delivery to enhance inference in outcome-based research: Measuring attendance at self-help group meetings. *Journal of Consulting and Clinical Psychology*. 1994; 62:686–94. [PubMed: 7962872]



Note: Lagged levels of self-help and empowerment variables not shown for the sake of clarity.

Figure 1.
Self-Help and Recovery Model

Table 1

Descriptive Statistics (n=553)

	Time 1	Time 2
Self-Help Involvement		
Meeting attendance (0-4)	2.16 (1.55)	1.67 (1.63)
Talking to/seeing members (0-5)	3.00 (1.95)	2.32 (2.13)
Empowerment		
Mental health confidence (1-6)	4.20 (.94)	4.11 (1.07)
Self-esteem (1-4)	2.75 (.64)	2.79 (.64)
Stigma	.24 (.43)	2.70 (.55)
Recovery outcomes		
Symptoms (0-4)	1.29 (.87)	1.18 (.86)
Quality of life (1-5)	3.36 (.84)	3.40 (.78)
Background Variables		
Male	.40 (.49)	-
White	.88 (.33)	-
Age	44.59 (12.93)	-
Education (1-7)	3.02 (1.47)	-
Married	.24 (.43)	-
Employed	.33 (.47)	-
Schizophrenia	.26 (.44)	-
Depression/bipolar	.54 (.50)	-
Anxiety	.37 (.48)	-
Substance	.31 (.46)	-

Note: Means are shown with standard deviations in parentheses

Table 2

Effects of Symptoms and Quality of Life on Self-Help Participation

	Meeting attendance (t2)	Talking to/seeing members (t2)
	(1)	(2)
Meeting attendance (t1)	.206 ^{***} (.029)	-
Talking to/seeing members (t1)	-	.210 ^{***} (.030)
Symptoms (t1)	-.098 [*] (.057)	-.077 [*] (.036)
Quality of life (t1)	.116 [*] (.059)	.130 [*] (.069)
R ²	.052	.100

Note: Unstandardized regression coefficients shown with standard errors in parentheses

^{***}
 $p < .001$

^{*}
 $p < .05$

Table 3

Effects of Participation in Self-Help and Empowerment Variables

	Mental health confidence (t2)	Self-esteem (t2)	Stigma (t2)
	(1)	(2)	(3)
Meeting Attendance (t1)	.002 (.027)	.023* (.011)	.067** (.028)
Talking to/seeing members (t1)	.002 (.021)	.010 (.012)	.023 (.018)
Mental health Confidence (t1)	.752*** (.037)	-	-
Self-esteem (t1)	-	.702*** (.031)	-
Stigma (t1)	-	-	.255*** (.056)
R ²	.437	.487	.030

Note: Unstandardized regression coefficients shown with standard errors in parentheses.

 $p < .001$ *
 $p < .05$

Table 4

Effects of Participation in Self-Help and Empowerment on Symptoms and Quality of Life

	Symptoms (t2)		Quality of Life (t2)	
	(1)	(2)	(3)	(4)
Symptoms (t1)	.766 ^{***} (.027)	.568 ^{***} (.030)	-	-
Quality of life (t1)	-	-	.560 ^{***} (.032)	.466 ^{***} (.030)
Meeting Attendance (t1)	.007 (.018)	.014 (.017)	.026 [*] (.012)	.019 (.012)
Talking to/seeing Members (t1)	.014 (.014)	.020 (.013)	.005 (.016)	.017 (.016)
Mental health confidence (t2)	-	-.104 ^{***} (.010)	-	.099 ^{**} (.034)
Self-esteem (t2)	-	-.322 ^{***} (.048)	-	.143 ^{***} (.037)
Stigma (t2)	-	.011 (.040)	-	-.112 ^{**} (.049)
R ²	.594	.679	.359	.412

Note: Unstandardized regression coefficients shown with standard errors in parentheses

*
 $p < .05$ **
 $p < .01$ ***
 $p < .001$