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## Community Membership and Social Networks in Mental Health Self-Help Agencies

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### Abstract

This article explores community membership among self-help agency (SHA) participants. It is suggested that SHAs foster the enhancement of peer-oriented social networks, leading to the experience of shared community. Social network analysis was used to examine the structure of support mechanisms, and to assess levels of community membership through peer inclusion. Results indicate that both individual and organizational characteristics play roles in predicting peer presence in social networks. Organizational empowerment is a key factor, with the SHA emerging as a promising locus for peer support development through enhanced social networks. Implications for the organization of consumer-based services are discussed.

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Consumer-run mental health organizations have in recent years proliferated as viable alternatives and adjuncts to traditional services (Davidson et al., 1999; USDHHS, 1999). As an example, self-help agencies (SHAs) are consumer-operated, non-profit organizations serving adults with psychiatric disabilities. In contrast to traditional providers, SHAs are characterized by increased focus on participant empowerment (Segal, Silverman, & Temkin, 1993), mutual support, and shared organizational decision-making. A central concept in SHAs, empowerment is viewed as both process and product. Another rich outcome of SHA participation is the opportunity for development, expansion, and maintenance of social support networks.

This article examines factors associated with enhanced potential support and community membership, defined by the inclusion of a peer component in the social networks of SHA users. The primary goal is to consider the relative importance of these factors and draw implications regarding the use of SHAs for provision of social support and mental health services. Using data from a study of 310 SHA users in California (Segal, Silverman, & Temkin, 1995a), we examined the extent to which members include peers in their networks, thus expanding opportunities for social support, ultimately leading to the experience of a shared sense of community.

## Self-Help and Social Networks

The mental health field has witnessed tremendous growth in the development of alternative, peer/consumer-focused and delivered services. As an outgrowth of the consumer movement, the mental health self-help agency (SHA) (Segal, Silverman, & Temkin, 1995a) is an example, signaling a larger transition from provider to consumer-oriented mental health services. SHAs have thrived in part due to their perceived utility for underserved and difficult-to-reach populations, while providing cost savings over staff-driven models.

Based on mutuality, collectivity, and interdependence, SHAs are an effective service modality for persons inadequately served by traditional mental health systems. Their theoretical underpinnings have been explored in the literature, drawing upon empowerment frameworks (Chamberlin, 1990; Rappaport, Resichl, & Zimmerman, 1992; Segal, Silverman, & Temkin, 1993). Gutierrez (1995) asserts that empowerment can take place on a collective as well as individual level, and it is this application that may best explain self-help in mental health. The self-help movement has a long history characterized by social change through collective action. Gutierrez further notes that group consciousness “results in a critical perspective on society that redefines individual, group, or community problems as emerging from a lack of power” (p. 150). Peer identification and the shared experience of psychiatric disability have the potential to tie SHA users together in a community. Rhoades and colleagues (1986) identified the self-help phenomenon whereby participants “develop a strong sense of empowerment and competence within a group that clearly understands and identifies with their problem or condition” (p. 5).

Social support has long been recognized as a critical component of successful community living for persons with mental disabilities (Biegel, Tracy, & Corvo, 1994). As early as the 1950s researchers utilized the social network concept to elucidate the exchange of interpersonal support (Barnes, 1954). The importance of strengthening networks for the mentally disabled has also been recognized at the Federal level since the late 1970s via the Community Support Program (CSP) along with other research and intervention initiatives (Tessler & Goldman, 1982; Anthony & Blanch, 1989; Stroul, 1989).

Powell (1990) notes that participation in self-help programs can positively influence network size and density, as well as content and function. Self-help environments give participants access to “experiential knowledge and frames of reference” (Borkman, 1990) distinctive from those offered by professionals. If peer-based knowledge and support is also shared outside of the agency (e.g. through the social network), we can draw implications about a positive carryover effect from SHA participation into one’s external life. It is hypothesized herein that SHAs play a role in fostering the enhancement of peer-oriented social networks.

Agency participation and the development of networks inclusive of a peer component offer a sense of belonging, or membership in a collective community. This community membership provides individuals with a substantive connection to a larger group of supportive peers than otherwise possible. Group belonging, shared culture, and community enable members to gain renewed hope through mutual support, respect, and cooperation (Rhoades et al., 1986;

Murphy, 1998). These change mechanisms are also congruent with the essential components of the recovery model (Ralph, 2000).

Building on mutual peer support, the SHA is a promising locus for social network development and enhancement. Since programs are consumer-operated with extensive peer interaction, a participating individual's access to potential peer network members should increase accordingly. Based on the literature, we hypothesized that certain factors of SHA participation would be related to peer inclusion in the social network. These factors are grouped into three categories: individual demographic, psychological, and organizational factors.

Individual demographic factors such as ethnicity, gender, and housing status may be particularly useful in assessing network composition and utilization. There is evidence, for example, that homelessness is accompanied by decreased support from the social network (Bassuk & Rosenberg, 1988). A similar negative relationship is noted between the presence of mental disability and network size (Harris & Bergman, 1985; Holmes-Eber & Riger, 1990). However, Segal, Silverman, & Temkin (1997) found that negative changes in structural network characteristics were associated with being housed, but not for individuals who are homeless. Such divergent findings suggest there is room for improving our understanding of the relationship between housing and the exchange of social support.

Ethnicity too remains a challenge for researchers studying social support. There is a strong tradition in African American communities of self-reliance, mutual support, and participation in services outside of the mainstream (Jones, 2000; Martin & Martin, 1995; Pollard, 1978; Carson, 1993). Borne out of the necessity created from discrimination, oppression and marginalization, the concepts of self-help, mutual aid, and informal support have had particular resonance for African Americans in this country.

According to research on African Americans and social support, there is a high utilization of family, friends, churches, and informal groups from local communities for emotional support (Neighbors, 1984; Wilson, 1991). Studies indicate that African Americans not only use high amounts of informal support in place of formal mechanisms, but in many cases use them in conjunction with mainstream, formal avenues of support (Neighbors & Jackson, 1984). However, recent research (Snowden, 1998) suggests that African Americans are in fact less likely than whites to seek mental health support from families or friends. Snowden found that rather than replacing professional services, African Americans use informal and formal avenues of mental health support alongside each other. As with homelessness, the findings here suggest a need for further research.

Finally, organizational factors can be powerful determinants of individual agency experience, particularly in self-help settings, where the organizational environment itself is a critical component in the delivery of services. As Moxley and Mowbray (1997) suggest, consumer-run organizations have often developed on their own, arising from social action spawned out of dissatisfaction with the mental health system. The grass-roots development of such programs has allowed for the creation of alternative organizational environments conducive to empowerment. However, the challenges associated with the organizational

maintenance of a self-help program are significant (Kaufmann, Ward-Colasante, & Farmer, 1993; Levin, 1997).

Organizational heterogeneity among self-help programs led to our hypothesis that certain agency environment and culture-related factors would be more conducive than others in stimulating social network enhancement through peer support. Granger (1997) suggests that organizational philosophies and goals must be attuned with those of individual participants, and that organizations should ultimately be responsive to members' needs. Using Segal et al.'s (1993) concept of organizational empowerment, we suggest that in order for individuals to obtain maximum social benefit from the SHA, they should be allowed to meaningfully participate in control of basic agency operations.

Agency climate and culture is thought to be an important organizational characteristic in considering participant outcomes. If SHA members are to be comfortable enough to engage in the exchange of social support above and beyond the mere receipt of concrete services, the organizational environment should be comfortable, accepting of diversity, and non-judgmental in nature. Other vital organizational ingredients in peer-run programs are the existence of minimal hierarchies (Zinman, 1987), the voluntary nature of services, and the fostering of individual autonomy.

In this article, we seek to further test Segal, Silverman, and Temkin's (1997) theorized link between agency environment and participant outcomes by hypothesizing that positive agency environmental factors foster greater likelihood of a consumer peer presence in the social networks of SHA members. This study presents an analysis of network composition among long-term SHA members, accounting for the types of individual and organizational factors discussed above.

## Methods

Secondary analysis was conducted using data from a study of four mental health SHAs in Northern California (Segal, Silverman, & Temkin, 1995a). A comprehensive survey was administered to SHA members at each agency. Two waves of interviews were collected, with baseline and 6-month follow-up measures. Only those persons with both baseline and follow-up measurements were included in the analyses here. The current study focuses on self-help community membership as viewed through peer enhancement of the social network.

### Study Sites.

Each SHA site was peer-run, located in an urban area, and served adults with psychiatric disabilities (Segal, Silverman, & Temkin, 1995a). Agency services included drop-in socialization, mutual support, and access to material assistance (e.g. food, telephones, showers, clothing, mail, etc.). Supportive individual and group counseling, referrals, advocacy, housing assistance, job referrals, living skills training and vocational training were also available. All agency participation was completely voluntary.

## Sample.

A total of 310 respondents at baseline and 248 at 6-month follow-up were interviewed, with response rates of 96% at baseline and 80% at follow-up (Segal, Silverman, & Temkin, 1995a). Respondents met inclusion criteria if they were long-term SHA members, with attendance at least once weekly for 3 months prior to empanelment. Recruitment took place at agency sites, on different days of the week and times to ensure access to an assortment of agency users. All participation in the study was fully voluntary.

At baseline, 72% of the respondents were men and 28% women, with a mean age of 38 years. The majority of respondents were African American (64%), with Caucasians (17%) and Latinos (7%) making up the next largest groups. Eighty-seven percent of the sample reported a DSM-III-R diagnosis, with 50% having a concurrent substance abuse or dependence diagnosis. Among the respondents, 8% had a bachelor's degree, and 31% reported at least some college experience. Forty-six percent of the sample was homeless at baseline. At 6-month follow-up, the mean social network size of respondents was 8.24 persons (median = 8.0). Seventy-one percent were African American, 73% male, and 41% homeless.

## Measures

### Network Membership (Criterion).

Network membership was assessed at baseline and follow-up, using an adapted version of Lovell, Barrow and Hammer's (1984) Social Network Interview. Respondents identified network members, individuals with whom they exchanged support, and reported whether or not each member was a fellow SHA participant and/or a "former psychiatric patient."

### Independent Variable Measures.

Demographic measures included ethnicity, gender, and housing status. Each were coded as binary variables, the latter indicating the presence of literal homelessness (e.g. staying in shelter, street, or car).

Psychological measures included: 1) the Brief Psychiatric Rating Scale (BPRS), a symptom severity index (Overall & Gorham, 1962) (internal consistency,  $\alpha=.80$ ); 2) Rosenberg's Self-Esteem Scale (Rosenberg, 1965), (internal consistency,  $\alpha=.82$  at baseline and  $\alpha=.83$  at follow-up) (Segal, Silverman, & Temkin, 1995b); 3) the Hope Scale (internal consistency,  $\alpha=.83$  at both baseline and follow-up) (Segal, Silverman, & Temkin, 1995b); 4) a binary measure of dual diagnosis (assessed using the Diagnostic Interview Scale); and 5) the Personal Empowerment Scale, measuring: (a) perception of choice and power in daily life, and (b) reduction of uncertainty in daily living (i.e. ability to minimize the likelihood of specific negative events, such as personal victimization, eviction, or homelessness). Internal consistency was  $\alpha = .84$  at baseline and  $\alpha = .85$  at 6-month follow-up (Segal, Silverman, & Temkin, 1995b).

Organizational measures included: 1) the Organizationally-Mediated Empowerment Scale, an assessment of organizational inclusion, measuring the extent to which members can share

in control of agency operations (internal consistency at baseline,  $\alpha = .87$ , and follow-up,  $\alpha = .90$ ) (Segal, Silverman, & Temkin, 1995b); 2) the Autonomy subscale of the Community-Oriented Program Environment (COPEs) scale (Moos, 1988), measuring respondents' perceptions of autonomy and independence within the agency; 3) respondents' ratings of the importance of concrete services in their decisions to attend; and 4) a five-point scale measuring the importance of the agency being "a place where people don't look down on you." This item measured the extent to which members value a non-judgmental, accepting agency environment.

### Analysis.

Using the network measure, a form of network analysis was used to examine social support mechanisms for participants, and ultimately to assess peer enhancement of networks. Descriptive statistics were used to look at basic network characteristics. Bivariate techniques were then utilized to look for subgroup differences in structural network composition. Finally, multiple logistic regression was used to examine factors predicting the presence of (a) other SHA members, and (b) other "former psychiatric patients" in the network at follow-up. Grouped according to substantive area, the same set of predictor variables was used in block entry across each model. Taken together, the two regression models examine factors predicting social network enhancement through inclusion of a peer component.

### Results

Bivariate analyses between the independent variables (grouped by substantive area) and social network characteristics indicated significant differences across groups using the two outcome measures. Among the demographic variables, ethnicity was significantly associated with both outcomes. African Americans in the sample were less likely to have other SHA members in their social networks (50% vs. 64%,  $\chi^2 = 4.249$ ,  $df = 1$ ,  $p = .039$ ) or other former psychiatric patients (31% vs. 60%,  $\chi^2 = 17.499$ ,  $df = 1$ ,  $p < .0005$ ). There was also a significant association with housing status, with fewer homeless persons including former psychiatric patients in their networks (32% vs. 46%,  $\chi^2 = 4.383$ ,  $df = 1$ ,  $p = .036$ ).

The psychological factors proved less significant in our bivariate analyses. There were no group differences between the five variables in this category in having SHA peers in one's social network. However, higher scores on the BPRS ( $t = -2.244$ ,  $df = 246$ ,  $p = .026$ ) and the social distance scale ( $t = -2.226$ ,  $df = 247$ ,  $p = .027$ ) were associated with having at least one former psychiatric patient in the network at 6-month follow-up. Thus, both symptom severity and more accepting attitudes about psychiatric disability were associated with the presence of former psychiatric patients in the social network.

Of the organizational factors, both organizationally-mediated empowerment and the relative importance of concrete services were found to have significant bivariate associations with the presence of SHA members in the network. Those with SHA members in their networks reported higher organizational empowerment ( $M = 5.50$  vs.  $M = 4.07$ ,  $t = -2.935$ ,  $df = 247$ ,  $p = .004$ ), and placed less value on concrete services ( $M = 3.75$  vs.  $M = 4.10$ ,  $t = 2.589$ ,  $df = 246$ ,  $p = .010$ ). Similarly, individuals with other former psychiatric patients in their networks

at follow-up were more organizationally empowered ( $M = 5.73$  vs.  $M = 4.27$ ,  $t = -2.816$ ,  $df = 181$ ,  $p = .005$ ).

We next utilized multivariate logistic regression techniques to incorporate various factors that may have co-varied with the outcome variables. This allowed for a more complex understanding of the relationships herein, and helped account for significant bivariate associations not further borne out in the multivariate analyses. The first logistic regression model, using the presence of other SHA members in the network at follow-up as outcome, was significant (Model  $\chi^2 = 50.078$ ,  $df = 14$ ,  $p < .00005$ ), with ethnicity, self-esteem, and all four organizational variables as statistically significant predictors. Controlling for other variables in the model, African Americans in the sample were 53% less likely ( $OR = .47$ ,  $\beta = -.75$ ,  $p = .0375$ ) to have other SHA members in their networks. Those with higher self-esteem were also more likely ( $OR = 1.07$ ,  $\beta = .07$ ,  $p = .0477$ ) to include SHA members in their networks. Further, those who were more organizationally empowered ( $\beta = .10$ ,  $p = .0180$ ), placed less value on autonomy within the agency ( $\beta = -.20$ ,  $p = .0348$ ), placed higher value on a non-judgmental environment ( $B = .33$ ,  $p = .0097$ ), and placed lesser value on concrete services ( $\beta = -.44$ ,  $p = .0056$ ) were all more likely to include other SHA members in their networks.

The second logistic regression substituted the presence of former psychiatric patients in the network at follow-up as the outcome variable, in order to capture a non-SHA involved peer expansion of one's network. This model was also significant (Model  $\chi^2 = 66.487$ ,  $df = 14$ ,  $p < .00005$ ) using the same block of independent variables. However, only two independent variables were significant: ethnicity ( $\beta = -1.59$ ,  $p < .0005$ ) and organizationally-mediated empowerment ( $\beta = .14$ ,  $p = .0028$ ). Directions of significance for the standardized beta coefficients for these two variables were the same as in the first model. Thus, African Americans in the sample were 80% less likely to have other former psychiatric patients in their networks at follow-up, controlling for the other variables in the model. Finally, those with higher levels of organizational empowerment were 15% more likely for each point increase in their scale score to have other former psychiatric patients in their networks at follow-up, controlling for other variables in the model.

## Discussion

Given the increasing presence of consumer-delivered services (USDHHS, 1999), and financial constraints on the delivery of professional services, peer-based means of support can be an innovative way to offer services for adults with serious psychiatric disabilities. Peer-run programs offer services congruent with the psychiatric recovery model (Ralph, 2000), enabling participants to lead empowered lives with a sense of hope, and as shown here, allow unique opportunities for organizational participation and social network enhancement.

Our network analysis represents a step toward understanding peer support within an organizational context. While participation in the SHA setting does not necessitate change in the egocentric social network, the inclusion of peers can raise the level of support and help

protect against negative outcomes, while also empowering individuals to make use of natural community supports.

The results suggest that African Americans in our sample utilize SHAs in a qualitatively different manner than do other persons. With less likelihood of including either SHA peers or former psychiatric patients in their networks, the relationship between agency participation and network composition appears to be less significant for this group. Rather than assuming that African Americans use SHAs primarily for social support (as might have been warranted had we not found less likelihood of peer network inclusion), the emerging utilization pattern emphasizes the seeking of concrete services as opposed to social and affective support.

These data suggest that SHAs may offer untapped opportunities to provide social support and network enhancement to African Americans. SHAs paying attention to the organizational issues highlighted here can achieve the principles of empowerment necessary for the African American community involved in self-help (Neighbors, Elliott, & Gant, 1990). SHAs serving African American communities face a specific set of challenges along with opportunities for community building and social action. Ultimately, the SHA represents an excellent locus for the operationalization of what Alice Johnson (1998) calls revitalized community practice, with its emphasis on local community-based, culturally competent, and empowerment-focused services.

Rather than implying that participation in SHAs replaces involvement in traditional settings, our data support the notion that specific and distinct benefits are available for individuals utilizing self-help services. Recent research further indicates that consumers are able to choose between peer-run and traditional services, and do so primarily based on factors of need, along with type of service and approach offered at each (Segal, Hodges, & Hardiman, 2002). One unique characteristic of SHAs (and by extension other peer-run programs) lies in their empowering approach and organizational environment that creates opportunities for enhanced social support.

Our robust organizational findings indicate that agency environmental and programmatic factors have an impact on the ability of SHAs to effectively foster shared community membership. The full set of organizational variables was predictive of SHA member inclusion in the network, but only organizational empowerment extended its utility into predicting the presence of other former psychiatric patients in the network. That only one organizational factor remained significant across both multivariate models suggests that empowerment is the key organizational indicator of the agency's ability to stimulate a broadly defined peer expansion of the social network.

The remaining organizational factors were significant only in predicting the presence of other SHA members in the network, and did not extend beyond the agency context. Organizational empowerment's focus on cooperation and shared governance may enable individuals to see others with psychiatric disabilities in successful roles, thus leading to greater acceptance of such individuals in their own networks. It is further likely that those members reporting high organizational empowerment experience their participation in



shared agency control in a manner that allows for the transfer of empowerment to other areas of their lives, where they are more likely to interact with non-SHA members also having psychiatric disabilities.

Strategically positioned to provide flexible, non-stigmatizing, and empowering services, effective peer-run programs must be attuned to the organizational issues discussed here, with an eye toward innovation. Drawing from our findings, one of the chief means for programs to achieve this goal is through fostering opportunities for peer-enhanced social network development. The provision of a non-judgmental, inclusive agency environment, emphasizing individual autonomy along with opportunities for shared agency control, is essential to the formula. Agencies should also be mindful of racial and ethnic differences in the utilization of support and should tailor services accordingly. SHAs and other peer-run programs should seek a healthy balance between the provision of social support and concrete services not offered elsewhere in the mental health system. Peer-run programs should also engage in collaborative dialogue with traditional providers, allowing for the explication of unique service elements, goals, and philosophies, while paving the way for cooperative relationships. Research indicates that such communication can also stimulate collaboration between self-help organizations and community mental health agencies (Powell, 1988). Finally, professionals have a responsibility to learn about local peer-delivered resources and specific peer support opportunities for their clients.

Our findings indicate that a core strength of the SHA is its ability to stimulate the development of peer-based support networks by allowing members to participate in shared activities and agency control. It must be stressed that there remains an inherent difficulty in trying to capture the intricacies of human interaction through empirical measures such as the social network instrument. Although this method does allow respondents to self-define networks, it is unclear whether the meanings researchers attach to social networks are shared by study participants. Such questions point toward future research, particularly that using qualitative methods.

## Conclusion

We have addressed a core benefit of self-help agency participation: membership in a collective community of peers linked through shared life experiences and common perspectives. Further studies may bear out the hypothesis that membership in said community is a critical factor in other, broader outcomes such as quality of life, housing stability, and improved mental health. Beyond the scope here, such outcomes warrant further research. However, this study suggests social network analysis provides a fertile opportunity for improving our understanding of how individuals with psychiatric disabilities develop, maintain, and utilize avenues of social support.

Peer knowledge and expertise is an oft-untapped and devalued source of support for adults with psychiatric disabilities. Self-help participation can lead to increased peer support and strengthened social networks. It is likely that such opportunities are unique to the consumer-operated setting. Solomon and Draine (2001) note it may be the type of service provided rather than its locus that is the critical factor in services aimed at network development. This

argument operates under the assumption that supportive services are the same whether delivered via professional or peer setting. The findings here suggest they may be partly correct. In our sample the critical factor fostering peer network enhancement was organizational environment, specifically empowerment via participatory inclusion. It is this dimension that represents a key contribution of peer-run organizations, arguing the importance of both locus and character of service.

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**Table 1—** Adjusted Odds Ratios and 95% Confidence Intervals from Logistic Regression for Inclusion of Other SHA Members in Social Network at 6-Month Follow-Up (N = 234)

Independent Variables	P Value	Odds Ratio	95% CI
Other SHA members in network @ baseline (control)	.0002 ***	3.21	(1.75, 5.90)
<b>Demographics</b>			
Ethnicity African Amer. (1.0) vs. Other (0)	.0375 *	.47	(.23, .95)
Gender Female (1.00) vs. Male (0)	.1836	1.59	(.80, 3.17)
Housing Status Homeless (1.00) vs. Housed (0)	.6974	1.14	(.59, 2.21)
<b>Psychological</b>			
Symptom Severity (BPRS)	.8414	.99	(.97, 1.03)
Dual Diagnosis (1.00) vs. Other (0)	.1844	1.52	(.82, 2.84)
Personal Empowerment	.8370	1.00	(.97, 1.04)
Self-esteem	.0477 *	1.07	(1.00, 1.14)
Hopefulness	.3067	.92	(.79, 1.08)
Attitudes Toward Psychiatric Disabilities (Social Distance)	.4601	.96	(.86, 1.07)
<b>Organizational</b>			
Organizational Empowerment	.0180 *	1.11	(1.02, 1.20)
Relative Importance of Autonomy	.0348 *	.81	(.67, .98)
Relative Importance of Non-Judgmental Agency Environment	.0097 **	1.39	(1.08, 1.79)
Relative Importance of Concrete Agency Services	.0056 **	.64	(.47, .88)

\*  $p < .05$ ;

\*\*  $p < .01$ ;

\*\*\*  $p < .001$

Model  $\chi^2 = 50.078$ ,  $df = 14$ ,  $p < .000005$ .

N.B. See Tabachnick & Fidell (1996) for discussion of odds ratios.

Adjusted Odds Ratios and 95% Confidence Intervals from Logistic Regression for Inclusion of Other Former Psychiatric Patients in Social Network at 6-Month Follow-Up (N = 234)

Table 2—

Independent Variables	P Value	Odds Ratio	95% CI
Other former psychiatric patients in network @ baseline (control)	.000 ***	4.30	(2.24, 8.26)
<b>Demographics</b>			
Ethnicity African Amer. (1.0) vs. Other (0)	.000 ***	.20	(.09, .43)
Gender Female (1.00) vs. Male (0)	.2604	.66	(.32, 1.36)
Housing Status Homeless (1.00) vs. Housed (0)	.9990	.99	(.49, 2.03)
<b>Psychological</b>			
Symptom Severity (BPRS)	.1077	1.03	(.99, 1.06)
Dual Diagnosis (1.00) vs. Other (0)	.1653	1.62	(.82, 3.19)
Personal Empowerment	.4353	1.01	(.98, 1.05)
Self-esteem	.6532	.98	(.92, 1.05)
Hopefulness	.7617	1.03	(.87, 1.20)
Attitudes Toward Psychiatric Disabilities (Social Distance)	.8561	1.01	(.89, 1.14)
<b>Organizational</b>			
Organizational Empowerment	.0028 **	1.15	(1.05, 1.26)
Relative Importance of Autonomy	.5910	.94	(.76, 1.16)
Relative Importance of Non-Judgmental Agency Environment	.1807	1.19	(.92, 1.56)
Relative Importance of Concrete Agency Services	.8078	.96	(.71, 1.31)

\*  $p < .05$ ;

\*\*  $p < .01$ ;

\*\*\*  $p < .001$

Model  $\chi^2 = 66.487$ ,  $df = 14$ ,  $p < .000005$ .

N.B. See Tabachnick & Fidell (1996) for discussion of odds ratios.