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BEHAVIOR CONTROL SELF-HELP GROUPS:
MEMBERS' ATTITUDES REGARDING HEALTH CARE PROFESSIONALS

by
Clarissa Coleti Marques

A Dissertation Submitted to the Faculty of the
DEPARTMENT OF PSYCHOLOGY
In Partial Fulfillment of the Requirements
For the Degree of
DOCTOR OF PHILOSOPHY
WITH A MAJOR IN PSYCHOLOGY
In the Graduate College
THE UNIVERSITY OF ARIZONA

1983
THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the Final Examination Committee, we certify that we have read
the dissertation prepared by Clarissa Colail Marques
entitled Behavior Control Self-Help Groups: Members' Attitudes
Regarding Health Care Professionals

and recommend that it be accepted as fulfilling the dissertation requirement
for the Degree of Doctor of Philosophy.

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the members of the self-help groups involved in this study. The members of the groups will always remain anonymous, yet their willingness to share an important aspect of their life with an outsider observer has gained my utmost respect and admiration for their struggles to make their lives more rewarding. Without their interest, support and cooperation, this research project could never have materialized.
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ABSTRACT

The demand for human services has grown exponentially in recent years. Self-help groups now fill the gap between consumer needs and the reach of traditional health care. This study examines the perception of the members of these groups toward the professional community. Four self-help groups, all based on the principles of Alcoholics Anonymous (AA) and all primarily concerned with the control of excessive behavior were examined: 1) Parents Anonymous (PA), 2) Overeaters Anonymous (OA), 3) Alcoholics Anonymous (AA) and 4) Narcotics Anonymous (NA). A 60 item questionnaire was designed to obtain the following information: 1) demographic, 2) membership participation, 3) professional contact, and 4) attitude expression regarding respondents' perception of their particular self-help group, perceptions of health care professionals and perceptions of society's beliefs regarding their behavior. Among the 110 respondents from the four groups responding to the questionnaire, (overall return rate of 52%), there was strong support of the methods and conduct of the self-help groups. Criticism of the self-help groups was negligible. Criticism of the health care community was consistently strong, although respondents indicated relatively high usage.
of health care providers. The respondents from all four groups appeared to support any individual member's decision to pursue whatever assistance that individual might deem necessary, but maintained firm delineation between the individual's freedom to choose alternative or adjunctive assistance and the group's decision to remain "forever nonprofessional". Despite a common theoretical background, the groups have developed in different directions. PA, which has included health care professionals as group sponsors since its inception, was most open to professional involvement in group affairs than the others and cited a higher rate of professional referral to the group. OA, with less mental health contact and with more medical involvement, expressed greater reluctance to involve professionals in any aspect of the group's activities. AA and NA tended to take more intermediate positions, however, both groups were firmly against professional involvement in group activities. Information of this nature may assist professionals and self-help groups in developing a collaborative and respectful working relationship.
CHAPTER 1

INTRODUCTION

Mutual Assistance

Self-help is actually a misnomer for what could be more accurately labeled as mutual assistance. Self-help is less an individualistic pursuit of help and more a collective experience of people banding together to provide mutual support. The rapid growth in recent years of mutual assistance groups indicates that, whatever the terminology used to describe these groups, their exponential growth reflects an increasing societal need for their services.

Likewise, the demand for human services has grown dramatically in recent years with little indication that the trend will diminish. To a great degree, self-help groups serving various needs have stepped in to fill the ever-broadening gap between consumer needs and the ability of traditional health care networks to fulfill those needs. Nor have consumers been uniformly satisfied with the traditional human service modalities. By banding together under the self-help banner, consumers have had the opportunity to create alternative delivery systems, often in direct opposition to the established human service networks and professional expertise. The rapid growth of self-help groups may indicate a strong swing in the pendulum
away from professional expertise and traditional services; the pendulum will return to center when professional assistance and mutual assistance have found some common ground. The search for a common ground may be aided by understanding the history and current status of the mutual assistance movement.

History and Current Status of Mutual Assistance

The development of mutual assistance as a social phenomenon may reflect Western society's basic ambivalence between contrasting themes of individual self-determinism and self-reliance versus collective pursuits and community cohesion.

A brief history. Mutual assistance, as a social movement, has a long and interwoven history. The earliest roots have been traced back to the physical survival of the human species. Kropotkin (1914/1955), arguing against the prevailing trend of social Darwinism, maintained that the survival of the human species and the development of human civilization was the result of early cooperative communal activities designed to maximize the survival of the collective, such as food-gathering and common defense. Katz and Bender (1976a, 1976b) trace this pattern of collective activity through the Middle Ages and into the Industrial era as it manifested itself in the form of guild associations,
trade unions and consumer cooperatives. One unique example is the Friendly Societies of England. Developed in response to the Elizabethan Poor Laws and the adverse living and working conditions forged out of the Industrial Revolution, Friendly Societies at first provided funds and support during financial crises, illness and death, and later covered nearly every aspect of life including commercial and building funds, agricultural loans and consumer collectives (Katz and Bender, 1976a, 1976b).

From the beginning of American history on through to the present, the self-help tradition has been expressed through values of community cooperation and group cohesion, as well as through seemingly contrasting values of individual self-determinism and self-reliance. An interesting example of mutual assistance in American history is the development of various ethnic and cultural "welcoming" organizations, created to meet the needs of incoming groups of immigrants. They were organized along ethnic or cultural lines to provide the new immigrant with an extensive assistance network aiding in housing, work, education, language, health and burial (Katz and Bender, 1976b). With the decline in immigration, many of the traditional groups have declined or disappeared; however, with the more recent interest in ethnic identification, many groups are experiencing a revival by third and fourth
generation children of the original immigrants.

The origins of mutual assistance are not limited to physical or economic assistance. Hurvitz (1976) traces the self-help movement through both sacred and secular channels. He finds the mutual assistance theme deeply embedded in the early origins of religious belief and expressed in the practices of confession of sin or guilt within a group, doing penance, experiencing repentance and being restored to a state of grace and to full participation in the group (Hurvitz, 1976). It is interesting to note that one hundred years prior to the formation of Alcoholics Anonymous, the Washingtonians, an essentially religious group established in 1840, met to conquer alcoholism through group confession of guilt-producing incidents and providing one another with support in their crusade against alcohol's effect on their life. The movement died out before the start of the twentieth century. Yet another group, the Oxford group established in 1930 led by a Lutheran minister, Frank Buchman, used similar principles of group confessional to bring about changes in the lives of group participants. Two of the people involved in the Oxford group were Bill W. and Dr. Bob, the co-founders of AA (Hurvitz, 1976).

The secular roots of mutual assistance are founded in a different philosophical tradition according to Hurvitz (1976). He points out the American conflict in values in
which we aspire to freedom, individualism, and self-determinism but, in contrast, also value community identification and mutual assistance. As a result of the American emphasis on the democratic ideal of an open society where an individual may attain whatever responsible goals that person might desire, the focus for change is on the individual, not the social structure. In other words, if the person is not successful in attaining goals, the target of intervention is the individual, not the social context. Mutual assistance, in the secular tradition, is based on the development of will power and personal responsibility, such that the recovering individual can successfully resume a role in society. The sacred tradition restores the individual to the collective through confession and repentance; the secular tradition requires the development of will and responsibility (Hurvitz, 1976).

The common thread that winds through the history of the mutual assistance movement is the need of the poor, the under-privileged and the powerless to establish some control over their destiny, control which eludes them on an individual basis. Following World War II, mutual assistance turned from offering physical and economic assistance to providing more emotional and social support. The reasons are difficult to specifically pinpoint, but several factors seem intertwined in the post World War II growth of the
1. The economy has more or less stabilized around an industrial and technological growth pattern which means that most people are able to meet basic housing, food and clothing needs; however, this industrial/technological society does not necessarily provide for a "psychological sense of community" (Sarason, 1974).

2. There is a strong movement toward a populist, anti-bureaucratic and de-centralized attitude throughout the nation, perhaps in response to the large corporate and bureaucratic growth of industrialized society. The small group setting of a self-help group reduces isolation and alienation (Gartner and Riessman, 1977).

3. There are increasing pressures on the nuclear family to fill niches previously filled by the extended family, neighborhood, church or fraternal organizations. The family is finding itself unable to support the increasing pressures prompting many family members to obtain other sources of emotional support (Parsons, 1958).

4. People are becoming increasingly discontent with the medical management of both acute and chronic health problems (Illich, 1977). Correspondingly, medical and other health care providers are finding themselves increasingly at a loss in trying to cope with medical problems that are largely the result of health-compromising lifestyles (Stachnik, 1980).

5. Despite the growth in human services, many individuals needing assistance remain outside of the human service network due to the perceived cost, linguistic, cultural, lifestyle, accessibility or age barriers.

6. Generalized therapy modalities are not always perceived as effective or appropriate for specifically defined problems. For example, even though it could be argued that AA is a form of group therapy, alcoholics usually prefer to be with a like-minded group of people (i.e., other alcoholics) than in group therapy with persons experiencing a wider range of difficulties.
Current status. To state that mutual assistance is a growing social phenomenon in Western society is to be guilty of understatement. Recent estimates of the number of different self-help groups indicate that there are well over a half million different groups (Gartner and Riessman, 1977). Alcoholics Anonymous (AA), perhaps the most widely known self-help group, and its auxiliary groups, claim a worldwide membership of approximately 750,000 participating in over 18,000 various groups. Groups exist to assist individuals in coping with practically any problem occurring in contemporary human existence, including groups for parents who abuse their children, breast feed their children or have two or more children at the same time; patients who have had ostomies, laryngectomies, heart attacks, mastectomies or cancer; ex-offenders, ex-psychiatric patients or ex-smokers; abusers of alcohol, food or money; and persons dealing with long term adjustments to widowhood, mental retardation, life as a midget, life as a welfare recipient or life with high intelligence. Not only does this list merely scratch the surface of the variety of self-help groups, it does not cover groups which are not commonly considered self-help groups, yet seem to have similar characteristics, such as food cooperatives, communes, labor unions, farming cooperatives and civil rights organizations. Although the
focus of this study is on mutual assistance groups that deal with problems of behavioral control, this does not deny the importance of other types of mutual assistance groups.

Not only is the number of self-help groups and the number of participants growing, but so is the attention being paid to the mutual assistance phenomenon by professional health care providers, social science researchers and governmental agencies. An example of the increased attention devoted to mutual assistance is the 1978 exploratory conference convened by the National Institute of Drug Abuse (NIDA) to examine the use of non-residential self-help organizations "as important sources of support and aid for a wide range of individuals with differing problems and needs" (NIDA, 1978). To further emphasize the substantive role self-help is playing in the area of substance abuse, the NIDA "identified as a new priority the encouragement of self-help groups for drug abusers" (NIDA, 1978). The conference concluded by examining ways in which the federal government could implement support for self-help organizations without undermining their autonomy and with a request for a greater body of knowledge from which to understand and analyze the mutual assistance movement.

Understanding and Analyzing the Mutual Assistance Process

A substantive body of literature exists on various
individual self-help groups, but only recently have researchers turned their eye toward understanding the process of self-help and the implications of the mutual assistance movement for how human services are provided (Levy, 1978; Knight et al., 1980). One of the first research goals has been to define what constitutes a self-help group.

What is a self-help group? Definitions do not exist in isolation from the theoretical and ideological roots that gave rise to the need to define an entity or process. An understanding of the mutual assistance process is no exception. It requires an examination of the many perspectives from which one can approach a definition of what constitutes a self-help group. Each approach emphasizes a different aspect of the mutual assistance process and offers a different explanation for the self-help movement. The most global and encompassing definition is offered by Katz and Bender (1976a).

Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumption of personal responsibility by members.
They often provide material assistance, as well as emotional support; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity (page 9).

**Classification systems for self-help groups.** From a research angle, one of the problems with using such an inclusive definition is that it does not provide a way for differentiating the various groups based on their differing ideologies, goals, techniques or membership. Killilea (1976) approached the conceptual understanding of mutual assistance by separating the interpretations placed on self-help groups from the essential characteristics of a self-help group. From the extant literature, she isolated twenty different interpretations placed on self-help groups and roughly divided these interpretations into four categories based on the focus of the definitions, ranging from the most global to the most specific. The four categories of interpretation are: 1) interpretations of a general explanatory nature, 2) interpretations emphasizing the relationship between mutual assistance groups and other formal assistance groups, 3) interpretations focusing on the lifestyle alternatives offered by the self-help groups and 4) interpretations based on the functional nature of the services rendered by the group (see Table 1 for a condensed version of Killilea's system).
TABLE 1
Mutual Help Organizations:
Interpretations in the Literature
Marie Killilea, 1976
Categories of Interpretation

1. Interpretations of a global explanatory nature
   A. Social assistance - A factor in evolution
   B. Support systems
   C. A social movement
   D. A spiritual movement and a secular religion

2. Interpretations emphasizing the relationship between mutual assistance groups and other formal assistance groups
   A. A product of social and political forces which shape the helping services
   B. A phenomenon of the service society
   C. An expression of the democratic ideal - consumer participation
   D. Alternate care giving system
   E. An adjunct to the professionals and a solution to the manpower problem
   F. An element in a planned care system

3. Interpretations focusing on the lifestyle alternatives offered by the self-help group
   A. An intentional community
   B. A subculture - A way of life
   C. A supplementary community
   D. A temporary/transitional community

4. Interpretations based on the functional nature of the services rendered by the group
   A. Agencies of social control and resocialization
   B. Organizations of the deviant and stigmatized
   C. Expressive/social influence groups
   D. A vehicle to aid in coping with long-term deficits and deprivations
   E. A vehicle to aid in coping with life cycle transitions
   F. A therapeutic method
Katz and Bender (1976a) offered a less complex classification system based on the primary focus of the group. They created five categories:

1. Groups that are primarily focused on self-fulfillment or personal growth. These groups more accurately reflect what is commonly considered self-help; that is, groups which are largely "therapeutic" in nature, oriented toward self-improvement of the membership. Groups such as AA, Recovery, Inc. and Parents Anonymous are prime examples.

2. Groups that are primarily focused on social advocacy. The basis underlying premise of these groups is that the membership is not receiving fair and equitable treatment by the larger society. By banding together they hope to educate, reform, legislate, create and advocate needed changes. Self-help in this sense becomes a social movement oriented toward societal change. Groups such as the National Congress of Organizations of the Physically Handicapped, the Gray Panthers or the National Welfare Rights Organization represent the social advocacy approach.

3. Groups whose primary focus is to create alternative patterns for living. As individuals attempt to forge lifestyles more suitable to their belief and value systems, much support can be gained through group solidarity and group effort. In recent years, women's collectives have been instrumental in providing support for women and men who were attempting to create non-sexist lifestyles. Gay organizations are among the most recent mutual assistance groups providing support for alternative lifestyles.

4. "Outcast haven" or "rock bottom" groups. Protecting the participant from the corrupting or deleterious effects of the larger society is the main focus of these groups. Usually the membership represents individuals who have been totally excluded from mainstream society (i.e., prisoners, long-term psychiatric patients, drug abusers) and need a protective intermediary reference group to facilitate re-entry into society.
5. To further complicate classification, Katz and Bender (1976a) included a fifth category, a mixed type, to emphasize the fact that mutual assistance groups rarely fit into "pure" categories.

Leon Levy (1976) provided yet another classification system but his work was more specifically focused on groups that dealt with problems of an essentially psychological nature. In as much as this research project is concerned primarily with groups dealing with problems centrally involved with behavior control, Levy's (1976) conditions for defining what constitutes a self-help group and his typology system were used as criteria measures for determining which self-help groups would be included in this study.

To meet his definition of a mutual assistance group, a group had to satisfy five conditions:

1. Purpose. Its express primary purpose is to provide help and support for its members in dealing with their problems and in improving their psychological functioning and effectiveness.

2. Origin and sanction. Its origin and sanction for existence rest with the members of the groups themselves, rather than some external agency or authority.

3. Source of help. It relies upon its own members' efforts, skills, knowledge and concern as its primary source of help, with the structure of the relationship between members being one of peers.

4. Composition. It is generally composed of members who share a common core of life experiences.
and problems.

5. Control. Its structure and mode of operation are under the control of members although they may, in turn, draw upon professional guidance and various theoretical and philosophical frameworks (page 311-312).

Groups meeting these five conditions were categorized into a four part typology.

1. Type I. Conduct reorganization or behavioral control is the focus of Type I groups. Type I can be regarded as abuse control groups. These are groups seeking to control abusive drinking patterns, abusive eating patterns, abusive parenting behavior and abusive drug habits. All groups studied in this project are Type I, behavioral control, groups.

2. Type II. The status of the participants in Type II groups is relatively fixed and/or permanent. The objective is to increase coping and adjustment skills to facilitate effective living despite a common predicament and the ensuing stress created by the deficit or deprivation. Reach to Recovery, a mastectomy group; Make Today Count, a group for cancer patients; Parents Without Partners, a group for single parents, are representative of Type II groups.

3. Type III. Type III groups are "survival-oriented". Some component of the lives of the participants has resulted in a negative societal reaction. The participants are labeled as deviant, or are discriminated against because of race, sex, sexual orientation, lifestyle or socioeconomic class. Individuals band together to provide mutual support as well as advocating societal changes. Examples of Type III groups would include: The Fortune Society, a group for ex-offenders; Delancey Street, a group for drug addicts; or the Sisterhood of Black Single Mothers.

4. Type IV. This group consists of persons primarily concerned with reaching their fullest human potential, whatever that might be, and seek the support and assistance from other like minded persons. Groups
such as Re-evaluation Counseling (Jackins, 1963) and Integrity Groups (Mowrer, 1972) are characteristic of this approach.

From the various classification systems and typologies, it is clear that there are a number of ways to conceptually carve up the mutual assistance pie. However different the various conceptual perspectives, there are some common characteristics of mutual help groups that cut across the classification systems.

1. Self-help groups always involve face-to-face interactions (Gartner and Riessman, 1977).

2. Sharing a central problem becomes the unifying thread to bring together an otherwise diverse population and permits the members to deal with a problem with some authority (Killilea, 1976).

3. Constructive action toward some specified goal is accomplished. Members have agreed upon and are engaged in active, specific behavior (Killilea, 1976; Katz and Bender, 1976a).

4. Personal participation is an essential ingredient. To the extent that a self-help group becomes bureaucratized, it ceases to function as a self-help group because mutual assistance relies heavily upon consumer intensive manpower as the "therapeutic" ingredient (Katz and Bender, 1976a; Gartner and Riessman, 1977).

5. The origin is usually spontaneous indicating that self-help groups arise out of a perceived need on the part of the individuals who will receive the services; therefore, strengthening their commitment to the group (Katz and Bender, 1976a; Gartner and Riessman, 1977).

6. A related concept is the common roots of self-help groups from a position of powerlessness, or perceived powerlessness. The group solidarity provides a new basis for hope among the members, particularly for those groups for whom human services have proved inadequate or unresponsive (Katz and Bender, 1976a;
Gartner and Riessman, 1977).

7. Mutual assistance groups provide a reference group, a new focal point for social activity, and a means of obtaining a new self-identification through differential association (Killilea, 1976).

8. Provision of information. To some extent, self-help groups may be more educational than therapeutic, focusing on pragmatic, realistic alternatives. Alternatives include both technical information and anticipatory guidance on expectable problems, phases and transitions (Killilea, 1976).

9. Utilization of the helper principle. Riessman (1965) recognized the benefits that individuals accrued when assuming the helper role toward someone experiencing a common problem. By transforming recipients of help into dispensers of help, the individual is forced to re-evaluate his/her sense of worthlessness and failure and accept a more successful, effective self-image (Killilea, 1976).

10. Reduction of isolationism. By participating in a self-help group, the individual loses his/her sense of uniqueness and comes to an understanding of his/her problem or experience through consensual validation. This understanding prepares the individual to accept coping strategies based on the principle of "what worked for someone else might work for me" (Levy, 1976).

The Professional Dimension

The common characteristics of mutual assistance serve to define mutual assistance as the opposite of, and as an alternative to, professional assistance. To understand why professional assistance is excluded, by definition, from self-help groups, the aprofessional nature of mutual assistance needs to be examined.
The Aprofessional Nature of Mutual Assistance

Implicit in the self-help movement is a condemnation of human service providers and the service they offer as being inadequate or inappropriate to meet the needs of a given group of people. The charters of most self-help groups exclude professional involvement except when professionals are participating as members sharing a common problem and treated as a peer, or, at the discretion of the group, when a professional is invited as a consultant on a specific problem or for a specific purpose. Indeed, in many groups, professional assistance is viewed not only as ineffective or inappropriate, but as destructive to the individual because of the system which encourages legitimization of certain behaviors as deviant by prescribing treatment for those behaviors and perpetuates professional elitism and domination of problems of living (Steinman and Traustein, 1976). Table 2 offers a comparison of the professional and aprofessional treatment modalities developed by Gartner and Riessman (1977) to highlight the differences between the two systems.

This indictment of human services involves both a rejection of professionalization and bureaucratization, qualities that tend to characterize traditional human service networks. This rejection of bureaucratic structure


<table>
<thead>
<tr>
<th>Professional</th>
<th>Aprofessional</th>
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<tr>
<td>1. Emphasis on knowledge and insight, underlying principles, theory and structure.</td>
<td>1. Emphasis on feeling and affect (concrete and practical).</td>
</tr>
<tr>
<td>2. Systematic.</td>
<td>2. Experience, common sense, intuition, and folk knowledge are central.</td>
</tr>
<tr>
<td>4. Empathy; controlled warmth.</td>
<td>4. Identification.</td>
</tr>
<tr>
<td>5. Standardized performance.</td>
<td>5. Extemporaneous, spontaneous (expressions of own personality).</td>
</tr>
<tr>
<td>7. Praxis.</td>
<td>7. Practice.</td>
</tr>
<tr>
<td>8. Careful, limited use of time; systematic evaluation; curing.</td>
<td>8. Slow; time is no issue; informal, direct accountability; caring.</td>
</tr>
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and professionalism is more than an angry, but empty revolt against "the system", but rather an empirical observation supported by case histories. Some mutual assistance organizations, the National Association for Parents of Retarded Children (NAPRC) as an example, grew from a relatively small, de-centralized, parent organized group to a large, national, highly visible and highly bureaucratic organization. The founding parents originally felt that "bigger" meant "better" until it became evident the bureaucratic structure resulted in fewer parents getting their needs met and that more of the organization's resources were being funneled into a bureaucracy which served to further perpetuate the bureaucracy. The NAPRC organization has recently been involved in disassembling the top heavy structure and returning it to the more personally relevant, de-centralized, parent controlled groups.

Problems with reliance on professional assistance can be exemplified by CanCervive's difficult history. CanCervive was created by a social worker associated with the American Cancer Society under an ambiguous mandate to examine the feasibility of using mutual assistance with cancer patients. Briefly, the group's survival was severely jeopardized by the loss of professional support through entanglement with the bureaucratic structure of the American Cancer Society (Kleiman, Mantell and Alexander, 1976).
Steinman and Traustein (1976), in an organizational analysis of 48 urban and 19 rural self-help groups, found that self-help groups preserve their independence by acting in the following manner:

1. act with considerable autonomy in an effort to influence definitions of where their members have a problem and, if so, how the condition is to be diagnosed - functions traditionally reserved for the professions,

2. challenge the profession's claim to exclusive domain over treatment,

3. promote social and emotional involvement among members - whether for service delivery, social action, or solidarity - as a substitute for the traditional affective neutrality and objectivity of professionals and bureaucracies,

4. establish self-help service networks as partial alternatives to bureaucratic-professional human-service delivery systems,

5. involve service consumers in governing organizations which serve them - in sharp contradistinction to established human-service bureaucracies governed by nonclients,

6. give greater credence to personal involvement as a basis for understanding and solving a problematic condition than to expert professional knowledge about treatment and

7. supplement professional therapeutic intervention with peer counseling or, indeed, replace it with the latter (page 359-360).

Nor have professionals been uniformly content with their role in the curing/helping enterprise. Critiques of the medical, psychological and social services networks have become more numerous in recent years, many of which have been written by professionals themselves (Illich, 1977).
And yet, there is more to professionalism than a bankrupt enterprise attempting to prop itself up on inflated elitism and mystical jargon. The middle ground between professional assistance and mutual assistance is obscured in an ideological conflict. This conflict was demonstrated in response to an article in the *APA Monitor* (McNett, 1979) in which two professionals, Alan Gartner and Frank Riessman, discussed their project to bring together human service professionals and mutual assistance organizations into joint collaboration. Two editorial letters appeared in a subsequent issue, one written by a non-professional supporter of self-help condemning professional services (Hatfield, 1980) and another letter written by a professional human service provider condemning self-help groups as lacking therapeutic qualities (Devine, 1980). The gray area between the two has yet to emerge.

**Exploring the gray.** Themes of self-care, self-help and self-management are cropping up with greater frequency in medical, psychological and social commentaries. An estimated 85% of health care is considered to be self-care (Levin, Katz and Holst, 1976). The price tag associated with all forms of health care has risen dramatically. In an issue of *Science*, an editorial statement proclaimed self-care as the "nation's best health insurance" (Stokes, 1979). The basic premise of the
editorial was the promotion of consumer-based self-help to minimize the drain on limited health resources and to maximize consumer control over the health services enterprise. At the same time that the economic realities of health care are being realized, more health care problems are being recognized as health maintenance problems dependent on the lifestyle of the individual with less focus on acute care problems (Stachnik, 1980). 

Between the human service provider and his/her service product lies the consumer of those services. The productivity of a human service provider can be dramatically affected by the behavior of the consumer. A patient who will not comply with a prescribed medication regime will not contribute to a successful cure and an alcoholic determined to prove that he/she is beyond assistance will not participate in a therapeutic relationship. Gartner and Riessman (1977) have labeled human services as "consumer intensive" activities based on the extent to which "the productivity of the provider depends on consumer activity". Human service productivity can only be increased if consumer involvement is increased. The demand for human services is potentially infinite, but the ability to meet that demand with professional human service providers is definitely finite.

Initially, efforts to meet the professional manpower
crunch involved training paraprofessionals to bridge the gap between the human service provider and the consumer (Rioch, 1967). Unfortunately, paraprofessionals ended up in an ambiguous "no man's land", denied full access to professional occupational ladders and yet having more status and training than the consumer. The paraprofessional development could not substantially increase consumer involvement in human services because to the consumer, a professional by any other name is still a professional and to a professional, a layman by any other name is still a layman. Mutual assistance has the potential to shift the balance of power in rendering of human services away from professional domination toward a more equitable and effective consumer-dominated approach. This is not to throw the baby out with the bath water, or the professional out with the professionally-based service model, only to re-orient the responsibility for behavioral change back on the consumer and to encourage the consumer to participate more fully in the process of service delivery.

Self-help not only increases the quantity of services that can be provided, but also the quality. Riessman (1965) pointed out that those persons involved in helping others are frequently helped the most. Gartner and Riessman (1977) state that "any aprofessional approach is likely to be much more consumer centered, immediately
relevant, demystified, credible, not held in an
imperialistic manner, nonelitist, more directly accountable
to the consumer, at least in terms of direct satisfaction,
and, of course, less expensive" (page 111). In addition,
mutual assistance is more likely to be available during
crisis periods, day or night, more active in its approach,
including home visits and providing transportation, more
likely to provide continuing, long-term support even after
the crisis has long since past, requires a far greater
degree of commitment from the consumer, and is less likely
to demand that the participant understand the reasons for
change, only that the participant engage in change behavior.

Limitations of self-help. There are disadvantages
to placing all the human service eggs in the self-help
basket. Within self-help groups a subtle form of
"victim-blaming" can serve to shift societal focus away from
the social context of the problem and societal
responsibility for that problem onto the individual. The
group spends its resources helping individuals to overcome
problems without ever examining the role that society played
in the creation of those problems and failing to apply
pressure for broader-based changes (Gartner and Riessman,
1977). Perlman (1976) believes that the survival of
self-help groups is linked to their ability to not only
provide individualized services, but also their ability to
forge a coherent political ideology and to mass a politically-active constituency capable of bringing power to bear on major societal reform. There is also the concern that in the interest of economy, self-help can be used as an excuse to curtail existing services or to substitute self-help for service expansion to groups needing professional services. A related concern is that volunteers can be used to replace trained professionals in areas where professional expertise is required. The expansion of self-help services can serve to allow professionals to "write-off" certain populations as not needing professional assistance (i.e., alcoholics, gamblers, child abusers) because self-help is available and relinquish the responsibility for examining why traditional services do not seem appropriately suited for these recalcitrant behavioral problems. Another unappealing side-effect of the expansion and support of mutual assistance could be a bifurcated service delivery system in which the lower socioeconomic classes receive self-help services and the upper socioeconomic classes receive professional services (Gartner and Riessman, 1977).

Even the services provided by self-help groups have come under attack as fostering dependence among the participants upon the group for their survival, substituting one authoritarian belief for another, and for creating a new
orthodoxy every bit as rigid as the previous one (Gartner and Riessman, 1977). A common distinction drawn between drunks and AA participants is that the former organize their life around obtaining a drink and the latter organize their life around avoiding a drink, in other words, the same coin, different sides. It can also be said that no one is harder on a drunk than another drunk. Many self-help groups define their problematic behavior in much harsher terms, perceive themselves as more deviant, and much less likely to return to normality than does the larger society (Sagarin, 1969).

The largest vocal opposition to the research into controlled drinking for the treatment of some alcoholics has come from members of AA. Zusman (1969) went even further in questioning the efficacy of self-help groups by referring to them as "no therapy" groups. He further stated that

no-therapy is essentially a method of suppressing symptoms and encouraging conformity. It does not deal directly with "inner life" - the thoughts and feelings of an individual. It is useful where the character or severity of symptoms is such that there is a great risk of social disability if symptoms continue, and where a disturbed "inner life" is either a comparatively minor problem or is not a problem at all (page 486).

Nor does the assistance offered by self-help groups exist in a societal or cultural vacuum, and, in some groups, ideologies can function to further the oppression of a particular sub-group of society. For example, one of the
self-help groups for transsexuals openly opposes any form of homosexuality to help define its members as "not homosexuals" and strives to assist members in locating surgeons and providing funds for sex change operations despite the lack of evidence that such surgical procedures help in an individual's adjustment to sex role orientation (Sagarin, 1969). Another example is the technique of ridicule and humiliation used in Weight Watchers to help an essentially female population strive to obtain some approximation to the cultural value of beauty and sexuality by emphasizing the sexually unappealing nature of obesity and the essentially self-indulgent and child-like nature of women (Ehrenreich, 1974).

Perhaps the most major indictment against self-help groups, at least from the human service provider's perspective, is the unwillingness of most groups to systematically evaluate their procedures and the efficacy of their approach. For some groups their aprofessional nature translates into a stridently anti-professional position which includes an avoidance of anything sounding of research. Agencies dependent on public funds can be mandated into accepting program research and evaluation. The autonomy of mutual assistance groups tends to place them beyond the specter of public accountability. And yet, if self-help groups align themselves too closely with
professionals and institutions, they risk being co-opted and losing their distinctive approach. The mere presence of a professional in some cases can invalidate a group's ideological stance, as in the AA saying "Only a drunk can help a drunk" (Gartner and Riessman, 1977). If the gray area exists at all between professional assistance and mutual assistance, it involves a delicate balance between the professional expertise, involving a systematic and objective approach to research and evaluation, a body of theoretical and applied knowledge concerning human growth and development, and a sense of perspective regarding the whole spectrum of human disorders; and the mutual assistance expertise, involving an intimate and intensely experiential approach to problematic behavior, a thoroughly pragmatic program of behavior change based directly on efficacy, and an intense personal commitment to helping.

The Role of the Professional

In analyzing the role played by professionals within self-help groups, it is important to differentiate between the ideological stance of the group and the actual behavior of the group. In some groups, Parents Anonymous as an example, have integrated professional involvement into both the ideology and the behavior of the group from the beginning. Professionals in Parents Anonymous do not lead
the groups, but a professional serving as a sponsor is present for each group meeting. This professional helps clarify emotional situations and identifies behavior that could better be handled by more intensive professional assistance. In Recovery, Incorporated, professionals are barred from leadership positions, but every participant must be undergoing professional treatment to remain in the group and professional authority in all aspects of treatment is supported. One of the specifically stated tenets of Recovery, Incorporated is that members may not discuss any aspect of their treatment, including diagnosis, prognosis or medication, nor may they recommend physicians (Lee, 1976). In others groups, the issue of professional involvement is less clearly specified and correspondingly, less clearly understood. For example, in AA, if the ideological stance is that "only a drunk can help a drunk", then does the involvement of a professional negate the ideological foundation (Antze, 1976)?

From a developmental standpoint, an anti-professional bias may be necessary to allow a self-help group to differentiate itself from the traditional service networks that may have not provided adequate service and to provide credibility in the eyes of persons seeking mutual assistance after a lack of success with professional assistance. But what happens to the alcoholic who after
nine years of sobriety still has sexual dysfunction difficulties? Does he congratulate himself on his sobriety and remember how much worse it could be, or does he seek professional assistance for his problem; or the mastectomy patient who does not pull out of post-operative depression even with the assistance of mutual assistance; or the abusive parent who goes beyond the abusive range and into a more schizophrenic behavior pattern? All three scenarios could benefit by professional intervention, but does it occur and how many people are lost in the cracks between professional and mutual assistance? In addition, professional involvement can assist in evaluation and program development. Part of the distrust harbored by professionals toward self-help groups is based on the free-wheeling, seemingly inflated success figures and the insistence by self-help groups that evaluation is unnecessary at best. How much ideological and procedural excess baggage are self-help groups carrying around over and above their useful, effective techniques? The research format provides an objective, systematic approach to questions of efficacy and provides a public forum for disseminating useful information to other providers engaged in similar work. Professional involvement also has the perspective necessary to integrate mutual assistance into the whole of human life. Currently, in the self-help
movement, a great deal of separatism is occurring. Separate groups for physical/psychological abusers of children and sexual abusers of children exist. Nearly every chronic disease has some form of mutual assistance group, and yet, sometimes, the similarities among the groups are more impressive than the differences. To go one step further, the same processes of coping and adjustment, acceptance and motivation to continue, are present in the lives of all humans, not just specifically afflicted persons. Professional human service providers have the unique opportunity to assist mutual assistance groups in recognizing their potential membership in the full spectrum of human life, rather than limiting themselves to one particular circumscribed behavior.

Professionals have had some excellent models for effective participation in self-help groups. The Widow to Widow program stands as a prime example of an effective intervention strategy. The Widow to Widow program was an outgrowth of the efforts of Harvard's Laboratory of Community Psychiatry to design and implement a primary prevention program to aid recently bereaved persons cope and adjust to life after the death of a spouse (Silverman, 1976). By using widowed individuals who had overcome their grief and had adjusted well as support agents for newly bereaved persons, the program fostered autonomous prevention
and mutual assistance services while maintaining an effective professional involvement as researchers and consultants. Other roles professionals have occupied include consultant, educator, program developer, advocate, evaluator and referral agent to various self-help groups (Gartner and Riessman, 1977). Despite these various roles that professionals have successfully played, it continues to be difficult to be a human service professional involved in mutual assistance. Perhaps this is as it should be. This essentially adversary stance protects mutual assistance from professional co-optation and keeps professionals from abandoning their responsibilities by over-glamorizing self-help as the human service solution to complex behavioral and societal problems.

**Self-Help Groups and Research**

To examine the interface between the professional community and the self-help group movement, it is perhaps best to start with the attitudes and experiences of the group members themselves, both in regards to their involvement with their group and with professionals. Although research with self-help groups is difficult, it is not impossible. Most studies, however, have focused on the analysis of individual mutual assistance organizations; sometimes limiting research to single groups, making
generalizations across organizations difficult. To deal with this difficulty, four organizations were selected within the limits of local availability and accessibility.

Research Rationale

Group Selection. Initially what was needed were groups having a greater likelihood of contact with the professional community, preferably groups with contact both with mental health, as well as, medical health care professionals. Mutual assistance groups involved with behavior management appeared to be well suited for this purpose; however, the underlying philosophical or ideological bases can vary dramatically from group to group. For example, both members of Emotions Anonymous and Recovery, Incorporated typically have had contact with medical and mental health professionals for similar problems with dysfunctional behavior, but there the similarities end. Recovery, Incorporated specifies that each member be actively involved in treatment, cannot discuss any aspect of treatment at group meetings and maintains a position of adjunctive, supportive assistance, while supporting professionals as direct service providers. Emotions Anonymous, an anonymous-based self-help group patterned after AA, focuses on individual responsibility for behavior following a behavior management program.
(the Twelve Steps) specified by the organization, allowing the group members to function as direct service providers, reserving professional intervention only as an adjunctive service if necessary. For reasons of clarity in interpretation of results, the four organizations selected for inclusion were all based on the foundations of one of the largest and oldest behavior-oriented self-help groups, Alcoholics Anonymous (AA). By examining groups all founded on similar anonymous-based traditions, it becomes easier to interpret inter-group variability.

In addition, all the anonymous-based self-help groups fall into Levy's (1976) Type I - Behavior Control category, indicating that all the members have a similar focus, striving for behavioral control of excessive behavior. Members of behavior control type groups are also typically dealing with the stigmatizing effects of their behavior. Two of the organizations selected, AA and Overeaters Anonymous (OA), are dealing with behaviors that are stigmatizing when done to excess, but are not illegal behaviors. The remaining two organizations, Narcotics Anonymous (NA) and Parents Anonymous (PA), deal with behaviors that are both stigmatizing, as well as, illegal. Although the focus of behavioral control of excessive behavior runs through these four groups, the behavior to be controlled varies from controlling consummatory behaviors.
(alcohol, drugs and food) to controlling or preventing the occurrence of physically or psychologically abusive parenting behaviors. Holding constant the type of group (behavior control), the major philosophical tenets (anonymous-based) and the likelihood of contact with both medical and mental health professionals, provided the basis for examining the attitudes and experiences of the group members, both in regards to their involvement with the group and with the professional community.

Methodology. The medium for obtaining the necessary information was a 14 page, 60 item questionnaire designed to tap information across four general areas: 1) information pertaining to the members' current participation in their group, 2) general demographic information, 3) information pertaining to the members' contact with the professional community and 4) 33 Likert-type attitude items sampling information across several information categories. The questionnaire methodology is the only permissible way to gain access to group members without compromising their anonymity. The sampling bias problems are enormous; however, at this early stage of explorative research any effort appears to be better than no effort.

Hypotheses. Although the research is largely explorative in nature, certain predictions were made:
1) Groups with a more tenured membership will be more accepting of professionals or alternative treatment modalities than groups with a less tenured membership,

2) Groups with a closer relationship with professionals, such as PA's involvement of professionals as group sponsors, will be more accepting of professional or alternative treatment modalities than groups with minimal professional contact and

3) Across all four organizations, the membership will consist primarily of a middle socioeconomic class leaving minorities, the elderly and the poor still largely underserved by mutual assistance as well as professional assistance.

This research was undertaken to help clarify the gray area between professional and mutual assistance with the hope that greater clarity will pave the way for cooperative understanding and coordination of efforts to improve services for all persons.
CHAPTER 2

METHODS

Group Selection

Selection Criteria

Four mutual assistance groups were selected for inclusion in this study: 1) Parents Anonymous (PA); 2) Overeaters Anonymous (OA), 3) Alcoholics Anonymous (AA), and 4) Narcotics Anonymous (NA). In order to be defined as a mutual assistance group, each group met the following criteria, as established by Levy (1976):

1) Its express primary purpose is to provide help and support for its members in dealing with their problems and in improving their psychological functioning and effectiveness;

2) Its origin and sanction for existence rest with the members of the groups themselves, rather than some external agency or authority;

3) It relies upon its own members' efforts, skills, knowledge and concern as its primary source of help, with the structure of the relationship between members being one of peers;

4) It is generally composed of members who share a common core of life experiences and problems;

5) Its structure and mode of operation are under the control of members although they may, in turn, draw upon professional guidance and various theoretical and philosophical frameworks (pages 311 - 312).

In addition, each group met the definitional requirements to be characterized as a Type I group in the
four part typology developed by Levy (1976). A Type I group is defined as a group in which conduct reorganization or behavioral control is the focus of the group’s activities. Mutual assistance groups seeking to control behavioral excesses; such as, abusive consumption of alcohol (AA), abusive consumption of food (OA), abusive consumption of drugs (NA) and abusive parenting behavior (PA), fall in the Type I category.

Description of Groups

A brief description of the four mutual assistance groups selected for this study is provided below.

Parents Anonymous (PA). PA is one of the newer mutual assistance groups, founded in 1969, designed to meet the needs of parents who demonstrate physically abusive behavior toward their children or feel that they may be at risk to demonstrate such behavior. From the organization’s inception, human service professionals have been integrated into the structure and functioning of the organization and the individual groups. Each PA group is run autonomously with a parent facilitator, but has a human service professional serving as a sponsor at each meeting to aid in clarification of difficult situations and to indicate when more intensive professional assistance may be needed.

Overeaters Anonymous (OA). OA, founded in 1960,
based on the program of behavior change developed by AA, is designed to meet the needs of individuals needing assistance in controlling compulsive over-eating and maintaining normal body weight. The program does not endorse any particular eating plan or any diet. The suggested plan includes consumption of three moderate meals a day with nothing in between meals but low-, or no-, calorie beverages and avoidance of all foods that may trigger over-consumption (such as; sugar, white flour, or fried foods). Each OA group is run autonomously by the members and guided by a local steering committee (inter-group committee) with consultation from a national organizational office (World Service Office).

*Alcoholics Anonymous (AA)*. As the largest, oldest and the most well-known mutual assistance group, AA stands as the prototype for many "spin-off" mutual assistance groups, particularly the anonymous-based groups. The AA literature indicates that their ideological stance is perhaps the least open to professional involvement. One of AA's twelve traditions (Tradition Eight) states "Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers" (AA World Services, 1953). This tradition accompanies an underlying belief that persons having experienced a problem are uniquely qualified to help others in a similar situation (Antze, 1976).
Narcotics Anonymous (NA). NA developed in response to the needs of addicts and poly-drug abusers. Many drug abusers also abused alcohol, but found that they were unable to find the support necessary to deal with their drug problems within the context of AA. NA is a direct "spin-off" from AA, yet deals specifically with the problems of drug abuse. It would not be uncommon for a NA member to also attend AA meetings for additional support and assistance specific to alcohol. The goal of an NA member is to become "clean and sober," referring to abstinence from both drugs and alcohol.

Questionnaire Development and Implementation

Construction of Questionnaire

A questionnaire was designed to obtain the following information:

1) demographic information to determine the socio-economic characteristics of the group members agreeing to participate in the study (see Table 3),

2) membership participation information to determine the length and degree of involvement in the mutual assistance group by the respondents (see Table 4),

3) professional contact information to determine the recent and past history of involvement with health care professionals (see Table 5),
4) attitudes expressed regarding respondents' perceptions of their particular self-help group, perceptions of mental health and medical health care professionals and perceptions of society's beliefs regarding their behavior (see Table 6).

The questionnaire consisted of a cover letter which explained the intent and purpose of the research project and the use of the information, a page explaining the procedure for completing the questionnaire and providing information necessary to obtain further assistance if problems developed, 11 pages of questions (60 items) covering the information listed above and a final page soliciting respondents' comments. (See Appendix A for the questionnaire forms used for each group.)

The questionnaire was customized to meet the needs of the specific mutual assistance group being addressed and permitted a more personalized approach with less cumbersome vocabulary; however, all questions remained in the same order and position across all questionnaires. The vocabulary was chosen to reflect the ways in which the group literature addressed the behavior problems of the members. Reviewers from each group completed pre-test questionnaires and made recommendations based on their perceptions of questionnaire intelligibility and applicability to a given group. Where the recommendations would not compromise the intent or meaning of the question, the recommendations...
### TABLE 3

**Demographic Variables Assessed by the Questionnaire**

- Age of Respondent
- Sex of Respondent
- Ethnicity of Respondent
- Educational Level of Respondent
- Occupation of Respondent
- Current Employment Status of Respondent
- Annual Household Income
- Marital Status of Respondent
- Household Size
- Geographic Mobility of Respondent
TABLE 4

Membership Participation Information Assessed by the Questionnaire

Length of Involvement
Length of Abstinence
Frequency of Attendance
Initial Contact with Group
Persistence of Association
 Interruption in Association
Resumption of Association
Perceptions of Reasons for Organizational Success
Perceptions of the "Ultimate Solution"
Perceptions of Organizational Goals
Necessity of Personal Experience with Target Behavior as Prerequisite to Assistance
TABLE 5

Information Regarding Contact with Health Care Professionals Assessed by the Questionnaire

<table>
<thead>
<tr>
<th>Professional Involvement: Medical</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Past Year</td>
<td>--</td>
</tr>
<tr>
<td>Professional Involvement: Medical</td>
<td></td>
</tr>
<tr>
<td>Within Past Five Years</td>
<td>--</td>
</tr>
<tr>
<td>Professional Involvement: Mental Health</td>
<td></td>
</tr>
<tr>
<td>Within Past Year</td>
<td>--</td>
</tr>
<tr>
<td>Professional Involvement: Mental Health</td>
<td></td>
</tr>
<tr>
<td>Within Past Five Years</td>
<td>--</td>
</tr>
</tbody>
</table>

Organizational Use of Professional Services
### TABLE 6

#### Categories of Information Tapped by the Questionnaire Attitude Items

- **Attitudes Regarding the Necessity of Personal Experience**
  - 3 Questionnaire Items: Q-21, Q-33 and Q-41

- **Attitudes Regarding the Acceptance of Alternative or Additional Treatment Modalities**
  - 5 Questionnaire Items: Q-37, Q-46, Q-30, Q-26 and Q-47

- **Attitudes Regarding those Individuals Who Leave the Mutual Assistance Organization**
  - 3 Questionnaire Items: Q-35, Q-25 and Q-27

- **Attitudes Regarding Familial and Social Involvement**
  - 2 Questionnaire Items: Q-20 and Q-42

- **Attitudes Regarding Acceptance by Larger Society**
  - 4 Questionnaire Items: Q-24, Q-29, Q-40 and Q-36

- **Attitudes Regarding Professionals: Medical Health Care Providers**
  - 4 Questionnaire Items: Q-22, Q-19, Q-44 and Q-48

- **Attitudes Regarding Professionals: Mental Health Care Providers**
  - 4 Questionnaire Items: Q-28, Q-34, Q-32 and Q-39

- **Attitudes Regarding the Appropriate Role for Professionals**
  - 2 Questionnaire Items: Q-43 and Q-49

- **Attitudes Regarding the Benefits of Association**
  - 4 Questionnaire Items: Q-45, Q-31, Q-38 and Q-23
were implemented.

The questionnaire was designed to incorporate research findings relevant to obtaining high rates of compliance with the questionnaire procedures (Bradburn, 1979; Dillman, 1978). Questionnaire length is not as critical a factor as question design (Kanuk and Berenson, 1975; Craig and McCann, 1978). The perceived length of the questionnaire was reduced by photocopying on both sides of a sheet of paper, reducing the amount of paper confronting the respondents. Questionnaires up to 35 pages in length have been completed with satisfactory return rates if the questions were designed for ease of completion (Sletto, 1940).

Informational questions were designed to encompass most of the response options that a member might want to provide and, basically structured as close-ended questions. A few informational questions included an "other" category to be specified by the respondent. The respondent was only required to circle the number next to the response option that most closely represented his/her opinion. Six informational items permitted multiple responses. To complete a multiple response item, the respondent was asked to circle up to three response options that corresponded with his/her opinion; then, in the blanks next to the response items, the respondent was asked to indicate his/her first, second and third choices. A sample item, at the
beginning of the questionnaire, reviewed the procedure for answering multiple option items.

Attitudinal items were constructed using a five point Likert-type scale and included a non-scorable "no opinion" response option to allow a respondent to refuse to answer an item without skipping that item. The Likert-type scale ranged from strongly agree at one end to strongly disagree at the other end of the continuum. The respondent was asked to circle the one response option that most closely represented his/her opinion. Attitudinal items from the various categories of information were mixed in a random fashion. Attitudinal items were counter-balanced to offset positive and negative response bias.

Distribution of Questionnaires

The distribution of the questionnaires was handled in different ways depending on the needs and recommendations of each group. The main goal was to develop a means of distribution and collection of the questionnaire materials that would yield a satisfactory return rate and yet preserve the anonymity, confidentiality and integrity of the group and group members agreeing to participate.

Two of these organizations (AA and NA) hold meetings in in-patient treatment facilities for individuals undergoing treatment specific to the target behavior.
of the group. These groups are specifically aimed at
the inpatient population, although typically are open to the
public and to members of that organization. These
groups frequently are required parts of the total treatment
plan. Questionnaires were not distributed to any group
meeting with an in-patient population.

Questionnaires were distributed to the various groups
according to the distribution plans listed below. The
distribution of questionnaires started with PA, followed
sequentially by OA, AA and finally NA in approximately one
month intervals. Respondents had approximately three weeks
to complete and return their questionnaire.

**Parents Anonymous.** The coordinating office
responsible for organizing the various PA groups within a
large metropolitan area was contacted by the researcher and
the questionnaire was pre-tested on a group of PA sponsors.
Following pre-testing, according to the recommendations of
the sponsors' group, the questionnaires were made available
to all interested group sponsors to distribute to their
groups. Interested group sponsors explained the research
goals and purpose, distributed the questionnaires, collected
the completed questionnaires and mailed them back to the
researcher in envelopes provided by the researcher.

**Overeaters Anonymous.** The coordinating group
responsible for organizing the various OA groups was
initially contacted by the researcher. The group requested
and received a statement of research goals and objectives, as well as participated in the pre-testing of the questionnaire. Interested group leaders distributed questionnaire packets including: the questionnaire, a letter explaining the nature of the project, and a postage paid, self-addressed return envelope. Group leaders not present at the organizational meeting were contacted by telephone by the researcher. Interested group leaders were sent the questionnaire packets for their group through the mail.

Alcoholics Anonymous. AA maintains a stance against becoming involved in issues, controversial or otherwise, not directly pertinent to AA. After contacting the chairperson of the local coordinating group and the person serving as liason with the professional community, it became evident that the organization of AA could not support the research project; however, members of AA could choose to participate. The questionnaire for AA was pre-tested on a group of eight individuals known to the researcher as members of AA and willing to complete the pre-testing materials. Questionnaire packets were distributed in groups by AA members known to the researcher who were interested in the project and willing to assist. The questionnaire packets were distributed to respondents unknown to the researcher. The questionnaire packets included: the questionnaire, a letter explaining the nature
of the project and a postage paid, self-addressed return envelope.

Narcotics Anonymous. The membership of NA is more unstable than in the previous three groups. Two members with former leadership positions within NA agreed to pre-test the questionnaire for the NA population. Three members of NA with leadership positions agreed to participate by completing the questionnaire and in making the questionnaire packets available to individual group members. The questionnaire packets were constructed in the same fashion as those assembled for AA and OA.

In summary, in all four groups efforts were made to clear the project through the local coordinating groups (local leadership) prior to implementation. The project was endorsed by two coordinating groups (PA and OA), relegated to individual choice by one group (AA) and no clear organizing group was evident for the last group (NA). In all four groups, the group members' anonymity was protected by having a group member or leader distribute the questionnaire materials. In three of the four groups (OA, AA and NA), interested group members received a self-contained questionnaire packet containing an explanatory letter, questionnaire and a self-addressed, postage-paid return envelope. Only in PA was the group leader responsible for explaining the project and returning the questionnaires as a group. Given the nature of these self-help groups, there
appeared to be no reasonable way to insure random distribution or random sampling of the population. Across all four groups, the population sampled by this questionnaire procedure consisted of members attending groups where the questionnaire was made available and interested and willing to complete the questionnaire and return it prior to the deadline specified on the cover letter. All generalizations drawn from the data, therefore, must be restricted due to the methodological problems in studying self-help groups.

**Population Sample and Return Rate**

The sample of self-help group participants was highly selected given that members were solicited to participate in the study based on the researcher's ability to obtain the cooperation of the group. Not all groups asked to participate agreed to participate, nor did all the members within a participating group agree to participate. The results are based on the participation of 110 respondents from the four self-help organizations (PA, OA, AA and NA) representing two Southwestern cities, one a large, urban metropolitan area and the other a moderate-sized, high growth, urban area. Table 7 presents the return rates for each group with additional information related to the representativeness of the sampling procedure.
TABLE 7

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximate # of</td>
<td>2</td>
<td>8</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Groups Involved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximate # of</td>
<td>50</td>
<td>80</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>Questionnaires</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Attendance</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>per Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Returned</td>
<td>13*</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
<tr>
<td>Questionnaires</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximate Rate</td>
<td>26%</td>
<td>57%</td>
<td>68%</td>
<td>50%</td>
</tr>
<tr>
<td>of Return for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaires</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*One questionnaire was returned but unscorable due to the refusal to answer all but two questionnaire items. This questionnaire was dropped from the study and is not included in this figure.
Three of the four groups (OA, AA and NA) demonstrate return rates in excess of the national norms for questionnaire research (40%); however, PA falls far short of the mark (Dillman, 1978). This may be related to the different distribution and collection procedure implemented in PA, as opposed to the other three groups. The overall return rate (52%) indicates a satisfactory return rate, but caution must be observed in interpreting the results from PA.

Sampling Bias

The problem of sampling bias appears to be inherent in research involving self-help groups due to the nature of these groups. The membership of any given group is essentially voluntary and consists of people who define themselves as experiencing the problem that is the central focus of the group. The process of self-definition can result in a wide variation in the severity of the presenting problem, length of duration of the presenting problem, acute versus chronic nature of the presenting problem, previous or concurrent experience with other treatment modalities and presence or absence of complicating, perhaps even more immediate, problems. Few, if any, records are maintained on current, or past, membership, making a number of analyses nearly impossible, including:

1) present size of the group,
2) rate of attrition,
3) rate of success and
4) contact rate, the proportion of people in a given geographic area experiencing a common problem who make some form of contact with a given self-help group.

Another complicating sampling variable is multiple group membership, both within an organization and between organizations. It would not be uncommon for a member of AA to attend several different AA meetings in a week in addition to his/her "home" meeting. Nor would it be unusual for a member of NA to also attend an AA meeting.

Given these sources of sampling bias, the choice becomes one of foregoing any research in the self-help area or proceeding with research attempts by providing appropriate cautionary statements about the limits of such biased research and tempering any inferences, however tentatively drawn, from the research. This project represents an attempt to empirically examine the attitudes of various self-help group members toward health care professionals, but does so with the full awareness that the sampling bias problem severely restricts the inferences that can be drawn.

Analysis of Data

Scoring Procedures
Scoring questionnaires items was accomplished by recording the response option selected by the respondent. In cases where the respondent endorsed more than one response option when only one response option was permitted, the scored option was determined by a random procedure. For multiple response items, the item was scored by giving the first choice option a weighted score of three, the second choice option a weighted score of two and the third choice option a weighted score of one.

Statistical Procedures

The data obtained from the informational questions (demographic information, membership participation information and information related to involvement with professionals) were treated as frequency (nominal) scale data and were analyzed using descriptive statistics. Group means, standard deviations and percentages were calculated for all informational questions and compared across the four groups.

Data obtained from the attitudinal items were treated as interval data consistent with the assumptions made when using a Likert-type scale (Schuessler, 1971). Consecutive integers (1, 2, 3, 4 and 5) were used as weights rather than sigma weights consistent with Likert’s (1932) work indicating a .99 correlation between arbitrary consecutive integers or ranks and sigma weights. The
"Strongly Agree" response option was given the weight of one and the "Strongly Disagree" end of the continuum was anchored with the weight of five. One-way analysis of variances for unequal samples were performed on each attitude item to compare the attitudes of the four group on each item. Results were regarded as rejecting the null hypothesis at the .05 level. Significance and difference among groups was further tested at .05 level using the conservative Tukey HSD post hoc test on all significant ANOVA results. Only those attitude items obtaining significance at the .05 level using the Tukey HSD post hoc test were treated as representing significant differences among groups.
CHAPTER 3
RESULTS

Acceptability of the Questionnaire

Before entering into a detailed examination of the results of the body of the questionnaire, it would be beneficial to examine the last question on the questionnaire (Q-60: How do you feel about taking part in this survey?) This question can be used as a general indicator of the acceptability of the questionnaire to the respondents and to provide some degree of confidence in their responses as reflecting their opinions, not a reaction to a difficult or poorly constructed questionnaire. Table 8 provides the results for this item and indicates a high degree of overall satisfaction with the questionnaire. When the "good" category and the "don't mind" category are combined into one positive response category, 93% of the respondents indicated a neutral to positive reaction to the questionnaire. The largest class of negative responses came from the PA group and the most frequently cited problem was a terminology problem. Specifically, they cited the use of "child abuse" rather than stating "potential for child abuse" to indicate that not all members of PA had actually experienced abusive parenting behavior, some members feared their potential to engage in abusive parenting behavior. The remaining
### TABLE 8

**Questionnaire Acceptability to Respondents By Group**

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good - Raw</td>
<td>3</td>
<td>23</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Good - %</td>
<td>23</td>
<td>50</td>
<td>29</td>
<td>60</td>
</tr>
<tr>
<td>Don't Mind - Raw</td>
<td>7</td>
<td>20</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Don't Mind - %</td>
<td>54</td>
<td>43</td>
<td>68</td>
<td>30</td>
</tr>
<tr>
<td>Other - Raw</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other - %</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment - Raw</td>
<td>6</td>
<td>33</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>Comment - %</td>
<td>46</td>
<td>71</td>
<td>66</td>
<td>70</td>
</tr>
<tr>
<td>No Comment - Raw</td>
<td>7</td>
<td>13</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>No Comment - %</td>
<td>54</td>
<td>28</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
responses in the "other" category across the three other groups were typically some type of comment about an individual group or some fine point of discrimination that a respondent made in regards to one or more items, rather than any negative reaction to the questionnaire itself. Only 5% of the respondents even indicated that their response to the questionnaire was other than neutral or positive.

Related to this item is the percentage of people who, after participating in a lengthy questionnaire, provided further personal comments at the end of the questionnaire on the final page. The comment page was provided to allow respondents to personalize some of their responses, elaborate further on questionnaire items and to provide some feedback regarding their experience with the questionnaire and with their particular self-help group. Two-thirds of the respondents (66%) provided comments on the last page. Comments ranged from personal testimonials to the efficacy of a particular group to discussions of the philosophical orientations of the different groups to recommendations of materials, people, literature, or treatment facilities that might be of further assistance in understanding the self-help process.
Analysis of Demographic Information

Age

The mean age and range of ages of the respondents from each group varied considerably as shown in Table 9. Both NA and PA respondents represented a younger population with a lower mean age than found in OA and AA. NA respondents were more restricted in age range and skewed toward a younger membership. Two factors could potentially explain the age variability among the various respondents: 1) parenting difficulties would be most likely to occur to persons in the child-bearing, child-rearing ages; similarly, drug abuse tends to be more prevalent in younger persons with a notable decrease in drug consumption as age increases (NIDA, 1981), and 2) the older the organization, the more likely it is to have members who have participated for longer periods of time and subsequently are older in age.

Sex

For the overall project, female respondents outnumbered male respondents three to two. As Table 10 indicates the sample drawn from OA was predominantly female (85%). There is no evidence that in general, women are disproportionately overweight as compared to men; however, the societal pressures and biases against overweight women may be reflected in the predominance of female respondents.
### TABLE 9

#### Mean Age of Respondents by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Age</th>
<th>S.D.</th>
<th>N</th>
<th># Missing</th>
<th>Range</th>
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</thead>
<tbody>
<tr>
<td>PA</td>
<td>31.5</td>
<td>8.2</td>
<td>13</td>
<td>0</td>
<td>20-52</td>
</tr>
<tr>
<td>OA</td>
<td>40.4</td>
<td>13.8</td>
<td>44</td>
<td>2</td>
<td>21-74</td>
</tr>
<tr>
<td>AA</td>
<td>42.2</td>
<td>12.1</td>
<td>41</td>
<td>0</td>
<td>18-69</td>
</tr>
<tr>
<td>NA</td>
<td>31.2</td>
<td>5.9</td>
<td>10</td>
<td>0</td>
<td>19-39</td>
</tr>
</tbody>
</table>
TABLE 10

Sex of Respondents by Group

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>QA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male - Raw</td>
<td>3</td>
<td>6</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Male - %</td>
<td>23</td>
<td>13</td>
<td>51</td>
<td>70</td>
</tr>
<tr>
<td>Female - Raw</td>
<td>10</td>
<td>39</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Female - %</td>
<td>77</td>
<td>85</td>
<td>49</td>
<td>30</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>45</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>

Sex of Respondents for Overall Project

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male - Raw</td>
<td>37</td>
</tr>
<tr>
<td>Male - %</td>
<td>34</td>
</tr>
<tr>
<td>Female - Raw</td>
<td>72</td>
</tr>
<tr>
<td>Female - %</td>
<td>66</td>
</tr>
</tbody>
</table>
from OA. PA has the next highest proportion of female respondents (77%) which may reflect a sampling bias. Or, perhaps, it may represent the societal perception of the mother as primary child-care provider and the reluctance of fathers to become centrally involved in primary child care. It may also reflect the growing number of single parent households where the child still typically resides with the mother and experiences the economic and social pressures of single parenthood.

Within AA sample the proportion of male (51%) to female respondents (49%) was fairly equal. It is possible that this finding reflects sampling bias and/or it is possible that this finding may reflect a growing tendency for women to self-define as alcoholics and to become involved in AA. The 1980 Survey of the Membership of AA indicated that 31% of the sample respondents were women, up from 22% in 1968, and a 34% increase in the number of female members since the previous survey in 1977 (AA World Services, Inc., 1980). The sample drawn from the membership of NA appeared to be predominantly male (70%) which is consistent with the research findings that men tend to be disproportionately involved in illegal drug use (NIDA, 1981), while women tend to abuse legal drugs, such as Valium or Librium.
Ethnicity

As might be expected, the population sample drawn from these mutual assistance groups tended to be predominantly Anglo in membership. Table 11 shows 100% Anglo membership for NA, 98% for AA and 91% for OA. Only PA had a significant minority group participation, an ethnic representation that far exceeds the norms for the metropolitan area in which the membership for PA was drawn.

Two factors may influence these results: 1) PA is the only group in which parents can be court-ordered to participate as a condition of retaining or regaining custody of their children and 2) it is possible that the self-help group treatment modality better serves the needs of minority parents, both economically and in terms of social support. These findings do not suggest that minority participation in these mutual assistance groups is as limited as expressed in the figures. Sampling procedures contributed to the limited access to minority populations. For example, in-patient or in-house treatment programs using mutual assistance groups as a part of the treatment program were excluded for methodological reasons; however, one of the largest local NA groups was an in-patient treatment group with a representative number of ethnic minority participants. Additionally, AA sponsors several "special" groups, including Spanish-speaking groups. Due to the difficulty of interpreting the questionnaire into Spanish, these groups
TABLE 11

Ethnicity of Respondents by Group

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>QA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo - Raw</td>
<td>6</td>
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<td>40</td>
<td>10</td>
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<td>100</td>
</tr>
<tr>
<td>Hispanic - Raw</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hispanic - %</td>
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<td>2</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Amerind - Raw</td>
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<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Amerind - %</td>
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<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Asian - Raw</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian - %</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other - Raw</td>
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<td>0</td>
</tr>
<tr>
<td>Other - %</td>
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<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>45</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
were excluded. Other research has suggested that most mutual assistance groups are oriented toward Anglo needs and values (Lieberman and Bond, 1976; Brugliera, 1976 and Durman, 1976). Even though the respondents to this questionnaire represented a predominantly Anglo population, these results cannot be used to confirm or deny other research findings due to the sampling difficulties.

Education

Education, income and occupation appear to follow a similar pattern. AA respondents tended to have the highest level of education, close to the highest number of respondents employed in professional positions and the highest income levels. Within the AA sample, 93% of the respondents had completed some form of education beyond high school graduation ranging from junior college to completion of post graduate studies. PA followed the reverse pattern having the lowest overall level of education, fewest number of respondents involved in professional positions and close to the lowest income level. Within PA, 15% of the respondents had not completed high school, 8% had only completed one to six years of formal education, and only 46% of the respondents had completed education post-high school as compared to 78% for OA, 93% for AA and 100% for NA.

Table 12 documents the differing levels of formal education among the four groups. Although sampling bias may account
TABLE 12

Educational Level of Respondents by Group

<table>
<thead>
<tr>
<th>Level</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
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<td>1-6 Years - Raw</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-6 Years - %</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7-11 Years - Raw</td>
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<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7-11 Years - %</td>
<td>8</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HS Grad - Raw</td>
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<td>7</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>HS Grad - %</td>
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<td>15</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Jr Coll - Raw</td>
<td>5</td>
<td>21</td>
<td>19</td>
<td>7</td>
</tr>
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<td>Jr Coll - %</td>
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<td>46</td>
<td>70</td>
</tr>
<tr>
<td>Coll Grad - Raw</td>
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<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Coll Grad - %</td>
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</tr>
<tr>
<td>Post Grad - Raw</td>
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<td>8</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Post Grad - %</td>
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<td>17</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>13</td>
<td>45</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
for some of the variability, it appears that the PA sample may differ in some significant ways from the sample of respondents drawn from the other mutual assistance groups involved in this study.

Occupation

The respondents' occupations (or former occupation, if retired) were categorized according to a modified Hollingshead (1957) nine part typology (see Appendix B for the occupational categories). As indicated in Table 13, both NA (40%) and AA (39%) had a relatively high number of respondents involved in professional occupations, most likely related to the comparably high educational levels for both groups. Both PA (23%) and OA (26%) had fewer respondents involved in professional occupations. It is interesting to note that OA, which had the highest proportion of female respondents, also had the highest proportion of respondents involved in secretarial/clerical/office occupations (37%). Due to the largely urban settings from which these populations were drawn, no respondents held farming or agricultural jobs. Nor was anyone in the sample involved in unskilled labor.

Related to occupation is the current working status of the respondent. Combining respondents employed full-time with respondents employed part-time, all four groups show a majority of respondents as employed in some capacity (see
<table>
<thead>
<tr>
<th>Occupation</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housekeeper/Student - Raw</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Housekeeper/Student - %</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Retired - Raw</td>
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<td>3</td>
</tr>
<tr>
<td>Skilled Labor - %</td>
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<td>9</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Clerical - Raw</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Clerical - %</td>
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<td>37</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Service - Raw</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Service - %</td>
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<td>13</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Business - Raw</td>
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<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Business - %</td>
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<td>11</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Agriculture - Raw</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agriculture - %</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Professional - Raw</td>
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<td>12</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
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</tr>
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<td># Missing - Raw</td>
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<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>N = 13</td>
<td>46</td>
<td>41</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>
Table 14), ranging from a high of 80% in NA to a low of 54% in PA. The highest percentage of housewives/househusbands is in PA (23%), closely followed by OA at 15%. This may be related to the relatively high number of female respondents in both of these groups. The percentages of unemployed, retired or student respondents are all relatively low. The majority of the respondents are quite active, either as employed individuals or as housekeepers, indicating that their involvement with a mutual assistance group exists in conjunction with occupational pursuits or household responsibilities.

Household Annual Income

Another leading indicator of socio-economic status is household annual income. Despite the comparatively high level of educational achievement and high number of respondents involved in professional pursuits, the respondents from NA indicate that 50% make under $20,000 annually followed by PA at 46%, then OA at 37% and finally AA at 34%. However, at the upper end, 20% of the NA respondents noted incomes in excess of $40,000, only exceeded by the 22% of the AA respondents indicating similar yearly incomes. This notable spread in annual household income among NA respondents may reflect a sampling bias problem. The single largest category for three of the four groups is the $20,000 to
<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, FT - Raw</td>
<td>7</td>
<td>17</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Yes, FT - %</td>
<td>54</td>
<td>37</td>
<td>54</td>
<td>70</td>
</tr>
<tr>
<td>Yes, PT - Raw</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Yes, PT - %</td>
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<td>17</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>No - Raw</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>No - %</td>
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<td>6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>No, Ret - Raw</td>
<td>0</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>No, Ret - %</td>
<td>0</td>
<td>20</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Student - Raw</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Student - %</td>
<td>8</td>
<td>2</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>HH/HH - Raw</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HH/HH - %</td>
<td>23</td>
<td>15</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>12</td>
<td>44</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
$29,999 category accounting for 38% of PA respondents, 37% of the OA respondents and 27% of the AA respondents. As indicated in Table 15, the respondents from NA appear to be fairly evenly distributed across the entire income continuum.

Marital Status

Marital status can be viewed as an indicator of social/familial support, particularly when dealing with problems of behavioral excesses. In examining households with a married couple present, OA and PA lead the way with 54%. AA and NA both had a majority of households with a single head of household present, 60% for NA and 56% for AA. From Table 16 it is evident that the largest single factor in single head of household homes is divorce, accounting for 50% of NA respondents, 30% of PA respondents and 20% of OA respondents. AA, on the other hand, had a larger single population (27%), than divorced population (24%). In the overall project, there was an almost even split between households with married couples present and households with single heads of household, with no remarkable differences between the four groups (see Table 17).

Related to marital status is household size. PA stands alone with the largest number of persons per household (3.92 persons/household). This may be related to
<table>
<thead>
<tr>
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<th>AA</th>
<th>NA</th>
</tr>
</thead>
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<td>&lt;5K - %</td>
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<td>0</td>
<td>20</td>
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<td>1</td>
</tr>
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<td>5K-9,999 - %</td>
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<td>9</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>10K-19,999 - Raw</td>
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<td>12</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>10K-19,999 - %</td>
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<td>26</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>20K-29,999 - Raw</td>
<td>5</td>
<td>17</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>20K-29,999 - %</td>
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<td>37</td>
<td>27</td>
<td>10</td>
</tr>
<tr>
<td>30K-39,999 - Raw</td>
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<td>3</td>
<td>2</td>
</tr>
<tr>
<td>30K-39,999 - %</td>
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<td>11</td>
<td>7</td>
<td>20</td>
</tr>
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<td>&gt;40K - Raw</td>
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<td>2</td>
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<tr>
<td>&gt;40K - %</td>
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<td>6</td>
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<td>20</td>
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<tr>
<td>IDK - %</td>
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<td>0</td>
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</tr>
<tr>
<td># Missing - %</td>
<td>8</td>
<td>2</td>
<td>5</td>
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<tr>
<td>N =</td>
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<td>Status</td>
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<td>OA</td>
<td>AA</td>
<td>NA</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Single - Raw</td>
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<td>7</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Single - %</td>
<td>8</td>
<td>15</td>
<td>27</td>
<td>10</td>
</tr>
<tr>
<td>Married - Raw</td>
<td>7</td>
<td>25</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Married - %</td>
<td>54</td>
<td>54</td>
<td>44</td>
<td>40</td>
</tr>
<tr>
<td>Widowed - Raw</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Widowed - %</td>
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<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated - Raw</td>
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<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Separated - %</td>
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<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Divorced - Raw</td>
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<td>9</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Divorced - %</td>
<td>31</td>
<td>20</td>
<td>24</td>
<td>50</td>
</tr>
<tr>
<td># Missing - Raw</td>
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<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>45</td>
<td>41</td>
<td>10</td>
</tr>
<tr>
<td>Household With Married Couple Present in Household - Raw</td>
<td>PA</td>
<td>OA</td>
<td>AA</td>
<td>NA</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Household With Married Couple Present in Household - %</td>
<td>7</td>
<td>25</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Household Without Married Couple Present in Household - Raw</td>
<td>6</td>
<td>20</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Household Without Married Couple Present in Household - %</td>
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<td>43</td>
<td>56</td>
<td>60</td>
</tr>
<tr>
<td># Missing - Raw</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
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</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>45</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
the greater likelihood that a married couple will be present in the household and the fact that parents experiencing parenting difficulties are more likely to have those difficulties when they are dealing with the demands of more than one child. OA had the next largest number of persons per household (2.6) which may reflect the greater likelihood of a spouse present in the home. AA respondents indicated 2.5 persons/household with NA at 2.3 persons/household (see Table 18).

Geographic Mobility

Overall, the population of respondents drawn from all four groups is a comparatively stable one; 60% of the NA respondents have lived in their local area for over 10 years, 54% of OA respondents, 51% of AA respondents and 38% of PA respondents. Table 19 demonstrates the fairly even distribution of geographic mobility across the four groups.

Analysis of Organization Involvement Information

Length of Involvement

The mean length of time that the respondents had been involved with a given mutual assistance organization varied notably among the four groups. By examining Table 20 it can be seen that the sample drawn from PA has the least tenure in the organization with over
TABLE 18

Size of Household of Respondents by Group

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>DA</th>
<th>AA</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td># of Persons Reported - Raw</td>
<td>47</td>
<td>119</td>
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<tr>
<td>Mean # of Persons Reported per Household</td>
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<td>2.3</td>
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<tr>
<td>N =</td>
<td>12</td>
<td>45</td>
<td>41</td>
<td>10</td>
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</tbody>
</table>
TABLE 19

Number of Years Resident in Local Area of Respondents by Group

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<tr>
<th></th>
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<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 2 Years - Raw</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1</td>
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<td>2</td>
</tr>
<tr>
<td>2-5 Years - %</td>
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<td>22</td>
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<td>20</td>
</tr>
<tr>
<td>6-9 Years - Raw</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>1</td>
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<td>6-9 Years - %</td>
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<tr>
<td>10-19 Years - %</td>
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<td>24</td>
<td>22</td>
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<td>20-29 Years - Raw</td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>20-29 Years - %</td>
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<td>17</td>
<td>22</td>
<td>30</td>
</tr>
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<td>30-39 Years - Raw</td>
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<td>3</td>
<td>2</td>
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</tr>
<tr>
<td>N</td>
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<td>45</td>
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<td>10</td>
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<td>Length of Involvement</td>
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<td>AA</td>
<td>NA</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>&lt; 6 Months - Raw</td>
<td>7</td>
<td>19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&lt; 6 Months - %</td>
<td>54</td>
<td>41</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>6-11 Months - Raw</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>6-11 Months - %</td>
<td>31</td>
<td>9</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>1-3 Years - Raw</td>
<td>2</td>
<td>11</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>1-3 Years - %</td>
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<td>34</td>
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<td>2</td>
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<tr>
<td>4-8 Years - %</td>
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<td>24</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>9-12 Years - Raw</td>
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<td>1</td>
<td>0</td>
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<tr>
<td>9-12 Years - %</td>
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<tr>
<td>&gt; 12 Years - %</td>
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</tr>
<tr>
<td># Missing - %</td>
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<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>40</td>
<td>10</td>
</tr>
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</table>
half of the respondents (54%) reporting less than 6 months membership and 85% of the respondents indicating less than one year of membership. The remaining respondents from PA (15%) indicated membership from one to three years with no one reporting membership lasting beyond three years. This is a fairly restricted range of membership length as compared to the other three groups and may have implications for the continuing success of PA members. Without role models who have experienced success in a given program over an extended period of time, members may not gain the same sense of support and hope as groups with a more tenured membership and may rely more heavily on the professional sponsors than on senior group members. OA, although it had a relatively large proportion of newcomers with less than six months membership (41%), also had members who had been involved in OA from four to eight years (24%) with one respondent reporting a length of involvement in excess of eight years. The OA respondents had an even split between members with under one year of involvement (50%) and those with membership in excess of one year (50%). AA respondents reported the greatest range in length of involvement. Very few AA respondents had less than one year of membership (17%), while 80% of the respondents had over one year of membership with 6 persons (15%) reporting involvement in excess of twelve years. The modal response for AA respondents was one to three years of involvement with AA.
The respondents from NA showed a somewhat restricted range of membership, intermediate between PA and OA, yet still had a relatively even split between those members with less than one year of tenure with NA (40%) and those with over one year of tenure (60%). The small number of NA respondents makes it difficult to say much about the patterns within that organization. Subtle patterns of bias may have influenced the distribution of membership length; however, the pattern of length of tenure with an organization follows the age of the organization, with PA and NA having a more restricted range than the next oldest organization, OA, followed by the oldest organization, AA with the greatest range in length of tenure.

Success of Involvement

One measure of the success of a member's involvement in a self-help group is the length of time that the member has been able to control his/her behavioral excess. The terminology for containing the target behavior varies from group to group, but the essential criteria of abstinence pervades each anonymous-based group, such as, abstaining from abusive behavior directed at children, abstaining from compulsive eating, abstaining from alcohol consumption and/or drug ingestion. OA has perhaps the most difficulty meeting the requirement of abstinence because members cannot abstain completely from food; therefore, members strive to
abstain from foods that trigger compulsive eating, such as sugar, white flour products, salty snack foods and to maintain a pre-decided daily food plan. The principle of abstinence is based on the idea of breaking the chain of behavior that leads an individual into uncontrolled excessive behavior. By not taking any alcoholic drink, a person with a history of alcohol use that leads to excessive consumption can interrupt the chain of behaviors that has led to alcohol abuse in the past. Members of OA are not able to obtain such a clear cut break in their chain of behavior which may explain the high number of OA respondents (74%) who report less than six months abstinence. Figure 1 shows how length of membership in PA corresponds with length of abstinence indicating that the length of membership is not necessarily a predictor of continued success. As indicated in Figure 2, the success of OA respondents in abstaining from abusive parenting behavior closely corresponds to length of membership. The AA respondents, as indicated in Figure 3, also tend to have fairly close correspondence between tenure with AA and success in maintaining sobriety. Figure 4 for NA respondents presents findings that probably appear more dramatic than they actually are. Fifty percent of the NA respondents reported less than one year of abstinence from drugs and alcohol, while 50% reported more than one year of abstinence (Table 21). Corresponding to these figures, NA also reported 40%
Fig. 1. PA: Length of Involvement and Length of Abstinence
Percentage of Respondents by Length of Time
Fig. 2. OA: Length of Involvement and Length of Abstinence Percentage of Respondents by Length of Time
Fig. 3. AA: Length of Involvement and Length of Abstinence Percentage of Respondents by Length of Time
Fig. 4. NA: Length of Involvement and Length of Abstinence Percentage of Respondents by Length of Time
<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>DA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
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<td>&lt; 6 Months - Raw</td>
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<td>34</td>
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<td>1</td>
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<td>&lt; 6 Months - %</td>
<td>46</td>
<td>74</td>
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<td>10</td>
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<td>7</td>
<td>4</td>
</tr>
<tr>
<td>6-11 Months - %</td>
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<td>1-3 Years - %</td>
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<td>39</td>
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</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
of the respondents with less than one year of tenure with the organization and 60% reporting more than one year.

Frequency of Attendance

Attendance at self-help meetings reflects at least two factors: 1) the number of available meetings within a geographic area and 2) the policy of the organization toward encouraging attendance. Typically a self-help group member will have a "home" group which is a group that the member has adopted as his/her main contact; however, the member is free to attend any other meeting he/she wishes to attend. The only exception would be "closed" groups which are sub-groups within the organization designed to meet specific needs, such as non-smokers meetings, meetings for same sex members only, for homosexual members only, same ethnic group members only or experienced members only. AA encourages group members to attend as many meetings as necessary to maintain abstinence which could include multiple meetings daily, each day of the week for newly abstinent individuals. This is also possible in the geographic area in which this study was conducted due to the numerous meetings held each week at varying times and places (in excess of 250 meetings per week). PA, on the other hand, tends to encourage members to remain with their "home" group, although members are free to transfer to other groups, and there were fewer groups available from which members could choose. NA
members frequently attended AA meetings to work on maintaining abstinence from alcohol, in addition to their attendance at NA meetings, and there were very few NA meetings (three meetings per week) from which an NA member could choose. Table 22 shows the frequency of attendance for the respondents from all four groups. PA respondents (100%) uniformly attended one meeting per week. One meeting per week was also the modal response for OA respondents (48%), closely followed by two meetings per week (35%). The modal response for AA respondents was three meetings per week (39%), closely followed by two meetings per week (32%) and a fair number of respondents attending daily meetings (15%). NA respondents reported attending one meeting per week as their modal response (40%), followed by three meetings per week for 30% of the respondents. It is interesting to note that frequency of attendance drops off dramatically after a member stops attending one meeting per week.

Initial Contact with the Mutual Assistance Group

To understand how a self-help group member comes into initial contact with an organization might help explain how a person comes to define himself/herself as needing assistance and the extent to which health care professionals had been involved in the referral process. This question, and several others, was structured in such a way as to allow for multiple responses. The results are reported in terms
<table>
<thead>
<tr>
<th>Frequency of Attendance of Respondents by Group</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
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<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Daily - %</td>
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<td>15</td>
<td>0</td>
</tr>
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<td>16</td>
<td>3</td>
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<td>0</td>
</tr>
<tr>
<td>Bi-Week - %</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
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<td>1X/Month - %</td>
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<td>0</td>
<td>10</td>
</tr>
<tr>
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<td>2</td>
<td>2</td>
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<tr>
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<td>45</td>
<td>40</td>
<td>10</td>
</tr>
</tbody>
</table>
of the cumulative weight and percentage assigned to each response option. Each option chosen as the number one response was assigned three points, the second response two points and the third response one point.

The overwhelming first choice across respondents from all four groups was "I was having problems with . . ." which indicates that for those individuals their involvement with a self-help group begins with self-identification and acknowledgement of problems. The secondary choices were more varied. Both AA and NA respondents indicated that their initial contact with their self-help group was a part of another treatment modality suggesting some professional involvement in the referral process. The second choice for PA respondents was "A medical or mental health professional encouraged me to come to PA", a clear indication of professional involvement in the referral process. This probably reflects the fact that many PA members have been referred to PA following some legal or social services involvement in the family. The second choice for OA respondents was "a family member or friend encouraged me to come to OA" suggesting a more informal social network referral process for OA and that OA members respond to family or friend encouragement. In regards to the third choice, both PA and AA respondents also indicated that they had been encouraged by friends and family members. Both OA and NA respondents reported for their third choice that they
had not been able to get the assistance they needed elsewhere indicating a perceived deficit in the availability or accessability of services.

It is equally interesting to note which options did not make the top three choices (see Table 23). A family member or friend experiencing problems did not bring many respondents into initial contact with a self-help group, nor did curiosity about the group. The initial contact appears to be related to a personal commitment to work on a problem area. The lack of money to go elsewhere for help did not play a major role in respondents’ choices to attend a self-help group as opposed to using professional resources. Health care professionals also did not appear to play a central role in the referral process with the exception of PA and the professionals involved in treatment facilities.

One factor could be health care professionals’ reluctance to refer clients to self-help groups. Another factor could be an interactive communication problem: 1) health care professionals are not always well-trained in probing for behavioral excess disorders, such that a person could parenthetically present a behavioral excess problem in the context of discussing another problem and the professional might not attend to that information and 2) persons with behavioral excess type problems do not always provide accurate or complete information to health care professionals.
### TABLE 23

Source of Initial Contact with Organization by Group
(Weighted Raw Scores, Percentages and Ranks)

<table>
<thead>
<tr>
<th>Source of Initial Contact</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having Problems-Raw</td>
<td>17</td>
<td>93</td>
<td>70</td>
<td>14</td>
</tr>
<tr>
<td>Having Problems-%</td>
<td>29(1)</td>
<td>42(1)</td>
<td>35(1)</td>
<td>26(1)</td>
</tr>
<tr>
<td>Fam/Friend-Raw</td>
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<td>13</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Fam/Friend-%</td>
<td>0</td>
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<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Curiosity-Raw</td>
<td>5</td>
<td>19</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Curiosity-%</td>
<td>8</td>
<td>8</td>
<td>0.5</td>
<td>9</td>
</tr>
<tr>
<td>Fam/Friend/Encouraged-Raw</td>
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<td>33</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>Fam/Friend/Encouraged-%</td>
<td>12(3)</td>
<td>15(2)</td>
<td>12(3)</td>
<td>15</td>
</tr>
<tr>
<td>Med/Mental Encouraged-Raw</td>
<td>15</td>
<td>6</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Med/Mental Encouraged-%</td>
<td>25(2)</td>
<td>3</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>No Money-Raw</td>
<td>3</td>
<td>24</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>No Money-%</td>
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<td>11</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Part of Other Treatment-Raw</td>
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<td>4</td>
<td>36</td>
<td>10</td>
</tr>
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<td>Part of Other Treatment-%</td>
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<td>2</td>
<td>18(2)</td>
<td>19(2)</td>
</tr>
<tr>
<td>Could Not Get Help Elsewhere-Raw</td>
<td>4</td>
<td>29</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Could Not Get Help Elsewhere-%</td>
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<td>10</td>
<td>17(3)</td>
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<td># Missing-%</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Persistence of Association

Persistence of association refers to the degree to which a member will persist in his/her association with a mutual assistance group, irrespective of frequency of attendance. The membership of any given self-help group consists of two populations: 1) those members with continuous membership since initial contact with the organization and 2) those members who have had a break(s), for whatever reason, in their association with the organization, but resumed their association following their break(s). There are, of course, members who break their association with the organization and never return. These people were not available for this research project, nor are they typically available for follow-up studies due to the anonymous nature of the group. What is of interest here are the perceptions of members who did experience a break in association of what the reason(s) for the break and, even more importantly, what brought the member back into association with the group.

Table 24 shows the overall pattern of affiliation. Within PA, respondents tended to have maintained continuous attendance (77%) with only 23% having stopped only once. The PA respondents, however, represent a fairly restricted tenure of membership, no one beyond three years, which leaves the members with less opportunity to have broken
TABLE 24

Continuation of Association by Group

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>DA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, Once - Raw</td>
<td>3</td>
<td>12</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Yes, Once - %</td>
<td>23</td>
<td>26</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Yes, Couple - Raw</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Yes, Couple - %</td>
<td>0</td>
<td>11</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Yes, Several - Raw</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Yes, Several - %</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Yes, Combined - Raw</td>
<td>3</td>
<td>19</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Yes, Combined - %</td>
<td>23</td>
<td>41</td>
<td>34</td>
<td>60</td>
</tr>
<tr>
<td>No - Raw</td>
<td>10</td>
<td>27</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>No - %</td>
<td>77</td>
<td>59</td>
<td>66</td>
<td>30</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td># Missing - %</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>N</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>9</td>
</tr>
</tbody>
</table>
membership and to have re-joined the group. This is reflected in the fact that the PA respondents who had broken their affiliation had only broken affiliation once, the other three groups all had respondents who had broken affiliation more than once. The AA respondents had the next largest proportion of respondents who had never had a break in membership (66%), while 34% had experienced some break in membership ranging from only one break (15%) to several breaks (5%). The OA respondents followed a similar pattern with 59% reporting no cessation in affiliation and 41% reporting some break in membership. Among OA respondents reporting a break in membership, the largest category was those members reporting one break (26%) followed by a couple of breaks (11%) and, finally, several breaks (4%). The NA respondents showed much greater difficulty in maintaining membership without cessation. Seventy percent of the respondents had experienced a break in membership with no one reporting only one break, 20% reporting a couple of breaks and 50% reporting several breaks in membership. Only 30% of the NA respondents had experienced no cessation in affiliation.

Interruption in Association

This question was only asked of respondents who reported some break in their affiliation with their self-help organization. Table 25 reports the results in
<table>
<thead>
<tr>
<th>Reason for Interruption in Association by Group*</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Need Help-Raw</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not Need Help-%</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not Ready to be Helped-Raw</td>
<td>4</td>
<td>28</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Not Ready to be Helped-%</td>
<td>29(2)</td>
<td>31(1)</td>
<td>27(1)</td>
<td>13(3)</td>
</tr>
<tr>
<td>Needed Different Kind of Help-Raw</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Needed Different Kind of Help-%</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Turned Off-Raw</td>
<td>3</td>
<td>9</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Turned Off-%</td>
<td>21(3)</td>
<td>10</td>
<td>23(2.5)</td>
<td>10</td>
</tr>
<tr>
<td>Had Slip-Raw</td>
<td>0</td>
<td>15</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Had Slip-%</td>
<td>0</td>
<td>17(3)</td>
<td>23(2.5)</td>
<td>10</td>
</tr>
<tr>
<td>No Time-Raw</td>
<td>1</td>
<td>16</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>No Time-%</td>
<td>7</td>
<td>18(2)</td>
<td>4</td>
<td>16(2)</td>
</tr>
<tr>
<td>Fam/Friend</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not Want-Raw</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Med/Mental</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not Want-Raw</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other-Raw</td>
<td>6</td>
<td>14</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Other-%</td>
<td>43(1)</td>
<td>16</td>
<td>14(4)</td>
<td>42(1)</td>
</tr>
<tr>
<td># Missing-Raw</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing-%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Answered only by respondents indicating a break in association.
terms of the percentages of people who experienced a break in membership according to the response items that the respondents selected. The reasons given by respondents for their break in membership varied considerably across the four groups. The number one ranked response option for PA respondents (43%) was the "other" category, which included two types of response: 1) dissatisfaction with the mental health professional sponsoring a given meeting and 2) transportation problems. The second ranked response option (29%) indicated that the PA respondents did not feel "ready to be helped at that time", closely followed by the third ranked option (21%) indicating that the respondents felt "turned off by PA at that time". For the OA respondents the number one ranked response option (31%) was the "not ready to be helped at that time" response. The second ranked option (18%) cited difficulties in finding sufficient time to attend meetings. The third ranked option (17%) included those respondents who had experienced a "slip", a failure to follow their stated program, and felt uncomfortable returning to their group following the "slip". The AA respondents shared the OA group's first ranked response option with 27% of the AA members reporting that they had not been ready to receive help at that time. The split-ranked options (2.5) was a tie between being "turned off by AA at that time" (23%) and having "had a slip and did not want to go back to AA" (23%). The third ranked option (14%) was the
"other" category which included geographic problems (i.e., moving to another region, living in an area where no meetings were available) and testing the limits of necessity (i.e., "didn't feel I needed it any longer"; "I was not convinced that it was necessary"). The top-ranked choice for NA (42%) reflected the interconnected nature of NA and AA. The first choice was the "other" category which included the comment by several respondents that they felt that their experience with AA was meeting their needs and time/scheduling problems (i.e., "I had to work on the night of the meeting", "moved to a location that had no meetings", "work time conflicts with meetings"). The second ranked option (16%), "I did not have time to attend meetings", could also reflect the relatively few meetings available in this particular geographic area forcing more potential time conflicts on perspective or continuing members. Not being ready to be helped was the third-ranked option for NA respondents accounting for 13% of the respondents.

Equally as important is the fact that no respondent reported that he/she had experienced a break in association with his/her mutual assistance group at the recommendation of a medical or mental health professional. In addition, only in OA did a respondent indicate that a family member or friend had recommended a break in affiliation. Each group appeared to emphasize a high degree of personal responsibility for behavior by promoting the notion
that if the person was not succeeding with the program it was due to a lack of readiness on the part of the individual to be helped.

Resumption of Association

This question, like the previous one, was only asked of respondents who had experienced some break in membership and had returned to the self-help groups. It was designed to tap respondents' perceptions of the reasons behind their resumption of association. The top-ranked choices across the four groups, as shown on Table 26, indicate that the respondents felt the need for further assistance. With PA, the top-ranked choice (37%) expressed the need for further assistance, while the second-ranked choice (25%) was the "other" category where respondents indicated that they had resolved the transportation and personnel problems. Medical and mental health care providers played a central role in encouraging 19% of the PA respondents to return to PA as shown in the third-ranked option. The OA respondents indicated a clear need for further assistance with their top three ranked choices: 1) the first-ranked option (36%) cited a readiness to be helped, 2) the second-ranked option (24%) cited the need for further assistance and 3) the third-ranked option (16%) noted that other treatment modalities had not worked. The AA respondents endorsed the readiness to be helped (37%)
<table>
<thead>
<tr>
<th>Reasons for Resumption of Membership by Group*</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed More Help-Raw</td>
<td>6</td>
<td>21</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Needed More Help-%</td>
<td>37(1)</td>
<td>24(2)</td>
<td>24(2)</td>
<td>18(3)</td>
</tr>
<tr>
<td>Ready to be Helped-Raw</td>
<td>2</td>
<td>32</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>Ready to be Helped-%</td>
<td>12</td>
<td>36(1)</td>
<td>37(1)</td>
<td>29(2)</td>
</tr>
<tr>
<td>Other Help Did Not Work-Raw</td>
<td>0</td>
<td>14</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Other Help Did Not Work-%</td>
<td>0</td>
<td>16(3)</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Fam/Friend Encouraged-Raw</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fam/Friend Encouraged-%</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Med/Mental Encouraged-Raw</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Med/Mental Encouraged-%</td>
<td>19(3)</td>
<td>3</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Other-Raw</td>
<td>4</td>
<td>12</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Other-%</td>
<td>25(2)</td>
<td>14</td>
<td>22(3)</td>
<td>50(1)</td>
</tr>
<tr>
<td># Missing-Raw</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Missing-%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Answered only by respondents indicating a break in association.
and the need for further assistance (24%). The third-ranked option, the "other" category, included making adjustments in schedules, experiencing problems in maintaining control of drinking and missing the social contact. The NA respondents (50%) endorsed the notion that even with the availability of AA, addicts needed an opportunity to meet with and share experiences specific to persons experiencing problems with drug addiction. The second-(29%) and third-(18%) ranked options cited the readiness to be helped and the need for further assistance.

Perceptions of the Success of the Organization

When respondents were asked "In your opinion, what was the reason that ... grew into a successful fellowship?", two response options were the overwhelming favorites (see Table 27). Across the four groups, 45% of the respondents indicated that their organizations' successes were a function of providing people needing assistance the opportunity to meet other people experiencing similar problems. This suggests that one of the major successes of the mutual assistance movement, at least for these respondents, is to reduce the sense of social isolation and uniqueness people experiencing behavioral control difficulties may feel. The second most frequent response option, accounting for 37% of the responses across the four groups, was the notion that only people who
### Perceptions of Organizational Success by Group

<table>
<thead>
<tr>
<th>Perception</th>
<th>PA</th>
<th>QA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services Were Unavailable - Raw</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Services Were Unavailable - %</strong></td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Professional Services Not Adequate - Raw</strong></td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Professional Services Not Adequate - %</strong></td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Necessity of Personal Experience - Raw</strong></td>
<td>1</td>
<td>22</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td><strong>Necessity of Personal Experience - %</strong></td>
<td>8</td>
<td>48</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td><strong>Needed More Help - Raw</strong></td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Needed More Help - %</strong></td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Meet Similar People - Raw</strong></td>
<td>8</td>
<td>17</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td><strong>Meet Similar People - %</strong></td>
<td>61</td>
<td>37</td>
<td>46</td>
<td>60</td>
</tr>
<tr>
<td><strong># Missing - Raw</strong></td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong># Missing - %</strong></td>
<td>15</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>N =</strong></td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
had experienced problems similar to the respondent could provide effective assistance for the target behavior problem. Only the PA respondents failed to endorse that response item as heavily as the other groups. This finding may indicate that another component of the mutual assistance process is identification with other people "just like me", (i.e., "having had experiences similar to mine"), and providing instant credibility, (i.e., "If he/she survived this problem maybe I can too"). Together, these two response options account for 83% of the total response and represent proactive choices by the respondents, not reactive choices against health care professionals or services in determining the success of their organization. Only 3% of the respondents indicated that services were unavailable; only 5% cited inadequate medical or mental professional services; while a mere 5% noted that people experiencing difficulties needed more assistance than they were currently receiving. The members' perceptions of the success of their group seems to be correlated with reduction of social isolation and provision of successful role models to facilitate identification.

"Ultimate Solution"

Two questions dealt with the larger social context in which the target behavior problems occurred. One question asked respondents to indicate their opinion about the
"ultimate solution" for the target behavior problem. This question was designed to tap the respondents' perception of future directions for their organizations and as an indicator of whether the respondents could consider larger societal changes as appropriate targets for intervention. The respondents from all four groups seemed to focus on individual responsibility as the sole target of intervention. As Table 28 indicates, the top-ranked choice for PA (41%), OA (39%), NA (35%) and the second-ranked choice for AA (24%) was the "solution will be found within each person". This stance is consistent with the philosophy of the anonymous-based groups stressing individual responsibility; it may, however, overlook the role societal policies may play in the development of some behavior problems. This apparent unwillingness to consider broader perspectives is reflected in the second-ranked option for OA (34%), NA (33%), PA (16%) and the first-ranked option for AA (41%) indicating that "there is no final solution because" the target behavior problem will always be present. Three groups, PA (14%), OA (10%) and NA (10%) indicated for their third-ranked choice that extending their services to all persons needing assistance might be a help in obtaining an "ultimate" solution. PA respondents (16%) also endorsed having more medical and mental health professionals available to provide services. Only within AA, and only 12% of the respondents, endorsed
TABLE 28

Perceptions of the "Ultimate Solution" by Group (Weighted Raw Scores, Percentages and Ranks)

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Person-Raw</td>
<td>28</td>
<td>87</td>
<td>44</td>
<td>18</td>
</tr>
<tr>
<td>Within Person-%</td>
<td>41(1)</td>
<td>39(1)</td>
<td>24(2)</td>
<td>35(1)</td>
</tr>
<tr>
<td>Within Research-Raw</td>
<td>0</td>
<td>3</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Within Research-%</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Societal Changes-Raw</td>
<td>6</td>
<td>3</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>Societal Changes-%</td>
<td>9</td>
<td>1</td>
<td>12(3)</td>
<td>4</td>
</tr>
<tr>
<td>Legislative Changes-Raw</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Legislative Changes-%</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Extending Services-Raw</td>
<td>10</td>
<td>22</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Extending Services-%</td>
<td>14(3)</td>
<td>10(3)</td>
<td>4</td>
<td>10(3)</td>
</tr>
<tr>
<td>More Med/Mental Services-Raw</td>
<td>11</td>
<td>13</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>More Med/Mental Services-%</td>
<td>16(2.5)</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>No Ultimate Solution-Raw</td>
<td>11</td>
<td>75</td>
<td>77</td>
<td>17</td>
</tr>
<tr>
<td>No Ultimate Solution-%</td>
<td>16(2.5)</td>
<td>34(2)</td>
<td>41(1)</td>
<td>33(2)</td>
</tr>
<tr>
<td>Other-Raw</td>
<td>0</td>
<td>20</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Other-%</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td># Missing-Raw</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td># Missing-%</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
societal changes as a potential direction for the "ultimate solution". Clearly these respondents were not interested in the expansion of their services to meet larger societal changes.

Goals

When respondents were asked to examine the "goals" of their organization to gain a perspective on the members' sense of the long-term directions of their self-help groups, the respondents across the four groups endorsed personal change as the goal. Table 29 indicates that the top-ranked response option for NA (42%), OA (36%), PA (35%) and the second-ranked option for AA (24%) was a hearty endorsement for personal change, once again, the emphasis on individual responsibility. Extending services to all similarly afflicted persons was a strong second-ranked response option accounting for 25% of OA respondents, 20% of NA, 19% of PA and placing as the AA respondents' top-ranked choice with 31%. However, the option of expanding services to cover a broader problem base was given only negligible support. The third-ranked "goal" for three groups was the goal of obtaining personal acceptance, getting people to accept their behavior, accounting for 18% of AA respondents, 16% of OA respondents and 12% of PA respondents. Respondents from
## TABLE 29

Perceptions of Organizational Goals by Group
(Weighted Raw Scores, Percentages and Ranks)

<table>
<thead>
<tr>
<th>Perceptions</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Change-Raw</td>
<td>24</td>
<td>91</td>
<td>49</td>
<td>23</td>
</tr>
<tr>
<td>Personal Change-%</td>
<td>35(1)</td>
<td>36(1)</td>
<td>24(2)</td>
<td>42(1)</td>
</tr>
<tr>
<td>Personal Acceptance-Raw</td>
<td>8</td>
<td>40</td>
<td>37</td>
<td>7</td>
</tr>
<tr>
<td>Personal Acceptance-%</td>
<td>12(3)</td>
<td>16(3)</td>
<td>18(3)</td>
<td>13</td>
</tr>
<tr>
<td>Societal Change-Raw</td>
<td>4</td>
<td>3</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Societal Change-%</td>
<td>6</td>
<td>3</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Societal Acceptance-Raw</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>0</td>
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<tr>
<td>Societal Acceptance-%</td>
<td>3</td>
<td>1</td>
<td>4</td>
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</tr>
<tr>
<td>Extending Services-Raw</td>
<td>13</td>
<td>63</td>
<td>64</td>
<td>11</td>
</tr>
<tr>
<td>Extending Services-%</td>
<td>19(2)</td>
<td>25(2)</td>
<td>31(1)</td>
<td>20(2)</td>
</tr>
<tr>
<td>Expanding Services-Raw</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Expanding Services-</td>
<td>10</td>
<td>0</td>
<td>0.5</td>
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</tr>
<tr>
<td>Legislative Changes-Raw</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Legislative Changes-%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prof. Change-Raw</td>
<td>3</td>
<td>17</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Prof. Change-%</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
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<td>Prof. Acceptance-%</td>
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<td>7</td>
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<td>Other-Raw</td>
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<td>6</td>
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<tr>
<td>Other-%</td>
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<td>4</td>
<td>12</td>
<td>11(3)</td>
</tr>
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<tr>
<td># Missing</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
NA ranked the "other" category in third place with responses indicating goals of developing "a spiritual foundation" and "accepting feelings and sharing solution".

Only a limited number of respondents indicated that the goals of a self-help group should include either professional change or professional acceptance. Larger societal changes or legislative changes are not considered legitimate goals. The organizations appear to maintain a fairly narrow, single-tracked focus on their objective to reach individuals interested in working with a given mutual assistance program.

Personal Experience as Prerequisite to Ability to Help

One issue that appears to be central in the attitudes of self-help group members toward health care providers is whether personal experience with the target behavior problem is prerequisite to a provider's ability to provide assistance. The argument frequently boils down to the difference between practical, applied experience and theoretical, academic expertise, practice versus praxis. The opinions of the respondents were not as polarized as might have been expected, particularly for AA. AA maintains a common dictum "Only an alcoholic can help another alcoholic"; only 32% of the AA respondents, however, indicated that personal experience with alcoholism was prerequisite to effective assistance. Over 40% of the AA
respondents did not feel that personal experience was necessary, while 24% were unsure. The NA respondents followed a similar response pattern with 40% believing that personal experience was prerequisite, 50% indicating that personal experience was not necessary and 10% undecided. The PA respondents predictably were less committed to the notion that personal experience is prerequisite to effective assistance, predictable because of PA's greater involvement with mental health providers, with only 15% endorsing the necessity of personal experience. Fifty-three percent of the PA respondents indicated that personal experience was not necessary and another 15% remained unconvinced. Only OA demonstrated the kind of polarized opinion that might have been expected with 80% of the OA respondents reporting that personal experience was indeed a prerequisite to effective assistance, while a mere 9% felt to the contrary and 11% were unsure (see Table 30). The explanation for this difference is difficult to pinpoint; it may, however, have something to do with the predominantly female population of OA coming in contact with health care providers who have been traditionally male, to deal with a problem that society has disproportionately pressured women to manage.

The opinions of most of the respondents might best be captured by the comments of one respondent when he stated, "I don't think personal experience is necessarily a
TABLE 30

Personal Experience as Prerequisite to Assistance by Group

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>DA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary - Raw</td>
<td>2</td>
<td>37</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Necessary - %</td>
<td>15</td>
<td>80</td>
<td>32</td>
<td>40</td>
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<td>Not Necessary - Raw</td>
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<td>4</td>
<td>17</td>
<td>5</td>
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<tr>
<td>Not Necessary - %</td>
<td>54</td>
<td>9</td>
<td>41</td>
<td>50</td>
</tr>
<tr>
<td>Unsure - Raw</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Unsure - %</td>
<td>15</td>
<td>11</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td># Missing - Raw</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
prerequisite, but it sure helps." The personal experience issue is related to the issue of credibility. Someone with successful personal experience dealing with the target behavior is credited with more instantaneous credibility, whereas a professional lacking personal experience may need to demonstrate skills necessary to establish credibility and to have patience while those skills are evaluated as to their worth to the individual. Academic credentials do not appear to insure credibility.

Professional Involvement: Medical Care Providers

One of the common misperceptions of health care providers about self-help group participants is that participants abandon seeking assistance for appropriate health care needs once they begin to attend a mutual assistance group. The respondents across the four groups indicate involvement with medical care providers. Tables 31 and 32 demonstrate the use of medical service within the past year and within the past five years. This use of medical services was not restricted to consultation for the target behavior problem, but instead referred to any use of medical services. The reasoning behind asking such a general question was that any contact with the medical system provides a mutual opportunity for the self-help group participant to discuss their target behavior problem, as well as an opportunity for the health care provider to probe
TABLE 31

Professional Involvement With Medical Care Providers by Group Within Past Year

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes - Raw</strong></td>
<td>9</td>
<td>35</td>
<td>31</td>
<td>9</td>
</tr>
<tr>
<td><strong>Yes - %</strong></td>
<td>69</td>
<td>76</td>
<td>76</td>
<td>90</td>
</tr>
<tr>
<td><strong>No - Raw</strong></td>
<td>3</td>
<td>11</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td><strong>No - %</strong></td>
<td>23</td>
<td>24</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td><strong>IDK - Raw</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>IDK - %</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong># Missing - Raw</strong></td>
<td>1</td>
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<tr>
<td><strong># Missing - %</strong></td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>N =</strong></td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
TABLE 32

Professional Involvement With Medical Care Providers by Group Within Past 5 Years

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - Raw</td>
<td>8</td>
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<td>39</td>
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<td>Yes - %</td>
<td>61</td>
<td>89</td>
<td>95</td>
<td>100</td>
</tr>
<tr>
<td>No - Raw</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>No - %</td>
<td>31</td>
<td>11</td>
<td>5</td>
<td>0</td>
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<tr>
<td>IDK - Raw</td>
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<td>IDK - %</td>
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<td># Missing - Raw</td>
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<tr>
<td># Missing - %</td>
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<td>0</td>
</tr>
<tr>
<td>N =</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
the patient about his/her involvement in mutual assistance groups.

Professional Involvement: Mental Health Care Providers

As indicated for medical professionals, the respondents from the four groups indicate substantial use of mental health services. Tables 33 and 34 show a relatively high percentage of respondents using professional mental health services. Only OA shows a somewhat lower rate of usage, but even at a lower rate, one-third (33%) of the OA respondents had used professional mental health services within the past year. Clearly self-help group members do not shy away from professional health care service and ample opportunities exist to explore the target behavior problem and involvement in a self-help organization.

It is also possible that the high professional contact rates reflect a form of sampling bias where only members inclined toward professional services would be inclined to complete a questionnaire designed to explore the relationship between self-help groups and health care professionals. In analyzing the attitudes of self-help group members toward their experiences with professional care providers, however, it becomes more apparent that the high contact rate does not necessarily mean a high degree of satisfaction with those services.
<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes - Raw</strong></td>
<td>7</td>
<td>16</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td><strong>Yes - %</strong></td>
<td>54</td>
<td>35</td>
<td>54</td>
<td>90</td>
</tr>
<tr>
<td><strong>No - Raw</strong></td>
<td>5</td>
<td>30</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td><strong>No - %</strong></td>
<td>38</td>
<td>65</td>
<td>46</td>
<td>10</td>
</tr>
<tr>
<td><strong>IDK - Raw</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>IDK - %</strong></td>
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<td>0</td>
</tr>
<tr>
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<td>0</td>
</tr>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>N =</strong></td>
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<td>46</td>
<td>41</td>
<td>10</td>
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<td>Response</td>
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<td>OA</td>
<td>AA</td>
<td>NA</td>
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<td>------------</td>
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<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Yes - Raw</td>
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<td>Yes - %</td>
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<td>48</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>No - Raw</td>
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<td>4</td>
<td>1</td>
</tr>
<tr>
<td>No - %</td>
<td>8</td>
<td>52</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>IDK - Raw</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>IDK - %</td>
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</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td># Missing - %</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>N</td>
<td>13</td>
<td>46</td>
<td>41</td>
<td>10</td>
</tr>
</tbody>
</table>
Use of Professional Services

The anonymous-based mutual assistance groups used in this project make a distinction between the organization and what individual members of that organization may choose to do. PA is the only organization in this study that specifies professional involvement and this is reflected in the 34% of the respondents who indicated that PA uses professionals as consultants, the 32% of the PA respondents noting professional involvement as service providers and the 17% specifying professionals as group co-leaders (see Table 35). The respondents from the other three organizations, following AA's lead, specify that their organizations will be forever non-professional, with 75% of NA respondents, 53% of the AA respondents and 32% of the OA respondents stipulating that their organization does not use professional services, although individual members may choose to do so. Within the "other" category, 16% of NA respondents endorsed the fact that although NA did not specifically use professional services, members could; 12% of the OA respondents also indicated that individual members could seek professional services; and 11% of the AA respondents indicated that AA used professional services as a referral source and received referrals from professionals. The boundary between mutual assistance and professional assistance is quite delineated, at least in the three groups.
<table>
<thead>
<tr>
<th>Group</th>
<th>PA</th>
<th>OA</th>
<th>AA</th>
<th>NA</th>
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<tbody>
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<td>Consultants-Raw</td>
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<td>39</td>
<td>15</td>
<td>3</td>
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<tr>
<td>Consultants-%</td>
<td>34(1)</td>
<td>23(2)</td>
<td>10</td>
<td>9(3)</td>
</tr>
<tr>
<td>Co-leaders-Raw</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Co-leaders-%</td>
<td>17(3)</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Guest Speakers-Raw</td>
<td>4</td>
<td>17</td>
<td>13</td>
<td>0</td>
</tr>
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<td>Guest Speakers-%</td>
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<td>0</td>
</tr>
<tr>
<td>Board of Directors Member-Raw</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Board of Directors Member-%</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Service Providers-Raw</td>
<td>17</td>
<td>17</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Service Providers-%</td>
<td>32(2)</td>
<td>10</td>
<td>15(2)</td>
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</tr>
<tr>
<td>Other-Raw</td>
<td>0</td>
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<td>18</td>
<td>5</td>
</tr>
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<td>Other-%</td>
<td>0</td>
<td>12(3)</td>
<td>11(3)</td>
<td>16(2)</td>
</tr>
<tr>
<td>Does Not Use Prof. Services-Raw</td>
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<td>54</td>
<td>83</td>
<td>24</td>
</tr>
<tr>
<td>Does Not Use Prof. Services-%</td>
<td>6</td>
<td>32(1)</td>
<td>53(1)</td>
<td>75(1)</td>
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</tr>
<tr>
<td># Missing-%</td>
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<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
not directly involved with professionals. The clear line of demarcation may help members to keep the various components of an already disrupted life clear and specific to the task at hand. There does not appear to be any hesitation though on the part of the respondents to seek professional services, only what appears to be an effort to clarify the lines between the two systems of assistance.

**Analysis of Attitude Items**

The attitude items were divided into nine categories of information covering a broad array of concerns pertaining to the respondents' experiences with their mutual assistance group and with family, friends, professionals and the larger society. The specific questionnaire attitude items along with the group means and standard deviations for each item can be found in Appendix C.

**Attitudes Regarding the Necessity of Experience**

Perhaps the three items of greatest interest on the questionnaire dealt with the exclusivity of service issue, that persons who have experienced a particular behavior problem are uniquely and exclusively prepared to assist others experiencing similar problems. Three items (Q-21, Q-33 and Q-41) provide some insight into the difference between the aprofessional and professional treatment approaches. The hallmark of mutual assistance is the
dependence upon practical, applied, problem-specific assistance. Problems arise when the professional community infers a rejection of professional services because of the mutual assistance community's dependence on an aprofessional approach. Likewise, problems are further complicated when self-help groups infer a rejection of their treatment modality by health-care providers who respond negatively to the practical, problem-specific help offered by self-help groups.

Question-21 (Only people who have experienced ... problems could help me and others like me) demonstrated a pattern that was fairly consistent across these items. There were significant inter-group differences, F (3,106) = 10.52, p < .01. PA, with its close contact with professional services providers, was more likely to disagree with that statement (M = 3.42, S.D. = 1.24) than were the other groups. The group most likely to respond affirmatively to that statement was OA (M = 1.73, S.D. = .95), which represented a significant difference from the PA respondents, (p < .01, Tukey HSD = 1.27). Both AA (M = 2.85, S.D. = 1.27) and NA (M = 2.70, S.D. = 1.25) were intermediate between PA and OA. OA respondents were even significantly different from AA respondents in their endorsement of Q-21, (p < .05, Tukey HSD = 1.04).

Question-41 (Only a ... can understand ...) yielded the same pattern only in a more striking fashion.
PA respondents were much more likely to disagree with that statement ($M = 3.82$, S.D. = .75), while OA respondents were more militantly in agreement ($M = 1.78$, S.D. = .85) with AA ($M = 2.76$, S.D. = 1.18) and NA ($M = 2.70$, S.D. = 1.34) intermediate between the two extremes. The differences among the groups were significant, $F(3,106) = 14.29$, $p < .01$, with PA being significantly different from OA, ($p < .01$, Tukey HSD = 1.15), AA, ($p < .05$, Tukey HSD = .94) and NA, ($p < .05$). Once again, OA respondents were even significantly different from AA in their endorsement of Q-41, ($p < .05$). The strength of this attitude is most likely related to the instant credibility attributed to a person who has successfully dealt with a behavior problem. Within PA, with the increased professional contact and relatively new population of members, the credibility issue is diminished in importance. One potential explanation for the difference between OA and AA respondents is that OA had a higher number of new members who would be in the initial phases of identification with successful role models and possible rejection of failed treatment programs and recent frustration that prompted initiation of contact with PA. The AA respondents were a more tenured population, less likely to be responding to recent failure and frustration. The strength of the attitude appears to be more related to the identification with successful role models and not necessarily tied exclusively to the mutual
assistance group as indicated in Q-33 (... is the only group which provides help for ...). OA respondents were more likely to endorse that statement (M = 2.71, S.D. = 1.27) than were the other groups. The other group respondents appeared more willing to acknowledge other treatment resources, particularly NA (M = 4.10, S.D. = .57). The OA respondents were significantly different, (F (3,106) = 5.30, p < .01) from the NA respondents, (p < .01, Tukey HSD = 1.28), with PA (M = 3.31, S.D. = 1.32) and AA (M = 3.46, S.D. = 1.05) as intermediates.

One component of the exclusivity issue is whether mutual assistance groups believe that there is only one right way to deal with a specific behavior problem, their way. Q-17 (There is no one right way to deal with ...) yielded a fair amount of agreement with no significant differences between groups. Similarly, in Q-18 (... should do whatever works for them in dealing with ... problem) the groups produced a even higher degree of endorsement. The only differences between groups, F (3,106) = 3.74, p < .025, were between PA and OA, (p < .05, Tukey HSD = .79), and PA and NA, (p < .05), because PA respondents failed to endorse this statement quite as highly as those in OA and NA. This attitude is consistent with the statement repeated throughout the AA literature that AA has no monopoly on the treatment of alcoholism. The bottom line for self-help groups involved in behavior change
is effective behavior change. Members appear to be open to people doing whatever they must do to obtain successful behavior change; however, in their experience, people who have experienced the behavior problem and have successfully dealt with it are more likely to be helpful than persons who have not experienced that difficulty.

Attitudes Regarding Those Individuals Who Leave the Mutual Assistance Organization

Three questionnaire items were concerned with respondents' attitudes toward individuals who left a given self-help group. One item (Q-35: ... who leave ... after a few meetings are not ready to deal with their ... problems) specifically asked about respondents' perceptions of newcomers and their reason for not remaining with the group. There are many potential reasons why a newcomer might not remain with a group. Respondents tended to believe, however, that leaving the group was related to a lack of readiness to be helped (PA: M = 2.82, S.D. = .87; AA: M = 2.11, S.D. = .95; NA: M = 2.0, S.D. = .67; and OA: M = 1.87, S.D. = .84). There were significant inter-group differences in the strength of this attitude, F (3,106) = 3.54, p < .025. Both OA, (p < .05, Tukey HSD = .80), and NA, (p < .05), were more likely to endorse "the lack of readiness to be helped" concept than were the PA respondents. The remaining two questionnaire items (Q-25: ...
may leave ... but almost always come back later; and Q-27: Some people attend ... meetings just to find friends, not to work on their ... problems) yielded a neutral response across the four groups with no significant inter-group differences.

Attitudes Regarding Familial and Social Involvement

Two questionnaire items (Q-20: It is important to involve the whole family when working with ... problems; and Q-42: I get a lot of support from friends and family outside of ... for working on my ... problems) dealt with the familial and social support a member both thought important and actually received during his/her involvement with a self-help group. No significant inter-group differences of opinion emerged on either item. The overall consensus was a favorable inclination toward the involvement of the entire family (PA: $M = 1.75, S.D. = .75$; NA: $M = 1.78, S.D. = .83$; AA: $M = 1.83, S.D. = .77$; and OA: $M = 2.40, S.D. = .96$). The overall perception of the support provided by friends and family members was in the positive direction, but slightly lower mean scores than in the previous item (PA: $M = 2.63, S.D. = .74$; OA: $M = 2.41, S.D. = 1.15$; AA: $M = 2.41, S.D. = 1.05$; and NA: $M = 2.10, S.D. = 1.20$). These slight differences in the mean scores between the two questionnaire items may reflect the difference between what would be ideal (i.e., involvement of
the whole family and friendship network) and what is closer to reality (i.e., some support from friends and family members).

Attitudes Regarding Professionals: Medical Health Care Providers

Four questionnaire items dealt specifically with members' perceptions of the assistance that they had received from medical health care providers. As indicated by Tables 31 and 32, 89% of the total number of respondents had had contact with the medical care system within the past five years and 76% within the past year. This finding indicates that the respondents had some basis for expressing their attitudes regarding their contact with the health care system.

Overall, the attitudes expressed by respondents toward medical health care professionals were not positive. In Q-22 (Medical professionals have been helpful to me in dealing with my ... problems) the response was neutral (NA: $M = 3.20$, $S.D. = 1.32$; and AA: $M = 3.33$, $S.D. = 1.29$) to negative (PA: $M = 3.90$, $S.D. = 1.10$; and OA: $M = 3.95$, $S.D. = 1.19$) with a fairly high degree of variability in response and no differences between groups. When asked whether aspects or parts of the target behavior problem were handled best by medical professionals (Q-19), respondents replied in a uniformly negative fashion (AA: $M = 3.68$, $S.D.$
Respondents were asked in Q-44 to express their opinions about the satisfaction of other group members regarding medical assistance that they may have received. The attitudes ranged from neutral (PA: M = 3.5, S.D. = .71) to negative (AA: M = 3.69, S.D. = .86; NA: M = 3.89, S.D. = .93; and OA: M = 3.94, S.D. = .76); however, there was a problem with this question that resulted in a lower response rate (only 87 out of a potential of 110 respondents answered this questionnaire item, 79% of respondents). Members of anonymous-based self-help groups are warned against "taking inventory" for someone else. Meaning that self-help group members are free to speak for themselves; however, they are not to speak for someone else or someone else's experiences. Twenty-one percent of the respondents refused to answer this questionnaire item and the effect of the prohibition on speaking for others on that item cannot be determined.

One frequent criticism of medical health care professionals, particularly in reference to their treatment of addictive behavior, is that they tend to deal with a problem by prescribing medication. One questionnaire item (Q-48: Medical professionals tend to deal with . . . problems by prescribing another drug) elicited general agreement across the four groups (PA: M = 2.70, S.D. = 1.16; OA: M = 2.58; S.D. = 1.15; NA: M = 2.20, S.D. = 1.19; PA: M = 3.90, S.D. = 1.10; NA: M = 3.90, S.D. = 1.37; and OA: M = 4.27, S.D. = 1.16).
1.03; and AA: \( M = 1.92, \text{S.D.} = .85 \) in favor of the observation. Whether this is actually occurring at the present time, or had occurred in reality to the respondents can not be determined from this questionnaire; however, it does appear to be a generalized perception of the respondents.

Attitudes Regarding Professionals: Mental Health Care Providers

Mental health care providers did not fare much better than medical professionals in the opinions of the respondents. According to Tables 33 and 34, 71% of the respondents had had some contact with some form of mental health assistance within the past five years, 49% within the past year. The contact rates were not as high as those for medical professionals, diminishing the opportunity for respondents to provide an opinion based on actual experience with the mental health care system.

One item (Q-28: Mental health professionals have been helpful to me in dealing with my ... problems) dealt with the helpfulness of mental health assistance and yielded neutral (NA: \( M = 3.0, \text{S.D.} = 1.32 \); AA: \( M = 3.13, \text{S.D.} = 1.19 \); and PA: \( M = 3.20, \text{S.D.} = 1.55 \)) to negative (OA: \( M = 3.95, \text{S.D.} = 1.19 \)) reactions. A similar pattern resulted with Q-34 (Aspects or parts of my ... problem have been handled best by mental health professionals). One group
(NA: M = 3.30, S.D. = 1.42) provided a neutral response, while the remaining three groups tended to disagree with this item (PA: M = 3.64, S.D. = 1.29; AA: M = 3.69, S.D. = 1.15; and OA: M = 4.08, S.D. = .94). No significant differences between the groups emerged.

When asked about their perceptions of other members' satisfaction with mental health services that they may have received, (Q-32), responses ranged from neutral (PA: M = 2.82, S.D. = .87 and NA: M = 2.67, S.D. = 1.12) to positive (AA: M = 2.43, S.D. = .92 and OA: M = 2.19, S.D. = .78). However, this question is subject to the same problem previously described in regards to medical professionals and the prohibition against "taking inventory" for someone else.

One common criticism of the mental health community is that necessary services are not readily available through mental health agencies. The opinions of the respondents tended to support that criticism (Q-39: People with ... problems are able to find the help they need from local mental health agencies). The respondents from PA provided a neutral response (M = 3.38, S.D. = 1.12) while respondents from AA (M = 3.97, S.D. = .86), OA (M = 4.00, S.D. = .97) and NA (M = 4.10, S.D. = .74) tended to disagree.

For whatever combination of reasons, self-help group members have experienced health care services, both medical and mental, as lacking.
Attitudes Regarding the Appropriate Role for Health Care Providers

Tackling the issue directly, one questionnaire item (Q-43: . . . should be expanded to include help and information from medical and mental health professionals) probed respondents to explore their willingness to allow their services to be expanded to include professional expertise. The response varied significantly between the four groups, \( F(3,106) = 7.25, p < .01 \). The respondents from PA produced a neutral response in a positive direction \( (M = 2.50; S.D. = 1.09) \) while OA also produced a neutral response but in a more negative direction \( (M = 3.44, S.D. = 1.20) \). However, both NA \( (M = 3.90, S.D. = 1.37) \) and AA \( (M = 4.15, S.D. = 1.03) \) disagreed with the thought of expanding services. The differences between the opinions of NA and AA respondents and those of PA respondents were significant, \( p < .01, \) Tukey HSD = 1.27. The door to PA is open, if only a crack, to professional expertise, but all four groups appear uneasy about any collaborative efforts with professionals.

The only legitimate role self-help groups seem to deem appropriate for health care providers is the role of referral source. Even at that, professionals do not appear to be involved in making referrals to self-help groups. Question-49 (Medical and mental health professionals refer . . . to . . . meetings for help) tried to determine the
perception of group members of professionals as referral sources. Only PA respondents \((M = 2.31, S.D. = .75)\) endorsed professionals as referral sources, perhaps because the respondents themselves may have been referrals. The remaining three groups produced a more neutral response \((NA: M = 2.70, S.D. = 1.06; AA: M = 2.76, S.D. = 1.01; and OA: M = 3.14, S.D. = 1.06)\), suggesting that mental and medical professionals could become more active in the referral process.

Attitudes Regarding Acceptance by Larger Society

These questionnaire items were designed to tap members' perceptions of the degree of awareness, acceptance and understanding demonstrated by the larger society of non-members toward persons experiencing difficulties with the target behavior problem. The target behavior problems across the four groups all have a social stigmatizing effect on the members. Two of the groups, PA and NA, are also dealing with target behavior problems that involve illegal activities (abusive behavior toward children and consumption of illicit substances). One observation regarding mutual assistance groups is that the members are more demanding of themselves and more critical of their behavior than is the larger society, exhibiting a form of confession and expiation that extends beyond social necessity to enable the member to deal with the guilt associated with the lack of
behavioral control. One questionnaire item (Q-36: Recovering . . . probably come down harder on themselves than do other people) asked respondents to comment explicitly on this issue. Respondents across all four groups tended to positively endorse this item (PA: M = 2.62, S.D. = 1.26; OA: M = 2.0, S.D. = 1.0; AA: M = 1.83, S.D. = .59; and NA: M = 1.8, S.D. = .42). Significant inter-group differences appeared, F(3,106) = 2.89, P < .025, with AA and NA respondents differing from PA respondents, (p < .05, Tukey HSD = .79). No meaningful differences emerged as a function of the legality versus illegality of the target behavior problem.

In terms of societal awareness and knowledge of the target behavior problems (Q-24: People in general know a great deal about . . .), most respondents disagreed that people in general had a substantial degree of knowledge (PA: M = 3.83, S.D. = .83; AA: M = 4.39, S.D. = .80; OA: M = 4.58, S.D. = .63; and NA: M = 5.00, S.D. = .00). The differences among the groups were significant, F(3,106) = 5.77, P < .01. The respondents from OA, (p < .05, Tukey HSD = .64), and from NA, (p < .01, Tukey HSD = .78), were more adamant in their disagreement than were PA respondents.

Societal acceptance of persons dealing with behavioral control type problems did not appear to be a major issue for respondents (Q-29: Society does not accept recovering . . .). Most respondents provided a neutral
response with some variability in both positive and negative
directions (AA: M = 3.72, S.D. = .81; OA: M = 3.40, S.D. =
1.19; PA: M = 3.09, S.D. = .94; and NA: M = 2.90, S.D. =
1.10). No significant inter-group differences emerged.
However, a significant divergence in opinion, (F (3,106) =
9.22, p < .01), did appear between AA respondents and OA
respondents when they responded to Q-40 (People in general
are becoming more understanding and accepting of
recovering . . .), (p < .01, Tukey HSD = 1.05). AA
respondents tended to endorse this statement (AA: M = 2.18,
S.D. = .69) while OA respondents disagreed (OA: M = 3.28,
S.D. = 1.17) with both PA (M = 2.50, S.D. = .67) and NA (M =
2.50, S.D. = .97) taking intermediate positions. This
difference between AA and OA may reflect 1) the different
tenure periods within the two organizations and 2) the
relatively substantial public awareness campaigns about
alcoholism waged by local health funding agencies and the
absence of such campaigns for compulsive eating disorders.

Attitudes Regarding Benefits of Association

Riessman (1965) suggested that the therapeutic
compound of association with a self-help group was the
benefit accrued to a member in the process of helping
someone else. The "helper principle" was indeed supported
by the near unanimous, strong positive endorsement of
questionnaire item Q-45 (Helping other . . . in . . . is an
important part of making . . . work). Across all four groups, respondents uniformly endorsed the "helper principle" (OA: \(M = 1.28, \text{S.D.} = .46\); PA: \(M = 1.23, \text{S.D.} = .44\); AA: \(M = 1.20, \text{S.D.} = .40\); and NA: \(M = 1.10, \text{S.D.} = .32\)). This process is formalized in anonymous-based self-help groups by tenets such as the "Twelfth Step" of AA which states "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs," (AA World Services, Inc., 1952). However, when members were questioned as to their own personal role in implementing the "helper principle" (Q-31: I have been able to help someone else cope with their . . . problems through my work with . . .), some significant inter-group differences appeared, (\(F(3,106) = 3.85, p < .025\)). Although all four groups positively endorsed that questionnaire item (PA: \(M = 2.4, \text{S.D.} = .52\); OA: \(M = 1.95, \text{S.D.} = .85\); AA: \(M = 1.63, \text{S.D.} = .59\); and NA: \(M = 1.6, \text{S.D.} = .70\)), PA respondents were less likely than AA respondents and NA respondents to positively endorse this item, (\(p < .01, \text{Tukey HSD} = .80\)). It is possible that this finding may reflect the limited tenure of membership found within PA and it is also possible that PA members may feel slightly less inclined to help someone else due to the presence of potential professional intervention.

Respondents strongly and uniformly disagreed with
the notion that mutual assistance groups are primarily gathering places to continue friendships (PA: M = 4.00, S.D. = .43; NA: M = 4.40, S.D. = .70; OA: M = 4.52, S.D. = .77; and AA: M = 4.59, S.D. = .55).

The final question dealing with the benefits of association was directed at whether association with a given group had provided a member with a "fresh start" on life (Q-23: . . . has provided a new way of life for me). The overall opinion was overwhelming positive, producing substantial endorsement of this item (PA: M = 1.69, S.D. = .63; OA: M = 1.49, S.D. = .66; NA: M = 1.60, S.D. = .70; and AA: M = 1.20, S.D. = .40). There seemed to be no doubt in the minds of these respondents that they were positively affected by their association with their particular mutual assistance group.

Attitudes Regarding the Acceptance of Alternative or Additional Treatment Modalities

This cluster of five questionnaire items attempted to probe respondents' opinions regarding adjunctive assistance. The first item (Q-37: There are problems that I have had that . . . was not able to handle) asked respondents to comment on the existence of any problems that could benefit from adjunctive assistance. The responses from three of the four groups were neutral (PA: M = 3.18, S.D. = 1.17; AA: M = 3.13, S.D. = 1.14; and OA: M = 2.68,
S.D. = 1.07) and somewhat variable, while NA produced a positive response (NA: M = 2.30, S.D. = .95). The anonymous-based self-help groups openly acknowledge that they cannot solve all problems. The first priority, however, is the control of the target behavior, all other behavior problems fall secondarily. Perhaps this is as it should be; gaining control of the target behavior may indeed eliminate or reduce in severity collateral behavior problems.

Members themselves did not seem to feel that they could benefit from further assistance. The next questionnaire item (Q-46: I could use more help than the help I am currently receiving from . . .) probed respondents for their perceived need for adjunctive services. The responses from three of the groups were neutral (OA: M = 3.15, S.D. = 1.11; PA: M = 3.18, S.D. = 1.17; and NA: M = 3.30, S.D. = .82), while the AA respondents tended to disagree with need for additional assistance (M = 3.89, S.D. = 1.03). The differences between the groups, however, were not significant.

Part of the willingness of individual group members to consider to use of adjunctive services is based on the attitudes expressed by the group consensus as to whether or not a wide variety of services are acceptable. The next question (Q-30: People with . . . problems like mine need to get help from a wide variety of people and places) was
met with a neutral response across the groups with no significant differences between groups (AA: M = 3.39, S.D. = 1.13; OA: M = 2.84, S.D. = 1.15; NA: M = 2.67, S.D. = 1.12; and PA: M = 2.50, S.D. = 1.24).

The respondents from the four groups involved in this study did not appear to be claiming their approach was the exclusive approach for persons experiencing particular behavior control problems. The fourth questionnaire item in this cluster (Q-26: . . . does not work for some people) dealt with the exclusivity of the approach and whether the group members would acknowledge that self-help methods did not work for some individuals. Two groups expressed a neutral opinion (PA: M = 2.55, S.D. = 1.21 and AA: M = 2.70, S.D. = 1.16) and two expressed positive endorsement for the concept that self-help did not work for everyone (NA: M = 2.33, S.D. = 1.00 and OA: M = 2.21, S.D. = .73).

The fifth and final questionnaire item in this cluster was concerned about the possible expansion of mutual assistance groups to include individuals experiencing different kinds of problems. There are several opinions regarding the recent trends toward finer discriminations made in developing self-help groups for increasingly specific problems. One opinion holds that the more specifically focused the group, the greater the
identification and the more salient the successful role models. An alternative point of view suggests that the similarities between the groups are greater than the differences. The tendency of NA members to also be members of AA lends some credibility to this opinion. This questionnaire item did little to answer the question (Q-47: . . . should be expanded to include people experiencing other kinds of problems). The PA respondents produced a neutral response with a fairly high degree of response variability (PA: \( M = 3.0, S.D. = 1.47 \)). The remaining three groups, however, issued a resounding rejection of expansion (OA: \( M = 4.09, S.D. = .92 \); NA: \( M = 4.20, S.D. = 1.03 \); and AA: \( M = 4.64, S.D. = .64 \)), \( F(3,106) = 9.91, p < .01 \). All three groups were significantly different from PA, \( p < .01, \) Tukey HSD = 1.04).

Perhaps the most surprising part of the analysis of this cluster of items is not in the strength of the opinions, but rather in the relative openness or neutrality of the responses. Particular group members may have quite strong attitudes; however, in sum, the expressed attitudes do not indicate a strong rejection of adjunctive services, only a rejection of expanding the existing groups.
CHAPTER 4

DISCUSSION

Perhaps the most problematic aspect in interpreting the results from this study is the difficulty in drawing inferences, particularly regarding PA and NA, given the small sample sizes. The results can be viewed as trends, suggesting future areas for research. Even the ANOVA results from the analysis of the attitude items must be approached with caution due to the less certain results stemming from the large differences in sample size between the four groups. Again, a study of this nature can only indicate areas for future research. These results alone cannot definitively answer any questions regarding the mutual assistance process in anonymous-based groups.

It was not surprising that the sample drawn from PA differed in many ways from AA, OA and NA. Even though PA is based on the principles and tenets of AA, the oldest anonymous-based group, PA has made some significant modifications, specifically the inclusion of mental health professionals as group sponsors and as organizational consultants. It was possible that some of the differences between PA versus AA and OA could be accounted for by the fact that PA members engage or took the risk to engage in an illegal behavior, whereas alcohol and food consumption are
legal forms of behavior. But this hypothesis is inconsistent with the pattern of responses from NA wherein NA is closer in pattern to OA and AA than to PA, yet NA members have engaged in or have the potential to engage in illegal activities. The presence of mental health professionals and a different response pattern from the other self-help groups are clearly correlated, but causation is difficult to determine. Does the difference lie in the presence of the professionals, in the type of behavioral excess problem, an interaction of the two or a sampling bias problem as a function of the inconclusive results from NA and PA due to the small population sample? It was surprising to find that OA was typically the more stridently doctrinaire group of the four groups. AA would have been expected to be more inclined to hold attitudes more consistent with the organizational literature due to its longer existence, larger membership and longer tenure of membership. However, AA respondents tended to be intermediate between PA and OA, even to the point of some significant differences emerging between AA and OA. A number of possible explanations emerge, but one seems to hold the greatest weight. OA had a combination of a relatively large number of persons with less than one year of tenure with the organization and a fairly high number of respondents dealing with less than six months of success with sustained abstinence. It is possible that this combination
of factors leads the group members to adhere more rigorously
to the group's basic tenets and values.

To return to the initial problem of this study: Is
there a basis for collaborative interchange between two,
such differing, perspectives on the control of behavioral
excesses, the professional and mutual assistance approaches?
The issue of whether one approach or the other should or
should not continue to provide services is a moot point in
this project. Both approaches exist and compete for the
attention and needs of similar client populations. The
efficacy of both approaches, professional and self-help, was
not examined. It is assumed that each approach is
effective, to some degree, with some individuals, because
both approaches continue to provide services to fulfill
client demands. If at least some consumer needs were not
being fulfilled, it would be unlikely that either approach
would be able to continue serving the client population. The
simple answer to the stated question is: Yes, there is a
basis for collaborative interchange between the two differing
perspectives. A more complete answer requires examining
three facets of the relationship:

1) What do self-help group members say about
   themselves, their groups and their involvement in
   the mutual assistance process?

2) What do self-help group members say about their
   interface with the professional health care
community?

3) How can health care professionals become involved, if interested, or co-exist with the self-help process?

What Do Self-Help Group Members Say About Themselves?

One distinction to keep in mind throughout this discussion, is the distinction made by anonymous-based self-help group members between the individual group member and the suprastructure of the organization. Individual members are free to do, say or act as they please; however, the organization has a constitution of its own which members are strongly encouraged to leave as it is. This distinction was developed within anonymous-based groups to diminish the possibility that an organization would become a cult of personalities, rather than an effective tool for behavior change. The prohibition against tampering with the suprastructure keeps the focus of behavior change in the forefront of each member's consciousness. The organization cannot be externally cited for contributing to someone's difficulties because the organization just is as it is; the individual shoulders full responsibility for personal behavior change. This makes the organization appear exceptionally intransigent from the outside and makes members speaking about the organization appear quite
dogmatic at times. Respondents appeared to be quite willing to share their personal thoughts and feelings throughout the questionnaire. It is even reflected in the frequency with which respondents provided personalized comments at the end of a lengthy questionnaire. Respondents were also quite willing to answer questionnaire items that appeared to derive directly from organizational materials, such as Q-45 (Helping other . . . in . . . is an important part of making . . . work), which comes from the Twelfth Step (AA World Services, Inc., 1952). Their responses tended to be uniformly in an affirmative direction with little variance around the mean. However, questionnaire items that dealt with questioning the organizational structure met with more resistance, a lower response rate, more variable responses and, not infrequently, a corrective note or comment in the margin. A questionnaire item, such as Q-47 (. . . should be expanded to include people experiencing other kinds of problems), elicited considerable deviation in response and a higher rate of refusal to answer. A behavioral scientist might argue that this refusal to critically examine and analyze components of a process demonstrates rigidity and close-mindedness. A self-help group member might equally as well argue that "If it works, don't fix it." For these respondents, at least, the groups appear to be working and not in need of tinkering. It is possible that in dealing with behavioral excesses, clients/members do not benefit
from the cognitive complexity of dealing with shades of gray, or ambiguity in their chosen treatment modality, at least initially in treatment. As a self-help group member gains tenure and successful abstinence within a group, he/she may find it easier to critically examine and analyze the components of the mutual assistance process and potentially see avenues for change or modification. But, with the continuing entry of newcomers, who would possibly be adversely affected by organizational shifts, and the decreased need of more tenured members on the organizational structure, the impetus for change is minimal. What change does occur may have to be the result of a long-developing, groundswell movement that cuts across the entire membership, so that no one individual, group or lobbying force could be seen as responsible for the change. Given the difficulty of this type of grassroots movement, the anonymous-based self-help organizations are likely to remain conservative and orthodox, at the same time, providing members with ultimate freedom and ultimate responsibility for their behavior. It is highly unlikely that any anonymous-based self-help group will ever expand its service mandate to include legislative changes or political action. The goals and purposes of the organizations remain clear, unambiguous and probably unchanging. In short, it is possible to access any individual member of an organization for change, but it appears unlikely that the organization itself will become
accessible to change.

Related to the unwillingness to critically examine and analyze their chosen mutual assistance group, is a tendency toward positivity, almost to a fault. It is as if, in the process of dealing with the disruptive behavior that lead to a behavioral excess problem, self-help group members have made a behavioral commitment to interrupt a pattern of negativity by supplanting a pattern of positivity. Respondents were more likely to respond to questionnaire items that dealt with positive aspects of their lives and their involvement in the group, then they were willing to deal with critical or analytical items. It is notable, therefore, that the one area in which the respondents were willing to be negative, was when discussing their experiences with mental and medical care professionals. Even the PA respondents, with their closer involvement with mental health professionals, did not provide a positive endorsement of professional services. In reality, their experiences may have been quite negative with health care providers. The entire health care system has come under repeated attacks for inadequate, ineffective and insensitive treatment modalities for addictive behavior or behavioral excess disorders.

Another explanatory mechanism could be found in the identification process. A newcomer to a given self-help group has most likely gone through a period of agonizing
self-doubt, personal failure, withdrawal from familial and social support, repeated attempts to establish behavioral control and externalizing denial of difficulties. This newcomer arrives at a self-help group and sees many successful role models of people who have obtained success with this program. They see palpable proof that professionals cannot readily provide. However, they also see many other individuals in various stages of development, some less acceptable than others. To seal their commitment to behavior change, the newcomer is asked "to surrender" to the process of change. Much has been written about the process of surrender and its importance to the mutual assistance process (Kurtz, 1979). The importance of surrender to this discussion is that in surrendering the newcomer acknowledges that he/she has been unsuccessful in establishing control over his/her behavior and he/she has no hope of establishing control unless he/she makes this commitment to behavior change. This behavioral commitment seals out past efforts, forgives the member for past failures and strengthens the identification process. Frequently, past health care providers become part of that past that was a failure prior to group involvement. This phenomenon is not restricted to a rejection of health care providers. Many times family members will report feelings of rejection after a member has found a new program of life through a self-help organization. Family members can feel
as if they were a part of the past that was a failure experience for the member. Anonymous-based self-help organizations work to help integrate the member back into that troublesome past, as in Steps Eight and Nine, "Made a list of all persons we had harmed, and became willing to make amends to them all," and "Made direct amends to such people wherever possible, except when to do so would injure them or others," (AA World Services, Inc., 1952), where the member acknowledges past failures and seeks to make appropriate restitution. The groups also make it clear that they cannot handle all problems and encourage members to seek help outside the organization if needed, but foremost in the members' minds is the ultimate goal of sustained abstinence. The strong negative experiences reported by respondents may reflect more of the members' struggles prior to involvement with the organization than any over-arching rejection of the totality of the health care system, especially as indicated by their continuing involvement with mental and medical health care professionals over the past five years.

When a self-help group member acknowledges a willingness "to surrender" to the process of change, the member also acknowledges that he/she has reached the bottom of his/her resources to cope with the difficulties. Earlier in the history of dealing with excessive alcohol use, providers believed that the individual had to "hit bottom", 
that is, lose everything including family, home, job, money and health, before he/she would be ready or willing to be assisted. In more recent treatment approaches, people have come to accept more subjective definitions of reaching "bottom", allowing individuals to define for themselves when they had reached the end of their resources. This willingness to be helped is a central ingredient in the anonymous-based self-help process; without it, it is assumed that the individual cannot progress through the program. However, this belief lends a circular quality to the self-help process. If a member benefits from association with a self-help group, then he/she was ready to be helped. If someone does not benefit (i.e., leaves group and does not return, never attends group), then it is assumed that the individual was not ready to be helped, had not "hit bottom" yet. As expressed in several questionnaire items, (Q-25; Q-27 and Q-35), members tended to view people who left the organization as unready for the program. Although placing full responsibility for behavior change on the individual may be a potent component of the success of the anonymous-based groups, it can also result in a subtle form of victim-blaming, blaming the individual seeking assistance for his/her own inability to benefit, rather than ever questioning the strategies of the organization. Many individuals could get lost in that chasm. Most anonymous-based self-help groups would state that they are
aware of drop-outs, yet with the demand for their services, their efforts are best directed toward individuals desiring their treatment modality, a philosophy of "attraction, not promotion" (AA World Services, Inc., 1952). The implicit message is that an individual experiencing behavioral control problems will eventually "hit bottom" and return to the group. Without any kind of follow-up information, this will never be ascertained, and many individuals may be lost to both approaches in the process. Indeed, uncontrolled studies of AA suggest that the dropout rate may run as high as 80 to 90% and little is known about the course of action taken by dropouts, whether they seek other forms of treatment, eventually return to AA, experience deterioration or find a self-cure (Miller, 1983).

The respondents across all four groups, but particularly OA, AA and NA, were exceptionally sensitive to any suggestion within the questionnaire that anything less than complete and total abstinence was the only appropriate goal. Abstinence is a major, if not the major, tenet of anonymous-based self-help groups. It is a tenet accepted without question with an almost religious fervor. This commitment to abstinence appears to be the cornerstone in a process that guides people with a history of a lack of behavioral control into attaining control by making a conscious decision that they can "not drink" (Kurtz, 1979). This philosophical twist takes a person who has experienced
failures and has begun to assume a negative pattern of behavior associated with the struggle between "I can" and "I can't" drink into a person with a positive pattern of behavior, "I can 'not drink'", side-stepping the resistance. The daily decision to not drink becomes a symbolic representation of a behavioral commitment to behavior change (Kurtz, 1979). Although initially the goal of abstinence is to disrupt a destructive behavior pattern, it later becomes a proud symbol of successful behavior change. Abstinence needs to be acknowledged as a legitimate goal in areas of behavioral excess, not for all people, but certainly legitimate for persons choosing abstinence as a behavioral goal. Our society, theoretically, does not tolerate any incidents of abusive behavior toward children. Our society is, theoretically, quite intolerant of some forms of drug consumption, whether or not consumption is abusive. And, our society is incredibly tolerant, in fact supportive, of other forms of drug consumption (alcohol, nicotine, caffeine) and food consumption, even when obviously health-compromising. Abstinence can be a legitimate personal and societal goal for any of these behaviors, although not necessarily the goal for every individual experiencing problems with control of excessive behavior. One component of the self-help process that the respondents across all four groups heartily endorsed, was the fact that they were helped by the process of helping others. The
"helper principle", as introduced by Riessman (1965) and expanded later by Gartner and Riessman (1977), points to an essential component of the self-help process that professionals cannot provide. The ability to help someone else within a mutual assistance group permits a member to regain self-esteem and a sense of personal efficacy. It also helps reinforce the principles of the program, a strategy long used to reinforce religious beliefs in the young or newly recruited, by having a relatively new member work on explaining the program to someone else. The "helper principle" can have a two-fold effect: 1) it can turn a formerly unproductive society member (because of disruptive behavior) into a productive help provider and also help manage the guilt the individual may feel about his/her former loss of behavioral control and 2) it can have a paradoxical effect of increasing the member's distance from the larger society. That is, the person becomes more reliant upon the support of the group when the newly initiated member receives rejection from someone not wanting to receive "the word". The professional-client relationship is by definition principally one-sided, the help flows from the provider to the client. Although this relationship is important in many ways too numerous to list for the process of psychotherapy, it may not as completely benefit the person with a loss of behavioral control. Missing is the personal "redemption" and the return to a state of social
and personal acceptance; however, it may also prevent the distancing effect from the larger society.

The open door for mental and medical health care providers lies in the fact that the respondents did not reject the possibility that persons who had not experienced a given problem could be helpful. Previous experience with loss of behavioral control was not perceived as a pre-condition for effective assistance, although it was perceived as potentially helpful. Members of these groups appeared to be willing to accept other treatment modalities; however, the criteria for acceptance lies in demonstrated expertise, not in professional credentials. The issue of credibility appeared to be quite salient for these respondents, with instant credibility accorded to successful role models. Other health care providers needed to demonstrate applied, practical knowledge and expertise in the specific target areas. More generalized clinical or research skills do not appear to hold much credibility. Anyone working in this area, without direct personal experience, will need a greater expertise in the specific target behavior, a reduced reliance on professional credentials and much patience.

The Professional and Aprofessional Interface

The relationship between professionals and these
anonymous-based self-help groups can be described as ambivalent at best. The distinction between the individual member and the organization becomes relevant when examining the interface between these two approaches. Individual members are free to pursue any kind of contact they desire with the professional community. The organizations, on the other hand, have clearly specified relationships with the professional community. Yet how clear and how specific are those relationships?

In Q-12 (In what ways does ... use the services of mental health or medical professionals?), only PA acknowledged any overt professional involvement, with 34% of the respondents indicating that PA used professionals as consultants, 32% noting professional involvement as service providers and 17% specifying professionals as co-leaders. The other three organizations maintained that their organizations will be "forever non-professional". Once respondents from these three groups provided the organizationally "correct" answer, however, many went on to say that members could seek whatever services that the individual deemed necessary and, still others, noted roles the professionals did play within the organization, such as, invited guest speaker, board of directors member or organizational consultant.

The major issue appears to be: who provides the direct services? Without question, and by definition, the
direct service providers in a mutual assistance group are the members themselves. Even if a professional is a member, he/she would function as a member, first and foremost. Professionals do appear to be accepted as indirect service providers. Models for indirect service provision are largely the domain of community psychology (Heller and Monahan, 1977) and could be the most legitimate design for professional involvement with mutual assistance groups.

The one dynamic involving professionals that mutual assistance groups fear most is co-optation. This fear may account for the number of barriers or filters that self-help groups erect between the group and professional involvement. First, the society at large accepts professional credentials and licensing procedures as legitimate criteria for professional expertise to handle a wide array of health care problems. Mutual assistance groups dealing with behavioral excesses do not necessarily accord the same legitimacy to the professional credentials and licensing procedures in reference to their specific behavioral problems. Criteria of applied, experience-based expertise and acceptance of the self-help group as the direct service provider are required of the professional wishing to become involved with a behavior control mutual assistance group. Second, the larger society does not require professionals to have experienced a problem to have credibility in dealing with a problem (i.e., an obstetrician does not have to have
given birth to a baby to be considered a credible obstetrician). In developing societies, it was common to find that someone who had survived a particular disease process or other trying circumstances was accorded the role of expert regarding that problem, such that, a tribal member who had survived the chickenpox may become the tribal designated healer/consultant for that disease. Self-help groups turn the table of societal norms of credibility for professionals by requiring professionals to establish their expertise by demonstrating specific skills and/or knowledge if they have not personally experienced the particular dysfunctional behavior. Even if a professional were to establish notable expertise within the self-help community, the greatest respect still lies with the individual who has personally struggled and has been successful within the organization. This effectively bars professionals from major positions of influence or leadership and any possibility of co-opting the group process.

Model programs of successful collaboration between the professional community and mutual assistance groups do exist. Parents Anonymous and the Widow-to-Widow program (Silverman, 1976) are notable examples. Professionals need to be aware of the fear of co-optation and to be willing to examine more collaborative relationships, particularly providing indirect services, rather than competing for direct service provision.
Health care professionals can also elect to focus direct service attention toward individuals who do not benefit from self-help groups and those individuals who remain under- or un-served by both professional and aprofessional treatment modalities. Informal estimates of the drop-out rate from AA range from 80 to 90% (Miller, 1983). For those individuals who go on to become regular members of AA, the outcomes are relatively favorable with approximately 50% maintaining abstinence at one year (Miller, 1983). Professional services might best be directed at the vast proportion of individuals for whom self-help groups are not effective or for whom abstinence is not the chosen behavioral goal. Research efforts could potentially help determine which individuals will be more likely to benefit from self-help group involvement and which individuals require abstinence as a behavioral goal.

Additionally, both treatment modalities, professional and mutual assistance, appear to continue to fail to meet the needs of minority and lower socio-economic group populations. Within this study, only PA had any appreciable minority and lower socio-economic group participation, and that finding may be a function of court-mandated involvement, not voluntary participation. The population of the remaining three groups, OA, AA and NA, appeared to resemble traditional psychotherapy populations, education, employed at relatively successful
levels and fairly young.

**Professional Co-existence with the Self-help Community**

One role that the anonymous-based self-help groups attributed to professionals was the role of referral source. Professionals may want to take a closer look at mutual assistance groups as appropriate sources of support and guidance for clients dealing with behavioral excess disorders. The differences in therapeutic approach contrasted in Table 2 indicate that self-help groups can provide enormous resources to the professional, including, in most cases, 24 hour on-call assistance, numerous and geographically disparate meetings and meeting sites, successful role models, opportunities to practice new skills in vivo with others experiencing similar problems and applied, practical information. It is possible that in referring an individual to a self-help group the professional may lose contact with that person; however, the contact may only be lost during the initial period of identification and it may be possible that the disruptive behavior that prompted the individual into professional care may be eliminated entirely once behavioral control is established.

As positive as self-help groups may be, care must be used in using self-help groups as a blanket referral source. Not all people respond positively to the mutual assistance
environment. Abstinence, the foundation of most anonymous-based groups, is not necessarily the behavioral goal for behavioral excess disorders (Miller, 1983). Further research is necessary to determine who succeeds within the self-help environment and who does not and why. Exploring a client's attitudes toward and experiences with any form of self-help group is an important first step, even for clients presenting problems other than behavioral excess problems. The reasons are two-fold: 1) the professional will want to avoid initially using a self-help group referral for individuals who have strong negative feelings or experiences and 2) the professional may find that a client was already involved in a group, but feared professional rejection of his/her involvement and was hesitant to acknowledge involvement.

To serve as an effective referral source or to work with a client actively involved in a mutual assistance group requires some knowledge and experience with the group in question. This process can be facilitated by knowing how to contact the group, knowing how the group will contact a client, attending a few representative group meetings, becoming familiar with the organizations' literature and developing some rapport with the local leadership of a particular organization. If the professional can accept the values and basic tenets of the organization, then there is some basis for collaborative interchange. If the
professional finds himself/herself unable to accept the values and basic tenets, then he/she needs to consider not working with clients involved with self-help treatment modalities. The conflict in value systems may be counter-therapeutic for the client.

Beyond direct services, professionals, if interested, can become active in the provision of indirect services. Research within the self-help community is difficult, but not impossible. Research needs are particularly important to the successful interface of the professional and aprofessional approaches. Questions, such as, who benefits from a self-help approach and who does not?, what accounts for the varying attitudes and experiences toward self-help groups? and what are the essential components of the mutual assistance process and what is excess baggage? need to be explored. Traditional research methodologies may have to tolerate some lack of methodological rigor in the data collection and analysis, but with enough efforts directed in similar directions may yield some consistent answers. What is clear is that mutual assistance as a treatment modality will continue to exist and grow. Professionals may benefit most from the strategy of learning about and working with the self-help movement, rather than fighting it. The benefits to both the professional and aprofessional approaches will be enormous.
REFERENCES


Likert, Rensis. A technique for the measurement of attitudes. *Archives of Psychology,* 1932, 140.


APPENDIX A: QUESTIONNAIRES

Parents Anonymous
Overeaters Anonymous
Alcoholics Anonymous
Narcotics Anonymous
Dear Parents Anonymous Group Member,

I am conducting a study to answer the question: How do members of self-help groups view health care professionals and their experiences with health care professionals? I would like to help bridge the understanding gap between self-help groups and the professional community. Members from several self-help groups, including Parents Anonymous, Alcoholics Anonymous, Narotics Anonymous and Overeaters Anonymous, will be completing this questionnaire. This questionnaire takes about 15 to 30 minutes to complete and asks questions about you, your group, your attitudes toward health care professionals and your experiences with health care professionals. All the information is strictly confidential. The results of the study will be provided to your Parents Anonymous organization for your information and planning.

In order to conduct this research and complete my doctoral dissertation, I need your help. This questionnaire is completely voluntary, but I would certainly appreciate your help and your opinions. Even if you have had some difficulties with the professional community, your opinions are very important to helping bridge the understanding gap.

The instructions for completing the questionnaire are on the following page. Please return it to your group leader when you are finished. The deadline for sending in the questionnaire is October 15, 1982, so please return it to your group leader as soon as you are done. I want to thank you for your time and attention and thank you in advance for what I hope will be your invaluable help.

Sincerely yours,

Clarissa Coelle Marques
Psychology Department
University of Arizona
Tucson, Arizona 85721
(602) 626-3914
The following questions deal with issues related to self-help in general and Parents Anonymous in particular. Several other self-help groups will be completing the same questionnaire, only oriented toward their group. The results of this survey will help bridge the understanding gap between self-help groups and the professional community. It is important that each questionnaire be completely filled out and returned as soon as possible. Even if you feel that the gap between self-help groups and the professional community should not be bridged, your opinion is important. Please give the questionnaire back to your group leader and your leader will send it back.

YOUR PRIVACY IS GUARANTEED

You may be assured of complete confidentiality. None of the personal information you give us on this questionnaire will be given to any other person or agency. There is no way for you to be identified.

WHAT TO DO IF YOU HAVE QUESTIONS

If you have any questions, please ask your group leader or call me in Tucson at 626-3914. The results of the survey will be available soon. If you are interested, please do not hesitate to call. Your interest is appreciated.

HOW TO FILL OUT THE QUESTIONNAIRE

Please circle the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. They will tell you when to circle more than one answer. If you circle more than one answer, please indicate in the blanks next to each answer which answer was your first, second and third choice.

Please fill out only one questionnaire. If you receive more than one questionnaire from different groups, only fill out one.
YOUR PARTICIPATION IN PARENTS ANONYMOUS (PA):

In this section you will be asked to answer some general questions about your participation in PA. Please circle the number next to the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. The question will tell you when you may circle more than one answer. Then, in the blanks next to each answer, indicate which was your first, second and third choice.

EXAMPLE:

What would you like to eat now? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1  BROWNIE
2  CARROT
3  HOT FUDGE SUNDAE
4  POPCORN
5  CELERY

Q-1 How long have you been involved with PA?

1  LESS THAN 6 MONTHS
2  6 MONTHS to 11 MONTHS
3  1 to 3 YEARS
4  4 to 8 YEARS
5  9 to 12 YEARS
6  LONGER THAN 12 YEARS

Q-2 How long have you been a recovering parent?

1  LESS THAN 6 MONTHS
2  6 MONTHS to 11 MONTHS
3  1 to 3 YEARS
4  4 to 8 YEARS
5  9 to 12 YEARS
6  LONGER THAN 12 YEARS

Please do not write below this line

1 2
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-3 On the average, how often do you attend these meetings?

1 DAILY
2 3 TIMES OR MORE EACH WEEK
3 2 TIMES EACH WEEK
4 ONCE A WEEK
5 EVERY 2 WEEKS
6 ONCE A MONTH
7 LESS THAN ONCE A MONTH

Q-4 What brought you to PA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 I WAS HAVING PROBLEMS WITH CHILD ABUSE
2 A FAMILY MEMBER OR FRIEND WAS HAVING PROBLEMS WITH CHILD ABUSE
3 I WAS CURIOUS ABOUT PA, LIKED THE GROUP AND DECIDED TO STAY
4 A FAMILY MEMBER OR FRIEND ENCOURAGED ME TO COME TO PA
5 A MEDICAL OR MENTAL HEALTH PROFESSIONAL ENCOURAGED ME TO COME TO PA
6 I DID NOT HAVE THE MONEY TO GO ANYWHERE ELSE FOR HELP
7 ATTENDING PA MEETINGS WAS PART OF OTHER TREATMENT FOR CHILD ABUSE
8 I COULD NOT GET THE HELP I NEEDED ANYWHERE ELSE

Q-5 In your opinion, what was the reason that PA was started?

1 SERVICES WERE UNAVAILABLE
2 MENTAL HEALTH AND MEDICAL SERVICE AGENCIES WERE NOT PROVIDING ADEQUATE SERVICE
3 ONLY PEOPLE WHO HAVE EXPERIENCED PROBLEMS WITH CHILD ABUSE CAN HELP OTHER PEOPLE WITH CHILD ABUSE PROBLEMS
4 PARENTS NEEDED MORE HELP THAN THEY WERE GETTING AT THE TIME
5 PARENTS NEEDED THE OPPORTUNITY TO MEET OTHER PEOPLE WHO WERE EXPERIENCING PROBLEMS WITH CHILD ABUSE

Please do not write below this line

3 4.1 .2 .3 5
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-6 Have you ever stopped attending PA meetings?

1. YES, I STOPPED ONCE
2. YES, I HAVE STOPPED AND STARTED AGAIN A COUPLE OF TIMES
3. YES, I HAVE STOPPED AND STARTED AGAIN SEVERAL TIMES
4. NO, I HAVE BEEN ATTENDING MEETINGS EVER SINCE I STARTED

If you said NO, go to Q-9

If you said YES, go to Q-7

Q-7 In your opinion, why did you stop attending PA meetings?
(You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I DID NOT NEED ANYMORE HELP AT THAT TIME
2. I WAS NOT READY TO BE HELPED AT THAT TIME
3. I NEEDED A DIFFERENT KIND OF HELP AT THAT TIME
4. I WAS TURNED OFF BY PA AT THAT TIME
5. I HAD A SLIP AND DID NOT WANT TO GO BACK TO PA
6. I DID NOT HAVE ENOUGH TIME TO ATTEND MEETINGS
7. MY FAMILY AND/OR FRIENDS DID NOT WANT ME TO ATTEND PA MEETINGS
8. MEDICAL OR MENTAL HEALTH PROFESSIONALS DID NOT WANT ME TO ATTEND PA MEETINGS
9. OTHER (PLEASE LIST) _______________________________

Q-8 In your opinion, why did you start attending PA meetings again? (You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I NEEDED MORE HELP
2. I WAS READY TO BE HELPED
3. OTHER FORMS OF HELP HAD NOT WORKED FOR ME
4. FAMILY OR FRIENDS ENCOURAGED ME TO ATTEND
5. MEDICAL OR MENTAL HEALTH PROFESSIONALS ENCOURAGED ME TO ATTEND
6. OTHER (PLEASE LIST) _______________________________

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<td>7.1</td>
<td>.2</td>
<td>.3</td>
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</table>
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-9 What do you see as the "final solution" to the problem of child abuse? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 SOLUTION WILL BE FOUND WITHIN EACH PERSON
2 SOLUTION WILL BE FOUND WITHIN THE RESEARCH BEING DONE IN THE MEDICAL/HEALTH COMMUNITY
3 SOLUTION WILL BE FOUND BY MAKING CHANGES IN HOW SOCIETY TREATS CHILD ABUSE PROBLEMS
4 SOLUTION WILL BE FOUND BY MAKING LEGISLATIVE CHANGES
5 SOLUTION WILL BE FOUND BY EXTENDING PA TO INCLUDE ALL PERSONS HAVING PROBLEMS WITH CHILD ABUSE
6 SOLUTION WILL BE FOUND WHEN MORE MEDICAL AND MENTAL HEALTH HELP IS AVAILABLE TO PEOPLE HAVING TROUBLE WITH CHILD ABUSE
7 THERE IS NO FINAL SOLUTION BECAUSE CHILD ABUSE WILL ALWAYS BE WITH US
8 OTHER (PLEASE LIST)

Q-10 What do you see as the "goals" of PA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 PERSONAL CHANGE - GETTING PEOPLE TO CHANGE THEIR BEHAVIOR
2 PERSONAL ACCEPTANCE - GETTING PEOPLE TO ACCEPT THEIR BEHAVIOR
3 SOCIETAL CHANGE - GETTING SOCIETY TO CHANGE ITS ATTITUDES AND BEHAVIOR TOWARD US
4 SOCIETAL ACCEPTANCE - GETTING SOCIETY TO ACCEPT OUR ATTITUDES AND BEHAVIOR
5 EXTENDING OUR SERVICES TO EVERYONE NEEDING HELP WITH CHILD ABUSE PROBLEMS
6 EXPANDING OUR SERVICES TO COVER A WIDE RANGE OF PROBLEMS AND NEEDS
7 LEGISLATIVE CHANGE
8 PROFESSIONAL CHANGE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO CHANGE THE SERVICES THAT THEY HAVE TRADITIONALLY OFFERED TO PEOPLE HAVING PROBLEMS WITH CHILD ABUSE
9 PROFESSIONAL ACCEPTANCE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO ACCEPT OUR EXPERTISE TO HANDLE PROBLEMS RELATED TO CHILD ABUSE
10 OTHER (PLEASE LIST)
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-11 Is personal experience with child abuse necessary for a person to help parents?
1 YES
2 NO
3 UNSURE

Q-12 In what ways does PA use the services of mental health or medical professionals? (You may check as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)
1 AS CONSULTANTS TO PA
2 AS GROUP CO-LEADERS
3 AS GUEST SPEAKERS
4 AS BOARD DIRECTORS
5 AS SERVICE PROVIDERS
6 OTHER (PLEASE LIST)
7 PA DOES NOT USE PROFESSIONAL SERVICES

Q-13 Have you used the services of a medical professional (such as, a doctor, nurse, family nurse practitioner, etc.) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-14 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Q-15 Have you used the services of a mental health professional (such as a psychologist, psychiatrist, counselor, social worker) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-16 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐ ☐
11 12.1 .2 .3 13 14 15 16
REMEMBER: CIRCLE ONLY ONE ANSWER

YOUR OPINIONS:

In this section you will be given some statements and asked to indicate whether you agree or disagree with the statement. You will have 6 options to choose from:

SA = STRONGLY AGREE
A = AGREE
I = INDIFFERENT
D = DISAGREE
SD = STRONGLY DISAGREE
NO = NO OPINION

Read each statement. Circle the one option that most closely represents your opinion.

Q-17
There is no one right way to deal with child abuse.  

SA A I D SD NO

Q-18
Parents should do whatever works for them in dealing with their child abuse problems.  

SA A I D SD NO

Q-19
Aspects or parts of my child abuse problem have been handled best by medical professionals.  

SA A I D SD NO

Q-20
It is important to involve the whole family when working with child abuse problems.  

SA A I D SD NO

Q-21
Only people who have experienced child abuse problems could help me and others like me.  

SA A I D SD NO

Please do not write below this line

☐ ☐ ☐ ☐ ☐
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-22 Medical professionals have been helpful to me in dealing with my child abuse problems.

Q-23 PA has provided a new way of life for me.

Q-24 People in general know a great deal about child abuse.

Q-25 Parents may leave PA but almost always come back later.

Q-26 PA does not work for some people.

Q-27 Some people attend PA meetings just to find friends, not to work on their child abuse problems.

Q-28 Mental health professionals have been helpful to me in dealing with my child abuse problems.

Q-29 Society does not accept recovering parents.

Q-30 People with child abuse problems like mine need to get help from a wide variety of people and places.

Q-31 I have been able to help someone else cope with their child abuse problems through my work with PA.

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REMEMBER: CIRCLE ONLY ONE ANSWER

<table>
<thead>
<tr>
<th>Q-32</th>
<th>Most people in PA have not been satisfied with the help they may have received from mental health professionals.</th>
<th>SA A I D SD NO</th>
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<tbody>
<tr>
<td>Q-33</td>
<td>PA is the only group which provides help for parents.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-34</td>
<td>Aspects or parts of my child abuse problem have been handled best by mental health professionals.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-35</td>
<td>Parents who leave PA after a few meetings are not ready to deal with their child abuse problems.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-36</td>
<td>Recovering parents probably come down harder on themselves than do other people.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-37</td>
<td>There are problems that I have had that PA was not able to handle.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-38</td>
<td>I only attend meetings to see old friends now, because I no longer really need help.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-39</td>
<td>People with child abuse problems are able to find the help they need from local mental health agencies.</td>
<td>SA A I D SD NO</td>
</tr>
<tr>
<td>Q-40</td>
<td>People in general are becoming more understanding and accepting of recovering parents.</td>
<td>SA A I D SD NO</td>
</tr>
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| 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-41 Only an abusive parent can understand child abuse. SA A I D SD NO

Q-42 I get a lot of support from friends and family outside of PA for working on my child abuse problems. SA A I D SD NO

Q-43 PA should be expanded to include help and information from medical and mental health professionals. SA A I D SD NO

Q-44 Most people in PA have been satisfied with the help they may have received from medical professionals. SA A I D SD NO

Q-45 Helping other parents in PA is an important part of making PA work. SA A I D SD NO

Q-46 I could use more help than the help I am currently receiving from PA. SA A I D SD NO

Q-47 PA should be expanded to included people experiencing other kinds of problems. SA A I D SD NO

Q-48 Medical professionals tend to deal with child abuse problems by prescribing another drug. SA A I D SD NO

Q-49 Medical and mental health professionals refer parents to PA meetings for help. SA A I D SD NO

Please do not write below this line

41 42 43 44 45 46 47 48 49
REMEMBER: CIRCLE ONLY ONE ANSWER

ABOUT YOU:
In order to understand your answers better, we would like to have the following general information about you. Remember, all information about you is strictly confidential and will be kept secret.

Q-50 In what year were you born? ______________________

Q-51 What is your ethnic group?
1 ANGLO, NON-HISPANIC
2 MEXICAN-AMERICAN, HISPANIC
3 BLACK
4 AMERICAN INDIAN (TRIBE: ______________________)
5 ASIAN, CHINESE, JAPANESE
6 OTHER (PLEASE LIST) ______________________

Q-52 What is your marital status?
1 SINGLE (NEVER HAVE BEEN MARRIED)
2 MARRIED
3 WIDOWED
4 SEPARATED
5 DIVORCED

Q-53 What is your sex?
1 MALE
2 FEMALE

Q-54 What is the last grade of school you completed?
1 1 to 6 GRADE
2 7 to 11 GRADE
3 12 GRADE - HIGH SCHOOL GRADUATE
4 SOME COLLEGE - JUNIOR COLLEGE
5 COLLEGE GRADUATE
6 POST GRADUATE COLLEGE

Q-55 What is (or was) your job? (Retired or unemployed people, please list your last job.) ______________________

Please do not write below this line

[ ] 50 [ ] 51 [ ] 52 [ ] 53 [ ] 54 [ ] 55
Q-56 Are you currently working?
1 YES, FULL-TIME (30 HOURS OR MORE)
2 YES, PART-TIME (29 HOURS OR LESS)
3 NO, OUT OF WORK
4 NO, RETIRED
5 STUDENT
6 HOUSEWIFE/HOUSEHUSBAND

Q-57 What is your family's yearly income? (Add together all money earned by people in your household.)
1 LESS THAN $5,000
2 $5,000 to $9,999
3 $10,000 to $19,999
4 $20,000 to $29,999
5 $30,000 to $39,999
6 MORE THAN $40,000
7 I DON'T KNOW

Q-58 How many years have you lived in Arizona?
1 LESS THAN 2 YEARS
2 2 to 5 YEARS
3 6 to 9 YEARS
4 10 to 19 YEARS
5 20 to 29 YEARS
6 30 to 39 YEARS
7 40 to 49 YEARS
8 50 YEARS OR MORE

Q-59 How many people (children and adults) currently live in your household? ____________ (Be sure to count yourself!)

Q-60 How do you feel about taking part in this survey?
1 GOOD
2 DON'T MIND
3 OTHER (PLEASE LIST) ________________

Please do not write below this line

I have asked about many subjects important to understanding PA and self-help in general. I am further interested in what thoughts you might have about PA and the role that self-help/mutual-help has played in your life. Your ideas are important to understanding how PA works for you. Please write any ideas, suggestions or questions that you might want to share in the space below.

Thank you for making this survey possible.

Clarissa Coelis Marques
Department of Family and Community Medicine
University of Arizona - AHSC
626-3914
Tucson, Arizona
Dear Overeaters Anonymous Group Member,

I am conducting a study to answer the question: How do members of self-help groups view health care professionals and their experiences with health care professionals? I would like to help bridge the understanding gap between self-help groups and the professional community. Members from several self-help groups, including Overeaters Anonymous, Alcoholics Anonymous, Narcotics Anonymous and Parents Anonymous, will be completing this questionnaire. This questionnaire takes about 15 to 30 minutes to complete and asks questions about you, your group, your attitudes toward health care professionals and your experiences with health care professionals. All the information is strictly confidential. The results of the study will be provided to your Overeaters Anonymous organization for your information and planning.

In order to conduct this research and complete my doctoral dissertation, I need your help. This questionnaire is completely voluntary, but I would certainly appreciate your help and your opinions. Even if you have had some difficulties with the professional community, your opinions are very important to helping bridge the understanding gap.

The instructions for completing the questionnaire are on the following page. Please return it as soon as possible in the enclosed self-addressed stamped envelope when you are finished. The deadline for sending in the questionnaire is October 8, 1982, but please return it as soon as you are done. I want to thank you for your time and attention and thank you in advance for what I hope will be your invaluable help.

Sincerely yours,

Clarissa Collell Marques
Psychology Department
University of Arizona
Tucson, Arizona 85721
(602) 626-3914
SELF-HELP through MUTUAL-HELP
SELF-AWARENESS through MUTUAL-AWARENESS

PURPOSE OF QUESTIONNAIRE

The following questions deal with issues related to self-help in general and Overeaters Anonymous in particular. Several other self-help groups will be completing the same questionnaire, only oriented toward their group. The results of this survey will help bridge the understanding gap between self-help groups and the professional community. It is important that each questionnaire be completely filled out and returned as soon as possible. Even if you feel that the gap between self-help groups and the professional community should not be bridged, your opinion is important. Please send the questionnaire back in the enclosed envelope as soon as possible.

YOUR PRIVACY IS GUARANTEED

You may be assured of complete confidentiality. None of the personal information you give us on this questionnaire will be given to any other person or agency. There is no way for you to be identified.

WHAT TO DO IF YOU HAVE QUESTIONS

If you have any questions, please call Clarissa Marques at 626-3914. The results of the survey will be available soon. If you are interested, please do not hesitate to call. Your interest is appreciated.

HOW TO FILL OUT THE QUESTIONNAIRE

Please circle the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. They will tell you when to circle more than one answer. If you circle more than one answer, please indicate in the blanks next to each answer which answer was your first, second and third choice.

Please fill out only one questionnaire. If you receive more than one questionnaire from different groups, only fill out one.
YOUR PARTICIPATION IN OVEREATERS ANONYMOUS (OA):

In this section you will be asked to answer some general questions about your participation in OA. Please circle the number next to the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. The question will tell you when you may circle more than one answer. Then, in the blanks next to each answer, indicate which was your first, second and third choice.

EXAMPLE:
What would you like to do now? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices in the blank next to the numbered answers.)

1  TAKE A NAP
2  TAKE A WALK
3  READ A BOOK
4  TALK TO A FRIEND
5  GO TO A MOVIE

Q-1  How long have you been involved with OA?
1  LESS THAN 6 MONTHS
2  6 MONTHS to 11 MONTHS
3  1 to 3 YEARS
4  4 to 8 YEARS
5  9 to 12 YEARS
6  LONGER THAN 12 YEARS

Q-2  How long have you been abstinent?
1  LESS THAN 6 MONTHS
2  6 MONTHS to 11 MONTHS
3  1 to 3 YEARS
4  4 to 8 YEARS
5  9 to 12 YEARS
6  LONGER THAN 12 YEARS

Please do not write below this line

0.1 .2 .3 .4 .5  1  2
Q-3 On the average, how often do you attend OA meetings?

1. DAILY
2. 3 TIMES OR MORE EACH WEEK
3. 2 TIMES EACH WEEK
4. ONCE A WEEK
5. EVERY 2 WEEKS
6. ONCE A MONTH
7. LESS THAN ONCE A MONTH

Q-4 What brought you to OA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I WAS HAVING PROBLEMS WITH COMPULSIVE OVEREATING
2. A FAMILY MEMBER OR FRIEND WAS HAVING PROBLEMS WITH COMPULSIVE OVEREATING
3. I WAS CURIOUS ABOUT OA, LIKED THE GROUP AND DECIDED TO STAY
4. A FAMILY MEMBER OR FRIEND ENCOURAGED ME TO COME TO OA
5. A MEDICAL OR MENTAL HEALTH PROFESSIONAL ENCOURAGED ME TO COME TO OA
6. I DID NOT HAVE THE MONEY TO GO ANYWHERE ELSE FOR HELP
7. ATTENDING OA MEETINGS WAS PART OF OTHER TREATMENT FOR COMPULSIVE OVEREATING
8. I COULD NOT GET THE HELP I NEEDED ANYWHERE ELSE

Q-5 In your opinion, what was the reason that OA grew into a successful fellowship?

1. SERVICES FOR COMPULSIVE OVEREATERS WERE UNAVAILABLE
2. MENTAL HEALTH AND MEDICAL SERVICE AGENCIES WERE NOT PROVIDING ADEQUATE SERVICE
3. ONLY PEOPLE WHO HAVE EXPERIENCED PROBLEMS WITH COMPULSIVE OVEREATING CAN HELP OTHER PEOPLE WITH COMPULSIVE OVEREATING
4. COMPULSIVE OVEREATERS NEEDED MORE HELP THAN THEY WERE GETTING AT THE TIME
5. COMPULSIVE OVEREATERS NEEDED THE OPPORTUNITY TO MEET OTHER PEOPLE WHO WERE EXPERIENCING PROBLEMS WITH COMPULSIVE OVEREATING

Please do not write below this line

3 4.1 2 .3 5
Q-6 Have you ever stopped attending OA meetings?

1. YES, I STOPPED ONCE
2. YES, I HAVE STOPPED AND STARTED AGAIN A COUPLE OF TIMES
3. YES, I HAVE STOPPED AND STARTED AGAIN SEVERAL TIMES
4. NO, I HAVE BEEN ATTENDING MEETINGS WITHOUT STOPPING EVER SINCE I STARTED

If you said NO, go to Q-9

If you said YES, go to Q-7

Q-7 In your opinion, why did you stop attending OA meetings?
(You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I DID NOT NEED ANYMORE HELP AT THAT TIME
2. I WAS NOT READY TO BE HELPED AT THAT TIME
3. I NEEDED A DIFFERENT KIND OF HELP AT THAT TIME
4. I WAS TURNED OFF BY OA AT THAT TIME
5. I HAD A SLIP AND DID NOT WANT TO GO BACK TO OA
6. I DID NOT HAVE ENOUGH TIME TO ATTEND MEETINGS
7. MY FAMILY AND/OR FRIENDS DID NOT WANT ME TO ATTEND OA MEETINGS
8. MEDICAL OR MENTAL HEALTH PROFESSIONALS DID NOT WANT ME TO ATTEND OA MEETINGS
9. OTHER (PLEASE LIST) ___________

Q-8 In your opinion, why did you start attending OA meetings again? (You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I NEEDED MORE HELP
2. I WAS READY TO BE HELPED
3. OTHER FORMS OF HELP HAD NOT WORKED FOR ME
4. FAMILY OR FRIENDS ENCOURAGED ME TO ATTEND
5. MEDICAL OR MENTAL HEALTH PROFESSIONALS ENCOURAGED ME TO ATTEND
6. OTHER (PLEASE LIST) ___________

Please do not write below this line

6 7.1.2 .3 8.1 .2 .3
Q-9 What do you see as the eventual "solution" to the problem of compulsive overeating? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. SOLUTION WILL BE FOUND WITHIN EACH PERSON
2. SOLUTION WILL BE FOUND WITHIN THE RESEARCH BEING DONE IN THE MEDICAL/HEALTH COMMUNITY
3. SOLUTION WILL BE FOUND BY MAKING CHANGES IN HOW SOCIETY TREATS COMPULSIVE OVEREATING
4. SOLUTION WILL BE FOUND BY MAKING LEGISLATIVE CHANGES
5. SOLUTION WILL BE FOUND BY EXTENDING OA TO INCLUDE ALL PERSONS HAVING PROBLEMS WITH COMPULSIVE OVEREATING
6. SOLUTION WILL BE FOUND WHEN MORE MEDICAL AND MENTAL HEALTH HELP IS AVAILABLE TO PEOPLE HAVING TROUBLE WITH COMPULSIVE OVEREATING
7. THERE IS NO FINAL SOLUTION BECAUSE COMPULSIVE OVEREATING WILL ALWAYS BE WITH US
8. OTHER (PLEASE LIST)

Q-10 What do you see as the "goals" of OA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. PERSONAL CHANGE - GETTING PEOPLE TO CHANGE THEIR BEHAVIOR
2. PERSONAL ACCEPTANCE - GETTING PEOPLE TO ACCEPT THEIR BEHAVIOR
3. SOCIETAL CHANGE - GETTING SOCIETY TO CHANGE ITS ATTITUDES AND BEHAVIOR TOWARD US
4. SOCIETAL ACCEPTANCE - GETTING SOCIETY TO ACCEPT OUR ATTITUDES AND BEHAVIOR
5. EXTENDING OUR SERVICES TO EVERYONE NEEDING HELP WITH COMPULSIVE OVEREATING
6. EXPANDING OUR SERVICES TO COVER A WIDE RANGE OF PROBLEMS AND NEEDS
7. LEGISLATIVE CHANGE
8. PROFESSIONAL CHANGE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO CHANGE THE SERVICES THAT THEY HAVE TRADITIONALLY OFFERED TO PEOPLE HAVING PROBLEMS WITH COMPULSIVE OVEREATING
9. PROFESSIONAL ACCEPTANCE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO ACCEPT OUR EXPERTISE TO HANDLE PROBLEMS RELATED TO COMPULSIVE OVEREATING
10. OTHER (PLEASE LIST)

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<td>10.1</td>
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REMEMBER: CIRCLE ONLY ONE ANSWER:

Q-11 Is personal experience as an compulsive overeater necessary for a person to help compulsive overeaters?
1 YES
2 NO
3 UNSURE

Q-12 In what ways does OA use the services of mental health or medical professionals? (You may check as many as 2 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 AS CONSULTANTS TO OA
2 AS GROUP CO-LEADERS
3 AS GUEST SPEAKERS
4 AS BOARD DIRECTORS
5 AS SERVICE PROVIDERS
6 OTHER (PLEASE LIST)
7 OA DOES NOT USE PROFESSIONAL SERVICES

Q-13 Have you used the services of a medical professional (such as, a doctor, nurse, family nurse practitioner, etc.) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-14 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Q-15 Have you used the services of a mental health professional (such as, a psychologist, psychiatrist, counselor, social worker) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-16 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Please do not write below this line
REMEMBER: CIRCLE ONLY ONE ANSWER

YOUR OPINIONS:

In this section you will be given some statements and asked to indicate whether you agree or disagree with the statement. You will have 6 options to choose from:

SA = STRONGLY AGREE
A = AGREE
I = INDIFFERENT
D = DISAGREE
SD = STRONGLY DISAGREE
NO = NO OPINION

Read each statement. Circle the one option that most closely represents your opinion.

Q-17
There is no one right way to deal with compulsive overeating. SA  A  I  D  SD  NO

Q-18
Compulsive overeaters should do whatever works for them in dealing with their compulsive overeating. SA  A  I  D  SD  NO

Q-19
Aspects or parts of my compulsive overeating problem have been handled best by medical professionals. SA  A  I  D  SD  NO

Q-20
It is important to involve the whole family when working with compulsive overeating. SA  A  I  D  SD  NO

Q-21
Only people who have experienced compulsive overeating could help me and others like me. SA  A  I  D  SD  NO

Please do not write below this line

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REMEMBER: CIRCLE ONLY ONE ANSWER

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<tr>
<th>Question</th>
<th>Statement</th>
<th>SA</th>
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<th>I</th>
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<tr>
<td>Q-22</td>
<td>Medical professionals have been helpful to me in dealing with my compulsive overeating.</td>
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<td>Q-23</td>
<td>OA has provided a new way of life for me.</td>
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<td>Q-24</td>
<td>People in general know a great deal about compulsive overeating.</td>
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<td>Q-25</td>
<td>Compulsive overeaters may leave OA but almost always come back later.</td>
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<td>Q-26</td>
<td>OA does not work for some people.</td>
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<td>Q-27</td>
<td>Some people attend OA meetings just to find friends, not to work on their compulsive overeating.</td>
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<td>Q-28</td>
<td>Mental health professionals have been helpful to me in dealing with my compulsive overeating.</td>
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<td>Q-29</td>
<td>Society does not accept recovering compulsive overeaters.</td>
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<td>Q-30</td>
<td>People with compulsive overeating problems like mine need to get help from a wide variety of people and places.</td>
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<td>Q-31</td>
<td>I have been able to help someone else cope with their compulsive overeating through my work with OA.</td>
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| 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
Q-32 Most people in OA have not been satisfied with the help they may have received from mental health professionals. SA A I D SD NO

Q-33 OA is the only group which provides help for compulsive overeaters. SA A I D SD NO

Q-34 Aspects or parts of my compulsive overeating problem have been handled best by mental health professionals. SA A I D SD NO

Q-35 Compulsive overeaters who leave OA after a few meetings are not ready to deal with their compulsive overeating. SA A I D SD NO

Q-36 Recovering overeaters probably come down harder on themselves than do other people. SA A I D SD NO

Q-37 There are problems that I have had that OA was not able to handle. SA A I D SD NO

Q-38 I only attend meetings to see old friends now, because I no longer really need help. SA A I D SD NO

Q-39 People with compulsive overeating are able to find the help they need from local mental health agencies. SA A I D SD NO

Q-40 People in general are becoming more understanding and accepting of recovering compulsive overeaters. SA A I D SD NO

Please do not write below this line
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-41
Only an compulsive overeater can understand compulsive overeating.  
SA  A  I  D  SD  NO

Q-42
I get a lot of support from friends and family outside of OA for working on my compulsive overeating.  
SA  A  I  D  SD  NO

Q-43
OA should be expanded to include help and information from medical and mental health professionals.  
SA  A  I  D  SD  NO

Q-44
Most people in OA have been satisfied with the help they may have received from medical professionals.  
SA  A  I  D  SD  NO

Q-45
Helping other compulsive overeaters in OA is an important part of making OA work.  
SA  A  I  D  SD  NO

Q-46
I could use more help than the help I am currently receiving from OA.  
SA  A  I  D  SD  NO

Q-47
OA should be expanded to include people experiencing other kinds of problems.  
SA  A  I  D  SD  NO

Q-48
Medical professionals tend to deal with compulsive overeating by prescribing another drug.  
SA  A  I  D  SD  NO

Q-49
Medical and mental health professionals refer compulsive overeaters to OA meetings for help.  
SA  A  I  D  SD  NO

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
REMEMBER: CIRCLE ONLY ONE ANSWER

ABOUT YOU:

In order to understand your answers better, we would like to have the following general information about you. Remember, all information about you is strictly confidential and will be kept secret.

Q-50 In what year were you born? ____________________________

Q-51 What is your ethnic group?
1. ANGLO, NON-HISPANIC
2. MEXICAN-AMERICAN, HISPANIC
3. BLACK
4. AMERICAN INDIAN (TRIBE: ________________________)
5. ASIAN, CHINESE, JAPANESE
6. OTHER (PLEASE LIST) ____________________________

Q-52 What is your marital status?
1. SINGLE (NEVER HAVE BEEN MARRIED)
2. MARRIED
3. WIDOWED
4. SEPARATED
5. DIVORCED

Q-53 What is your sex?
1. MALE
2. FEMALE

Q-54 What is the last grade of school you completed?
1. 1 to 6 GRADE
2. 7 to 11 GRADE
3. 12 GRADE - HIGH SCHOOL GRADUATE
4. SOME COLLEGE - JUNIOR COLLEGE
5. COLLEGE GRADUATE
6. POST GRADUATE COLLEGE

Q-55 What is (or was) your job? (Retired or unemployed people, please list your last job.) ____________________________

Please do not write below this line

50 51 52 53 54 55
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-56 Are you currently working?
1 YES, FULL-TIME (30 HOURS OR MORE)
2 YES, PART-TIME (29 HOURS OR LESS)
3 NO, OUT OF WORK
4 NO, RETIRED
5 STUDENT
6 HOUSEWIFE/HOUSEHUSBAND

Q-57 What is your family's yearly income? (Add together all money earned by people in your household.)
1 LESS THAN $5,000
2 $5,000 to $9,999
3 $10,000 to $19,999
4 $20,000 to $29,999
5 $30,000 to $39,999
6 MORE THAN $40,000
7 I DON'T KNOW

Q-58 How many years have you lived in Arizona?
1 LESS THAN 2 YEARS
2 2 to 5 YEARS
3 6 to 9 YEARS
4 10 to 19 YEARS
5 20 to 29 YEARS
6 30 to 39 YEARS
7 40 to 49 YEARS
8 50 YEARS OR MORE

Q-59 How many people (children and adults) currently live in your household? (Be sure to count yourself!) ________________

Q-60 How do you feel about taking part in this survey?
1 GOOD
2 DON'T MIND
3 OTHER (PLEASE LIST) ________________________

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐
I have asked about many subjects important to understanding OA and self-help in general. I am further interested in what thoughts you might have about OA and the role that self-help/mutual help has played in your life. Your ideas are important to understanding how OA works for you. Please write any ideas, suggestions or questions that you might want to share in the space below.

Thank you for making this survey possible.

Clarissa Coell Marques
Psychology Department - University of Arizona
626-3914
Tucson, Arizona
Dear Alcoholics Anonymous Group Member,

I am conducting a study to answer the question: How do members of self-help groups view health care professionals and their experiences with health care professionals? I would like to help bridge the understanding gap between self-help groups and the professional community. Members from several self-help groups, including Alcoholics Anonymous, Overeaters Anonymous, Narcotics Anonymous and Parents Anonymous, will be completing this questionnaire. This questionnaire takes about 15 to 30 minutes to complete and asks questions about you, your group, your attitudes toward health care professionals and your experiences with health care professionals. All the information is strictly confidential. The results of the study will be available to your Alcoholics Anonymous organization for information and planning.

In order to conduct this research and complete my doctoral dissertation, I need your help. This questionnaire is completely voluntary, but I would certainly appreciate your help and your opinions. Even if you have had some difficulties with the professional community, your opinions are very important to helping bridge the understanding gap.

The instructions for completing the questionnaire are on the following page. Please return it as soon as possible in the enclosed self-addressed stamped envelope when you are finished. The deadline for sending in the questionnaire is December 31, 1982, so please return it as soon as you are done. I want to thank you for your time and attention and thank you in advance for what I hope will be your invaluable help.

Sincerely yours,

Clarissa Colell Marques
Psychology Department
University of Arizona
Tucson, Arizona 85721
(602) 626-3914

November 30, 1982
SELF-HELP through MUTUAL-HELP
SELF-AWARENESS through MUTUAL-AWARENESS

PURPOSE OF QUESTIONNAIRE

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WHAT TO DO IF YOU HAVE QUESTIONS

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Please fill out only one questionnaire. If you receive more than one questionnaire from different groups, only fill out one.
YOUR PARTICIPATION IN ALCOHOLICS ANONYMOUS (AA):

In this section you will be asked to answer some general questions about your participation in AA. Please circle the number next to the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. The question will tell you when you may circle more than one answer. Then, in the blanks next to each answer, indicate which was your first, second and third choice.

EXAMPLE:

What would you like to eat now? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. BROWNIE
2. CARROT
3. HOT FUDGE SUNDAE
4. POPCORN
5. CELERY

Q-1 How long have you been involved with AA?

1. LESS THAN 6 MONTHS
2. 6 MONTHS to 11 MONTHS
3. 1 to 3 YEARS
4. 4 to 8 YEARS
5. 9 to 12 YEARS
6. LONGER THAN 12 YEARS

Q-2 How long have you been sober?

1. LESS THAN 6 MONTHS
2. 6 MONTHS to 11 MONTHS
3. 1 to 3 YEARS
4. 4 to 8 YEARS
5. 9 to 12 YEARS
6. LONGER THAN 12 YEARS

Please do not write below this line
Q-3 On the average, how often do you attend these meetings?

1. DAILY
2. 3 TIMES OR MORE EACH WEEK
3. 2 TIMES EACH WEEK
4. ONCE A WEEK
5. EVERY 2 WEEKS
6. ONCE A MONTH
7. LESS THAN ONCE A MONTH

Q-4 What brought you to AA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I WAS HAVING PROBLEMS WITH ALCOHOLISM
2. A FAMILY MEMBER OR FRIEND WAS HAVING PROBLEMS WITH ALCOHOLISM
3. I WAS CURIOS ABOUT AA, LIKED THE GROUP AND DECIDED TO STAY
4. A FAMILY MEMBER OR FRIEND ENCOURAGED ME TO COME TO AA
5. A MEDICAL OR MENTAL HEALTH PROFESSIONAL ENCOURAGED ME TO COME TO AA
6. I DID NOT HAVE THE MONEY TO GO ANYWHERE ELSE FOR HELP
7. ATTENDING AA MEETINGS WAS PART OF OTHER TREATMENT FOR ALCOHOLISM
8. I COULD NOT GET THE HELP I NEEDED ANYWHERE ELSE

Q-5 In your opinion, what was the reason that AA was started?

1. SERVICES WERE UNAVAILABLE
2. MENTAL HEALTH AND MEDICAL SERVICE AGENCIES WERE NOT PROVIDING ADEQUATE SERVICE
3. ONLY PEOPLE WHO HAVE EXPERIENCED PROBLEMS WITH ALCOHOLISM CAN HELP OTHER PEOPLE WITH ALCOHOLISM
4. ALCOHOLICS NEEDED MORE HELP THAN THEY WERE GETTING AT THE TIME
5. ALCOHOLICS NEEDED THE OPPORTUNITY TO MEET OTHER PEOPLE WHO WERE EXPERIENCING PROBLEMS WITH ALCOHOLISM
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-6 Have you ever stopped attending AA meetings?

1. YES, I STOPPED ONCE
2. YES, I HAVE STOPPED AND STARTED AGAIN A COUPLE OF TIMES
3. YES, I HAVE STOPPED AND STARTED AGAIN SEVERAL TIMES
4. NO, I HAVE BEEN ATTENDING MEETINGS EVER SINCE I STARTED

If you said NO, go to Q-9
If you said YES, go to Q-7

Q-7 In your opinion, why did you stop attending AA meetings?
(You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I DID NOT NEED ANYMORE HELP AT THAT TIME
2. I WAS NOT READY TO BE HELPED AT THAT TIME
3. I NEEDED A DIFFERENT KIND OF HELP AT THAT TIME
4. I WAS TURNED OFF BY AA AT THAT TIME
5. I HAD A SLIP AND DID NOT WANT TO GO BACK TO AA
6. I DID NOT HAVE ENOUGH TIME TO ATTEND MEETINGS
7. MY FAMILY AND/OR FRIENDS DID NOT WANT ME TO ATTEND AA MEETINGS
8. MEDICAL OR MENTAL health professionals DID NOT WANT me TO ATTEND AA MEETINGS
9. OTHER (PLEASE LIST) ____________________________

Q-8 In your opinion, why did you start attending AA meetings again? (You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I NEEDED MORE HELP
2. I WAS READY TO BE HELPED
3. OTHER FORMS OF HELP HAD NOT WORKED FOR ME
4. FAMILY OR FRIENDS ENCOURAGED ME TO ATTEND
5. MEDICAL OR MENTAL health professionals ENCOURAGED ME TO ATTEND
6. OTHER (PLEASE LIST) ____________________________

Please do not write below this line

6 7.1 .2 .3 9.1 .2 .3
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-9 What do you see as the "final solution" to the problem of alcoholism? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 SOLUTION WILL BE FOUND WITHIN EACH PERSON
2 SOLUTION WILL BE FOUND WITHIN THE RESEARCH BEING DONE IN THE MEDICAL/HEALTH COMMUNITY
3 SOLUTION WILL BE FOUND BY MAKING CHANGES IN HOW SOCIETY TREATS ALCOHOLISM
4 SOLUTION WILL BE FOUND BY MAKING LEGISLATIVE CHANGES
5 SOLUTION WILL BE FOUND BY EXTENDING AA TO INCLUDE ALL PERSONS HAVING PROBLEMS WITH ALCOHOLISM
6 SOLUTION WILL BE FOUND WHEN MORE MEDICAL AND MENTAL HEALTH HELP IS AVAILABLE TO PEOPLE HAVING TROUBLE WITH ALCOHOL
7 THERE IS NO FINAL SOLUTION BECAUSE ALCOHOLISM WILL ALWAYS BE WITH US
8 OTHER (PLEASE LIST) __________________________

Q-10 What do you see as the "goals" of AA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 PERSONAL CHANGE - GETTING PEOPLE TO CHANGE THEIR BEHAVIOR
2 PERSONAL ACCEPTANCE - GETTING PEOPLE TO ACCEPT THEIR BEHAVIOR
3 SOCIETAL CHANGE - GETTING SOCIETY TO CHANGE ITS ATTITUDES AND BEHAVIOR TOWARD US
4 SOCIETAL ACCEPTANCE - GETTING SOCIETY TO ACCEPT OUR ATTITUDES AND BEHAVIOR
5 EXTENDING OUR SERVICES TO EVERYONE NEEDING HELP WITH ALCOHOLISM
6 EXPANDING OUR SERVICES TO COVER A WIDE RANGE OF PROBLEMS AND NEEDS
7 LEGISLATIVE CHANGE
8 PROFESSIONAL CHANGE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO CHANGE THE SERVICES THAT THEY HAVE TRADITIONALLY OFFERED TO PEOPLE HAVING PROBLEMS WITH ALCOHOLISM
9 PROFESSIONAL ACCEPTANCE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO ACCEPT OUR EXPERTISE TO HANDLE PROBLEMS RELATED TO ALCOHOLISM
10 OTHER (PLEASE LIST) __________________________
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-11 Is personal experience with alcoholism necessary for a person to help alcoholics?
1 YES
2 NO
3 UNSURE

Q-12 In what ways does AA use the services of mental health or medical professionals? (You may check as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)
1 AS CONSULTANTS TO AA
2 AS GROUP CO-LEADERS
3 AS GUEST SPEAKERS
4 AS BOARD DIRECTORS
5 AS SERVICE PROVIDERS
6 OTHER (PLEASE LIST)
7 AA DOES NOT USE PROFESSIONAL SERVICES

Q-13 Have you used the services of a medical professional (such as, a doctor, nurse, family nurse practitioner, etc.) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-14 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Q-15 Have you used the services of a mental health professional (such as a psychologist, psychiatrist, counselor, social worker) in the past year?
1 YES
2 NO
3 DON'T KNOW

Q-16 ... in the past 5 years?
1 YES
2 NO
3 DON'T KNOW

Please do not write below this line

11 12.1 .2 .3 13 14 15 16
REMEMBER: CIRCLE ONLY ONE ANSWER

YOUR OPINIONS:

In this section you will be given some statements and asked to indicate whether you agree or disagree with the statement. You will have 6 options to choose from:

SA = STRONGLY AGREE
A = AGREE
I = INDIFFERENT
D = DISAGREE
SD = STRONGLY DISAGREE
NO = NO OPINION

Read each statement. Circle the one option that most closely represents your opinion.

Q-17
There is no one right way to deal with alcoholism.

Q-18
Alcoholics should do whatever works for them in dealing with their alcoholism.

Q-19
Aspects or parts of my alcoholism problem have been handled best by medical professionals.

Q-20
It is important to involve the whole family when working with alcoholism.

Q-21
Only people who have experienced alcoholism could help me and others like me.

Please do not write below this line

17 18 19 20 21
Q-22 Medical professionals have been helpful to me in dealing with my alcoholism. 
Q-23 AA has provided a new way of life for me. 
Q-24 People in general know a great deal about alcoholism. 
Q-25 Alcoholics may leave AA but almost always come back later. 
Q-26 AA does not work for some people. 
Q-27 Some people attend AA meetings just to find friends, not to work on their alcoholism. 
Q-28 Mental health professionals have been helpful to me in dealing with my alcoholism. 
Q-29 Society does not accept recovering alcoholics. 
Q-30 People with alcoholism problems like mine need to get help from a wide variety of people and places. 
Q-31 I have been able to help someone else cope with their alcoholism through my work with AA.

Please do not write below this line
Q-32  Most people in AA have not been satisfied with the help they may have received from mental health professionals.

Q-33  AA is the only group which provides help for alcoholics.

Q-34  Aspects or parts of my alcoholism problem have been handled best by mental health professionals.

Q-35  Alcoholics who leave AA after a few meetings are not ready to deal with their alcoholism.

Q-36  Recovering alcoholics probably come down harder on themselves than do other people.

Q-37  There are problems that I have had that AA was not able to handle.

Q-38  I only attend meetings to see old friends now, because I no longer really need help.

Q-39  People with alcoholism are able to find the help they need from local mental health agencies.

Q-40  People in general are becoming more understanding and accepting of recovering alcoholics.

Please do not write below this line

☐  ☐  ☐  ☐  ☐  ☐  ☐  ☐  ☐  ☐
<table>
<thead>
<tr>
<th>Q</th>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>I</th>
<th>D</th>
<th>SD</th>
<th>NO</th>
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<tr>
<td>41</td>
<td>Only an alcoholic can understand alcoholism.</td>
<td>SA</td>
<td>A</td>
<td>I</td>
<td>D</td>
<td>SD</td>
<td>NO</td>
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<td>42</td>
<td>I get a lot of support from friends and family outside of AA for working on my alcoholism.</td>
<td>SA</td>
<td>A</td>
<td>I</td>
<td>D</td>
<td>SD</td>
<td>NO</td>
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<td>43</td>
<td>AA should be expanded to include help and information from medical and mental health professionals.</td>
<td>SA</td>
<td>A</td>
<td>I</td>
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<td>SD</td>
<td>NO</td>
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<td>Most people in AA have been satisfied with the help they may have received from medical professionals.</td>
<td>SA</td>
<td>A</td>
<td>I</td>
<td>D</td>
<td>SD</td>
<td>NO</td>
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<td>45</td>
<td>Helping other alcoholics in AA is an important part of making AA work.</td>
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<td>A</td>
<td>I</td>
<td>D</td>
<td>SD</td>
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<td>I</td>
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<td>Medical and mental health professionals refer alcoholics to AA meetings for help.</td>
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</table>
REMEMBER: CIRCLE ONLY ONE ANSWER

ABOUT YOU:

In order to understand your answers better, we would like to have the following general information about you. Remember, all information about you is strictly confidential and will be kept secret.

Q-50 In what year were you born? _______________________

Q-51 What is your ethnic group?

1 ANGLO, NON-HISPANIC
2 MEXICAN-AMERICAN, HISPANIC
3 BLACK
4 AMERICAN INDIAN (TRIBE: _______________________
5 ASIAN, CHINESE, JAPANESE
6 OTHER (PLEASE LIST) _______________________

Q-52 What is your marital status?

1 SINGLE (NEVER HAVE BEEN MARRIED)
2 MARRIED
3 WIDOWED
4 SEPARATED
5 DIVORCED

Q-53 What is your sex?

1 MALE
2 FEMALE

Q-54 What is the last grade of school you completed?

1 1 to 6 GRADE
2 7 to 11 GRADE
3 12 GRADE - HIGH SCHOOL GRADUATE
4 SOME COLLEGE - JUNIOR COLLEGE
5 COLLEGE GRADUATE
6 POST GRADUATE COLLEGE

Q-55 What is (or was) your job? (Retired or unemployed people, please list your last job.) _______________________

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐ ☐

50 51 52 53 54 55
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-56 Are you currently working?
1 YES, FULL-TIME (30 HOURS OR MORE)
2 YES, PART-TIME (29 HOURS OR LESS)
3 NO, OUT OF WORK
4 NO, RETIRED
5 STUDENT
6 HOUSEWIFE/HOUSEHUSBAND

Q-57 What is your family's yearly income? (Add together all money earned by people in your household.)
1 LESS THAN $5,000
2 $5,000 to $9,999
3 $10,000 to $19,999
4 $20,000 to $29,999
5 $30,000 to $39,999
6 MORE THAN $40,000
7 I DON'T KNOW

Q-58 How many years have you lived in Tucson?
1 LESS THAN 2 YEARS
2 2 to 5 YEARS
3 6 to 9 YEARS
4 10 to 19 YEARS
5 20 to 29 YEARS
6 30 to 39 YEARS
7 40 to 49 YEARS
8 50 YEARS OR MORE

Q-59 How many people (children and adults) currently live in your household? (Be sure to count yourself!)

Q-60 How do you feel about taking part in this survey?
1 GOOD
2 DON'T MIND
3 OTHER (PLEASE LIST)

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐ ☐
I have asked about many subjects important to understanding AA and self-help in general. I am further interested in what thoughts you might have about AA and the role that self-help/mutual help has played in your life. Your ideas are important to understanding how AA works for you. Please write any ideas, suggestions or questions that you might want to share in the space below.

Thank you for making this survey possible.
Dear Narcotics Anonymous Group Member,

I am conducting a study to answer the question: How do members of self-help groups view health care professionals and their experiences with health care professionals? I would like to help bridge the understanding gap between self-help groups and the professional community. Members from several self-help groups, including Narcotics Anonymous, Overeaters Anonymous, Alcoholics Anonymous and Parents Anonymous, will be completing this questionnaire. This questionnaire takes about 15 to 30 minutes to complete and asks questions about you, your group, your attitudes toward health care professionals and your experiences with health care professionals. All the information is strictly confidential. The results of the study will be provided to your Narcotics Anonymous organization for your information and planning.

In order to conduct this research and complete my doctoral dissertation, I need your help. This questionnaire is completely voluntary, but I would certainly appreciate your help and your opinions. Even if you have had some difficulties with the professional community, your opinions are very important to helping bridge the understanding gap.

The instructions for completing the questionnaire are on the following page. Please return it as soon as possible in the enclosed self-addressed stamped envelope when you are finished. The deadline for sending in the questionnaire is January 7, 1982, so please return it as soon as you are done. I want to thank you for your time and attention and thank you in advance for what I hope will be your invaluable help.

Sincerely yours,

Clarissa Coelio Marques
Psychology Department
University of Arizona
Tucson, Arizona 85721
(602) 621-3916

December 6, 1982
SELF-HELP through MUTUAL-HELP

SELF-AWARENESS through MUTUAL-AWARENESS

PURPOSE OF QUESTIONNAIRE

The following questions deal with issues related to self-help in general and Narcotics Anonymous in particular. Several other self-help groups will be completing the same questionnaire, only oriented toward their group. The results of this survey will help bridge the understanding gap between self-help groups and the professional community. It is important that each questionnaire be completely filled out and returned as soon as possible. Even if you feel that the gap between self-help groups and the professional community should not be bridged, your opinion is important. Please send the questionnaire back in the enclosed envelope as soon as possible.

YOUR PRIVACY IS GUARANTEED

You may be assured of complete confidentiality. None of the personal information you give us on this questionnaire will be given to any other person or agency. There is no way for you to be identified.

WHAT TO DO IF YOU HAVE QUESTIONS

If you have any questions, please call Clarissa Marques at 626-3914. The results of the survey will be available soon. If you are interested, please do not hesitate to call. Your interest is appreciated.

HOW TO FILL OUT THE QUESTIONNAIRE

Please circle the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. They will tell you when to circle more than one answer. If you circle more than one answer, please indicate in the blanks next to each answer which answer was your first, second and third choice.

Please fill out only one questionnaire. If you receive more than one questionnaire from different groups, only fill out one.
YOUR PARTICIPATION IN NARCOTICS ANONYMOUS (NA):

In this section you will be asked to answer some general questions about your participation in NA. Please circle the number next to the one answer that is closest to your opinion. A few questions allow you to circle more than one answer. The question will tell you when you may circle more than one answer. Then, in the blanks next to each answer, indicate which was your first, second and third choice.

EXAMPLE:

What would you like to eat now? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices in the blank next to the numbered answers.)

1. BROWNIE
2. CARROT
3. HOT FUDGE SUNDAE
4. POPCORN
5. CELERY

Q-1 How long have you been involved with NA?

1. LESS THAN 6 MONTHS
2. 6 MONTHS to 11 MONTHS
3. 1 to 3 YEARS
4. 4 to 8 YEARS
5. 9 to 12 YEARS
6. LONGER THAN 12 YEARS

Q-2 How long have you been clean and sober?

1. LESS THAN 6 MONTHS
2. 6 MONTHS to 11 MONTHS
3. 1 to 3 YEARS
4. 4 to 8 YEARS
5. 9 to 12 YEARS
6. LONGER THAN 12 YEARS
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-3 On the average, how often do you attend NA meetings?

1 DAILY
2 3 TIMES OR MORE EACH WEEK
3 2 TIMES EACH WEEK
4 ONCE A WEEK
5 EVERY 2 WEEKS
6 ONCE A MONTH
7 LESS THAN ONCE A MONTH

Q-4 What brought you to NA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 I WAS HAVING PROBLEMS WITH DRUGS
2 A FAMILY MEMBER OR FRIEND WAS HAVING PROBLEMS WITH DRUGS
3 I WAS CURIOUS ABOUT NA, LIKED THE GROUP AND DECIDED TO STAY
4 A FAMILY MEMBER OR FRIEND ENCOURAGED ME TO COME TO NA
5 A MEDICAL OR MENTAL HEALTH PROFESSIONAL ENCOURAGED ME TO COME TO NA
6 I DID NOT HAVE THE MONEY TO GO ANYWHERE ELSE FOR HELP
7 ATTENDING NA MEETINGS WAS PART OF OTHER TREATMENT FOR ADDICTION
8 I COULD NOT GET THE HELP I NEEDED ANYWHERE ELSE

Q-5 In your opinion, what was the reason that NA grew into a successful fellowship?

1 SERVICES FOR ADDICTS WERE UNAVAILABLE
2 MENTAL HEALTH AND MEDICAL SERVICE AGENCIES WERE NOT PROVIDING ADEQUATE SERVICE
3 ONLY PEOPLE WHO HAVE EXPERIENCED PROBLEMS WITH ADDICTION CAN HELP OTHER PEOPLE WITH ADDICTION PROBLEMS
4 ADDICTS NEEDED MORE HELP THAN THEY WERE GETTING AT THE TIME
5 ADDICTS NEEDED THE OPPORTUNITY TO MEET OTHER PEOPLE WHO WERE EXPERIENCING PROBLEMS WITH ADDICTION

Please do not write below this line

[ ] [ ] [ ] [ ]
REMEMBER: CIRCLE ONLY ONE ANSWER

Q-6 Have you ever stopped attending NA meetings?

1. YES, I STOPPED ONCE
2. YES, I HAVE STOPPED AND STARTED AGAIN A COUPLE OF TIMES
3. YES, I HAVE STOPPED AND STARTED AGAIN SEVERAL TIMES
4. NO, I HAVE BEEN ATTENDING MEETINGS WITHOUT STOPPING EVER SINCE I STARTED

If you said NO, go to Q-9
If you said YES, go to Q-7

Q-7 In your opinion, why did you stop attending NA meetings?
(You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I DID NOT NEED ANYMORE HELP AT THAT TIME
2. I WAS NOT READY TO BE HELPED AT THAT TIME
3. I NEEDED A DIFFERENT KIND OF HELP AT THAT TIME
4. I WAS TURNED OFF BY NA AT THAT TIME
5. I HAD A SLIP AND DID NOT WANT TO GO BACK TO NA
6. I DID NOT HAVE ENOUGH TIME TO ATTEND MEETINGS
7. MY FAMILY AND/OR FRIENDS DID NOT WANT ME TO ATTEND NA MEETINGS
8. MEDICAL OR MENTAL HEALTH PROFESSIONALS DID NOT WANT ME TO ATTEND NA MEETINGS
9. OTHER (PLEASE LIST) ____________________________

Q-8 In your opinion, why did you start attending NA meetings again? (You may choose as many as 3 answers for this question. Remember to indicate your 1st, 2nd and 3rd choices.)

1. I NEEDED MORE HELP
2. I WAS READY TO BE HELPED
3. OTHER FORMS OF HELP HAD NOT WORKED FOR ME
4. FAMILY OR FRIENDS ENCOURAGED ME TO ATTEND
5. MEDICAL OR MENTAL HEALTH PROFESSIONALS ENCOURAGED ME TO ATTEND
6. OTHER (PLEASE LIST) ____________________________

Please do not write below this line

6  7.1  .2  .3  8.1  .2  .3
Q-9 What do you see as the eventual "solution" to the problem of addiction? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. SOLUTION WILL BE FOUND WITHIN EACH PERSON
2. SOLUTION WILL BE FOUND WITHIN THE RESEARCH BEING DONE IN THE MEDICAL/HEALTH COMMUNITY
3. SOLUTION WILL BE FOUND BY MAKING CHANGES IN HOW SOCIETY TREATS ADDICTION
4. SOLUTION WILL BE FOUND BY MAKING LEGISLATIVE CHANGES
5. SOLUTION WILL BE FOUND BY EXTENDING NA TO INCLUDE ALL PERSONS HAVING PROBLEMS WITH ADDICTION
6. SOLUTION WILL BE FOUND WHEN MORE MEDICAL AND MENTAL HEALTH HELP IS AVAILABLE TO PEOPLE HAVING TROUBLE WITH DRUGS
7. THERE IS NO FINAL SOLUTION BECAUSE ADDICTION WILL ALWAYS BE WITH US
8. OTHER (PLEASE LIST)

Q-10 What do you see as the "goals" of NA? (You may choose as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1. PERSONAL CHANGE - GETTING PEOPLE TO CHANGE THEIR BEHAVIOR
2. PERSONAL ACCEPTANCE - GETTING PEOPLE TO ACCEPT THEIR BEHAVIOR
3. SOCIETAL CHANGE - GETTING SOCIETY TO CHANGE ITS ATTITUDES AND BEHAVIOR TOWARD US
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8. PROFESSIONAL CHANGE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO CHANGE THE SERVICES THAT THEY HAVE TRADITIONALLY OFFERED TO PEOPLE HAVING PROBLEMS WITH ADDICTION
9. PROFESSIONAL ACCEPTANCE - GETTING MEDICAL OR MENTAL HEALTH PROFESSIONALS TO ACCEPT OUR EXPERTISE TO HANDLE PROBLEMS RELATED TO ADDICTION
10. OTHER (PLEASE LIST)

Please do not write below this line

9.1 .2 .3 10.1 .2 .3
Q-11 Is personal experience as an addict necessary for a person to help other addicts?

1 YES
2 NO
3 UNSURE

Q-12 In what ways does NA use the services of mental health or medical professionals? (You may check as many as 3 answers. Remember to indicate your 1st, 2nd and 3rd choices.)

1 AS CONSULTANTS TO NA
2 AS GROUP CO-LEADERS
3 AS GUEST SPEAKERS
4 AS BOARD DIRECTORS
5 AS SERVICE PROVIDERS
6 OTHER (PLEASE LIST)

7 NA DOES NOT USE PROFESSIONAL SERVICES

Q-13 Have you used the services of a medical professional (such as, a doctor, nurse, family nurse practitioner, etc.) in the past year?

1 YES
2 NO
3 DON'T KNOW

Q-14 ... in the past 5 years?

1 YES
2 NO
3 DON'T KNOW

Q-15 Have you used the services of a mental health professional (such as a psychologist, psychiatrist, counselor, social worker) in the past year?

1 YES
2 NO
3 DON'T KNOW

Q-16 ... in the past 5 years?

1 YES
2 NO
3 DON'T KNOW

Please do not write below this line

11 12.1 .2 .3 13 14 15 16
REMEMBER: CIRCLE ONLY ONE ANSWER

YOUR OPINIONS:

In this section you will be given some statements and asked to indicate whether you agree or disagree with the statement. You will have 6 options to choose from:

SA = STRONGLY AGREE
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Read each statement. Circle the one option that most closely represents your opinion.

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Please do not write below this line
Q-22
Medical professionals have been helpful to me in dealing with my addiction.

Q-23
NA has provided a new way of life for me.

Q-24
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Q-25
Addicts may leave NA but almost always come back later.

Q-26
NA does not work for some people.

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Society does not accept recovering addicts.

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I have been able to help someone else cope with their addiction through my work with NA.

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Q-40 People in general are becoming more understanding and accepting of recovering addicts. SA A I D SD NO
Q-41
Only an addict can understand addiction.  
SA  A  I  D  SD  NO

Q-42
I get a lot of support from friends and family outside of NA for working on my addiction problem.  
SA  A  I  D  SD  NO

Q-43
NA should be expanded to include help and information from medical and mental health professionals.  
SA  A  I  D  SD  NO

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Most people in NA have been satisfied with the help they may have received from medical professionals.  
SA  A  I  D  SD  NO

Q-45
Helping other addicts in NA is an important part of making NA work.  
SA  A  I  D  SD  NO

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I could use more help than the help I am currently receiving from NA.  
SA  A  I  D  SD  NO

Q-47
NA should be expanded to include people experiencing other kinds of problems.  
SA  A  I  D  SD  NO

Q-48
Medical professionals tend to deal with addiction by prescribing another drug.  
SA  A  I  D  SD  NO

Q-49
Medical and mental health professionals refer addicts to NA meetings for help.  
SA  A  I  D  SD  NO

Please do not write below this line
REMEMBER: CIRCLE ONLY ONE ANSWER

ABOUT YOU:

In order to understand your answers better, we would like to have the following general information about you. Remember, all information about you is strictly confidential and will be kept secret.

Q-50 In what year were you born? __________________________

Q-51 What is your ethnic group?

1 ANGLO, NON-HISPANIC
2 MEXICAN-AMERICAN, HISPANIC
3 BLACK
4 AMERICAN INDIAN (TRIBE: __________________________)
5 ASIAN, CHINESE, JAPANESE
6 OTHER (PLEASE LIST) __________________________

Q-52 What is your marital status?

1 SINGLE (NEVER HAVE BEEN MARRIED)
2 MARRIED
3 WIDOWED
4 SEPARATED
5 DIVORCED

Q-53 What is your sex?

1 MALE
2 FEMALE

Q-54 What is the last grade of school you completed?

1 1 to 6 GRADE
2 7 to 11 GRADE
3 12 GRADE - HIGH SCHOOL GRADUATE
4 SOME COLLEGE - JUNIOR COLLEGE
5 COLLEGE GRADUATE
6 POST GRADUATE COLLEGE

Q-55 What is (or was) your job? (Retired or unemployed people, please list your last job.) __________________________

Please do not write below this line
Q-56 Are you currently working?
1 YES, FULL-TIME (30 HOURS OR MORE)
2 YES, PART-TIME (29 HOURS OR LESS)
3 NO, OUT OF WORK
4 NO, RETIRED
5 STUDENT
6 HOUSEWIFE/HOUSEHUSBAND

Q-57 What is your family's yearly income? (Add together all money earned by people in your household.)
1 LESS THAN $5,000
2 $5,000 to $9,999
3 $10,000 to $19,999
4 $20,000 to $29,999
5 $30,000 to $39,999
6 MORE THAN $40,000
7 I DON'T KNOW

Q-58 How many years have you lived in Arizona?
1 LESS THAN 2 YEARS
2 2 to 5 YEARS
3 6 to 9 YEARS
4 10 to 19 YEARS
5 20 to 29 YEARS
6 30 to 39 YEARS
7 40 to 49 YEARS
8 50 YEARS OR MORE

Q-59 How many people (children and adults) currently live in your household? (Be sure to count yourself!)

Q-60 How do you feel about taking part in this survey?
1 GOOD
2 DON'T MIND
3 OTHER (PLEASE LIST)

Please do not write below this line

☐ ☐ ☐ ☐ ☐ ☐ ☐
I have asked about many subjects important to understanding NA and self-help in general. I am further interested in what thoughts you might have about NA and the role that self-help/mutual help has played in your life. Your ideas are important to understanding how NA works for you. Please write any ideas, suggestions or questions that you might want to share in the space below.

Thank you for making this survey possible.

Clarissa Colell Marques
Psychology Department - University of Arizona
626-3914
Tucson, Arizona
APPENDIX B: OCCUPATIONAL CATEGORIES
The occupational categories that were used in the study were based on a modified version of the categories used in the Hollingshead Two Factor Index of Social Position (1957). The modified version was developed and tested for reliability in a project that encompassed a similar geographic area with a population representing a comparable socioeconomic and educational background. The major modification was to collapse some of the least well represented occupational categories into a single, combined category.

The procedure for obtaining the occupational status of the respondent consisted of asking the respondent to list his/her current job. If the individual has retired, or was currently unemployed, he/she was asked to list his/her last job. The jobs were then matched to the occupational examples listed in the Hollingshead monograph (1957), and assigned to an occupational category using the modified nine point occupational scale.

The modified nine point occupational scale is presented below.

1. HOUSEKEEPER/STUDENT

This category was used for any respondent listing their sole occupation as housekeeper, including; mother, parent or housewife or any respondent listing their sole occupation as student. If an another occupation was listed in addition to the housekeeper or student listing, that additional occupation was scored rather than the housekeeper or student listing.

2. RETIRED

This category was reserved for any respondent who reported only that he/she was retired and failed to specify his/her former occupation. If the respondent indicated that he/she was retired and also listed his/her former occupation, then the former occupation was scored rather than the retired listing.

3. UNSKILLED LABOR

This category came directly from the Hollingshead
Scale and included some of the following occupations:

- Amusement Park Workers
- Ash Removers
- Attendants, Parking Lots
- Car Cleaners, Railroad
- Countermen
- Dairy Workers
- Farm Helpers
- Freighter Handlers
- Woodchoppers
- Janitors, Sweepers
- Laborers, Construction
- Laborers, Unspecified
- Messengers
- Platform Men, Railroad
- Roofer’s Helpers
- Street Cleaners
- Unskilled Factory Workers

This category also included respondents indicating the public or private relief funds were their sole occupation, or who listed themselves as unemployed and failed to specify a former occupation.

4. CRAFTSMAN/SKILLED LABOR

This category encompassed two occupational categories, Skilled Manual Employees and Machine Operators/Semi-Skilled Employees, from the Hollingshead Scale. A sampling of the occupations from these scales would include:

- Auto Body Repairers
- Barbers
- Bartenders
- Bulldozer Operators
- Carpenters
- Cement Finishers
- Exterminators
- Electricians
- Guards
- Firemen, City
- Gardeners, Landscape
- Gunsmiths
- Hairdressers
- Roofers
- Lineman, Utility
- Sprayers, Paint
- Truck Drivers
- Painters
- Plumbers
- Welders
- Policemen, City
- Postmen

This category also included small farmers with an annual income of $10,000 or less.

5. CLERICAL/CLERK

This category came directly from the Hollingshead Scale and included occupations some technical occupations in addition to what is normally considered clerical/clerk occupations. A sample of the occupations from this category would include:

- Bank Clerks/Tellers
- Bill Collectors
- Factory Storekeeper
- Post Office Clerk
Dental Technician
Draftsmen
Driving Teachers
Claims Examiners
Clerical or Stenographers
Laboratory Technician

Operators, P.B.X.
Safety Supervisors
Sales Clerks
Shipping Clerks
Truck Dispatchers
Window Trimmers

This category also included the owners of small business (such as, newstand, flower stand, tailor shop) and farmers with an annual income between $10,000 and $20,000.

6. LOW SKILL SERVICE PERSONNEL

This category was not a part of the Hollingshead Scale, but seemed to represent an important occupational category. The occupations in this category included:

Aide, Hospital
Aide, Library
Babysitter
Laundry Worker
Window Washing
Dog Sitting

Aide, Home
Aide, Teacher
Cafeteria Worker
House Cleaning
House Sitting

7. BUSINESS/MANAGERIAL/SALES

This category came directly from the Hollingshead Scale and includes administrative personnel, small business owners, semi-professionals and larger farm owners ($25,000 to $35,000).

Examples of these occupations would include:

Adjusters, Insurance
Advertising Agents
Senior Ranking Enlisted Military
Interior Decorators
Sales Representatives
Car Dealers

Service Managers
Store Manager
Reporters, Newspaper
Traffic Managers
Section Heads of Federal, State or Local Government

It also included owners of small business such as:

Auto Accessories
Cattle Dealers
Insurance Agency
Bakery
Dry Goods
Gas Station
Jewelry

Clothing Stores
Electrical Contractors
Beauty Shop
Dog Supplies
Real Estate
Tire Shop
Trucks and Tractors
8. FARMER

This category was reserved for respondents listing their sole occupation as migrant farm labor. In the Hollingshead Scale, migrant farm workers and share croppers were listed under the general classification of unskilled labor. Due to the high number of migrant farm workers in this area, a distinct category was developed just for persons identifying themselves as migrant farm laborers.

9. PROFESSIONAL/SEMI-PROFESSIONAL/EXECUTIVE AND CLERGY

This category encompassed two categories on the Hollingshead Scale. There were so few persons in the Higher Executives, Proprietors of Large Concerns and Major Professionals category that it was combined with the category that included Business Managers, Proprietors of Medium-Sized Businesses and Lesser Professionals. A sample of these occupations would include:

- Judges
- Advertising Directors
- Auditors
- Architects
- Clergymen
- Dentists
- Health Educators
- Contractors
- Farm Managers
- Librarians

- Accountants
- Engineers
- Opticians
- Lawyers
- Teachers
- Postmaster
- Social Workers
- Psychologists
- Veterinarians
- Pharmacists
APPENDIX C: ATTITUDE ITEMS

Q-17
Q-18
Q-19
Q-20
Q-21
Q-22
Q-23
Q-24
Q-25
Q-26
Q-27
Q-28
Q-29
Q-30
Q-31
Q-32
Q-33
Q-34
Q-35
Q-36
Q-37
Q-38
Q-39
Q-40
Q-41
Q-42
Q-43
Q-44
Q-45
Q-46
Q-47
Q-48
Q-49

226
Attitude Item:
Group Means and Standard Deviations

Q-17: There is no one right way to deal with . . .

<table>
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\[ F(3, 106) = 2.11 \] N.S.
**Attitude Item:**

**Group Means and Standard Deviations**

Q-18: . . . should do whatever works for them in dealing with their . . . problems.

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\[ F(3,106) = 3.74 \quad p < .025 \]

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*Tukey HSD (.05) = .79

**Tukey HSD (.01) = .96
### Attitude Item:

*Group Means and Standard Deviations*

Q-19: Aspects or parts of my ... problem have been best handled by medical professionals.

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\[
F(3,106) = 1.70 \quad \text{N.S.}
\]
Attitude Item:
Group Means and Standard Deviations

Q-20: It is important to involve the whole family when working with ... problems.

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F (3,106) = 4.08 p < .01

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*Tukey HSD (.05) = .82
**Tukey HSD (.01) = 1.01
Attitude Item:
Group Means and Standard Deviations

Q-21: Only people who have experienced . . . problems could help me and others like me.

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F (3,106) = 10.52 p < .01

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*Tukey HSD (.05) = 1.04
**Tukey HSD (.01) = 1.27
Attitude Item:
Group Means and Standard Deviations

Q-22: Medical professionals have been helpful to me in dealing with my ... problems.

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<td>3.95</td>
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<td>1.10</td>
<td>1.19</td>
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<td>1.32</td>
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F (3,106) = 2.36 N.S.
Attitude Item:
Group Means and Standard Deviations

Q-23: ... has provided a new way of life for me.

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<th>NA</th>
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<tr>
<td>M</td>
<td>1.69</td>
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<td>.66</td>
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F (3,106) = 3.58 \( p < .025 \)

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<td>NA</td>
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*Tukey HSD (.05) = .52
**Tukey HSD (.01) = .64
Attitude Item:
Group Means and Standard Deviations

Q-24: People in general know a great deal about . . .

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<td>.63</td>
<td>.80</td>
<td>.00</td>
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F (3,106) = 5.77, p < .01

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<tr>
<td>PA</td>
<td>.75*</td>
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<tr>
<td>AA</td>
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<td>.61</td>
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<tr>
<td>NA</td>
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*Tukey HSD (.05) = .64
**Tukey HSD (.01) = .78
Attitude Item:

Group Means and Standard Deviations

Q-25: ... may leave ... but almost always come back

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<tr>
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\[ F(3,106) = 3.59 \quad p < .025 \]

\[ \begin{array}{cccc}
PA & OA & AA & NA \\
.76 & .09 & .02 & \\
.67 & .78 & & \\
.11 & & & \\
\end{array} \]

*Tukey HSD (.05) = 1.00

**Tukey HSD (.01) = 1.22
Attitude Item:

Group Means and Standard Deviations

Q-26: ... does not work for some people

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$F (3,106) = 1.68$ N.S.
Attitude Item:
Group Means and Standard Deviations

Q-27: Some people attend ... meetings just to find friends, not to work on their ... problems.

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\[ F(3,106) = 2.02 \quad \text{N.S.} \]
Attitude Item:
Group Means and Standard Deviations

Q-28: Mental health professionals have been helpful to me in dealing with my ... problems.

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F (3, 106) = 3.46  p < .025

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*Tukey HSD (.05) = 1.20
**Tukey HSD (.01) = 1.46
Attitude Item:

Group Means and Standard Deviations

Q-29: Society does not accept . . . .

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$F(3,106) = 2.25$ N.S.
Attitude Item:

Group Means and Standard Deviations

Q-30: People with . . . problems like mine need to get help from a wide variety of people and places.

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<td>Mean</td>
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$F(3, 106) = 2.78$  \( p < .05 \)

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*Tukey HSD (.05) = 1.10
**Tukey HSD (.01) = 1.35
Attitude Item:
Group Means and Standard Deviations

Q-31: I have been able to help someone else cope with their problems through my work with...

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\[ F(3,106) = 3.85 \quad \text{p < .025} \]

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*Tukey HSD (.05) = .66
**Tukey HSD (.01) = .80
**Attitude Item:**

**Group Means and Standard Deviations**

**Q-32:** Most people in ... have not been satisfied with the help they may have received from mental health professionals.

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<td>.87</td>
<td>.78</td>
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\[ F(3,106) = 1.83 \quad \text{N.S.} \]
**Attitude Item:**

**Group Means and Standard Deviations**

Q-33: ... is the only group which provides help for ... 

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\[ F(3,106) = 5.30 \quad p < .01 \]

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<td>.64</td>
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*Tukey HSD (.05) = 1.05

**Tukey HSD (.01) = 1.28
**Attitude Item:**

Group Means and Standard Deviations

Q-34: Aspects or parts of my ... problem have been handled best by mental health professionals.

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\[ F(3,106) = 1.65 \] N.S.
Attitude Item:
Group Means and Standard Deviations

Q-35: . . . who leave . . . after a few meetings are not ready to deal with their . . . problems.

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\[ F (3,106) = 3.54 \quad p < .025 \]

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</tbody>
</table>

*Tukey HSD (.05) = .80
**Tukey HSD (.01) = .97
Attitude Item:

Group Means and Standard Deviations

Q-36: Recovering . . . probably come down harder on themselves than do other people.

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<tr>
<td>F (3,106) =</td>
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<td>p &lt; .05</td>
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*Tukey HSD (.05) = .79
**Tukey HSD (.01) = .96
Attitude Item:

Group Means and Standard Deviations

Q-37: There are problems that I have had that ... was not able to handle.

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<td>1.07</td>
<td>1.14</td>
<td>.95</td>
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F (3,106) = 2.27 N.S.
**Attitude Item:**

**Group Means and Standard Deviations**

Q-38: I only attend meetings to see old friends now, because I no longer really need help.

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F (3,106) = 2.64 N.S.
Attitude Item:

Group Means and Standard Deviations

Q-39: People with ... problems are able to find the help they need from local mental health agencies.

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F (3,106) = 1.68  N.S.
**Attitude Item:**

*Group Means and Standard Deviations*

**Q-40:** People in general are becoming more understanding and accepting of recovering . . . .

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\[ F(3,106) = 9.22 \quad p < .01 \]

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<td>.00</td>
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<td><strong>OA</strong></td>
<td></td>
<td></td>
<td>1.10**</td>
<td>.78</td>
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<td><strong>AA</strong></td>
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*Tukey HSD (.05) = .86
**Tukey HSD (.01) = 1.05*
**Attitude Item:**

**Group Means and Standard Deviations**

Q-41: Only a . . . can understand . . . .

<table>
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<th>NA</th>
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<td><strong>S.D.</strong></td>
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\[ F (3,106) = 14.29 \quad p < .01 \]

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<td>1.06*</td>
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<td>OA</td>
<td></td>
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<td>.92</td>
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</tr>
<tr>
<td>AA</td>
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<td>.06</td>
</tr>
<tr>
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</table>

*Tukey HSD (.05) =  .94

**Tukey HSD (.01) =  1.15
Attitude Item:
Group Means and Standard Deviations

Q-42: I get a lot of support from friends and family outside of ... for working on my ... problems.

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<th>OA</th>
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F (3,106) = .37 N.S.
Attitude Item:
Group Means and Standard Deviations

Q-43: ••• should be expanded to include help and information from medical and mental health professionals.

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F (3,106) = 7.25, p < .01

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<td>.94</td>
<td>1.65**</td>
<td>1.40**</td>
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<td>OA</td>
<td></td>
<td>.71</td>
<td>.46</td>
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</tr>
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<td>NA</td>
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*Tukey HSD (.05) = 1.04
**Tukey HSD (.01) = 1.27
**Attitude Item:**

**Group Means and Standard Deviations**

Q-44: Most people in ... have been satisfied with the help they may have received from medical professionals.

<table>
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\[ F (3,106) = .98 \text{ N.S.} \]
Attitude Item:

Group Means and Standard Deviations

Q-45: Helping others ... in ... is an important part of making ... work.

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\[ F(3,106) = 0.64 \text{ N.S.} \]
**Attitude Item:**

**Group Means and Standard Deviations**

Q-46: I could use more help than the help I am currently receiving from . . . .

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F (3,106) = 3.63  p < .025

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*Tukey HSD (.05) = .98

**Tukey HSD (.01) = 1.19
**Attitude Item:**

**Group Means and Standard Deviations**

Q-47: . . . should be expanded to include people experiencing other kinds of problems.

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\[ F(3,106) = 9.91 \quad p < .01 \]

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*Tukey HSD (.05) = .85
**Tukey HSD (.01) = 1.04
Attitude Item:
Group Means and Standard Deviations

Q-48: Medical professionals tend to deal with ... by prescribing another drug.

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F (3,106) = 3.17 \( p < .05 \)

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*Tukey HSD (.05) = \( .85 \)
**Tukey HSD (.01) = \( 1.04 \)
**Attitude Item:**

**Group Means and Standard Deviations**

Q-49: Medical and mental health professionals refer . . . to . . . meetings for help.

<table>
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<td>1.01</td>
<td>1.06</td>
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</table>

F (3, 106) = 2.42 N.S.