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A qualitative study investigating the potential for collaborative relationships between clinical psychologists and self-help groups in the field of mental health, and comparing clinical psychologists' views about self-help groups with self-help group members' views about the professional care system.

SUSAN E. WHITING BSc Hons.

Submitted in partial fulfilment of the requirements for the degree of  
DOCTORATE OF CLINICAL PSYCHOLOGY

CLINICAL PSYCHOLOGY  
SALOMONS CENTRE  
ACCREDITED INSTITUTION OF THE OPEN UNIVERSITY

Date of award: 11<sup>th</sup> September 1996

SEPTEMBER 1996

**DECLARATION**

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed ..... *Susan Whiting* ..... (Candidate)

Date ..... *24<sup>th</sup> July, 1996* .....

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This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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## **ACKNOWLEDGEMENTS**

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Special thanks to Dr Rob Lieper for supervising the project and his continued encouragement and support. I would also like to thank Claudia for her help with inter-rater reliability and Mark for proofing, tea and re-assurance.

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<sup>1</sup> All of the information contained in this dissertation has been written-up to preserve the anonymity of the clinical psychologists and self-help group members who took part. Any information which would have led to their recognition has been omitted.



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## **ABSTRACT**

This study explores the potential for collaborative relationships between clinical psychologists and self-help group members in the field of mental health, comparing the views of each group in relation to the other and their preferred relationships. The participant group comprised: (a) 16 clinical psychologists working in adult mental health services, twelve with previous contact with self-help groups and four without any previous contact and (b) fourteen self-help group members from various self-help groups for adults experiencing personal or emotional difficulties. Face to face interviews were conducted using semi-structured interview schedules. These were designed for each group to understand in-depth their views in relation to the other and about entering into collaborative relationships. Grounded theory and thematic analysis were used to analyse the interviews. Both groups perceived benefits from a collaboration but envisaged problematic relationships. Tension emerged as a major issue and was expressed in various ways. Three major dimensions of tension were similarity versus difference, power versus equality and resources versus deprivation. Managing the resulting tensions poses threats for both groups in collaborative relationships, particularly to their identity. Findings suggest that both groups need to find ways of managing their genuine differences without introducing threats into the relationship or preventing the full potential of collaborative relationships from being realised. The study's findings are critically evaluated and directions for future research in the field are discussed. Implications for clinical practice are addressed.

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## **1. INTRODUCTION**

Today, a vast array of self-help organisations exist (Orford, 1992) for practically every known health or mental health related issue (McFadden, Seidman & Rappaport, 1992). General impressions suggest the number of self-help groups will continue to rise and that members find them beneficial (Wilson, 1993). The recent re-structuring of the NHS and changes in community care legislation have led to an increased interest in a mixed economy of care and more opportunities for involvement with the voluntary sector, including self-help groups (Wilson, 1993). This raises issues about the relationship between self-help groups and the professional care system and how they should interface. The pros and cons of collaborative relationships are much debated in the literature. Little is known about the potential for mutually supportive relationships between self-help groups and clinical psychologists and what the profession thinks of them. This study investigates these issues in the field of mental health. Literature about self-help groups and their relationship with professionals is reviewed and discussed in terms of the limitations of existing research.

### **1.1 Nature of self-help groups: History and development**

#### ***1.1a What are self-help groups?***

Hess (1982) described self-help as an ancient philosophy which recognises, develops and nurtures the strength of people to not only help themselves but also to reach out and help others to help themselves. This reciprocity of help has led many to advocate the term 'mutual-aid' (Orford, 1992) in preference to the do it yourself emphasis conveyed by



**'self-help' (McFadden et al., 1992).**

**There is general agreement that self-help groups are essentially member-governed, charge minimal or no fees and consist of people sharing the same problems who meet to exchange support (Jacobs & Goodman, 1989; Meissen & Warren, 1993; Wilson, 1995). Groups tend to be characterised by a democratic ideology and non-professional status, relying on the collective, experiential knowledge of the group for help (Jacobs & Goodman, 1989). Pure self-help groups are usually regarded as autonomous from professional bodies although some are affiliated to national self-help organisations (Kurtz & Powell, 1987). Generalising any further about the nature of self-help groups becomes extremely difficult as they are also characterised by diversity (Levy, 1978). Differences include broad varieties of style, format and ideology (Jacobs & Goodman, 1989; Levy, 1978).**

### ***1.1b History and development of self-help groups***

**Modern self-help organisations have their origins in the friendly societies, consumer co-operatives and the early trade-union movement which emerged during the industrial revolution to support the interests of those who were both politically and economically disadvantaged (Borkman, 1990; Katz & Bender, 1976, cited in Orford, 1992). Contemporary self-help groups date back to the 1930s when 'Alcoholics Anonymous' started (Borkman, 1990). The pace at which self-help groups developed mushroomed in the 1970s (Borkman, 1990; Kurtz, 1990). Since then, there has been a phenomenal growth in self-help organisations both in number and the problems they cover (Gartner & Reissman, 1984; Orford, 1992).**

Orford (1992) claims that today, they collectively provide one of the principle resources for the prevention and treatment of psychological distress.

### ***1.1c Factors associated with the rise of self-help groups***

Stewart (1990) highlighted two major themes in the recent expansion of self-help groups: disillusionment with health care services and the decline of supportive institutions.

Recognition of the importance of social support and of non-professional help for people experiencing psychological distress were other important factors (Jacobs & Goodman, 1989).

#### ***(i) Disillusionment and dissatisfaction with professional services***

Much dissatisfaction has been directed towards health care services over recent years including lack of resources and gaps in service provision (Katz, 1981; Yoak & Chesler, 1985). Indeed, the continued strain on health care services with the recent NHS reforms, leading to cuts in services and perceived inability to meet demand, has furthered this disillusionment.

Dissatisfaction has also been directed towards the nature of professional help and Yoak & Chesler (1985) discuss how disillusionment with professionals' assumptions and the general ineffectiveness of professional help has led people to question their expertise and authority.

#### ***(ii) Decline of supportive institutions***

Both Kurtz (1990) and Stevenson & Coles (1993) highlight several social trends which have reduced the support available to people. For example, increased mobility of people and consequent lack of support from the extended family; anonymity of people and resulting lack

of neighbours with whom to share; reduced interest in the church which people traditionally turned to for help; increased numbers of single parent families and also increased loneliness. Even when community and personal networks exist, Borkman (1984) argued that they can be just as unsupportive as professional services, for example, through lack of understanding and stigma.

***(iii) Recognition of the importance of social support and value of non-professional help***

Research suggests that only a fraction of people experiencing psychological distress reach the attention of services (Orford, 1992) and that many people turn to more informal sources of support for help (Cowen, 1982; Powell, 1990). Cowen (1982) argued that people generally prefer to speak with others who are known and trusted and in more natural contexts.

In 1979, Durlack (cited in Orford, 1992) reviewed 42 studies which compared the effectiveness of professional and non-professional help. His controversial finding was that non-professional helpers achieved outcomes that were equal to or significantly better than those achieved by professionals in mental health. This finding was still supported in a later re-evaluation of studies. Orford (1992) notes that recognition of the benefits of non-professional help led to a trend within the field of community psychology to train non-professional helpers. The results of this exercise will be addressed later.

***1.1d Summary of self-help groups today***

The convergence of factors in society at large and within health care services may have led people to seek help elsewhere (Gartner & Reissman, 1984). Some of the gaps in formal



service provision have been filled by the voluntary sector of which self-help groups constitute an important part (Yoak & Chesler, 1985). Self-help groups offer a very different kind of help to professionals and Wilson (1994) draws attention to their 'different worlds'. She comments that self-help groups rely on experiential knowledge, an informal structure and egalitarianism of members, whereas professional services rely on learned knowledge and tend to be more formal and hierarchical. Commenting on their distinctness, Jacobs & Goodman (1989) suggest that self-help groups should be regarded as part of the helping continuum, not just as an adjunct to services.

Indicators suggest that self-help groups are flourishing. Jacobs & Goodman (1989) estimated that the number of people in self-help groups in North America rivalled the number of psychotherapy clients. Wilson (1995) comments on a general impression of growth of self-help groups in the UK, but remains cautious about generalising as there has been no attempt to quantify the numbers of groups and people involved.

## **1.2 Review of the literature and research findings on self-help groups**

### ***1.2a Do self-help groups help?***

Much of the early research on self-help groups concentrated on developing descriptive typologies of what self-help groups do and documenting the effects associated with membership (Meissen & Warren, 1993; Yoak & Chesler, 1985). Most of the research to date is North American and has relied heavily on survey data. The field remains at an early stage of

development, beset by various methodological difficulties, such as problems with sampling and measurement (Jacobs & Goodman, 1989). Research findings will first be presented, followed by a critical review of studies.

**(i) *Review of the research findings***

Studies have shown benefits for members of self-help groups (Jacobs & Goodman, 1989), however any systematic analysis beyond the level of description and anecdotal evidence is lacking (Maton, 1988; Yoak & Chesler, 1985). In 1982, Gottlieb surveyed 18 self-help groups for members' views about the benefits of participation. He found positive evaluations and beneficial changes in social support networks. Knight, Wollert, Levy, France & Padgett (1980, cited in Wollert, 1990) also found evidence of positive gains associated with membership. Trojan (1989) surveyed 232 members of various self-help groups in Hamburg and reported that over three-quarters of members had achieved most of their goals for joining. Other findings were positive impacts on difficulties, relationships with others and with services. Only between one and four per-cent of members mentioned negative impacts. The range of self-help groups Trojan (1989) evaluated strengthened the external validity of findings, thus increasing generalisability to other self-help group populations.

Wilson (1993; 1995) comments on the lack of British research on the benefits of belonging to a self-help group. She argued that anecdotal evidence from case studies and the experience of self-help development workers tends to support the view that for many members, self-help groups are very effective. However, she also highlighted insufficient attention to the

limitations of self-help groups and suggests this may be because of enthusiasm to promote them. In a qualitative study of 50 health service professionals and members of 49 self-help groups, Wilson (1994) found that participants largely agreed that the benefits of involvement in a self-help group were mutual support, information of many kinds and increased confidence.

Based on a review of the literature, Orford (1992) identified eight major functions of self-help groups: (a) emotional support; (b) role models; (c) a powerful ideology; (d) information; (e) ideas about ways of coping; (f) opportunity to help others; (g) social companionship and (h) a sense of mastery and control. Kurtz (1990) identified similar functions in her review of the literature. A number of these functions overlap with professional services but there are also differences. For example, Yoak & Chesler (1985) note the importance of talking with others 'who've been there' and the possibility of developing friendships and assisting others, giving reciprocal and mutually empowering relationships (Yoak & Chesler, 1985).

### ***1.2b Theories and research on the helping processes in self-help groups***

Various theories have been suggested to explain how self-help groups help. One popular explanation is that they provide social support functions (Gartner & Reissman, 1984; Orford, 1992) as found by Gottlieb (1982). This may be particularly important for people with mental health difficulties who may experience a lack of support from their personal networks or exclusion by society (Orford, 1992). Other theories include social learning and cognitive explanations. However, there has been a lack of research examining these perspectives directly, although they have plausibility when considering the functions of self-help groups.



**(i) Social support theory of self-help groups**

Borkman (1984) argued that self-help groups can strengthen the supportiveness of social networks by providing complementary social support, transforming the person's perspective on their network, and by reconstructing personal networks. Kurtz & Powell (1987) also argue that self-help groups can expand social networks and provide an antidote to feelings of alienation and isolation. Another way in which self-help groups could provide social support is through the opportunity to both give and receive support.

Maton (1988) examined the relationship of two social support and three group organisational variables to the psychological well-being and group appraisal of 144 members of three different self-help populations, via a survey. Results showed that those members who both gave and received support reported more positive well-being and group appraisal. This supports Reissman's (1965) 'helper-therapy' concept, that those who help are helped most.

Maton (1988) suggested three possible explanations: there might be benefits from both giving and receiving support; there might be psychological costs associated with non-reciprocity; or psychological well-being might be a precondition, rather than a consequence of bi-directional supporting. Maton (1988) also found that friendship was associated with greater self-esteem and perceived group benefits. Possible explanations include more opportunities to exchange support or the importance of friendship amongst individuals whose needs may be unmet by existing social supports. Clearly, further research to examine these differing explanations would be useful.

Other findings were that greater role differentiation amongst members, order and organisation at meetings, and leadership were also associated with member well-being and group satisfaction. However, it is difficult to generalise these findings to other self-help groups as the study was limited by small sample size and reliance upon self-report measures of group function.

Maton (1988) study was extremely valuable as there had been no previous attempt to evaluate the link between salient social and organisational variables to member well being. However, members themselves may have emphasised different variables to Maton. Further study of the potential for bi-directional support between professionals and service users would be valuable, particularly as findings suggested comparatively less benefits when just receiving support, a position service users commonly find themselves in.

**(ii) *Social learning theory of self-help groups***

Kurtz & Powell (1987) suggested that self-help groups promoted new behaviours through social learning, for example, the modelling of new skills. Gartner & Reissman (1984) argued that self-help groups helped by increasing coping skills through the provision of information, sharing of experiences and problem solving. However, empirical evidence is lacking.

### ***(iii) Cognitive theory of self-help groups***

Kurtz & Powell (1987) suggested that self-help groups could also help by promoting change at a cognitive level. For example, Reissman's (1965) helper-therapy concept proposes that through helping, helpers learn to think differently about themselves. This change in self-concept could foster the growth of new skills and relationships. Other aspects of the cognitive explanation include cognitive reframing, as well as strengthening mastery of problems through re-experiencing them in a group. Again, there is a need for empirical support.

### ***1.2c Critique of research***

Research on self-help groups is unsatisfactory from both a theoretical and a methodological point of view (Trojan, 1989) and considering the growth of self-help groups and the number of people involved (Meissen & Warren, 1993). Lieberman (1986, cited in Jacobs & Goodman, 1989) stated:

**“Compared to the relative sophistication and frequency of empirical studies on psychotherapy, the number and quality of studies available for assessing the effects of self-help groups resembles the status of psychotherapy research in the 1950's.” (p. 749)**

Lieberman (1986, cited in Jacobs & Goodman, 1989) argued that research has yet to prove the effectiveness of self-help groups, who benefits most and under what conditions. Much of the research to date has relied on survey and retrospective self-report (Kurtz, 1990). The

correlational nature of this type of research makes it difficult to establish whether reports of positive benefits are attributable to participation in the self-help group or to some additional factor. It is possible that with increasing methodological rigour, early positive findings may be reduced (Jacobs & Goodman, 1989).

The lack of traditional outcome research with self-help groups could be attributed to difficulties in researching this area (Kurtz, 1990; Levy, 1984). Firstly, there are threats to internal validity because it is impossible to randomly assign individuals to self-help groups and control conditions without seriously compromising the nature of the phenomena being studied. External validity is also poor because of lack of a clear definition of self-help groups and heterogeneity of groups which makes it difficult to obtain representative samples (Levy, 1984; Meissen & Warren, 1993). Other more practical issues make recruitment difficult because self-help groups by their nature are not affiliated with services and the philosophy of certain groups may discourage research participation (Meissen & Warren, 1993). Findings are also biased by the self-selection of members because self-help groups may only comprise of those who expect them to be beneficial (Trojan, 1989). For these reasons, Meissen & Warren (1993) suggest qualitative research may be particularly appropriate to study self-help groups and as Borkman (1990) suggests, to gain in-depth understanding of the nature of self-help groups and why people find them useful.



### **1.3 Review of the literature and research findings on the relationship between self-help groups and professionals**

#### ***1.3a Relationship between self-help groups and professionals today***

Historically, a certain animosity has been observed between self-help groups and professionals (Gartner & Reissman, 1984). Yoak & Chesler (1985) suggest that despite their potential benefits, self-help groups exist on the 'margins of organised service provision' (p. 430). Most of the research which has examined issues in the relationship has used questionnaire surveys, predominantly in North American populations. Thus, the research is beset by similar methodological difficulties as those studies investigating the effectiveness of self-help groups. Research findings will first be presented, followed by a critical review of studies

#### ***1.3b Professionals views about self-help groups and involvement with them***

Early studies of mental health professionals' views of self-help groups reveal positive attitudes. In 1978, Levy surveyed 748 mental health professionals and found positive attitudes but reservations about services becoming involved. He argued that professionals' views of self-help groups were important because if negative, this could affect the use of self-help groups by the community. Todres (1982) surveyed 308 Canadian mental health professionals and found favourable attitudes and a willingness to refer clients with 43 per-cent of professionals reporting involvement with self-help groups, usually as speakers or consultants.

Later studies revealed more detailed information about professionals' views. Kurtz, Mann & Chambon (1987) surveyed 120 mental health social workers regarding their involvement with four mental health self-help groups. Despite positive attitudes about self-help groups, a surprising finding was that social workers made the least referrals to those groups which best served the interests of their clients. Kurtz et al. (1987) argued that results support theories of inter-organisational conflict, that is, co-operation decreases and competition increases when domain similarity is high. They argue for closer ties with self-help groups which preserve differences and decrease competition. Other findings were that social workers lacked information about self-help groups and favoured more 'expert' roles of linking.

In a survey of 168 graduate clinical psychology and social work students, Meissen, Mason & Gleason (1991) found that although students expressed positive attitudes and intentions towards self-help groups, 47 per-cent regarded self-help groups for mental illness as inappropriate. Students also rated all roles in relation to self-help groups as appropriate with a preference for a consultancy role. Meissen et al. (1991) argue that the naive view that 'any help is good help' may have been based on a lack of understanding of self-help groups. They argue that findings support the view that positive attitudes and beliefs towards self-help groups could be nested in a framework based on expert power and traditional roles.

Claffin (1984) reported anecdotally on his observations of professional resistance towards setting up self-help groups within community mental health centres. He proposed that a key issue was: how can troubled or disturbed individuals help each other with emotional health



problems? Claffin (1984) argued that perhaps the concept that an individual in distress could help another was difficult to entertain.

Chesler (1990) argued that professionals commonly express concerns about the quality of emotional support and information shared in self-help groups. She suggests that these concerns are often based on assumptions about what is different when a professional guides a group and how professionally led groups avoid these problems. In a qualitative study of 68 health professionals' views of the dangers of self-help groups, Chesler (1990) discovered concerns about dangers to members, such as whether the group might escalate emotional problems. Other findings concerned dangers to professionals, such as challenging their authority. Only 15 participants had seen evidence of dangers associated with self-help groups. Chesler (1990) suggests that findings support the view that the roots of professionals' beliefs about self-help groups are in their ideology not their experiences.

Salzer, McFadden & Rappaport (1994) argued that there is little evidence to support views that self-help groups are inappropriate for people with mental health problems. They built upon previous research by comparing professionals' views of self-help groups with their views on professionally led groups. Surveys from 831 professionals from over 100 agencies were analysed. Regardless of setting or professional discipline, professionally led groups were seen as most helpful. Salzer et al. (1994) argued that results supported a professional centric bias, a belief that only professionals can help, and suggest this may explain earlier findings of a lack of support for mental health self-help groups.

**Kurtz (1990) reviewed research on professional interaction with self-help groups between 1980 and 1990 and found limited involvement with the most common and acceptable linking role as referral agent. Stewart (1990) reviewed 12 studies which had examined professionals' relationships with self-help groups. She found that lack of information and preparation for appropriate roles were commonly perceived barriers to involvement. Other barriers included: conflict between professionals and self-help groups; role ambiguity and role conflict; and lack of time. Professional roles of consultant and referrer received most support. Wilson (1994) found similar barriers in her study and commented that the differences between the 'two worlds' of self-help groups and professionals was a major obstacle to co-operation.**

**In comparison to the extensive North American literature on the relationship between self-help groups and professionals, little has been published in Britain (Wilson, 1993). In a review of the British literature between 1981 and 1991, Wilson (1993) found that health-care professionals expressed an interest in working with self-help groups and generally held favourable attitudes. Within the psychological literature there is Sue Holland's (1992) work which involved setting up mutual support groups for women as part of a neighbourhood social action project. There is also interest within the field of community psychology (Orford, 1992).**

### ***1.3c Critique of research***

**Professionals express ambivalent views about self-help groups for mental health although this is not entirely clear why. Possible explanations include a professional centric bias or perceived competition. There is also ambivalence about involvement. Stewart (1990) argues**

that one difficulty in interpreting professionals' views on involvement with self-help groups is the confounding of actual and preferred professional relationships and roles. Differing designs, samples, measures and aims of studies also render comparisons amongst studies difficult. As with the research on the effectiveness of self-help groups, there is a lack of qualitative studies. Kurtz et al. (1987) recommend this as a useful approach to investigate professionals views about self-help groups in depth. There is also a lack of British research and no studies of clinical psychologists' views.

### ***1.3d What do self-help groups think about involvement?***

Considering the historical roots of self-help groups, some maintain a strong anti-professional stance whereas others do involve professionals (Stewart, 1990). Maton, Leventhal, Madara & Julien (1989, cited in Meissen & Warren, 1993) examined organisational variables that affected the birth and death of self-help groups and found that links with professionals were an important factor in survival. However, too much involvement was related to higher odds of disbanding, suggesting an optimal level of support for groups.

Halperin (1987) reported on his involvement as facilitator to a self-help group for parents whose children were in cults. His observations are interesting though anecdotal. He found that parents shared the belief that professionals would see them in a critical and judgmental way which is why they preferred the self-help group. Halperin (1987) also reported that professionals were viewed with profound ambivalence, as experts essentially lacking in empathy but also as idealised objects capable of providing magical solutions.

Stewart (1990) reviewed seven studies on self-help group members relationships with, and attitudes towards, professional involvement. Findings suggested that professional interaction was considered desirable with preferences for more indirect facilitation, consultation and referral roles. Five studies reported on barriers to professional involvement, for example, control and protectionism and their lack of time. Stewart (1990) argued that widespread variance in design, sampling and measures made comparison amongst studies difficult. Wilson's (1994) study found similar barriers to involvement as reported by Stewart (1990). She comments that involvement seemed to work best when there was a sense of mutuality. Other findings were that self-help group members wanted professionals to put people in touch with self-help groups and they also valued background support and practical resources from professionals.

Another factor in understanding the relationship is the philosophy of self-help groups.

Emerick (1990) surveyed 104 self-help groups for former mental health patients about actual and potential partnerships with mental health professionals. He found a relationship between the self-help groups' attitudes towards professionals and their preferences for involvement. Not surprisingly, those groups with the lowest level of interaction were the radically separatist groups, set up to eschew professional contact. Emerick (1990) argued that these groups were very conscious of the potential for co-option by professionals and were thus ideologically resistant to the concept of developing partnerships. Groups expressing the most positive attitudes and where partnerships were most likely to develop were those with more of an individual therapy model and a more conservative approach.



### ***1.3e Critique of the research***

Considering the diversity of self-help groups, there is little knowledge about how different types of group view involvement with professionals, besides Emerick's (1990) study. As with research on professionals' views, it is difficult to know whether favourable attitudes towards involvement are simply preferences or whether involvement is actually sought. Again, the majority of data is from surveys and there is a lack of interview based research looking in-depth at self-help group members' views and relationships with professionals. Kurtz (1990) argued that continued evaluation using both quantitative and qualitative research was needed. Wilson (1993) notes the need for more information about what self-help group members want from professionals.

### ***1.3f Summary of current understanding about the relationship between professionals and self-help groups***

Based on the literature reviewed it seems that professionals generally express favourable attitudes towards self-help groups and that their involvement is considered generally desirable by members. However as Stewart (1990) points out, there are also tensions and ambivalences in the relationship. The precise nature of these ambivalences has yet to be clarified and Wilson (1993) argues that while there is an underlying tension, there will be confusion about the possibility of a collaboration. She argues that more research is vital if professionals are to develop relationships with self-help groups.

## **1.4. Collaboration between self-help groups and professionals**

### **1.4a Why the interface between self-help groups and the professional care system is important**

Stewart (1990) argues that the interface between self-help groups and the professional care system is of theoretical and practical interest and in need of further research. Various reasons explain the current interest. Firstly, predictions suggest that self-help groups are likely to continue to expand and greater use be made of them in the future (Jacobs & Goddman, 1989). Kurtz & Powell (1987) argue that professionals may increasingly work with clients who are actual or potential members of them. Like others in the field (Borkman, 1990; Levy, 1978; Orford, 1992) they believe that professional awareness and understanding of self-help groups and their potential is vital, for example, to help clients make effective use of them. Salzer et al. (1994) argue that a failure to support self-help groups could lead to the reduction, not the enhancement, of mental health.

The possibility that collaboration could produce a powerful approach to mental health care has also generated interest (Salzer et al., 1994; Todres, 1982; Wollert, Knight & Levy, 1980). This may be particularly important in the current climate as services are often unable to meet needs and may not be suitable for everyone. Both Hess (1982) and Salzer et al. (1994) argue that self-help groups could alleviate some of the pressure on services, leading to their more efficient use. Self-help groups could also change services for the better. Katz (1984) suggested that they could offer alternative models and point out service deficiencies. Borkman (1990)



and Salzer et al. (1994) suggest that self-help groups could be used to humanise services and change professional attitudes and practices. Therefore both parties might gain from a collaboration, as Powell (1990) suggests.

#### ***1.4b Current debate***

Within the professional literature, much attention and debate has centered on how self-help groups and professionals should collaborate (Checkoway, Chesler & Blum, 1990). Kleiman, Mantell & Alexander (1976, cited in Wollert et al., 1980) concluded that collaboration was not possible because self-help groups surrender their autonomy and egalitarianism, whereas professionals find their identity, power and control questioned. In the literature, there are repeated warnings about the dangers of professional co-option masquerading as collaboration, and possible domination and control of self-help groups (Katz, 1984; Mowrer, 1984).

Some of these concerns about collaboration are legitimate, considering the results of the trend within community psychology in the 1970s to work with non-professional helpers. This experience led to concerns that it may be unwise to try and alter systems that might already be functioning adequately by introducing well-intentioned, yet misguided professional biases (Orford, 1992).

Borkman (1990) suggests egalitarian relationships which respect the self-help groups' autonomy. There is acknowledgement that such relationships require a departure of professionals from traditional ways of working. For example, appreciating and respecting that

the ideology of a self-help group may be different from those of professionals and being prepared to adapt customary professional roles. Wilson (1993) argues that appropriate professional attitudes and sufficient relevant knowledge are pre-requisites for the development of good practice. Orford (1992) argues that one difficulty in establishing working relationships is the lack of a guiding framework.

#### ***1.4c Theories and models of collaborative relationships***

The potential for collaborative relationships between self-help groups and professionals is explored by analysing current theories of collaborative relationships. Some evidence of successful collaboration is then presented.

##### ***(i) The sociology of professions***

Stewart (1990) highlights the sociology of professions as one way of analysing professionals' relationships with self-help groups. She argues that professionalism is a culture, or set of learned values, that reinforces the public's consciousness of dependence and vulnerability. One consequence of this is to make lay persons more dependent upon experts in society. Therefore professional power, control and expertise are emphasised within this framework. Self-help groups are clearly one alternative to professional control, adopting a fundamentally different approach to helping relationships.

Hornby (1993) argues that difficulties in collaboration between any groups can stem from previous experiences and inter-group tensions, such as mistrust. Stewart's (1990) theory on

the sociology of professions implies that perceived professional self-interest and power over clients could be one tension in collaborative relationships between professionals and self-help groups. For example, fears of co-option or criticism by professionals. Emerick (1990) found that these fears were major issues for self-help groups who opposed relationships with professionals.

Hornby (1993) suggests various other hindrances to professional collaboration with self-help groups. For example, professional undervaluing of self-help groups as a source of help as Salzer et al. (1994) found and professional ignorance of self-help groups, repeatedly found in the literature (Stewart, 1990). Hornby (1993) argues that ignorance could be exacerbated by limited contact, another common finding (Kurtz, 1990), and could lead to the formation of stereotypes. She notes other potential hindrances as communication difficulties, perceived competition and role insecurity of professionals.

**(ii) *Balance theory***

Stewart (1990) argues that balance theory could provide another useful framework to understand the potential for collaborative relationships. Katz (1990) used balance theory (Litwak & Meyer, 1966, cited in Katz, 1990) to review existing research on professionals' relationships with self-help groups. She argued that optimal collaboration occurs with neither under, nor over, involvement by professionals. One example of under involvement was professional lack of awareness and understanding of self-help groups which was associated

with a failure to refer. Katz (1990) predicted that more active involvement would improve relationships and could also strengthen and support self-help groups. However, over involvement could imperil the groups survival and risk transforming the group into a 'bureaucratic health service organisation'. Stewart (1990) argues that over professional involvement also risks negative reactions to help from perceptions of inequity and indebtedness in the relationship. This framework predicts that collaboration would have most success of occurring with balanced involvement.

### ***(iii) Models of successful collaboration***

The idea of consultant and consultee is central to the theory of consultation, and also provides one model for the role of professionals in relation to self-help groups (Orford, 1992). Wollert et al. (1980) adopted a consultative role in their work with a self-help group and argue that this is essential for successful collaboration as well as a rapport building approach and adequate professional knowledge of the workings of self-help groups.

Yoak & Chesler (1985) looked at different leadership roles professionals play in self-help groups for children with cancer. This was a qualitative study and involved group and individual interviews with 43 self-help groups. Groups were described as either independent, shared leadership or professionally led. Yoak & Chesler (1985) were surprised to find that shared leadership groups worked best and described this in terms of a coalition model. In forming a co-alition, they argue that self-help groups and professionals must struggle with prior experiences and that conflict could arise from their different roles, status and power: 'a



clashing of two cultures' (Froland, Pancoast, Chapman & Kimbot, 1981, cited in Yoak & Chesler, 1985). The danger is that the dominant group will co-opt, covertly direct, or even dominate. As a result of this they argue for new roles for professionals, suggesting they move from controlling to more collaborative roles.

#### ***1.4d Summary***

What is lacking in the literature is an understanding of how self-help groups and professionals should interface. Collaboration is frequently debated but few studies have directly addressed partnership issues or compared professionals' views on these issues with self-help group members' (Stewart, 1990). Also lacking are British perspectives (Wilson, 1993), yet this is important in the changed health service context which emphasises collaboration with other services and agencies through joint working and different relationships between clients and services. Wilson (1993) argues for more research and debate and quotes Unell, Wilson & Marsden (1992):

**“It is only too easy to prescribe solutions to what is a complex relationship, one that is both vital and problematic and which would benefit from more research and debate.” (p. 217)**

As a small profession, clinical psychology needs to address how to interface with other more available services to meet need. There is no research on how disposed the profession is towards working alongside informal support systems, such as self-help groups, and whether they are regarded as resources for mental health.



The author's own experience of working in services for mental health has brought a close contact with various community and self-help organisations whose principles have been based on the value of mutual help. This helped to develop an appreciation of the importance of talking to others 'who've been there' when experiencing personal or emotional difficulties. Other observations have suggested a lack of contact between clinical psychology departments and self-help groups and that there remains uncertainty about the appropriateness of involvement.

## **1.5 Research aims, questions and methodology**

### ***1.5a Research aims***

The overall aim of the study is to understand the potential for collaborative relationships between clinical psychologists and self-help groups. In seeking to address this, the study aims to discover some of the different points of view that exist within the profession about self-help groups and about entering into collaborative relationships with them. Of equal importance is to understand self-help group members' views of professional help and involvement with professionals in order to inform the development of appropriate ways of working. By introducing a comparative element within the design of the study the views of both groups can be compared to understand their mutual perceptions and desired relationships. This is also helpful to illustrate sources of underlying tension or ambivalence within the relationship.

Although the author was interested in self-help groups in general, this was considered too large an area to address meaningfully in one study. A decision was made to focus on self-help groups for adults experiencing personal or emotional difficulties and clinical psychologists working in adult mental health services. The review of the literature suggested there might be particular issues in the field of mental health, such as professionals' concern about whether people with emotional health problems can help one another. There is also a potential for rivalry considering the current climate of competition within services and the rise in alternatives to formal mental health services. The study did not include self-help groups for people experiencing more severe mental health difficulties, such as psychosis, as the author considered this would raise issues worthy of a study in its own right. Accordingly, clinical psychologists working in continuing care services were not included.

### ***1.5b Research questions***

The following questions guided the research:

- 1A. What do clinical psychologists think about self-help groups? What experiences have influenced these views? What factors are important in seeking to explain these views?
- 1B. How do clinical psychologists perceive themselves in relation to self-help groups and how do they think self-help groups perceive them?
- 1C. Do clinical psychologists' views about self-help groups affect their relationships with

self-help groups, or influence how they feel about working with or alongside of them?

- 2A. What do members of self-help groups think about professional help? What experiences have influenced these views? What factors are important in seeking to understand these views?
- 2B. How do members of self-help groups perceive self-help groups in relation to professional services, and how do they think professional services perceive self-help groups?
- 2C. Do self-help group members' views about professionals influence how they feel about self-help groups working with or alongside of professionals?
3. In seeking to understand the themes which emerge to describe how each group perceives the other, what model best explains their mutual perceptions?

### ***1.5c Reasons for choosing a qualitative approach***

Qualitative methods were selected on both practical and philosophical grounds.

#### ***(i) Practical reasons***

On a practical level, qualitative methods were chosen because they are most suited to investigating the research questions. This research is at an early stage of enquiry in an area

which has received limited previous investigation. The focus is on discovering how clinical psychologists and self-help group members perceive each other and collaborative relationships, not on testing a priori hypotheses. As qualitative methods are particularly appropriate to the inductive phase of research (Orford, 1995; Pope & Mays, 1995) and to the uncovering of meanings and understandings (Banister, Burman, Parker, Taylor & Tindall, 1994; Henwood & Pigeon, 1995) they were chosen for this project.

**(ii) *Philosophical reasons***

On a philosophical level, the choice of qualitative methods reflects wider epistemological issues. In quantitative research paradigms, research is guided by pre-determined assumptions about what the central issues are. These are then tested out empirically in the search for universal laws and truths (Henwood & Pigeon, 1995). The author was particularly conscious of the dangers of imposing a professional world view onto the self-help arena. As qualitative methods aim to build theory which is grounded in the personal experiences of participants, rather than a reflection of the researcher's a priori assumptions (Banister et al., 1994; Henwood & Pigeon, 1995) a qualitative approach seemed particularly appropriate for this project. Qualitative research paradigms also assume a constructivist epistemology, reflecting a view that knowledge is socially constructed (Henwood & Pigeon, 1995). Multiple meanings and interpretations are assumed to exist as opposed to any objective notions of the truth. Again, this stance is particularly helpful to uncover the different understandings that might exist amongst clinical psychologists and self-help group members.



### ***1.5d Judging quality in qualitative research***

Two central concepts in any discussion of rigour in scientific research are 'reliability', the apparent consistency and replicability of observations and 'validity', the generalised truth of statements (Silverman, 1993). These concepts cannot be applied in the same way to evaluate qualitative research as no claims are made to 'objectivity' and multiple meanings are assumed (Banister et al., 1994). Different concepts have been generated to assess rigour in qualitative research and these are more concerned with assessing the degree of trustworthiness of the quality of the method and of the interpretations made (McLeod, 1994; Quinn-Patton, 1987; Stiles, 1993). Accordingly, the following principles were selected to evaluate this research and enable a degree of 'quality control' over its findings.

#### ***(i) Auditability***

This refers to 'opening up' the process of conducting the research for scrutiny by others (Sandelowski, 1986; Stiles, 1993). A research diary was kept throughout the study and enables others to understand how decisions concerning the research were made and also provides a reflexive account of the research process. The process of the analysis was also opened-up for scrutiny and the researcher's interpretative processes, subjective experiences and stance in relation to the research revealed.

#### ***(ii) Respondent validity***

This refers to the degree to which findings represent participants' realities and is important in judging the quality of the researcher's interpretations (Banister et al., 1994; Silverman, 1993).

In order to assess this, the emerging analysis was fed-back to participants to verify whether the account reflected their experiences and views accurately. Their comments and understandings were then used as additional information and insight to inform the final stages of the analysis.

**(iii) *Inter-rater reliability***

To help judge the accuracy of the researcher's interpretations, an independent rater categorised examples of text. Agreement between the independent rater and the researcher was then compared (Silverman, 1993).

**(iv) *Generativity***

Generativity refers to the extent to which the research facilitates further issues and questions for research (Henwood & Pigeon, 1995).

**(v) *Rhetorical power***

Rhetorical power refers to the effectiveness of the results in persuading others to accept them and can be judged in terms of participant's feedback on the findings and the reader's reactions to the results (Henwood & Pigeon, 1995).

## **2. METHOD**

### **2.1 Research diary**

The author kept a diary throughout the study to document experiences and decision-making processes whilst conducting the research (Appendix 1).

### **2.2 Design**

Qualitative methods were used to gain in-depth understanding of clinical psychologists' and self-help group members' views towards each other and towards collaboration. Data was obtained from face to face interviews using semi-structured interview schedules. These were designed for each group to facilitate exploration of the research questions; dimensions investigated were the same for both groups (Appendices 2 & 3).

### **2.3 Participants**

#### ***2.3a Self-help group members***

Group one comprised 14 members of self-help groups, recruited from a range of self-help groups for adults experiencing personal or emotional difficulties, such as groups for depression and for anxiety, but where difficulties were not severe enough to warrant in-patient care (Table 1.). All interviews were conducted within participants' homes at their request.

### 2.3b Clinical psychologists

Group two comprised 16 clinical psychologists working in adult mental health services. Of these, 12 had had some contact with self-help groups and four had never had contact (Table 2.). All interviews were conducted at the psychologist's work-place except one, which was conducted at the psychologist's home at their request.

**Table 1. Participant details: Self-help group members**

<i>Participant</i>	<i>Age</i>	<i>Sex</i>	<i>Type of SHG</i>	<i>Length of SHG involvement</i>	<i>Contact with clinical psychology</i>
1	52	F	Stress & anxiety	9 months	No
2	23	F	Eating problems	9 months (facilitator)	Yes (current)
3	48	F	Stress & anxiety	Intermittent over a 20 year period	Yes
4	33	M	Depression	4 months	No
5	42	F	Depression	8 months	Yes
6	30	F	Manic depression	5 months	No
7	25	F	Manic depression	3 months	Yes (current)
8	52	F	Depression	9 months	No
9	45	F	Depression	2 and a half years (facilitator)	No
10	36	M	Depression	1 year	No
11	38	F	Depression	1 year	Yes
12	67	F	Phobias	7 months	Yes
13	39	F	Survivors of sexual abuse	2 years	No
14	24	F	Survivors of sexual abuse	1 year	No

**Table 2. Participant details: Clinical psychologists**

<i>Participant</i>	<i>Sex</i>	<i>Length qualified</i>	<i>Time in present post</i>	<i>Contact with SHG's</i>
1	M	18 years	2 and a half years	Direct
2	F	23 years	15 years	Direct
3	F	22 years	19 years	Direct
4	M	14 years	5 months	Direct
5	M	25 years	16 years	Direct
6	M	22 years	13 years	Contact through clients
7	F	15 years	7 years	Direct
8	F	7 years	3 years	Contact through clients
9	M	24 years	4 years	Contact through clients
10	F	17 years	10 years	Contact through clients
11	M	29 years	29 years	Direct
12	F	7 years	5 years	Direct
13	F	2 and a half years	2 and a half years	None
14	F	10 years	1 year	None
15	F	5 years	5 years	None
16	M	9 years	9 years	None



### **2.3c *Inclusion criteria***

Self-help group members were required to have had at least three months involvement with a self-help group for adults experiencing psychological distress. Only self-help groups which were member-led and autonomous from professional services were included. Self-help groups for people experiencing more severe mental health difficulties, such as psychoses, were not approached.

Clinical psychologists were required to have been qualified for at least two years and to be working in services for adult mental health. Initially, only psychologists with previous contact with self-help groups, such as direct contact or experience of working with clients who had been involved with self-help groups, were included. Later in the study, psychologists who had never had contact were also recruited to develop the emerging account.

### **2.4. *Developing the interview schedules***

Semi-structured interview schedules were designed for each group to address the research questions (Appendices 2 & 3) and to last no longer than one and a half hours. These were based on the review of the literature and contained open-ended questions guided by preliminary ideas about the central issues. The interview schedules were developed through piloting.

Interviews started with standard comments to be read to participants and did not proceed until an informed choice about participation was established and both written and verbal consent

had been given (Appendices 2 , 3 & 4). Interviews were tape-recorded with the participant's permission; notes were also taken by hand during to track the discussion. Interview tapes were fully transcribed after the interview.

The schedules were divided into four main sections, each beginning with standard introductory comments. Questions were followed by a series of prompts which could be used during the interview to explore questions in depth. Follow-up questions were also used to clarify participant's responses, such as who, when, what or how questions. The interview ended with a debriefing section to ensure that participants were not left with any difficult feelings and to establish whether they still consented to their contributions being used in the research.

#### ***2.4a Interview schedule for clinical psychologists***

##### ***Section 1. Background information***

Details were sought about background within adult mental health clinical psychology services; contact with self-help groups to date; and awareness of self-help groups for people experiencing mental health difficulties.

##### ***Section 2. Views about self-help groups***

Questions sought to elicit views about self-help groups for people experiencing mental health difficulties and about how self-help groups helped people.

### ***Section 3. Perceptions of self in relation to self-help groups***

This section addressed perceptions of how self-help groups saw clinical psychologists and how the psychologist perceived themselves in relation to self-help groups.

### ***Section 4. Collaboration***

Questions explored views about working with or alongside of self-help groups; what issues might arise from this; and how self-help groups could most effectively interface with mental health services.

### ***Section 5. Debriefing***

This began with standard comments which were read out to participants. Questions included: how the person felt after completing the interview; had any difficult issues been raised; were there any immediate questions about the interview or how the information would be used; and was there anything that had not been covered. The author's contact number was given out and participant's were asked whether they would like to take part in the second stage of the study which involved commenting on the emerging analysis; all but one consented. Participants were asked whether they would like to receive information about the research findings after the study was completed and all indicated that they would.

## **2.4b Interview schedule for self-help group members**

### **Section 1. Background information**

Details were sought about involvement with the self-help group; personal experience of clinical psychology services or services for mental health to date; and knowledge of the group's contact with services.

### **Section 2. Views about professional help**

Questions sought to elicit views about professional help and about how professionals helped people.

### **Section 3. Perceptions of self-help groups in relation to mental health services**

This section addressed perceptions of how professionals saw self-help groups and how self-help group members saw groups in relation to professionals.

### **Section 4. Collaboration**

Questions explored views about professional involvement with self-help groups and what issues might arise from this.

### **Section 5. Debriefing**

This section followed the same format as in the previous schedule and differed in that



self-help group members were also asked for their age and whether they wanted any information about services and how to access them. All of the participants said they would like to take part in the second stage of the study and receive the research findings.

#### ***2.4c Piloting the interview schedules***

The interview schedules were piloted using the first two participants from each group and minor changes were made. An addition to the interview schedule for self-help group members was to ask them about their experiences of the group, in section one. It had felt disrespectful not to enquire during the interview and comparisons with experiences of professional help could not be made. The bulk of changes to the interview schedule for clinical psychologists was to condense some of the prompts beneath questions which had been repetitious. One addition was to ask how clinical psychologists might benefit from involvement with self-help groups, in section four. It was apparent that questions around collaboration were framed to suggest the direction of help was from professional to self-help group, a professional centric bias.

Other changes related to how the interview was conducted. During the pilots, participants often raised issues which were to be addressed in later sections. The researcher continued to follow the interview format but summarised participant's responses to avoid repetition later on.

The interview schedule for clinical psychologists was later adapted for use with psychologists who had never had contact with self-help groups. In section one, instead of enquiring about contact with self-help groups, psychologists were asked whether there were any reasons why they had not had any previous contact. The only other change was to modify the introductory comments to each section.

## **2.5. Procedure**

### **2.5a Ethical considerations**

Procedures were devised to ensure that participants were able to make an informed choice about participation and that they were not left with any difficult feelings after the interview. The research proposal was scrutinised by the Salomons Centre Ethics Panel and full ethical approval was granted with no conditions on 9 January, 1996 (Appendix 7).

#### **(i) Briefing procedures**

Information sheets (Appendices 5 & 6) were developed for each group and explained (a) the nature of the research and what was expected of participants; (b) how confidentiality and anonymity would be addressed; (c) right to withdraw at any time, both during and after the interview; (d) details of how to contact the author. Participants were briefed again when arranging the interview and at the start of the interview. They were encouraged to ask any questions about the research and time was given to address any issues fully.

**(ii) *Establishing consent***

A standard consent form was devised and this was completed prior to the interview (Appendix 4). After participants were briefed at interview, consent was re-established verbally before proceeding. Participants were asked for their permission to tape-record the interview; one person did not consent and the author relied on written notes of the interview verbatim.

**(iii) *De-briefing procedures***

All participants were debriefed after the interview. The author's work number was given again and participants were encouraged to make contact should any issues about the research or the process of participating emerge subsequent to the interview; no-one did so. Self-help group members were also asked whether they would like any information about services; none was requested.

**2.5b *Recruitment procedure***

**(i) *Clinical psychologists***

Adult mental health clinical psychology departments within the South Thames area and within one and a half hours driving distance from the author were identified; seven in total. The author contacted each head of service by telephone to explain the purpose of the research and request permission to forward information to be circulated within the department. An offer to attend a departmental meeting to discuss the research in person was made, though this was never taken up. Once permission had been granted, information sheets (Appendix 5) were sent



to named psychologists with a consent form, (Appendix 4) a covering letter (Appendix 8) and a pre-paid return envelope.

A total of 22 clinical psychologists were approached. Of these, ten agreed to take part; four did not fit the selection criteria because they had no experience with self-help groups; three did not reply; four said they were not interested; and one psychologist said they were too busy. Psychologists who had agreed were contacted by telephone to arrange an interview time.

Two more clinical psychology departments within the South Thames area were approached during the second recruitment phase. The same recruitment procedure was adhered to but was modified to include a reply slip to return to the author to indicate whether or not the psychologist was interested in taking part. The covering letter was also modified to extend the selection criteria to psychologists who had not had any contact with self-help groups (Appendix 9).

Thirteen clinical psychologists were written to in the second recruitment phase. Of these, two more psychologists with previous contact with self-help groups were recruited and four without any contact; one psychologist said they were too busy; three did not reply; one said they were not interested; and two expressed an interest after the author had completed recruitment.



**(ii) *Self-help group members***

Information sources close to the author's home and work-place were used to find out about self-help groups and included: libraries; resource directories; health information telephone lines; and MIND. Five self-help groups were identified who fitted the selection criteria. A further three groups were identified through contacting two national self-help organisations for depression and anxiety respectively.

The author contacted each group facilitator by telephone to explain the purpose of the research and request permission to forward information to be circulated within the group. An offer to attend a group meeting to discuss the research in person was made which one group took up and the author recruited direct from the meeting. With the other self-help groups, once the facilitator had granted permission, information sheets (Appendix 6) were forwarded to be distributed at the next group meeting. Facilitators were asked to discuss with interested members how they would like to make contact with the author; either by telephoning the author at work or leaving a contact number with the facilitator. The author arranged to contact the facilitator after the next group meeting to find out whether any of the members were interested and if so, how to contact them to discuss the research further. Members who expressed an interest were all contacted at home, at their request. This was an opportunity to discuss any issues regarding the research and arrange an interview time. Written consent was gained at interview (Appendix 4). This resulted in the recruitment of fourteen self-help group members from a total seven groups (Table 3.).

**Table 3. Details about self-help groups approached and number of members recruited**

<i>Nature of self-help group</i>	<i>Number of members recruited</i>
Stress & anxiety	3
Manic depression	2
Survivors of sexual abuse	2
Eating disorders	1
Depression	3
Phobias	1
Survivors of suicide	0
Depression	2

## **2.6 Data management**

Interview transcripts were analysed individually for each group using aspects of grounded theory, an approach to qualitative analysis first outlined by Glaser & Strauss (1967). Later revisions include accounts by Turner (1981) and Strauss & Corbin (1990). The ultimate goal of grounded theory approaches is to generate 'emergent' theory which is then extended through further theoretically driven sampling of new cases. Henwood & Pigeon (1995) describe this as 'ambitious' and argue that many studies fall short of building a 'total' theory. In this study, a second round of data collection was not possible and further theoretically driven sampling is required to build on the present analysis. An attempt was made to develop the preliminary categories emerging from the analysis of psychologists' interviews by interviewing psychologists who had not had contact with self-help groups.

The analytic sequence was as follows:

### **1. *Immersion***

Analysis started with a process of reading and re-reading the data to become familiar with the qualitative material.

### **2. *Coding***

Transcripts were then analysed by underlining meaningful segments of text, expressing a single coherent thought. These were then abstracted from the transcript and labelled as a basic code. Segments of text which appeared not to relate to the research questions were discarded. This applied to approximately 30 per-cent of the text overall. As further transcripts were analysed re-occurring codes as well as new codes were identified.

### **3. *Categorisation***

This stage involved grouping together basic codes which appeared to be related under broad headings. These groupings were then used to develop preliminary categories to describe the main features of the data (Appendices 10 & 11). A definition was generated for each category and exemplary quotes were selected from the transcripts to illustrate the categories.

### **4. *Developing the categories for clinical psychologists through analysis of interviews from psychologists without any contact***

The categories which emerged from the first set of interviews with clinical psychologists were used to analyse the interviews with psychologists who had not had contact with self-help



groups. Similarities and differences between the two groups of psychologists were looked for in the data, as were any new basic codes (Appendix 12).

#### **5. *Respondent validity***

The emerging analysis was sent to participants for feedback (Appendices 13, 14 & 15). Their comments were incorporated into the final analytic stages (Appendix 16).

#### **6. *Inter-rater reliability***

Inter-rater reliability of categories was performed by a psychology colleague on four interviews; two from each respondent group. This involved sorting segments of text into categories. Agreement between the independent rater and the author was then compared.

Inter-rater reliability of basic codes within categories was conducted on four categories; two from each respondent group. This involved sorting segments of text under basic codes.

Agreement with the author was then compared.

#### **7. *Comparing categories for each group***

Categories which emerged from both groups were then compared by looking for commonalities and differences.

#### **8. *Thematic analysis***

Later stages of analysis moved from description to interpretation with the aim of constructing the theoretical framework. Themes were identified across both groups by closely examining



the emergent categories for each group and looking for links and connections between categories. Themes were developed and explored in relation to each group and through discussion with the supervisor. Core aspects of themes were then selected and used in the final stage of the analysis to develop an explanatory, theoretical framework to understand the data.

### **3. RESULTS**

#### **3.1 Overview**

The emerging conceptual categories are presented for each group. These are briefly described and exemplary quotes <sup>1</sup> used to illustrate certain categories. Results from inter-rater reliability and from respondent validity are then presented. The section continues with a description of themes which emerged from the thematic analysis and by presenting the emerging theoretical framework to understand issues in collaborative relationships.

#### **3.2 Clinical psychologists**

Initial coding of the first set of clinical psychologists' interviews generated 222 basic codes and led to 36 basic conceptual categories, further detailed in Appendices 10 and 13. A set of codes were produced about accessing information about self-help groups but as they did not form a conceptual category of any salience to the respondents they were not included in the next stage of analysis. The basic conceptual categories were used to analyse the second set of interviews with clinical psychologists who had never had contact with self-help groups

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<sup>1</sup>The use of ... within quotations refers to a speech pause and not an omission of text

(Appendix 12). Nineteen new basic codes emerged and could be incorporated within the existing conceptual categories. One new category emerged: 'The transient nature of self-help groups'. The following is a summary presentation of the conceptual categories which are numbered in the text as they are referred to in Tables, 4 and 5.

### **3.2a Clinical psychologists' views about self-help groups**

Table 4, shows those categories which emerged to describe clinical psychologists' views about self-help groups. The first bracketed number besides each category refers to the number of psychologists in the first set of interviews who gave at least one response in that category, the second bracketed number refers to psychologists in the second set of interviews.

**Table 4. Identified categories relating to clinical psychologists' views of self-help groups (SHG's)**

<i>Clinical psychologists' views of self-help groups</i>	
<i>Broad groupings</i>	<i>Basic conceptual categories</i>
<b>Helpful aspects</b>	1. Belief in the principle of self-help & SHG's (6) (3) 2. Provides support & social contact (10) (3) 3. Provides opportunities to share with others (10) (2) 4. Provides opportunities to meet others with similar difficulties (11) (4) 5. Groups are generally helpful (3) (1) 6. Empowerment of members (8) (3) 7. Provision of non-professional help (8) (3)
<b>Unhelpful aspects</b>	8. Too much professionalism: a threat to mutual-help culture of SHG's (4) (0) 9. Concern about lack of professionalism (7) (3) 10. Concern that members motives may not be altruistic (6) (0) 11. Single problem SHG's are less helpful than generic groups (9) (1) 12. Concerns about how SHG's handle information (7) (1) 13. SHG's may not help members to overcome their difficulties (6) (3)
<b>Who might go to an SHG?</b>	14. Mixed views about who might go to an SHG (9) (3)

#### **(i) Helpful aspects of self-help groups**

Clinical psychologists perceived many helpful aspects of self-help groups and some regarded the idea of self-help as generally desirable (1). Self-help groups were seen as places to give and receive support and expand social networks, reducing feelings of isolation and loneliness



(2). They were also seen as places to share with others, for example, information (3).

Particular value was placed on being with others experiencing similar difficulties including: feeling less alone with problems; normalisation; and hope of change (4). Some thought self-help groups shared many helpful aspects with professionally led groups (5).

**“...essential advantage is that it says to the client better than I could..you’re not the only person, others feel this way too.” (4)**

Other helpful aspects included empowerment of members, as well as self-help groups becoming pressure groups for change. This was seen as particularly helpful to combat experiences of disempowerment from services (6). Self-help groups were also valued as places of non-professional, informal support and because of the reduced stigma, dependency and power inequalities (7).

**“...combating disempowerment; importance of people being involved as far as they can; getting understanding of their own difficulties; having some power, a voice in the system...” (5)**

### ***(ii) Unhelpful aspects of self-help groups***

Concerns emerged about ‘professionalism’ within self-help groups, such as a group culture based on the value of experts, not on mutual help (8). There were also concerns about lack of ‘professionalism’, for example, risks to members if no-one was trained or responsible for running the group and managing group process issues, or if the group ‘got out of its depth’ (9). Another concern was the potential for group members to be influenced in unhelpful ways, such as members exploiting the group for their own personal agendas (10).

**“...about the people who are in charge or facilitating them and about their degree of expertise, experience and knowledge and self-awareness which is important because any group situation can be potentially damaging if things go wrong.” (9)**

Single-problem focused self-help groups generated most concern. Fears included: the potential to exacerbate difficulties; to promote a belief that only similar others can understand; to deny differences; to become 'stuck in a role' and re-inforce keeping the problem to stay in the group (11). Other concerns were about the inaccuracy of information and the potential for information to be mis-interpreted. Another aspect was concern about polarised views and exclusion of other perspectives and about groups which only considered external explanations of people's distress (12).

**"A concern was that a lot of the ideas, well, how much basis in research and literature was debatable; felt bizarre. Some of the things they said were quite concerning, I felt they hadn't got accurate information."** (12)

Other comments hinted at the limitations of self-help groups in helping people to overcome their difficulties and the limitations of groups in general. For example, whether members would become 'stuck' or find it hard to leave because of the social aspect, or whether unhelpful group norms could be established. Other fears were about the group becoming comprised of people with chronic problems and then, whether it would be supportive enough to be helpful (13).

**"I wonder whether they help people to change or whether they just help people to stay the same. Given a lot of my work is to help people to change...I suppose I am aware that it can support maladaptive defences or behaviours...people can get stuck."** (13)

***(iii) Who might go to a self-help group?***

Clinical psychologists typically expressed uncertainty about who might go to a self-help group, views ranged from dependent to self-reliant people or people with difficult experiences of



services. Some wanted to protect groups from people who might be unhelpful to have as members (14).

“Some people I’ve thought would get on well have hated it and some I’ve thought would not be able to manage the lack of self-direction in a self-help group have.” (14)

### 3.2b *Clinical psychologists’ views about involvement with self-help groups*

Table 5, shows those categories which emerged to describe clinical psychologists’ views about involvement with self-help groups.

**Table 5. Identified categories relating to clinical psychologists’ views about how SHG’s perceive them; how they see SHG’s in relation to services; and views on collaborative relationships**

<i>Clinical psychologists’ views about involvement</i>	
<i>Broad groupings</i>	<i>Basic conceptual categories</i>
<b>Psychologists’ views about how SHG’s see professionals</b>	15. Who are they? (11) (4) 16. Negative views of mental health services (4) (0)
<b>Views of SHG’s in relation to services</b>	17. As valuable (3) (2) 18. As having unique things to offer people (5) (1) 19. With danger warnings (3) (0) 20. Services may be dismissive of SHG’s (3) (0) 21. Possible tensions in SHG’s relationship with services (5) (0)
<b>Pro-collaboration with SHG’s</b>	22. For collaboration with SHG’s (5) (4)
<b>Benefits of collaboration</b>	23. Benefits for SHG’s (6) (0) 24. Benefits for professionals: Service alternatives (5) (3) 25. Benefits for professionals: Opportunity to learn more (8) (3)
<b>Sources of tension in the relationship</b>	26. Can’t stop being a psychologist: professional responsibilities (5) (0) 27. Different perspectives to the SHG (7) (1) 28. Managing criticisms of services (9) (1) 29. Threat to future working relationships (2) (0) 30. Responsibilities to the organisation (8) (2) 31. Un-helpful for SHG’s: threatens the essence of SHG’s (7) (2) 32. Emotional issues for the psychologist in the relationship (11) (4) 33. Transient nature of self-help groups (0) (2)
<b>Ways of relating</b>	34. Indirect & non-authoritarian (10) (2) 35. Don’t get too close (5) (2) 36. Communication & clear roles (9) (4) 37. Direct ways of relating to SHG’s: possible roles (10) (4)

**(i) *Psychologists' views about how self-help groups see professionals***

There was considerable uncertainty about how self-help groups might see clinical psychologists and most felt they would not know who psychologists were. Others saw the possibility for a spectrum of views from helpful to unhelpful, or general stereotypes of professionals. Some thought there would be criticisms of accessing clinical psychology services and under-resourcing (15). Those who commented, thought that self-help groups would perceive mental health services negatively (16).

**“There’s a feeling that people don’t know who we are, maybe people find us remote...one of them.” (15)**

**(ii) *Views of self-help groups in relation to services***

Self-help groups were described positively in relation to services, some psychologists saw them as part of the overall network of services, not an adjunct (17). They were valued for offering different services to professionals and sometimes seen as a preferable option. Some thought that both forms of help were vital because of their different strengths and drawbacks, a non-competitive view of the relationship (18). Danger was perceived in using self-help groups to de-professionalise services and promote a view that only self-help groups can help. There were also concerns about views that only professionals can help (19).

**“..we co-exist..they give one part of the service and I give another. I do think there are areas in which there isn’t an overlap and therefore it’s better that we both exist.” (17)**

Those who commented thought that mental health services would dismiss or undervalue self-help groups or be exploitative (20). Some referred to possible tensions in the relationship, such as services viewing self-help groups as a problem or a threat, or finding it difficult to work with them because of a lack of control or criticisms of services (21).



**“Sometimes services can be a bit snooty, they can be patronising perhaps not wishing to recognise the extent to which people are able to help and support themselves.” (20)**

***(iii) Views of collaboration with self-help groups and its benefits***

Most psychologists were for collaboration with self-help groups (22). Benefits were described for both parties including: extra resources for self-help groups (23); access to service alternatives for psychologists and more choice for clients (24); opportunities to learn about consumer’s views and gain insight into people’s difficulties and personal resources (25).

**“I feel there should be more collaboration: there’s quite a gulf.” (22)**

***(iv) Sources of tension in collaborative relationships with self-help groups***

A number of areas emerged as possible sources of tension. There was anxiety about having to compromise professional responsibilities because of a lack of authority within self-help groups and some preferred involvement outside of their professional role (26). Another tension was managing different points of view (27) and criticisms of services (28). Other tensions related to role-blurring, such as concern that involvement could threaten future working relationships with group members or be awkward if former clients were members of the self-help group (29).

**“I don’t know that I’d be too happy about them saying could you come along now and sit in on a group..because if I think if I was in a group I’d have a professional responsibility, if things were happening that I had a conflict about, would I have the permission to raise those concerns.” (26)**

Tensions also arose from psychologists’ responsibility to their employing organisations, such as work pressures and whether involvement with self-help groups was seen as a legitimate role. Potential for conflicting loyalties was envisaged (30). Other tensions were the possibility of stigmatising the self-help group; threatening their autonomy and fostering dependency, thus

losing the mutual-help culture of the group and risking co-option by services. Some psychologists had found it hard to withdraw from involvement with self-help groups and felt the group had resisted this despite expressing a wish to be self-directed (31).

**“Taking over or being seen to take over or changing the actual nature of the group. If it’s self-help it should be self-help. Difficult if you were involved in a more regular, informal way, it would change it irretrievably.” (31)**

Other tensions can be described as emotional issues for psychologists. Many described the role as awkward and uncomfortable, a clash of cultures, although some had had positive experiences. Managing negative feelings from both sides of the relationship and from other colleagues was clearly uncomfortable, as was being the only person not sharing personal experiences and uncertainty about being able to offer anything (32). Another source of tension was the transient nature of self-help groups, making it difficult to maintain relationships (33).

**“It was awkward because I was in the shadow of the facilitator; because I wasn’t sure of my role; no-body’s asked for my opinion so I felt I shouldn’t give it; because they’re sharing their experiences and I’m not.” (32)**

#### **(v) *Ways of relating to self-help groups***

The majority of psychologists advocated non-authoritarian ways of relating which were non-intrusive and did not take away the self-help group’s control or autonomy. Most preferred to be generally encouraging, supportive and to be available as a resource (34). Some psychologists avoided too close a relationship with self-help groups because of the inherent dangers, such as threats to the group’s autonomy. Finding the right balance between closeness and distance was emphasised and some thought this depended upon the nature of the group whereas others thought self-help groups should remain separate (35).



**“..it seems to me that there is a tension between assisting them and developing them to do what they do but also leaving them alone to do their own thing. It’s a matter of helping them at arms length.” (35)**

Ways of helping the relationship to work included: channels of communication; opportunities to link; increasing understanding; more awareness of self-help groups; and clear roles (36).

Psychologists also discussed possible direct roles in relation to self-help groups, such as supervision and consultation. Some said they informed clients about self-help groups, others were more hesitant and would never suggest them without prior knowledge of the group (37).

**“I think it’s about opening up a system; bringing knowledge and information about what goes on inside of organisations and how to access people in organisations and that’s quite a big organisational shift for services...” (37)**

### **3.3 Self-help group members**

Initial coding of self-help group members’ interviews generated 142 basic codes and led to 38 basic conceptual categories, further detailed in Appendices 11 & 14. Three codes were not used because they did not form a relevant conceptual category. The following is a summary presentation of the conceptual categories which are numbered in the text as they are referred to in Tables, 6 and 7.

#### ***3.3a Self-help group members’ views about self-help groups and professional help***

Table 6, shows those categories which emerged to describe self-help group members’ views about professional help. The bracketed number refers to the number of self-help group members who had at least one response in that category.

**Table 6. Identified categories relating to self-help group members' views about self-help groups and professional help**

<i>SHG members' views of self-help groups and professional help</i>	
<i>Broad groupings</i>	<i>Basic conceptual categories</i>
Helpful aspects of SHG's	1. SHG's are generally helpful (9) 2. Being with others who are also experiencing difficulties (12) 3. Help and social support (10) 4. General informal atmosphere (8)
Unhelpful aspects of SHG's	5. General concerns about SHG's (5)
Mixed views of professional help	6. Positive experiences of professional help (10) 7. Both positive and negative experiences of professional help (5) 8. Ambivalent views (3) 9. Negative experiences of psychiatric services (7)
Helpful aspects of professional help	10. Can help you to move on (7) 11. Helpful if a good working relationship can be established (7)
Unhelpful aspects of professional help	12. Lack of services & resources (12) 13. How professionals can treat you; make you feel (8) 14. Stigma (8)
Differences between SHG's & professional help	15. Professionals can move you on more than an SHG (2) 16. Professionals are less understanding & provide less support (8)

**(i) *Helpful aspects of self-help groups***

For many people, belonging to the self-help group was described as a generally important and valued part of their lives (1). Being with others who were also experiencing difficulties was highly valued, helping people to feel less alone with their problems. Many felt that people who had experienced difficulties themselves were more able to understand (2). Self-help groups were also described as providing help and social support and some people said they had joined specifically to help themselves. Many commented that the group had helped them. Also valued were opportunities to help others and share ideas and information about ways of coping. Some valued the social side of the group, also their relationships with other members which meant support happened both in and outside of the group (3). Many people referred to the informal, relaxed atmosphere of self-help groups. They were described as more genuine, warm, caring and humanising than professional help (4).



**“It’s good to give something back...when you’ve had help yourself...you give a bit and someone helps you to...” (10)**

**(ii) *Unhelpful aspects of self-help groups***

Few self-help group members expressed concerns about their group. General comments were made including: concern about the quality of advice given; insufficient attention to the causes of problems; and not pushing people to change (5).

**“The impression I get is that we’re telling one another how we sort it out...but we could be doing it wrong...maybe it’s a good idea I don’t know.” (5)**

**(iii) *Views about professional help***

Self-help group members’ views of professional help varied. Many described positive experiences (6) and some of these people had also experienced unhelpful contacts (7). Some people were ambivalent (8) and about half described adverse experiences of psychiatric care which had put them off professional help (9).

**“I do think professional help can be beneficial.” (6)**

**(iv) *Helpful aspects of professional help***

Being helped to change was frequently described as useful. People valued talking to someone who was distant from their situation and more able to be objective (10). Establishing a good working relationship helped people to use professional help, aspects of this included: trust; being listened to and having feelings acknowledged; and signs the professional cared and was interested (11).

**“..that’s how I’ve benefited...to have someone to talk to who doesn’t get caught up in the emotional turmoil.” (10)**

**(v) *Unhelpful aspects of professional help***

The majority of people were concerned about lack of resources and difficulties accessing services and anger about being offered 'drug solutions'. People were worried about poor availability of professionals, long waiting lists, limited time and poor communication amongst professionals (12). Other reservations emerged from people's experiences of professional help, particularly: lack of feedback and consultation; confusion about how professionals were trying to help; disempowerment; and potential for the relationship to be abusive. Some people described professional help as clinical and de-humanising and felt professionals were too remote and detached. Other general concerns were about lack of understanding and not being helped to change (13). Many people also discussed the stigma associated with mental health difficulties and of seeking help; some avoided professional help because of this (14).

**"..there was no real understanding there, he was just being very clinical. That would be another concern of it being too clinical with no real person to person thing...fairly remote." (13)**

**(vi) *Differences between self-help groups and professional help***

Reference was made to differences between self-help groups and professional help. Some people thought professionals were more able to 'get at the root of problems' than self-help groups (15), but less able to understand because they had not 'been there' and unable to offer as much support as self-help groups (16).

**"..I think sometimes whilst you're with a professional you can explore certain ideas...with others with similar problems to yourself..you've got that human understanding...which does not always come to the fore with a one to one with a professional." (16)**



### 3.3b Self-help group members' views about involvement with professionals

Table 7, shows those categories which emerged to describe self-help group members' views about involvement with professionals.

**Table 7. Identified categories relating to self-help group members' views about how professionals perceive them and SHG's; views about SHG's in relation to services and views on collaborative relationships**

<i>Self-help group members' views about involvement</i>	
<i>Broad groupings</i>	<i>Basic conceptual categories</i>
SHG members views about how professionals see them	17. Uncertain (3) 18. Negatively (6) 19. Respectfully (3)
SHG members views about how professionals see SHG's	20. Uncertain (2) 21. As helpful (7) 22. Experiences of positive relationships (2) 23. As unhelpful: with concerns about them (6)
Views of SHG's in relation to services	24. As valuable (9)
Views on collaboration	25. For collaboration with professionals (12) 26. Against collaboration with professionals (2)
Benefits of collaboration	27. Benefits for SHG's (5) 28. Benefits for professionals (6)
Sources of tension in the relationship	29. Associated with uncomfortable feelings (7) 30. Fears of professionals' reactions (9) 31. General difficulties for SHG's (5) 32. General difficulties for professionals (5)
Ways of relating	33. Uncertain (3) 34. Professionals could encourage and be more aware of SHG's (4) 35. Professionals could be available and offer their resources (9) 36. Be respectful of SHG's (7) 37. SHG's should not give away their power (2) 38. Egalitarian relationships (4)

#### (i) Self-help group members' views about how professionals see them

No strong views emerged about how professionals would see people who were experiencing difficulties. Some expressed uncertainty (17), others thought professionals could be quite negative, such as seeing people as being unable to cope (18), and others thought professionals would be much more respectful (19).

**"In the past I do feel that I was viewed as a bit pathetic...that it was my responsibility, my fault that I was unwell and it was up to me." (18)**

**(ii) *Self-help group members' views about how professionals see self-help groups***

Some people were uncertain about how professionals would view self-help groups (20). Many thought professionals would be in favour of them because they took some of the pressure off services and because people need other forms of support. For many people, a professional had actually recommended the group (21). Some referred to existing good relationships between their group and services (22). Others thought professionals might disapprove of self-help groups, seeing them as unhelpful and as dangerous for members, or as a threat to services (23).

**“...feel they do see it as an integral part of the whole thing...not them and us but them and us together.”  
(22)**

**(iii) *Views of self-help groups in relation to services***

The majority of people thought self-help groups were extremely helpful in relation to services and saved the NHS a lot of money and resources. Some saw self-help groups as the way forward and anticipated more groups in the future, others commented on the importance of having both professional and self-help groups to meet people's needs (24).

**“Don't know which is most valuable, both are important in their own way.” (24)**

**(iv) *Views of collaboration with professionals and its benefits***

Most self-help group members were for collaboration with professionals and some thought this would depend upon the individual group and professional involved (25). Others foresaw problematic relationships but only one person was totally unwilling for professional involvement (26). Benefits were described for both parties, including access to expertise and different perspectives for self-help groups and additional help for members (27). Perceived



gains for professionals included professional accountability, a greater insight into people's difficulties and increased resources (28).

**"I'm all for it, I think there should be more...but I don't think there is an easy way..it's one of those ideals."** (25)

**(v) *Sources of tension in collaborative relationships with professionals***

A number of areas emerged as possible sources of tension. Much discomfort was associated with professional attendance at meetings. Some described this as intrusive, especially if the group was small or if professionals came frequently. There was concern that people might be put off coming or would 'open-up' less (29). Another tension concerned professionals' attitudes to the group, such as attempts to 'take-over', criticism or patronising reactions. Others foresaw potential for disagreements and wondered how different viewpoints would be managed. Another source of tension was that professionals might expect too much and that members would be unable to live up to their expectations (30).

**"Sometimes...professionals may sneer at the achievement of a self-help group and say the group isn't very structured, the facilitator doesn't pull up so and so...if a professional facilitator went in the group they might organise it differently but they might end up with three people...we're a bit more laid-back, we accept behaviour...because we understand where it's coming from people are given a bit more help."** (30)

Other sources of tension included more general difficulties for self-help groups and professionals, such as whether it would be a waste of the group's time. Some saw tensions from professionals not having experienced the difficulties themselves or if the group had set up in opposition to services (31). People also anticipated tensions for professionals, such as lack of time, not regarding the role as important, difficulties coping with boundary issues or feeling threatened by self-help groups (32).

**“I don’t know what professionals would think about crossing professional boundaries...would this be allowed...could they cope with it...cope with the detachment.” (32)**

**(vi) *Ways of relating to professionals***

Some self-help group members were uncertain about how professionals and self-help groups could relate to one another (33). One possibility was that professionals could encourage self-help groups by suggesting them to clients and being more aware of groups (34). The majority of people thought professionals could be available to help and offer their resources, more of an ‘arms length’ type of relationship. Some mentioned that support and advice for facilitators would be useful (35).

**“If it was a contact of we know you’re there, get in touch...then there would be better links...could use this...to be available...establishing a link...a gentle link. Uncompromising for both parties.” (35)**

The majority of people emphasised the need for professionals to respect the value of self-help groups and their autonomy for relationships to work (36). Some people thought that self-help groups also had a responsibility not to put themselves in positions where professionals could take away their power and suggested that groups needed to find the right level of involvement for them (37). Those who commented on the type of relationship that should exist between professionals and self-help groups suggested egalitarian relationships, also increasing mutual understanding and reducing the ‘them and us’ feeling (38).

**“...respect the group, the structure of the group and offer what they can which is relevant to us...Be sensitive to our needs...because it is a good group it works very well.” (36)**

**3.4 *Results of inter-rater reliability***

The independent rater sorted segments of text into categories from four interviews’ two clinical psychologists’ and two self-help group members’. Percentage agreement on category



assignment with the author was calculated for each interview. Table 8, shows adequate to good inter-rater reliability across all interviews.

**Table 8. Results of inter-rater reliability of categories**

<i>Interviews</i>		<i>Percentage agreement</i>
Clinical psychologists'	1	78%
	2	71%
SHG members'	1	82%
	2	75%

The same independent rater sorted segments of text into basic codes within categories on two categories from both respondent groups. Percentage agreement on basic code assignment with the author was calculated for each category. Table 9, shows high inter-rater reliability across all categories.

**Table 9. Results of inter-rater reliability of basic codes**

<i>Clinical psychologists' categories</i>	<i>Percentage agreement</i>
Concern about how SHG's handle information	100%
Provision of non-professional help	93%
<i>Self-help group members' categories</i>	
Differences between SHG's & professional help	83%
Perceptions of self by professionals	93%

### **3.5 Results of respondent validity**

Detailed summaries of the 'emerging' conceptual categories were prepared for each of the respondent groups based on the data from their group only and sent out to participants (Appendices 13 & 14). Feedback was requested to verify whether the account was an accurate reflection of their experiences and views (Appendix 15). Eight of the 16 clinical psychologists returned feedback forms. Of these, six described the account as accurate; one person said they were unable to comment on whether the feedback was accurate for psychologists as a whole;

another person did not comment on accuracy. Four of the 14 self-help group members returned feedback forms. Everyone made positive comments about the content of the report; two people described the feedback as generally accurate; one person described the account as 'excellent' but disagreed with categories 14 & 23; one person commented on the difficulty of judging the accuracy of an account based on the views of many:

**"Difficult to comment, obviously one person's views might not be another's. Self-help groups really have to be able to accept everyone-one, views and all!"**

Respondents comments are further detailed in Appendix 16.

### **3.6 Thematic analysis**

Themes were identified across both groups to understand the issues in collaborative relationships and are presented and explored in relation to each group.

#### ***(i) Coming out of the cold and into the warmth***

This theme was expressed by both groups and has implications for collaborative relationships. Self-help group members' descriptions of professionals as remote, distant and clinical evoked cold feelings, as did people's experiences of being related to as 'just another case'. Any signs which showed professionals cared and were genuinely interested were valued. Clinical psychologists were also aware that professionals might be seen in this way.

In comparison, self-help groups were seen to offer more of a 'human touch' and descriptions by members evoked feelings of warmth, friendliness and comfort. The atmosphere was felt as

one of shared understanding and acceptance. These differences suggest tensions in collaborative relationships because professional involvement risks 'bringing in the cold' to self-help groups and creating discomfort.

**(ii) *Support and demand***

The theme of support and demand reflects another difference between self-help groups and professional help. Self-help group members valued the general supportiveness of self-help groups and saw them as more easy-going and less demanding than professional help. Clinical psychologists also valued the supportiveness of self-help groups but saw limitations to this in not helping people to change. This was also recognised by self-help group members who said they valued professional help because it 'pushed' people to change, whereas self-help groups by nature were less challenging and confrontative.

This tension between support and demand could create difficulties in collaborative relationships. Some anxiety was expressed by self-help group members that professional involvement could reduce the supportiveness of self-help groups. There might also be a wish for some 'expert' direction and demand, but resentment when this happens because of threats to the supportiveness of the group.

**(iii) *Risk versus safety***

Both groups perceived different levels of risk from belonging to a self-help group relative to professional help. Clinical psychologists expressed anxiety that self-help groups could be



unsafe for members. Many of these concerns were about problematic group processes and how these would be managed in a self-help group, especially if no-one was in charge or trained to monitor group process issues as in professionally led groups. Some psychologists wanted to protect self-help groups from 'unhelpful' members or protect 'vulnerable' people from joining. Whereas self-help group members acknowledged that professionals might see dangers in self-help groups, they expressed much less anxiety about this. Some also referred to the potential for professional help to be 'abusive' and place clients at risk. Managing these different conceptions of danger might create tensions in collaborative relationships.

**(iv) *Abundance and emptiness***

Self-help group members' descriptions of services as lacking in resources, time and availability created an image of emptiness and deprivation. In comparison, self-help groups appeared bounteous, able to give more time and support. Clinical psychologists acknowledged that self-help groups might express concern about lack of resources and availability and be critical of this. This might also lead to difficulties in establishing collaborative relationships, acknowledged by both parties and in self-help group members' concerns about whether professionals had any time or anything to offer that would be helpful and a good use of the group's time.

**(v) *Power and inequality***

The theme of power and inequality was expressed across both groups. Self-help groups were seen as places where people could give and receive support and where members were more



equal, whereas exchange in professional helping relationships is one-way and power differentials exist. Clinical psychologists said they valued the lack of power differentials in self-help groups. They were concerned about members taking on too much responsibility and control, causing the balance of power to become less equal and threatening the mutual help culture of the group. Self-help group members described experiences of disempowerment from contact with services and were concerned about the lack of a two-way exchange, such as a lack of consultation, communication and feedback from professional helpers.

Managing power and inequality could create tensions in collaborative relationships. Self-help group members were concerned that professional involvement might disempower self-help groups by trying to take-over or control them. These fears were also shared by clinical psychologists who recognised the potential to recreate power differentials and foster dependency, for example, group members looking to the professional for help and advice, not to each other.

Both groups expressed preferences for non-authoritarian ways of relating which did not attempt to change self-help groups or foster dependency. Some self-help group members suggested that groups should avoid putting themselves in positions where professionals could 'take their power' away; egalitarian relationships were also advocated. Another suggestion was to emphasise the potential mutuality of the relationship and gains for both parties from collaboration.

**(vi) *Similarity and difference***

Similarity in self-help groups emerged as a strength across both groups but was also a concern for clinical psychologists and a possible tension in collaborative relationships. Self-help group members' descriptions of their groups emphasised similarity and inclusion, such as 'being in the same boat' and a sense of common humanity. Clinical psychologists expressed concerns that self-help groups organised around similar problems would hinder change. Another concern was that minimising difference between members could create problems for members who were not the same. Some clinical psychologists spoke of the discomfort of feeling on the outside in a self-help group, being the 'only one not sharing'.

Inevitably, there are differences between professionals and self-help group members. For example, professionals are paid to care and are not mutual members. Managing difference could create tensions in collaborative relationships. One way in which both groups dealt with difference was by claiming to value it, recognising that both had unique things to offer.

**(vii) *Managing disparagement***

This theme cut across both groups and raises issues for collaborative relationships. Both groups acknowledged potential for criticism from the other and the potential for collaboration to evoke unpleasant feelings in the relationship. Clinical psychologists expressed anxiety that self-help groups would disparage services as well as their own role if collaborative relationships were developed. They also thought that services would be critical and undervaluing of self-help groups. Self-help group members were also anxious that their group



would be disparaged by professionals, such as fear of critical and patronising reactions.

Managing potential negative feelings in the relationship is clearly an issue in collaborative relationships.

***(viii) Threats to identity***

Both groups referred to threats to identity in collaborative relationships. Clinical psychologists expressed concerns that their professional responsibilities would be compromised in a self-help group because of a lack of power and authority in that environment to act on any concerns, thus threatening their professional identity. There were also threats of role blurring, such as meeting former clients in a self-help group or having group members referred for help, and also from conflicting loyalties to the self-help group and responsibilities to employing organisations. Another threat was role uncertainty and lack of clarity in relation to involvement with self-help groups. Experiential not professional knowledge was valued in self-help groups, thus creating tensions about how psychologists could help without relating in ways which might be problematic for the relationship, such as 'expert' roles. For some psychologists, the tensions were so problematic that they preferred involvement outside of their professional role; thus avoiding the issue of their professional identity altogether. Some managed the tensions by becoming involved away from their work place.

Self-help group members' experiences of disempowerment and of being treated as 'just another case' suggested threats to identity in professional helping relationships. Both self-help



groups and clinical psychologists were concerned that collaborative relationships would threaten the survival of the self-help group, such as risk of take-over or co-option. Safe-guarding identity and managing boundaries could create issues in collaborative relationships for both groups.

***(ix) Regulating distance***

Regulating distance emerged as a theme to describe how both groups anticipated they would manage collaborative relationships. Findings suggested that too close a relationship brought threats for both clinical psychologists and self-help groups, such as threats to identity and tensions from managing the differences between them. Both groups referred to the need to find a comfortable balance between closeness and distance in the relationship. Often this was about not getting 'too close' and both parties favoured more of an 'arms-length' type of relationship with channels of communication open for dialogue and by establishing structures to link. Some participants thought professionals and self-help groups should remain totally separate. At present there is probably too much distance in the relationship suggested by both groups' uncertainty in their mutual perceptions and lack of clarity about roles in relation to the other.

**3.7 Emerging theoretical framework**

Core aspects of themes were abstracted and used to develop the emerging theoretical framework to understand issues in collaborative relationships between self-help groups and clinical psychologists. Managing tension was crucial and was expressed in various ways

across themes. Three major dimensions are explored in the theoretical framework: similarity versus difference; power versus equality and resources versus deprivation. Managing the resulting tensions poses threats for both groups in collaborative relationships.

Both groups have to grapple with the discomfort of difference and the tensions this creates, as expressed in the theme 'similarity and difference'. For example, there are inevitable differences between clinical psychologists and self-help group members and between the two forms of help. Whereas self-help groups emphasise similarity and inclusion, one characteristic of professional helping relationships is difference between the helper and the help seeker. Both groups expressed a desire to minimise difference in the relationship by emphasising their similarity. Although this was a useful way of managing the tensions it was also problematic because it threatened a loss of identity for both groups as expressed in the theme 'threats to identity'. Preferences for involvement with self-help groups outside of the role of clinical psychologist, as expressed in the theme 'regulating distance', helps to manage the discomfort of difference but at the expense of identity. Finding an appropriate distance in collaborative relationships was another useful way of managing the tension. Too much distance or too much closeness was unhelpful; the former deprives both parties of potentially useful resources and the latter suggests threats to identity.

Both groups also have to grapple with the discomfort of power in collaborative relationships and the tensions this creates. Whereas self-help groups emphasise egalitarianism, the balance of power in professional helping relationships resides mostly with the helper. Professionals



are also perceived as having more power because of their expert status. The themes 'support and demand', 'safety versus risk' and 'power and inequality' all express issues of power. An imbalance of power creates tensions in collaborative relationships because of the fear that professionals will attempt to dominate and control self-help groups. Both groups expressed a desire to minimise power differentials by emphasising equality and non-authoritarian ways of relating. These are both helpful strategies to manage the tensions but could also threaten both groups' identity and prevent either group from bringing potentially useful resources to the relationship.

The themes 'coming out of the cold and into the warmth' and 'abundance and emptiness' express resource issues. Both groups have to manage tension arising from a perceived imbalance of resources in collaborative relationships. Whereas self-help groups were seen as nurturing and bounteous, services were seen as uncaring and deprived of resources. This leads to tensions in collaborative relationships arising from doubt about whether psychologists would have anything to offer self-help groups or whether their involvement would create discomfort. There is also threat of criticism, as expressed in the theme 'managing disparagement'. Both groups were anxious about being disparaged and this would be an unhelpful way of managing the tension. Emphasising deprivation also risks losing potentially helpful resources from the relationship.

This framework suggests that there will be conflicts both within and between groups from managing these three major dimensions of tension in collaborative relationships. A major



issue is how to have contact which acknowledges the differentials between them but which does not cause either group to feel threatened or prevent them from bringing potentially useful resources to the relationship. Findings suggest gains for both groups if respect and value are encouraged and both groups are clear about their role in the relationship.

## **4. DISCUSSION**

### **4.1 Overview**

The study's findings are addressed in relation to the research questions and the existing literature and debate on collaborative relationships. The principles set out in the introduction are then used to evaluate the study's findings and general design and methodological issues are addressed. The discussion ends with suggestions for future research and implications for clinical practice.

### **4.2 Discussion of findings**

The study set out to understand the potential for collaborative relationships between clinical psychologists and self-help groups in the field of mental health. Research questions sought to uncover both groups' views in relation to the other and about working together. Findings can be related to previous research at the level of the conceptual categories. Section 4.2c considers models of collaborative relationships in relation to the emergent themes and theoretical framework.

#### **4.2a Clinical psychologists**

Clinical psychologists were broadly positive in their evaluations of self-help groups which supports previous research (Kurtz et al., 1987) that mental health professionals generally express positive views. Many psychologists said they believed in the principle of self-help groups and thought non-professional help was valuable and empowering, offering something alternative to professional services. This helps to explain their concern about threats to the mutual help culture of self-help groups by members and by professional involvement, as this contradicts what they perceive as valuable. Negative views of self-help groups were largely absent, but were to some degree located in the anticipated 'dismissive' reactions of services. As the majority of psychologists who took part had had some contact with self-help groups, it is possible that they were more inclined towards them anyway. In comparison to psychologists' positive views about self-help groups, they thought services would be seen as negative and that self-help groups would have no clear idea about who clinical psychologists were. Fears about disparagement also emerged as an issue in working along-side of self-help groups.

Many of the functions of self-help groups Orford (1992) identified were present in the analysis, suggesting that psychologists were generally knowledgeable about how they worked. Those aspects considered as helpful have much compatibility with a social support explanation of self-help groups (Borkman, 1984; Kurtz & Powell, 1987). Many processes considered as unhelpful support Chesler's (1990) view that concerns are rooted in professional assumptions about what sorts of groups are useful and how professionally led groups manage difficulties arising from problematic group processes. This study did not support Claffin's (1984)

observations that mental health professionals express concerns about whether people with emotional health problems are able to help themselves. Psychologists did differ in their willingness to suggest self-help groups to clients and for most this depended upon their perceptions of the quality of the group. Some adopted quite a protectionist stance, wanting to protect self-help groups from 'destructive' people as well as 'vulnerable' people from joining them.

There was both interest and reservations about collaborative relationships with self-help groups and a desire 'not to get too close' which supports Stewart's (1990) review of studies. As argued extensively in the results section, tensions were widespread in the relationship and there were many barriers to involvement, such as concern about maintaining professional identity and about threatening the autonomy of self-help groups. Other barriers were lack of knowledge of what self-help groups wanted, if anything at all, and lack of information and poor channels of communication as noted by Wilson (1993) and Stewart (1990). Besides concern about de-professionalisation of services, competition itself did not emerge as a major tension in the relationship as Kurtz et al. (1987) predicted it would between organisations where domain similarity is high. Considering the current re-structuring and cost controls in the NHS, more concern about competition might have been expected. Instead, psychologists anticipated that services would gain from more collaboration with self-help groups which supports other views in the field (Powell, 1990; Salzer et al., 1994).



Psychologists considered a range of possible roles in relation to self-help groups. They viewed 'expert' roles as inappropriate and advocated non-authoritarian ways of relating. This differs from Meissen et al.'s (1991) study of professionals in training which found that positive attitudes and intentions towards self-help groups were based on expert power and traditional roles.

#### **4.2b *Self-help group members***

In support of previous research (Trojan, 1989; Wilson, 1994), self-help group members perceived positive benefits associated with belonging to a self-help group. Many described the shared understanding from being with similar others and the support that self-help groups provided as far superior to that which professionals offered. Unlike professional help, the support of the group happened both in and outside of meetings through relationships which had developed with other members. This supports Kurtz & Powell's (1987) view that self-help groups expand social networks. No-one mentioned any negative impacts associated with membership, similar to Trojan's (1989) study, although a minority did express concerns. It is possible that members were keen to promote the group in a positive light and that this may have effected their evaluations. When comparing self-help group members' views to clinical psychologists' there is a general consensus except the latter express more concerns and differentiate them more theoretically. Self-help group members anticipated that professionals would express anxieties but did not share them themselves.

In spite of psychologists' anxieties that professionals would be viewed negatively, the majority of self-help group members described positive experiences of professional help. Professionals were valued for helping people to 'move on' from their difficulties whereas self-help groups were seen more as places which provided: "strength through sharing experiences". Most concern was expressed about contact with psychiatric services. Considering Stewart's (1990) association of disillusionment and dissatisfaction with professional help and the rise of self-help groups, less positive evaluations overall might have been expected. One possible explanation is that those self-help group members with more of an anti-professional stance did not come forward or that participants were keen to promote good relations with professionals. More negative views might have been expressed among self-help groups for people experiencing more severe mental health difficulties who may have had had more contact with the controlling aspect of psychiatric services as found by Emerick (1990). Nevertheless, strong concerns were expressed about health service cuts and the difficulties in accessing services as well as how it feels to be at the receiving end of professional help.

The majority of self-help group members thought collaborative relationships with professionals were desirable which supports Stewart's (1990) conclusions. However, there was also ambivalence about professional involvement and considerable reservations rooted in fears that professionals would relate to self-help groups as the 'expert', thus mirroring traditional helping relationships. Another anxiety was of critical and judgemental reactions from professionals which Halperin (1987) also discovered through his involvement with a



self-help group. In support of previous literature in the field (Stewart, 1990; Wilson, 1993), self-help group members advocated more indirect ways of relating to professionals which encouraged respect and did not threaten the autonomy of the group. Some suggested egalitarian relationships as Borkman (1990) also advocates. More awareness and encouragement of self-help groups was also advocated which supports the view expressed by Orford (1992) and others in the field.

#### ***4.2c Models of collaborative relationships***

The thematic analysis and intensive qualitative study has built upon previous research in the field by helping to clarify major issues in collaborative relationships between professionals and self-help groups and sources of underlying tension in the relationship. Due to the highly interpretive nature of the analysis, findings are only briefly reviewed in relation to the two models of collaborative relationships presented in the introduction.

Stewart's (1990) account of the sociology of professions has particular relevance to the study's findings. She argues that professionalism as a culture emphasises values of power, control and expertise which re-inforce dependency upon professionals in society. In comparison, self-help groups emphasise a different way of helping based on egalitarianism and experiential knowledge. Current debate in the field and the limited research evidence to date supported predictions of difficulties in collaborative relationships if professionals approached self-help groups as the 'expert'.



The thematic analysis supports Stewart's (1990) ideas about the relevance of 'professionalism' in understanding issues in collaborative relationships. The emergent themes suggest that issues of power, control and equality lead to tensions which both groups have to grapple with in collaborative relationships. This supports Yoak & Chesler's (1985) finding that conflict could arise from the different roles, status and power of professionals and self-help groups. These ideas were further developed in the theoretical framework through the three major dimensions of underlying tension. Although both groups expressed a desire to reduce the differentials between them and move away from traditional helping relationships based on expert power and traditional roles this posed considerable threats, especially to identity. The framework suggests that conflict will arise for both groups from managing tension. One implication for collaborative relationships to realise their full potential is to develop ways of relating which acknowledge the differentials between professionals and self-help groups without causing either group feeling threatened.

Balance theory was also presented as a framework to view the potential for collaborative relationships. Kurtz (1990) argued that optimal collaboration occurs with neither under, nor over involvement by professionals. The thematic analysis also found that both groups grapple with finding a comfortable balance between closeness and distance in the relationship and further clarified this by relating it to managing tensions which arise from the differences between them. As argued previously, exchange in collaborative relationships depends upon both groups finding ways of dealing with tension without feeling threatened.

### **4.3 Evaluating the study's findings**

This section evaluates the study's findings using the five principles set out in the introduction:

#### **4.3a Auditability**

The principle of auditability refers to opening up the process of conducting the research for the scrutiny of others so that they can understand how decisions concerning the research were made. The research diary (Appendix 1) documents the different stages involved in the development of the research and the process of conducting the analysis. By noting down personal reactions, assumptions and interpretations throughout the study, the diary provides a reflexive account of the research process.

Bannister et al. (1994) argue that reflexivity is central to qualitative research and enables the reader to judge the researcher's influence in shaping the emergent account. The author's position in relation to the research as a psychologist who values self-help groups and is interested in the development of mutually supportive relationships is made clear. The study's conclusions support these values but findings suggest that collaborative relationships are more problematic than had been anticipated. This helps the reader to judge the study's findings because even though data has been presented as 'close to the ground' as possible, later stages of the analysis relied heavily on the author's interpretations of the central issues. The diary also allows readers to develop alternative interpretations and explanations of the data as does the documentation of the different stages of the analysis in the method and the appendices.



#### **4.3b Respondent validity**

The author attempted to validate the study by feeding back the emerging analysis to participants to see whether they regarded it as a reasonable account of their experience.

Although feedback from the majority of participants who returned forms suggested the account was accurate, the return rate was low. Other feedback suggested that this was a problematic way of judging the quality of the researcher's interpretations. Two participants, one from each group, commented on the difficulty of judging the accuracy of an account which was based on the experiences of a group, not just their own interview. Another way of asking for respondent validation would have been to provide separate feedback on each individual's interview.

However, Henwood & Pigeon (1995) still argue that validity claims in qualitative research cannot just be based on the correspondence between the researcher's account and the participant's experiences, partly because of the role of power relations and the possibility that participants may not challenge the researcher if perceived as an 'expert' in the field.

Nevertheless, Silverman (1993) suggests that respondents' comments can generate further data and suggest new paths for analysis.

#### **4.3c Inter-rater reliability**

An independent rater was used to judge the accuracy with which the author had categorised segments of text. Inter-rater reliability was high for basic code assignment but somewhat lower for category assignment. This might have been expected considering basic codes represent the level of analysis which is most 'close to the ground'. In comparison, the level of categorical analysis involves more of the researcher's interpretive processes and thus might be



subject to alternative explanations. The concept of reliability itself has been criticised in qualitative research because it is assumed that people bring different perspectives to the research, rendering doubt on the meaningfulness of replicability (Sandelowski, 1986). However, Silverman (1993) argues that inter-rater reliability is still useful to ensure that categories are used in a standardised way.

#### ***4.3d Generativity***

Generativity refers to the extent to which the research facilitates further issues and questions for investigation. The emerging theoretical framework raises interesting questions which were not possible to test out in this study because a further stage of theoretically driven sampling was not manageable. Further research using quantitative methods would be useful to test out the emergent theory with a larger participant group. This would help to understand whether the study's findings have meaning to other groups of psychologists and self-help group members beyond this study. An attempt was made to develop the emerging conceptual categories from the analysis of clinical psychologists' interviews by further interviewing of psychologists who had never had contact with self-help groups and no major differences were found. The process of conducting the research itself and contact with participants raised new issues outside the remit of the present study. The research also generated ideas for better practice when working with self-help groups which could be implemented out and evaluated. Implications for further research and clinical practice are detailed in sections 4.5 and 4.6 respectively.

### ***4.3e Rhetorical power***

Another way of considering the usefulness of the study's findings is their rhetorical power. Do the ideas presented in the thematic and theoretical framework convince others of their relevance to understanding issues in collaborative relationships between self-help group members and clinical psychologists? Ultimately, this is for the reader to decide. Although the final stage of the analysis was reviewed by the supervisor, further respondent validation would also have helped to judge the relevance of the thematic and emerging theoretical framework.

### **4.4 General design and methodological issues**

A number of limitations need to be borne in mind. One consideration stems from the method of recruitment which required participants to volunteer. The resulting self-selected sample may have been biased towards participants with a vested interest in collaborative relationships and who may have altered their presentation to make a favourable impression. A further bias may have been introduced by the opportunistic nature of the sample, particularly recruitment for self-help group members because of the difficulties associated with accessing this group. Even though a range of self-help groups and psychology departments were approached, the final sample though quite large for qualitative research, comprised mainly of female self-help group members and clinical psychologists who had been qualified for many years. There was much variation within both of the respondent groups: clinical psychologists had a range of different contacts with self-help groups at different points in time and self-help group members also had different levels of involvement with professionals at different times in their life. Thus, one might question the general significance of findings beyond those thirty people who took



part. However as Pope & Mays (1995) point out, in qualitative research sampling decisions tend not to be based on statistical assumptions about generalisability but more on accessing people who will help illuminate exploration of the research questions. Henwood & Pigeon (1992) discuss 'transferability' of findings as more useful, meaning how relevant findings are in contexts similar to those in which they were first derived. It is possible that this study's findings are not transferable to members of self-help groups for people with more severe mental health difficulties and to psychologists working in continuing care services. Clearly, more research would be needed to test out the emerging theoretical framework.

Readers might also question the researcher's assumption that it would be meaningful to relate self-help group members' views about professional help to understand issues in collaborative relationships with clinical psychologists. However, as so little demographic information exists on members of self-help groups it was impossible to gauge how many people might have had contact with clinical psychology services. It turned out that two people were currently seeing a psychologist and four had had some contact in the past. One might also question whether the difference between clinical psychologists with and without contact with self-help groups was meaningful, considering that one of the criteria for previous contact was working with clients who have been involved with self-help groups which is quite a minimal level of involvement.

Another consideration relates to the nature of the qualitative interview itself. Although the production of the transcript was 'reliable' because the majority of interviews were taped and transcribed verbatim, the interview itself varied. Even though questions were decided in



advance, each interview was partly shaped by the interaction between the researcher and the participant and the time available. Thus, certain follow-up questions may have emerged from the discussion in one interview but not in another. The author's values in relation to the research are also important for the reader to consider as they will have influenced the interview process, as argued earlier.

#### **4.5 Suggestions for further research**

Ideas for testing out the emerging theoretical framework and for further evaluating the study's findings are presented as well as suggestions for further work in the field.

##### ***4.5a Testing-out the emerging theoretical framework***

To further develop this research the emerging theoretical framework needs to be tested out by theoretically driven sampling and the search for 'negative' cases which do not fit the framework. Possible questions include: Do other clinical psychologists perceive similar difficulties in collaborative relationships with self-help groups? Under what conditions are collaborative relationships easier for both groups? Do other health care professionals find their identity challenged in a self-help group? Are different issues raised for members of self-help groups with more severe mental health difficulties or self-help groups outside of the mental health field?

##### ***4.5b Further evaluating the study's findings***

The author has been invited to present the study's findings at a national conference for

self-help group facilitators from the organisation Depression Alliance. This provides another opportunity to evaluate the study's findings and their 'transferability' to other self-help group members. A summary report of the emerging themes and theoretical framework will be sent to all participants. Feedback on this would be very useful to find out what each group thinks of the other's views and whether they agree or disagree with the thematic analysis and theoretical framework.

#### ***4.5c Further research in the field***

The process of conducting the research itself raised issues the author had not considered. When liaising with self-help group facilitators they often described feeling un-supported. Although it was not a focus of the present study, the author has been unable to locate any studies which have investigated the support facilitators receive. This could be an important area for future research. Another important area emerged from feedback from respondent validity. One self-help group member said that they had decided to leave the group because it was 'encouraging stagnation and not change' (Appendix 16). The author has been unable to locate any studies which have investigated why people stay and why they leave self-help groups. Investigating the 'paths' of members through self-help groups would be useful.

#### **4.6 Conclusions and implications for clinical practice**

Findings suggest that there is potential to develop mutually supportive relationships between self-help groups and clinical psychologists and that both groups perceive benefits from a

collaboration. However, the analysis also indicates problematic relationships and various hurdles to negotiate before the full potential of a collaboration can be realised. Wilson (1995) discusses the need to 'build a bridge' between the 'two different worlds' of professionals and self-help groups and argues that professionals will have to adapt their customary ways of working. One implication from this study is to find ways of enabling both groups to manage their genuine differences without introducing threats into the relationship.

The analysis highlighted the importance of safeguarding identity and managing boundary issues appropriately. Another crucial issue was to remain mindful of the power imbalance and to respect the autonomy of self-help groups. On a practical level, one way of addressing these issues would be to establish clear roles in relation to collaborative relationships and encourage self-help groups to negotiate what involvement they wanted from professionals. Findings suggest that encouraging mutual respect and value were pre-requisites for a collaboration. Practically, creating opportunities for both groups to link and establishing channels of communication so that a mutual dialogue can take place would help to further their mutual understanding.



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<sup>1</sup> The nature of qualitative research is such that the information contained in the appendices is extensive. The typed notes from the interviews are not included, nor are any illustrative quotes for the basic codes and conceptual categories due to space limitations. These are all available from the author.

<sup>2</sup> SHG appears as an abbreviation for self-help group.



## APPENDIX 1

### Author's research diary

- April - June, 1995:** Research week: Begin to formulate tentative ideas about looking at the relationship between clinical psychologists and self-help groups. Feel we're all 'in the same boat together' and working towards similar goals but I am aware that we have little contact with one another. Continue reading about self-help groups.
- June - July, 1995:** Rob Lieper agrees to supervise my research. Start to think further about why it is that professionals and self-help groups don't mesh well together despite what seem to be positive attitudes. Feel aware of my own biases and how this could affect the research. Can I remain neutral if I am investigating my own profession and if I am interested in involvement?
- July - August, 1995:** Have been 'immersing' myself in qualitative research books, feel this would be a very helpful approach to looking at the issues but feel very unconfident about how to do it.
- Aug. - Oct., 1995:** Submit my research proposal and wait for comments. Continue to read more literature and think about designing my interviews.
- Oct. - Dec., 1995:** My proposal was passed but I need to do more work on how the qualitative approach will address my research questions and on 'validity' and 'reliability' issues. Have supervision and come away feeling quite positive and clear. Spend most of my time reading and preparing to submit for ethical approval. Struggle to design the interview schedules for self-help group members and battle with terminology. Need to remain neutral and 'try and get behind the issues'.
- 15. 12. 1996:** Submit to ethics.
- 2. 1. 1995:** Spend an afternoon in the local library looking for information on self-help groups, most of it was out of date!
- 4. 1. 1995:** Spoke to a woman from MIND about accessing information on self-help groups. Some self-help groups used to meet on their premises but did not work because members were 'frightened' of other members' behaviour - paid workers run the groups now. Later on, wrote off to two national self-help organisations and telephoned various others.
- 8. 1. 1996:** Full ethical approval granted with no conditions.
- 9. 1. 1996:** Manage to contact six psychology departments and send out information sheets and also arranged the first interview. Later on, started to phone facilitators of self-help groups. On the phone for 1hr and 15 minutes to one woman. She expressed many concerns about professional help and talked a lot about how valuable the group had

been personally. Willing to help with my research but unsure about whether members would talk to me and anxious that the interview might stir people up. Spoke to the group facilitator of 'survivors of suicide' who was willing to help with the research. I came away wondering about the powerful emotions which might be stirred up in a group for people affected by suicide and how these feelings would be managed.

- 12. 1. 1996:** Supervision: Helped me to think about my contact with self-help groups. Aware of not wanting to come across as the 'bad' professional and also wondered how groups would tolerate positive feelings towards professionals. I also wonder about how boundaries are managed in self-help groups considering how much personal information was revealed to me over the phone.
- 16. 1. 1996:** Send out information sheets to another psychology department and contact a self-help group for people with eating disorders. All of the people I have spoken with so far seem willing to help with the research. Feel hopeful about getting participants.
- 18. 1. 1996:** First interview with a psychologist. Seemed to go o.k. but felt my questions had been quite repetitious. Took me 5 and a half hours to transcribe the interview!
- 19. 1. 1996:** Research group at the course: Come away feeling anxious about sampling issues and generalisability and about the qualitative approach in general. Go away and immerse myself back into books on qualitative research until I feel clear again. Henwood & Pigeon (1992) talk about 'transferability' of research in similar contexts. I received a letter from 'Depression Alliance' who were very positive about the research and keen to establish links with professionals.
- 23. 1. 1996:** Second interview with a psychologist who was willing to consider involvement with self-help groups but finds it difficult practically. Only took 3 and a half hours to transcribe this time! Once more, questions had been repetitious and I decide to condense some of the interview prompts as well as add a question about what psychologists could gain from involvement. I have been thinking about what psychologists with no previous contact with self-help groups would say: would they be as interested in involvement? Hear back from one facilitator that three people are interested in the research and also arrange to meet her to discuss the project.
- 25. 1. 1996:** Meet to talk with the facilitator. Come away thinking about how self-help groups as community support networks and struck by the amount of personal energy members invest. Aware that professionals are much less available and unable to provide this sort of support.
- 26. 1. 1996:** Interview the third psychologist. Psychologist felt that self-help groups were philosophically sound but problematic in reality. Hear back from 'survivors of suicide' that no-one wanted to take part; two people had been interested but were too anxious to participate. Heard from two psychologists who cannot take part because they have not had any previous contact with self-help groups.



- 30. 1. 1996:** Hear back from the facilitator of the self-help group for eating disorders that members were anxious about taking part but that she would like to be interviewed.
- 5. 2. 1996:** First interview with a self-help group member. Spoke very highly of the group and was positive about professional involvement. I felt very awkward at a comment about my use of the word 'mental health' on the information sheet and the possibility that I had labelled someone. Afterwards, I wondered about the stigma associated with using professional help in comparison to self-help groups.
- 6. 2. 1996:** Second self-help group interview. Lots of frustration about accessing services. Thought professionals would be too busy to get involved but that it was a good idea. Spoke to the co-ordinator of one of the national self-help organisations I had written to. One group would like me to attend a meeting to talk about the project and another were also interested. Quite a long telephone conversation. A lot of interest in partnership issues with professionals. Interviewed another self-help group member who was also pro-involvement. I came away wondering why there was so little collaboration considering all of these positive views?
- 7. 2. 1996:** Speak to a facilitator of a self-help group for people with manic-depression and arrange to send information sheets on.
- 9. 2. 1996:** Feeling despondent about not having heard much from clinical psychologists. Hear from another psychologist who was unable to take part because of no previous contact with self-help groups. I wonder whether this is why I have not heard from other psychologists? Have supervision and set targets for the next few weeks. Make a change to the self-help group interview schedule to ask them about their experiences of the group as this had felt dis-respectful not to enquire about this at interview. Reflect generally on how the interviews have been going and the amount of time it is taking to transcribe each interview.
- 12. 2. 1996:** Feeling anxious that not many self-help group members have come forward to take part. Spend the morning telephoning information lines to find out about other self-help groups which I later contact. Leave lots of messages with psychology departments in the hope that psychologists will contact me back. Some success and two psychologists say they will take part. Later on, interview a fourth self-help group member. Felt concerned that the facilitator was described as a 'professional' and wondered about how this affects the mutual help culture of self-help groups.
- 19. 1. 1996:** Interviewed another psychologist and managed to arrange another interview as well.
- 20. 2. 1996:** Interview the fifth psychologist. Hear back from one psychology department that no-one was interested in taking part. Phone the psychology departments that I have not heard anything back from. Start thinking about a second recruitment phase.
- 27. 2. 1996:** Interview with another psychologist.
- 29. 2. 1996:** Manage to arrange four self-help group interviews!



- 4. 3. 1996:** Interviewed the fifth self-help group member. Described awful experiences of professional help which was why the self-help group was preferred.
- 5. 3. 1996:** Interviewed two psychologists today.
- 7. 3. 1996:** Interview another self-help group member. Once more, there was a lot of positive views about collaborative relationships and also a strong message that professionals need to be more respectful of the achievements of self-help groups.
- 8. 3. 1996:** Supervision: Discuss extending the selection criteria to psychologists without contact with self-help groups to compare their views with psychologists who have had contact. Discuss embarking on the second recruitment stage for psychologists. I feel anxious about not having enough time to do this. Have also been feeling quite exhausted from all the transcribing.
- 9. 3. 1996:** I attend the self-help group meeting which I was invited to. Group were very welcoming and interested in the research. I was struck by how relaxed and at ease the atmosphere was and how nervous I felt in comparison! Opinion was unanimous that being with others who were in the 'same boat' was the most helpful aspect of self-help groups. There was also a lot of discussion about the power of professionals and how the 'expert' is always right. I felt quite aware again of not wanting to come across as the 'bad' professional. I also feel awkward at being 'out on a limb' and feeling unable to offer anything. Two group members volunteered to take part in the research.
- 12. 3. 1996:** Interview another psychologist, nine in total. Later on, phone more self-help groups and spoke to one facilitator who felt very unsupported and said her experiences of trying to get some support from professionals had been unsuccessful. She had wondered whether professionals felt threatened by the group's success. Spoke to someone from the 'survivors of sexual abuse' network who said that they had found that groups with a professional facilitator worked best and that self-help in its truest sense was more difficult. Very willing to circulate information about the research but wanted to check out my 'credentials' first. Noted that this was the first time that any of the groups had addressed this issue.
- 14. 3. 1996:** Hear back from a self-help group member who had changed their mind about taking part because of anxieties about what the interview could stir up. Receive an encouraging letter from 'Depression Alliance' who are interested in the findings of the research and ask if I would like to present this at a conference later this year.
- 18. 3. 1996:** Had a long conversation with a psychologist who has had a lot of involvement with self-help groups and now feels that this is too problematic because of the 'boundary' issues. Arranged to meet for a formal interview.
- 20. 3. 1996:** Hear back from the facilitator that I had spoken with on the 12th that two people were interested in taking part. She was keen on the research because it focused on

how professionals and self-help groups could work together and talked again about a lack of support for facilitators.

- 25. 3. 1996:** Interviewed a woman from the self-help group I had visited. Talked about how professionals can never understand the true 'depth' of people's anguish.
- 26. 3. 1996:** Interview another self-help group member, eight in total.
- 30. 3. 1996:** Interview two more self-help group members. One woman facilitated the group and described feeling unsupported in her role and anxious about whether she was running it properly. I came away thinking again about the support facilitators receive. Later on, heard from a self-help group member who had decided not to take part.
- 1. 4. 1996:** Interviewed a self-help group member. Raised many issues about the power of professionals.
- 3. 4. 1996:** Supervision: Almost reached my recruitment goal and talk about how difficult I am finding it to recruit more psychologists. Wonder whether I might be picking up some of the feelings from self-help group members that professionals are unavailable. I am also concerned about having enough time to analyse the material which already seems huge.
- 5. 4. 1996:** Contact two more psychology departments and send out fifteen letters. Now on annual leave and concentrate on writing up my introduction and method sections whilst waiting to hear back from people.
- 15. 4. 1996:** Interview another psychologist and hear from two more who have not had contact with self-help groups and would like to take part. I also arrange another interview with a psychologist who has had contact.
- 17. 4. 1996:** Interview the tenth psychologist.
- 18. 4. 1996:** Interview a self-help group member and come away feeling shocked about her experiences of the mental health system.
- 24. 4. 1996:** Interview two psychologists who had never had contact with self-help groups and was struck by how positive they were about them. Practical, not philosophical reasons had caused them not to have contact. Hear back from the 'survivors' network that two people are interested in taking part.
- 26. 4. 1996:** Receive feedback slips from psychologists who are interested in taking part. I am going to be able to reach my recruitment goals but feel daunted by how much material there will be to analyse.



- 3. 5. 1996:** Have supervision and feel clearer about how I am going to tackle the analysis. Carry on with the write-up and transcribing interviews.
- 10. 5. 1996:** Interview a psychologist who has not had any contact with self-help groups and later on interview a self-help group member.
- 16. 5. 1996:** Do my last two interviews with clinical psychologists. Have now interviewed twelve psychologists with previous contact with self-help groups and four without any.
- 17. 5. 1996:** Research seminar at the course on qualitative analysis by a previous trainee who had 'been there'. Found this very helpful and practical.
- 24. 5. 1996:** LAST INTERVIEW. Meet with the fourteenth self-help group member. Feeling eager to start the analysis. Miss supervision. Later that day, crash my car! Now feel totally set back and anxious about getting finished.
- 28. 5. 1996:** All interviews transcribed, a massive 200 pages of text! Talk with Rob who impresses the urgency of starting the analysis. Stand back and think about all of my experiences in relation to the research and re-read my diary before going any further. Make a note of my general impressions and how all participants seemed to be genuinely interested in working together but how problematic this is in practice.
- 1. 6. 1996:** Have been reading through the first six clinical psychologist interviews. Feel thoroughly immersed and daunted by the prospect of making sense of all of the information. Start to list basic codes and go through all the interviews methodically.
- 7. 6. 1996:** Have been coding psychologists' interviews all week. 167 basic codes from the first six interviews and a further 55 from the next six interviews. Have supervision and clarify the next stage of grouping together basic codes into categories.
- 10. 6. 96:** Worked constantly to develop the conceptual categories and prepare feedback for psychologists. Surprised to find that the interviews from clinical psychologists without any contact were not strikingly different and that the emerging conceptual categories were able to explain most of the material.
- 14. 6. 96:** Start work on self-help group members' interviews. Follow exactly the same process as before and feel relieved that it seems more manageable the second time around. Working flat out and wish I had more time think about the data.
- 24. 6. 96:** Feel things are finally coming together. Have finished analysing the self-help group members' interviews and have been preparing feedback for participants. Concerned about whether there is time still to get feedback. Hand over some material for inter-rater reliability and pleased when this turns out to be satisfactory. Have supervision and start to think about the thematic analysis. Very helpful discussion. Decide to stand back from the analysis and finish off some of the write-up so that I can approach it feeling more fresh.



- 28. 6. 96:** Start the thematic analysis. Ideas about the two different cultures of professionalism and self-help stand out and issues of power and equality. Have some study leave but very anxious about getting everything finished, project still feels very BIG.
- 3. 7. 1996:** Supervision: Find it very helpful to bounce ideas around about the emerging themes and relieved that we have both been having similar thoughts about the data. Decide to apply for an extension as I feel I need more time to think about the thematic and theoretical framework. Feel very disappointed about not being able to finish for the 19th.
- 8. 7. 1996:** Have my first draft of the results written! Have had to condense a lot of material because of space limitations and hope that I have still been able to represent people's meanings. I regret not having been able to use more quotes from participants.
- 12. 7. 1996:** Finally, start to write the discussion and prepare to submit on the 26th.

## **APPENDIX 2:**

### **Semi-structured interview: Clinical psychologists**

**Participant number** \_\_\_\_\_

#### ***To be read out before each interview begins:***

- Thank you for agreeing to take part in this research. I hope you will find it helpful to talk about your views on self-help groups for people experiencing mental health difficulties and how you think clinical psychologists should involve themselves or not. As I have already mentioned, I am carrying out this research during my final year of training in clinical psychology and will be writing up the findings for my dissertation project. I hope the research will help us to understand the contribution self-help groups can make to people's well-being and to services for mental health.
- Before we start the interview, I would like you to re-read the consent form and ask me any questions you have about the research or about taking part, then I will ask you formally to give your consent to the interview.
- I would like to remind you that you can at any stage withdraw from the interview and I will not use any of the information you have given me, and also, that if you decide to take part I shall not record or use any information that might lead to your identification.

Now that you have re-read the consent form, are there any questions you would like to ask?

Record: \_\_\_\_\_

I would like to tape-record the interview with your permission: record whether consent given to record the interview: \_\_\_\_\_

**Interview date:** \_\_\_\_\_

**Time interview began:** \_\_\_\_\_

**Section 1: Background information**

I would like to start the interview by finding out some basic information about your background within adult mental health clinical psychology services and your contact with self-help groups to date.

- 1) Could you please tell me how long you have been qualified and how long you have worked as a clinical psychologist within adult mental health services?

***Prompt***

- (i) How long have you been working within this area?

- 2a) Please could you tell me about the contact you have had with self-help groups?

***Prompts***

- (i) What was the nature of this/these contact(s)?

- (ii) Could you explain what led to this/these contact(s)?

- (iii) Could you describe your experience of this/these contact(s)?

- 2b) Have you ever been involved with self-help groups outside of your role as a clinical psychologist, or on a personal level? If yes: Are you willing to talk a little bit about this?

- 2c) How knowledgeable and aware would you say you were about self-help groups for people experiencing mental health difficulties both within your local area and nationally?

***Prompt***

- (i) Do you find it easy or difficult to access information about self-help groups?

**Section 2: Views about self-help groups for people experiencing mental health difficulties**

On the basis of what you have just told me about your experiences with self-help groups I would now like to find out how you view self-help groups for people experiencing mental health difficulties (explain to participants that I do not mean people with more serious mental health problems, such as psychosis).

- 1) Could you please tell me what you think about self-help groups for people with mental health problems?

***Prompts***

- (i) How do you see the benefits of self-help groups?

- (ii) Does anything concern you about self-help groups?

- (iii) Do you think there are limitations to what self-help groups should be doing?

- (iv) Who do you think might use a self-help group?

- 2) How do you think self-help groups actually help people?

***Prompts***

- (i) Do you think self-help groups hold any particular psychological models?

- (ii) How do you think they see themselves as helping?



**Section 3: Perceptions of self in relation to self-help groups**

Bearing in mind what you have just told me about your views on self-help groups I would now like to find out how you think self-help groups see you as a professional, and how you see yourself, as a clinical psychologist, in relation to self-help groups.

1) How do you think self-help groups see you as a clinical psychologist?

*Prompt*

(i) How do you think self-help groups see mental health services in general?

2) How does this compare with how you see yourself in relation to self-help groups?

*Prompt*

(i) How does this compare with how you see mental health services in relation to self-help groups?

**Section 4: Collaboration**

Bearing in mind what you have told me about your views on self-help groups and your previous experiences in this area, I would now like to talk with you about collaboration between mental health services and self-help groups and your views on clinical psychologists becoming involved with self-help groups.

Firstly, I would like to ask you for your views on clinical psychologists becoming involved with self-help groups.

1) What are your views on clinical psychologists working with or alongside of self-help groups?

*Prompts*

(i) Do you think self-help groups have relevance to your clinical work?

(ii) Do you consider yourself knowledgeable about how clinical psychologists could be of use?

(iii) What relationships do you think clinical psychologists and self-help groups should have and how do you think this could best be facilitated?

(iv) Do you perceive any barriers against involvement?

(v) How do you think clinical psychologists might benefit from involvement with self-help groups

2) What particular issues do you see arising from working with or alongside of self-help groups?

*Prompts*

(i) What are your particular fears/concerns/anticipations?

(ii) Do you perceive any conflict between the professional method of helping and the self-help group method?

I would now like to think about collaboration between self-help groups and mental health services in general.

- 3) How do you think self-help groups could most effectively interface with mental health services?

**Prompts**

- (i) What roles do you think would be appropriate and inappropriate for them to have within mental health services?
- (ii) What factors do you think might help this to work and what do you think might hinder it from working?

**Section 5: Debriefing**

***To be read out after each interview:***

- Thank you for taking part in this interview. I will be looking at what you and other clinical psychologists have told me and will try to understand your points of view and how as a profession we see self-help groups. I hope to compare this to what members of self-help groups tell me about their views on professional help and professional involvement with self-help groups.
- 1) Could you tell me how you feel having completed the interview?
  - 2) Has taking part raised any particular difficulties or issues for you?
  - 3) Do you have any immediate questions about the interview or about how I will be using the information?
  - 4) Finally, I would like to ask you whether there is anything that was not covered during the interview that you would like to talk about now?

***Read out:***

- If any issues arise about the research, or if you have any questions that you were unable to ask today, please contact me on: (01323) 440022 and ask for extension 2591. I shall be there on Wednesdays and Thursdays. If I am not available please leave a message and I will return your call as soon as possible.
- I would like to send you a summary of the emerging analysis. If you would like to receive this, please tell me now: \_\_\_\_\_ If you would like to feedback comments about the interview or summary report, I would be very happy to hear from you.
- I will be providing a summary of the study's findings which will be available after November, 1996. If you would like a copy, please tell me now: \_\_\_\_\_

Thank you for time and for taking part.

**Time interview ends:**



### APPENDIX 3:

#### Semi-structured interview: Self-help group members

**Participant number** \_\_\_\_\_

**To be read out before each interview begins:**

- Thank you for agreeing to take part in this research. I hope you will find it helpful to talk about your views and experiences of professional services, and also, about your views on self-help groups and professionals working with each other. As I have already mentioned, I am carrying out this research during my final year of training in clinical psychology and will be writing up the findings for my dissertation project. I hope the research will help us to understand the contribution self-help groups can make to people's well-being and to services for mental health.
- Before we start the interview, I would like you to re-read the consent form and ask me any questions you have about the research or about taking part, then I will ask you formally to give your consent to the interview.
- I would like to remind you that you can at any stage withdraw from the interview and this will not affect any services you are in contact with or will have contact with in the future. I will not use any of the information you have given me if you decide to withdraw. I would also like to remind you that if you take part I shall not record or use any information that might lead to your identification.

Now that you have re-read the consent form, are there any questions you would like to ask?

Record: \_\_\_\_\_

I would like to tape-record the interview with your permission: record whether consent given to record the interview: \_\_\_\_\_

Interview date: \_\_\_\_\_

Time interview began: \_\_\_\_\_



### **Section 1: Background information**

I would like to start the interview by finding out some basic information about your involvement with the self-help group and about any contact that you or the group have had with services for mental health to date.

- 1) Could you please tell me how long you have been involved with the self-help group and what led you to join the group? Please could you tell me about your experiences of the group?
- 2) Have you ever been involved with any other self-help organisation?
- 3a) Please could you tell me about any contact you have had with clinical psychology services?  
*Prompts for questions 3a, b & c*
  - (i) What was the nature of this/these contact(s)?
  - (ii) Could you explain what led to this/these contact(s)?
  - (iii) Could you describe your experience of this/these contact(s)?
- 3b) Have you ever had any contact with other mental health professionals? If yes: please could you tell me about this?
- 3c) Could you tell me about any contact you are aware of that the group has had with mental health services?
- 4) Where there has been no contact with services: Are there any reasons why you/the group has not had any involvement with services?

### **Section 2: Views about professional help**

On the basis of what you have just told me about your personal experiences I would now like to find out how you view professional help.

- 1) Could you please tell me what you think about professional help?  
*Prompts*
  - (i) What do you consider are the benefits of professional help?
  - (ii) Do you have any concerns about professional help?
  - (iii) Do you think there are limitations to what professional help can offer people?
- 2) How do you think professionals actually help people?  
*Prompts*
  - (i) How do you think they see people with psychological difficulties?
  - (ii) How do you think they see themselves as helping?

### **Section 3: Perceptions of self in relation to mental health services**

Bearing in mind what you have just told me about your views on professional help I would now like to find out how you think professionals see self-help groups, and how you see self-help groups in relation to them.

- 1) How do you think professionals see self-help groups?

#### ***Prompt***

- (i) How do you think mental health services see self-help groups in general?

- 2) How does this compare with how you see self-help groups in relation to professionals?

#### ***Prompt***

- (i) How does this compare with how you see self-help groups in relation to mental health services in general?

### **Section 4: Collaboration**

Bearing in mind what you have told me about your views on professional help and your previous experiences, I would now like to talk with you about collaboration between professionals and self-help groups and your views on professionals becoming involved with self-help groups.

- 1) What are your views on professionals working with or alongside of self-help groups?

#### ***Prompts***

- (i) Do you think professionals have any relevance to self-help groups?
- (ii) Do you consider yourself to be knowledgeable about how professionals could be of use?
- (iii) What relationships do you think professionals and self-help groups should have? How do you think this could best be facilitated?
- (iv) How willing are you for involvement and do you perceive any barriers against involvement?
- (v) What involvement/relationships would you like from/with professionals in the group?

- 2) What particular issues do you see arising from self-help groups working with or alongside of professionals?

#### ***Prompts***

- (i) What are your particular fears/concerns/anticipations?
- (ii) Do you perceive any conflict between the professional method of helping and the self-help group method?
- (iii) How do you see the benefits of involving professionals? Under what circumstances could you imagine the group involving professionals?
- (iv) Do you think there are limitations to how much professionals could be of use?



### **Section 5: Debriefing**

#### ***To be read out after each interview:***

- Thank you for taking part in this interview. I will be looking at what you and other members of self-help groups have told me and I will try to understand your points of view and how you see professional help and involvement with self-help groups. I hope to compare this to what clinical psychologists tell me about their views on self-help groups.
  
- 1) Could you tell me how you feel having completed the interview?
- 2) Has taking part raised any particular difficulties or issues for you?
- 3) Do you have any immediate questions about the interview or about how I will be using the information?
- 4) I would like to ask you whether there is anything that was not covered during the interview that you would like to talk about now?
- 5) Finally, please could you tell me your age: \_\_\_\_\_

#### ***Read out:***

- If any issues arise about the research, or if you have any questions that you were unable to ask today, please contact me on: (01323) 440022 and ask for extension 2591. I shall be there on Wednesdays and Thursdays. If I am not available please leave a message and I will return your call as soon as possible.
  
- Is there any information you would like me to send you about services, or about accessing services?
  
- I would like to send you a summary of the emerging analysis. If you would like to receive this, please tell me now. If you would like to feedback comments about the interview or summary sheet, I would be very happy to hear from you: \_\_\_\_\_
  
- I will be providing a summary of the study's findings which will be available after November, 1996. If you would like a copy, please tell me now: \_\_\_\_\_

Thank you for time and for taking part.

**Time interview ends:** \_\_\_\_\_



**APPENDIX 4:**

**CONSENT FORM**

***Self-help and professional help: Exploring the views of members of self-help groups and clinical psychologists.***

**Researcher:** Susan Whiting, Psychologist in Clinical Training

**Research outline:** When people experience personal or emotional difficulties they often seek help and support from sources other than professional services, such as self-help groups. This research will look at self-help group members' views of professional help and clinical psychologists' views of self-help groups. I hope the research will increase our understanding of the contribution self-help groups make to people's well-being.

**What taking part will involve:** This will involve a face-face interview with myself, lasting no longer than an hour and a half, during which I will ask you about your views and experiences of self-help groups and professional services. The interview will be confidential and I will not use any information when I write the research up that might identify you.

I .....(Name)  
of .....(Address)  
.....(Telephone contact)

hereby fully and freely consent to take part in the above research. I have been given an information sheet about the nature and purpose of the research, which I have read and understand, and can keep for future reference. I have asked any questions I wanted to about the research and these have been answered to my satisfaction. I understand that I may withdraw my consent at any stage during the research without having to explain my reason for doing so.

Signed .....  
Date .....

## **APPENDIX 5:**

### **INFORMATION SHEET FOR CLINICAL PSYCHOLOGISTS**

**Ethics panel:** Salomon's Centre (project approved on 9/1/1996)

I am a psychologist in my final year of clinical training on the South Thames Clinical Psychology Training Scheme. As part of this year, I am carrying out research in an area which interests me for my final year project.

#### **Research outline**

I am interested in sources of help and support, other than professional help, for people who are experiencing personal or emotional difficulties. People often seek help from friends and family and do not turn to professional services. Joining a self-help group and being with others who are facing similar difficulties or have been through similar experiences, is another way in which people seek help and support. These groups are usually very separate from professional services. I would like to find out what members of self-help groups think about professional help and what clinical psychologists think about self-help groups. I would also like to find out whether there are ways in which self-help groups and clinical psychologists can help each other. I hope the research will help to understand the contribution self-help groups make to people's well-being and to services for people who are experiencing mental health difficulties.

#### **What taking part would involve**

I would like to interview clinical psychologists who work in adult mental health services and have had some contact with self-help groups, such as working with clients who have been involved with self-help. The interview would last no longer than one and a half hours and would be arranged at a mutually convenient time and place. The sorts of questions I would be asking you would be about your contact and experiences of self-help groups, your views about self-help groups and about working with or alongside of self-help groups. I would like to tape-



record the interview, with your permission, so that I can have an accurate record of what you have told me. After the interview, I would like to send you a summary of the interview and of my understanding of what we have talked about. I would be very interested for your feedback on this, but you do not have to do this part of the research if you prefer not to.

### **Your rights as a participant**

Taking part in the research is entirely voluntary. Before taking part, I will ask you for your written consent to be interviewed. However, you still have the right to withdraw from the research at any stage and I will not use any of the information you have told me. Information from the interview, such as the tape recording and written notes will be confidential and anonymous. When the project is written-up it will not contain any information that might identify you. All information from the interviews will be destroyed when no longer needed for the research project.

### **What to do if you're interested**

If you are interested in taking part or would like some more information about myself or the research project, please contact me on: (01323) 440022 and ask for extension 2591.

Alternatively, you could reach me via the training scheme on: (01892) 515152 and ask for the psychology department. Thank you for taking the time to read this information sheet.

Yours sincerely

Susan Whiting

Psychologist in Clinical Training



## **APPENDIX 6:**

### **INFORMATION SHEET FOR MEMBERS OF SELF-HELP GROUPS**

**Ethics panel:** Salomon's Centre (project approved on 9/1/1996)

I am a psychologist in my final year of clinical training on the South Thames Clinical Psychology Training Scheme. As part of this year, I am carrying out research in an area which interests me for my final year project.

#### **Research outline**

I am interested in sources of help and support, other than professional help, for people who are experiencing personal or emotional difficulties. People often seek help from friends and family and do not turn to professional services. Joining a self-help group and being with others who are facing similar difficulties or have been through similar experiences, is another way in which people seek help and support. These groups are usually very separate from professional services. I would like to find out what members of self-help groups think about professional help and what clinical psychologists think about self-help groups. I would also like to find out whether there are ways in which self-help groups and clinical psychologists can help each other. I hope the research will help to understand the contribution self-help groups make to people's well-being and to services for people who are experiencing mental health difficulties.

#### **What taking part would involve**

I would like to interview members of self-help groups who have been involved in a group for at least three months. The interview would last no longer than one and a half hours and would be arranged at a mutually convenient time and place. The sorts of questions I would be asking you would be about your experience of professional services and your views about this form of help and support, and also, about your views on self-help groups and professionals working with each other. I would like to tape-record the interview, with your permission, so that I can have an accurate record of what you have told me. After the interview, I would like to send

you a summary of the interview and of my understanding of what we have talked about. I would be very interested for your feedback on this, but you do not have to do this part of the research if you prefer not to.

### **Your rights as a participant**

Taking part in the research is entirely voluntary. Before taking part, I will ask you for your written consent to be interviewed. However, you still have the right to withdraw from the research at any stage and I will not use any of the information you have told me. If you decided you did not want to take part, this would not in any way affect any services you are in contact with or will have contact with in the future. Information from the interview, such as the tape recording and written notes will be confidential and anonymous. When the project is written-up it will not contain any information that might identify you. All information from the interviews will be destroyed when no longer needed for the research project.

### **What to do if you're interested**

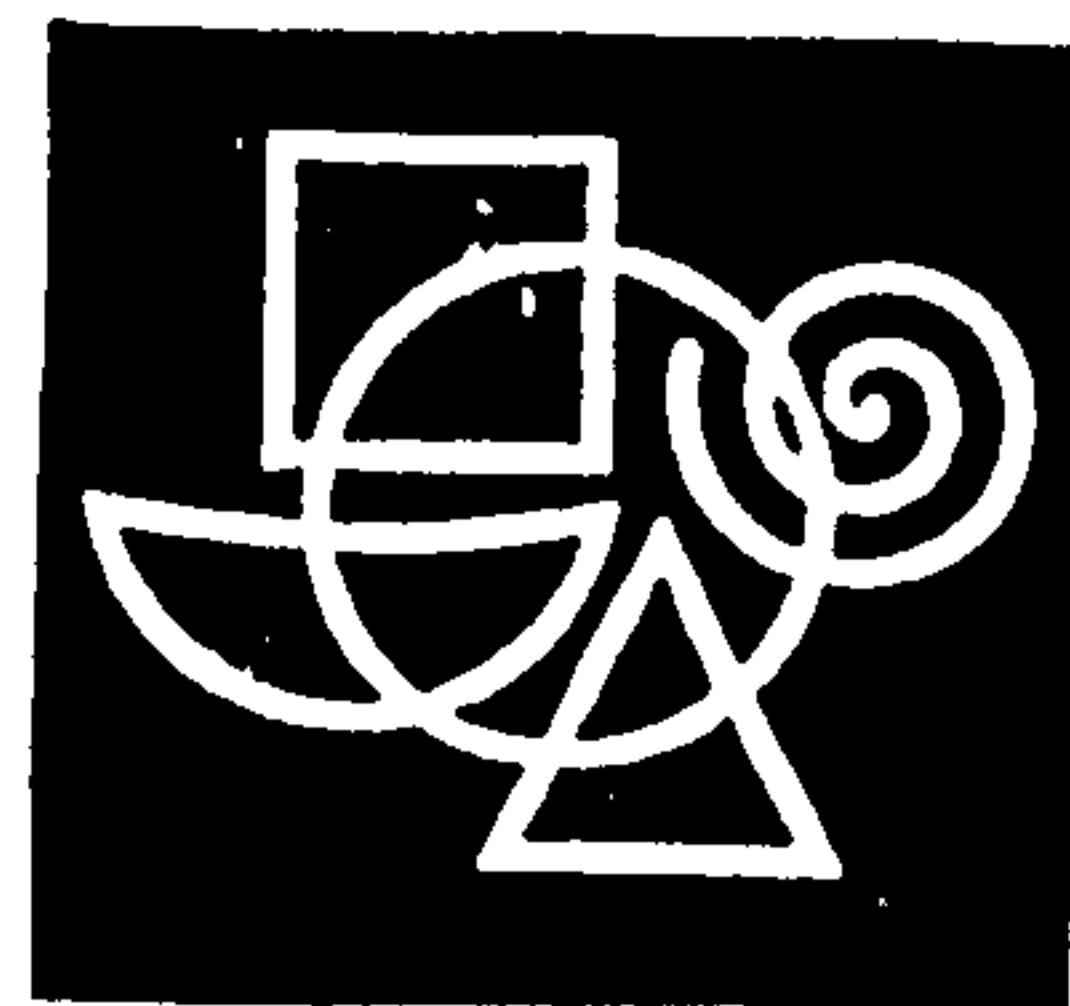
If you are interested in taking part or would like some more information about myself or the research project, please contact me on: (01323) 440022 and ask for extension 2591.

Alternatively, you could contact me via the South Thames Clinical Psychology Training Scheme on: (01892) 515152 and ask for the psychology department. Thank you for taking the time to read this information sheet.

Yours sincerely

Susan Whiting

Psychologist in Clinical Training



**SALOMONS  
CENTRE**

**APPENDIX 7:**

**Letter of ethics approval**

AL/LT/075

9th January 1996

Ms S Whiting  
Trainee Clinical Psychologist  
Salomons Centre

Dear Susan,

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were impressed with the thoroughness with which the ethical issues had been considered and taken into account. We wish you well with the project and would be very interested to see the results.

Yours sincerely,

Dr Tony Lavender  
Director  
Clinical Psychology  
Training Scheme

Ms Anne Tofts  
Director  
Development Programmes

Mr Michael Maltby  
Top Grade Clinical Psychologist  
Weald of Kent Community  
NHS Trust



**APPENDIX 8:**

**Covering letter to clinical psychologists in the first recruitment phase**

Dear,

Please find enclosed an information sheet about research I am carrying out for my final year dissertation in Clinical Psychology. I am currently contacting clinical psychologists working in adult mental health to find out whether they might be interested in taking part in the research. I would be very grateful if you could take the time to read the information sheet and consider whether you might be able to help with this research. If you are interested, or would like any further information before deciding whether to take part, please do not hesitate to contact me. You can contact me via either of the numbers on the information sheet and I will call you back as soon as I can. Alternatively, simply return the consent form in the envelope provided and I will contact you to arrange an interview time.

Thank you for your time.

Yours sincerely,

Susan Whiting  
Psychologist in Clinical Training  
South Thames Clinical Psychology Training Scheme

**APPENDIX 9:**

**Covering letter to clinical psychologists in the second recruitment phase**

Dear,

I am a psychologist in my final year of training on the South Thames Clinical Psychology Training Scheme. I am writing with some information about research I am carrying out for my dissertation which is in the area of self-help groups for people who are experiencing personal or emotional difficulties. I am interested in clinical psychologists' views of self-help groups and their views on collaboration with self-help groups. I am also looking at how self-help group members' view professional help and collaboration with professional services.

I am currently contacting clinical psychologists working in adult mental health to find out whether they might be interested in taking part. I would be very grateful if you could take the time to read the information sheet enclosed and consider whether you might be able to help. Although the information sheet requests psychologists who have had contact with self-help groups, I have since extended the research and would be very interested to talk to psychologists who have not had any contact with self-help groups.

Please could you complete the attached slip to let me know whether or not you are interested in taking part and return it to me in the envelope provided. If you are interested, or would like further information before deciding whether or not to take part, I will contact you as soon as I have received the slip. I am also contactable via my work numbers which are on the information sheet enclosed.

I look forward to hearing from you and thank you for your time.

Yours sincerely,

Susan Whiting  
Psychologist in Clinical Training

---

**Name:** \_\_\_\_\_

**Workplace:** \_\_\_\_\_  
\_\_\_\_\_

**Contact number:** \_\_\_\_\_

**I am interested in taking part in the research: YES/NO**

**I would like more information before deciding whether to participate: YES/NO**

## APPENDIX 10:

### Categorisation of basic codes into conceptual categories: Clinical psychologists

The basic codes which emerged from analysing the interviews of the twelve clinical psychologists with previous contact with self-help groups are listed and grouped beneath the emerging conceptual categories. The number in brackets besides each category heading refers to the number of clinical psychologists who gave at least one response in that category. The number in brackets besides each basic code refers to the number of clinical psychologists who had at least one response which was labelled as that basic code.

### Helpful aspects of self-help groups:

1. ***Belief in the principle of self-help and self-help groups (6)***
  - SHG's as positive for mental health (1)
  - Belief in the principle of SHG's (3)
  - The idea of SHG's is great (1)
  - SHG's have therapeutic value (2)
  - Mixed feelings about SHG's; agree but don't know how to make them work (1)
2. ***Self-help groups provide support & social contact (10)***
  - Mutual support (3)
  - Support in general (4)
  - Can become a support network (1)
  - Feeling less of a burden to others (1)
  - Reducing isolation and loneliness through opportunities for social contact (5)
3. ***Self-help groups provide opportunities to share with others (10)***
  - Sharing experiences with similar others (3)
  - Sharing experiences (2)
  - Sharing information, knowledge, ways of coping (10)
  - Mutual support (3)
4. ***Self-help groups provide opportunities to meet others with similar difficulties (11)***
  - Sharing experiences with similar others (3)
  - Knowing there are similar others (3)
  - Feeling less alone with difficulties (6)
  - Normalisation (5)
  - Hope (4)
5. ***Groups are generally helpful (3)***
  - Being in a group (3)
6. ***Empowerment of members (8)***
  - Empowerment (4)
  - Importance of SHG's for service users (3)
  - Focuses for action (5)



Can make people healthily anti-professional (1)

- 7. *Provision of non-professional help (8)***  
Value of non-professional support (3)  
Less stigmatising and pathologising (3)  
Encourages self-responsibility (1)  
They might see themselves as an alternative to services (2)  
Genuineness (3)

**Unhelpful aspects of self-help groups:**

- 8. *Too much professionalism: a threat to the mutual help culture of self-help groups (4)***  
Professionalism of lead member a threat to mutual help culture of SHG's (1)  
A leader who is too active in the SHG threatens the survival of the group (1)  
Professionalism of any member a threat to mutual help (1)  
Culture of the SHG not based on mutual help but on waiting for the expert (1)  
Professionalism in SHG's is a contradiction (2)
- 9. *Concern about lack of professionalism (7)***  
Lack of professional training and awareness of lead member: who's in charge, are they capable? (3)  
Lack of monitoring of group processes (4)  
Lack of boundaries and concerns the group is not containing enough for members (5)  
Who's left holding the baby, running the SHG? (3)  
Potential for the group to upset people, be damaging (3)  
Can traumatised people cope in a SHG? (1)  
Risks to members from participation (1)  
Difficulties from group dynamics (3)  
Difficulties from difficult people in the group (1)  
Success of the group depends on key individuals to run the group (1)  
Professionalism without the awareness of the potential for abuse (1)
- 10. *Concern that members motives may not be altruistic (6)***  
People who exploit the SHG for their personal ends (2)  
Motives for involvement in the SHG (3)  
Personal agendas of the facilitator (1)  
People who set-up SHG's are odd (1)  
People who attend the group for secondary reasons (1)
- 11. *Single-problem self-help groups are less helpful than generic groups (9)***  
SHG's organised around symptoms/disorders are less helpful than generic groups (3)  
SHG's which focus on the problem can perpetuate the problem (2)  
Only people with similar problems can understand (3)  
Identifying self by the problem (2)  
Alienation from society (1)  
Members thinking they are the same and denying differences (3)

Hard to move on from the group because can re-inforce keeping the problem (1)  
Group encourages conformity and generality (3)

**12. *Concerns about how self-help groups handle information (7)***

Misleading information (2)

Misusing information (2)

Polarised views (4)

**13. *Self-help groups may not help members to overcome their difficulties (6)***

Can be hard for people to leave SHG's because of the social element (2)

Hard to move on from the group because can re-inforce keeping the problem (1)

Groups can become a refuge for people with chronic problems (1)

Group needs to focus on coping to be helpful (1)

SHG's which focus on the problem can perpetuate the problem (2)

Will there be enough support in the group (1)

Potential for abandonment when group ends (1)

Limits to the SHG's ability to address people's difficulties (2)

Not one to one therapy (1)

**Who might go to a self-help group?**

**14. *Mixed views about who might go to a self-help group? (9)***

People in SHG's may have had bad experiences of services (3)

Can't say who would join a SHG (5)

Self-motivated people who want to take responsibility get involved in SHG's (1)

People with psychological problems about their problems (1)

People who are more dependent; seeking re-assurance (1)

**Psychologists' views about how self-help groups see professionals:**

**15. *Who are they? (11)***

On the other side of the fence; one of them (2)

SHG's probably have no strong views about clinical psychology (2)

SHG's might confuse clinical psychology with other professions (1)

It's hard to know what SHG's think of clinical psychologists (2)

SHG's won't have a clear view (2)

Varies: whole spectrum of views positive to negative (3)

Hopefully not a threat (1)

As a resource (1)

As the expert (3)

Difficult to access (1)

Under-staffed (1)

**16. *Negative views of mental health services (4)***

Exploitative; uncaring (1)

Negatively (3)

**Views of self-help groups in relation to services:**

- 17. *As valuable (3)***  
SHG's are part of the service network we should be positive to each other(1)  
Informal services contribute a great deal (1)  
SHG's are one way of supporting the community; community psychology perspective (1)  
SHG's as part of services, not an adjunct (2)
- 18. *As having unique things to offer people (5)***  
SHG's offer different services to professionals (3)  
Sometimes SHG's are the preferred way of working for clients (1)  
Some people may not need professional help (2)  
Don't see myself in competition with them (1)  
Recognising the limits of professional help (2)  
There's room for both (3)
- 19. *With danger warnings (3)***  
Danger of using SHG's to de-professionalise services (1)  
Danger of seeing SHG's as the new solution (1)  
Danger of thinking you don't need any other forms of support (1)
- 20. *Services may be dismissive of self-help groups (3)***  
May be dismissive of SHG's; disinterested (1)  
Services can undervalue other forms of support (1)  
Services can be narrow-minded (1)  
Services not wanting to recognise that people can help themselves (1)
- 21. *Tensions in self-help groups relationship with services (5)***  
Services find it hard because not in control (1)  
Services could be antagonistic if SHG's are critical (1)  
May see SHG's as a possible threat (1)  
Fear of loosing your job; competition (1)  
SHG's can be seen as a problem by services (1)  
SHG's can be seen as a way of reducing the waiting list (1)  
Some will have concerns about them (2)

**Pro collaboration with self-help groups:**

- 22. *For collaboration with self-help groups (5)***  
For more involvement (1)  
Collaboration could be positive (2)  
It should be part of our role (3)



### **Benefits of collaboration:**

- 23. *Benefits for self-help groups (6)***  
Professional involvement could give the SHG more credibility (2)  
Empowerment of SHG's (1)  
Could negotiate on behalf of the SHG (1)  
Clinical psychology has resources to offer to SHG's (4)
- 24. *Benefits for professionals: service alternatives (5)***  
Services gain resources they can't provide (4)  
Service alternatives; being able to offer clients more choice (2)  
Good to feel psychologists could approach SHG's (1)  
Satisfying to work with non-NHS organisations (1)
- 25. *Benefits for professionals: opportunity to learn more (8)***  
Good for clinical psychology to be accountable (1)  
Learning more about consumer's views (6)  
Learning through the SHG (1)  
Learn more about clients and insight into problems (1)  
Reminded of people's own resources (2)

### **Sources of tension in the relationship:**

- 26. *Can't stop being a psychologist: professional responsibilities (5)***  
Professional responsibilities: can't ignore these; do you have permission to comment? (1)  
Being asked to behave in non-professional ways (1)  
Wouldn't want to go to a group because of professional responsibilities: no permission to act on them (1)  
Difficult because we have no control in that environment, can't be a professional, need to feel comfortable about this. (2)  
Prefer to get involved outside my work area and outside of the role of clinical psychologist (3)
- 27. *Different perspectives to the self-help group (7)***  
SHG's may have different points of view to psychologist (3)  
SHG's may be at odds with the psychologist's model (3)  
Clinical psychologist's rigidity of thinking (2)  
SHG's which exclude other perspectives (4)
- 28. *Managing criticisms of services (9)***  
Criticisms of services (2)  
Anti-services: dissatisfaction (2)  
Being exposed to criticism (1)  
Difficulties as a result of SHG members' previous experiences with services (2)  
Being seen as a representative of system (2)  
SHG's don't always realise the constraints of services (1)

- SHG's may set up in opposition to statutory services (3)
- 29. *Threat to future relationships (2)***  
 Threat to professional relationships outside of the SHG (2)  
 Boundary issues (1)
- 30. *Responsibilities to the organisation (8)***  
 Time factor (2)  
 Position in organisation (1)  
 Conflict of loyalties; being clear about where yours lie (5)  
 Not a high enough priority (1)  
 Pressure of work and responsibilities to the organisation (3)  
 Not regarded as a legitimate role by management (3)  
 Time permitting (6)  
 See self as marginal to SHG's because of work pressures (2)
- 31. *Unhelpful for self-help groups: threatens the essence of self-help groups (7)***  
 Risks fostering dependency and losing mutual support focus (3)  
 Dangers of co-option, being over-run by professionals (5)  
 Potential to replicate the same problems (1)  
 May fear professionals taking over (1)  
 Hard to withdraw involvement (4)  
 Hostility when expert role avoided (1)  
 With ambivalence: desire for empowerment wish for direction by the 'expert' (1)  
 Seen as withholding information (1)
- 32. *Emotional issues for the psychologist in the relationship (11)***  
 Positive experiences of involvement (2)  
 Difficult, awkward role (2)  
 Not an easy relationship (1)  
 Because they're sharing their own personal experiences and I'm not (1)  
 Rivalry (2)  
 Could be seen as unhealthy to get involved; lead to burn-out (1)  
 Professional arrogance (1)  
 Moral obligation to stay once involved (1)  
 See it as down to us (1)  
 Go but don't come back to us to sort it out (1)  
 Being made to feel the 'badie' (1)  
 Being blamed when things go wrong (1)
- 33. *Transient nature of self-help groups (new conceptual category from clinical psychologists without contact with self-help groups: refer to appendix 12)***

**Ways of relating:**

- 34. *Indirect and non-authoritarian (10)***  
Avoiding combat (1)  
Don't take over (8)  
Don't tell them what to do (2)  
Be encouraging (2)  
Be supportive (4)  
Supporting SHG's at a managerial level (1)  
Non-authoritarian (3)  
Being available to SHG's: accessible (3)  
Being a resource (3)  
Groups have to be autonomous (1)
- 35. *Don't get too close (5)***  
According to the nature of the group and their relationship with services (1)  
Need a balance between closeness and distance (1)  
Keep your distance (3)  
Support from a distance (1)  
Keep it totally separate (2)
- 36. *Communication and clear roles (9)***  
Knowledge of the other pre-requisite for linking (6)  
Establish supportive links (6)  
Interfacing through planning groups (1)  
Having a dialogue: channels of communication (7)  
SHG's could state their needs (1)  
What do SHG's want from us? (2)  
What's my role (2)  
If my role was clear (1)  
Keep your own views secure (1)  
Group was in control: worked well (1)  
Would be easier if role was clear and mutually agreed (4)  
Interface ideal: respect, clear role definition, clear awareness about the intersection of the two roles, non-threatened feeling, seeing each other as a resource (1)
- 37. *Direct ways of relating to self-help groups: possible roles (10)***  
Linking clients in with SHG's (1)  
Non-judgmental of SHG's; offer people choice (5)  
Informing people about SHG's (2)  
Happy to refer if I know the organisation (1)  
Would want to know about the group to refer (1)  
Would never recommend without knowing the quality of the group (1)  
Never refer (1)  
Educate; enabling the SHG to have access to psychological views (1)  
Establishing SHG's (2)



**Helping others to set-up SHG's (2)**

**Evaluation for SHG's (2)**

**Supervision and support for facilitators (4)**

**Encouraging SHG's to act as pressure group for change (1)**

**Consultancy to the SHG (2)**

## APPENDIX 11:

### Categorisation of basic codes into conceptual categories: Self-help group members

The basic codes which emerged from analysing the interviews of the fourteen self-help group members are listed and grouped beneath the emerging conceptual categories. The number in brackets besides each category heading refers to the number of self-help group members who gave at least one response in that category. The number in brackets besides each basic code refers to the number of self-help group members who had at least one response which was labelled as that basic code.

### Helpful aspects of self-help groups:

1. ***Self-help groups are generally helpful (9)***  
General comments about the value of self-help groups (9)
2. ***Being with others experiencing difficulties (12)***  
Realising you're not the only one who's experiencing problems (4)  
Normalising (1)  
People who've been through it themselves can understand more (7)  
Helpful to meet with others who are in the same boat as you, share a common experience (4)
3. ***Help and social support (10)***  
Socialising (2)  
Building relationships (2)  
Opportunity for mutual support (4)  
Opportunity to give help is very important (2)  
Sharing ideas, information, ways of coping, gaining understanding (4)  
Hope of change (1)  
Can work on your difficulties (1)  
Reason I joined the self-help group was to help myself (4)
4. ***General informal atmosphere (8)***  
Informal, relaxed, easy going, no pressure (6)  
Free to come and go (2)  
Genuine, caring, humanising (4)

### Unhelpful aspects of self-help groups:

5. ***General concerns about self-help groups (5)***  
Not enough talking about the causes of problems (1)  
Concerned about the quality of the advice given (1)  
Can sometimes be tedious (1)  
Are the people who run self-help groups capable enough (1)  
Lack of objectivity (1)  
May not push you to change (1)

### Mixed views of professional help:

6. **Positive experiences of professional help (10)**  
References to experiences of professional help which have been valued (10)
7. **Both positive and negative experiences of professional help (5)**  
Some professionals do help; people who've had both positive and negative experiences (5)
8. **Ambivalent views (3)**  
Ambivalent (3)
9. **Negative experiences of psychiatric care (7)**  
Negative experiences of psychiatric care (7)

### Helpful aspects of professional help:

10. **Can help you to move on (7)**  
Can help you to change (4)  
Can help you to gain understanding of yourself (1)  
Can encourage you to think about things (2)  
More objective and able to stand back from your situation because not emotionally involved (4)  
Can point you in the right direction (4)  
Can help you to recognise that you need help (1)
11. **Helpful if a good working relationship can be established (7)**  
Helpful if you're able to express your feelings and talk, also if they listen and acknowledge your feelings (4)  
Signs which show they care and are interested (3)  
Importance of trust (2)

### Unhelpful aspects of professional help:

12. **Lack of services and resources (12)**  
Not enough time (5)  
Comments reflecting concerns about community care (2)  
Hard to access help (6)  
Hard to recognise that you need help and for others to pick this up (2)  
Lack of resources (7)  
Lack of specialist care (1)  
Lack of communication amongst professionals (2)  
Drug solutions, not addressing people's 'real' problems (6)
13. **How professionals can treat you, make you feel (8)**  
Lack of feedback; not two way (1)  
Lack of consultation (2)



- Professional help can be abusive (2)
- Didn't understand my problems, no real insight or listening (5)
- Not being treated as an individual (3)
- Detachment of the professional, don't relate to you as another person (4)
- Disempowering (5)
- Confusing (3)
- Lack of sensitivity (2)
- Understood my problems but didn't help me to overcome them (1)

**14. Stigma**

- Stigma associated with seeking help and experiencing mental health difficulties (8)

**Differences between self-help groups and professional help:**

- 15. Professionals can move you on more than a self-help group (2)**  
 Able to say things not able to say at the self-help group (1)  
 Can get at the root of problems more than a self-help group can (1)  
 Can push people into helping themselves more than a self-help group can (2)
- 16. Professionals are less understanding and provide less support (8)**  
 Have less understanding than people who've been through it themselves (5)  
 Need more support than a professional can offer (3)

**Self-help group members' views about how professionals see them:**

- 17. Uncertain (3)**  
 I don't know (3)
- 18. Negatively (6)**  
 As people who can't cope (2)  
 As neurotic (2)  
 As crazy (1)  
 As just another case (3)
- 19. Respectfully (3)**  
 With empathy (1)  
 With respect (1)  
 Some are very caring (1)

**Self-help group members' views about how professionals see self-help groups:**

- 20. Uncertain (2)**  
 Don't know (2)
- 21. As helpful (7)**  
 As helpful because they reduce professionals' work-load (2)

As helpful because services recognise that people need other forms of help (1)  
Broadly in favour of self-help groups (5)  
Professional had recommended the self-help group (5)

**22. *Experiences of positive relationships (2)***

Good relationships (1)  
Professionals see the self-help group as part of local services (1)  
Professionals see the self-help group as an ally (1)  
Group has input into local service development: member's views are represented (1)

**23. *As unhelpful: with concerns about them (6)***

Concerned they might be dangerous (2)  
Professionals wouldn't think much of them (1)  
Concerned that self-help groups might go against what professionals think is helpful (1)  
As a threat (3)  
They disapprove (1)  
They dismiss them (1)  
They see them as having limitations (1)

**Views on self-help group in relation to services:**

**24. *As valuable (9)***

As a resource/helpful (6)  
Not everyone needs professional help (1)  
Can be the preferred option to formal services (1)  
Conserve professional resources, save their time (3)  
We need both (4)

**Views on collaboration:**

**25. *For collaboration with professionals (12)***

See involvement as positive (10)  
Recognition that this depends on the group and the professional involved (4)  
It's a possibility (1)

**26. *Against collaboration with professionals (2)***

See involvement as negative (1)  
See involvement as problematic (1)

**Benefits of involvement:**

**27. *Benefits for self-help groups (5)***

Some people need more help than the self-help group can offer (1)  
Provides access to 'expertise', other perspectives (4)

- 28. *Benefits for the professional (6)***  
Could lead to a greater professional accountability (1)  
A greater insight into people's problems (2)  
Benefit the professional most (1)  
Gives professionals access to more resources (1)  
Broaden their outlook (1)

**Sources of tension in the relationship:**

- 29. *Associated with uncomfortable feelings (7)***  
Some people would be uncomfortable with professional involvement, may even put them off coming (3)  
Some people might not open-up if a professional was there (4)  
May feel intrusive (3)
- 30. *Fears of professionals' reactions (9)***  
Fear that professionals would come to the group and tell people what to do (3)  
If they came in as the 'expert' (1)  
Fear of criticism (2)  
Potential for disagreements (2)  
Fear of patronising or disrespectful reactions (3)  
Professionals sneering at the group's lack of structure or seeing dangers in the self-help group (3)  
Fear of scare-mongering (1)  
Fear the professionals might expect too much of the self-help group and members might then feel bad if they can't live up to this (3)  
Fear they would not treat us as individuals (1)
- 31. *General difficulties for self-help groups (5)***  
Fear that there would not be enough time for the group to talk (1)  
Waste of the SHG's time (1)  
Would be difficult if the SHG' was set up in opposition to services (1)  
They've not experienced the difficulties themselves, not the real experts (2)
- 32. *General difficulties for professionals (5)***  
No time (3)  
They might find it demeaning (1)  
Could professionals cope with crossing the boundaries (1)  
If they saw the self-help groups as a threat (1)

**Ways of relating:**

- 33. *Uncertain (3)***  
Don't know how professionals could help the self-help group (3)



- 34. Professionals could encourage and be more aware of self-help groups (4)**  
Suggest them to people (3)  
Encourage self-help groups, be more aware of them (3)  
Get to know us, be more aware of self-help groups and find out about them (2)
- 35. Professionals could be available and offer their resources (9)**  
Come along occasionally (3)  
Be available (4)  
Offer their resources to the self-help group (2)  
Support and advice for the facilitator (5)  
Be available (7)  
Hold back (11,14)
- 36. Be respectful of self-help groups (7)**  
Respect, recognition and value (3)  
Listen and observe (3)  
Respect the boundaries of the group, don't take away the group's autonomy (3)
- 37. Self-help groups should not give away their power (2)**  
Group needs to be established first (1)  
Self-help group's should also not give away their power (1)  
Finding the right balance, some input but not too much (1)
- 38. Egalitarian relationships (4)**  
Egalitarian relationship (2)  
Less 'us and them', a closer relationship (2)

## APPENDIX 12:

### *New codes and conceptual category from analysing the four clinical psychologists' interviews who had never had any contact with self-help groups*

The nineteen new basic codes which emerged from the analysis are emboldened and listed below the relevant conceptual categories. (All other textual material from these interviews was incorporated within the existing basic codes) The number in brackets besides each basic code refers to the number of psychologists who gave at least one response which was labelled as that basic code. Only one new category emerged (33) and is this is also emboldened. The conceptual categories are numbered as they appear in tables 4 & 5.

7. Provision of non-professional help  
***No power differentials (2)***
9. Concern about lack of professionalism  
***Concern that the group could get out of its depth (2)***
11. Single-problem self-help groups are less helpful than generic groups  
***People in single-problem groups could get stuck in a role (1)***
12. Concerns about how self-help groups handles information  
***May locate all problems outside of the group and not consider internal explanations (1)***
13. Self-help groups may not help members to overcome their difficulties  
***People could get stuck and not move on (2)***  
***Unhelpful group norms could get established (1)***
14. Mixed views about who might go to a self-help group  
***Some people might be unhelpful to have in a self-help group (2)***
22. Collaboration with self-help groups is generally a good idea  
***Collaboration is a possibility to explore (1)***  
***Not sure why I've not had any involvement (1)***  
***Collaboration is a good idea ideologically but difficult practically (1)***
31. Unhelpful for self-help groups: threatens the essence of self-help  
***Stigmatisation (1)***
32. Emotional issues for the psychologist in the relationship  
***Clash of cultures (13)***  
***Have I got anything to offer? (2)***  
***Self-help group's lack of professionalism, being let-down (1)***  
***Not interested enough personally to get involved (1)***

**33.** *Transient nature of self-help groups makes involvement difficult (2)*  
*Hard to keep track of self-help groups (2)*

**35.** *Don't get too close*  
*Wait to be asked (2)*

**36.** *Communication and clear roles*  
*Need to know what self-help groups exist (2)*  
*Having a link person (2)*



**APPENDIX 13:**

**Summary report of the emerging analysis for clinical psychologists<sup>3 4</sup>**

**Dear**

***Self-help & Professional Help: Exploring the views of clinical psychologists and self-help group members***

I am writing to you again for any further help you might be able to give to this project. At interview you said you would be happy to receive a summary of the emerging analysis to comment on. I have now completed the first stage of my analysis of clinical psychologists' interviews and have enclosed a summary of this for your interest. I would be very pleased to receive your feedback, positive or negative, on the analysis so far before I complete the final stages. I appreciate that the summary is quite lengthy and there are many other pressures on time but I would be grateful for any comments you are able to send me. I have enclosed a return envelope and a feedback form for any comments. I will be able to send you a full summary of the research when it is completed later this year.

Thanks again for all your help with this research.

With best wishes,

Susan Whiting  
Psychologist in Clinical Training

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<sup>3</sup> The author regrets that due to space limitations for the appendices, it has not been possible to include the illustrative quotes from participants which formed part of summary report. The full feedback report with illustrative quotes can be obtained from the author.

<sup>4</sup> The information contained in the summary report preserves the anonymity of the clinical psychologists who took part in this research.

**Six ways in which self-help groups were seen as helpful:**

**1. *Belief in the principle of self-help and self-help groups***

Some saw the idea of self-help as extremely desirable and thought self-help groups were generally a good idea and could be positive for people's mental health and also have a therapeutic value. Another view was more mixed; agreeing with self-help groups in principle but remaining unsure about 'how to make them work'.

**2. *Self-help groups offer support & social contact***

One way in which self-help groups were seen as helpful was as places which offered support to members; potentially expanding people's support networks and also providing an opportunity to both give and receive support. Through offering social contact self-help groups were also seen as reducing isolation and loneliness and providing a space for people to feel less of a 'burden' to others.

**3. *Self-help groups provide an opportunity to share with others***

Self-help groups were also seen as places where people could share things together, such as experiences, information, knowledge, ways of coping and support.

**4. *Self-help groups offer people opportunities to meet others with similar difficulties***

Being with and knowing that there are others experiencing similar difficulties was considered extremely valuable. For example, this was considered to help people to feel less alone with their difficulties; to provide an experience of normalisation; and also to offer hope of change from seeing others who may have overcome their difficulties or whose circumstances may have altered.

**5. *Self-help groups could empower people***

Self-help groups were also seen as empowering of members. On an individual level self-help groups were seen as places where people could gain more awareness and understanding of their difficulties; perhaps making people 'anti-services' in a healthy way. On a group level self-help groups could also become a pressure group for change in services and society in general. Mention was made of the value of 'user' groups for people who may have been disempowered by contact with psychiatric services.

**6. *Self-help groups provide non-professional help***

Value was seen in the fact that self-help groups provided non-professional informal sources of support. One aspect of this was that support might be more 'genuine' as it was based on personal experience not professional expertise. Considerably less stigma was seen to be attached to attending a self-help group and they were also seen as fostering less dependency than professional services might, and encouraging more self-responsibility. It was thought that self-help groups might see themselves as alternatives services.

**Six ways in which self-help groups might be unhelpful:**

**1. *Too much 'professionalism': a threat to mutual help***

Concern about 'professionalism' within self-help groups. For example, certain members taking on too much responsibility and control within the group or a group culture based on the value of experts,

not on the value of helping each other. There was concern that this threatened the mutual help culture of self-help groups, the egalitarianism of members and potentially the survival of the group.

**2. *Not enough 'professionalism'***

In comparison to the first area, there were also concerns about a lack of 'professionalism' within self-help groups or 'professionalism' without awareness. There was concern about the difficulties this could create for the self-help group and for the members. Specifically, is anyone looking after the group and if so, are they capable of monitoring group process issues and dealing with the sorts of difficulties that can arise in groups, such as difficulties from group dynamics? Furthermore, is anyone in the group trained to do this or is anyone in the group identified as having this role? There was some concern about risks for members if there was no-one to oversee the self-help group; particularly whether more 'vulnerable' people would be able to cope.

**3. *Members motives may not be altruistic?***

There was also some concern about people's motives for starting a self-help group or becoming a member; particularly about whether people could be exploiting the group to satisfy their own personal agendas or if they had an 'axe to grind'. Again, there was concern about the potential to influence members in unhelpful ways?

**4. *Single-problem groups less helpful than generic groups***

Self-help groups organised around specific problems, such as groups for people with phobias, were seen as less helpful. Reservations included the following; focusing on the problem could make the problem worse; a strong identification with the problem and with the group could lead to a belief that only similar others can understand and the possible alienation of others who don't share the problem; individual differences between members could be denied; and the group could re-inforce keeping the problem so as to remain within the group.

**5. *How the group handles information***

There were concerns about the information given within self-help groups and whether it could mislead people and whether members could misinterpret information when applying it to themselves. Another concern was that self-help groups might hold singular, polarised views and exclude other perspectives.

**6. *Self-help groups may not help people to overcome their difficulties***

A number of comments were made about the limitations of self-help groups in addressing people's difficulties and helping them to cope better. Again, there were concerns about whether members might find it difficult to leave self-help groups because of the social aspect of being in the group, and whether members would find it hard to move on from their problems. Another issue was whether the group could end up being full of people with longer term needs and then whether there would be enough support in the group for it to be helpful to members. Other concerns were common to all groups, such as the potential for 'abandonment when the group ends and that individual issues are less likely to be picked up in a group setting in comparison to one to one work



### **Clinical psychologists views about who might go to a self-help group?**

In relation to who might attend a self-help group and find it useful, psychologists typically expressed uncertainty and there was little consensus of views. The majority considered it was hard to generalise about this; extremes were also expressed from thinking that more dependent people might go to people who were more self-reliant. Other views were that people with a greater 'psychological' problem and their problem might use self-help groups or people who had had difficult experiences of services.

### **How clinical psychologists think self-help groups might see them:**

#### ***Who are they?***

There was much uncertainty about how the profession would be viewed. The over-riding feeling was that self-help groups would not have strong or clear views about clinical psychologists; perhaps because of a lack of contact or because the profession is so small. A whole spectrum of possible views were expressed from seeing clinical psychologists as having resources which could be helpful to self-help groups to being viewed as more malevolent and as 'one of them'. Another view was that self-help groups might view clinical psychology using general stereotypes of professionals. Some also commented that self-help groups might have criticisms of accessing clinical psychology and regard the service as under-resourced.

### **How clinical psychologists think self-help groups might see services:**

#### ***Negatively***

Not many comments were made about this. Those who commented felt that self-help groups would not see services in a very positive light, but might view them as more uncaring and exploitative.

### **3 ways in which clinical psychologists see self-help groups in relation to services:**

#### **1. *As valuable***

Some considered self-help groups were part of the overall network of services, contributing a great deal to support the community and people's mental health. There was a view that self-help groups should not be seen as an adjunct to services, if anything the other way around, and that they are sometimes an alternative to services.

#### **2. *Having unique things to offer people***

Self-help groups were valued for offering different services to professionals. Some comments reflected a recognition of the limitations of professional help for people experiencing personal or emotional distress and the view that attending a self-help group was sometimes a preferable option. Other views were that there was 'room for both'; emphasising that self-help groups and professional sources of help had different strengths and drawbacks. Perhaps because self-help groups were seen as offering something different, there was also a view of not being in competition with them.

#### **3. *With danger warnings***

Some psychologists were concerned about the possible dangers of using self-help groups as the 'new solution' or as a way of de-professionalising services. There was some concern about the danger of

'either or views'. For instance, thinking that only self-help groups can help and that people do not need other forms of support.

### *How clinical psychologists think services might see self-help groups:*

#### *1. Dismissively*

Some comments expressed the view that services might be dismissive of self-help groups, not wanting to recognise that people could help themselves. There was also a sense that services might look down on self-help groups and undervalue them as sources of support.

#### *2. Tensions in the relationship*

Other comments can best be grouped as potential sources of tension in the relationship between services and self-help groups. One view was that services might see self-help groups as a 'thorn in the side' or be concerned about them. Self-help groups might be regarded as a threat to services and to people's jobs. They might also be exploited by services as a way of reducing the waiting lists. Other views were that services might find it difficult to work with self-help groups because they are not in control of them and could become antagonistic towards them if self-help groups were too critical of services.

### *Clinical psychologists views on involvement with self-help groups?*

#### *1. For collaboration*

Some psychologists held the view that collaboration with self-help groups was desirable and were clearly in favour of involvement. Some also considered that working with self-help groups should be a legitimate part of the clinical psychologists' role.

#### *2. Benefits for the self-help groups*

A range of views were expressed suggesting benefits for self-help groups from a relationship with clinical psychology. Some comments expressed the view that a link with clinical psychology could possibly strengthen the group or give it more credibility in the eyes of others. Other views were that psychologists had resources which self-help groups could benefit from. Another view was that psychologists might be able to act as advocates on behalf of the group.

#### *3. Benefits for clinical psychologists and services:*

##### *A. Service alternatives*

A number of comments indicated benefits for the recipients of clinical psychology services. For example, more choice could be offered to clients and they could also access support which the statutory services by their nature were unable to provide. One view was that it would be very positive if psychologists were able to approach self-help groups and there was another suggestion that working with voluntary organisations could be quite refreshing for psychologists in comparison to the NHS.



## ***B. Learning more***

Other views can be summarised as being able to learn from the self-help group. For instance, learning much more about consumer's views and being accountable to people; gaining insight into people's difficulties and lives and being reminded of people's own resources.

### **Seven possible sources of tension in the relationship:**

#### ***1. Can't stop being a clinical psychologist: professional responsibilities***

There was some anxiety about being able to maintain professional responsibilities when working with self-help groups. Some comments suggested that getting too close to self-help groups, such as attending a meeting, could be uncomfortable if the psychologist observed things which they felt they a professional duty to act upon. This seemed difficult because of a lack of control in that environment and uncertainty about whether or not there would be permission to express such views. Some psychologists expressed a preference for involvement outside of the role of clinical psychologist; possibly to avoid some of these tensions.

#### ***2. Different perspectives to the self-help group***

Another tension in the relationship concerned having to manage different points of view. This could be uncomfortable if the self-help group's way of thinking was at odds with or excluded a psychological perspective. Another view was that 'rigidity' of thinking on the part of the psychologist might be a barrier to working with self-help groups.

#### ***3. Threat to future relationships***

Some thought that working with self-help groups could threaten other professional relationships with individual members of the group. For instance, if a group member was to be referred for psychological help both parties might find it hard to relate in a different context. This could be particularly difficult if there had been tensions in the relationship between the psychologist and the self-help group. It might also be difficult to meet a former client in a self-help group setting. So, there seemed to be some issues about a 'blurring' of roles and how to manage this.

#### ***4. Responsibilities to the organisation***

A number of participants mentioned barriers in relation to responsibility to the organisations they worked for. Comments were made about time availability and work pressures. Other views were that working with self-help groups was not a high enough priority and not regarded as a legitimate role by management. The psychologist's position in the organisation might also make it difficult to work with self-help groups because of a conflict of loyalties. A number of participants emphasised the importance of being clear about where loyalties lie when working with self-help groups.

#### ***5. Managing criticisms of services***

Another group of comments related to sources of tension from criticisms of services by the self-help group. Some thought that groups could be quite anti-services or have members with difficult experiences of services. Being exposed to these dissatisfactions or being seen as a representative of the system was seen as an uncomfortable position to be in.



**6. *It may be unhelpful for the self-help group: a threat to the essence of self-help***

Some felt that professional involvement might threaten the essence of self-help and risked fostering dependency and losing the mutual support focus. Thus, there was a potential to replicate the same problems of dependency and professional control which the self-help group might have set up to avoid. Other risks were that the self-help group might be co-opted by services or over-run by professionals. Some self-help groups might also resist a relationship because of a fear of being taken over. Some psychologists had experienced these issues in their relationships with self-help groups and had found it very hard to withdraw their involvement. Some commented that the self-help group wanted to be self-directed but resisted moves to let go of the 'expert'. Again, managing this tension was difficult.

**7. *Emotional issues for the psychologist in the relationship***

Another potential source of tension was that working with self-help groups could be an uncomfortable experience personally for the psychologist. Some referred to the role as generally awkward and difficult; although others had had positive experiences of involvement. One group of comments can be summarised as having to manage negative feelings which might arise from the self-help group, such as being blamed when things go wrong. Also, having to manage difficult feelings which might arise towards the self-help group including arrogance; resentment; rivalry; or feeling a moral obligation to stay and help the group. Being the only one who was not sharing personal experiences was also described as an uncomfortable position to be in. Also difficult could be disapproving reactions from other colleagues regarding involvement.

**What might help the relationship to work?**

A number of views emerged. A group of comments reflected the need for communication between self-help groups and clinical psychologists. Aspects of this included; having a dialogue; knowledge of the other; and opportunities to link. Another group of comments reflected the need for a clear role when working with a self-help group. There was also uncertainty about what self-help groups wanted from clinical psychologists. Some comments suggested that involvement had felt easier when there had been clarity on both sides of the relationship. Perhaps because this reduces the threat of the self-help group being 'taken-over'; uncomfortable for both parties.

**Ways of relating to self-help groups:**

**1. *Indirect and non-authoritarian***

The majority of comments about involvement with self-help groups advocated non-authoritarian ways of relating which did not take away control or autonomy from the self-help group. A strong view was to be generally encouraging and supportive of self-help groups where appropriate in one's work. Also, to be available as a resource to self-help groups which they could access when needed as opposed to being too intrusive.

**2. *Don't get too close***

Another group of comments emphasised the need to find the right balance between closeness and distance in relation to self-help groups. Concern was expressed about getting too close to self-help groups and comments emphasised the importance of 'keeping your distance' because of the dangers associated, such as the threat of taking away the control of the group. Some thought that self-help

groups should be kept totally separate. One view on how close an involvement psychologists and self-help groups could have was that it would depend upon the group's relationship with the service.

**3. *Direct ways of relating: possible roles in relation to self-help groups***

A number of more direct roles in relation to self-help groups were mentioned. One possible role was to link clients in with self-help groups and disseminate information about them. Psychologists views ranged from never recommending self-help groups to being happy to recommend groups which they knew about. A number of psychologists felt it was important to be non-judgemental about self-help groups and offer clients an informed choice. Other roles in relation to self-help groups included; education; supervision and support; evaluation; establishing self-help groups; consultancy; and also supporting the group to act as a pressure group.

**APPENDIX 14:**

**Summary report of the emerging analysis for self-help group members<sup>5 6</sup>**

Dear

***Self-Help & Professional Help: Exploring the views of clinical psychologists and self-help group members***

I am contacting you again for any further help you might be able to give to this project. At interview you said you would be happy to receive a summary of the emerging analysis to comment on. I have now completed the first stage of my analysis of self-help group members' interviews and have enclosed a summary of this for your interest. I have included quotes from the interviews in the summary and have changed some details slightly to ensure people's anonymity. I would be very pleased to receive your feedback, positive or negative, on the analysis so far before I complete the final stages. I appreciate that the summary is quite lengthy to read but would be grateful for any comments you are able to send me. I have also enclosed a return envelope and a feedback form for any comments. I will be able to send you a full summary of the research when it is completed later this year.

Thanks again for all your help with this research.

With best wishes,

Susan Whiting  
Psychologist in Clinical Training

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<sup>5</sup> The author regrets that due to space limitations for the appendices, it has not been possible to include the illustrative quotes from participants which formed part of the summary report. The full feedback report with illustrative quotes can be obtained from the author.

<sup>6</sup> The information contained in the summary report preserves the anonymity of the self-help group members who took part in this research.



### *Self-help group members' views of self-help groups:*

#### **1. *They are generally helpful***

Many people commented that being a member of the self-help group was an important and valued part of their lives.

#### **2. *Value of being with others who are also experiencing difficulties***

Being with others who were also experiencing difficulties in their lives or who were in the 'same boat' was frequently mentioned as helpful. Many people talked about feeling less alone with their problems and a sense of relief that others shared similar difficulties or experiences. Being able to share with others who had 'been there' was highly valued and many felt that people who had experienced difficulties themselves were more able to understand.

#### **3. *Self-help groups provide help and social support***

For some, the self-help group was also a social experience. Some people said they valued the companionship of the group and also the relationships which they had built-up with other members. So, support happened both in and outside of the group. Self-help groups were also seen as places to both give and receive support and for some the opportunity to help others was an important part of being in the group. Another way in which the group helped was the opportunity to share ideas and information about ways of coping. A number of people said that they had joined the self-help group specifically because they wanted to help themselves. Some people talked about gains in understanding, one person said the group had helped them to overcome their difficulties and another that the group provided hope of change.

#### **4. *General atmosphere of self-help groups***

Many people commented on the relaxed, easy going and informal atmosphere of the self-help group; 'light relief' in comparison to professional help. For example, some people said they felt free to say as much or as little as they wanted to and there was also freedom to 'dip in and out' of the group. Another strong view was that self-help groups were more genuine, warm and caring than professional help; also places where people could feel more 'human'.

#### **5. *Concerns about self-help groups***

Very few people expressed concerns about the self-help group. Those who did made very general comments. For example about whether people should be giving each other advice. Other comments were more about the limitations of self-help groups. One person wanted more time to talk about the causes of problems; another felt the group did not push people to change.

### *Self-help group members' views of professional help:*

#### **1. *Mixed views about professional help***

Most people felt that professional help was useful and described positive experiences. Many felt they could only say that some professionals help as they had also had negative experiences. About half of the people who took part talked about negative experiences of psychiatric care and for some this had totally put them off this form of help. Therefore, there was a mixed range of views.



**2. *Helpful aspects of professional help***

Being helped to change or being steered in the right direction were frequently mentioned as ways in which professional help was useful. Specifically, some people said that professional help had encouraged them to think about things more and helped them to gain more understanding. Many people said they valued the opportunity to talk to someone who was distant from their situation and might be able to provide a more objective ear. People also talked about what helped them to use professional help. For example, the importance of trust; signs which show they care and are interested; being listened to and having feelings acknowledged.

**3. *General comments about services and lack of resources***

Many people highlighted the lack of resources in the health service and were concerned about this. Many said they had found it difficult to access professional help and be referred for help. A lot of people were concerned and also, angry about being offered drugs as a solution to their difficulties and some felt this ignored other underlying issues. People were worried about the lack of availability of professionals and talked about long waiting lists and professional's general lack of time. Some were also concerned about the lack of communication amongst the different professionals they were involved with.

**4. *How it feels to be on the receiving end of professional help***

People described various aspects of professional help which they had reservations about. Some concerns can be described as poor communication. For example, a general lack of feedback and consultation, such as not having views and opinions sought. Also, confusion about how services were trying to help. A number of people had felt very disempowered by their contact with services. Another aspect was the clinical feel about the relationship with the professional. For example, some people described feeling as if they were just 'another case' and others described the professional as too remote and detached or insensitive. Others felt that the professional had not been able to understand their difficulties or help them to change. Some also described the potential for the relationship to be 'abusive'.

**5. *General comments about the difference between professional help and self-help groups***

Some people talked about how they saw the self-help group and professional help as different. Some felt that professionals were more able to 'push people along' or 'get at the root of problems' than a self-help group. However, many people felt that professional help was limited because professionals were less able to understand than people who had 'been there' and because people needed more support than a professional could offer.

**6. *Stigma***

Many people talked about the stigma associated with mental health difficulties and of seeking help. Some people said they had not talked about their feelings with others because of this and others said they wanted to keep professional help to a minimum to avoid the stigma.



**Ways in which self-help group members think professionals see people who are experiencing personal or emotional difficulties:**

**1. *Mixed views***

No strong views emerged about how people thought professionals would see people who were experiencing difficulties in their lives. Some people were very unsure; others thought that professionals would be quite negative, such as seeing people as being unable to cope, or as 'neurotic', or even 'crazy', or as 'just another case'. Others felt that professionals would be much more empathic and respectful in how they saw people who were experiencing difficulties.

**Ways in which self-help group members think professionals see self-help groups:**

**1. *As helpful***

Many people thought that professionals were broadly in favour of self-help groups and many had actually heard about the group from a professional who had recommended it. Some thought that professionals would value self-help groups because they can take some of the pressure off services and because professionals recognise that people need other forms of support.

**2. *As unhelpful; with concerns about them***

Other people thought that professionals would have concerns about self-help groups and might see dangers in them for people who attend. Some people thought that professionals could be quite disapproving and dismissive of self-help groups. Others thought that professionals might see self-help groups as a threat to the survival of services.

**3. *Comments expressing positive experiences of relationships with professionals***

Some people described good working relationships between their self-help group and local services and felt the group was highly valued.

**How self-help group members see self-help groups in relation to services:**

**1. *As valuable***

Many people saw self-help groups as extremely helpful in relation to services, saving the NHS a lot of money and resources. Some people thought that self-help groups were the way forward and that there would be more self-help groups in the future. Many people also felt that both professional and self-help were needed in order to meet people's needs.

**Views about involvement with professionals:**

**1. *Collaboration with professionals is generally a good idea***

Most people thought that collaboration with professionals was a good idea. Some highlighted that this would of course depend upon the individual group and professional involved. One person felt it was a possibility to consider; another thought it would be problematic; only one person said they would be unwilling towards professional involvement.



### **Benefits of involvement:**

#### **1. Benefits all round**

People thought there would be a number of benefits from self-help groups and professionals collaborating with each other. Some people thought that self-help groups might gain from having access to 'expertise' and other perspectives in the group. Also, because some members might need more help than the group can offer. Other gains could be that involvement might lead to greater professional accountability. Some thought that professionals would benefit from having a greater insight into people's difficulties and lives and also from having access to more resources. Therefore, involvement has the potential to benefit both parties.

### **Sources of tension in the relationship:**

#### **1. How it would feel to have professional involvement with the group: Uncomfortable**

One possible source of tension was how people would feel if professionals came along to a self-help group meeting. Some people thought this was too intrusive; especially if the group was small in numbers or the professional came along too often. Others said they would feel very uncomfortable if a professional was there. People thought it could put people off coming to self-help groups and also, that people might 'open-up' less.

#### **2. Fears of how professionals might react to the self-help group; what their attitudes towards it would be**

One fear was that professionals might try and take over and tell the self-help group what to do; come in as the 'expert'. Many people talked about a fear of criticism or of patronising or disrespectful reactions from professionals. Others saw the potential for disagreements and were concerned about how different viewpoints would be managed. Some people thought that professionals might expect too much from the group and that this could make people feel worse if they could not live up to their expectations.

#### **3. General difficulties for the self-help group**

Other potential sources of tension were that professional involvement at a group meeting might not leave the group any time to talk; or could even be a waste of the group's time. Some thought there could be tensions because the professional had not experienced the difficulties themselves and were not the real 'experts'. Another view was that involvement would be difficult if the group was set up in opposition to services.

#### **4. Difficulties for the professional**

People also thought there might be difficulties for the professional in the relationship. Some felt that professionals simply would not have enough time; others wondered whether professionals would be able to cope in a self-help group, for example, with crossing the boundaries or whether they would consider the role important enough. Another source of tension was if professionals saw the self-help group as a threat.

### **Ways of relating:**

#### **1. *Ideas about how self-help groups and professionals could relate to each other***

A range of views were expressed about how professionals and self-help groups could relate to each other; although some people were more uncertain. One view was that professionals could come along occasionally and find out about self-help groups. Another view was that professionals could encourage self-help groups, suggest them as one option to clients and generally be more aware of them in their work. Many people thought that professionals could be available to self-help groups and offer their resources if the group needed help. Another possible role, which was mentioned by quite a few people, was to offer support and advice to the facilitator of self-help groups.

### **What might help the relationship to work:**

#### **1. *How professionals approached self-help groups***

Various suggestions were made about how professionals could approach involvement with self-help groups. Some people emphasised that professionals should be respectful of self-help groups and recognise the benefits they provide for members. Also, that they should be respectful of the autonomy of the self-help group and not try and take away the group's control. As mentioned before, some people felt that professionals could try and find out about self-help groups; come along occasionally and see how the group works; and be available to assist the group if needed; more of an 'arms length' type of relationship.

#### **2. *How self-help groups approached involvement***

Some people also commented on ways in which the self-help group could approach involvement with professionals. One view was that the self-help group should try not to put themselves in a position where a professional could take their power away or should not involve professionals until they are 'off the ground'. Another view suggested that the group needed to find the right level of involvement with professionals for them.

#### **3. *Egalitarian relationships***

Finally, a few people commented on the type of relationship they would like to see between professionals and self-help groups. This can be described as egalitarian with self-help groups and professionals on the same level. Also, more of a closer relationship to reduce the 'them and us' feeling and increase understanding of each other.







## APPENDIX 16<sup>7</sup>

### Participant feedback on the emerging analysis

#### A: Self-help group members

##### **1. Please could you comment on the content of the summary report.**

“Excellent content of the summary report. Thought the comments were put together extremely well. Liked the quotes from interviews - gave a personal touch to the paper.” (1)

“It seems to give quite varied views, a lot of which I agree with. It seems to cover a broad spectrum of views and covers most points of view from the group.” (2)

“Having read it - good, makes me think of all the things I didn't stress in interview!” (3)

“I thought the content was very good - covering most of the aspects of opinion on both kinds of help in a comprehensive manner.” (4)

##### **2. How accurate do you think the feedback is, is there anything you agree or disagree with in the analysis so far?**

“‘Stigma’ - I believe society has moved forward and appreciates that mental health *difficulties need* to be addressed rather than administering pills. ‘As unhelpful’ - with concerns about them - I'm doubtful whether professionals would see self-help groups as a threat to the survival of services.” (1)

“The feedback is varied therefore it's hard to agree with all of it, but a lot of truth is there amongst the different viewpoints.” (2)

“Difficult to comment, obviously one person's views might not be another's. Self-help groups really have to be able to accept everyone, views and all!” (3)

“I think that the feedback is generally very accurate (judging by my experiences) from both a personal and professional perspective.” (4)

##### **3. Do you have any other comments, thoughts or feelings about the research or your experience of taking part which you would like to add?**

“Since I saw you Susan, I was contacted by a counsellor. I did in fact take up the offer of more help. I know I said I may not but felt it would be beneficial. My counsellor is super, and contrary to what I thought has continued beyond six sessions - will in fact go on for as long as I wish. I see her once a fortnight, for between an hour and an hour and a half. She has helped me to look forward gradually. Again a real need in society for this kind of support. Although you know I had to wait a while.” (1)

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<sup>7</sup> The information contained in the summary report preserves the anonymity of the participants, some comments which may have led to their recognition have been omitted.

**“Sorry! Couldn’t think of much else to say!” (2)**

**“Perhaps if self-help groups are taken as a serious and valid contribution to mental health care - relations with professionals will improve and better communication between clients, professionals and groups will eventually improve. I feel communication has to improve within the professional services very much!” (3)**

**“I appreciated Susan’s sensitive manner in which she conducted the interview, she made me feel like I was contributing an opinion which would be validated and respected - and I thank her for that.” (4)**

**B: Clinical Psychologists**

**1. Please could you comment on the content of the summary report.**

**“I thought it seemed extremely comprehensive. It raised a number of issues which I hadn’t considered, but also many which I recognised.” (1)**

**“Find it interesting to see the psychologists views and to place mine on the spectrum. It seems that a broad range of views have been accessed but also a clear psychology voice and the issues inter-relating.” (2)**

**“I should like to see more figures (some said.....others said...). At the very least the majority view could be stated on some items.” (3)**

**“In the first part (six ways in which CP’s saw SHG’s as helpful) I felt points 2,3 and 4 weren’t sufficiently differentiated. They overlapped to the extent that I couldn’t easily see the difference - so I think a bit more clarity is needed here. In the second part (unhelpful) I thought point 3 should be renamed ‘nobody joins a SHG for altruistic motives!’ Perhaps you have to call it something like ‘individuals may seek power at the expense of other members’ - that’s not very good either!” (4)**

**“Interesting. Food for thought.” (5)**

**“I found it very interesting and well laid out and summarised. I think the main addition/change I would have liked would have been some indication of the strength and consensus about different views (mostly you state ‘some’ or ‘a number’).” (6)**

**“Detailed and comprehensive. I liked the quotes from psychologists. They confirmed that the summaries were accurate and not just the researcher’s interpretation.” (7)**

**“I’m sure it’s a faithful reflection of what was said. What’s missing for me is any underlying model or set of ideas which would provoke a framework into which both professionals and self-help services could be fitted. Self-help groups seemed to ‘float’ in a conceptual void. I’m sure there are ‘social action’ models from USA community mental health literature which would allow the summary to pinned down theoretically.” (8)**



**2. How accurate do you think the feedback is, is there anything you agree or disagree with in the analysis so far?**

**“I couldn’t think of any comments I had made that were not covered in the analysis. The themes and issues you have pulled out make sense and it seems helpful to consider ways of relating to SHG’s in terms of distance.” (1)**

**“Accuracy seems fine. Agree with analysis so far.” (2)**

**“Perfectly accurate from what I recall.” (4)**

**“I don’t see how I can comment on the accuracy of the feedback, as I was only present at my own interview!” (5)**

**“As far as I can judge. No significant disagreement.” (6)**

**“Accurate feedback. Is there any way of condensing the summaries which precede the quotes so the feedback is generally less lengthy and easier to absorb?” (7)**

**“It feels like the range of views one would expect to encounter.” (8)**

**3. Do you have any other comments, thoughts or feelings about the research or your experience of taking part which you would like to add?**

**“My impression from reading the analysis is that SHG’s are much more widespread than I would have imagined based on my own experience in the area in which I work. Also it seems that psychologists generally have more involvement than I would have anticipated.” (1)**

**“I’m very impressed by the length’s you’re going to to get feedback, check that participants feel accurately represented, etc.. It’s a very collaborative approach which feels nice, and also I think has a better chance of coming up with interesting and relevant information than many research undertakings which rely on anonymous questionnaires, with no opportunity for participants to say what they think of the results.” (4)**

**“It would be interesting to know how many people were questioned. The qualitative nature makes me aware of how number orientated research generally is - I was almost missing seeing a table with figures.” (5)**

**“Overall very interesting. Perhaps it might help to bring out more sharply any differences of perspective if they exist and where they stem from. I enjoyed taking part though found some questions very similar.” (6)**

**“Just being asked about support groups has made me think a little more about them and their value. It has been interesting to take part and receiving the feedback so soon made taking part feel more mutual.” (7)**

**“It seems clear that the respondents lack any clear model within which to conceptualise**



self-help groups. The terms used when talking about team 'support', 'social contact', 'sharing' etc., denies any fundamental therapeutic role for them. They are seen as at best 'supportive' at worst dangerous. They are not seen as primary sources of help. To some extent at least the NHS might be seen as evolving from a set of 'self-help' agencies. I'd like to see a much more incisive kind of analysis,? discourse analysis." (8)