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Patterns and correlates of self-help group membership in the United States

AUTHOR ABSTRACT

Data from a recently completed national survey are presented on patterns and correlates of self-help group participation in the United States. Over twenty-five million Americans are estimated to have participated in a self-help group at some time in their lives; over ten million, in the past 12 months. These estimates are conservative and might, in fact, be substantially lower than the actual numbers of participants due to the fact that we excluded groups organized or facilitated by professionals. Clearinghouse data show that professional facilitation is common in contemporary self-help support groups. Synthetic cohort analysis suggests that group membership has been rising over the past three decades, excepting groups concerned with eating problems or with life transitions. Although self-help groups exist to address a wide range of life problems, more than one-third of participants--accounting for more than 70 percent of self-help meeting attendance--are involved in groups for substance use problems. Large proportions of people who use self-help groups for substance (50 percent) and emotional (76 percent) problems also see a professional for these same problems. Self-help group participants are more likely than nonparticipants with the same problems to be young, female, white, and unmarried. Participants generally have lower incomes than nonparticipants, although the opposite is true in groups for eating disorders. Those reporting less support and more conflict in their social networks were more likely to participate in self-help groups than those with more supportive networks. Generally, those with a lower sense of personal control and higher levels of neuroticism were more likely to participate in self-help groups than their counterparts. However, extroversion, openness to experience, and commitment to personal growth are not significant predictors of self-help group participation.

Editor's Note: It is unusual for *Social Policy* to publish a research paper of this kind, but we believe that this important study deserves a special section in the magazine. *Social Policy* has been writing and theorizing about the self-help movement for two decades now. This research, showing that there are substantially more Americans involved in self-help groups than previously thought, is critical to any analysis of the movement now and in the future.

Unlike previous research that asked people whether they were participating in self-help groups "like AA," Kessler and his coauthors offer a careful and more detailed definition of self-help groups and find a much higher level of participation--while still excluding from their study support groups that involve professionals and make use of self-help techniques. Taken together, a huge number of Americans are touched by the self-help movement.

At a time when some tout self-help as an alternative to professional care, this study finds that those who participate in self-help groups are more likely to seek out professional help than those who do not. As policies are developed by government, foundations, and health care systems relating to self-help, this finding must be taken into consideration. While some people can get much of their mental health needs satisfied through participation in self-help groups, these groups will never be a substitute for all professional care. Such groups should not be looked to as a cheap and quick fix to the health care crisis. As several other articles in this issue point out, self-helpers and professionals must learn to work together and complement each other.

INTRODUCTION

A new interest in self-help groups has developed among clinicians and social policy analysts as financial constraints increasingly have restricted the range of services available to clients of the human services system (Riessman & Carroll, 1995). The hope is that more active use of self-help groups might reduce the growing disparity that exists between need and access to services for people with a variety of life problems. Although the

little available data suggest that self-help groups are sometimes able to promote emotional recovery from life crises (Emrick et al., 1993; Galanter, 1984, 1988; Lieberman & Borman, 1991; Videcka-Sherman & Lieberman, 1985), methodological limitations make it impossible to draw firm conclusions (Levy, 1984; Humphreys & Rappaport, 1994).

The dearth of research on the effects of self-help groups is part of a long-standing neglect of the self-help movement among human services professionals. As noted nearly a decade ago by Jacobs and Goodman (1989), it has been easy to overlook the size and importance of the self-help movement because most self-help groups are small and local. Yet it is becoming increasingly clear that self-help is now a major institution in American society. A recent national survey on the epidemiology of psychiatric disorders found that the largest single sector in the American mental and addictive disorders treatment system is the self-help sector (Kessler et al., 1997). Forty percent of all visits for psychiatric problems reported by respondents in this survey were in the self-help sector compared to 35.2 percent in the mental health specialty sector, 8.1 percent in the general medical sector, and 16.5 percent in the human services sector. Another recent national survey, this one concerned with membership in small groups, found that aside from Sunday school and Bible study groups, self-help groups are the most prevalent formal support groups in America today (Wuthnow, 1994). This survey estimated that between eight and ten million Americans belong to a self-help group and that there are approximately 500,000 such groups in the country.

We know from the Self-Help Sourcebook (Madara & White, 1992) that self-help groups exist for virtually every physical disorder known to medicine. There are self-help groups for people who have survived various traumatic life experiences as well as for people grappling with various current life problems and for the families and friends of people with this same range of problems. However, no representative data have, to date, been presented on the number of people involved in each of these types of groups nor on the characteristics of group members compared to nonmembers. This report presents such data from a recently completed national survey. Lifetime and recent self-help group membership, the most commonly used types of self-help groups, trends in group membership, and personal characteristics of group members compared to nonmembers are examined.

STUDY METHODOLOGY

The data reported here come from the Midlife Development in the United States (MIDUS) survey, a nationally representative telephone-mail survey carried out in 1995--1996 under the auspices of the John D. and Catherine T. MacArthur Foundation Network on Successful Midlife Development. The sample of 3,032 respondents was recruited from a random digit dial sampling frame of the coterminous United States. Eligibility was restricted to people in the age range 25 to 74. Men and older respondents were oversampled. Only one respondent was selected from each eligible household.

The survey was carried out in two phases; the first was a telephone interview averaging 30 minutes to complete, and the second was a self-administered mail questionnaire estimated to average two hours. The phase one response rate was 70.0 percent, and the conditional phase two response rate was 86.8 percent, for an overall response rate of 60.8 percent. Tract-level data from the 1990 Census were linked to the telephone central office codes of all sample households and used to weight the survey for differences between respondents and nonrespondents on a profile of Census variables. A more detailed description of the MIDUS study design is presented by Brim and Featherman (in press).

There is some disagreement regarding whether groups that are facilitated by professionals should be included in the definition of a self-help group (Rootes & Aanes, 1992). For purposes of this study, we excluded such groups. The MIDUS mail questionnaire inquired about self-help group membership by providing the following definition: "The next questions are about self-help groups, by which we mean groups organized and run by people who get together on the basis of a common experience or goal to mutually help or support one another. Groups organized and led by doctors, psychologists, social workers, or other professionals do not qualify as self-help groups." Respondents were then asked if they ever in their life attended each of the 11 different types of self-help groups listed in Table 1 and, if so, their age at first attending each type of group and the number of meetings attended during the past 12 months.

STUDY RESULTS

Participation in Self-Help Groups. As noted above, Wuthnow (1994) estimated that between eight and ten

million Americans currently participate in a self-help group. He also estimated that four out of every ten such individuals are in a group that focuses on addiction. The MIDUS results are consistent with these conclusions. As shown in Table 2, more than one out of every six respondents (18.1 percent of the sample) participated in a self-help group at some time in their life and 6.9 percent did so in the past year. These percentages are equivalent to approximately twenty-five million lifetime participants and ten million participants in the past 12 months.

By far, the largest segment of self-help participants in MIDUS comprises people with substance use problems, with 6.2 percent of the sample reporting lifetime participation (more than one-third of the people who ever participated in any self-help group) and 2.5 percent reporting participation in the past 12 months (more than one-third of the people who participated in any self-help group in the past 12 months). Participants in substance use groups also reported attending more meetings (an average of 76 in the past year) than those in other self-help groups (averages of between one and 24 in the past year), resulting in 70 percent of all self-help group visits in the past 12 months being to substance use groups.

Another noteworthy feature of groups for people with substance use problems is that participants often remain active for many years. This can be seen indirectly in Table 2 by noting that 40 percent of the respondents who reported ever participating in a substance use group were still doing so during the past 12 months. Groups for people with disabilities and parent support groups also have high ratios of recent to lifetime participation, although the typical participant in such groups only attends a few meetings per year. Substance use groups are distinct among self-help groups in having both a high rate of continuity and very active involvement of most participants. At the other extreme are self-help groups explicitly defined as helping with transitions. As expected, only a small proportion of lifetime participants in such groups are active in a given year (18 percent). Low median attendance in the past 12 months, in the range of between one and four meetings, is found among members of life transition groups, bereavement groups, disability groups, parent support groups, and groups for the families of people with physical illnesses.

Differences in Lifetime Participation. A good deal is known about the growth of self-help groups from archival data on founding dates. Beginning with the founding of Alcoholics Anonymous in 1935, there has been a steady increase in the varieties of self-help groups in the US up to the present (Katz & Bender, 1990). Much of this growth occurred after World War II, stimulated by the community mental health movement in the 1950s, the initiation of government programs in the 1960s, and the women's movement in the 1970s (Wuthnow, 1994; Riessman & Carroll, 1995). Much less is known, though, about trends regarding the numbers of people who participate in various self-help groups. It is plausible to think that the dramatic increase in types of groups has been accompanied by an increase in group members, but an alternative possibility is that membership has become increasingly differentiated rather than larger.

Some indirect data on this question can be gleaned from the MIDUS data by using retrospective reports about age of first participation to estimate cumulative Kaplan-Meier (1958) lifetime participation curves in separate cohorts. Data of this sort are presented in Figure 1 for lifetime participation in any self-help group. It is important to recognize that retrospective recall errors and selective mortality can introduce bias into these estimates. Taken on their own terms, though, these data suggest that there has been a consistent increase in lifetime participation in self-help groups across the cohorts included in the survey. For example, the curve for the youngest MIDUS cohort (age 25-34 at the time of interview) estimates that more than one out of every four in this cohort will participate in some type of self-help group by their mid-30s. By comparison, only about one out of every ten individuals in the 35-44 cohort had participated in a self-help group by their mid-30s and less than one out of every 20 had done so by this age among members of earlier cohorts.

We also find some differentiation across types of groups. The results in Figure 2, for example, show rates of lifetime participation in substance use groups. These data suggest that there was a substantial increase in lifetime participation in this type of self-help group beginning with cohorts born after World War II and a steady increase thereafter in more recent cohorts. For example, the curve for the youngest MIDUS cohort estimates that 13 percent of its members will participate in a substance use self-help group by their mid-30s as compared to only 4 percent of the 35-44 age cohort and less than 1 percent of those in the pre-World War II birth cohorts.

The results are somewhat different when we consider groups for people with eating problems, the type of self-help group with more lifetime participants than any self-help group other than substance use groups. As

shown in Figure 3, the data suggest that lifetime participation in this type of group is also much greater in MIDUS cohorts born after World War II than earlier cohorts. However, there appears to have been no meaningful increase in lifetime participation within recent cohorts, in each of which approximately 3 percent of its members participated in an eating problems group by their mid-30s.

Although the numbers of participants are too small for stable estimates of cohort differences in any of the other types of groups assessed in MIDUS, exploratory analysis suggests that most of the broadly defined types of groups considered here have had growth patterns like the one seen in Figure 2, with a large post-World War II birth cohort increase followed by continuing growth in more recent cohorts. The exceptions are groups for people with eating disorders and groups for people making life transitions (such as Parents without Partners or The Empty Nesters), both of which have had growth patterns like the one shown in Figure 3, with a large post-World War II birth cohort increase in participation but little growth in more recent cohorts.

Self-Help and Professional Help-Seeking. There is currently a great deal of interest in self-help groups among clinicians and social policy analysts based on the hope that these groups might represent a cost-effective solution to the budget cuts being experienced in the human services system. However, this hope is inconsistent with the observation that many people who use self-help also obtain professional treatment. A recent national survey of service use for psychiatric problems found that the vast majority of people who participate in self-help groups for psychiatric problems do so in addition to, rather than instead of, seeing a professional about these same problems (Kessler et al., under review). Furthermore, no evidence was found in this earlier survey that patients who participate in self-help groups use fewer professional services than those who do not participate in self-help groups. These results suggest that self-help groups, at least in the way they are currently used, are not the alternative to declining human services resources hoped for by many social policy analysts.

In order to discern whether a similar pattern exists in the broader sample of self-help group participants assessed in the MIDUS data, we compared patterns of past year professional help-seeking for both physical and emotional problems among participants in self-help groups versus nonparticipants. As shown in Table 3, participants are slightly more likely than nonparticipants to have seen a medical doctor in the past year for their physical health (94 versus 90 percent) and much more likely than nonparticipants to have seen a professional in the past year for an emotional problem (46 versus 28 percent). Fully half of participants in substance use groups and over three-fourths of participants in groups for broadly defined emotional problems also consulted a professional in the past year. These results suggest that some forms of self-help are often adjuncts to, rather than alternatives to, professional treatment.

Demographic Characteristics of Participants. As shown in Table 4, past 12-month participation in self-help groups is inversely related to age and income. The one exception is a higher relative odds of participation in groups for eating problems among people with high incomes. Women are more than twice as likely to participate in self-help groups as men, the exception being groups for people with substance use problems where there is no significant sex difference in participation. Married people have lower rates of participation than the unmarried. Blacks are only half as likely as whites to participate in self-help groups overall, but this difference is largely due to an extremely low rate of participation in groups for people with eating problems. There are no significant race differences in participation in groups for substance use problems or emotional problems.

These results are somewhat misleading in that they confound the demographic correlates of having problems with the demographic correlates of using self-help groups to manage these problems. We are able to focus on the latter for some types of groups by using information in the survey about problems with alcohol, excess weight, and emotional disorders to form subsamples of people who have these problems and examine the sociodemographic correlates of using self-help to deal with them. Results are reported in Table 5.

Focusing first on substance use groups, we see several important differences from the results in Table 4. First, there is a much stronger inverse age gradient, which means that young people with a substance use problem are more likely than older people with the same problem to seek help in a substance use group in the last 12 months. Second, we see a considerably higher proportion of women with a substance problem participating in substance use groups than comparable men, a difference masked in Table 4 by the fact that substance use problems are much more common among men than women. Third, we find that Blacks with a substance use problem are much less likely than comparable whites to participate in a substance use group in the past 12 months, a difference that was again masked in Table 4 by the much higher prevalence of substance use

problems among whites than Blacks. The higher rates of substance problems among men and whites than women and Blacks have been documented previously (Anthony et al., 1995; Warner et al., 1995).

The results in Table 5 regarding participation in self-help groups for people with eating problems are also different in some ways from those in Table 4. The age gradient is stronger, while the preponderance of women is smaller, due to age and sex differences in being overweight. The same is true for participation in self-help groups for people with broadly defined emotional problems, where the age and income gradients and the elevated rates among unmarried people and Blacks in Table 5 are weaker than in Table 4 due to significant relationships of these variables with emotional disorders.

Predictors of Self-Help Group Attendance. We also examined several personality predictors of self-help group attendance. A sense of personal control over one's life was a negative predictor while neuroticism was a positive predictor of attendance. Extroversion, openness to experience, and commitment to personal growth were not significant predictors. The subsample of individuals with psychiatric problems showed a similar pattern of results as the whole group, except that in the psychiatric subsample neuroticism was not a significant predictor. Results for the subsamples are reported in Table 6.

When we examined the subsamples of people with problems involving substance use and excess weight, neither sense of personal control nor neuroticism was a significant predictor of attending the substance use or eating problems group. However, two significant predictors not found in the group as a whole did appear when examining these subsamples. First, among those with a substance use problem, those with a strong commitment to personal growth were more likely to attend a substance use group than those with the same problem but a lower commitment to personal growth. Second, among those with excess weight, being open to experiences was a negative predictor of attending an eating problems group.

We noted above that self-help group participants are less likely to be married than nonparticipants. We also found that social support was a strong predictor of attending a self-help group in the last 12 months. Those who reported having less supportive social networks were more likely to attend a self-help group than those with more supportive networks. Furthermore, married individuals who reported low marital quality were more likely to attend a self-help group than those who reported high marital quality. As shown in Table 6, when we examined the subsample of individuals with a substance use problem, excess weight, or psychiatric problems, marital quality was no longer a significant predictor of attending these groups; and, for the most part, social support from family and friends was no longer a significant predictor of attendance.

DISCUSSION

The MIDUS estimate that 25 million Americans have participated in self-help groups at some time in their life is likely to be conservative because: 1) the survey excluded people younger than 25 and older than 75, and 2) the definition of a self-help group in MIDUS excluded groups either organized or led by professionals. Clearinghouse data suggest that a substantial proportion of support groups are, in fact, facilitated by a professional (Jacobs & Goodman, 1989). Countering this narrow definition, though, is the fact that the MIDUS sample contains a higher proportion of help-seekers than the population as a whole. This can be seen in the fact that the proportion of MIDUS respondents who reported seeing a doctor in the past year and the proportion who reported seeking help for emotional problems from some professional in the past year are considerably higher than the comparable proportions found in official government statistics and general population surveys with higher response rates (Kessler et al., 1997). The MIDUS estimate that 10 million Americans participated in a self-help group in the past year, on the other hand, is virtually identical to the projection made by Jacobs and Goodman (1989) as well as to the estimate from a recent survey carried out by Wuthnow (1994).

Synthetic cohort analysis found evidence of dramatic growth in the number of people participating in self-help groups beginning with cohorts born after World War II, a result consistent with the analysis of group-level data on founding dates, but not previously documented with representative individual-level data. It is interesting to note in this connection that the estimate of people using self-help groups in a year made by Jacobs and Goodman (1989) was based on a projection from data collected in a 1979 national survey that 7.5 million people were involved in a self-help group in that year. Jacobs and Goodman projected that there would be 10 million people using self-help groups each year by the end of the millennium. This turns out to be virtually identical to the MIDUS estimate.

The Jacobs and Goodman estimate was based on the assumption, consistent with data on the growth of the

number of new self-help groups tracked by the New Jersey Self-Help Clearinghouse (Leventhal, Maton & Madara, 1985), of an eight percent annual growth rate in the number of people who participate in self-help groups in a given year. The consistency of their projection with the MIDUS data suggests that this assumption was accurate. However, we also found in the MIDUS data that this growth has been uneven, with no growth among post-World War II birth cohorts in groups for people with eating disorders or groups for people making life transitions, but with substantial growth in other types of self-help groups. We suspect that a broader analysis of groups developed as formal adjuncts to professional treatment (e.g., Edmundson et al., 1982), a comparatively recent development in the self-help movement, would show even more dramatic growth.

Most commentators on the self-help movement emphasize the wide range of problems addressed by these groups (e.g., Katz, 1993; Riessman & Carroll, 1995). The MIDUS data show, though, that only a small number of people participate in groups for most types of problems and that the average participant attends only a small number of meetings in a given year. Consistent with Wuthnow (1994), the MIDUS data show that more than one-third of self-help group participants are involved in groups for substance abuse. Even more striking, if we focus on the number of meetings attended rather than the number of people attending at least one meeting as the unit of analysis, then substance groups account for nearly three-fourths of annual self-help group participation.

It is tempting to speculate that self-help groups represent a particularly viable and therapeutic form of symptom substitution. The "adhesiveness" that drives the addiction is reoriented from maladaptive substance use to the tonic of membership support. More than half of the remaining participation, in terms of meetings attended, is accounted for by participation in groups for people with broadly defined emotional problems or for the families of people with emotional problems.

It was noted in the introduction that clinicians and social policy analysts are becoming increasingly interested in the possibility that self-help groups represent a cost-effective alternative to professional human services. The MIDUS data are inadequate to evaluate this issue, as they cannot estimate the comparative effectiveness of self-help and professional treatment. However, it is important that many participants in self-help groups are also in professional treatment. As noted above, this result is consistent with the finding of another recent national survey, which found not only that the vast majority of self-help participants with current psychiatric problems were also seeing a professional for these same problems, but that participation in self-help groups was not associated with less intense professional treatment (Kessler et al., under review).

Clearly, if self-help is to be an effective accommodation to budget cuts in the human services system it will be necessary to develop new models. One such model might recruit participants who are not also in professional treatment. Given how uncommon this is among people with active psychiatric problems, though, a more realistic model might be one in which there is greater coordination than currently exists between self-help and professional treatment. The aim here would be to achieve an offset effect of the sort we are unable to document in current treatment data between use of self-help and reduced professional treatment intensity.

It is important to remember in this regard that the MIDUS definition of a self-help group excluded groups that are facilitated by a professional. It is likely that such groups are in a better position to coordinate care, in which case we might find more evidence of a treatment offset effect in an investigation of these latter groups than in one that, like the MIDUS survey, focuses on groups that have no professional facilitation. It is also important to remember that the MIDUS data on offset show only that a high proportion of self-help participants also made at least one visit to a professional for the same problem in the past year. We did not investigate whether the number of professional visits was lower than among people under professional treatment with the same problems who were not participating in self-help. This is the key issue to study in future investigations of treatment offset due to self-help group participation.

In thinking through opportunities for coordination between self-help and professional treatment, questions will arise as to whether self-help group participants differ from nonparticipants with similar life problems in their need for affiliation and, if so, whether this will limit the effectiveness of efforts to offset some of the treatment burden currently met by the human services system to the self-help sector. Little evidence for such a difference was found in our data. Self-help participants do differ from nonparticipants in having a lower sense of personal control over their lives, presumably making participants more attracted than nonparticipants to group membership. But participants do not differ from nonparticipants in other personality dimensions that might be considered important for self-selection into groups such as extroversion or commitment to a personal growth ideology.

Much more important in differentiating participants from nonparticipants with similar problems are variables that are either indirectly or directly related to low access to supportive social networks. Participants are found disproportionately in population segments that are less likely than others to be firmly connected to strong social networks (e.g., the young and unmarried). In addition, those with lower levels of social support from family and friends were more likely to attend self-help groups than those with higher levels of support. These differences suggest that self-help groups may help to provide the sense of belonging and affirmation that in earlier times was supplied by informal networks.

While professional helpers may be able to meet some of the needs met by participation in self-help groups, it is clear from the fact that many people in professional treatment also participate in self-help groups that this generally does not occur. By the same token, the fact that many self-help group participants also seek out professional treatment suggests that the mutual support model of self-help groups lacks something that is provided in the helper-recipient model of professional treatment. Clearly, some integration of the two models is likely to be superior to either alone.

Added material

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Table 1. Types of Self-Help Groups Assessed in the Survey

- Groups for people with substance problems (such as Alcoholics Anonymous or Rational Recovery)
- Groups for people with emotional problems (such as GROW, the Manic Depressive and Depressive Association, or Emotions Anonymous)
- Groups for people with eating problems
- Groups for dealing with the death of a loved one (such as The Compassionate Friends or Widow to Widow)
- Groups for people making other life transitions (such as Parents without Partners or The Empty Nesters)
- Groups for survivors (such as Adult Children of Alcoholics or Survivors of Childhood Sexual Abuse)
- Groups for people with physical disabilities or illnesses (such as Living With Cancer or Living With AIDS)
- Parent support groups (such as Toughlove or Parents Anonymous)
- Groups for the families of people with emotional or substance problems (such as The National Alliance for the Mentally Ill or Al Anon)
- Any other self-help group, mutual help group, or support group

Table 2. Lifetime Participation, Past Twelve Month Participation, and Average Number of Meetings Attended in the Past Twelve Months

number		Average
in the past		of meetings
months among	Twelve Month	twelve

participants (se) of Mean	Lifetime Participation		Participation		twelve-month	
	%	(se)	%	(se)	Median	Mean
Substance problems (12.2)	6.4	(0.4)	2.6	(0.3)	15	75.9
Eating problems (1.7)	4.0	(0.3)	1.1	(0.2)	8	11.9
Emotions or life crises Emotional problems (1.6)	1.2	(0.2)	0.3	(0.1)	10	10.0
Death of a loved one (0.7)	2.0	(0.2)	0.5	(0.1)	2	3.2
Life transition (1.9)	1.1	(0.2)	0.2	(0.1)	1	3.2
Survivors (4.5)	1.8	(0.2)	0.5	(0.1)	6	16.8
Any emotion/crisis group (1.9)	5.3	(0.4)	1.4	(0.2)	3	9.4
Physical illness/disabilities (1.4)	0.7	(0.1)	0.3	(0.1)	1	3.6
Family groups Parent support (1.9)	1.0	(0.2)	0.4	(0.1)	3	5.5
Families/physical illness (0.0)	0.4	(0.1)	0.1	(0.0)	1	1.0
Families/mental illness (6.5)	3.0	(0.3)	0.8	(0.1)	12	24.2
Any family group (4.5)	4.1	(0.3)	1.2	(0.2)	8	17.3
Other (4.9)	4.7	(0.4)	2.0	(0.2)	5	16.5
Any self-help group (5.1)	18.7	(0.7)	7.1	(0.4)	9	38.9

The total sample consists of 3,032 respondents.

Table 3. Percent of Professional Help-Seeking in the Past Twelve Months by Self-Help Group Type

Psychiatrist Emotional Problems (se)	MD(FNa)		MD		for
	for Physical Problems		for Emotional(FNb) Problems		
	%	(se)	%	(se)	%
Substance problems (4.7)	88.9	(3.4)	27.7	(4.8)	24.8
Eating problems (5.4)	98.9	(1.7)	22.8	(6.6)	14.1
Emotions or life crises Emotional problems (15.1)	90.2	(10.5)	76.9	(14.9)	75.8
Death of a loved one (9.4)	95.4	(4.9)	54.7	(11.7)	19.7
Life transition (10.3)	100.0	(0.0)	53.0	(22.3)	5.7
Survivors (14.1)	95.6	(5.9)	62.8	(14.0)	38.8
Any emotion/crisis group (7.4)	94.7	(3.5)	58.6	(7.6)	36.2

Physical illness/disabilities (10.4)	100	(0.0)	44.9	(14.4)	15.4
Family groups					
Parent support (8.0)	91.5	(8.0)	28.9	(13.1)	8.5
Families/physical illness (0.0)	100.0	(0.0)	0.0	(0.0)	0.0
Families/emotions (6.5)	91.5	(5.4)	19.2	(7.6)	13.2
Any family group (4.8)	92.0	(4.1)	20.1	(6.1)	11.1
Other (4.1)	98.8	(1.3)	27.8	(5.2)	14.5
Any (2.2)	93.9	(1.5)	29.5	(2.8)	16.1
None (0.4)	90.0	(0.5)	20.8	(0.7)	6.3
			Therapist(FNc)	Spiritual Adviser(FNd)	Any
Professional(FNe)			for Emotional Problems	for Emotional Problems	for
Emotional Problems			%	(se)	%
(se)					
Substance problems (5.4)	38.8	(5.3)	21.8	(4.4)	50.0
Eating problems (7.1)	9.9	(4.7)	9.4	(4.6)	28.6
Emotions or life crises					
Emotional problems (8.6)	80.9	(13.9)	7.0	(9.0)	93.7
Death of a loved one (11.1)	25.8	(10.3)	17.6	(9.0)	66.4
Life transition (22.0)	33.0	(21.0)	8.9	(12.8)	58.7
Survivors (9.2)	58.4	(14.2)	38.4	(14.0)	88.7
Any emotion/crisis group (6.6)	46.2	(7.7)	21.9	(6.4)	76.0
Physical illness/disabilities (14.4)	19.7	(11.5)	15.4	(10.4)	49.2
Family groups					
Parent support (14.4)	15.4	(10.4)	25.5	(12.6)	(53.0)
Families/physical illness (0.0)	0.0	(0.0)	0.0	(0.0)	0.0
Families/emotions (9.6)	46.1	(9.6)	24.8	(8.3)	54.7
Any family group (7.6)	33.2	(7.2)	23.7	(6.5)	50.2
Other (5.8)	30.1	(5.3)	18.2	(4.5)	48.4
Any (3.1)	28.3	(2.8)	16.9	(2.3)	46.4
None (0.8)	9.2	(0.5)	7.0	(0.4)	28.0

FOOTNOTES

a MD for physical problems includes visiting a doctor, hospital or clinic for routine exams, urgent care, or scheduled treatment.

b MD for emotional problems includes physicians seen in the general medical sector but not psychiatrists.

c Therapist includes psychologists, professional counselors, marriage therapists, or social workers.

d Spiritual adviser includes ministers, priests, rabbis, or other spiritual advisers.

e This category includes any visit to a medical doctor for emotional problems, a psychiatrist, therapist, or spiritual adviser.

Table 4. Prediction of Attending Self-Help Groups by Demographic Variables (univariate)

Group Predictors life crises(FNa)	Substance problems		Eating problems		Type of Emotions or
	OR	(95% CI)	OR	(95% CI)	OR
(95% CI)					
Age					
25-34 (0.7 - 23.8)	3.3(FN*)	(1.1 - 10.1)	2.3	(0.4 - 12.6)	3.9
35-44 (0.6 - 23.0)	3.7(FN*)	(1.2 - 11.2)	2.2	(0.4 - 11.7)	3.8
45-54 (0.6 - 23.6)	2.1	(0.6 - 6.9)	2.9	(0.5 - 15.8)	3.8
55-64 (0.5 - 21.2)	0.8	(0.2 - 3.5)	2.4	(0.4 - 14.1)	3.2
65-74	1.0		1.0		1.0
Gender					
female (1.1 - 4.8)	1.2	(0.7 - 1.9)	11.3(FN*)	(2.8 - 45.9)	2.3(FN*)
male	1.0		1.0		1.0
Marital status					
married	1.0		1.0		1.0
previously married (1.5 - 6.3)	2.6(FN*)	(1.6 - 4.2)	1.2	(0.5 - 2.7)	3.1(FN*)
never married (1.4 - 7.4)	1.5	(0.8 - 3.1)	1.0	(0.3 - 3.1)	3.3(FN*)
Race					
white	1.0		1.0		1.0
black (0.6 - 3.6)	0.8	(0.3 - 1.7)	(- - -)		1.5
others (0.2 - 4.4)	2.0	(0.9 - 4.5)	(- - -)		0.9
Income					
0 - 19,000 (0.5 - 4.1)	2.7(FN*)	(1.3 - 5.5)	0.6	(0.2 - 1.6)	1.5
20,000 - 34,000 (0.8 - 5.0)	1.5	(0.7 - 3.2)	0.5	(0.2 - 1.3)	2.0
35,000 - 69,000 (0.4 - 2.4)	1.2	(0.6 - 2.5)	0.5	(0.2 - 1.2)	0.0
70,000 +	1.0		1.0		1.0
		Family			
Predictors		Groups(FNb)		Any(FNc)	
	OR	(95% CI)	OR	(95% CI)	
Age					
25-34	1.3	(0.4 - 4.2)	1.6	(0.9 - 2.8)	
35-44	1.2	(0.4 - 3.8)	1.9(FN*)	(1.1 - 3.2)	
45-54	0.9	(0.2 - 3.3)	1.5	(0.8 - 2.7)	
55-64	0.7	(0.2 - 3.2)	0.9	(0.5 - 1.9)	
65-74	1.0		1.0		
Gender					
female	2.3(FN*)	(1.1 - 4.9)	2.2(FN*)	(1.6 - 3.0)	
male	1.0		1.0		
Marital status					
married	1.0		1.0		
previously married	1.7	(0.8 - 3.8)	1.9(FN*)	(1.4 - 2.6)	
never married	2.7(FN*)	(1.2 - 6.3)	1.3	(0.8 - 2.0)	

Race				
white	1.0		1.0	
black	0.9	(0.3 - 2.8)	0.5(FN*)	(0.3 - 0.9)
others	2.2	(0.7 - 6.9)	1.1	(0.6 - 2.1)
Income				
0 - 19,000	2.6	(0.9 - 7.5)	1.5(FN*)	(1.0 - 2.4)
20,000 - 34,000	1.4	(0.5 - 4.4)	1.4	(0.9 - 2.1)
35,000 - 69,000	1.5	(0.5 - 4.1)	0.0	(0.6 - 1.4)
70,000 +	1.0		1.0	

The odd ratios (OR) are exponentiated logistic regression coefficients based on bivariate logistic regression analyses.

FOOTNOTES

* Significant at the .05 level, two-tailed test.

a Includes attending a self-help group for emotional problems, bereavement, life transitions, or survivors.

b Includes attending a self-help group for parent support, families with physical illness, or families with mental illness.

c Includes attending any of the ten self-help groups asked about in the survey.

Table 5. Prediction of Attending Self-Help Groups Among People with Relevant Problems by Demographic Variables (univariate)

Predictors life crises(FNc)	Type of Group					
	Substance problems(FNa)		Eating problems(FNb)		Emotions or	
(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	
Age						
25-34 (0.2 - 13.0)	5.8	(0.5 - 63.4)	3.5	(0.3 - 48.2)	1.5	
35-44 (0.1 - 10.2)	8.4	(0.8 - 91.5)	3.4	(0.3 - 44.1)	1.2	
45-54 (0.3 - 20.0)	4.0	(0.3 - 46.0)	3.9	(0.3 - 51.1)	2.3	
55-64 (0.1 - 10.3)	1.6	(0.1 - 28.5)	2.1	(0.1 - 32.6)	0.8	
65-74	1.0		1.0		1.0	
Gender						
female (0.9 - 7.1)	5.2(FN*)	(2.6 - 10.5)	6.4(FN*)	(1.5 - 27.6)	2.5	
male	1.0		1.0		1.0	
Marital status						
married	1.0		1.0		1.0	
previously married (0.7 - 4.1)	3.1(FN*)	(1.5 - 6.3)	1.9	(0.7 - 5.3)	1.7	
never married (0.8 - 6.1)	1.2	(0.5 - 3.2)	1.2	(0.3 - 5.0)	2.2	
Race						
white	1.0		1.0		1.0	
black (0.1 - 3.2)	0.2	(0.0 - 2.5)	(---)		0.6	
others (0.1 - 5.2)	2.1	(0.7 - 6.3)	(---)		0.8	
Income						
0 - 19,000 (0.3 - 3.1)	3.0(FN*)	(1.0 - 8.6)	0.5	(0.1 - 2.1)	0.9	
20,000 - 34,000 (0.4 - 4.2)	1.8	(0.6 - 5.6)	0.6	(0.2 - 2.2)	1.3	

35,000 - 69,000 (0.4 - 3.4)	1.2	(0.4 - 3.6)	0.5	(0.2 - 1.6)	1.2
70,000 +	1.0		1.0		1.0

FOOTNOTES

The odds ratios (OR) are exponentiated logistic regression coefficients based on bivariate logistic regression analyses.

* Significant at the .05 level, two-tailed test.

a Individuals were defined as having had a substance problem if they reported that during at least one year of their life they regularly drank one or more days per week and had an average of five or more drinks on those days. While approximately one quarter of the total sample (22.2%) met these criteria, over half (55.6%) of those who attended a substance self-help group in the last twelve months did so.

b Eating problems were defined using the body mass index (BMI; Quetelet, 1869). The formula is Weight (kg)/Height (m)[sup2]. Individuals with a BMI over 28.5 were classified as having an eating problem. While approximately one-third (29.5%) of the total sample met this criterion, almost 60 percent (59.1%) of those who attended an eating self-help group in the last twelve months met this criterion.

c Emotional disorders were assessed with a screening version of the Composite International Diagnostic Interview (CIDI; World Health Organization, 1997). Individuals who met the CIDI criteria for having clinical depression, panic attack, or generalized anxiety disorder in the last twelve months were classified as having an emotional problem. While approximately one-third (28.7%) of the total sample met these criteria, two-thirds (66.6%) of this who attended an emotional or life crisis self-help group in the last twelve months met these criteria.

Table 6. Psychosocial and Personality Predictors of Attending Self-Help Groups Among People with Relevant Problems (univariate)

Predictors life crises(FNc) (95% CI)	Substance problems(FNa)		Eating problems(FNb)		Emotions or
	OR	(95% CI)	OR	(95% CI)	OR
Social Support(FNd)					
Family (positive) (0.4 - 1.1)	0.8	(0.5 - 1.2)	0.9	(0.5 - 1.7)	0.7
Family (positive) (1.3 - 4.3)	2.2(FN*)	(1.4 - 3.4)	1.1	(0.5 - 2.2)	2.4(FN*)
Friends (positive) (0.7 - 1.9)	2.1(FN*)	(1.2 - 3.5)	1.2	(0.6 - 2.3)	1.1
Friends (negative) (0.8 - 3.4)	1.2	(0.7 - 2.3)	1.0	(0.4 - 2.3)	1.7
Spouse (positive) (0.4 - 1.8)	0.5	(0.3 - 1.0)	0.9	(0.4 - 2.2)	0.9
Spouse (negative) (0.6 - 2.9)	0.9	(0.5 - 1.7)	1.4	(0.6 - 2.3)	1.3
Personality(FNe)					
Neuroticism (0.8 - 3.0)	0.9	(0.6 - 1.4)	0.9	(0.4 - 1.7)	1.5
Openness (0.7 - 3.1)	0.9	(0.5 - 1.7)	0.4(FN*)	(0.2 - 0.9)	1.5
Extroversion (0.5 - 2.0)	1.1	(0.7 - 2.0)	0.6	(0.3 - 1.2)	1.0
Personal Mastery(FNf) (0.5 - 0.9)	0.8	(0.6 - 1.1)	0.8	(0.5 - 1.1)	0.6(FN*)
Personal Growth(FNf) (0.9 - 2.1)	1.5(FN*)	(1.1 - 2.2)	1.0	(0.7 - 1.4)	1.4

The odds ratios (OR) are exponentiated logistic regression coefficients based on bivariate logistic regression analyses.

The predictors are all continuous variables that were standardized to a mean of zero and a variance of one.

FOOTNOTES

* Significant at the .05 level, two-tailed test.

a Individuals were defined as having had a substance problem if they reported that during at least one year of their life they regularly drank one or more days per week and had an average of five or more drinks on those days. While approximately one quarter of the total sample (22.2%) met these criteria, over half (55.6%) of those who attended a substance self-help group in the last twelve months did so.

b Eating problems were defined using the body mass index (BMI; Quetelet, 1869). The formula is Weight (kg)/Height (m)². Individuals with a BMI over 28.5 were classified as having an eating problem. While approximately one-third (29.5%) of the total sample met this criterion, almost 60 percent (59.1%) of those who attended an eating self-help group in the last twelve months met this criterion.

c Emotional disorders were assessed with a screening version of the Composite International Diagnostic Interview (CIDI; World Health Organization, 1997). Individuals who met the CIDI criteria for having clinical depression, panic attack, or generalized anxiety disorder in the last twelve months were classified as having an emotional problem. While approximately one-third (28.7%) of the total sample met these criteria, two-thirds (66.6%) of this who attended an emotional or life crisis self-help group in the last twelve months met these criteria.

d Social support was assessed with a series of scales developed by Schuster et al., (1990).

e Personality was assessed with a series of scales developed by Goldberg, (1992).

f Personal mastery and growth were assessed with a series of scales developed by Ryff & Keyes, (1995).

Figure 1. Cumulative Probability of Lifetime Participation in Any Self-Help Group by Cohort

Figure 2. Cumulative Probability of Lifetime Participation in a Self-Help Group for People with a Substance Use Problem by Cohort

Figure 3. Cumulative Probability of Lifetime Participation in a Self-Help Group for People with an Eating Problem by Cohort

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