Among the various mental and physical health intervention modalities, none are likely to be as compatible with the values, goals, and ideology of community psychology as self-help groups (SHGs). Ecologically, while they are part of the community’s health care delivery system, their roots are in the community, rather than in the various professional disciplines that staff the other components of that system. Furthermore, they are the only component of the delivery system whose sanction for existence comes from its immediate beneficiaries, rather than from the sociopolitical structure. While SHGs were initially born out of dissatisfaction with the established health care system (Katz & Bender, 1976), their surge in growth and their prevalence today can largely be explained by the changes in the social and cultural climate of America following the social and political eruption of the 1960s, which left in its wake, among other things, counterculturalism, the consumer movement, and a devaluation of the respect and privileges traditionally accorded professionals and others in authority. Thus, SHGs are the component of the health care system most likely to be identified with, and accessible, to the community served by the system.

At the level of public policy, SHGs hold the promise of increasing the community’s health care resources at minimal cost to its citizens. And at the individual level, because SHGs are for the most part under the control of their members themselves, participation in these groups should enhance their members’ sense of empowerment, which may itself have positive mental health consequences (Rappaport, 1987).

Despite their ideological compatibility, however, before community psychology as an empirically based discipline can give SHGs their full endorsement, much remains to be known about their effectiveness. Put more positively, there is much about SHGs that commends them to community psychology as an appropriate and important arena of research. Indeed, given their proliferation and popularity—estimates of the one-year prevalence of participation in SHGs range from 7.5 million in 1992 (Lieberman & Snowden, 1994) to over 10 million in 1999 (Jacobs & Goodman, 1989)—it would not be hyperbole to say that the need for research on their effectiveness is urgent.

Systematic research and scholarship concerned with SHGs are of quite recent vintage, beginning in 1976. That year saw the publication of both Support Systems and Mutual Help...
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(Caplan & Killilea, 1976), *The Strength in Us* (Katz & Bender, 1976), and a special issue of *The Journal of Applied Behavioral Science* (12, 1976) devoted to SHGs. Together, these three publications summarized the state of conceptualization and research on SHGs up to that time and did much to set the direction for future work on this topic. Readers are referred to these publications for a historical perspective on the current research scene.

This chapter will selectively review the research literature on SHGs since 1976 from three different perspectives: From a mental health perspective, it will be concerned with their effectiveness and with the processes and mechanisms that subserve their role as clinical interventions; from an organizational perspective, its focus will be on their growth and functioning as social systems; and from the perspective of public policy, it will consider the implications of our current knowledge of SHGs for public support of SHGs, and for their role as an integral component of the organized health care delivery system. It will be helpful, however, to begin with a brief discussion of the defining characteristics of SHGs and with a consideration of the particular methodological problems associated with research on them.

DEFINING CHARACTERISTICS OF SELF-HELP GROUPS

In his pioneering articulation of the concept of support systems, Caplan (1974) clearly captured many of the essential characteristics of SHGs. He defined support systems as "continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations about others, which may offset deficiencies in these communications within the larger community context" (pp. 4–5). He went on to note that within these social aggregates,

The person is dealt with as a unique individual. The other people are interested in him in a personalized way. They speak his language. They tell him what is expected of him and guide him in what to do. They watch what he does and they judge his performance. They let him know how well he has done. They reward him for success and punish or support him if he fails. Above all, they are sensitive to his personal needs, which they deem worthy of respect and satisfaction (pp. 5–6).

Caplan considered SHGs to be support systems, referring to them as "mutual-help groups of 'people in the same boat' " (p. 23). Thus, they have also been characterized as "ready-made social support systems in specific domains of problems" (Shumaker & Brownell, 1984). However, while it is true that SHGs are formed around particular problems or afflictions shared by all their members, there are other, more specific characteristics that should also be noted that distinguish them from other support systems and from the other components of the health care system.

Unlike other social support systems, such as family and friends, because all the members of SHGs share the same problem, they relate to each other as peers within the context of their group, each acting as both a provider and a recipient of help, focused on their common problem or condition. These three characteristics of SHGs, commonality of problem, members relating to each other as peers, and members playing dual roles as both providers and recipients of help, are often cited as keys to understanding the unique effectiveness of SHGs (Gartner & Riessman, 1977; Levine & Perkins, 1987). This is not to say that there are no hierarchies of roles within SHGs but, in contrast to professional care systems, the roles are functionally defined and open to any member qualified and willing to perform them.

SHGs also differ from naturally occurring social support systems in that they are intentional, and their activities are guided, in varying degrees, by particular ideologies con-