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INITIATING A QUASI-SELF-HELP GROUP IN NORTH IRELAND: A CASE STUDY OF NEW GROUPS FOR TRANQUILIZER ADDICTS

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ABSTRACT

An innovative format is used to describe the founding of a quasi-self-help group for tranquilizer addicts in Northern Ireland. The experiential perspective of a recovering tranquilizer addict named Kevin is used to tell his story of how and why he initiated the group as well as how the group has evolved over the past decade. A social science analysis then links Kevin's experiences in founding the group with the larger social, economic, and political context of Northern Ireland and situates the development of the group within the body of literature on self-help groups. Kevin controls the recruitment to and the dynamics of the group and uses professional knowledge acquired from training courses; these hallmarks of professionally-facilitated support groups in combination with its mutual aid features defines his group as a "quasi-self-help group." The implications of this mixing of models for group functioning and expansion are discussed.

Note: An innovative format is being used in this article. Typically, articles present either the experiential knowledge of self-helpers conveyed in narrative or story form or the professionally-based knowledge of the social scientist using third-person, linear, and analytical language to present their information. However, the

researchers thought it was very important to preserve the founder's (Kevin) perspective, as he told his story about how the self-help group was founded and evolved over the next ten years. Moreover, we wanted to place Kevin's story within a larger context of the social, economic, and political climate of North Ireland at the time and to relate his story to more general knowledge about how and under what conditions self-help groups have been founded. Accordingly, we have divided the article into five sections: first is an introductory statement of the social science issues presented in this article; second is Kevin's story of addiction and recovery that led to his founding of the group; third is the social and political context in which Kevin's story unfolded; fourth is Kevin's story of his first group, the professional training in addiction he received, and how the groups evolved over the next decade; the final section discusses Kevin's story in relation to the social science literature on self-help groups. Kevin has reviewed and approved of this article.

INTRODUCTION

How do new self-help groups get started in local areas? Under what conditions do innovative groups begin? We have some personal accounts from founders of groups (e.g., Nidetch, 1970; Guthrie, 1975) but few researchers have studied the genesis of groups. The advantage of personal accounts from the founder is that one obtains the founder's perception of the situation they faced, their perception of obstacles and opportunities, and the process they saw unfold. In contrast, scholarly examination allows one to more systematically study similarities and differences and identify some general principles that obtain as well as the social and political context in which new enterprises are founded. Leonard Borman (1979) is a notable exception among social scientists who looked at the founding of ten well known self-help groups including AA, Recovery, Inc. Borkman (1999) more recently analyzed in depth the founding and development over a seventeen-year period of a self-help group for people who stutter. The population ecology perspective has been applied to self-help groups to look at rates of founding and dissolution of groups in a geographical area (Maton, Leventhal, Madara, & Julien, 1990) but this study is very general and does not distinguish new kinds of groups from new chapters of established groups. Moreover, these studies are all from the United States. We lack information on how self-help groups in other cultural and societal contexts are created, the obstacles faced, and the conditions under which they arise.

Researchers have achieved some consensus in defining a self-help group as a member-owned voluntary group of people who share the common concern for which the group was intentionally formed that relies largely on the experiential knowledge of recovering persons (Borkman, 1999; Kurtz, 1997). In contrast, a quasi-self-help group that characterizes the group described in this article has some elements of a self-help group but its other features are from professional

support groups; for example, Parents Anonymous for parents who abuse their children is another quasi-self-help group as it requires co-leaders, one of whom must be a professional, and thus the group relies on both professional and experiential knowledge (Borkman, 1999, p. 83).

Kevin's story emerges as a cameo from a DPhil research project on "Voluntary Action, Community Development, Health and Social Well Being in the North West of Ireland" which entailed interviewing representatives from grassroots voluntary associations in the city of Derry in Northern Ireland in 1996. In itself, this is a significant piece of work being probably the only such city specific study as yet undertaken in the United Kingdom. During that work, the researcher, Jenny Sproule, encountered "Kevin." She sensed that his story illuminated the process whereby voluntary action can generate self-help groups in divided societies. Encouraged by her colleagues and with Kevin's full consent, Jenny undertook to share his experience with the readership of this *Journal.* In the process of gathering the information, all authors interviewed Kevin at different times, Jenny doing so on four occasions. The following story we believe to be factually accurate, but all identifying names of persons and agencies have been changed to protect those involved.

KEVIN'S STORY OF ADDICTION AND RECOVERY

Kevin is a forty-six-year-old, married, Roman Catholic man with three adult children and one dependent. His story begins during 1974 when, at twenty-two years of age, he was shot in his left side outside his front door by the British Army who mistook him for an armed member of the Irish Republican Army which had been actively engaged in "terrorist" activities in that area. Some weeks later, he was discharged from the hospital with considerable physical pain from his injuries and enduring psychological trauma. Due to the difficulty he experienced in coming to terms with what had happened, he became severely depressed and suicidal and was unable to continue with his job as a process operator. Being unable to cope, Kevin decided to seek help and approached his local doctor (General Practitioner) who prescribed him tranquilizers and sleeping tablets. He became addicted to these and remained so for twelve to thirteen years. During this period his wife was also treated with tranquilizers.

During the early 1980s, a range of contributing factors led to the breakdown of Kevin's marriage. His wife could no longer cope with his behavior. He was still classed as a security risk and as such their family home was frequently raided by the British army. The family too had to live with the stigma attached to having a perceived gunman in their home. Kevin continued to feel helpless, this was further aggravated by the fact that he empathized with the victims of shootings which continued to take place in his community. This increased his anxiety and undermined his self-confidence as "being a man you are not supposed to be afraid." Financial strains were also placed on the family due to his inability to return to

work. Instead, Kevin survived by using what little money he received in compensation for his injuries by starting a small, one-man business, selling fish and chips from a rented van. His wife was later hospitalized and received withdrawal treatment for her addiction. She was successfully rehabilitated by 1984-85.

Kevin, being determined to overcome his dependency on prescribed drugs enrolled at The Foyle, a voluntary treatment center for addiction in the city, which is a long-established, reputable, professionally staffed unit receiving government funding. The Foyle employed a confrontational and challenging therapeutic approach to its clients which bewildered and alienated Kevin. He could not come to terms with this approach. Kevin then attended some Alcoholics Anonymous meetings but was told to leave as he did not have an alcohol problem and they had no understanding of his drug problem. Indeed, at that time and in that cultural context there was no awareness of drug addiction problems and no self-help groups in existence. In due course Kevin was referred to a psychiatrist from a local mental health hospital who specialized in addiction. This was the first person who listened, expressed no judgements, and did not offer him tablets. He attended counseling sessions at this clinic every two to three months for two to three years.

Kevin slowly weaned himself off prescribed drugs: initially from the pain killers, then the sleeping tablets, and finally the tranquilizers. It took twelve months for him to completely withdraw, and by 1986 he was no longer tranquilizer dependent. At many times during this period he stated he could have killed himself because of the negativity of his feelings and because he had no one to listen to him. His psychiatrist suggested he contact a local branch of the voluntary based Northern Ireland Mental Illness Society in the city. Here Kevin instantly felt relief at meeting people like himself, suffering from a mixture of anxiety-based disorders and drug addiction, who needed help. But this was short lived. Kevin felt that the people involved were not committed to their own recovery, they had no resolve but consisted merely of a group who met informally for a cup of coffee and adhered to what he referred to as"rescue remedies." Kevin was deeply committed to pursuing his own recovery and left the group determined to ensure that others would not have to go through what he went through alone.

THE SOCIAL AND POLITICAL CONTEXT

Kevin's story unfolds in Londonderry, now largely known as "'Derry." This abbreviation has resulted from the exception taken by those from the Roman Catholic (and mainly nationalist) tradition to the link made with the capital city of their ancient enemy. It is the province's second largest city. It now has a population of almost 100,000, comprised of approximately 30 percent Protestants and 70 percent Catholics and an unemployment level of approximately 12 percent (Northern Ireland Office [NIO], 1991). It is situated in the top left hand corner of Northern Ireland a few miles from the border with the Republic of Ireland. The city, in keeping with the uncertainty surrounding its name, has perhaps always had

an ill-defined identity. It was initially an English Protestant fortress town in Ireland. It was established in the heart of an Irish Catholic indigenous population which extended up to the walls of the city. This balance between fortified town and hinterland, between urban and rural, and between Protestant and Catholic populations has changed considerably, particularly during the past thirty years of the current political unrest. In the process of becoming a city, the conurbation has extended far beyond its initial walled perimeter. It has developed a manufacturing infrastructure based mainly on the garment industry (since collapsed) and has greatly enlarged its Catholic population (Derry City Council, 1994). A large scale re-distribution of the city's population during this period of unrest has resulted in a city geographically divided into different religious sectors. Until recent years, the pattern of division was fairly clearly established, but lately a more fundamental change is becoming evident—the Protestant population is migrating in piecemeal fashion out of the parts of the city it has traditionally occupied. Indeed, there is a general draining of Protestants from Derry, away from the border and towards the more Protestant towns of Coleraine and Ballymoney.

The political conflict in Northern Ireland, which has persisted in one form or another for some three hundred years, revolves around the intersection of nationalism, unionism, and religion (Whyte, 1990). Many Catholics, the numerical and socioeconomic minority, seek to break away from the United Kingdom and to politically re-unify the six counties north of the island with the independent twenty-six counties of the Republic of Ireland (which most people mean when they refer to "Ireland"). Resisting this nationalist aspiration are the majority Protestant population who, in conjunction with the parliament at Westminster, control the major institutions and armed forces and seek to retain Northern Ireland's status as a jurisdiction within the United Kingdom. Extremists who react with violence and exacerbate the tensions between the two polarized groups are to be found on both sides. Moderates on both sides attempt to develop local community institutions that encompass all involved parties as a way of defusing conflict, beginning at the grassroots level.

What has not changed is the fact that the city today, as it was 300 years ago, remains a garrison for English soldiers. The police force is at least 95 percent Protestant and, until very recently, the City Council was run by a mainly Protestant administration. The implications of this for the majority Catholic population must remain largely a matter for conjecture. However, some tentative guesswork is perhaps permissible. Catholics in Derry are likely to have grown up with a sense of alienation from the armed forces and from the administrative framework which, in a literal sense, controlled so much of their lives. The thirty years of violence constituting this particular cycle of civil unrest has left the Catholic population with a pronounced level of fear and insecurity. This fear and insecurity was exacerbated by the psychological scars left by the "Bloody Sunday" killings (13 unarmed Catholics shot dead by the English army's parachute regiment in 1974). The fact that the city has probably the highest unemployment rate of any

city in these islands has been an added stressor. The city's Catholics have acquired a strong sense of identity of being a society within a society.

The effects of what is termed the "democratic deficit" in Northern Ireland (refers to the prevailing Direct Rule from Westminster in London, through an administrative framework which does not provide a mechanism for local accountability) is particularly acute in Derry. The sense of alienation, of submissive hopelessness, has distanced the Catholic community from the formal institutions which play an important role in any society, particularly one where unemployment and associated poverty have such an enduring hold. The links between poverty and ill health have been well catalogued in the international literature as indicative of areas which have high levels of second- and third-level intergenerational unemployment (Barker et al., 1988; Ewles & Simnett, 1992; Feuerstein, 1997; Smith & Egger, 1993; Townsend & Davidson, 1982).

For example, access to state social welfare and health agencies requires a psychological concession to the state apparatus which many may have felt unable to make. Possibly, a society accustomed to looking inwards for political leadership (and, to a degree, for paramilitary defense) would also learn to become self reliant in terms of community based self help groups. If those in need feel that the related service institutions do not "belong to them" they may have placed their trust in locally-based informal groups and networks. Politics, of course, creates the space for self-help groups. In divided societies this can be the intended consequence of a focussed use of political authority to positively discriminate in favor of one group. The history of Yugoslavia, South Africa, Israel, Rwanda, and many other countries testifies to the power of politics to formally deselect groups from full and equal participation in their social institutions. Usually, however, it comes about as an unintended consequence of careless politics which leaves particular groups feeling socially marginalized. The history of social movements promoting equal rights for groups such as the disabled, gypsies, racial minorities, etc., provides many illustrations of how politics can informally and unintentionally deny full citizenship to all members of society. Catholics in Derry, like French-speaking Canadian residents in majority English-speaking areas (see Adam, 1991), feel equally excluded. From their perspective it matters little whether this results from intentional or unintentional use of politics; they feel that the opportunities provided by their social institutions are not fully available to them. Using the space howsoever created by politics, socially excluded groups tend to cohere around mutual support mechanisms as a substitute for membership of their society's institutions. The dynamics surrounding the formation of self-help groups and their subsequent interaction with social institutions provide valuable insight into how politics can faciliate or impede the growth of a socially inclusive civil society.

It is from this background that our study is drawn. We suggest that the study illustrates dynamics which transcend their particular context. The lessons have an applicability to other social contexts where the alienation of those in need inhibits

access to formal health and social care service structures and stimulates the growth of alternative, community-based, self-help groups.

In Derry, this link is compounded by the environmental backdrop of a community characterized by conflict. As a consequence, many have turned to drugs to seek solace (McLaughlin et al., 1997). Perhaps most alarming has been the increase in illegal drugs such as cannabis, amphetamines, LSD, and ecstasy with approximately one in five people having at least experimented with them (NIO, 1996). However, a less recognized and indeed seldom publicized problem has been the increased tendency for people to become "hooked" on prescription tranquilizers. In Northern Ireland research has shown that tranquilizers rank as the sixth most commonly used "illegal" drug (NIO, 1996). In other words, people who have not been prescribed such drugs by a member of the medical profession have become users. Therefore, even the medical profession cannot determine the true figure for the number of users. The situation is exacerbated by the number of people who over-prescribe on their medication and thus leave health professionals with no real idea of the actual extent of the problem. Again, recent research in Derry shows that women in particular were making use of informal networks to avail themselves of tablets (e.g., valium, diazeparn) to help them cope (McLaughlin et al., 1997, p. 84). Unfortunately relatively little research has been done or is planned to examine the problem of prescription drug addiction. This has been overshadowed by the high media profile given to the abuse of illegal drugs.

KEVIN'S STORY OF PROFESSIONAL TRAINING AND THE INITIATION OF GROUPS

During 1987-88, Kevin, along with the coordinator of the Northern Ireland Mental Illness Society and a social worker, initiated two therapeutic self-help groups. After the initial meetings, Kevin was left to develop the groups as he saw fit. He received in-house training from the mental health association and attended courses in addiction studies and counseling at the University of Ulster, receiving certificates in both addiction and counseling; all of his university courses were paid for by the association. He felt motivated to learn in order to improve the group work as he said, "I could only take them as far as I was."

Drawing from his personal experience of tranquilizer addiction, withdrawal, the panic attacks, and other accompanying symptoms, Kevin was able to pass on to the group his coping strategies and his method of recovery. From his experience with the Alcoholics Anonymous (AA) fellowship, he was able to extract and transfer some ideas to his new groups. He selected only those ideas that he believed had helped him. As a result, he now employs four of AA's twelve steps: 1) admitting we were powerless over tranquilizers; 4) making an inventory of shortcomings; 5) admitting our shortcomings to another person; and 12) carrying the message to help other addicts and practice these principles in all our affairs (Mäkelä et al., 1996). Kevin describes himself as a "service volunteer" and as such he currently

contributes an average of thirty volunteer hours per week. The mental illness society offered him a full-time paid job but he declined it feeling that it would impinge on his freedom to develop the program and perhaps affect his motivation. If he became an employee, he would have to accept the assignments given to him by the mental health association. While he receives no financial rewards for his work, the Society does reimburse him for his expenses, and he takes great satisfaction from the number of Christmas cards he receives annually. In his own words, he has . . . "everything I want and more than I need." His view is that people who work in the mental health field have the *choice* to work in it, people who become mentally ill *do not choose* to become ill.

KEVIN'S CURRENT GROUPS

Kevin is now the coordinator of two quasi-self-help groups, the Prescriptive Drug Addiction Support Group and the Coping with Anxiety Support Group, in Derry. He designed the groups and modified them over the last ten years to be more workable.

Phase 1: Six-Week Assessment Period

Like professional treatment programs, Kevin screens prospective group members, but in an unusual way: he is concerned about their motivation to recover from their addictions. Prospective group members undergo a six-week assessment on a one-to-one basis with Kevin in order to identify their motivational determination to recover. According to Kevin, people who are in the group who do not want to get better are a "cancer to the rest of the group" and thus thwart the collective will to recover. Therefore, screening non-motivated people out of the group is paramount to its success. In some cases, he would stress, people only attend the group in order to please someone else while in fact remaining in denial.

Kevin applies his training in addiction studies and his skills learned through counseling to educate people about addiction, how to safely withdraw from prescription drugs, and how to cope with their side effects. Withdrawal needs to be undertaken over a period of time and under the supervision of a knowledgeable person who knows the physiological effects as this can be a dangerous, if not a lethal process. He employs a combination of counseling skills that he describes as including: engagement, self-awareness, acceptance, empathy, integrity, communication, exploration, understanding, and action. The program addresses the particular pattern of addiction presented by each member of the group and provides the support for people to move toward autonomy and ultimate recovery. Kevin's role also includes monitoring drugs as they come onto the market and detecting those relaunched under a new name by a different drug company.

Phase 2: Support Groups

Kevin as coordinator of the groups acts as gatekeeper, selecting who can become a group participant. Those permitted to join the wider group have to abide by four mandatory rules. In Kevin's words: "Firstly, you must keep appointments; secondly, I am here to help you to help yourself and the only way I can do that is for you to help me so that I can help you to help yourself; thirdly, you have to be honest; and finally, you must never be afraid to ask for help."

Each group has seven to eight members, all of whom suffer either from anxiety disorder or tranquilizer dependence and are all at different stages in the recovery process. New people can be added over time in the same way that older members "graduate" or leave after two or three years. People can enter the anxiety support group, then when ready to withdraw from tranquilizers, they enter the tranquilizer support group. The groups tend to be made up of equal numbers of males and female, mostly in the age range thirty to forty-five years, although this tends to vary over time. Both groups have a cross-community membership and thus involve both Protestants and Roman Catholics. Indeed, Kevin emphasized that the group would accommodate and respond to the needs of all people suffering from addiction and associated anxiety problems, including members of the armed forces. People attending the program come from all parts of the city and include people not just in the rural areas of the Council boundary but also from all over Northern Ireland.

As people progress over time in recovery, the more experienced then adopt a "partner" or newcomer to the group—this is similar to the buddy system found in some self-help groups or the sponsor-sponsee relationship in the twelve-step groups. The more experienced person shares information with the newcomer. They exchange phone numbers and are expected to help each other, including meeting outside the group. This helps them to face their fears and thereby make a full recovery. Kevin sees people in his groups outside of meetings only in emergencies, otherwise their partners are expected to help them. The idea of the longest person in the group becoming an assistant to the group leader is evolving.

Group meetings provide an opportunity for people to openly discuss their addiction and recovery in a confidential and non-judgmental environment. Individuals are afforded the opportunity to talk about where they are in the recovery process and how they feel about it. They provide a family-oriented nurturing environment where people work together, this explains why the numbers are kept so small. They use personal experience to help individuals face their own fears. Being made to feel welcome, needed, and involved helps to rebuild trust. The program also accepts that once withdrawal has been achieved and the person leaves the group, he or she remains prone to relapse in the same way as alcoholics risk returning to alcohol. Therefore, the program ensures that the individual can return to the group should they require further help. For those few who do return, it is seen as an opportunity to grow and to become stronger.

In the same way as members gain strength from the group process so too does Kevin. He believes that people now get better in his group faster than five years ago because he has more self-confidence, knows how to handle them better, and is more effective personally. He feels that the more support he gets himself, then the quicker the people attending the group will recover. He himself takes three or four days off to get some respite and relaxation every six weeks or so. The average recovery rate is between twelve and fifteen months.

When the groups first started, members were all self-referred, but now referrals come from community psychiatric nurses, social workers, and GPs. Kevin said he was "despised" by health practitioners initially but now that the success of his groups has spread by word of mouth the situation has changed. The groups now enjoy good relationships with GPs and they both have a lot of regard for each other. However, Kevin feels that although the "old timer" professionals value control, the younger members of the profession accept that he must be doing something right.

Kevin is concerned that his project will grow into "a doctor's surgery," that is it will inevitably become more formalized and bureaucratic. His long term goal is to develop this same approach throughout Northern Ireland and in the border regions of County Donegal in the Republic of Ireland. However, to do this he needs help to recruit people who have come through his groups, have them undergo the type of professional training in addiction and counseling which he received, and so teach them his method. His attempts to do this have been somewhat stifled as he feels a victim of his own success as when people get better they want to simply move on. He has also been developing a new group that deals with young people and street drugs and has two young people who help him with it. A carers group also exists for family members to attend.

DISCUSSION

Kevin can be seen very much as a pioneer in evolving his present approach toward anxiety management and tranquilizer addiction. Few formal treatment programs or self-help group options were available in Derry when Kevin started to recover from his drug addiction. Evidence obtained from GPs in the area indicates that they have since tightened up in terms of writing repeat prescriptions as most are now more apprehensive about enlisting drugs in the treatment process and, when they do, they now insist on scheduling appointments at which the patient must present himself/herself. Part of the cycle of blame has meant that some people were reluctant to approach their GP for help with withdrawal as they saw him/her as having instigated the whole process in the first place. In either case, some GPs still do not readily admit to over-prescribing. The situation is further compounded by the fact that those with addiction problems are not fully aware of the support available to them, either through referral to the statutory community and hospital-based services offered or through the voluntary sector open-door

based Foyle center. Unfortunately, both agencies have a public image of not dealing with addictions to legal drugs but concentrating predominantly on alcohol addiction.

Kevin believes that the endemic fear evoked by the political stalemate and the armed conflict in Northern Ireland has tainted the lives of many people who have ultimately sacrificed their health by turning to tranquilizers. Healthly choices exist initially for a drug user but are severely curtailed as users become addicted; tranquilizers are no longer a choice but become a necessity for drug addicts (Downie & Calman, 1994). He states that during the cease-fire people are now beginning to feel more secure and as a result they want to leave tranquilizers behind. People begin to come out of their "rabbitholes" and want to deal with their addiction. Kevin's main concern emanates with the problem of coping with the increased numbers and having the resources to deal with them. Many of the communities in Northern Ireland have been traumatized by "the troubles" and for many of the people in such communities they still live with the indelible memories of incidents such as Bloody Sunday and the Greysteel massacre. For those who will never forget such traumas, hope lies in the fact that one day they will forgive. If Kevin's concerns are realized, tranquilizer withdrawal will no doubt become a salient issue as the constitutional and political affairs of Northern Ireland unfold. The main concern will be to ensure that facilities are in place to deal with it.

Kevin pieced together his own self-help rehabilitation based on what he learned (both positively and negatively) from his short-lived participation in AA, the psychiatrist, and his exposure to what was in effect a "social club" of people uninterested in problem-solving their recovery at the Northern Ireland Mental Illness Society. His motivation to develop groups was partly so that others would not have to repeat the same negative experiences attempting to obtain help and suffer from the lack of ongoing emotional support. This story of Kevin's innovativeness in developing quasi-self-help groups in response to the inadequacies of help in his local environment is probably emblematic of how countless scores of self-help groups have been initiated in local towns and cities in the United States, Canada, Europe, and other countries.

After Kevin's personal recovery and initiation of a group he obtained professional training in counseling and drug addiction rehabilitation, thereby combining experiential knowledge of tranquilizer addiction and recovery with professional knowledge (Borkman, 1990). Kevin's combination of experiential and professional knowledge shaped the kind of quasi-self-help groups he initiated that are still evolving. The self-help and mutual aid components of his groups include the sharing of personal experience in the group, the experienced group member adopting a partner role to a newcomer, Kevin's experientially-based coping strategies to managing the recovery process, and his adoption of some of the AA's twelve steps. The professionally-based aspects of the groups include his role as gatekeeper in assessing who is committed to recovery and is allowed into the group, his basic control of the size and dynamics of the group, and his

transmission of his professional knowledge about anxiety management and safe withdrawal from tranquilizers. In a true self-help group (White & Madara, 1998; Kurtz, 1997) that is open to self-identified addicts, voluntary attendance acts as a filtering device to weed out the unmotivated; they might attend the group a few times and then drift away. Kevin's use of the professionally-controlled group model means that members do not own the group and therefore they do not develop the same investment in helping others and assisting in maintenance of the group. If the group were not as controlled by Kevin, but its functioning depended on members involvement and ownership, it is likely that fewer members would leave after the average of fifteen months of recovery and they would be available for recruitment to work with Kevin. Founders of self-help or support groups can develop special "ownership" attitudes toward their group that discourage others from sharing leadership (Medvene & Teal, 1997; Medvene, Wituk, & Luke, 1999). To replicate Kevin's model of a quasi-self-help group probably requires a considerable financial investment for recruitment, education and training, and group maintenance since it is predicated on a professionally-controlled group. Voluntary groups that depend on member's ownership and volunteering would be more risky but they can be replicated with fewer resources. Voluntary groups will often fail due to the liabilities of newness (Aldrich et al., 1990; Stinchcombe, 1965) including lack of volunteer effort by members to maintain them but they can spread relatively quickly with little money.

This article contributes to the literature on the genesis of self-help groups and their variations internationally. Borman's (1979) analysis of the founding of ten self-help groups that were primarily in the United States found that they all had professionals or agencies as co-founders or supporters. Kevin and his groups in Derry, North Ireland were similar in that they were significantly supported by a nonprofit mental health agency—the Northern Ireland Mental Illness Society. The Society provided Kevin a volunteer position, paid for professional training courses in addiction, legitimized his work with the groups, assisted him in setting up his first group, and donated space and other aid to the groups. Borman (1979) also points out that the groups he studied developed in divergent directions in organizational structure, size, sources of financial support, program focus, the nature of leadership and membership, and relationships with professionals and agencies. Kevin's quasi-self-help groups reveal a distinctive combination of attributes—partial elements of twelve-step groups, other voluntary groups, and of professional treatment programs—that reflect Kevin's experiences, the initial and subsequent conditions in the Derry, Northern Ireland environment, and the kinds of support, including the freedom to innovate, that Kevin has continually received from the nonprofit mental health association. Additional research on the genesis of self-help organizations in all their variety are needed to further our understanding of how and under what conditions they arise in various local and national contexts. Other case studies that portray in-depth the conditions surrounding the founding of groups in other countries would broaden our international perspectives.

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