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UTILIZATION OF AND EXPERIENCE WITH SELF-HELP GROUPS AMONG PATIENTS WITH MENTAL DISORDERS IN GERMANY

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ABSTRACT

This study explores utilization of self-help groups by patients with mental disorders, and compares data for patients with positive or negative self-help experiences. The authors surveyed 4,447 patients in clinics for psychotherapy

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and psychosomatic medicine regarding their utilization of and experience with self-help groups and outpatient psychotherapy. Data were compared for 106 patients with positive experience and 70 patients with negative experience who were self-help group members. Patients completed a range of standard questionnaires supplemented by some questions on self-help groups and psychotherapy especially designed for their project. About 11% of the patients had experience with self-help groups when admitted to hospital, usually in combination with psychotherapy. More than half of them were satisfied with their groups. Satisfaction with self-help group was associated with longer duration of participation, lower level of psychological distress, more self-efficacy, more extraversion, and a stronger network of social support. We found similar results in patients who were satisfied with their outpatient psychotherapy. The authors concluded that patients in self-help groups for mental disorders were mostly satisfied with their group experiences. Satisfaction was related to good personal resources and low psychological distress. Self-help groups deserve more attention as an alternative to or complementary element in psychotherapeutic care.

INTRODUCTION

> Self-help groups are voluntary, mostly loose associations of people, whose activities are directed towards common coping with illnesses, psychological or social problems, by which they—either themselves personally or as relatives—are affected. . . . Self-help groups are not led by professional helpers though some consult experts now and again on particular questions [1].

In Germany self-help groups have been receiving an increasing amount of recognition in many areas of health care and health policy [2, 3]. There are 70,000 to 100,000 self-help groups with some three million members [2, 4] in Germany, a country with 80 million inhabitants. Estimated percentages of people joining self-help groups range from 1% to 4% in the general population [5-7], and from 6% to 9% in patient cohorts [8, 9].

There are professionally organized self-help contact centers (clearing houses) in 300 German cities. Some 100 national self-help organizations for chronic diseases are organized within umbrella organizations. By contrast, there are also smaller local self-help discussion groups which deal with psychosocial problems (anxiety, depression, mourning, etc.) and can be seen as "group therapy without a therapist" [2, 10]. Traditionally they meet on a regular basis (usually weekly) and consist of 6 to 15 members. New members are only accepted by arrangement and if the group becomes too small by drop-outs (slow-open groups). As a rule, there are not any official group leaders; instead, all members share responsibility for the group [11].

The first research on self-help groups in Germany was conducted in the 1970s and 1980s, such as by Moeller's team in Giessen [12-16], but since that time there have hardly been any studies about groups for people with mental

disorders [17, 18]. As a result, little is known about when and under which circumstances people with mental health problems turn to self-help groups, and to what extent they benefit from them.

Some authors report that more members of the middle and upper classes participate in self-help groups than members of lower social strata [8, 19-21]. A recent meta-analysis of German studies on social factors influencing participation in self-help groups showed inconsistent results; however no class-gradient was obvious [22]. Participants of self-help groups have a higher knowledge about their disease and higher compliance than non-participants [23-25]. Cheung and Sun [26] as well as Laudet et al. [27] report that patients with higher self-efficacy derived more benefits from a self-help group. In a trial by Caserta and Lund [28], there was evidence which showed that members benefited more strongly from bereavement groups if they had well-developed interpersonal resources. Citron et al. [29] found a positive correlation between the benefits of self-help groups and the duration of participation by family members of psychosomatic patients.

Therapists often do not give self-help groups much credit for being able to help patients; fearing that in such an environment, patients' conditions might become chronic, or that their abilities to adapt socially might worsen. Furthermore, self-help groups are often regarded as being in competition with professional therapy, competition that might create unconscious resistance among experts [30]. The lack of research in this field may indicate that the prevailing critical attitude among health-care professionals is often the result of subjective experiences or stereotypes. If physicians and therapists show a lack of acceptance and inadequate knowledge about self-help groups, they are generally unlikely to provide patients with recommendations or information about self-help.

This study assessed a larger patient cohort in clinics for psychotherapy and psychosomatics. It examined the following questions:

1. How many patients in these clinics have had (at intake or previously) experience with self-help groups?
2. Which combinations of self-help groups and professional therapies have been reported?
3. What is the patients' level of satisfaction with self-help and psychotherapy?
4. What differences are found between patients who have had positive or negative experiences?

METHOD

In a multicenter study, all patients from five in-patient clinics for psychotherapy and psychosomatics (cf. list of authors) were surveyed upon intake. We enrolled all of the patients who were admitted between January 2003 and July 2004 and

who gave their written informed consent to participate in the study. Of the 6,090 enrolled patients 4,447 (73.0%) participated in the trial.

The participants and non-participants in the study do not show differences in terms of their sociodemographic data. However, study participants (M_1) remained in in-patient treatment longer than non-participants (ES: 0.34, M_1 = 41.2 days, SD_1 = 17.2; M_2 = 34.8, SD_2 = 20.3; t = 11.4; df = 2568.0; $p < .001$), which probably explains the differences in drop-out rates for in-patient treatment.

Sixty-eight percent of the study participants were female. The average age was 42.8 years (SD = 12.1); 44.8% were married and 29.7% were single. Of all study participants, 37.9% had completed a school-leaving certificate, 36.6% at O-levels and 19.3% at A-levels. Most patients were employed full-time or part-time (43.2% and 15.6%, respectively); 17% were registered as seeking employment.

The most common primary diagnoses according to ICD-10 classification were depression (F32, F33; 57.0%), followed by anxiety disorders (F40, F41, F41.2; 10.6%) and stress and adjustment disorders (F43; 7.9%). A somatoform disorder (F45) was the primary diagnosis in 6.7% of patients, and eating disorders (F50) were diagnosed in 6.3%.

Upon intake, patients filled out standardized self-assessment questionnaires (IIP-D, NEO-FFI, FKK, F-SOZU, SCL-90-R) and answered some questions about self-help which the authors developed as part of the project. The *Inventory of Interpersonal Problems* [31] documents the patient's perceptions of their difficulties in interactions with others, by eight subscales and by overall score for interpersonal problems. The *NEO Five-Factor Inventory* covers the personality traits of neuroticism, extroversion, openness, agreeableness, and conscientiousness [32].

The patients' self-efficacy and control orientation were determined by a corresponding questionnaire called the *Fragebogen zu Kompetenz- und Kontrollüberzeugung* (questionnaire on competence and control beliefs) [33]. The social support questionnaire, *Fragebogen zur Sozialen Unterstützung* assesses an individual's network of social support [34]. The *Symptom Checklist* measures the psychological distress of the past 7 days [35]. Here we used the overall mean of the 90 items (Global Severity Index, GSI).

The other questions were developed as part of a pilot study on self-help groups. Incoming patients were asked: how long they had currently or previously been members of a self-help group; the type of group (twelve-steps, open, slow-open), number of members; frequency of consultations with professionals, frequency of group meetings; and an assessment of their participation in a self-help group (satisfaction, changes in psychological and physical condition). We also gathered data about previous psychotherapeutic treatments and how the patients assessed them.

The data about sociodemographic status and therapists' assessments (diagnosis based on ICD-10) were derived from documentation at each clinic based on the national German standard of basic documentation [36].

DATA ANALYSIS

Parametric (t-tests) and non-parametric (chi^2) statistical analyses were conducted using SPSS (11.0 for Windows). For every significant finding, information was provided as to whether it was significant at a level of 5%, 1%, or 0.1%. Results at the 10% level were recorded as a tendency. Due to the partly sizable samples, we reported not only the significance but also effect sizes (ES = (M_1 – M_2) / SD_1^2 + SD_2^2 / 2). Following the categorization created by Cohen [37], we only reported findings with effect sizes greater than 0.20.

RESULTS

Utilization of Self-Help Groups

Of the 4,447 patients surveyed, a total of 497 (11.2%) had experience with self-help groups: 309 (6.9%) stated that they had been a member of a self-help group previously, and 188 patients (4.2%) were currently (i.e., upon intake) active in a self-help group. Of all patients, 39.1% said that they had participated in their self-help group between 1 and 3 months; 26% of them had been active for 3 to 12 months; and 34.9% had been involved for over a year. For the most part, the self-help groups were described as open (66.7%), with new members able to join at any time. The majority of groups met on a weekly basis (56.3%). Around half of the groups (47.4%) had up to 12 members and worked completely independent of professionals (46.4%).

Use of Self-Help Groups in Combination with Psychotherapy

Of those receiving in-patient care, 66.1% stated that they had previous experience with psychotherapeutic treatment; 9.8% of them had experience both with psychotherapy and with self-help groups (see Figure 1); 56.3% had only had experience with psychotherapy; and only 1.4% had experience with self-help groups alone.

Most patients (55.4%) had experience with out-patient psychotherapy, and 24.9% had been in in-patient psychotherapy before; 6.8% had participated in out-patient group therapy, and 5.6% had worked with other approaches (e.g., hypnosis); 32.3% of the patients were, at intake, currently undergoing out-patient psychotherapy.

On the whole, patients who had been in a self-help group (87.2%) had more experience with psychotherapy than patients without experience in self-help groups (63.4%; $chi^2 = 110.29$; $df = 1$; $p < .001$).

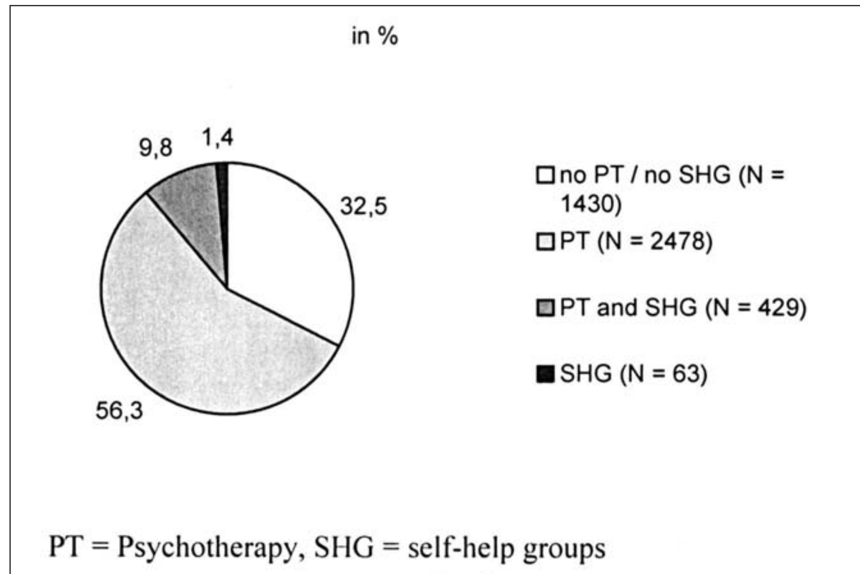

Figure 1. Summary of self-help groups and/or psychotherapy utilization (N = 4,400).

Satisfaction with Self-Help Groups vs. Psychotherapy

A total of 54.8% stated that they were satisfied with their self-help groups; 23.8% expressed a neutral opinion, and 21.4% were dissatisfied with their self-help groups. In total, 45.5% stated that their psychological condition improved due to their participation in a self-help group; 47.4% observed no improvement, and 7.1% said that their psychological condition had worsened.

Current participants were significantly more satisfied with their group (78.1%) than earlier members of self-help groups (40.5%; $\text{chi}^2 = 62.90$; $df = 1$; $p < .001$). Current participants also stated with significantly greater frequency that their psychological condition had improved because they had participated in the group (60.2% vs. 36.7%; $\text{chi}^2 = 24.50$; $df = 1$; $p < .001$).

In terms of their psychotherapy, 62.9% were satisfied, 24.6% were neutral, and 12.5% were dissatisfied. In total, 61.6% of the patients said that their psychological condition improved through therapy, 31.2% observed no change, and 7.2% said their psychological condition had worsened.

Here as well, patients currently in psychotherapy were more satisfied (69.3%) than patients with previous therapeutic experience (54.9%, $\text{chi}^2 = 57.08$; $df = 1$; $p < .001$). They also stated more frequently that their psychological condition

had improved (62.2%) than those patients who had had therapy previously (59.6%, $chi^2 = 4.12$; $df = 1$; $p < .05$).

Patients with "Successful" vs. "Unsuccessful" Experiences with Self-Help Groups

To analyze the differences between characteristics of participants with positive experience vs. negative experience with self-help groups, we examined the data of all those patients who were currently members of a self-help group ($n = 188$).

We then asked the patients whether their psychological condition had improved or worsened by participating in the group or if it had remained unchanged. We used the responses to this question to create two groups. In the first group (referred to as "successful" participants in self-help groups) there were patients who stated that their psychological condition had improved somewhat or greatly ($n = 106$, 60.2%). The second group (referred to as "unsuccessful" participants in self-help groups) consisted of patients who said their psychological condition had not improved or even worsened ($n = 70$, 39.8%). Only nine patients (5.1%) stated that their condition had worsened (see Figure 2).

There were no differences in sex, educational background, or professional status of participants considering successful vs. unsuccessful self-help group experience. But successful participants were less likely to be single (24.0% vs. 34.8%) or married (42.0% vs. 51.5%), they were more frequently divorced, separated, or widowed (34.0% vs. 13.6%; $chi^2 = 8.80$; $df = 12$; $p < .05$).

Successful participants in self-help groups (M_1) were older than unsuccessful participants (ES: 0.31; $M_1 = 45.6$, $SD_1 = 11.4$; $M_2 = 41.9$, $SD_2 = 12.1$; $t = 2.1$; $df = 174$; $p < .05$). There were no differences in terms of psychological or somatic diagnoses and in the duration of disorders. The psychological distress of the last 7 days (GSI of the SCL-90-R) was significantly lower among successful participants in self-help groups (M_1) than among the unsuccessful ones (ES: 0.52; $M_1 = 1.06$, $SD_1 = 0.64$; $M_2 = 1.42$, $SD_2 = 0.75$; $t = -3.1$; $df = 109.8$; $p < .01$).

Successful participants in self-help groups (M_1), were also significantly less frequently absent from work in the prior 12 months (ES: 0.45; $M_1 = 7.76$ weeks, $SD_{S1} = 12.78$; $M_2 = 14.95$, $SD_2 = 18.44$; $t = -2.7$; $df = 105.3$; $p < .01$) and took psychotropic medication at a significantly less frequent level (66.3% vs. 85.5%; $chi^2 = 7.9$; $df = 1$; $p < .01$).

Successful participants included a significantly higher proportion of people who had belonged to a group for over 1 year, and their self-help groups were more likely to meet on a weekly basis. There were no significant differences in terms of the other characteristics (see Table 1).

Successful participants (M_1) described themselves as significantly less quarrelsome and competitive than unsuccessful participants (ES: 0.33; $M_1 = 1.20$,

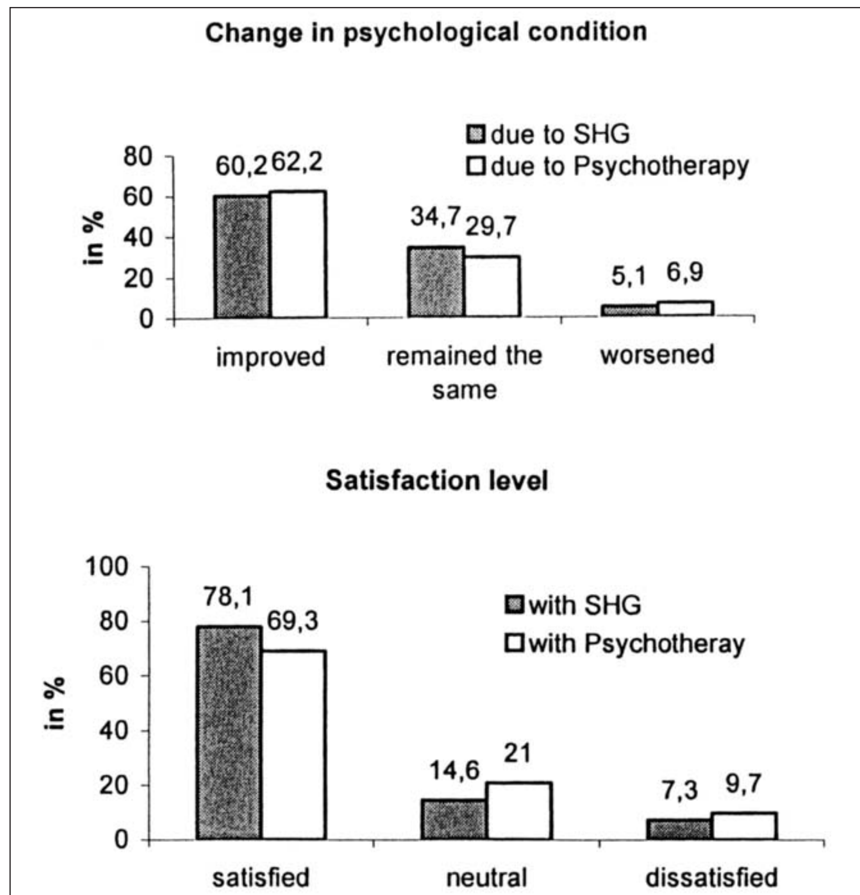

Figure 2. Improvement from and satisfaction with self-help groups and psychotherapy.

$SD_1 = 0.61$; $M_2 = 1.41$, $SD_2 = 0.68$; $t = -2.1$; $df = 172$; $p < .05$). They also showed less external attribution (ES: 0.38; $M_1 = 53.89$, $SD_1 = 11.32$; $M_2 = 58.49$, $SD_2 = 12.97$; $t = -2.5$; $df = 171$; $p < .05$), and they demonstrated greater self-efficacy (ES: 0.37; $M_1 = 58.08$, $SD_1 = 9.88$; $M_2 = 54.37$, $SD_2 = 10.32$; $t = 2.4$; $df = 170$; $p < .05$).

Successful participants in self-help groups (M_1) stated that there was a significant difference in the support they received from their environment (ES: 0.50; $M_1 = 3.73$, $SD_1 = 0.84$; $M_2 = 3.31$, $SD_2 = 0.85$; $t = 3.2$; $df = 172$; $p < .01$), and they were more extroverted (ES: 0.35; $M_1 = 1.98$, $SD_1 = 0.53$; $M_2 = 1.78$, $SD_2 = 0.60$; $t = 2.3$; $df = 107$; $p < .05$) than unsuccessful participants.

Table 1. Membership Characteristics of Self-Help Groups (SHG) as Defined by Successful Participants (i.e., Those Who Reported a Subjective Improvement of Their Psychological Condition) and Unsuccessful Participants (i.e., Those Who Reported a Subjective Lack of Improvement/Worsening of their Psychological Condition)

	Successful participation in SHG *N* (%)	Unsuccessful participation in SHG *N* (%)	Total *N* (%)	Chi^2
Length of membership				
1-3 months	22 (21.0)	25 (36.2)	47 (27.0)	$chi^2(3) = 10.88$; $p < .05$
4-12 months	22 (21.0)	21 (30.4)	43 (24.7)	
13-36 months	24 (22.9)	7 (10.1)	31 (17.8)	
Over 36 months	37 (35.2)	16 (23.2)	53 (30.5)	
Type of group				
Anonymous	14 (13.6)	9 (13.2)	23 (13.5)	Not significant
Open SHG[a]	69 (67.0)	49 (72.1)	118 (69.0)	
Slow-open SHG[b]	20 (19.4)	10 (14.7)	30 (17.5)	
How often were professionals consulted				
Never	43 (40.6)	25 (36.8)	68 (39.1)	Not significant
Rarely	38 (35.8)	23 (33.8)	61 (35.1)	
Often	25 (23.6)	20 (29.4)	45 (25.9)	
Numbers of members				
Up to 6 members	16 (15.2)	22 (31.9)	38 (21.8)	Not significant
7-12 members	54 (51.4)	26 (37.7)	80 (46.0)	
13-18 members	24 (22.9)	13 (18.8)	37 (21.3)	
> 18 members	11 (10.5)	8 (11.6)	19 (10.9)	
Frequency of meetings				
Weekly	64 (60.4)	28 (41.8)	92 (53.2)	$chi^2(3) = 8.06$; $p < .05$
Twice a month	24 (22.6)	16 (23.9)	40 (23.1)	
Monthly	14 (13.2)	19 (28.4)	33 (19.1)	
Less frequently	4 (3.8)	4 (6.0)	8 (4.6)	

[a]i.e., new members were accepted at any time. [b]i.e., new members were only accepted occasionally.

Patients with "Successful" vs. "Unsuccessful" Experience with Psychotherapy

In a manner analogous to our approach to participants in self-help groups, we also surveyed everyone who indicated upon admission to the clinic that she or he was in out-patient psychotherapy (individual/group therapy or other approaches) (n = 1,438) to determine whether their psychological condition had improved, worsened, or remained the same due to therapy. The responses could be sorted into two categories. In the first category ("successful" psychotherapy) were those patients who said that therapy helped improve their psychological condition (62.2%), and the second category ("unsuccessful" psychotherapy) consisted of all patients whose psychological condition had remained unchanged (29.7%) or grown worse (6.9%) (see Figure 2).

There were no differences between these two groups in terms of social data and diagnosis according to ICD-10. Patients who had undergone successful psychotherapy showed a significantly lower level of psychological distress (GSI) than patients with unsuccessful therapy ($p < .001$; ES: 0.41), and they took a significantly lower amount of psychotropic medication (69.4% vs. 78.1%; $chi^2 = 12.2$; $df = 1$; $p < .001$).

As was the case with participants in self-help groups, there were differences in interpersonal relationships, control orientation, social support, and what is known as the "Big Five" personality traits (all differences $p < .001$). Patients who had successful psychotherapy described themselves as less introverted and socially avoiding than patients with unsuccessful therapy (ES: 0.21), and they reported fewer interpersonal problems (ES: 0.21).

Patients with successful therapy had less external attribution (ES: 0.22) and a higher level of self-efficacy (ES: 0.30). They reported a significantly higher level of social support (ES: 0.22) and described themselves as more extroverted (ES: 0.24) and open (ES: 0.22). They received lower scores on the neuroticism scale (ES: 0.28).

DISCUSSION

Patients in clinics for psychosomatic medicine and psychotherapy in Germany have a considerable rate of previous experience with self-help groups without a professional leader. Eleven percent report that they have already taken part in a self-help group; this figure is slightly higher than the one cited by Borgetto, who estimated a rate of 6% to 9% of participation for various conditions in chronic disease and addiction [8].

Upon admission to the clinic, 4% were active in a group. Current participants in self-help groups had participated in their groups for a significantly longer period and had accrued more subjective benefits than those who had participated at an earlier time. This shows the self-selection process of self-help groups'

participants. Longer periods of participation may be a factor of higher satisfaction (see below). At the same time, a longer period of participation increases the statistical likelihood that a patient will belong to a self-help group upon admission to the clinic.

Patients with self-help experience had taken advantage of professional psychotherapeutic help more frequently than patients without self-help experience. Grunow also reported that participants of self-help groups for somatic conditions take advantage of medical services more often [6]. On a related note, participants in self-help groups are better informed about their condition [23-25]. This greater knowledge and a higher motivation may be responsible for the fact that these patients seek more therapeutic options. Another reason resides in the longer duration of the disorder by participants in self-help groups, which means that these patients work with more therapeutic options and resources.

Despite the frequent concerns of psychotherapists that self-help groups without professional leaders can be seen as competition to professional psychotherapy, our data imply that patients combine self-help groups and psychotherapy in numerous ways.

With 55%, the levels of satisfaction with participation in a self-help group were somewhat lower than satisfaction with psychotherapy (63%). It is interesting to note that those currently in self-help groups and/or psychotherapy are more satisfied than patients who had worked with one of these approaches at an earlier date. Patients who had current experience with self-help or therapy showed a significantly greater frequency of improvement in their psychological condition. Since current self-help participants have been members in their groups for longer, there are two possible explanations for this phenomenon.

1. The participants stay in their groups because they are satisfied and feel that their psychological condition is improving.
2. As is the case with other therapeutic approaches, a prerequisite to therapeutic success is regular participation for a longer period of time.

Findings by Caserta and Lund [28] and Citron et al. [29] support the latter hypothesis that self-help groups are only helpful over a longer period of participation. One may hypothesize a mutually causal relationship between both factors.

Successful participants were more likely to meet on a weekly basis, whereas less successful participants were more likely to meet monthly. There seems to be a correlation between the “dose” and effect, an observation which is further supported by the fact that satisfied participants participated in their group for a significantly longer period than those who were dissatisfied. Both results show the positive effects of continuity.

Successful participants of self-help groups reported lower levels of psychological distress, less absenteeism at work, and less need for psychotropic medication than participants who were not as successful. On the one hand, successful participation in a self-help group could have a positive effect on severity of

symptoms, and correspondingly would influence the duration of absenteeism and need for psychotropic medication. On the other hand, successful participants might also have experienced less distress from the outset. There are certainly economic and health-policy issues involved here; however, they can only be explored by a long-term study. The data obtained by follow-up examination are currently being collected.

In the field of interpersonal relationships, successful participants in self-help groups report that they are less quarrelsome. This could have particularly positive effects in such a group without a professional leader. Consequently, there might be fewer conflicts in the group, which facilitates longer (and thus more successful) participation.

Positive self-help experiences have been linked to lower external attribution and higher self-efficacy. Cheung and Sun [26] as well as Laudet et al. [27] and Seelbach and Berthe [25] have reached similar findings. It seems certain that having faith in one's own competence is conducive to successful self-help activity.

Patients with positive experiences in self-help groups describe themselves as more extroverted and have access to a stronger social network. There may be a correlation between these variables as well. It is quite conceivable that patients who have successfully participated in self-help groups are less aggressive, more extroverted, and have greater self-efficacy. This makes it easier for them to participate for longer periods and with more enjoyment, which in turn leads to more social support, a better psychological state, and thus less absenteeism and less need for psychotropic medication. An inverse causality is possible as well; however, the self-help group as a kind of psychosocial laboratory might offer an opportunity to develop greater self-efficacy, more pronounced extroverted behavior and greater willingness to compromise. Ultimately this cannot be resolved without long-term study.

A critical note must be added to emphasize that this is a retrospective survey, obviously not allowing for clear-cut resolution of cause and effect. Another disadvantage relates to the fact that this research is based on self-reporting by patients. In particular, the data about improvements in the patients' psychological condition come only from their own subjective assessments. We share these limitations with other consumer report studies [38]. And finally, this study has to be seen in the framework of the German health system where self-help groups receive more awareness and support than in other countries.

CONCLUSIONS

1) Eleven percent of the patients in clinic for psychotherapy and psychosomatics utilized self-help groups; the majority of participants report positive experiences.

2) Positive experiences are closely linked to the duration of patients' participation. This suggests that when therapists recommend self-help groups, they

should let their patients know that their success is contingent on long-term participation (cf. Moeller's continuity principle) [15]. To make it easier for patients to participate for longer periods, it would be wise to acquaint them thoroughly with the concept, options, and limits of self-help groups.

3) We found that self-help usually takes place concurrently with professional therapy. There is no basis for the concerns held by some therapists and physicians that self-help would replace professional psychotherapy. On the contrary: participants in self-help groups appear to be very open to psychotherapy.

4) Successful participation in a self-help group is related to the following: less feeling of psychological distress, less need for psychotropic medication, less co-morbidity, greater self-efficacy, higher levels of extraversion, and higher amounts of social support from the individual's personal environment.

5) Similar findings were reported for successful psychotherapy. These results indicate that the same patients benefit both from self-help and from psychotherapy.

6) Since both approaches co-exist and can be used before, during, and after one another, it is worth taking the patients' wishes into account along with health-care and organizational considerations (such as the slots that are available for therapy patients and the accessibility of suitable self-help groups). This means that self-help groups can be implemented as a complementary form of (self-administered) care and/or follow-up after professional in-patient or out-patient psychotherapy. They might also fit into "stepped care" models where low-professional methods are tried out first before high-professional methods are implemented. The "indication" would be largely a "self-indication" on the part of the patients. But professionals can provide as needed the necessary information and help to resolve ambivalence. This can be their function in promoting and supporting self-help groups [1].

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