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PREPARATION FOR PARTNERSHIP: REFORM OF PROFESSIONAL EDUCATION[1]

Miriam J. Stewart
Dalhousie University School of Nursing

Abstract

This review paper examines factors in the evolution of self-help groups and lay support which challenge human service professionals to change traditional roles and ideologies. The inherent strengths and weaknesses of educational approaches for meeting this challenge are analyzed. Reported obstacles to collaboration with lay persons include deficiency in the professional knowledge and skill base and attitudinal misconceptions. Educational change efforts must be directed at attitudinal, skill and knowledge development. Given the historical and social construction of a discipline, health professionals and adult educators would be well-advised to reflect on the implications of professional socialization, paradigmatic shifting and social movements. Clearly, societal and institutional influences must be acknowledged and congruent changes in these spheres should accompany educational reform.

Résumé

Dans ce compte rendu on étudie les facteurs intervenant dans l'évolution des groupes d'entraide et dans l'assistance assurée par les non-spécialistes, qui incitent les professionnels des services sociaux à reconsidérer les rôles et les idéologies traditionnels. On y analyse les forces et les faiblesses inhérentes aux moyens utilisés par le système de formation pour relever ce défi. Parmi les raisons qui font obstacle

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à la collaboration avec les non-spécialistes, on compte une manque de connaissances, et d'habiletés professionnelles et des attitudes fondées sur de fausses conceptions. Les efforts visant à modifier le système de formation doivent porter sur le développement des attitudes, des habiletés et des connaissances. Etant donné qu'une discipline est le résultat d'une évolution historique et sociale, les professionnels des services de santé et les éducateurs d'adultes devraient prêter attention aux implications qu'entraînent le processus de socialisation professionnelle, un changement de paradigme et les mouvements sociaux. Il est clair qu'il faut tenir compte des influences sociétale et institutionnelle et que des changements appropriés dans ces domaines devraient aller de pair avec une réforme du système de formation.

The evolving needs and accompanying economic restraints in contemporary society cannot be met by professional resources alone. Lay networks can convert needs into resources and may enhance, complement or serve as alternatives to professional services. This points to the professional responsibility for acknowledging and accommodating consumer interests and redefining professional roles in the public interest. Using health professionals as an example, this article initially examines factors in the evolution of consumer and self-help movements which challenge professionals to transform traditional roles and ideologies from expert provider of services to partner. The inherent strengths and weaknesses of educational approaches for meeting this challenge to prepare for partnership will be analyzed.

Professionalization and
Colonization of Disciplines

Traditional professional education programs are based on an ideology of professionalism and socialization into professional values of expertise vis à vis lay persons. The sociological theories of professionalism could be considered applicable to analysis of the relationship between professional and lay systems. Yet, there has been little theoretical work done in the sociology of professions on the "fit" of lay helpers and self-help with the formal system. (Dingwall & Lewis, 1983)

Professionalism is a culture, or set of learned values, which reinforces the public's consciousness of dependence and vulnerability. (Bledstein, 1976) The monopoly of professionals over "necessary" skills and

knowledge derives from special training. (Reuschemeyer, 1983) The social significance of professional knowledge in reproducing a particular order and maintaining a protective mystique has been reaffirmed. Schon (1987, p. 340) ironically depicts the traditional view of professional knowledge as "I am presumed to know and must claim to do so, regardless of my own uncertainty." A consequence of the professionalization of knowledge is to make laypersons more dependent upon experts in society. (Popkewitz, 1984)

Professional socialization is considered to be an interactive process whereby the professional culture and ideology is transmitted initially through an educational process, leading to the acquisition of requisite knowledge, skills, values and roles (Jarvis, 1983; Stark, Lowther, Hagerty & Orczyk, 1986) and to "internalization of standards defined by the profession's elite". (Larson, 1977, p. 200) Adult educators recognize that socialization can also be viewed as a life long process. (Griffin, 1977) Yet, the adult education literature reveals that few studies of professional socialization have considered the societal structure into which professionals are socialized, (Feinberg, 1983) or the social formation of professional practice and knowledge. There is however, an evolving critique among adult educators (Rockhill, 1985; Selman, 1988) of the professionalization of adult education discourse and practise, which emphasizes social and reflective concepts of learning.

Certainly, the activities of recipients of services are also constrained by hierarchical regulatory norms in bureaucratic organizations. (Schon, 1987) The bureaucratized health-care system presses for a compliant and passive clientele (Bledstein, 1976) and for psychological distance between helper and helpee (Lieberman & Bliwise, 1985), as does the educational bureaucracy. (Freire, 1970; Selman, 1988) Nevertheless, commitment to a scientifically oriented and bureaucratic paradigm is nearly universal among professional disciplines.

Challenges within Professions to Dominant Professional Models

A profession's capacity for excluding competing paradigms in education and research and for assuming control is augmented by its connection with science. (Larson, 1977; Popkewitz, 1984) Kuhn (1970) raises the question of professional socialization in the context of paradigms which are comprised of disciplinary matrices and

exemplars. The paradigm, an encapsulating framework of consensual beliefs accepted by most members of a self-contained community within a discipline, organizes perceptions and defines research interests and methodologies. Disciplinary matrices are acquired implicitly through modelling and shared exemplars in the educational process. (Eckberg, 1979) Students are taught to learn and accept the paradigm revealed in its textbooks, lectures and laboratory sessions. Kuhn (1970, p. 19) links curricula to paradigms: "The claim for a special place in the curriculum has usually been associated with a group's first reception of a single paradigm."

Three main paradigms in the philosophy of science—the empirical-analytical, phenomenological or symbolic sciences and critical social theory—have intersected the educational sciences and health professional education research. (Bernstein, 1976; Dallmayr & McCarthy, 1976; Popkewitz, 1984) Many health professionals have continued to depend on the medical model, which is firmly rooted in positivistic scientific methods and philosophies. (Clarke, 1986) The traditional medical model has been criticized because of the asymmetrical profession-patient relationship in which recipient dependence is fostered and professionals establish the rules governing behaviour. Most professional-treatment models depend on complex technologies (Lieberman & Bliwise, 1985) and a bioreductionist model which restricts comprehension of health problems to the function of the human organs. (Laura, 1985)

The empirical positivistic tradition ignores political and social reality, thereby reinforcing dominant societal values and misrepresenting human action. (Bernstein, 1976; Feinberg, 1983) For this reason, there appears to be a shifting paradigm in educational research and practice from dominance of scientific ideals to a personal, social and holistic focus. (Allender, 1986) Likewise, social constructionist and holistic views are beginning to receive attention as potential paradigms for medical practitioners (Laura, 1985; Wright & Treacher, 1982) and nurses (Meleis, 1986) and as alternatives to the dominance of the medical model.

Dissatisfactions with and decisions to reject one paradigm because of emerging anomalies, accompanied by the decision to accept a new paradigm, can lead to advances in professions. Paradigm shifts or "revolutions" only affect members of a professional subspeciality

through an increasing shift in the distribution of professional allegiance. (Kuhn, 1970)

Thus, Kuhn's doctrine of scientific change may be one framework for explaining pressures for professional change. Another is the sociology of professions (discussed earlier), which is beginning to refer to clients' growing unwillingness to accept without question the authority, expertise and ethics of professionals (Friedson, 1983) and to the necessity for "reprofessionalization". (Larson, 1977) Control of expert services by consumers is considered one alternative to professional and bureaucratic control. (Derber, 1982; Reuschemeyer, 1983) The theoretical critique of professionalization in adult education has led to a paradigm shift which permits a broadening of the traditional paradigm to one which is responsive to consumer social movements. (Freire, 1970; Selman, 1988)

Consumer Social Movements
Challenge Professionalism

From the professional viewpoint, the growing phenomenon of self-help groups can also be conceptualized as a social movement which challenges professional beliefs, methods and prerogatives. (Touraine, 1985) The issues such movements raise are those connected with shifting boundaries between professional providers in the formal sector and lay helpers and consumers in the informal sector.

Thus, the social-movement literature provides a third framework for considering pressures toward professional change. Social movements are defined as collective action directed toward social change and as conflict expression between groups fighting for control of resources. (Cohen, 1985; Melucci, 1985; Touraine, 1985) Major movements are purportedly not formed because the system is in crisis (unlike paradigm shifts) but are the result of new kinds of social conflict. (Gundelach, 1984) The values of new social movements are autonomy, identity and opposition to manipulatory control and bureaucratization. (Offe, 1985) Thus these movements tend to involve consumer/citizen "battles" against the establishment. Knowledge plays a fundamental role, not only in the sociology of professions and paradigm formation, but in the development of social movements because the need for new forms of knowledge is at the center of new conflicts. Social movements include social learning and identity formation. (Cohen, 1985; Touraine, 1985)

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Several ideas in the social-movement literature have relevance for consumer self-help groups. Self-help groups aim to demystify professional expertise by shifting power to consumers and by altering traditional roles of lay people and professionals. Offe (1984, p. 237) concludes that self-help initiatives "could come to play an important role as long as they were recognized as socially normal and vital". This reference indirectly reflects the dilemma posed by the professional self-help group interface, a common theme in the self-help literature. Clearly, the self-help movement satisfies the following social-movement criteria: decentralized units connected personally and structurally, an ideology, real or perceived opposition from society or the established order, and a sense of common purpose. (Katz, 1981; Smith & Pillemer, 1983) Self-help groups are characterized by the need for individual and social change. Hence, the self-help movement could be expected to affect the provider-consumer relationship (Schiller & Levin, 1983) and the preparation and education of health care professionals. This is a growing conviction among adult educators that a new focus is needed which is less elitist and permits more dialogue with consumers, reflected in "popular education methods" used in community settings. (Freire, 1970; Selman, 1988)

In sum, the impetus and need for professional transformation and the influence of professional knowledge, learning and education, although viewed from differing perspectives, are recurrent themes in these three distinct literatures.

Barriers to Transformation and Potentiating Influences

Factors which may have an impact on the effectiveness of educational approaches to transformation are suggested in discussions of social change, attitudinal change, theory/education-practice dissonance, organization structure, societal forces and paradigm shifts.

The effectiveness of education in creating social change is the subject of considerable controversy. Cross (1983) contends that it is difficult to think of any social change which does not require attention to lifelong adult learning. Conversely, the influence of societal change extends to the domain of education. (Allender, 1986) The perennial debate about whether schools can change the values and structure of society or vice versa continues. (Feinberg, 1983) Any educational model of change must contain an understanding of the reproductive

dimensions in a society (Popkewitz, 1984) that make orientations resistant to change. That educational progressiveness is not necessarily connected with social structural change has been argued with some success over the past few years by adult educators, (Brookfield, 1983; Griffin, 1977) The "lived experience" of learners acts as a mediating force in what is actually taught, learned and rejected.

Regrettably, students who enter professional programs in the health fields typically come from a middle-class culture, which socializes them to believe that expert solutions take precedence over experiential solutions. (Gottlieb & Farquharson, 1985) Such early ingrained attitudes (which have cognitive and affective dimensions) frequently resist challenge and change. Further, attitudes which relate to the professional ideology and which have become internalized as part of the ego identity of the practitioner (Jarvis, 1983) are relatively slow to alter. Moving to a conception of consumers and lay helpers as partners runs counter to the health professional's traditional understanding of the helping process and of professional roles. This fundamental shift in attitudes is complex and will require much more than theoretical, didactic curricular change. Educational approaches to attitudinal change must elicit the attention and comprehension of the individual. Faculty commitment to the revised ideology of professional practice and experiential opportunities to practice skills are also required.

Gaps between education and practice, linked in some instances to theory-practice gaps, have been reported in diverse professional literatures. Theory-practice dissonance is prevalent in adult education and other applied fields. (Gottlieb, 1985) Griffin (1977, p. 45-46) in his discussions of adult education, perceptively purports that "philosophical analysis has failed to uncover adequately the dynamic relations between 'forms' and 'fields' or between theories 'about' and theories 'of' or between theory and practice itself." Separation of theory from practice is also continually problematic for nursing (Clarke, 1986) and medicine. (Wright & Treacher, 1982)

Perhaps professionals contemplating change should keep both the broad view of "what is" and the formulation of "what ought to be" in mind, thereby combining realism with idealism. Nevertheless, idealism is necessary if professionals are to prepare for the challenge of consumer-participation movements and relevant practice roles.

Preparation programs continue to influence the professional community through their graduates and are in turn influenced by their own graduates. (Stark et al., 1986) However, there is also a feedback loop back from the traditional practice setting to education, which may explain the tenacious adherence to outmoded medical-model views by some health professional educators. Unlike the empirical-analytical paradigm, which imposes a distinction between theory and practice, (Popkewitz, 1984) critical theory might fill the intellectual and practical vacuum as it "seeks a genuine unity of theory and revolutionary praxis." (Bernstein, 1976, p. 182)

As noted, values and norms of professional roles may be aligned with work-setting demands. Organizational structures may determine professional choice of helping model which may not be congruent with consumer preference. In fact, the bureaucratic context is considered pathogenic because it suggests dependence on experts. (Bernstein, 1983) Further, assumptions of traditional sociological theory indicate that bureaucracy will supplant the primary group and vitiate initiative and involvement at the local level. Certainly educational attempts to reduce lay reliance on professionals and bureaucratic organizations, which ignore social conditions and beliefs that legitimize these features of human services, will be undermined.

Jarvis (1983) is undoubtedly mistaken in his belief that there should be no intrinsic connection between the needs of society and the aims of professional education. Professional preparation programs are influenced by internal, intra-organizational and external societal forces, which interact to create a professional preparation environment that in turn influences the design of educational processes intended to achieve professional preparation outcomes. (Stark et al., 1986) Professional practice is based not just on education but on a number of sociocultural assumptions and expectations. Recent "revolutionary" thinkers in the human service fields, both health (Wright & Treacher, 1982) and adult education, (Popkewitz, 1984) emphasize "social practice" and linkage with society rather than the traditional view of distinctive spheres. This implies that professionals need to acknowledge and interact with lay social networks.
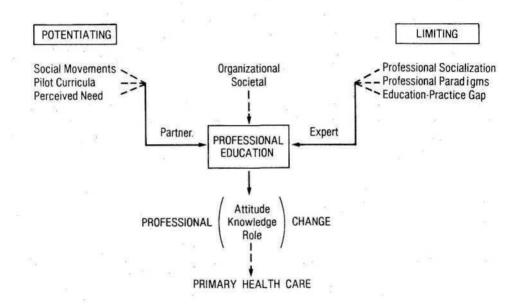
Health professional efforts to construct a discipline and to legitimize practice through enhanced education and theory construction could conceivably oppose new social movements and increase consumer-practitioner gaps. It could be contended, however, that these risks

increase when health professionals are educated in the traditional mode. An educational process is one approach to early socialization of professionals away from the traditional mode. Rather than making them more "expert", as early versions of the sociology of professions would suggest, this reprofessionalization could facilitate attitudinal, knowledge and skill changes which are more amenable to partnership with lay participants. However, educators must remember that socialization activities directed toward the development of a professional identity are not always consciously undertaken by educators. Further, faculty may reflect different, if not conflicting, paradigms, particularly if the theoretical/conceptual framework for curricular reform has not been accepted.

The transfer of allegiance from paradigm to paradigm cannot be forced and resistance to paradigm shifts will be encountered as long as some believe that the older paradigm will solve all the professional community's problems. It is difficult for health professionals to give up a dominant role reached through years of education, credentialism, and monopoly on practice areas. There is a threat to professional identity in addressing weaknesses in the professional sphere and in citizens becoming agents rather than targets of change. Individuals "who embrace a new paradigm at an early stage must often do so in defiance of the evidence…and have faith that the new paradigm will succeed with the many large problems that confront it knowing only that the older paradigm failed with a few." (Kuhn, 1970, p. 158) However, most health professions are undoubtedly in the preparadigm stage, characterized by conflicting schools of thought, and lack of agreement on theories, methodologies and beliefs. Therefore, educational efforts at paradigmatic "change" or "creation" may encounter fewer obstacles than in other, more established disciplines. Further, there is an emerging belief in many disciplines that we are not confronted with exclusive choices in the selection of paradigms and that we should not accept inappropriate restrictions in the range of paradigms that may legitimately be used. (Bernstein, 1983; Susskind & Klein, 1985)

In summary, although there are numerous potentiating and limiting forces (See Figure 1) within the health disciplines and society, which would influence the impact of educational strategies for professional change, the promising power of concomitant attitudinal, knowledge and role changes can be considered congruent with the premises of a primary health care model. (World Health Organization [WHO], 1985)

In contrast to the medical model, this assumes reliance on lay health workers and partnership with consumers. These forces may be similar to those operating within adult education, which appears to be moving from a traditional, technical model toward a more dialogical model of teaching and learning. Thus the dissemination of ideas would shift from "elitist" to "popular" methods.

Figure 1

Factors Influencing Effectiveness of Professional Education to Prepare for Work with Lay Groups

Educational Preparation of
Professionals for Transition

Professional responses to lay-help groups and consumers are influenced by education. Lenrow and Burch (1981) hope that interdependence of professionals with clients and sensitivity to the views of clients will become a principle modelled in professional training and exemplified in professional practice. However, Katz (1985, p. 135) recommends that "as long as it [interdependence] remains an unrealized vision...emphasis in professional curricula...on self-help forms" should occur.

The preceding discussion points to the need for professional education in appropriate roles, skills and attitudes. Some consider the greatest obstacle to collaboration with lay persons/groups to be a deficiency in the professional knowledge and skill base. Tensions between different types of knowledge and values, including ideological assumptions about the helping process (Kurtz, 1984) and respective roles, make partnership difficult. A review of the self-help literature reveals that knowledge deficits regarding the alternative modality and attitudinal misconceptions surrounding power and control issues predominate as barriers to positive interaction. It would seem that unique differences must be respected, tensions must be acknowledged, and perceived obstacles to "partnership" from the perspective of each party must be identified before interdependence can occur.

Interviews and surveys of professionals working with mutual-aid self-help groups and of self-help group members reveal a prevalent perception of a professional knowledge gap. Professional knowledge was found to be strongly associated with referrals to and linkages with self-help groups (Miller, 1983) and with supportive attitudes toward group development. (Black & Drachman, 1985) However, the vast majority of professionals reported little or no coverage in their educational programs, rated their current knowledge as either fair or poor, and desired further information about such groups. (Black & Drachman, 1985; Levy, 1983; Todres, 1982; Toseland & Hacker, 1985) Both lay persons and professionals also identify role ambiguity as a problem. Virtually all reviews of linkages between formal and informal helping point to fundamental shifts and redefinitions in professional roles. These differ in significant ways from the direct service roles played in traditional professional-client relationships.

As self-help groups acquire autonomy and as the professional role changes from expert provider to invited catalyst, consultant or partner, learning must occur. Rather than manipulation, hostility or indifference, professionals need to learn a partnership orientation to consumers which, in Larson's (1977, p. 189) words, "challenges the division between professionals and laity." New competencies (which imply changed knowledge, skills and attitudes) should be developed in educational programs. Two competencies described by Stark et al. (1986) as outcomes of professional education could be considered particularly relevant to professional preparation for working with consumer and lay helpers. "Contextual" competence is an understanding of the broad social, economic and cultural setting in which the profession is practiced, and "adaptive" competence is the ability to adjust to new conditions in a rapidly changing society.

Attitudes, knowledge and skills can be modified through education. The World Health Organization recommends changes in professional training internationally and nationally to enable professionals to develop knowledge and understanding of self-help groups. (Hatch & Kickbusch, 1983) A few successful examples of curricula which achieve this goal to a greater or lesser extent are emerging. At the University of Toronto, medical students meet in seminars with members of self-help groups in a program which stresses experiential strategies. Medical students who participate in self-help groups themselves report benefits such as support from peers and insight into problem solving. (Goetzel, Shelov & Croen, 1983) One curriculum for social workers seeks to force a re-examination of a professional enterprise that casts non-professionals into the subservient role of client, (Gottlieb, 1985, p. 32) experientially and didactically. One could speculate that the emphasis on experiential teaching strategies is derived not only from a grounding in educational theory but in efforts to be congruent with the experiential knowledge core (Borkman, 1976) of self-help groups. However, this is never explicitly stated.

Experiential approaches to adult education in Canada have been articulated by Griffin (1988) who suggests that professionals and clients should be "working together in cooperative inquiry" rather than casting the professional in the role of "expert". Thus adult educators, like health professionals, need to move from expert provider to egalitarian partner.

In sum, the potential power of professional-educational reform to meet the challenges posed by informal support networks is reinforced by these successful pilot projects and perceived need among both professionals and self-help group members. (Figure 1)

Conclusions

Given the historical and social construction of disciplines, health professionals as well as adult educators would be well-advised to reflect on the implications of professional socialization, paradigmatic shifting, and social movements. Clearly, societal and institutional influences must be acknowledged and congruent changes in these spheres should accompany educational reform. Educational change efforts must be directed at attitudinal, skill and knowledge development.

Nevertheless, a professional educational strategy would necessarily be an incomplete effort directed at only one member of the partnership. Some consumers may have been socialized to prefer dependence on the expert specialist. It is hoped, however, that professional preparation for appropriate roles may, in the long term, mobilize and enhance lay support networks and facilitate consumer education. Further, it is anticipated that theory-practice dissonance may be reduced if these sectors are interrelated under a theoretical framework which is socially congruent because it is responding to consumer demands reflected in a social movement. Relevant progressive curricula are needed to prepare professionals to meet changing societal needs.

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