

HOW SCANDINAVIAN PUBLICATIONS PORTRAY SELF-HELP GROUPS IN RELATION TO HEALTH AND WELFARE SYSTEMS*

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ABSTRACT

The aim of this article is to review the relationships of self-help groups to health and welfare services and professionals/service representatives in a Scandinavian research context. Eight Swedish, Norwegian, and Danish publications written by researchers within an academic research context are discussed; understanding self-help groups in a national context is stressed. The analysis was based on a conflict/consensus model proposed by the author. Results indicate that Scandinavian researchers often view the relationship between health and welfare services and professionals/service representatives and self-help groups as more consensus-oriented than groups described in early American self-help group literature where there is a higher degree of distrust. The high level of trust toward governmental organizations in Scandinavian countries is suggested as one explanation for this difference.

INTRODUCTION

As noted in the Introduction (Borkman, 2006-2007), self-help groups were defined in the United States more than 3 decades ago. In the works of early

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researchers, such as Katz and Bender (1976) and Borkman (1976), *relationships between self-help groups and professionals/welfare services were frequently discussed*; these relationships were often seen as conflicted. For example, Katz and Bender (1976, p. 278) pointed out in their well-known definition of self-help groups that “The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions.” Borkman (1976) posited that members in self-help groups develop their own understanding of the common problem (and how to solve it) based upon personal experiences which can differ substantially from professionals’ perspectives. Smith and Pillemer (1983) discussed self-help groups as social movement organizations, stating that, “In modern society, with highly professional and bureaucratized help-delivery systems in the area of health and social welfare, the very notion of self-help involves a challenge to the system and an attempt to bring about a kind of systemic change” (p. 214).

Noticeably, *most influential academic contributions considering self-help groups came from a U.S. research context*. The understanding of self-help groups in a health and welfare context has been related primarily to the U.S. health and welfare organizations, their professional representatives, and to the U.S. civil society. Lavoie, Borkman, and Gidron (1994a) stated that international and inter-cultural perspectives on self-help have not received proper attention in the research literature. There have been contributions from European researchers since the early 1970s (for a discussion see Barath, 1991; Unell, 1989), but a brief look at the literature shows that an American research context has dominated the field both when it comes to empirical as well as theoretical findings (Karlsson, 2002).

Gidron and Chesler (1994) made an important contribution when they identified different dimensions in understanding and comparing self-help groups in different countries and contexts. They claimed that the *universal attributes* of self-help include the distinctive culture that shapes individual identity, social support especially in time of crisis, and empowerment of members through participation. But, the *national and cultural differences* among self-help groups are related to their structural conditions—the legal and administrative structures on a national level, ethnic/racial cultures, and the issues around which groups are formed. The authors stated that self-help groups in Scandinavia and Western Europe are supported by government and governmental policies and are seen as complementary services, whereas such groups in the United States “. . . often [are] seen as a substitute for governmental service, or as an opportunity to pressure the state to provide services for a particular population. Within such framework, self-help groups are more likely to be independent and even antagonistic to formal services, and in struggle with them for resources. / . . / the patterns of self-help groups that we primarily read about in the U.S. literature are initiated by indigenous people and sustained by them relatively independently

of formal authorities; this is less common outside the North American continent” (Gidron & Chesler, 1994, p. 23).

Here, the aim is to review the understanding of self-help groups in a Scandinavian research context when it comes to their relationships to health and welfare services and professionals/service representatives. Research questions are:

- Do authors include the relationship to health and welfare services/representatives in their definitions of self-help groups?
- Do authors apply a consensus or conflict perspective when understanding the relationships between self-help groups and health and welfare services/representatives?

To set the context, the Scandinavian health and welfare systems, the role of professionals, and the non-profit sector are briefly described.

THE SCANDINAVIAN HEALTH AND WELFARE SYSTEM, PROFESSIONALS, AND THE NONPROFIT SECTOR

The health and welfare systems in countries vary significantly. In Sweden, Norway, and Denmark the health and welfare systems build on similar core ideas and are sometimes referred to as *the Scandinavian model*. Even so, they differ in parts. For decades, the three Scandinavian countries have been characterized by strong and homogenous welfare states—general social insurance systems, well developed and government-run social service systems with universal and individual social benefits. Taxation has been high compared to other countries, partly because it includes income redistribution. Private companies and non-profit organizations have been considered as less important actors within the core social services, and most professionals within the social, health, and care fields are employed by public services.

In Scandinavian countries, most health and welfare services are general and provided by government to all citizens, even if for-profit and non-profit organizations can also be providers of health and welfare services. Scandinavia’s system is more comprehensive with a commitment to meet the needs of the individual as opposed to the United States where there is less public entitlement and the responsibilities of the state and professionals are viewed more narrowly.

The term *professional* is frequently used in the self-help group literature, both in Scandinavia and internationally. Important to say, in Scandinavia, most welfare service representatives—professionals—are engaged by the government; these may be doctors, nurses, social workers, etc. This means that:

1. any person having a position in a public welfare organization and employed to do human services is often seen as a professional regardless of the level of formal education; and

2. the system (where most professionals are engaged by the government) differs from what is common in many other countries (where professionals also are frequently employed by for-profit or non-profit organizations).

In this text, the concept *welfare representative* is used to designate persons employed in welfare services to promote social and medical health, while the term professional is only used when quoting other authors who use the term.

Non-profit organizations flourish in Scandinavia, and the size of the non-profit sector in many aspects is comparable to those in the United States and England (Lundström & Wijkström 1997, Salamon, Sokolowski, & List, 2003). However, according to Lundström and Svedberg (1998, 2003), the typical Scandinavian non-profit organization differs from its Anglo-Saxon voluntary counterpart in several ways: the Scandinavian non-profit is based on members' interests, unpaid efforts, democratic decision making at all levels, a social change-oriented ideology and self-help. In Anglo-Saxon countries, such as the United States, a non-profit organization is often hierarchical, with paid staff, and characterized by professional activities: they help people that are not members of the organization and they do not primarily seek social change. Salamon, Sokolowski, and List (2003) draw a similar conclusion while they state that "In short, the Nordic pattern features a large civil society sector staffed mainly by volunteers and engaged mostly in expressive rather than service functions" (p. 39) while Anglo-Saxon countries (here: the United Kingdom, the United States, and Australia) "have also historically shared a common approach to social policy characterized by a relatively small, 'hands-off' role for the state and a significant reliance instead on private, charitable activity. . . . A second [feature] is the heavy focus of these organizations on essentially service functions (especially among paid staff) . . ." (p. 34f). In these senses, self-help groups have more similarities to Scandinavian than to Anglo-Saxon non-profit organizations. It should, however, be noticed that self-help groups have emerged for a long time in other welfare settings (see, for example, Dill & Coury, 2008, about self-help associations in Slovenia and Croatia).

Scandinavian countries score extremely high when it comes to *trust* (Uslaner, 2002) and the existence of *social capital* (Rothstein, 2003). It is worth noticing since Banks (1997) acknowledges that mutual-aid groups became more common at the same time as social trust and bonds were eroding. If self-help groups might compensate for receding social capital in a society, it could be one reason for the limited expansion of self-help groups in the Scandinavian countries.

METHODS

Reviewing Scandinavian Self-Help Group Literature

To understand self-help groups within a Scandinavian context, a literature review was conducted. This review was qualitative and explorative, and did not

aim to meet demands for a systematic literature review. Even so, criteria were set-up in the selection process, national research literature databases were employed, and publications were analyzed from the standpoint of the distinctive research questions.

Research literature on self-help groups from Denmark, Norway, and Sweden, books, journal articles, and academic publications, such as dissertations, were sought. Search criteria were:

1. publications should be written by researchers within an academic research context;
2. they should be published as result of research distinctively directed toward self-help groups;
3. they should include an extensive discussion about how self-help groups can be understood generally in a national context and present some empirical data that complements/exemplifies this discussion; and
4. they should be included in existing national research literature databases (Bibsys in Norway, Rex in Denmark, and Libris in Sweden) and found by the search term "self-help groups" in the national languages respectively (Denmark: selvhjælpsgrupper, Norway: selvhjelpsgrupper, Sweden: självhjälpsgrupper); when the same author/authors were represented by several publications in the findings, the one considered most relevant was chosen.

Research on Scandinavian self-help groups is seldom published in international journal articles. Criteria concerning international and/or peer reviewed publications would in most cases be relevant, but does not apply. In Table 1, results of the literature search in national databases are summarized.

The proportionately small number of relevant publications was because most of them were not research-oriented and lacked discussions about how to understand self-help groups within a national/Scandinavian context. Instead, many of them were handbooks and manuals on how to start and run self-help groups, or

Table 1. Publications about Self-Help Groups in Scandinavian National Research Literature Databases

	Denmark (Rex)	Norway (Bibsys)	Sweden (Libris)	Total
Publications matching "self-help groups" in national language	34 (1983-2006)	51 (1985-2006)	32 (1994-2006)	115
Publications of relevance	4 (1992-1995)	2 (1995, 1997)	2 (2002, 2005)	8

they reported on specific groups or group scenarios (e.g., grief or mentally ill). Only 8 of the 115 publications met the given criteria and are presented below.

Analyzing Data

Using a qualitative approach, selected publications were analyzed through an analytical model that focuses on self-help groups in relation to public and professional services. Results were thematized and differences/similarities were identified. In some cases, results were interpreted from international literature on self-help groups, but there were no attempts at national comparisons nor comparisons among different research traditions.

Identified publications are in Danish, Norwegian, or Swedish except in one case—Carlsson (2005)—which was published in English. They were read by this author, whose native language is Swedish (thereby also reading Norwegian and Danish) and second language English. This author also did the English translations presented below.

CONFLICT OR CONSENSUS PERSPECTIVES: AN ANALYTICAL MODEL

In reviewing the broader self-help group literature, it appears that even when theoretical fundamentals are similar in many definitions and descriptions, there are still substantial semantic and cultural differences—for example, the professional involvement in groups. Shepherd et al. (1999), among others, show that there has been a dichotomous view toward peer-led “self-help groups” compared to professionally led “support-groups” (Shepherd et al., 1999; see also Lavoie, Borkman, & Gidron, 1994). Many researchers have suggested that professional leadership has a negative impact on self-help groups, while others argue that professionals and self-help groups can benefit and learn from each other (given that group autonomy, integrity, and culture are preserved).

Here, I propose a theoretical framework that focuses on the relationship between self-help groups and health and welfare services. The framework builds upon the common sense dichotomy that such relationships can be consensus or conflict oriented. In all, it contains four categories on a continuum: conflict, semi-conflict, semi-consensus, and consensus. Fundamental to each category is Gidron and Chesler’s (1994) general definition of self-help groups: “The recruitment and mobilization of peers in an informal and non-hierarchical setting, and the sharing of their common experiences, are the basic building blocks for almost all form of self-help, in all nations and cultures” (p. 3).

The theoretical continuum suggests that a critical question about professional involvement in self-help groups is that groups heavily reliant on professional knowledge differ from those relying on their mutual experiences and experiential knowledge (for a elaborated discussion on professional and experiential

knowledge, see Borkman, 1990). To some extent, it is inspired by Emerick's (1991) three categories of psychiatric self-help groups in the United States: *radical groups* trying to change the mental health system and politicize experiences by ex-mental health patients and to promote non-psychiatric identities through self-help activities; *conservative groups* which cooperate with the mental health systems but embrace some ideas from self-help groups (e.g., the 12 steps); and finally a type *midway* (moderate) between the radical and conservative groups. The framework used for analysis in this article is based upon ideal types rather than empirical data and is not group specific but can be more generally applied.

Conflict and Semi-Conflict Self-Help Groups

Conflict self-help groups arise from disillusionment with professional services and are "aimed to demystify and demonopolize professional expertise" (Stewart, 1990, p. 1143). Such groups can be described as antiprofessional or aprofessional, and professional services are mistrusted, seen as being without reasonable effects or even as oppressive since they deny individuals the ability to formulate their own problems or life situations (Hellerich, 2001; Katz, 1986). As a result of this, conflict self-help groups collaborate with public services on a minimal level, and professional representatives do not participate in—even less, lead—the group. Instead, groups rely completely on their own meaning perspective, similar to "unaffiliated groups" described by Schubert and Borkman (1991, p. 780).

These groups are analogous to Emerick's (1991) *radical* groups. They often won't work with health and welfare systems, and they often seek social change since they claim that their common problem originates not from individual but from social circumstances, or that the problem may be on an individual level, but needs are not properly met on a social level (Katz, 1986; Levine, 1988). In here, it is important to notice that in a Scandinavian context, "seeking social change" often implies changes in the public health and welfare systems, while this might not be true in countries with mixed welfare systems.

Semi-conflict self-help groups build on the same core ideals as conflict self-help groups, but are willing to negotiate with health and welfare service representatives. These groups have similarities with Emerick's (1991, p. 1122) "moderate" groups. One reason for negotiating might be that groups find opportunities to collaborate with "friendly professionals." Borman (1976, p. 47) says, "While self-help groups operate outside professional agencies, many of them have been initiated and supported by professionals behind the scenes. Many of these professionals have had to 'bootleg' their efforts since they were never sanctioned by the agencies for which they worked, nor by their professional colleagues." A second reason for collaboration might be that both actors, the self-help group and the health and welfare service representative, agree on well-defined interaction areas. For example, the representative concerned may refer

individuals to groups, and the groups may use distinctive facilities owned by government. A third reason might be that groups are able to promote their meaning perspective through communicating with professionals and health and welfare service representatives. Regardless of the reason, the semi-conflict self-help group as well as the conflict self-help group mistrust professionals and professional knowledge, and build on their own strong meaning perspective.

Consensus and Semi-Consensus Self-Help Groups

Consensus groups, similar to Emerick's (1991, p. 1122) "conservative" groups, acknowledge the benefits of self-help/mutual-aid, and members of such groups claim that help given by professionals cannot replace support given by peers (e.g., Munn Giddings & McVicar, 2006). Nevertheless, these groups welcome relevant professional involvement; professional knowledge is seen as a good complement to the experiential knowledge developed in the group and vice versa. Often, consensus groups are pragmatic, result-oriented, and lack a common ideology. In such self-help groups, professionals can participate as consultants, facilitators, or even co-leaders (Barath, 1991; Shepherd et al., 1999; Stewart, 1990; Stewart et al., 1994). Professionals who share the mutual problem are here seen as having double competencies and are a resource to the group: they have gained both experiential and professional knowledge and the combination is considered a bonus, not a problem (Frese & Walker Davis, 1997, p. 245).

Smith and Pillemer (1983, p. 225) state "the literature on SHGs [self-help groups] provokes some evidence that groups that exhibit strong ties to professionals are more likely to focus on individual change and less on institutional or social change." There are reasons to believe that individual change is in line with the medical model where a person has a problem and obtains help from a person with professional skills to identify and solve/cure the problem.

Semi-consensus self-help groups, again with similarities with Emerick's (1991) midway groups, also welcome collaboration with professionals but are aware of the downside of professional involvement and have a readiness to limit it. Such groups claim their own meaning perspective; when they invite professionals as consultants to share their knowledge, they set the agenda and decide what knowledge should be discussed and adopted. Professionals are not seen as co-leaders. Such groups distinguish between their own understanding of the problem and professional understanding, and they are more likely to question professional knowledge.

FINDINGS

Self-Help Groups in Denmark, Norway, and Sweden

Self-help groups were discovered as a new social phenomenon during the 1980s (Denmark and Norway) and 1990s (Sweden) and surveys with different

aims and objectives were undertaken in all three countries in the 1990s. These surveys showed that about 0.5% of the adult population took part in a self-help group at a given time in the 1990s (Karlsson, 2002; Mehlbye & Nygaard Christoffersen, 1992; Seim, Hjemdal, & Nilsen, 1997). It is possible that organizations which were similar to SHGs but had existed before the “new social phenomenon” was discovered were left out. For example, Circles of Study (Studiecirklar), which had been common in Sweden for a long time and which match self-help group definitions, were seldom included in the Swedish surveys.

The focal problem of the groups showed a large variation: groups for alcohol and drug abuse (Alcoholics Anonymous and the Link movement) were well represented, but there were also groups on bereavement, mental illness, physical disabilities, parenting, love and relationship problems, loneliness, among others. Groups varied on funding sources, affiliation to larger organizations, and organizational structure though many were registered non-profit organizations or affiliated to such (Karlsson, 2002; Mehlbye & Nygaard Christoffersen, 1992; Seim et al., 1997). Results from the national studies were strikingly similar even though they should be considered as rough approximations drawn from different surveys lacking a common research design.

Self-Help Groups in Publications of Scandinavian Countries

Definitions

In six out of eight publications, authors articulated definitions of self-help groups; mutual-aid, a common problem shared by members, and the intention to handle the problem within the group were articulated (Table 2). However, most definitions had no obvious theoretical connections; for example, definitions connected neither to experiential knowledge nor to any particular meaning perspective, presented by Borkman (1976). Instead, the definitions most often were descriptive; who was attending the group (people with a common problem) and what was their objective (to handle the problem through mutual aid). One text (Høgsbro, 1992) did not mention mutual-aid or an equivalent, but defined self-help groups in relation to other concepts discussed (e.g., social work); however, nothing in the definition precluded mutual-aid as an essential part of a self-help group.

In the definitions, the groups' relations to professionals/public service representatives are also expressed on a descriptive level. Four of the six raised the question of professional collaboration and/or involvement. Two stated that professionals can initiate self-help groups, and two highlighted the autonomy of self-help groups as a general principle (see Table 2).

Finally, none of the given definitions provided anything explicit about social or individual change. Gamst and Gamst (1995) touched upon the subject when

Table 2. Aspects of Authors' Definitions of Self-Help Groups

	In line with Gidron and Chesler's (1994) definition above	Mention experiential knowledge or mutual-aid	Mention relation to welfare service representatives/professionals	Focus on social and/or individual change
Høgsbro, 1992 (Denmark)	Yes	—	—	—
Mehilbye & Nygaard Christoffersen, 1992 (Denmark)	Yes	"... all [participants] have a well defined problem and meet solely to discuss this problem." (p. 71)	"... the group is autonomous. Sometimes, an initiator or a professional educated person participates as a consultant, but the group decides for themselves, whether they like this support or not." (p. 71)	—
Gamst & Gamst, 1995 (Denmark)	Yes	"They share a common problem and want to commonly handle, overcome, or learn a better way to live with it. . . . The central in the group activities is the mutual sharing of experiences and help." (pp. 21-22)	"... groups, voluntarily created on own initiative or with very little help from professionals. . . . They emphasize self determination and are not led by, or to little extent, professionals. However, some groups temporarily use experts to get help in certain questions. . . ." (pp. 21-22)	"Thereby, the groups become means to break external (social) and internal (personal) and emotional isolation." (p. 22)

<p>Adamsen, Guldager, Gundorph-Malling, & Hertz, 1992 (Denmark)</p>	<p>Yes</p>	<p>"A self-help group is a group of people, who want to support and help each other through being together in a group for a problem, which is shared by the participation." (p. 34)</p>	<p>"Self-help groups or self-help activities can be initiated by relatives, patients, patient associations, private organizations, staff members at hospitals, staff groups, etc. Participants in self-help groups/ activities can have meetings at wards, in patients' home, or at an association or similar." (p. 34)</p>	<p>—</p>
<p>Schack Abrahamsen, 1995 (Norway)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>
<p>Seim, Hjemdal, & Nilsen, 1997 (Norway)</p>	<p>Yes</p>	<p>"... people with a common problem or need, get together to find solutions or alleviation through mutual aid." (p. 34)</p>	<p>"This means that self-help activities can verge on other activities under the auspices of government or voluntary efforts." (p. 34)</p>	<p>—</p>
<p>Karlsson, 2002 (Sweden)</p>	<p>Yes</p>	<p>"... people who meet regularly to process common problems through mutual aid." (p. 56)</p>	<p>—</p>	<p>—</p>
<p>Carlsson, 2005 (Sweden)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

they stated that groups were meant to break external and internal isolation but did not extend the discussion beyond that. To reiterate, existing definitions are primarily on a descriptive level and seldom contain any theoretical concepts used in the self-help group research field; Høgsbros' (1992) definition is an exception in that it connects to theoretical discussions with concepts such as "social work" and "social self-help."

Social or Individual Change

Do self-help groups focus on social or individual change according to the authors? No text is very explicit on this question, but most of them discuss both personal problems/solutions and structural factors that might possibly be connected to social change. Thus, it is possible to identify some indicators that might reveal the tacit understanding of the publications.

Four publications (Adamsen et al., 1992; Gamst & Gamst, 1995; Mehlbye & Christoffersen, 1992; Schack Abrahamsen, 1995) compare self-help groups to psychotherapy groups or the equivalent: in itself, this suggests an individual focus. In these comparisons, there is no indication, for example, that the purpose of self-help groups is social change while that of therapeutic groups is individual change. One of the publications (Karlsson, 2002) specifically states that self-help groups aim for individual change.

Several of these five publications also discuss self-help groups in relation to problems that appear to be on an individual level rather than on a structural level. For example, Gamst and Gamst (1995) identify four groups of problems concerning existentialism, personal change, social or health issues (and how single individuals handle them), and "special groups" where the common problem is very rare. Also, Adamsen et al. (1992), Mehlbye and Nygaard Christoffersen (1992), and Karlsson (2002) include lists of problems that are often seen as individual: cancer, grief, HIV/AIDS, and alcohol and drug abuse. To handle problems, Adamsen et al. (1992) highlight the importance of meeting peers, processing the crisis, helping others, sharing experiences, and gaining new knowledge. Karlsson (2002) emphasizes mutual aid and the development of a common meaning perspective, while Schack Abrahamsen (1995) focuses on social networks and social support. Neither the lists of problems nor solutions prove an individual change focus, or exclude a social change perspective. However, taken together they strongly indicate an individual focus.

Three publications (Karlsson, 2005; Høgsbro, 1992; Seim et al., 1997) have theoretical frameworks that can be seen as focusing on structural rather than individual issues. Høgsbro (1992) understands self-help groups from a social policy point of view, and also looks upon them as social movements. He identifies the primary functions for self-organized self-help (p. 205) as creating alternative ways of framing social problems and networks of people with a non-stigmatizing

understanding of their own problem; self-organized self-help is a response to structural changes that have created new kinds of social problems.

Seim et al. (1997) focus on marginality and see self-help activities as part of an integration process. Self-help groups can be a place for “internal integration processes” (p. 32) that strengthen individuals and prepare them to meet the demands of the surrounding society. Later on, in an “external integration” (p. 31) process, marginalized groups can try to redefine their situation in society.

Carlsson (2005) discusses Swedish patient associations as self-help groups, and in this work she highlights their role as advocates. Groups had a “voice,” advocating the patients’ perspective to the general public and the health care system.

Self-Help Groups in Relation to Health and Welfare Services and/or to Professionals

Several publications use definitions of self-help groups that include their relationship to health and welfare services and/or professionals; they also are written on a descriptive level containing few theoretical aspects. Most publications have a chapter titled “The roles of professionals” or something similar (Adamsen et al., 1992; Carlsson, 2005; Gamst & Gamst, 1995; Schack Abrahamsen, 1995; Seim et al., 1997) but use the word “professional” without specifying who is a professional and who is not. It appears that professionals are primarily defined by their position in public welfare organizations and by the fact that they get paid for human services. Professionals in the Scandinavian health and welfare system are primarily employed by the government; relatively few professionals are in private practice, which is more common in the United States and some other countries.

Two of the publications (Adamsen et al., 1992; Seim et al., 1997) include groups led by professionals in their definition of self-help groups. Adamsen et al.’s (1992) definitions are based on empirical data from a study of self-help groups in Denmark for people with life-threatening diseases; the authors disagree with definitions that exclude professionals from self-help groups. Four other publications apparently do not include professionally-led groups in their definition of self-help group: two (Karlsson, 2002; Mehlbye & Nygaard Christoffersen, 1992) explicitly state that their understanding of the definition of self-help groups excludes professionals; one can infer from their content that Schack Abrahamsen (1995) and Gamst and Gamst (1995) exclude professionals in their definition. No specific definition of self-help group was made in one publication, e.g., Høgsbro (1992).

All publications discuss the pros and cons of professional involvement in self-help groups and they vary in how positive they are regarding such involvement; not surprisingly, the authors who include professionally-led groups in their definition of self-help groups are more positive about such involvement. Adamsen et al. (1992) state that the authors disagree with definitions that exclude professionals from self-help groups and claim, “Our point of view is, therefore,

that professionals can participate in self-help groups without the group losing any substantial characteristics as self-help groups” (p. 172). They, together with Høgsbro (1992) and Seim et al. (1997) also argue that professionals, in fact, frequently participate in self-help groups but the authors are not always explicit in what capacity professionals participate—as experts or just as members.

Most authors agree that professional involvement might include initiating and facilitating groups, supporting groups in crisis, and referring potential members to groups (see Table 3). Most of them also indicate it was appropriate for professionals to share their knowledge in groups, even if it is expressed in different ways: some view professionals as “consultants” offering groups their knowledge when requested (e.g., Karlsson, 2002), while others (e.g., Adamsen et al., 1992)

Table 3. What is Concluded about Self-Help Groups in Publications

	Professionals may share their knowledge in groups	Professionals may lead groups	Professionals may support groups in crisis	Professionals may refer to groups
Høgsbro, 1992 (Denmark)	—	—	—	—
Mehlbye & Nygaard Christoffersen, 1992 (Denmark)	Yes	No	Yes	—
Gamst & Gamst, 1995 (Denmark)	Yes	—	Yes	Yes
Adamsen, Guldager, Gundorph-Malling, & Hertz, 1992 (Denmark)	Yes	Yes	Yes	Yes
Schack Abrahamsen, 1995 (Norway)	Yes	No	Yes	Yes
Seim, Hjemdal, & Nilsen (Norway)	Yes	Yes	Yes	Yes
Karlsson, 2002 (Sweden)	Yes	No	Yes	Yes
Carlsson, 2005 (Sweden)	Yes	—	Yes	Yes

emphasize the use of expert knowledge more explicitly. Gamst and Gamst (1995) state that they are positively inclined to professional involvement, but formulate that: “Professionals should be aware, that by sharing their knowledge, it can be about a special topic as for example communication, they affect the orientation and understanding of the problem in the group. This can be problematic, if the professional is motivated by self-interest and makes the group dependent” (p. 92).

The aim of this review was to detail the relationships between self-help groups and the health and welfare services and representatives in a Scandinavian research context. The publications reviewed have often focused upon the relationship between single welfare service representatives, “professionals,” and self-help groups. Political and/or economic aspects of the relationship have not been considered—for example, whether self-help groups contribute to empowerment of groups or what is the funding situation.

As seen in Table 4, while there is some variation in the publications’ positions on the conflict-consensus continuum, the researchers seem to view self-help groups as consensus or semi-consensus groups. Only one researcher (Høgsbro, 1992) takes the extreme conflict position but, as described below, he is also the only author who discusses self-help groups in very abstract structural terms and as social movements. Some are aware of risks of co-optation and also note that the professional meaning perspective interferes with the knowledge and understanding developed in the groups. Still, most authors have confidence in the shareholders’ ability—primarily the professionals—to avoid these problems. In many cases, as in Adamsen et al. (1992) and Seim et al. (1997), positive conclusions concerning professional involvement are drawn from empirical findings. Other publications, such as Høgsbro (1992) and Karlsson (2002), also include empirical findings showing professional participation in self-help groups, but keep a more critical attitude toward this issue based on theoretical arguments.

Høgsbro (1992) appears to be the only author who distinctively discusses structural aspects in the development of modern self-help groups. He highlights the significance of a civilization critique (i.e., a cross-political critique of modern civilization and the roles both of the state and the market, often recognized in Europe in youth movements), new social movements and subcultures when studying self-help, and also claims that professionals tend to “. . . implant the problem understanding of the surrounding society into the organizations’ frame of references” (Høgsbro, 1992, p. 206). This is similar to what Borkman (1990) and some other U.S. researchers claim.

This widespread confidence in professionals/welfare representatives can be understood from different perspectives. First, the Scandinavian welfare societies have had close collaboration with democratic, peer-led, non-profit organizations for a long time. Moreover, most individuals in the Scandinavian countries think that government can be trusted.

Table 4. Analytical Positioning of Publications

	Conflict	Semi-conflict	Semi-consensus	Consensus
Høgsbro, 1992 (Denmark)	Groups seen as part of civilization critique and partly focus on social change.			
Mehlbye & Nygaard Christoffersen, 1992 (Denmark)			Professionals may initiate and supervise groups—but not lead them.	
Gamst & Gamst, 1995 (Denmark)			Professional involvement may be positive, but should continuously be questioned.	
Adamsen, Guldager, Gundorph-Malling, & Hertz, 1992 (Denmark)				Groups are compared to therapy groups and can include professionals. Traditional definitions of self-help groups are questioned.

<p>Schack Abrahamsen, 1995 (Norway)</p>	<p>Professionals can decide about external group conditions, but the group decides about internal conditions.</p>
<p>Seim, Hjemdal, & Nilsen (Norway)</p>	<p>Groups can be, and are often, facilitated but also led by professionals.</p>
<p>Karlsson, 2002 (Sweden)</p>	<p>The developing of a meaning perspective in a group can hardly be combined with extensive professional involvement even if groups focus on individual change.</p>
<p>Carlsson, 2005 (Sweden)</p>	<p>Groups acts as advocates for social change but can exchange knowledge with professionals.</p>

Scandinavian welfare systems are quite similar to each other compared to those in other countries, and representatives for public services are most often involved in all welfare efforts—as funders and/or as executors. It is reasonable to believe that in such contexts self-help groups are not seen as a threat, but welcomed as an exciting flavor. The authors view the groups as consensual or semi-consensual and as focusing not on social but on individual change. Whether this is a perquisite or a result of consensus is difficult to say. In any case, there are reasons to believe that collaboration with professionals and a focus on individual change are concomitant.

The consensus perspective, the focus on individual change compatible with a professional perspective, and the relationship between self-help groups and health and welfare services and professionals, indicate that self-help groups in the Scandinavian countries can be seen as acting as *complements* or *forerunners/innovators* to public services, rather than as *alternatives* or *replacements*—in line with suggestions from Smith and Pillemer (1983). Instead of challenging professional efforts and knowledge, groups fill a niche complementing existing services within the health and welfare context. Some of the authors presented are more or less explicit on this. What is seldom discussed in Scandinavian publications is the role of self-help groups as innovators, finding and responding to new or not yet formulated social needs. There are reasons to believe that many public services, which are taken for granted today, once started as minor self-help initiatives (for a discussion, see Glenn, 2001).

CONCLUSION

To conclude, the results indicate that Scandinavian researchers often view self-help groups as more consensus-oriented than groups described in early American self-help group literature. Some of the roles for professionals are viewed as similar—for example, two prime tasks have to do with initiating and facilitating groups, both in Scandinavia and in the United States. But some Scandinavian authors argued that professionals could also co-lead or even lead groups whereas in the United States professionally-led groups are seen as “support groups.” The attitude of professionals in Scandinavia seems to be more facilitative than competitive. These differences should be taken into consideration when comparing self-help groups in different countries. Comparative studies, where similar empirical data on self-help groups and their role in the welfare systems were collected and analyzed, would be most welcome. There are reasons to believe that differences within countries, welfare systems, and between different group types (e.g., groups that handle medical or social problems) would make the picture more nuanced. Nevertheless, the analytical tool presented above could probably be used for this purpose also.

Finally, concepts of trust and social capital in relation to self-help groups open up many new avenues of consideration and research, especially when it comes to

comparative analyses. Self-help groups have sometimes been discussed in relation to social capital. Interestingly, Putnam (2000) highlights that self-help groups differ from other types of non-profit associations since they seem to build bonding, but not bridging, social capital.

The meaning of trust in society, when it comes to understanding the relationship between health and welfare services and self-help groups, is completely unexamined. Does general trust in society, or individual trust in governmental organizations (Rothstein, 2003), affect the relationship between self-help groups and health and welfare services? Does participation in self-help groups generate trust, or does it make members more skeptical of the world “outside”? Does participation lead to less trust toward the health and welfare systems and professionals? Interestingly, in many Western countries it appears as if many self-help groups were established at the same time as trust in governments declined in line with the civil rights, women’s and student movements. In the case of trust and self-help groups, studies are needed both on an individual and societal level (see Ryan, 2006-2007).

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