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**Self-help Groups**

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Synonyms

Self-help/mutual aid, mutual help groups, mutual aid groups, self-help support group, peer-led group

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Key Words

Mutual aid, peer-led, peer volunteering, experiential knowledge, citizen-driven, self-help group

Definition

While their names such as self-help/mutual aid group, self-help group or mutual help group, and definitions are contested, researchers studying them tend to agree on three central characteristics: (1) they “are run for and by people (nearly always volunteers) who share the same health, economic, or social problem or issue; (2) the primary source of participants’ knowledge about their issue is direct experience; and (3) these groups operate *predominantly i*n the nonprofit sector) (Munn-Giddings et al., 2016, p. 394). The groups usually intentionally and voluntarily convene around a common focal issue “that is challenging and/or stigmatizing for them all (thus, peers) in order to ameliorate or improve their conditions or situations. A critical feature of these groups is that they are run for and by the people who share the situation, which distinguishes them from groups run by trained professionals (e.g., social workers), which tend to be referred to as ‘support groups’ in the academic literature” (Munn-Giddings and Borkman, 2018, pp.59-60). Self-help/mutual aid conveys the dual features: self-help connotes relying on one’s resources and lived experience while mutual aid refers to the distinctive form of volunteering—the reciprocal relationships of mutual helping (i.e., active participants both give and receive help). They are usually founded by citizens but can be instigated by professionals who later withdraw and pass leadership onto members of the peer group.

Introduction

By 2000, citizen driven self-help/mutual aid in civil society had created an alternative paradigm of support, “service,” and identity to that practiced by professionals and government. Egalitarian peer relationships transform seekers simultaneously into givers—those who both provide and consume services (Munn-Giddings & Borkman, 2018). Participants share their experiences of living with the common issue in the self-help group (SHG) context; experiential knowledge becomes collectively accumulated and vetted; new identities and agendas for advocacy can emerge (Borkman, [*1999*](#CR2_84)). Peer-based support is qualitatively different than support provided by family, friends, or coworkers who lack experiential understanding of the issue. SHGs are not to be confused with do-it-by-yourself self-help tapes, books, or videos, as is frequently done by “cultural pundits” who offer superficial analysis of ideas, symbols, and other cultural phenomena without reference to the structures in which they are embedded, thereby, distorting them.

The number of these informal groups is difficult to determine as they are very local, have small memberships, high turnover, and are so informal that they are not on tax rolls or other records. Estimates are often made by extrapolating from representative surveys of the adult population or from data bases that self-help clearinghouses maintain. Usually, SHGs are single issue groups: in industrialized Western democracies, thousands of SHGs have been initiated for physical and mental illnesses, all chronic diseases, disabilities, genetic disorders, life transitions (e.g., bereavement, divorce), disasters (e.g., relatives of victims of plane crashes), for parents of children with various diseases, and for various stigmatized statuses (e.g., Parents of Suicide). The hundreds of thousands of informal SHGs collectively make a huge impact. Unfortunately, they are overlooked by most researchers, professionals, and policy makers. David Horton Smith ( [*2000*](#CR17_84)) has referred to them as the most prevalent part of the invisible dark matter of the Third Sector universe.

The informal SHGs, at almost no cost, extend mutual aid and support to their participants but they thrive with help from self-help clearinghouses that provide organizational training and member recruitment. A SHG is a form of Grassroots Association (GA) (Smith, [*2000*](file:///E%3A%5C2019%5Cmanuscript%20%2815%29tjb%20edited%20astbas3CMGJuly3.docx#CR18_84)). Self-help groups are unlike social clubs whose members engage primarily in socializing and leisure time activities and their peer-helper relations distinguish them from philanthropies or charities that are organized to help others.

Self-help organizations (SHOs) which are forms of nonprofit organizations are more formalized and require money in order to maintain a facility and to hire staff. SHOs often evolve from SHGs but many retain their emphasis on mutual helping (Archibald, 2007).

Historical Background

Mutual aid is a ubiquitous part of human evolution along with competition (Kropotkin, [*1972*](#CR9_84) [1902]). Historically, mutual aid was found within one’s kin, village, or whenever people grouped together to give and receive help to improve survival. Mutual aid in developing countries coalesces around economic survival; millions of small scale groups of friends and neighbors form as microcredit groups known by various names (e.g., ROSCAs, self-help groups, on-lending groups). Forerunners of SHGs in industrialized societies were the Friendly Societies, consumer and producer cooperatives, and the fraternal organizations that ethnic immigrant groups developed in the eighteenth and nineteenth centuries in Europe or in the United States. These mutual aid groups provided needed services such as burial insurance, sickness insurance before the governmental programs of the modern Welfare State were in place. As governmental programs expanded, mutual aid changed to embrace areas of illness and stigma where emotional and social support were needed.

 Key Issues

The beginning of contemporary SHGs is usually dated to the development of Alcoholics Anonymous (AA) in the United States in 1935. Now, internationally, four traditions of research within English publications on contemporary SHGs have been distinguished (Borkman, [*2008*](#CR3_84)), primarily, by their insularity and failure to know, reference, or build upon the concepts and findings of the other branches. For brevity, the traditions will be referred to as Addictions’ Recovery (renamed from Addictions Treatment in 1st Ed.), North American Psychosocial, European Psychosocial, and Economic Development.

 The Addictions’ Recovery tradition actually consist of two separate but related branches of research. First are the positivist-oriented clinical trials of treatment effectiveness funded with large grants by the National Institutes of Health in the United States. This tradition has become more significant as scientific medicine recognized substance use disorders as chronic diseases requiring lifelong recovery support (White, 2009). The scientific effectiveness of AA for higher rates of abstinence and better psychosocial functioning either alone or as aftercare following treatment has been largely established. The second branch is the qualitative and quantitative studies of 12-step groups like Alcoholics Anonymous, Narcotics Anonymous or other SHGs for addictions. Favored topics have been commitment processes, identity change, or the recovery process (e.g., Kaskutas et al., 2014) and user’s preferences for AA or alternative groups (Zemore et al., 2018). Researchers are primarily in the fields of public health, epidemiology, psychology, sociology, and medicine.

The North American Psychosocial tradition emphasizes the psychological level of individual analysis because many researchers are community psychologists, social workers, and nurses. Early studies tended to be case studies of individual SHGs or participants in SHGs in the United States or Canada. Later studies included national surveys (e.g., Goldstrom et al., 2006). Online groups have been of more recent interest, but are not well researched; they clearly provide new opportunities for geographically and socially separated persons and families with rare diseases, contested medical syndromes (see Hearn, 2006/07) or conventional illnesses to connect, support, and advocate with peers. Substantial research shows that SHG participants are less likely to be re-hospitalized (mental illness), use medical care more judiciously, are more likely to combine conventional medical care and SHG approaches, and perceive extensive informational and support benefits from their participation (SCRA, 2013). Consistently ignored by this tradition are the broader issues of the impact of SHGs on social capital or civil society.

During the last decade the silo walls of the two psychosocial traditions became more porous and opened to wider international representation. The distinctive nature of SHG volunteering was featured in a Handbook article with international authors (Munn-Giddings et al., 2016).

The European psycho-social perspective brings together research by academics and practitioners working primarily in the fields of social work, social policy, social psychology, sociology and community development. This tradition now draws on and quotes much of the US evidence base mirroring the examination of individuals’ motivations for and outcomes from their use of SHGs as well as bio-medical treatment-evaluation focused studies. However, arguably more emphasis is given in this tradition to the impact and democratic role of groups and their members in civil society (See Chaudhary et al, 2013). Attention is also given to ways in which professionals and SHGs groups can find ways of working together without damaging the fundamental mutual aid ethos (Wilson, 1995; Munn-Giddings et al, 2017). The latter emphasis is perhaps reflective of the stronger welfare state systems in many of these countries, particularly in the Nordic countries (e.g., Lundström and Wilkström, 1997; Høgsbro, 2012).

The fourth, more recent and more disparate tradition, Economic Development features development specialists, anthropologists, and economists studying developing countries with large, very poor populations. Microfinance as a tool to alleviate poverty in developing countries has developed since the 1970s and microcredit groups especially for women and how they contribute to empowerment are widely studied (e.g., Alemu et al., 2018). The research of this tradition is sufficiently removed as to make it inappropriate to include here.

International Perspectives

A major lesson we can learn from the above history of mutual aid efforts and the key issues arising is that the entire societal economic, social, and cultural context needs to be taken into account in order to understand the distinctive form and expression SHGs and SHOs take. Cultural attitudes toward family, professionals, government are crucial factors in the type and scope of the SHGs that are developed. The style of interaction and other features of SHG (e.g., the relationship to professionals) differ from country to country and are affected by values such as willingness to self-disclose personal experiences or if expressing private experience may be regarded as an affront to one’s family (Lavoie et al., [*1994*](file:///C%3A%5CUsers%5CMark%5CDesktop%5Cmanuscript_edited_July22CMG.docx#CR11_84)).

This is explored in more depth in Munn-Giddings et al. (2016) but for example; in communist and post-communist countries which lack a viable civil society, barriers to forming informal SHGs deter many from developing. Slowly, as citizens become familiar with taking initiative, there is less resistance to using voluntary action to solve personal and community problems in post-communist countries (see Dill and Coury [*2008*](file:///C%3A%5CUsers%5CMark%5CDesktop%5Cmanuscript_edited_July22CMG.docx#CR24_84)). In some post-communist countries such as Croatia, physicians initiated and maintain control of self-help groups for physical diseases but lay self-helpers lead the meetings with semi-autonomy (Dill, 2014). Countries with restrictive civil societies such as Japan can thwart SHGs and SHOs from utilizing peer-based approaches (Oka, 2013). Countries with distinctive social research traditions, such as in Japan, additionally affects how SHGs are studied (Oka and Chenhall, 2006-2007).

The role of government and the relationship between government and SHGs is also critical in furthering the development and operation of SHGs and SHOs. The economic value of the SHGs’ freely provided services to society is difficult to calculate and has rarely been recognized by governments or policy makers. Government funding of grassroots community-based efforts does not necessarily strengthen innovative and alternative approaches because governments tend to favor professional and bureaucratic approaches to problem solving.

By 2000 SHGs were institutionalized, that is, known about and taken for granted as an integral part of the sociocultural landscape in many countries (Archibald, 2007). As a consequence of institutionalization, diversification and co-optation of the phenomena accelerated, for example, in the U.S. in four broad ways: First, SHGs and SHOs continued operating as autonomous entities in their traditional format in civil society, especially the 12 step/12 tradition groups whose innovative form of federated groups protected against formalization. Some face-to-face groups declined while online and telephone groups increased. New autonomous groups for novel issues were forming. Second, health professionals co-opted the SHG format of peers sharing lived experience except that the groups were convened, controlled and run by the professionals usually in hospitals or clinics (e.g. stroke support groups, dementia caregiver’s support groups, breast cancer groups). Groups were usually called support groups and became an integral part of patient participation policy especially in managing chronic diseases and addictions. Third, therapists, online entrepreneurs and others co-opt and repackage innovative ideas for new research or services and profit monetarily while providing less-empowering forms of support than the original SHG (Madera, [*2008*](file:///E%3A%5C2019%5Cmanuscript%20%2815%29tjb.docx#CR12_84)). Fourth, key concepts of SHGs such as peers sharing lived experience were borrowed, refashioned into a wide variety of innovative cousins of SHGs that are both in the marketplace and in civil society. For example, radio shows will feature a novice interested in sensitive topics such as adopting a child internationally and will ask listeners with lived experience to call in and share their experience. The largest and most significant development is in behavioral health: in addictions, for example, SHG related affordable housing run by recovering roommates practices mutual helping; in mental health state and local governments fund mental health consumer-run organizations and other initiatives; training and certification programs for mental health peer support providers have been developed by 36 of 50 states and they are in paid positions in many settings (Myrick and del Vecchio, 2016).

SHGs have also become institutionalized in some European countries, especially Germany, Norway, Sweden and UK. SHGs are incorporated into national health and welfare policies. In Germany and Norway state health funds are allocated for self-help advice centers (Germany) (see Matzat, 2001-2002) or government controlled and monitored groups (Norway) (see Hedlund et al., 2019). SHGs and SHOs maintain their autonomy in civil society in Germany but tend to be understood and framed in a medical model in Norway. In the UK SHGs tend to be on the periphery of health and social care policies with more emphasis placed on the involvement of ‘experts by experience’ in statutory and voluntary sector organizations and thus an emphasis on individual rather than collective experiential knowledge (see Boyce et al., 2017).

The four kinds of diversification/co-optation occurring in the US outlined above therefore can also be seen in some European countries although these need to be understood in context of the stronger welfare states in many of these countries and the consequent nuances in relationships between professionals and self-helpers (Stokken and Munn-Giddings, 2012).

While the early research literature is uneven and contradictory about the role of professionals in SHGs and SHOs, recent literature distinguishes between professionals who understand and respect the autonomous nature of MAGs and those who would co-opt or ignore them (Munn-Giddings et al., 2017). SHGs operate with few resources but need external assistance from intermediaries for legitimization, member recruitment, and connection to the public and professionals. Self-help clearinghouses (North America and the United Kingdom) or self-help advice centers (Germany) can be effective intermediaries. Only Germany has invested in a countrywide system of self-help advice centers that are statutorily funded from health insurance monies (Matzat, [*2001*](file:///C%3A%5CUsers%5CMark%5CDesktop%5Cmanuscript_edited_July22CMG.docx#CR13_84)– [*2002*](file:///C%3A%5CUsers%5CMark%5CDesktop%5Cmanuscript_edited_July22CMG.docx#CR13_84)).

The above discussion points to the importance of more cross-cultural research and understandings of the relevant context such as the substantive area (e.g., health care) and the civil society. The experiential perspectives of self-helpers can be integrated into the research through participatory methodological approaches. Researchers also need to develop clarity of definitions in relation to international understandings of words and concepts.

Future Directions

1. SHOs for the addictions, mental illness, and the physical disabilities which have developed as alternative paradigms of service but complementary to professional services are likely to increase and spread to more countries and contexts.
2. Self-help groups have been slowly recognized as a distinctive form of reciprocal volunteering. The added value that SHGs and SHOs contribute to society needs to be calculated. Similarly, the value and importance of the alternative paradigm of self-help/mutual aid needs to be advertised to increase their value and visibility among professionals, governments, and foundations.
3. A synthesis of knowledge gained from the research in the four traditions needs to be undertaken, especially the role of supporter and non-supportive professionals.
4. With the institutionalization of SHGs, research is dwindling and being replaced with research on peer support in mental health and addictions, among other issues. In Europe the ‘peer’ support concept tends to be used about 1:1 relationships and often there is an asymmetrical power relationship similar to professional-patient. There is some evidence that people use a variety of peer support services (groups/online/1:1) but research is nascent and requires further development.
5. As the focus changes away from SHGs to peer support, the changing terminology has disconnected it from the earlier rich research on SHGs and SHOs which tends to be marginalised and at worst ignored in current research and the disconnect needs remedying.

Cross-References

Civic Agency

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[Commons](http://dx.doi.org/10.1007/978-0-387-93996-4_18)

[Gift Relationship](http://dx.doi.org/10.1007/978-0-387-93996-4_550)

[Grassroots Associations](http://dx.doi.org/10.1007/978-0-387-93996-4_20)

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Reciprocity

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