Work 65 (2020) 617–623
DOI:10.3233/WOR-203116
IOS Press

The role of self-help groups in promoting self-confidence and hope for the future among people on sick leave in Norway: The importance of educational level

Mikael Nordenmark[a,*], Bodil Landstad[a,b] and Marianne Hedlund[c,d]
[a]*Department of Health Sciences, Mid Sweden University, Östersund, Sweden*
[b]*Levanger Hospital, Nord-Trøndelag Hospital Trust, Norway*
[c]*Faculty of Health Science, Nord University, Levanger, Norway*
[d]*Department of Social Work and Health Science, NTNU, Norway*

Received 2 May 2018
Accepted 17 April 2019

Abstract.
BACKGROUND: Vocational rehabilitation is important for supporting long-term sick-listed employees in returning to work or continuing in working life.
OBJECTIVE: The aim of this study was to analyse self-confidence and hope for the future among people on sick leave in Norway who joined a self-help group, with a special focus on the importance of educational level.
METHODS: 109 persons who completed a 20-week program at a rehabilitation centre in the middle of Norway during the years 2007-2012 answered questions related to the importance of emotions as either motivating or discouraging forces influencing the individual's return to work. The response rate was 52 percent.
RESULTS: Eighty-five percent of participants who joined a self-help group stated that the group helped them to tackle everyday life better than before. Low-educated participants in the self-help group, to a greater extent than high-educated, stated that the self-help group had increased their self-confidence and hope for the future.
DISCUSSION AND CONCLUSIONS: Most of those who participated in the self-help group stated that joining a group increased their self-confidence and hope for the future. Motivational factors, such as hope for the future and self-confidence, can be important factors in the rehabilitation process, as they can enhance sick people's motivation to participate in rehabilitation and re-think their future prospects of returning to work.

Keywords: Mental illness, vocational rehabilitation, psychological processes

1. Introduction

Sickness absence rates in the Nordic countries have historically fluctuated; however, the overall conclusion is that sickness absence in Norway and Sweden is higher than in Iceland and Denmark, and Finland is

*Address for correspondence: Mikael Nordenmark, Department of Health Sciences, Mid Sweden University, 831 25 Östersund, Sweden. Tel.: +46 (0)10 1428515; E-mail: mikael.nordenmark@miun.se.

somewhere in between [1]. The Nordic countries have used similar strategies to reduce sickness absence rates, including close follow-up of long-term sick-listed employees, workability assessments, and the possibility of partial sick leave for ill employees. The results of follow-up studies have been mixed, and the Nordic Social Statistical Committee has concluded that there is a need for more interventions for people with multiple health issues [1].

Vocational rehabilitation is important for supporting long-term sick-listed employees in returning to work or continuing in working life. Vocational rehabilitation measures should assist people in mastering their functional abilities in working life [2, 3]. This makes it important to find measures that help people with multiple health issues improve their chances of returning to work after sick leave [4–6].

Research shows that rehabilitation is influenced by socio-economic inequalities. Particularly, persons with low levels of education seem to suffer from delayed rehabilitation [7]. Having a low level of education is also predictive of a higher risk of not returning to working life after rehabilitation [5]. It is important to take into account an individual's experiences, motivation, current life situation and perceived future possibilities in the vocational rehabilitation process [8].

Attending a self-help group (SHG) can be a meaningful activity for people attending a vocational rehabilitation program, as such a group provides a secure setting for people to manage their sickness and pursue changes in their life situation [9, 10]. A classical definition of a SHG is that such groups represent "small voluntary group structures for mutual aid and the accomplishment of a special purpose" [11]. According to Borkman [12], self-help is based on people sharing personal problems and engaging in therapeutic interventions within a group context without the aid of skilled professionals. The term self-help can refer to the methods, skills, and strategies used to achieve outcomes such as goal setting, decision-making, self-evaluation, self-intervention and self-development [9, 13].

Thus, participation in a SHG can help people regain confidence and create a space where they can reinforce their emotional energy [14]. Self-help groups are found to benefit individuals as they share experiences not presented by 'experts' but rather by peers [15, 16, 17]. For people on sick leave, emotional energy is an important driving force behind successful rehabilitation and the return to work [18]. It is likely that the activities that occur within a SHG will be beneficial for people having problems mastering their functional abilities in working life [2, 3]. The level of education can also influence who benefits from activities in SHG.

In one study where participants in SHG were compared with control subjects, it was found that participants in SHG had more hope than the controls [19]. Help perceived from the SHG included support, encouragement, enhancement of self-confidence, spiritual assistance and reflection of values. SHG was also useful to provide mutual support to participants in maintaining a job in the community, which is important for vocational rehabilitation. SHG can help participants find acceptance and a sense of belonging that can bring meaning and hope for the future [19].

There is, however, limited knowledge of whether a SHG is a form of method that works for people on long-term sick-leave and whether such groups make people better equipped to return to work life. There is also little knowledge of whether a SHG is a valuable tool for encouraging the return to work of people with limited socio-economic resources or low education compared to people with higher education and a more beneficial position in the labour market.

In sum, this study is of importance for several reasons. First, there is still a great need to find valid methods that can support long-term sick-listed employees in returning to work or continuing in working life. Second, earlier studies have found that SHG is a method that can improve personal abilities but there is limited knowledge of whether a SHG is a form of method that works for people on long-term sick-leave and whether such groups make people better equipped to return to work life. Finally, there is also a great importance to study if SHG can be of greater value to certain groups of people than to others, who are on long-term sick leave.

2. Aim

The main aim of this study is to evaluate the role of self-help groups in supporting self-confidence and hope for the future among people on sick leave in Norway, with a special focus on the importance of educational level. By the term self-confidence we here mean trust in one's worth, ability to achieve goals, and ability to face challenges [20, 21]. The term "hope for the future" in this research context, refers to hope of returning to the workforce, rather than a more general hope for better things to come.

The following research questions will be analysed:

1. Are there any differences in background characteristics between those who have chosen to attend the SHG and those who have not?
2. What are the main reasons for not attending the SHG?
3. How important is the SHG for self-confidence and hope for the future in general?
4. Are there any differences between low- and high-educated individuals regarding the importance of the SHG for self-confidence and hope for the future?

3. Method

3.1. Data

The sample consists of 210 persons (20 percent men and 80 percent women) who, during the 2007-2012 period, participated in a 20-week program at a rehabilitation centre in the middle of Norway. The persons were recruited from the database of the rehabilitation centre. Some persons had recently participated in the rehabilitation program at the time the survey was completed, while others had been involved in the rehabilitation program further back in time. All persons recruited had been on sick-leave for at least 90 days before entering the rehabilitation program.

A total of 109 of the 210 persons answered the survey; a response rate of 52 percent. The response rate to invitation 1 was 32%. Invitation 2 was sent out 3 weeks later which resulted in an increased return rate of 20%.

The rehabilitation centre works with vocational rehabilitation and offers treatment to people with minor mental health issues and multiple health issues. The goal of the rehabilitation period is for the individuals to return to working life. Those who participated in the program had been referred by their family GP.

Participants were offered help at both the individual and group levels. For example, they had access to individual sessions with a psychologist, coaching, group therapy, work place evaluations, work training, physical therapy, physical activity and movement, and training in body awareness and relaxation. After the rehabilitation period, the participants were invited to join a SHG for ten sessions. An initiator, a so-called 'starter' [5], participate the first two times in the SHG, and help set up the rules and norms for how to form a group. In these two sessions, the group decided about the rules of the group, when and where to meet and sign a voluntary confidentiality agreement. There were no predetermined topics for what the participants in the SHG should discuss.

3.2. Variables

The survey consisted of questions related to the importance of emotions as either motivating or discouraging forces influencing the individual's return to work. The questions asked for background data such as educational level, whether the individual was participating in a SHG, and labour market attachment. There were also statements regarding the value of attending SHG for different aspects. Some of these statements related to aspects of self-confidence and hope for the future. Self-confidence refers to a person's perception of worth, ability to achieve goals, and ability to face challenges [20, 21]. To have faith in the future is also an emotional state were you have general hope for better things to come, tackle your problems related to employment.

The main unit of analysis is the degree to which the SHG provided self-confidence and hope for the future. Overall there were 29 statements related to the importance of SHG for the individual in different aspects. A factor analysis of the statements made it possible to distinguish seven statements that formed one dimension, which measured the degree to which the SHG provided self-confidence and hope for the future (analysis not shown). These statements were the following:

- Participation in self-help groups helped me to tackle everyday life better than before
- The self-help group helped me to accept my strengths and limits
- Participation in the self-help group gave me hope for the future
- In the self-help group, I gained more insight about myself
- Participation in the self-help group gave me the ability to take responsibility for my own problems
- In the self-help group, I learned new ways to tackle problems
- The self-help group provided support in the process of returning to work

The response alternatives for each of these statements were presented in four different steps: strongly agree, agree to some extent, disagree to some extent, and strongly disagree. The answers to the statements were summarised in an additive index ranging from 0

to 21; the higher the score, the more self-confidence and hope for the future provided by the SHG (Cronbach's alpha 0,934).

The relationships between the general dimension self-confidence and hope for the future and the single measures are based on pragmatic assessments that some of the measures connect to, and measure, self-confident and some hope for the future. Therefore it is reasonable to claim that the single measures all together to some extent are related to a dimension named self-confidence and hope for the future.

The main independent variable is educational level (1 = primary education or high school (low education, meaning 2–4 years education after primary school), 0 = university education (high education, meaning 5 –9 years education after secondary school). The multivariate analysis controls for background characteristics such as gender (1 = women, 0 = men), age, civil status (1 = cohabiting/married, 0 = single) and the presence of children (1 = children living at home, 0 = no children living at home).

3.3. Ethical considerations

The study was approved prior to data collection by the Regional Committee for Medical and Health Research Ethics in Norway (REK); no. 2013; 2010/3323.

REK required that the rehabilitation centre did the first contact with potential responders, so the responders did not feel obliged to participate in the survey. The researchers should not know their names before they agreed to participate. Hence, the rehabilitation centre distributed the questionnaire and send out the reminders. The rehabilitation centre established a list on which each name was given its own code. The centre then sent a questionnaire to all 210 persons treated during a five-year period. The reply envelopes were returned to one of the involved researchers. The researchers had no access to the name list, and the rehabilitation centre had no access to who answered. The rehabilitation centre sent out two reminders to maximize the response rate.

Participants who were invited to the survey were persons who had been part of a vocational rehabilitation program. They were invited not to evaluate the program as such, but to share their experiences from participating in relation to return to work after the sick leave. The potential responders were informed about the purpose of the study, that their responses would be anonymous, and that it was voluntarily to participate. They were also informed that information given would not be reported back to the rehabilitation centre or the social security authorities. They could as well withdraw at any time without giving any reasoning. The responders who participated in self-help groups were asked to answer certain questions about the role of self-help groups in supporting self-confidence and hope for the future. Participation in the survey was optional, and when the participant completed the questionnaire, he or she thereby gave their written content. The study subjects were informed in the invitation letter that they could withdraw their consent at any time without giving a reason and that doing so would not affect their contact with the rehabilitation centre or other health authorities.

4. Results

The analyses of the data are structured as follows. First, the background characteristics of the people who attended the SHG and of the people who did not will be presented. This will be followed by an analysis of the reasons for not attending the SHG given by those who did not attend. The two final parts of the paper will analyse the statements related to the degree to which the SHG provided self-confidence and hope for the future among those who did attend the SHG; these statements will be analysed for low- and high-educated individuals separately. First, the statements will be analysed individually, followed by a multivariate analysis (OLS-regression) of the relationship between the index constructed from these statements and educational level, controlled for other relevant background characteristics.

Table 1 provides a description of the background characteristics of those who attended the SHG and those who did not. There were 50 people who chose to attend the SHG and 59 who chose not to attend. The people who attended were somewhat higher educated, younger and more often single compared to those who did not attend. However, none of the differences were significant. This means that the studied background characteristics were fairly similar among those who attended the SHG and among those who did not.

In the questionnaire, it was possible for those who chose not to attend the SHG to indicate their reasons for not attending. Table 2 shows how common the different reasons were. Almost 40 percent stated that they had already had enough group activities earlier when they were in treatment at the rehabilitation centre. Slightly more than 20 percent indicated that

Table 1
Background characteristics of people who attended the SHG and of those who did not (percent)

Background characteristics	Attended	Did not attend
University	68.0	62.7
Women	82.0	78.0
Aged 47 -	44.0	49.2
Cohabiting/married	74.0	79.7
Children	56.0	57.6
N	50	59

***$p = 0.001$ **$p = 0.005$ *$p = 0.05$ (*)$p = 0.1$.

Table 2
Reasons for not attending the SHG among those who did not attend (more than one option was possible)

Reasons for not attending	Percent
Enough group activities when I was in treatment	39.5
Had no need	20.9
Had no time	18.6
It was too far away	16.3
Do not like to be in groups	4.7
Wanted another follow-up option	4.7
Did not receive the offer to attend	0

they had no need to join the SHG. Nineteen percent stated that they had no time for the SHG, and approximately 16 percent said that the SHG was too far away from home. Five percent indicated that they did not like being in groups, and the same percentage stated that they wanted another follow-up option. No one selected the response alternative that they had not received the offer to participate in the SHG.

The next step of the analysis will study the degree to which the SHG provided self-confidence and hope for the future and whether there was a difference depending on educational level. Table 3 shows the percentages of respondents who agreed to some extent or strongly agreed with each statement. Results are shown for all participants and for high-educated and low-educated participants in the SHG.

Eighty-five percent of all participants stated that SHG helped them to tackle everyday life better than before, and this was even more prominent among people with low education, all of whom agreed with this statement. A total of 88 percent agreed with the statement that the SHG helped them to accept their strengths and limits, and 100 percent of the low-educated agreed with that statement. Slightly more than 80 percent stated that the SHG gave them hope for the future, and even though the percentage was higher among the low-educated, the difference was not significant. Slightly below 80 percent agreed that they had gained more insight about themselves

Table 3
Percentages of those who agree or strongly agree with statements related to the SHG providing self-confidence and hope for the future

Statements	All	High education	Low education
1. SHG helped me to tackle everyday life better than before	85.4	78.1	100*
2. SHG helped me to accept my strengths and limits	87.5	81.3	100(*)
3. SHG gave me hope for the future	80.9	74.2	93.8
4. I gained more insight about myself in the SHG	79.2	71.9	93.8(*)
5. I took more responsibility for my own problems	77.1	68.8	93.8*
6. I got learned new ways to tackle problems in the SHG	72.9	62.5	93.8*
7. The SHG provided support on the way back to work	70.8	62.5	87.5(*)
N (ca)	48	32	16

***$p = 0.001$ **$p = 0.005$ *$p = 0.05$ (*)$p = 0.1$. [1]The distinction between Statement 1 and Statement 6 is that the first one measured insights about how to tackle everyday life problems, and Statement 6 measured practical advices given about these problems.

Table 4
OLS-regression. Self-confidence and hope for the future provided by the SHG (index) by education, sex, civil status and presence of children

	Model 1		Model 2	
	B-coefficient	Standard error	B-coefficient	Standard error
Constant			10.109	
Low education	3.835*	1.613	3.759*	1.690
Women			–0.630	2.213
Age			0.023	0.107
Cohabiting/married			2.245	1.973
Children			1.697	1.970
R^2	0.112		0.167	

***$p = 0.001$ **$p = 0.005$ *$p = 0.05$ (*)$p = 0.1$.

through their participation in the SHG. Among the low-educated, 94 percent agreed with this statement, which was significantly higher – on a 0.1 level – compared to the high-educated. Overall, the results indicate that most people who participated in the SHG stated that the group increased their self-confidence and hope for the future. This is even more prominent among the low educated.

Table 4 presents the results of a regression analysis of the relationship between educational level and the index indicating the degree to which the SHG provided self-confidence and hope for the future when controlling for background characteristics such as gender, age, civil status and the presence of children.

Model 1 shows the bivariate relationship between educational level and the extent to which the SHG provided self-confidence and hope for the future. The b-coefficient for low education is 3.8 and is significant. This indicates that low-educated participants in the SHG, to a greater extent than high-educated participants, state that the SHG increased their self-confidence and hope for the future. The R^2 indicates that educational level explains approximately 11 percent of the variance in the dependent variable.

Model 2 controls for the other relevant independent variables. The results show that the relationship between educational level and the index indicating the degree to which the SHG provided self-confidence and hope for the future is nearly unaffected when controlling for background characteristics such as gender, age, civil status and the presence of children. This means that the relationship between education and the dependent variable cannot be explained by differences in the included background characteristics. The results in model 2 also show that none of the variables of sex, age civil status or the presence of children is significantly related to the degree of self-confidence and hope for the future provided by the SHG.

5. Conclusion

It is difficult to find suitable rehabilitation strategies for people on long term sick leave that help them return to work [4, 5, 6]. In this study, we analysed a SHG as an alternative strategy to provide people with a sense of meaning, self-confidence and hope after they completed a 20-week program at a rehabilitation centre. The SHG appeared to be more attractive to people who are more comfortable working in a group setting and interested in taking responsibility for organising the group activity themselves.

There were no significant differences in the background characteristics of people who opted to join a SHG compared to those who chose not to attend. Most of the people who participated in the SHG stated that joining a group increased their self-confidence and hope for the future. Educational level matters in the sense that increased self-confidence and hope for the future were more evident among the low-educated than the high-educated. This is in line with earlier research indicating that especially among the low-educated, the activities of the SHG can help people to change focus and find resources to deal with problems and make necessary life changes [9, 10, 12, 22].

Research shows that persons with low levels of education seem to suffer particularly from delayed rehabilitation [7], which puts them at higher risk of not returning to working life after rehabilitation [5]. Joining a SHG might therefore be a rehabilitation method that increases self-confidence and hope for the future especially among persons with low levels of education. Motivational factors, such as hope for the future and self-confidence, can be important factors in the rehabilitation process, as they can enhance sick people's motivation to participate in rehabilitation and re-think their future prospects of returning to work. This may in turn increase their actual chances of returning to work [23]. However, this hopeful assumption needs to be empirically tested by further studies analysing the direct link between SHG and job prospects.

Finally, there has to be noted that there are some limitations in this study which means that the results have to be interpreted with some caution. First, the main analyses are based on a small sample of 48 respondents; 32 persons with high education and 16 persons with low education. This is a low number of persons to do advanced calculations on. An even greater problem is the high non-response rate, which can mean that the sample included in the study in some respects differs from the total population. Second, the sample is from a specific region in the middle part of Norway which makes it questionable to what extent the results are generalised to other regions. Results are context dependent and a similar study in other regional and national contexts may generate different results. Third, the data is crossectional which means that it is difficult to conclude if a significant relationship between variables is causal, and if it is, in what direction. Results are generated from subjective assessments from respondents regarding the importance of SHG for aspects related to self-confidence and hope for the future. The study design would have been strengthened if the same measures were done before and after people participated in the SHG. This was impossible to do as the respondents were recruited after attending SHG and not before.

If the study was combined with qualitative interviewing of some of the respondents, we might have got a deeper understanding of the relation between illness, hope, self-confidence, everyday life and future perspectives. This might have led to more specified statements in the questionnaires and qualified the interpretation of the agreement with these statements. All these limitations imply that there is a need for further studies analysing the importance of SHG

by using larger, more representative and longitudinal data sets. This will increase the probability for generating more robust results that are representative for larger geographical regions and can be interpreted in causal terms.

Acknowledgments

The authors wish to express their gratitude to Mid Sweden University, Sweden, and Nord University, Norway for financing this study. We would also like to thank Marit Magnussen for assistance with the data collection.

Conflict of interest

The authors report no conflict of interest.

References

[1] Nordic Social Statistical Committee. Sickness Absence in the Nordic Countries. Copenhagen: Nordic Social Statistical Committee. 2015.
[2] Ekhom J, Westerhäll L, Bergroth A, Schüldt Ekholm K. Rehabiliteringsvetenskap – Rehabilitering till arbetslivet i ett flerdisciplinärt perspektiv. Lund: Studentlitteratur. 2015:272.
[3] Hedlund M. Shaping justice. Defining a category of disability in Swedish social security, Thesis, Lund University. 2004.
[4] Rinaldo U, Selander J. Return to work after vocational rehabilitation for sick-listed workers with long-term back, neck and shoulder problems: A follow-up study of factors involved. Work. 2015;55:115-31.
[5] Landstad BJ, Wendelborg C, Hedlund M. Factors explaining return to work for long-term sick workers in Norway. Disability and Rehabilitation. 2009;31(15):1215-26.
[6] Landstad BJ, Hedlund M, Wendelborg C, Brattaas HV. Long-term sick workers experience of professional support for re-integration back to work. Work – A Journal of Prevention, Assessment and Rehabilitation. 2009;32(1):39-48.
[7] Gould R, Härkäpää K, Järvikoski A. Too Late? The Timing of Vocational Rehabilitation. International Journal of Rehabilitation Research. 2009;32:64.
[8] Härkäpää K, Järvikoski A, Gould, R. Motivational orientation of people participating in vocational rehabilitation. Journal of Occupational Rehabilitation. 2014;24(4):658-69.
[9] Hedlund M, Landstad BJ. The construction of self-help in Norwegian health policy. International Journal of Self-help and Self-care. 2012;6(1):65-87.
[10] Borkman T, Munn-Giddings C. Self-help groups challenge health care systems in the US and UK. Advances in Medical Sociology. 2008;10:120-50.
[11] Katz AH. The strength in us: self-help groups in the modern world. New York: New Viewpoints. 1976.
[12] Borkman T. Understanding self-help/mutual aid: experiential learning in the commons. New Brunswick, N.J.: Rutgers University Press. 1999.
[13] Aglen B, Hedlund M, Landstad B. Self-help and self-helps-groups for people with long-lasting health problems or mental health difficulties in a Nordic context – a review. Scandinavian Journal of Public Health. 2011;39:813-22.
[14] Collins R. Interaction ritual chains. Princeton, N.J.: Princeton University Press. 2004. http://dx.doi.org/10.1515/9781400851744.
[15] Avis M, Elkan R, Patel S, Walker BA, Ankti N, Bell C. Ethnicity and participation in cancer self-help groups. Psycho-Oncology, 2008;17(9):940-47. doi:10.1002/pon.1284.
[16] Burns D, Taylor M. Mutual aid and self-help: coping strategies for excluded communities. Bristol: Policy Press. 1998.
[17] King SA, Moreggi D. Internet Self-Help and Support Groups-Chapter 9: The Pros and Cons of Text-Based Mutual Aid*: Elsevier Inc. 2007.
[18] Landstad BJ, Åhrberg Y. Conceptualizing the driving forces for successful rehabilitation back to work. Disability and Rehabilitation, published online 11th April 2017.
[19] Luk A. Investigating the long-term effects of a psychiatric rehabilitation programme for persons with serious mental illness in the community: A follow-up study. Journal of Clinical Nursing. 2011;20(19-20);2712-20.
[20] Bandura A. Self-Efficacy: The Exercise of Control. Macmillan. 1997. ISBN 9780716728504.
[21] Snyder CR, Lopez Shane J. Oxford Handbook of Positive Psychology. Oxford: Oxford University Press. 2009. ISBN 9780195187243.
[22] Karlsson, M. Självhjälpsgrupper: Teori och praktik. Lund: Studentlitteratur. (Self-help groups – theory and practice). Lund: Studentlitteratur 2006.
[23] Nordenmark M. Non-financial employment motivation and well-being in different labour market situations – A Longitudinal Study. Work Employment and Society. 1999;13(4):601-20.