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The disciplining of self-help: Doing self-help the Norwegian way

M. Hedlund[a,b,*], B.J. Landstad[c,d], J.Q. Tritter[e]

[a] Faculty of Nursing and Health Science, Nord University, Levanger, Norway
[b] Department of Social Work, NTNU, Norway
[c] Levanger Hospital, Nord-Trøndelag Hospital Trust, Norway
[d] Department of Health Sciences, Mid Sweden University, Östersund, Sweden
[e] Department of Sociology and Policy, Aston University, Birmingham, UK

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ABSTRACT

We explore how Norwegian self-help groups are defined and managed to create a particular form of health system governmentality. Self-help groups are typically framed as therapeutic communities where participants define the agenda creating a space where open and equal interaction can produce individual learning and personal growth. In Norway, however, self-help groups are managed in a way that integrates them in to the health system but insulates them from clinical medicine; an approach that disciplines participants to act in a particular way in relation to the health system. We draw on the analysis of 1456 pages of public documents and websites from the National Nodal Point for Self-Help (NPSH), the organisation that manages self-help groups, and central government including individual testimonies from participants published between 2006 and 2014. We argue, drawing on Foucault, that self-help premised on lay-leadership and self-determination is at odds with the centrally defined regulation apparent in the model adopted in Norway and an example of disciplining that reinforces health system governmentality and serves the interests of the medical profession and the state. Further we propose that this illustrates the contestation between the pastoral power of medics, the National Nodal Point for Self-Help and the Ministry of Health. Our analysis of Norwegian self-help as a mechanism to create a particular form of health system governmentality helps explain the expansion of self-help and self-management within developed health systems and provides an explanation for why self-help within health systems, is typically situated adjacent to, rather than integrated into, clinical medicine.

1. Introduction

The burden of illness in developed countries is increasingly related to long-term rather than acute conditions. Often the challenge for people with these conditions is learning to manage their situation rather than seeking curative interventions from health professionals. A dominant response from health systems has been the provision of group-based interventions to support self-management and self-help (Beatty and Lambert, 2013; Grøholt et al., 2014; Karlsson et al., 2002; Seebohm et al., 2013). Self-help groups are typically defined as "small voluntary group structures for mutual aid and the accomplishment of a special purpose" (Katz, 1976: 11). Self-help is driven by personal motivation and bottom-up organisation where participants determine the organisation and structure of the group rather than a top down model based on professional suggestions and interests (Borkman and Munn-Giddings, 2008: Aglen et al., 2011; Matzat, 2017). Such approaches seek to support patients to think of themselves differently, take more responsibility for their own condition and make life changes, rather than relying on clinical interventions (Borkman, 1999; Borkman and Munn-Giddings, 2008). Although there has been a growing interest in self-help groups since the 1970s, there is limited research on this phenomenon in the United Kingdom (Boyce, 2016) or in Scandinavia (Aglen et al., 2011). Existing research has focused on how individuals develop coping strategies or undertake activities to develop support and provide information for individuals or their families. The benefits of participating in self-help group are primarily related to interaction and sharing experience between peers rather than with 'experts' (Burns and Taylor, 1998; Avis et al., 2008; King and Moreggi, 2006; ESTEEM, 2011). Self-help or mutual aid groups are criticized for their tendency to look inward, rather than outward (Boyce, 2016) and to focus more on individual experiences rather than larger social issues. Some research has considered self-help groups as part of third sector anti-poverty measures while others have conceptualised self-help groups as catalysts to empower poor people, especially women. This research

* Corresponding author. NTNU, Department of Social Work, NO-7491 Trondheim, Norway.
E-mail address: marianne.hedlund@ntnu.no (M. Hedlund).

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suggests that self-help groups promotes educational and nutritional improvement among deprived populations as well the use of birth control (Ghosh, 2014; Bali Swain and Varghese, 2014).

In Norway, self-help is linked to public health policy."Help-to-self-help" is an established principle of Norwegian welfare state policy, meaning that a person should support him or herself and manage everyday life and that welfare measures should be used only when necessary (Hedlund and Landstad, 2012). Norway is considered an advanced welfare state, according to Esping-Andersen (1996) classification. Thereby, illness, health and incapacity and their management are conceptualised as something to be addressed not only as an individual issue, but also as the subject of public policy generally and welfare policy in particular. Research on self-help groups in Norway relates mostly to patient education programs or therapy groups led by professionals (Stang and Mittelmark, 2009, 2010; Aglen et al., 2011). There are studies that consider self-help groups as networks or interaction systems, promoting collective empowerment and a type of social movement for change (Karlsson, 2006; Borkman and Munn-Giddings, 2008; Brown and Wittuk, 2010). Studies of participation in self-help groups address empowerment as an outcome, although the mechanisms leading to empowerment are not well described (Hatzidimitriadou, 2002; Karlsson et al., 2002).

The relationship between self-help groups and nationally funded health systems varies, as they are not part of the third sector but rather an example of civil-society organisations that support active citizens (Giarelli and Spina, 2014). In Norway, however, self-help groups are dealt with in a way that integrates them in to the health system, but insulates them from clinical medicine; a particular form of health system governmentality.

This article uses the case of self-help groups for people with long-term conditions in the publicly funded Norwegian health system to illustrate how disciplinary practice is used to transform participants in to accepting a new form of health system governmentality. Self-help can be understood as a 'technology of the self' (Starkey and McKinlay, 1998; Townley, 2008) through which "individuals lose themselves in regimes of power but are also constituted as subjects by them" (Ferlie et al., 2012: 342). The particular approach to self-help within Norway, disciplines individuals ensuring that the transformation that occurs, the new selves that are formed, are situated within the governmentality of the health system rather than as is traditional, as active citizens or empowered patients (Dean, 1999). This is a form of health system governmentality, we argue, drawing on Waring and Latif (2017), that can be understood in terms of pastoral power with the state and the medical profession having an interest in the organisation and delivery of self-help for people with long-term conditions. Our analysis of Norwegian self-help as a mechanism to create a particular form of health system governmentality helps explain the expansion of self-help and self-management within developed health systems and provides an explanation for why self-help is typically situated adjacent to, rather than integrated into, clinical medicine within health systems. The interests of both the state and clinical medicine and medics, rather than those of individual service users or patients, are served by this form of governmentality. Applying Foucault's concept of pastoral power, we suggest that doing self-help the Norwegian way is more about helping the state and the health system than helping those who wish to help themselves.

1.1. The discipline of human options and action

For Foucault (1987: 341) discipline is a form of power defined in terms of the "conduct of conducts"; power is regarded as a general term for all advocacy processes whether described as, for example, education, training, or therapy. The potential value of this approach to reinterpreting self-help resides in Foucault's use of the twinned concepts of normalization and surveillance to define disciplinary practices. Foucault refers to practices that correct and *normalize* human actions (Foucault, 1987) partly through encouraging the internalization of external standards. Outwardly, self-help is premised on supporting people to change their understanding and actions in relation to long-term conditions, but at the same time it has the potential to be reimagined as a power technology aimed at ensuring individuals struggling with health issues internalize imposed norms of behaviour (Foucault, 1987). Foucault suggests that disciplining encourages the internalization of rules creating a new normality and enabling new practices and potentially a form of individual capacity building. Moreover, self-help shapes the expectations of people with long-term conditions about what they must do for themselves and what they should expect from the health system. This is a type of disciplining (Foucault and Sheridan, 1977) that is directly linked to a specific form of health system governmentality in which 'difficult' and demanding patients for whom biomedicine has little benefit are channelled into accepting a different mode of healthcare.

Normalization that occurs within self-help groups is enacted through participants being encouraged to define their problems and build the capacity to change their situation but the group also serves as a mechanism to categorise, surveil and discipline abnormal subjects (Foucault, 1994; Foucault and Sheridan, 1977). Surveillance occurs in, and is constituted by, three linked stages: first, it happens through people's willingness to participate in a self-help group; second, it takes effect through regulated social instructions for participating in these groups; and third, through contract-based commitments and the formal mechanism for founding groups. Self-help groups as a technology of the self, require individuals to reframe their understanding of themselves and their condition and take responsibility for a different way of managing their condition through personal transformation (Martin et al., 1988). The consequence of self-help is not the generation of collective pressure for change in healthcare provision or organisation (enacting active citizenship) but rather a reorientation of the individual to focus on their own behaviour and the improvement of their individual health and wellbeing rather than relying on the traditional clinically-controlled part of the health system. Self-help groups provide a mechanism for shifting the responsibility for 'getting better' from clinical healthcare to the individual; a mechanism of health system governmentality.

1.2. Health system governmentality, self-help and pastoral power

Governmentality is based on three processes: applying technologies of the self, the creation of new institutions that develop 'science like' thinking, and the development of a power/knowledge nexus (Ferlie et al., 2012). As we have suggested self-help groups are a 'technology of the self'. In 2004, the Norwegian Directorate of Health and Social Affairs (DHSA) adopted a National Plan for Self-Help (DHSA, 2004) and in 2006, the National Nodal Point for Self-Help (NPSH) was established as the expert center to coordinate and implement self-help nationally. In this way, the Norwegian state endowed self-help through the NPSH as a source of knowledge that was taken for granted and not open to challenge. The model for self-help promoted by the NPSH is an alternative to biomedicine: it is deliberately separated from the rest of the health system, does not engage with healthcare professionals, epidemiological evidence or impact in relation to health outcomes or health service utilisation. For Foucault a key process in the construction of governmentality is the power/knowledge nexus based on the "development of a series of specific governmental apparatuses on the one hand, and on the other a development of a series of knowledges." (Foucault, 2007: 108). The disciplining of self-help by the NPSH is the process by which the power/knowledge nexus is enacted. Together these interlinked processes generate a particular Norwegian health system governmentality.

In his later writing Foucault (2007) discussed 'pastoral power' as the exercise of 'experts' or 'shepherds' watching over and guiding the moral conduct of the 'flock' (Waring and Latif, 2017:2). Expertise in self-help

is founded in self-knowledge and the individuals participating in a group rather than in biomedicine and commitments to curative intervention. Within the Norwegian health system, however, this expertise and moral authority is vested in the NPSH and, to an extent, the Health Ministry rather than participants of self-help groups. The Norwegian approach to self-help relies on a particular form of lay knowledge that is validated by the NPSH and aligned with a key third sector organisation (Norwegian Anxiety Ring); a different source of pastoral power than either biomedicine or the DHSA (Foucault, 2007).

1.3. The Norwegian model of self-help

The Public Health Report No. 16 (Ministry of Health, 2003) set an objective to make self-help available to more people and promote a systematic approach to the development self-help groups. The vision set out in the report was that all Norwegians should have knowledge of self-help so that it could be deployed when problems occurred (DHSA, 2004).

The Directorate of Health and Social Affairs (now the Norwegian Directorate of Health) within the Ministry of Health and Care Services (Helse og Omsorgsdepartementet) (HOD) launched the *National Plan for Self-help* in 2004 as part of the *Action Plan for Mental Health* (1999–2008) (DHSA, 2004). The *National Plan for Self-Help* was started with work undertaken by the Norwegian Self-Help Forum (Norsk Selvhjelpsforum) (NSF) with various external contributors. Among the initiatives agreed was the establishment of a resource center for self-help, later named Self-help Norway that would be run by the NSF.

Self-Help Norway, the self-help resource center, started as an NSF and the Norwegian Anxiety Ring (Angstringen) project funded by what is now called the Norwegian Extra Foundation for Health and Rehabilitation (ExtraStiftelsen). This foundation is a state-owned funding body for health development in the voluntary sector. The project, titled 'Resource Network Anxiety Ring' (Ressursnettverk Angstringer) (NSF, 2003) included the aim to develop a resource center for self-help. The consequence was the founding of the Nodal Point for Self-Help (NPSH) which was initially financed as a project within the national program for mental health (DHSA, 2004), but the funding was integrated into the national health budget in 2009.

The purpose of the NPSH is to be a resource center gathering, systematizing and disseminating knowledge about self-help particularly in the field of mental health. The NPSH promotes a model for self-help groups based on the following characteristics. Self-help groups:

- are built on the principle of mutual help and self-help work is based on the participants' own experience and knowledge. A method motivates individuals to use their own resources to enable them to handle the stresses they meet. It is a process to enable individuals to identify and articulate their problems and thereby create a basis for improving their life situation;
- are based on each participant's inherent resources;
- are composed of participants who acknowledge a need to deal with their problems, are motivated and have made a choice to participate actively;
- are based on reciprocity, equality and tolerance;
- depend on an active participant role;
- are based on participant communication about their thoughts and feelings;
- adopt a transparent approach acceptable to participants;
- encourage participants to grow from within, not depending on external sources of help or teaching;
- are based on applying resources to a recognized problem;
- ensure both confidentiality and notification: what is said in the group stays in the group and members of the group are obliged to give notification if they cannot attend a group meeting (Directorate of Health, 2014).

These characteristics define the official model of self-help in Norway rather than a model defined by the participants. The *National Plan for Self-Help 2014–18* (Directorate of Health, 2014) defines the ideological guiding principles for those who want to work with, or facilitate self-help in Norway. Indeed, if a group does not follow these principles for doing self-help, they are not acting in accordance with the National plan for Self-Help in Norway and are not acknowledged as part of the programme coordinated and resourced by the NPSH. The Directorate of Health is formally responsible for this model for doing self-help, and they provide resources and outsource the implementation of the National plan for Self-Help 2014–18 to the NPSH (Directorate of Health, 2014).

2. Methods

The research reported here was part of a larger project funded by the DHSA, the Nord-Trøndelag University College and the Nord-Trøndelag Regional Research Fund. We used publicly accessible online documents relating to the definition, purpose, experience and ways of running self-help groups in Norway as data. Norway is a country with high levels of citizen satisfaction with public services in health care and education well above the OECD average (OECD, 2017). Communication through digital technology and online sources is very common in Norway which leads the OECD in the use of computers by households. Our main approach was to study the arguments and ideas behind the promotion of self-help groups within the national healthcare system and how these regulations were reflected in online documents. The online documents were not designed to engage with members of the public and therefore provide insight into how policy makers and providers seek to present self-help. The online documents provide a very particular account of reality within the public domain. The main dataset of public documents were collected up to 2014, but most of the documents are still available online. Computer-based data sources can be regarded as authentic as other type of qualitative data (Marshall and Rossman, 2006).

2.1. Data collection

The data was collected by searching for key words in public online sources including www.government.no (information from the Government and Ministries) and www.stortinget.no (information from the Parliament) and www.norway.no (gateway to information about the public sector in Norway) and www.selvhjelp.no (National Nodal Point for Self-Help). These documents were published between 1998 and 2013 and downloaded between January 1st, 2006 and February 28th, 2014. Documents, at 1456 pages, were identified and downloaded based on search terms of "selvhjelp" [self-help]; "selvhjelpsgruppe" [self-help group]; "selvstyring" [self-management]; and "helse" [health].

2.2. Analysis

We analysed relevant texts for their formal and informal genres or expressions of how self-help should be understood and practiced. We also analysed data based on "narratives" presented in public online documents. We addressed all data as positions or points of view (Patton, 2002), not only as "written" or "oral" scripts that are written or spoken without purpose. Instead, the data was approached as a language of social-institutional practice (Fairclough, 2003); a practice reflecting a certain ideology or knowledge that frames the presentation of 'facts'.

The Norwegian researchers, the first and second authors, carried out the primary analysis. All documents were analysed and additional references to government documents and reports published before 2006 were identified. Using BIBSYS the first author identified and obtained these documents that were then subjected to the same analytical process. BIBSYS is a key supplier of products and services for higher

educational institutions and other research institutions in Norway, public administrative institutions and the National Library of Norway.

Both Norwegian researchers marked and made notes in the analysed documents. These notes were then compared and discussed. The analysis was based on multiple readings to identify the meanings of self-help and self-help group presented in the documents (Prichard, 2005). We also analysed the interpretive and political strategies apparent in the documents and critically examined the documents for the particular target groups they addressed and how they referred to other sources. We analysed information about particular agents (politicians, organisations or networks) and how the definitions and content of self-help was established. The interpretive analysis addressed the mentality of rules delineated from a discursive field in which the exercise of power (disciplining) over the meaning and contextual framing of self-help and self-help group took place. We then categorised the extracts in relation to three Foucauldian concepts relating to discipline: normalization, surveillance, and pastoral power.

The primary analysis undertaken by the Norwegian researchers was discussed with the third author. Based on consensus within the research team we grouped all extracted items into categories and labelled them by similarities of expression. We particularly searched for topic sentences and utterances that defined self-help or framed the relationship between self-help and the practice of self-help groups in a certain way. The remaining items that we could not label, we put into an unlabelled category. Then the research team analysed the meaning, content, organisation, format, legibility and any other aspects we considered important for the comprehension of the text of the categories. Then the categories were reorganized and re-labelled retaining their difference of meaning within the context of the source documents i.e. what type of documents were the self-help message presenting and to whom the message was addressed. All quotations from the source documents are presented in English based on an agreement between the two Norwegian researchers following independent translation and then consultation with the third author to ensure clarity of expression.

3. Findings

In this section, we present the results of our analysis of the policy documents and public testimonies structured in relation to key aspects of discipline. The initial section explores the evidence of normalization; the internalization of rules defined by the NPSH that govern behaviour within self-help groups and enables participants to generate new self-management capacities. We go on to consider how surveillance is enacted as part of the disciplining process in Norwegian self-help. Finally, we discuss the evidence of pastoral power in Norwegian self-help: in the organisation and management of group, the role of group members, those who manage the groups and the NPSH that sets the rules that govern self-help groups.

3.1. Normalization

Heyes (2006: 128) argues that organisations that claim to promote self-knowledge, such as weight watchers, embody “the paradox Foucault highlights: that normalizing disciplinary practices are also enabling of new skills and capacities”. On the one hand, participants in a self-help group manifest themselves and their problems in a group. On the other hand, participants in such a group are expected to share their innermost thoughts and feelings with people they previously did not know. In Norwegian self-help groups, this is readily apparent. For instance, the NPSH explains that

> Self-help is to come to believe that you really are able to change your own life. Self-help is about how you are presently and not why it is so, or who is to blame (for your situation). Self-help is to dare to trust (these) driving forces - and learn to make use of them. Self-help is to gain the courage and energy to try (NPSH, 2012).

The explication of specific rules is essential to enable their internalization. NPSH recommends that self-help groups be established according to certain rules and techniques. Participants should sign a contract of confidentiality about discussions within the group, and agree to notify a contact point if they miss a session (Norwegian Directorate of Health, 2014). Participants are also discouraged from meeting in private homes and instead to use a neutral meeting. Ideally, meetings should take place at a ‘clearinghouse’ run by regional NPSHs or in a public building. There are explicit rules that govern how meetings should be run including a maximum meeting length of 2 h and the availability of only moderate refreshments such as coffee and not more than a small biscuit per person (NPSH, 2013). Groups should consist of 5–8 people and meet regularly, preferable once a week. Participants should share leadership of the group rather than a permanent leader.

According to the NPSH, the context of self-help groups represents an arena for practicing feedback to personal problems (Norwegian Directorate of Health, 2014). Each group participant should talk one at a time, and not comment on choices or habits of other participants but rather focus on their story. The participants are strongly recommended to avoid socializing with each other outside the group. Self-help groups are presented as a setting that enables individuals to take responsibility and become motivated to undertake self-therapeutic processes but only if NPSH methods are followed.

One consequence of the Norwegian approach to self-help is normalization at an individual level and this is apparent in the individual testimonies presented by the NPSH. As *John* explains,

> Fortunately, we were introduced to several types of self-help groups, and one of them struck a chord with me. Being able to sit together with others, to hear that others have felt the same way, have fled in the same way and been trapped by drugs in the same way, gives me a great sense of community. When we have meetings, we need to be solution orientated. We're not talking only about problems; or burying ourselves in misery. We help each other to find hope, experience and strength. We share in order to lift each other. I would never have been able to remain drug-clean without going regularly to a self-help group. The best thing is that I do not feel alone anymore, even when I am alone. … This is something I never would have without a self-help group. Thank you! (NPSH, 2010a).

The self-help group context promotes a feeling of community and stresses a belief in human progress and development. In this sense, the message in the account is that self-help groups can make people aware that they are authors rather than victims of their fate and encourage moral conduct.

The message from NPSH is that participants that want to join a self-help group should follow the rules communicated by NPSH and use their premises. Our interpretation is that these rules form a Norwegian self-help dogma.

> At the third meeting, we signed a confidentiality agreement - we agreed on regular meeting days, one night per week, two hours. The framework around it was important, and we closed the group to new members once we were into the self-help process. I see now that this was very important (NPSH, 2010b).

The message from NPSH is that participants should follow appropriate methods and techniques and take personal responsibility and generate therapeutic outcomes and must be carried out in a particular way to be successful (NPSH, 2010c). The ideology of the NPSH promotes self-help as a universal way of mobilizing people to deal with their problems. Such outcomes are only possible when self-help groups are governed and set certain limits. In this way, self-help in Norway is presented as a distinctive context for practicing self-therapy moulding participants into appropriate behaviour in contrast to those who have bad habits and make poor choices. We argue that NPSH exercising control over this transformation through disciplinary practices by

ensuring that self-help is shaped by, and conforms to certain rules. These rules, disciplinary practices, define how, where and when groups should meet and the nature and extent of the interactions within them as well as the organisation of the meeting and the type of refreshments that should be available.

3.2. Surveillance

For the NPSH self-help groups must be established according to formal rules and the oversight of these rules, and the surveillance of group members, is a key aspect of the process that supports internalization and the normalization of these practices. Within groups, participants surveil each other. In one of the NPSH pamphlets *Magner* describes these practices in his testimony,

> Working in a self-help group is about having respect and making allowances for each other. Making allowances for each other is a basis for the group and we do not give into pitying each other. We have now worked together for seven months, and it was 3–4 months before we had sufficient confidence in each other to be able to 'push' each other. When we 'push' each other, it is not an attack, but we challenge and question our thinking/ways. Participants in the group encourage each other. We came into the group with different backgrounds, but we feel that we have the 'same' problem, such as feeling inferior - we socialize little (NPSH, 2010b)

Magnar provides an account of self-help as a powerful tool to encourage moral conduct and overcome feelings of inferiority. Self-help groups can provide a space for the mutual recognition of problems and a crucible for interaction to identify and reflect on one's own behaviour and that of other participants.

Surveillance reaffirms the enactment of rules and normalises behaviour. As *Reidun* explains,

> We had 'here and now' experiences. For example, once I experienced a person starting to rant about something I cared about, and I thought her presentation was unjustified. Then I got really angry. She felt offended, and it was obviously scary. It's not nice to hurt people. But in a self-help group, we are adults who meet to work and for your own sake must dare to speak out. Not only for your own sake, by the way. The woman who was offended took it well and managed to reverse the situation. She saw that she needed opposition and that my reaction to her was valuable (NPSH, 2010b).

The centrality of surveillance as an aspect of self-help group practice is apparent in the characteristics of self-help groups as defined and accepted by the Norwegian Health Directorate. Self-help groups should "ensure both confidentiality and notification: what is said in the group, stays in the group and members of the group are obliged to give notification if they cannot attend a group meeting" (Norwegian Directorate of Health, 2014). The key actor that surveills group processes and monitors them is the self-help group 'starter' who, in Foucault's terminology is a 'sheepdog'.

3.3. Pastoral power

Foucault describes an approach to constituting obedient self-governing subjects as pastoral power. The conduct of different pastors both enacts surveillance and generates legitimacy. Within health care, Waring and Latif (2017) describe this as a relationship between sheep (patients) and sheepdogs who through herding "nurture more obedient and self-regulating patients" (p.9). In turn, shepherds (doctors) supervise the sheepdogs. In Norwegian self-help groups the 'patients' are members of the group, the sheepdogs are self-help group 'starters' who are supervised not by physicians but by the NPSH on behalf of the Ministry of Health.

Power is not possessed by individuals or professionals but is a product of discursive practice and Waring and Latif (2017) propose that health systems can be understood as having multiple discourses overseen by competing pastors. Modern pastoral power has four aspects: *analytical responsibility*, *exhaustive and instantaneous transfer*, *sacrificial reversal* and *alternate correspondents* (Foucault, 2007). The *pastor* or *shepherd* is responsible for leading people to worldly salvation in terms of health, well-being, security and protection against accidents. The conduct of the sheep, good and bad, reflects on the standing of the *pastor*, who must also be willing to sacrifice themselves for the good of the flock. Finally, the turning of sheep from immoral to moral behaviour increases the *pastor's* reputation while the faults of the *pastor* help guide the sheep to salvation (Foucault, 2007). In sum, "Pastoral power is a power of care." (Foucault, 2007: 172).

Self-help groups, at least in Norway, do not start themselves. Instead, an 'initiator' or 'starter' should form a group. Norwegian health authorities have outsourced the recruitment, training and delivery of *starters* to the NPSH (NPSH, 2005). The NPSH recruits people from existing self-help groups to become *starters* and conceptualises the *starter* as a catalyst; an individual who is necessary for the reaction (the founding of a self-help group) but observes rather than participates in the group and remains unchanged by the interaction within the group. *Starters* are 'immune' to the impact of self-help.

> It is important that the starter is motivated and has commitment to the work. The role of a starter is not to be 'kind' or 'strong'. The goal of the starter's presence is to create a safe platform so that the group manages itself, among other things through the dissemination of frameworks and principles of work. Their main task is to contribute knowledge and experience on self-help in addition to the practical arrangements for start-up meetings (NPSH, 2006).

A *starter* plays a key role in mobilizing and socializing people into a self-help group that requires participants to operate at and between the individual and collective level; participants have to engage with the group (the collective self) but also act on themselves (the individual self). The NPSH also emphasize that the *starter* should be a disinterested party who enacts a helping rather than leadership role in the group and typically, the *starter* initiates the first 4–6 meetings of a group (NPSH, 2006).

> As a starter of self-help groups, I have experienced being a part of the process together with the group and I have grown as a person. To experience the great communication and the progress we make together is very nice and incredibly stimulating. As a starter, you participate from day one, not as an outsider, but as someone who is equal with and allowed to be with the group and, grow together with the group. I recommend most warmly being a starter of a self-help group; it has given me a deeper understanding and better insight into my own and others' challenges in life (NPSH, 2006).

A starter can be understood as a sheepdog "who observes, monitors and checks the behaviours of the 'sheep' like patients" (Waring and Latif, 2017: 12). The sheepdog enacts disciplinary techniques for the exercise of power on behalf of the NPSH (Foucault, 1987) rather than physicians. In the Norwegian case the shepherds are not physicians but the NPSH, who are contracted by the Ministry of Health.

Medical professionals cannot be starters and do not play any role in their training. Indeed, the rules that govern self-help are defined and monitored by the NPSH and do not refer to medical interventions, are not framed as treatment and are not justified based on health outcomes. The absence of the medical profession in the public and policy debates about the competence of the NPSH or the relevance and utility of self-help is notable. The medical establishment has not challenged the self-defined competence of the NPSH and is complicit in their disciplining practices, in part, we argue, due to the type of patients in self-help groups. This response from the medical establishment may be in part because self-help groups are seen as a way of lessening the workload of doctors (Nickel et al., 2012). Indeed, the participants in self-help groups in Norway are primarily those for whom no medical interventions will

yield any improved outcomes. It is in the interest of medics to be able to refer these 'heartsink' patients somewhere and self-help groups provide an answer. "Heartsink' patients are a great source of stress to doctors … Heartsink patients cause much clinical insecurity" (O'Dowd, 1988: 530). In the Norwegian context, at least in relation to self-help, medical professional do not exercise pastoral power and instead the shepherds in Norwegian self-help are the NPSH.

4. Discussion

Our analysis shows that in Norway self-help is an arena for regulation and discipline supporting health system governmentality. In the literature, self-help groups are defined as normative, egalitarian, and supportive of participants (Borkman, 1999). In Norway, self-help groups should serve the same purpose, but the NSPH requires that self-help be practiced in a particular way.

We argue that the approach to self-help in Norway is heavily codified. Specific processes must be followed to initiate the founding of a self-help group and explicit rules, including signing non-disclosure agreements, govern the action that occurs within the groups. Self-help groups should also be organised in a specific way. The location of a self-help group should be 'neutral', preferably a place that is depersonalised – not the house of a participant. The surroundings should not interfere or influence the interaction between participants. The participants should not meet or greet each other outside the group meeting to ensure that people do not become friends. The result is that Norwegian self-help groups are instrumental settings that are heavily regulated and depersonalised. Such an approach transforms a subjective process into an objective mechanism where self-help is compartmentalised and people remain intimate acquaintances but cannot be friends. This is justified because the activity within the self-help group is work and is undermined by overly close friendships or intimacy. This is very different from definitions found in the self-help research literature that emphasize self-help groups as driven by closeness, self-motivation, encouragement and personal engagement (Borkman and Munn-Giddings, 2008; Karlsson, 2006; Nylund, 2000).

The NPSH exercises its pastoral power (Berten and Foucault, 2006) to promote a model for doing self-help in Norway that can be described as disciplinary (Foucault, 1987). The introduction of disciplinary practices in different institutions is typically a product of economic conditions, innovations introduced in industry or a flare-up of certain epidemic diseases (Foucault, 1987). When the NPSH establishes certain rules and circumstances for practicing self-help this is a form of discipline that is fundamentally technical, practical and practiced (Foucault, 1987). However, the NPSH is a shepherd that needs sheepdogs and by educating people to become *starters*, the NPSH supplies self-help groups with an approved actor who teaches strict standards and procedures ensuring group participants learn the right way to practice self-help. These *starters*, or sheepdogs, enact disciplinary techniques for the exercise of power on behalf of the NPSH (Foucault, 1987), which are accepted by the Norwegian government, health authorities and the medical profession. The NPSH directly and indirectly through *starters* exercises an explicitly non-medical gaze that rejects epidemiological evidence and a language of cure and replaces these with an experiential and holistic vision that is 'lay' rather than patient based.

These reflections suggest that rather than providing self-help the NPSH is delivering a particular normative approach to how people should manage their chronic illness. Indeed, the definition of what counts as self-help within Norway is the sole preserve of the NPSH. As important, the separation between healthcare institutions such as hospitals and health professionals (framed by a medical-gaze) and Norwegian self-help groups premised on a non-medical gaze challenges the categorisation of NPSH-led programmes as healthcare despite HOD funding and oversite. Indeed, the top-down disciplined nature of how self-help is organised and delivered in Norway seems to be at odds with how self-help is defined in the literature. Perhaps Norwegian self-help is neither self-help nor healthcare.

Waring and Latif (2017) propose that governmentality within healthcare can comprise multiple pastors operating in dynamic competition. Our findings suggest that indeed the NPSH can be considered a pastor that operates within a lay regime promoting wellbeing for individuals while medical professionals operate as another pastor promoting heath for patients and both practice pastoral power within a common health system and often on the same individuals. However, there is a third source of pastoral power that shapes governmentality within the health system and this is practiced by the HOD that oversees the funding, legitimacy and regulation of both clinical care and self-help. Indeed, The HOD mediates balances and intervenes between the pastoral power operated by the NPSH and the medical professionals suggesting a superior episcopal, rather than pastoral power. We propose that pastoral power, is not only in competition as Waring and Latif (2017) suggest, but may also be hierarchically organised as the HOD is a shepherd that leads the other shepherds (the NPSH and medical professionals).

5. Research limitations and ethical considerations

This research was based on published documentary sources from public bodies rather than systematically collected data from participants in Norwegian self-help groups. Our intention is not to document the experience of self-help but rather to illustrate how the regulation and governance of Norwegian self-help reveals underlying power relations between different statutory and non-statutory actors within the health system. As the data we analyse is from publicly available published sources, no formal ethical approval was required; however, the larger project had formal ethics approval from the Mid-Norway Regional Ethics Committee (REK 4.2009.776). Our approach to analysis and interpretation has followed professional ethical standards and has ensured no individual can be identified.

6. Conclusions

The promotion of self-help in Norway is premised on an approach to the management of long-term conditions that are not amenable to cure embedded in the biomedical model of illness. This approach is based on the assumption that people with long-term conditions are experts in their own conditions and primarily self-manage their own situations with only limited clinical intervention. However, a significant proportion of people with long-term conditions are unable to manage their situations effectively and this leads to complex and expensive health and social care needs. Self-help groups are accepted as a response to this problem and the NPSH, an organisation with its roots in the voluntary sector, has responsibility for delivering this solution on behalf of the Norwegian health system.

The NPSH has been very successful in carving out a space in public policy and practice that is not subject to direct clinical regulation or scientific scrutiny but instead self-regulates. This has been achieved in part by disciplining self-help in a way that creates systematic practice and measurable processes. The approach generates evidence acceptable to government authorities (e.g. the number of groups initiated, the number of participants) and reinforces health system governmentality for those who participate in self-help groups. Simultaneously the NPSH has argued that the activities within self-help groups are therapeutic but neither medical nor clinical. This framing of self-help activity removes it from the auspices of medical authorities, who have done little to contest this definition. The consequence of participating in self-help groups is presented as promoting self-management and lessening the burden on health services; a claim that is never tested or justified with any scientific evidence.

NPSH defines what counts as self-help and these practices extend to how self-help groups are founded, run and the activities deemed

appropriate. Further, the NPSH specifies the types of condition that are acceptable and the appropriate responses of participants. This is an example of disciplining and ensures that the NPSH defines legitimate self-help in the Norwegian context. The disciplining by the NPSH is complemented by an exercise upward to government defining their competence in this arena and safeguarding their leadership over publicly funded self-help.

Self-help in Norway is distinctive and different from the model of self-help defined in the literature which is self-determined and lay led (Hedlund and Landstad, 2012; Munn-Giddings and Borkman, 2018). In the Norwegian context self-help is funded and defined by a dogma specified by the National Nodal Point for Self-Help (NPSH) and policed, in part, by the 'professionals' who found self-help groups: the self-help group starters.

We extend and apply the concept of pastoral power to understand governmentality in the Norwegian health system by proposing that the NPSH and the medical profession each act as 'shepherds' or pastors within the system. Further, we suggest that the *starters* act as sheepdogs corralling and managing the sheep who are the group participants. People with long-term conditions are therefore subject to both medical power in the shape of the medical profession but for those who join self-help groups in Norway also the power of the NPSH. Each of these pastors negotiates different types of influence over the definition and management of this patient population. Nevertheless, self-help groups are explicitly non-medicalised and premised on helping people manage their lives. Yet, the NPSH and the self-help groups are funded by and a part of the HOD.

We suggest that this is possible if we think of the HOD not simply as another pastor who negotiates power with the medics and the NSPH but rather one that exercises power mediating between the other two pastor and can require them to compromise; a Bishop to their pastors. Despite this apparent hierarchy in pastoral power, the position of the pastors and the Bishop is dependent on the action of the individuals with long-term conditions and the operation of the self-help groups. For just as sheepdogs are directed by shepherds who determine a larger plan, the shepherds, or pastors, are subject to the plans and direction of Bishops and all three roles are constrained by the expectations and actions of their flock. Doing self-help the Norwegian way, provides a solution for both medics and government by shifting their responsibility for a category of patients that is 'difficult' to the NPSH. What is less clear is whether this solution serves the interest of the patients or the public.

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