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Nota bene

Counseling by psychologists in a medical situation would benefit from an oath of allegiance to the Hippocratic rule that one should always persist in making every possible effort for the good of the patient. (Proposition in: A. P. Messer. Serious eating problems and intractable bed-wetting. [Zeer moeilijk eten en moeilijk beïnvloedbaar bedplassen.] *Thesis Leiden,* 1979.)

The fact that a 4-year-old boy, after a visit to the locum tenens of a specialist, says „It was the same doctor, but with a different head on" is characteristic of the white coat image. (Proposition in: P. E. de Jong. Sickle cell nephropathy, new insights into its pathophysiology. *Thesis Groningen,* 1980.)

Self-help

Backgrounds, postulates and problems of a new phenomenon

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Although the self-help phenomenon was in the air, it did not come out of the blue. It can be regarded as a consequence of certain social and scientific developments; as a symptom of „larger potential shifts in society's problems, priorities and solutions". This paper is a plea for a new balance between professional care, self-care and communal care.

Concept definition

Van Harberden and Lafaille distinguish three features in the self-help phenomenon:
- self-help as ideology;
- self-help as self-treatment;
- self-help as self-help group.

The significance of the term self-help varies as the accent on one of these features varies.

> *But I hold that it is possible to profit by the art of medicine even without calling in a physician. (Hippocrates, The art. V, 3-4).*

Most authors focus on self-help groups and define self-help operationally as that which happens in and about these groups. *Katz and Bender* list the following characteristics:
- spontaneous origin and voluntary participation;
- a common problem or a common need;
- focus on a specific objective: elimination of a problem or need, personal or social change;
- specific means: mutual help on the basis of personal contacts between participants, and personal responsibility for each other;
- the conviction that needs and problems cannot be eliminated by social institutions but must be tackled by the group members themselves.

Whereas self-help groups can be regarded as a collective manifestation of the self-help phenomenon, self-treatment („self-doctoring") is a more individual undertaking. Both, however, may be regarded as manifestations of a certain „ideology" – a system of ideas focused on the conviction that one can help oneself, regardless of various professional services. As a source of motivation and inspiration, this self-help ideology as a rule receives but little attention.

A different terminology is used by *Hattinga Verschure* (1977), who distinguishes three contexts of care:
- self-care: the individual meets his own requirements for care;
- communal care: a group of persons look after themselves;
- professional care.

Self-treatment is evidently an aspect of self-care, and a self-help group is one of the circles in which communal care can take shape. The characteristics of communal care as listed by *Hattinga Verschure* (1977) in fact largely correspond with those of self-help groups. Within this system of concepts, therefore, the term self-help would seem to refer to self-care on the one hand, and to communal care on the other.

Backgrounds

Although the self-help phenomenon was in the air, it did not come out of the blue. It can be regarded as a consequence of certain social and scientific developments; as a symptom of „larger potential shifts in society's problems, priorities and solutions" (*Levin et al.*). The increased interest taken in self-help can be placed in the context of changes which, somewhat schematically and at random, can be classified as follows.

Social changes:
- reduced significance of various primary reference groups or communal

care contexts (family, neighbourhood, club);
- diminished prosperity, with consequently the necessity to establish priorities (*Veder-Smit*)

Cultural changes:
- emphasis on self-realization, self-development;
- pursuit of emancipation and democratization;
- resistance to totalitarian and authoritarian structures;
- changes in life-style: against conformism, achievement compulsion and traditional norms.

Scientific changes:
- wider dissemination and increased availability of information (higher general educational level, influence of mass media);
- a critical attitude to science and technology.

Changes in medicine:
- demystification of medical knowledge and health care;
- distrust of professional motives (attention for financial aspects, abuse and mistakes);
- concern about medicalization and depersonalizing consequences of the so-called medical model;
- more attention for the effectiveness of services rendered.

Confining ourselves to medicine, we could discern a line in certain developments that leads to the current interest in self-help. After a period of enormous advances in medical science (roughly: from World War II until the end of the Sixties), the uncritical and expectant attitude to medicine gradually changes to an attitude of criticism and scepsis. As to the critical attitude, three phases might be roughly distinguished, not as a historical sequence but as a conceptual trend.

The first phase is mostly that of identification of „medical power" and all its consequences (*Van den Berg; Hamburger; Verbrugh; Bernard; Zola* 1973; *Klinkert; Terborgh-Dupuis*).

The next phase is that of debunking this power. The owners of medical knowledge, i.e. power, are described as a „profession" (*Freidson*) or, less kindly, as a „stronghold of wiseacres" (*Van den Hoofdakker*). It is maintained that the totalitarian inclinations of medical power should be confined within clearly marked boundaries (*Powles; Illich* 1975, 1976; *Zola* 1977), and *McKeown* shows that, even within these boundaries, the effectiveness of medical knowledge is a myth.

The third phase is that of attempts to neutralize or reduce medical power. An increasing interest is taken in alternatives to what is known as official, professional or academic medicine, in the form of alternative therapies (*Van Dijk* 1976), alternative services (*De Klerk and Van der Zande*) and „health shops" (*Van Dijk* 1978). Humanistic or holistic medicine attempts to prevent the depersonalizing and dehumanizing effect of medical intervention (*De Vries*). Attemps are made to reinforce the position of those who require care by demands of democratization and emphasis on the rights of patients *(Aghina; Gezondheid(szorg).*

The increasing interest in self-help can be regarded as an important element in the current, third phase of the developments outlined above. The power of the individual faces the power of medicine; a book on self-help groups is appropriately titled *The strength in us* (*Katz and Bender*).

Postulates

The possibility of self-help proceeds from a number of postulates:

The limitations of professional care. Professional care tends to extend its expertise to ever more aspects of human life. It is beginning to be understood that, in several areas, the care may be expert but certainly is not complete. Unlimited faith in professional knowledge is gradually being superseded by relativation and limitation of the range of application of this knowledge. This understanding of limitations necessarily precedes a shift of attention to the areas outside these limits; to problems and needs which cannot be solved by professionals.

Faith in the power of the individual. Self-help postulates confidence in one's own competence with regard to one's health, and one's illness: faith in one's own ability to influence one's health, not as a supplement to professional care but as substitute for this care. To some extent, this faith is also alive among professionals, as demonstrated by the findings of Williamson (*Levin et al.*) in a group of general practitioners. These professionals estimate that some 25 percent of the episodes of illness in general practice can be entirely managed by self-help. *Bremer* reports that, in The Netherlands, medical advise is sought on about two-thirds of all instances of illness.

The achievements of medicine. „Self-care presupposes an active and educated public", wrote *Levin et al.* Self-help is not a return to pre-scientific practices, but is based on available scientific knowledge. However, this knowledge is no longer regarded as the exclusive property of the professionals. Technology is gradually preparing itself for such a transfer (disposable specula, Predictor, home dialyzer, gluco-check, and so forth). Self-help, therefore, is not the antithesis to modern medicine but – paradoxical as it may seem – in fact proceeds from a medicine that is effective in some areas.

Problems

The self-help phenomenon is bound to pose a number of problems for the medical practitioner, and particularly for the general practitioner.

The professional's attitude to self-help. Self-help groups are established spontaneously by people who experience a common problem. „Professionals have no task in self-help groups", wrote *Wolffers*. There is in fact a danger of self-help being usurped by professional care. Even now we find that it is mostly professionals who write about and devote research to the self-help phenomenon. Professional involvement, however, affects the essence of this phenomenon. Should professionals then stand aloof entirely from the self-help movement? *Van Harberden and Lafaille* advocate a modest attitude on the level of initiating and advising in an equitable relationship. *Wolffers* views the professional's role in this context as entirely that of „utility". According to *Hattinga Verschure* (1977), however, the general practitioner is the person par excellence to assess the self-care and communal care situations of his patients. He could motivate and stimulate more self-care and communal care activities in his territory; and he could support and guide as adviser the existing communal care structures.

The boundary between self-help and professional help. The question of how to determine the boundary between self-help and professional help is closely related to the above. In principle, everybody is entitled to self-diagnosis and self-treatment. To what extent can self-help groups adopt professional methods and techniques for this purpose? What about the responsibility of the profession? Within medicine, in fact, there is a movement in the direction of greater awareness of the limitations of profes-

sional knowledge and skills; a growing awareness of the provisional nature of facts and theories; a search for quality yardsticks of medical activities. In some ways, the self-help movement flatly opposes this. The Laetrile affaire demonstrates that scientific arguments are sometimes far from decisive.
The right to self-help is thus set off against the professional's sense of responsibility. The problem becomes accentuated when the adoption of professional techniques by self-help groups is concerned. Should the profession indicate which techniques are suitable for these groups, or wait to see what the self-help movement wants to adopt? Is there not a risk of increasing medicalization of life (what *Illich* calls „social iatrogenesis"), and increasing commercialization (audiovisual courses, „do-it-yourself" diagnostics, „body books") – the very trends that elicited the reaction of the self-help movement?

Changes in the doctor-patient relationship. Self-help implies more personal responsibility and emancipation. The professional is expected to adopt the attitude of the „educator" rather than that of the therapist (*Levin et al.*). It is demanded that the helper-helped relationship become more equitable and more democratic (*Kroon*).
The question arises whether this is entirely possible. After all, a person is a professional on the basis of a certain knowledge. This implies a difference in *this* respect, but it does not imply that the relationship should be asymmetrical in other respects too. Tutelage is not inherent to professional care.

Empirical expertise versus professional expertise. The literature on self-help sets off empirical expertise against professional expertise (*Borkman*). Experiential knowledge is equated to (or considered superior to) knowledge acquired by training or study. To phrase it more mundanely: you cannot know anything unless you have experienced it. In the terms of this vision, self-help groups possess expertise on the basis of shared experience. Professionals derive their expertise from the possession of a „piece of paper" (*Wolffers*).
In our view this contrast between practical and theoretical knowledge is spurious. A general practitioner does not have to have had a myocardial infarction to know what his patients experience in such a situation. His expertise is not solely based on formal education but certainly also on experience gained in the day-to-day management of patients, and on the collective experience of his colleagues past and present. Whether personal experience of a given illness does not substantially enrich this professional experience, is a different question (*Fiore*).

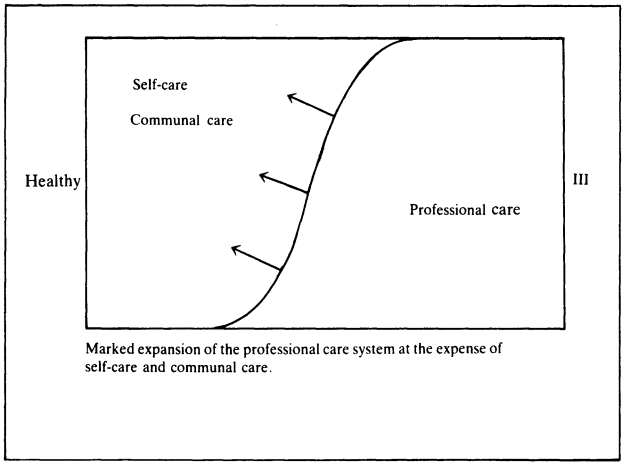
Evaluation of self-help practices is likewise a problem. *Levin et al.* hold that self-help should not be evaluated on the basis of criteria of professional care (promotion of health, alleviation of illness). Instead it should focus more on changes in the decision-making process of the infirm, reduction of iatrogenic illness, and changes in the general level of well-being of a population.
Exactly how an evaluation on these lines should be made, remains uncertain. An increase in self-help activities may well be accompanied by a changed appeal to professionals. *Sehnert* reported that a self-help program reduced the number of telephone calls to the family doctor and alleviated the patients' anxiety, but *Berg and Logerfo* found that exact observance of instructions in a well-known American self-help handbook in fact caused an increase in the number of visits to doctors.

Restoring the balance

The relationship between professional care and self-care and communal care has been rather variable in the course of time. The past few decades have witnessed a marked expansion of professional care at the expense of the two other care systems. The professional system largely usurped the care of the ill, and in addition tended to expand its activities in other areas of life (*figure 1*).

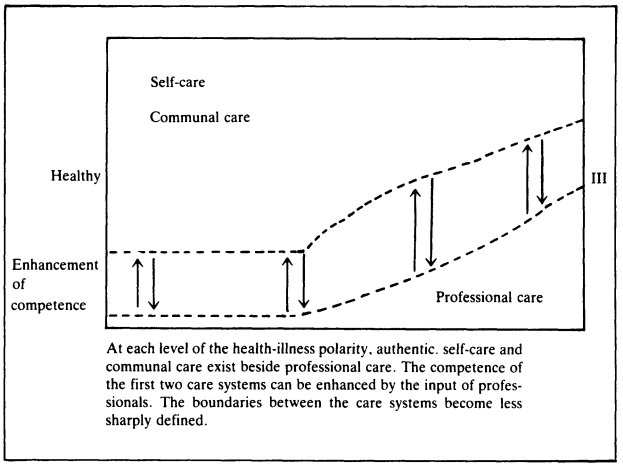
The disadvantages of this trend are gradually becoming evident, and the increasing interest in self-help may indicate that stimulation of self-care and communal care is viewed as a means to halt this trend. The balance between the three systems of care must be restored, says *Hattinga Verschure* (1977). This means that the professional system should retire a little. Professionals should take a modest attitude and accept a less intervening, more educational task. They can contribute to the development of self-care and communal care by supplying information; they can contribute also by promoting a value system and a pattern of life aimed at personal efforts to promote and maintain health (*Hattinga Verschure* 1979).
A professional attitude of this description is desirable at any level of the illness-health polarity (*figure 2*), for an element of self-care always precedes the time when professional medical care is provided.

Figure 1. Antithesis.



Marked expansion of the professional care system at the expense of self-care and communal care.

Figure 2. Complementarity.



At each level of the health-illness polarity, authentic self-care and communal care exist beside professional care. The competence of the first two care systems can be enhanced by the input of professionals. The boundaries between the care systems become less sharply defined.

Little research has generally been devoted to this so-called premedical phase (*Weyel*). It can be maintained that the boundary from the professional care system is exceeded only after two fundamental decisions:
- the decision to place a given problem in the illness-health context, that is to interpret it as a health problem;
- the decision to take this problem to an expert, that is to interpret it as a medical or professional problem.

It seems that both decisions are currently made more frequently and more quickly than in the past (*Fahrenfort and Klinkert*).

Promotion of self-care and communal care could in any case influence the second decision-making process. *Hattinga Verschure* (1979) points out, moreover, that certain types of self-care remain possible (and desirable) even after professional care has been sought: ensuring that professional care is properly carried out (patient compliance, etc.), self-care in illness and self-care in handicaps. The professional can substantially enhance the competence of these types of self-care without usurping them.

Summary. The self-help phenomenon is attracting increasing attention. Self-help refers to the conviction that one can personally handle problems without resorting to profession services. The term self-help encompasses an individual aspect (self-care) and a collective aspect (communal care). The phenomenon is considered against the background of various social and scientific changes, particularly with regard to medicine.

The possibility of self-help postulates the limitations of professional care, faith in the power of the individual and, finally, confidence in the achievements of medicine.

For the medical practitioner, the confrontation with self-help may pose several problems: his attitude to self-help groups, differentiation between self-help and professional care, changes in the doctor-patient relationship, empirical expertise set off against professional expertise, and the evaluation of self-help practices.

If self-help is approached, not as antithesis but as complementary to professional care, then the professional can help to enhance the competence of self-helpers by education and information. In this way the decision to call in professionals can be made in a more responsible manner.

Samenvatting. Zelfhulp. Achtergronden, vooronderstellingen en problemen bij een nieuw verschijnsel. Het verschijnsel zelfhulp trekt steeds meer belangstelling. Zelfhulp verwijst naar de overtuiging dat men zelf kan omgaan met problemen zonder inschakeling van professionele hulpverleners. De term zelfhulp omvat een individueel aspect (zelfzorg) en een collectief aspect (mantelzorg). Het verschijnsel wordt geplaatst tegen de achtergrond van een aantal maatschappelijke en wetenschappelijke veranderingen, met name ten aanzien van de geneeskunde.

De mogelijkheid van zelfhulp vooronderstelt de begrensdheid van de professionele zorg, geloof in de macht van het individu en tenslotte de verworvenheden van de geneeskunde.

Voor de medicus zal de confrontatie met zelfhulp een aantal problemen kunnen oproepen, zoals de houding ten opzichte van zelfhulpgroepen, de afgrenzing van zelfhulp en professionele hulp, veranderingen in de arts-patiënt verhouding, het stellen van ervaringsdeskundigheid tegenover professionele deskundigheid en tenslotte de evaluatie van zelfhulppraktijken.

Wanneer zelfhulp niet als antithese maar als complementair aan professionele hulp benaderd wordt, kan de professional door voorlichting en opvoeding ertoe bijdragen de competentie van zelfhelpers te vergroten. De beslissing tot het inroepen van professionele hulp kan hierdoor op meer verantwoorde wijze worden genomen.

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Acknowledgment

I am indebted to my colleagues T. Carlier, general practitioner in Rotterdam, and A. Molendijk, head of the department of medical examination and supervision of the Rotterdam Municipal Health Service, for their comment on earlier versions of this article.