

Chapter 10

Living a Healthier Life Online: On Blending Professional and Experiential Knowledge in Online Self-Help Groups

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ABSTRACT

The chapter explores how organizations can facilitate online self-help initiatives in a manner that allows mutual aid to flourish between the participants. It takes a theoretical approach on the basis of pedagogy and self-help/mutual-aid research. It first develops an educational model, and then turns to practical aspects and investigates the Norwegian course “Living a healthier life – online.” The initiative is transformed from face-to-face to online as a design-based research project. The two most important elements to pay attention to in the facilitation of online self-help initiatives are found to be socialization and overall assignments: the former to prepare for mutual exchange of knowledge, and the latter to make content relevant to daily life.

INTRODUCTION

In self-help groups, people who share the same or similar circumstances or conditions discuss and share ways of coping as mutual aid (Borkman, 1999). Computer-mediated self-help groups suit those who for various reasons are prevented from

attending face-to-face initiatives, and they have existed for several decades; nowadays as discussion boards on the Internet, earlier on bulletin board systems (BBS). For the most part, such online groups have arisen from the same premises as traditional face-to-face groups: from fiery souls and mutual need, and they have been moderated and maintained on a voluntary basis.

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Nowadays online self-help groups are more often provided as e-health services by organizations within the public, voluntary and private sectors. As opposed to mutual need as a driving force, these stem from a demand for services to the target group. Nevertheless, mutual aid is a driving force, and the organizations' motive is often to help people to help themselves. In this article we explore how organizations can facilitate such online initiatives in a manner that lets mutual aid flourish between the participants.

Sharing knowledge of one's own experience, what Borkman (1976) terms 'experiential knowledge', is of great importance in self-help/mutual-aid groups, but is often not sufficient. This is reflected in the significant body of literature that concerns the role of professionals and professional knowledge in self-help groups (e.g. Matzat, 1993; Powell, 1987; Wilson, 1995). This body concerns in the main face-to-face groups, and literature concerning professional and experiential knowledge in online initiatives is, even outside the self-help literature, virtually non-existent. Furthermore, organizations in general possess knowledge of a certain topic, like cancer, diabetes or anxiety that they desire to impart. Due to its nature, this knowledge is to be considered as professional knowledge.

On this basis we adopt a theoretical approach to investigate how both experiential and professional knowledge can flourish and be amalgamated within online self-help initiatives. On the basis of pedagogy and self-help/mutual-aid research, we first develop an educational model that facilitates the amalgamation of professional knowledge and experiential knowledge. We then turn practical, and investigate the course 'Living a healthier life – online'. In the discussion we relate our findings to other initiatives where the exchange of experiential knowledge is central. From this we deduce some aspects that are vital when experiential and professional knowledge in online self-help initiatives is to be amalgamated.

BACKGROUND

On the basis of Borkman's seminal article from 1976, the body of self-help literature distinguishes between three kinds of knowledge: professional, experiential and lay. (1) Professional knowledge is developed, applied, and transmitted by an established specialized occupation that has financial and career interest in the topic. (2) Experiential knowledge is learned from personal experience and acquired by living through a problem firsthand. The experientialist is often thought of as the one in possession of a problem, like breast cancer or anxiety. Significant others, such as spouses, siblings or close friends, may also obtain experiential knowledge. This knowledge is not the same as that developed by the one suffering from the condition, but it overlaps somewhat. (3) In contrast to professional and experiential knowledge, lay knowledge is acquired by a bystander that has second-hand information of the problem, often from a combination of rumours, the media, professionals and experientialists (Borkman, 1976, 1999).

Professional and experiential knowledge relate to two modes of thought (Borkman, 1999). Professional knowledge is, according to Bruner, constructed within the "paradigmatic or logico-scientific [mode, which] attempts to fulfil the ideal of a formal, mathematical system of description and explanation" (1986, p. 12). On the contrary, experiential knowledge is constructed within the narrative mode of thought, which leads "to good stories, gripping drama, believable (though not necessarily 'true') historical accounts" (1986, p. 13). "Unlike the professional knowledge that is generated by logical and scientific procedures that can be weeded out by falsification; experiential knowledge can only achieve 'verisimilitude'." (1991, p. 4) For, narratives are bound to the context and thus their verisimilitude depends upon them appearing true or real in the context where the narrator is a central part. This makes professional knowledge more or less universal and context-

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