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Self-help, reciprocity and redistribution in a changing Welfare State

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Introduction

Self-help groups and especially new models of associations constituted by people suffering from various health problems, largely chronic diseases, have been growing in number and size during the last ten years in Spain. This phenomenon follows a similar path to other countries, but must be considered within the particular developments of Spanish social policy and the historical process of the changing relations between the state, health services and citizens. These are also related, beyond the health field, to a wider and deeper historical and cultural background. Though the subject of this paper is part and parcel of a more general stream, at least in Western societies, its specific use at the local level is the only one that can be observed and read as a real fact, closer than abstract definitions of reality which are perhaps more useful in explaining wider global developments.

In the Spanish case there is considerable confusion between genuine self-help groups and associations providing services or working to vindicate rights. Although both models are necessary for the affected people and are mainly created by the people themselves, they properly represent different forms of help relations with different meanings for their members. In order to analyse this phenomenon, I shall focus my argument on some theoretical key points, founded on classical concepts in Economic Anthropology. By analysing the roles and the workings of self-help groups and associations, we see how *reciprocity* and *redistribution* are very useful concepts to help us understand what these groups are, and the place that they occupy in these times when the welfare state paradigm is changing.

The various forms of reciprocity and redistribution are conceptual constructions proceeding from research on “primitive” or “traditional” societies. Although redistribution has become a core concept in social policy in our historical context, reciprocity is in danger of becoming an abstract ideal type and it is frequently neglected because it is considered to be marginal in urban-industrial societies. This marginal role is, to say the least, highly controversial, because reciprocity even exists between individuals and groups at the top of financial and political organisations. Anyway, it is necessary here to assert the cardinal role of reciprocity in relations involving help and care. Even if we help somebody who is unknown to us, perhaps somebody we will never meet again, we do so because we believe in a generic reciprocity which ideally would entail all human beings in an invisible web of real or potential mutual services. The awareness of our own fragility leads us to acknowledge that we need the help of others at some moments. In some sense, moral economy is more economic than moral, although ideology usually leads to confusion; therefore, we must always deal in applied work.

The main aim of this paper is to propose a model for analysing self-help groups and associations according to the prevailing role of reciprocity or redistribution in them. The prevailing drifts towards reciprocity or towards redistribution are two poles of reference, which define different practices in help and social support. The first one is more inclined towards self-help among peers, following the most accepted model of self-help groups. The second one is more involved in larger redistribution systems and is dealt with more by other kinds of associations and non-profit organisations. Their functions, organisational patterns, activities and, above all, meanings for members and their consequences in rebuilding the self-identity of affected people are very different in each case.

As well as its theoretical interest and the need to check the validity of these classic anthropological concepts in our context, the research has an underlying applied aim. After I had discovered self-help groups, I used a proposal by Menéndez (1984), which defined mutual help as a concrete form of reciprocity, in an attempt to provide an anthropological explanation for them. I’ll come back to this theoretical approach later. With these still very rudimentary theoretical tools I became involved in courses, conferences and symposia about the subject, sometimes addressed to health professionals, sometimes to associative promoters and sometimes to both categories. Those situations were very satisfactory because people involved in practice rarely ask anthropologists about theory. By discussing the different ways in which reciprocity works and how new meanings about the experience of illness are symbolically rebuilt in self-help, the people involved can understand their practices better and perhaps improve them. Finding a promising field that linked theoretical developments and applied work, and also feeling useful in it, was like a dream. But the dream turned into a nightmare when recently the confusion noted above took root in self-help organisations in Spain. Strengthening the theoretical approach became a compelling objective not only for the researcher's theoretical aims, but also for the people who were experiences the practical consequences of this confusion. Thus, the nightmare became a powerful stimulus.

A history of confusion and discourses on dependency

Here it is impossible to avoid explaining how the confusion between self-help groups and other kinds of associations appeared and was detected. In the late eighties and early nineties, when I first became aware of self-help groups, they usually matched the standard definitions imported from the Anglo-Saxon world. They were small groups, many of which were very unstable, characterised by horizontality in their internal relationships. The words *self-help* and *mutual aid* were used as synonyms (1). But at the time when confusion openly appeared, in the middle nineties, the people involved in these organisations begin to use the terms *group* and *association* indiscriminately, but progressively employing the latter. When I asked why they preferred the word *association*, some people answered that they considered both terms to be synonymous, but others, especially leaders and promoters, said that *association* was more useful, because *association* means an organisation with a legal statute giving more trust to people. «*To be an association is more serious*», one of them told me. Meanwhile, *self-help* was progressively preferred to *mutual aid.* If this last label was mainly, but not always, restricted to the most classic small groups, *self-help* covered a wide spectrum of associations constituted by affected people. This situation persists even now, and is further complicated by the frequent use of *self-help* to refer to care which individuals or families give to themselves, especially with preventive aims, instead of the more precise *self-care* (2). The new fashion of the so-called *inspirational* literature (literally "self-help books" in Spain), added further imprecision to the usual meanings of *self-help*.

My first detection of an incipient confusion was therefore a semantic one. It would not have been so important if it should had remained in the field of semantics, but at the same time deeper changes took place in practice, though they were well hidden at first. Some self-help groups realised that they needed to diversify their activities if they were to face new aims that members felt to be very important because of their own practice. These aims consisted of extending the news of the group to new people, having permanent places for meetings, searching for funding, getting more medical, legal and social information, demanding rights or specific services from authorities, sensitising society about their problems and so on. All this involved at least two different levels of action, both of which were perceived as absolutely complementary and necessary alike: self-help itself, on the one hand, and work in organisations, on the other. In that almost underground process, the way these different tasks were done in the practical life of groups was very revealing. Improvisation and voluntarism were the common rules. Very often, times and tasks were mixed in their meetings. Mutual support and help shared the same session with accountancy tasks, writing letters and putting them in envelopes, for instance. Everybody did everything, all the time. Thus, in this mixture of times and tasks, group members did not realise that mutual aid had been dumped in favour of organisation and a greater capacity for social and political influence. The search for this latter benefit – which is, of course, very important in itself – took a lot of time and work away from the specific aims of self-help (facing a shared problem, giving and receiving material and emotional help, learning new skills together, reinforcing autonomy and redefining members' own identity through sharing experiences, knowledge, strength and hope in the group) (Katz, 1981; Borkman, 1991; Roca, Villalbí, 1991).

A wide range of organisations are defined under the label *self-help* more through what they are not than by what they really are. Self-help has become a term used to name all organisations created to group people affected by a particular health problem (sometimes one's own illness, sometimes sickness affecting close relatives). Concurrent with that process of change from the original self-help groups to more complex associations, there also appeared a lot of new organisations, which did not experience the first step as mutual aid groups. This is an important fact, and it reflects a loss of autonomy in the initiative of affected people. Professionals, especially doctors and psychologists, increasingly intervened in creating groups and associations or supporting them from inside, sometimes also managing and leading them although they were not affected people. Confusion between self-help groups and support or therapy groups became an element present in our landscape. Although self-help groups may be an attractive alternative to medicalization, and they became a new object for professional intervention. It is important to remember here that the lack of hierarchical structure and professional intervention, except when the group specifically asks for it, are basic elements in all accepted definitions of genuine self-help groups.

At the same time that the above changes happened, another decisive factor came into play. In health and social policies all official administrations agree more or less on the principle of devolving part of their responsibilities for care and assistance to the people. *Civil Society* became a holy concept for social policy makers swimming in the stream of neo-liberalism hegemonic postulates and demanding profound reform of the Welfare State. Promoting associations became an explicit and important objective for them in order to discharge state administration of some direct implications in assistance. NGOs and associations located in the so-called *third sector* were considered more efficient and cheaper because they had less bureaucratic burden and, perhaps, because they were more subjectively involved in solving problems. The phrase *«to be an association is more serious»* (than to be "only" a self-help group), takes on a new significance in this context. Public funding is more attainable for associations since the administrations are also interested in promoting health associations. Of course, a necessary condition for applying for funds is that the association must be officially registered and has a formally constituted executive board. This also means that the association leaders become necessary interlocutors for the state agencies looking to delegate the management of services.

In Spain, however, the welfare state is still incipient and weak and it still supplies few services compared to average European standards. Therefore, in seeking care and assistance, the expectations of the majority should be the same for public agencies and services as for civil associations or NGOs. Though health services are the most developed branch of the Spanish welfare system, they are quite deficient for people needing special attention. For many affected people, new associations are simply perceived as providing the same services as public institutions, and they perceive themselves as users or clients according to patterns learned in public health services. The fact is – and this is what makes the difference – that associations offer services not provided, or poorly provided, by the public health system. Their own empowerment and full autonomy are not considered as objectives to be fulfilled by this group of affected people. So, although people join new associations voluntarily, the experiences and expectations of these people are perhaps not the same as those stated by people joining self-help groups.

Growing professional intervention and the place reserved for associations in the adjustment of the Welfare State must both refer to the same historical and cultural background, although at first sight they are different things. And they must also relate to attitudes such as those of dependant users on the one hand, or of leading professionals on the other. It is very important to remember here that self-help groups are an imported alternative in our country. Health professionals mainly introduced them and social workers that had found out about this kind of experience in other countries, directly or through literature. Usually, they respected the rule about accompanying the group in their first steps and afterwards promoting its independent life. These professionals were generally critical towards dependency in professional-patient relationships or they were fully convinced of the usefulness of self-help groups for patients' empowerment or as tools for dealing with problems where Medicine usually failed. These experienced professionals also found that not everybody would agree to join a self-help group. In fact, the most successful experiences were based on spontaneous groups when people began to meet in hospital services, unaware of what a self-help group was. But all these cases involved only a small minority of the potential membership. This kind of process still happens now, but it is conditioned by the attraction of formal associations. Although some associations are based on foreign models, they are usually based on a particular development rooted in Spanish conditions, with some variations due to historical, cultural and social diversity in different parts of Spain.

I want to emphasise that importing a structure from abroad is very different from importing meanings and ways of working. *Self-help*, as well as mutual aid groups, is an imported concept. If the English meanings of *self* are not easy to translate in a full sense, their applications are also prone to confusion. Something similar happens with the concept *autonomy,* so closely related to self-help. In the way *autonomy* is used here in Medicine, Psychology or Social Work, it is also a concept imported from another cultural universe. It is closely related to ideas about self-responsibility that are closely linked to Protestant concepts of individual and social behaviour. However, autonomy does not have a place in major everyday thought in societies with a Catholic background, where constituted help relations and related institutions are based on strong ties of dependency (3). Probably the celebrated individualism of Latin and Mediterranean people is only a stereotype, or it is reserved for public life, as a form of distrust in institutions. In current times, only people involved in the most competitive fields in the labour market embody anything like the concept of autonomy in everyday life, but health professions have done it for many years (at least, with reference to their patients). Although at first autonomy referred to physical capabilities, it was soon extended to psychological, social and moral meanings. Of course, this was the result of professional discourses from the most influential countries. In spite of this, many health professionals, especially doctors, are very suspicious of all forms of self-care, including mutual aid groups or any sort of practices which they do not control. Intervention through formal associations, where a hierarchical relationship between professionals and patients is maintained, is more reassuring for these professionals.

We should point out that reinforcing the autonomy of patients and their relatives is an idea that is consistent with policies looking to "return responsibilities to society" in fields related to assistance and caring. Returning to the central issue, it is possible now to assert that associations providing services which ignore mutual help or back it only on a secondary level, are better rooted in our social and cultural background than genuine self-help groups, at least in the way they are defined by theory. As a member of an association confessed once, *«we prefer to depend on an association belonging to us, but in any case we want to be dependent»*.

At this point I want to underline that the anthropologist must not be involved in technical or militant vindication of a concrete model of "good practice". He/she must only try to understand and explain how and why things happen, and perhaps remark on the benefits and difficulties of each way of working. The right to choose what to do belongs only to the people affected. Perhaps the confusion noted here allows transactions between theory and practice when the former is not adaptable enough to the context in which the latter is working. Conceptual indefinition may also be useful in this sense.

Mutual aid and reciprocity

The first step on the way to confronting the different types of organisations consists of analysing how mutual aid is generated in some models of reciprocity. Afterwards, we'll compare it with structures in which we can find another pattern of reciprocity and where functions of redistribution play a prevalent role. It is also important to relate the quality of the involved reciprocity with the possibilities it can offer in order to redefine the experience of illness in seeking a new "normality".

Here I prefer to use the term *mutual aid*, not only because it is closer to the Spanish *ayuda mutua*, but also because it allows us to avoid the more polysemic *self-help*, which also refers to other ideas like self-care, for instance.

Silverman (1980) said that mutual aid only happens when the person giving help and the person taking it share a history of the same problem. According to Silverman the process lies in mutuality and reciprocity, two terms which are often synonyms, though the second has a more precise and restrictive sense, at least for anthropologists. Many authors agree with Silverman and it is commonly accepted that reciprocity is the kind of relationship which distinguishes mutual aid from other forms of help:

> «The word help is defined as the action of giving a service or collaboration to somebody, or to put the means in order to fulfil something: the term mutual defines the reciprocity between two or more persons.» (Roca, Llauger, 1994: 214)

According to Menéndez (1984: 85), mutual aid groups are a modern variation of self-attention in health (*autoatención en salud* in the Spanish original), which is a structural and universal fact produced in domestic life. This author underlines the cardinal role of reciprocity in self-attention, following theoretical conceptions used by Mauss, Malinowski, Lévi-Strauss and Gouldner, among others, which were first codified by everyday practice. The basic norm of reciprocity asserts that a person is obliged to help whoever has helped him/her before. Menéndez also remarks that symmetrical reciprocity is essential for keeping equal relations between people, but reciprocity can also exist between asymmetrical positions. In this case, mutual aid tends to disappear; making it easier to establish relations based on dependency. Therefore, reciprocity only means mutual aid when it works between equal or equivalent people. Therefore, reciprocity acting as mutual aid needs a horizontal level in relationships which is not necessarily involved in reciprocity by itself (Menéndez, 1984: 91-92).

Following Menéndez's proposal it is possible to define those conditions in reciprocity that allow mutual aid: horizontality between partners and symmetry in things or actions exchanged. But in order to maintain this kind of reciprocity over time, it is necessary take into account a third factor: there should be no time restrictions on returning the help received. To exchange help depends on concrete needs at concrete moments, which are not always foreseeable. In this sense, it is different to exchanging gifts throughout the year on such well-known dates as Christmas or birthdays. In mutual help it is necessary to be able to return the debt with no fixed time limits. This means applying the concept of generalised reciprocity defined by Sahlins (1974)(4). In conclusion, horizontal, symmetrical and generalised reciprocity are the necessary conditions for discriminating reciprocity in mutual aid groups from relations involving giving and receiving help which we can find in other more complex and hierarchically organised associations. In these latter organisations there are help relations too, but the lack of horizontality and symmetry makes them different from mutual aid and favours dependency (5).

The theoretical frame described above has proved to be useful when trying to identify mutual help in empirical research. But these theoretical concepts can sometimes appear in practice as ideal types, formalised in a narrow *etic* approach and in conflict with real facts, which are more complex, polymorphous and fluid than concepts produced by theory. In an *emic* approach we find that reciprocity is an undefined reference, almost always unconscious and stated in a moral way. As is usual in everyday life, reciprocity is mostly perceived when somebody does not conform to its rules. Then, the complaints adjust quite well to the contents of theoretical concepts. Anthropological theories on reciprocity, when used to analyse mutual aid groups, show some weakness when they deal with complex interactions working over time. Theorists in an overly bilateral scheme have conceived definitions of reciprocity, while real interactions are usually multilateral. If we observe how the giving, taking and returning of services unfolds in groups, we can verify that the implicit bookkeeping of these exchanges is not, in fact, a bilateral one. The group as a whole acts as a general receiver, allowing individual members to balance their accounts without necessarily returning services directly to the same people from whom they received help previously. In this sense, *generalised* reciprocity takes another meaning. It can refer not only to the possibility of returning without conditions in time, quantity or quality, as Sahlins defined it, but also to a diffusion of giving and receiving in the group, all the members of which are subject to a common book-keeping. Therefore, members can feel that their actions and relations are altruistic, when in fact they are really following rules of reciprocity, precisely because they do not act in a bilateral way. In a certain sense, the group is like an impersonal redistributor. And because it is impersonal it does not disturb the horizontality and symmetry in relations between the members, avoiding asymmetries which redistribution tends to produce and which will be discussed below in this paper.

Reciprocity in redefinition of illness and self-identity

Beyond the conditions related to the dynamics of exchanges, one of the important keys for understanding why the mentioned forms of reciprocity are necessary in mutual aid groups is the close relation between these forms of reciprocity and the redefinition of the experience of illness and self-identity. This redefinition is important for affected people to be able to adapt themselves to their social world and to overcome the handicaps they suffer. Of course, not everybody succeeds, and some people make use of the group as a shelter which protects them from an adverse external world. Anyway, in a mutual aid group what is abnormal outside is the common rule inside, shared by all members. This gives meaning to the shared history of the same problem, in Silverman's words (see above).

One of the premises for fulfilling the forms of reciprocity that produce mutual aid is to answer questions about the necessary equivalence and symmetry between members in a group. Equivalence is a better term than equality because the members of a group are reall not equal in many respects, but the shared problem and similar experiences can give them the feeling of being equivalent enough. Of course, equality, equivalence and symmetry are ideal concepts which only can be applied in practice through pragmatic transactions. Anyway, the symbolical efficacy of mutual aid lies in factors that depend on a strong perception of equivalence and symmetry. If this perception is to be strengthened, the common problem may need to be emphasised, perhaps more than is apparently necessary. It is more than a question of identity. In this respect, external observers often think that members of groups are too obsessed with their own problems and illness. The well known formula *«My name is John and I'm an alcoholic»*, takes all its ritual meaning from this symbolical context (6).

Maintaining the best equivalence possible involves, of course, a positive identification between the people. The case of associations devoted to degenerative diseases, such as multiple sclerosis for instance, shows how the search for equivalence must be very strict on some occasions. If mutual interactions between people that are at the same stage of this disease prove to be useful, contact with people at a more advanced stage is usually felt to be very negative, a warning of the worst face of their own possible future. The perception of equivalence is broken because the potentially equivalent experiences are not the same at different stages of multiple sclerosis. Symbolic efficacy is then threatened by future fears and doubts are raised about the validity of the efforts that affected people are making to overcome the consequences of their sickness.

Establishing a sufficient degree of equivalence between members is a powerful reason for keeping professionals out. Strong leadership within the group is generally avoided, which is one of its greatest difficulties, while people try to replace the leader figure by other kinds of roles which are assumed to make the group work better (7). But this reason is not enough to keep professionals out. Some professionals are not authoritarian, but in a context of self-help there is something which only the members of the group can do: they can define themselves by giving a shared sense to the group and to the relations within it. If the definer is a non-affected professional, he/she can retain the power, which the act of defining confers by itself. Moreover, defining without sharing the history of the same problem introduces considerable asymmetry into the group, beyond previous asymmetries between "who knows" and "who does not know", so beloved by many professionals. I should also point out that professional empathy is much more limited in practice than the kind of communication that we can observe among people affected by the same problem. For instance, experiences, feelings, perceptions or fears shared by women with mammary cancer can be understood but hardly felt by others. One of these women told me once:

> *«My doctor does not listen to me when I say that I need my husband to caress the scar in my operated breast. But in the group we are always talking about these kinds of wishes...»*

Another woman, before her operation, spoke about a very common question in very common terms:

> *«According to my doctor I must be optimistic and live as if my cancer did not exist, making projects for the future, but I do not feel like it. My sense of future has changed. I'm living as if the future did not exist, but I'm well aware that my cancer does exist. Of course, I can go to a psychologist, but in the worst moments I cannot avoid thinking: 'What are you saying? You do not have a cancer!' (....) My family does not know how to talk to me. They only say: 'Do not think about it'. It's not so easy... They are the ones who really do not want to think about it! You need to live something if you want to really understand it.»*

This subtle difference between professional understanding and sharing feelings also makes the difference between the best professional intervention and mutual aid. People with good experience of mutual aid are keen to remark on this difference and many of them are convinced that nobody can fully understand it from the outside (8).

The group is also a field of symbolical interaction, which produces its own meanings and specific codes. So, the group goes far beyond its instrumental usefulness. Of course, the problem, which leads people to the group, is the first object that needs to be symbolically rebuilt. Moreover specific services or practical learning in each case affected people's need to orientate themselves, when faced with a situation that changed their "normality" and their position in the world around them. All these subjects must be redefined in order to give a new sense to life. In this way, "normality" also needs new definitions, free from all kinds of stigma. The term "temporally valid", employed by some physically handicapped people as a label for 'non-handicapped' people, expresses very well what I am trying to explain here. In a similar sense, the relation between the affected person and her/ his illness can undergo interesting changes. For instance, an asthmatic woman sketches her new relation with the disease in terms of friendship, after she has been re-elaborating it in a mutual aid group:

> «*Asthma is for me like a friend* (in the feminine, the gender that asthma is in Spanish). *She is quite a strange friend and you must know how to treat her.*»

As a good example of this seeking for new meanings of "normality", it is interesting to mention a group of parents whose daughters are anorexic. Because of their experience, members of this group show a radical rejection of professional intervention. In fact, the group has its origin in casual encounters in psychologists' waiting rooms, and even now psychiatrists and psychologists are the main targets of their criticism. They explain how in their former visits to these professionals they felt more and more guilty, increasing the feeling they already had. These parents are very lucid in their denouncing of the diffuse psychological impregnation our society is undergoing. A mother in this group says that she thought, before going to visit a psychologist, that in society there is a very elementary and mistaken understanding of some psychological assertions, but after being treated for some time by a psychologist, she now thinks there is not a big difference between the tendency to blame in the psychologist's office and in everyday social life. It is also interesting to remark how that group, at the beginning, tried to help her daughters and gradually it was more interested in empowering the parents facing their stigma as parents who "failed" in their duties. This drift has been very useful in order to overcome frustration, becoming more relativist in the belief in their possibilities to influence their daughters' cure. In fact, now they are helping their daughters better because they are less anxious and have improved their domestic relations.

The cases mentioned can help us to understand how horizontal, symmetrical and generalised reciprocity is a necessary condition in order to redefine illness and normality in an adaptive sense for groups' members. Of course, analysing all these facts we must work in an *emic* approach, avoiding interferences from professional languages and statements. In the process of redefinition in mutual aid we can observe interesting developments in illness semantic networks (Good, 1977, 1994), illness narratives and representations (Rappaport, 1993; Good, 1994), coming from the different fields where all involved persons built their own experiences.

Associations providing services: towards an industry of help?

In the city of Barcelona alone, 168 associations were registered at the end of 2000 under the label *Health Associations and Mutual Aid Groups.* Some of these associations have a short life or remain for a long time in an initial degree of development. As I have stated above, the origins of some of them were in mutual aid groups, while others were created by a leading group or directly by health professionals "from the top". In the first case, most mutual aid groups get lost on the path to becoming a more complex association. But a few associations, as in the mentioned example of women affected by mammary cancer, present a very interesting combination of formal organisation, supply of services and mutual aid group. Perhaps the intimate feelings related to the body, which they experience and exchange, make it easier to maintain structures based on genuine self-help. In general, where social stigma associated to sickness is stronger, mutual aid works better in spite of the hierarchical structures of the associations. In contrast, we can see how big associations group people affected by diabetes – sometimes a very grave illness, but the beneficiary of a social imagery that is closer to "normality"– provide services, teach abilities and sell clinical tools below market prices. And by so doing, they generate a big majority of passive users amongst their associates. And it is possible to find small groups of people everywhere interacting among one another as mutual aid groups in an informal way, while making use of other services or activities in an association. For instance, the physiotherapy service belongs to a foundation for multiple sclerosis (9).

The strongest associations are characterised by taking professionals as salaried employees. For some young professionals, to begin as volunteers in an association is an efficient way of finding employment in the future when it is very difficult to do the same in public services. This point is highly relevant to the process through which associations are increasingly becoming delegate agencies in the national health and welfare systems. The most powerful associations have activities and results that allow them to get more public and private funding. The increase in their economic resources and their more complex organisation reinforce the drift to creating more specialised roles in managing the association and to hierarchical structures, which follow the same bureaucratic schemes as public agencies or private business. Finally, achieving political influence is an important aim when negotiating with governmental departments, private funding providers (perhaps "politically correct" enterprises) or the most influential media.

Two years ago, a social worker expert in mutual aid groups made some speeches in an important association where mutual aid groups had never existed. Some people amongst her audience became very interested in the subject and they proposed that a group of this kind should be created in their association. The executive board angrily rejected their proposal, understanding it as a contest or a challenge to the existing organisation and its leadership. Only after a long argument, with the intervention of the social worker who had involuntarily sparked off the conflict, did the board accept a limited space for mutual aid. This story highlights very well the distance existing between the genuine mutual aid groups and this kind of association.

It should be pointed out that, with few exceptions mainly related to addictions, most members of in-groups and associations are female. If in some cases this makes relations based on mutual help easier, on other occasions it simply tends to reproduce a professional-patients hegemonic pattern, where women work very usually as mediators between their families and health professionals.

If we analyse how those associations get their resources and how they provide services to associated people, we find a typical scheme of redistribution. Some people, in this case the association's managers, get resources, concentrating and re-distributing them in accordance with established norms. Redistribution, of course, is a key concept in our societies as a way of acquiring better equality of opportunities. But redistribution is always a decisive way of building and legitimising power (Godelier, 1984). As new *big men*, associations are creating structures which, although useful and necessary for many people, also set up new positions, which enjoy power within their own organisations and welfare systems.

A provisional conclusion: on the need to link help relations and political economy

Under the label *self-help* we can find different forms of help relations which could be contradictory in many aspects. If mutual aid is an alternative way of medicalisation, other organisations that have recently appeared in Spain and have also made use of the terms *self-help*, are in fact delegate entities that assume their part in managing governmental redistribution policies, and also maintain the established models in professional-patient relationship. The hegemonic, economic and political tendencies in Europe, and almost everywhere, lead us to think that these developments will be more visible in the near future. Taking into account the tradition of dependency on institutions devoted to giving health care and to helping people in distress, deeply rooted in our historical and cultural background, it becomes necessary to clarify the ideas and concepts related to help and care. These aims are increasingly relevant when an increasing number of patients, or potential patients, are criticising more and more the hegemonic bio-medical model. Not only through ideological assumptions but also, in a big majority, based on their own experiences. At the same time, health professionals feel more distressed every day. These facts are closely related to the growing prevalence of chronic diseases, which are a difficult challenge for a medical practice that is unable to produce miracles in these pathologies, and also for health systems which are full to overflowing because of the prevalence of chronicity. In this context it becomes necessary to gain a deep knowledge of help and care relations, which is an important responsibility for social scientists on two different levels: as a contribution to improving health policy and in advocacy for patients and their relatives needs and rights. Moreover, when appeals to holy duties in the domestic and familiar frame, that is to say to women's traditional duties, are not so successful as they were in the past.

In the topic treated in this paper, discriminating between actions based on reciprocity and others based on redistribution systems shows that classic concepts from Economic Anthropology can be useful when they are applied to new objects of research and are linked to the more specific contributions made by Medical Anthropology. I think that this bringing up-to-date of classic concepts, which are sometimes linked too much to the old objects of Anthropology in "primitive" and "traditional" societies, is one of most interesting contributions that Medical Anthropology can bring to general Anthropology. In the same sense, research on so-called "micro-social" facts, as help relations apparently are, reveals the need to establish relations between different levels of social reality: general and specific aspects of culture, local and global developments in history, institutions in the widest sense, health and welfare systems and a wide range of facts which can be included in political economy. Medical Anthropology must deal with complexity and is therefore an excellent ground for learning how to overcome constrictions imposed by traditional observing units. As the Catalan anthropologist Lluís Mallart (1992:13) wrote: «Anthropology it is nothing more than the art of tying strings.» (10)

Notes

(1) In Spanish, *autoayuda* and *ayuda mutua,* respectively.

(2) *Autocuidado* in Spanish. For a useful comparison of concepts referring to care in their different dimensions, see Haro (2000).

(3) Beyond the involvement of churches in activities related to help and care, we must take into account that religion has been the last complete cosmovision, keeping an important influence on attitudes and behaviour with a heavy moral burden.

(4) Specially in chapter 5.

(5) Of course, dependency between individuals, in a more psychological sense, can always exist in horizontal and symmetrical reciprocity.

(6) In its origin that saying was adapted from a religious way of redemption.

(7) Training for implement those roles is a common activity in agencies supporting groups from outside (*clearinghouses* in the Anglo-Saxon world). In Barcelona there is an agency depending from the city hall and in Madrid another linked to regional government. But their main offer in training refers to managing in associations.

(8) For a suggesting distinction between *perception* and *experience as a feeling* (*vivencia* in the original Spanish), see Valderrama (1995: 17).

(9) It is interesting to remark how the marginal place of mutual aid in associations reflects the same place of self attention in the domestic frame seen from the institutional health system.

(10) Literal translation. The equivalent English saying is *to put two and two together.*

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