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Posted Date: 20 February 2024

doi: 10.20944/preprints202402.1047.v1

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Article

# Study Circles as a Possible Arena to Support Self-Care—A Swedish Pilot Study

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**Abstract:** Today, issues related to people's mental health and well-being have been described as a challenge for society, globally as well as in Sweden. This calls for new approaches to mental health promotion. The aim was to evaluate the adequacy of the content and structure, describing experiences of study circles as a means of supporting participants' self-care and self-compassion. The overall design is a descriptive, QUAL+quan design, where quantitative and qualitative results are integrated. Five participants participated in a focus group interview, of whom four completed questionnaires. One individual interview was conducted with the study circle leader. Study circles can be an arena for mental health promotion as learning and sharing of experience contributes to a sense of coherence, as well as self-compassion and a genuine concern for one's own and others' wellbeing, but not considered an alternative to psychiatric care, for those in need of professional services. Study circles can be a possible means to support self-care and thereby promote mental health in the general population, and a valuable contribution to public health. However, in addition to modifications of the content, further research is needed on the qualifications for study circle leaders as well as the dissemination of study circles.

**Keywords:** mental health; mixed methods; self-care; self-compassion; study circles

## 1. Introduction

Today issues related to people's mental health and well-being have been described as a challenge for society, globally [1] as well as in Sweden [2]. This has been a problem for decades, but the Covid-19 pandemic further added to this problem [3]. These figures do not include people with psychiatric diagnoses. Rather they represent people struggling with symptoms, such as worries, anxiety, insomnia, and altered mood, that negatively affect their well-being and quality of life without fulfilling all the criteria needed for a psychiatric diagnosis according to DSM-5. Consequently, more people turn to healthcare facilities with problems that are not within the realm of the service providers' responsibility. It has been argued that the incorporation of "mental ill health" in ordinary language has contributed to a psychiatrization of ordinary life problems [4]. In addition, people who frequently contact healthcare services describe problems in coping with their ordinary lives [5]. Psychological distress is also associated with poor work ability [6]. This is also in line with a person-centred approach to mental health as an experience of life as meaningful and oneself as capable of managing problems encountered in life [7].

Educational groups that include self-compassion and are organized by the healthcare system and led by professionals can contribute to experiences of stress reduction, well-being, and confidence in managing stressful situations in different clinical contexts outside psychiatric care [8,9]. However, as the World Health Organization, (WHO) [10] guidelines put forth that self-care must work as an extension of the health system, it is important to explore new approaches to strengthening people's self-care skills on a societal level. In this article, we will describe a pilot study where we introduced a study circle (SC) focusing on self-care and self-compassion, as the latter has been suggested as being as important for self-care as compassion in the care of others [11].

Even though SCs exist in different parts of the world, their status in Sweden as a mass phenomenon has been described as rather unique [12]. Their history dates to the first decades of the 20<sup>th</sup> century when they provided an opportunity for people to educate themselves and gain knowledge outside of university [13]. Today SCs are organized by study organizations, such as the Peoples University (Folkuniversitetet) and the Worker's Educational Association (ABF). Their content could vary from theoretical, more or less academic courses to practical skills training. SCs are partly financed by state subsidy and led by laymen with knowledge and skills in the specific subject [12]. Hence, it could be a possible format for disseminating knowledge on self-care and mental health outside the healthcare organization. Previous research is sparse, but SCs have been presented as easily administered and cost-effective health-promoting interventions [14].

Orem [15] highlights the importance of supporting patients in upholding their self-care needs. However, self-care cannot be reduced to knowledge and skills. For example, nurses do have sufficient knowledge about the importance of self-care, yet they often fail to execute self-care in their own lives [16]. To succeed, self-care needs to involve both a genuine concern and compassion for oneself [17].

Self-compassion includes three aspects 1) the ability to be consciously present and available to oneself and in touch with one's feelings (mindfulness), 2) understanding that to be human is to be vulnerable and that no one is perfect (common humanity), and 3) the ability to be kind, show concern and not being judgemental towards oneself (self-kindness) [18]. Self-compassion is also associated with less psychopathology and stress, as well as with increased resilience and self-care [19,20].

#### *Context and Aim*

The point of departure for the SC was a therapeutic group programme on a cognitive, relational basis (CRGP) that was originally developed for the treatment of patients on long-term sick leave in connection with work-related depression [21]. The CRGP was modified for preventive purposes among people with stress-related health problems and shorter periods of sick leave [22]. The CRGP was modified further to be used as a SC.

The SC consisted of an introductory session and six group sessions of 90 minutes which took place 1-2 weeks apart. The structure and content are described in Table 1. In addition, the participants received written material to support learning and further reflections.

**Table 1.** Overview of the Study Circles.

| <b>Joint structure for all sessions</b>   | <b>Session Themes</b>  |
|---|--|
| Mindfulness exercise  | Session 1: Caring for myself and things that matter in life  |
| Follow up, reflections on last session's theme and experiences of homework (1 session, reflection on being in the SC) | Session 2: My emotions - friends or enemies                  |
| Group leader introduction of a new theme  | Session 3: My thoughts - facts or prejudices                 |
| Joint reflection on the theme   | Session 4: Competencies that can facilitate my everyday life |
| Self-assigning of homework  | Session 5: Communication and interactions in relationships   |
| Mindfulness exercise  | Session 6: Everyday living as the basis for a valued life    |

To evaluate the adequacy of the content and structure, we designed a pilot study aiming to describe the experiences of the SC as a means for supporting participants' self-care and self-compassion.

## 2. Methods

### 2.1. Design

In this study, the design was informed by Dattilio, Edwards and Fishman's [23] recommendation to use case studies within a mixed methods approach, as well as Clark's [24] impetus on accounting for the interplay between theories, and how they inform practice when developing new treatments. The case is our pilot SC and the theoretical point of departure the person-centred approach to mental health described above, as well as an understanding of self-care and self-compassion as contributing to experiences of mental health. The overall design is a descriptive QUAL+quan mixed methods design [25], where quantitative results are integrated with the presentation of the qualitative findings.

### 2.2. Participants and recruitment

People were invited to the SC in conjunction with an open lecture about mental health and self-care in the municipality's library. Five participants were recruited. However, one participant did not complete the questionnaires. Participants were women between 42 – and 59 years old, and all had employment and a structured social life. The study circle leader (SCL) was a licensed cognitive therapist with many years of experience both with individual and group psychotherapy, including the CRGP.

### 2.3. Data collection

Qualitative data was collected after the last session. The third author conducted a focus-group dialogue with participants and a semi-structured interview with the SCL. In the focus-group dialogue participants were encouraged to recall and jointly reflect on their experiences of the SC and its impact on their self-care and experiences of well-being. The interview with the SCL focused on experiences of possibilities and challenges associated with leading a SC. The focus group dialogue as well as the interview was transcribed verbatim.

In addition, the participants answered questionnaires on three occasions, at baseline, after the last session, and as a three-month follow-up, including the Self-Compassion Scale (SCS) [26] and Sense of Coherence (SOC-29) [27]. SCS is a 26-item self-report questionnaire that reflects the three dimension of self-compassion and their counterparts [26]. SOC-29 has a salutogenic perspective on health and refers to comprehensibility, manageability, and meaningfulness in life [27], and has a strong relationship with mental health and self-care ability [28].

### 2.4. Analyses

Qualitative data were analysed using qualitative content analysis [29] in cooperation between the first and the third author. The transcripts were divided into meaning units, that were condensed and coded. Thereafter nine sub-categories and three categories were formulated and synthesized into a theme. While categories and sub-categories describe *how* the phenomenon (i.e. SCs) is experienced, the theme linking them together focuses on describing *what* is experienced at an abstract level [29]. The process is exemplified in Table 2.

**Table 2.** Example of the process of analysis.

| Meaning unit (quote)   | Condensed Meaning units                                      | Code              | Sub-categories                      | Categories                       |
|--|--|-------------------|-------------------------------------|----------------------------------|
| When we talked to each other, when we were allowed to share and someone listened, and it's very special when the group says "No, what do you say?" | Being allowed to share while others are listening is the key | Being listened to | To be mutually engaged in narration | To share experiences with others |

|   |  |                                  |  |  |
|---|--|----------------------------------|--|--|
| Oh, tell me more." I think that is a very important key   |  |                                  |  |  |
| Yeah, but I think it's good that an occasion would have to be like this that you look at everybody's experiences and how it all ties together and ... for me, communication, and relationships, I think, communication to others, communication to myself and ... and relationships, relationships to others, relationships to myself | You look at how experiences are tied together, for example, communications and relationships | Reflecting on experiences        | To integrate experiences with knowledge  | To develop new understandings and competencies |
| It is required of a conversation leader ... to be able to handle strong emotions, to be able to handle silence, and so on, and how do you get people to talk. But also, what tools can you give if you see that this is a person who might need something else?   | The conversation leader must be able to guide the conversation and adjust to people's needs  | SCL has control and is attentive | To balance between structure and freedom | To navigate new ground                         |

Concerning the quantitative analyses, the SOC and SCS scales are presented with mean scores and standard deviations. For measuring the effect size the Cohen's *d* was used to present differences in terms of standard deviation units in relation to the SC.

### 2.5. Ethical considerations

The study was approved by the Swedish Ethical Review Authority (Dnr: 2021-04928) and in accordance with the Helsinki Declaration. Information regarding the aim, the confidentiality of data handling, and voluntariness were provided verbally and in writing, and participants gave their written informed consent. To provide a safe environment for sharing experiences, issues relating to confidentiality between group members were jointly reflected on in the informational meeting.

## 3. Results

The presentation of findings is structured around the categories and sub-categories that arouse from the qualitative analysis, ending up in a theme describing the SC as an *arena to create changes* (Table 3).

**Table 3.** Overview of qualitative results.

| Sub-categories   | Categories                                     | Theme                      |
|--|--|----------------------------|
| To be mutually engaged in narration<br>To normalize emotional struggles<br>To be equal with others       | Sharing experiences with others                | An arena to create changes |
| To integrate experiences with knowledge<br>To increase one's self-care competencies<br>To stay committed | Developing new understandings and competencies |                            |
| To balance between structure and freedom<br>To allocate the appropriate time<br>To spread the word       | Navigating new grounds                         |                            |

In line with the QUAL-quant mixed methods approach quantitative data are integrated with qualitative data. An overview of quantitative data is presented in Tables 4 and 5. In summary, there was a significant change between the total SOC 1 and SOC 2,  $t(3) = -2.08$ ,  $p = .025$ ,  $d = 4.16$ , but no significant differences between the subscales. There was no statistically significant change between the total SCS. Among the subscales there were significant changes between Self-kindness 1 and Self-kindness 2,  $t(3) = -4.90$ ,  $p = .016$ ,  $d = 2.45$ , and Self-judgement 1 and Self-judgement 2,  $t(3) = 8.33$ ,  $p = .004$ ,  $d = 4.17$ .

**Table 4.** Sense of Coherence, SOC. Subscales and total scores.

|                   | Before SC<br><i>n</i> = 4<br>mean (SD) | After SC<br><i>n</i> = 4<br>mean (SD) | Three months after SC<br><i>n</i> = 2<br>mean (SD) |
|-------------------|--|---------------------------------------|--|
| Meaningfulness    | 45.00 (5.60)                           | 47.50 (6.24)                          | 45.50 (0.71)                                       |
| Comprehensibility | 45.50 (8.81)                           | 47.00 (10.65)                         | 52.50 (10.61)                                      |
| Manageability     | 51.00 (14.21)                          | 52.50 (11.36)                         | 49.00 (14.14)                                      |
| SOC Total         | 141.50 (27.14)                         | 147.00 (25.47)                        | 147.00 (25.46)                                     |

SC = Study Circle.

**Table 5.** Self Compassion Scale (SCS). Subscales and total scores (Self-judgement, Isolation and Over-identification reversed).

|                     | Before SC<br><i>n</i> = 4<br>mean (SD) | After SC<br><i>n</i> = 4<br>mean (SD) | Three months after SC<br><i>n</i> = 2<br>mean (SD) |
|---------------------|--|---------------------------------------|--|
| Self-kindness       | 3.05 (1.04)                            | 3.85 (0.81)                           | 4.30 (0.71)  |
| Self-judgment       | 11.90 (5.12)                           | 10.10 (4.96)                          | 7.90 (5.23)  |
| Common humanity     | 4.06 (0.24)                            | 3.94 (0.43)                           | 4.12 (0.53)  |
| Isolation           | 9.44 (4.58)                            | 8.38 (4.10)                           | 9.75 (4.60)  |
| Mindfulness         | 3.44 (0.66)                            | 4.12 (0.32)                           | 3.75 (0.35)  |
| Over-identification | 11.88 (4.05)                           | 9.25 (2.80)                           | 9.00 (5.30)  |
| SCS Total           | 80.50 (18.66)                          | 92.25 (14.31)                         | 95.00 (21.21)                                      |

SC = Study Circle

In the following text, sub-headings refer to categories, while sub-categories are integrated in the text and written in *italic*. To adjust for grammar the naming of them is slightly modified in the text.

### 3.1. *Sharing experiences with others*

The SC provided an opportunity to share experiences with others on equal terms, *to be mutually engaged in narration*, and thereby receive and give support and compassion.

To be able to tell and get compassion from others and so on. When memories fade, you will remember things (like this sharing) that are connected to emotions better.

This was also acknowledged by the SCL who put forth participants' engagement and willingness to jointly reflect on their experiences in relation to the SC themes. Sharing experiences in an SC also enabled participants to *normalize emotional struggles*. This was discussed as being less stigmatizing than a therapeutic group session within the context of (mental) health care. Normalizing emotional struggles could also be related to the comprehensibility subscale in the SOC.

Being in a situation where one was involved in joint exploration rather than treatment, made a difference and contributed to a sense of *being equal with others*. This was also in line with the SCL's experience.

There is a difference between patients and people who are interested and attending an SC. [— ] What they wanted to talk to each other about had an impact and it was much more relational and self-reflective work [than with patients].

Hence, sharing experiences with others on equal grounds contributed to a sense of not being the only one experiencing challenges in life. This corresponds to the results from the SCS and experiences of an increased common humanity and decreased isolation.

### 3.2. Developing new understandings and competencies

The theoretical material, i.e., the texts provided to read and reflect on between sessions was perceived as adding nuances to the reflections made during sessions. This contributed to an increased self-awareness as emotional, cognitive, existential, relational, and behavioral *experiences became integrated with knowledge*.

So, this is what really matters, to create this sensitivity for when things suddenly change, when the weather changes inside me. Yes, here comes the new weather. What happened? Can I discover (more) or return this way? There are things that are ... well, directly applicable.

This could also be understood in terms of being mindful, in contrast to over-identification (SCS), and contributing to *increased self-care competencies*.

Self-care can be several different things. How I speak to myself can be one thing, or how I feel can be another. But it can also be keeping routines and managing commitments [---] but also dealing with conflicts.

This could be understood as becoming less self-judgemental, and demonstrating more self-kindness (SCS), but also as increased manageability (SOC). Developing new competencies was also challenging, and participants sometimes failed/avoided to assign themselves personal homework between sessions. Hence, they highlighted the need for more structured "homework" between sessions as a complement to the written materials. This was described as a means *to stay committed* between sessions, and not just read through the material and think "This was interesting". The SCL also noted a need to develop general assignments that could give support and directions to the homework, but still be flexible enough to adjust to participants' individual needs.

### 3.3. Navigating new grounds

While the previous categories are related to the content of the SC, this category departs from participants' and SCL's reflections on what needs to be considered in future development based on their experiences from the group. Participants as well as the SCL highlighted the need *to balance between structure and freedom*. The SCL should lead the way, but also give space for participants to elaborate on their reflections, and if necessary, regulate people who tend to dominate and take care of emotional responses that might arise. The SCL also pointed out that the less experienced a SCL is, the higher the need for structure. There is also a need *to allocate the appropriate time*, both to make more practical exercises in sessions and to commit to and follow up on homework to create a personalized plan based on the insights made during the SC.

Then you could leave for the last time and have a little plan for yourself that 'yes, but this is important to me, to take better care of myself, I would have to prioritize this and this and then I need to work a little more on this and that'.

SC was perceived as a valuable alternative to therapeutic interventions, building on trust in peoples' capability to address challenges in life as fellow human beings (common humanity, SCS). Hence, participants also described an urge *to spread the word*.

It could be like this wonderful guerrilla activity. You just spread it like this and then people sit and talk on their own and (are able to) take care of it.

Hence, engaging in a SC could be described as a meaningful (SOC) activity if people are willing to invest time in it. The theme highlights the SC as **an arena for change**, as the sharing of experiences with others as well as the content of the SC contributed to new understandings and competencies. SC was also described as an opportunity to create change in a wider context.

#### 4. Discussion

This pilot study indicates that SC can be a possible arena for mental health promotion as learning and sharing of experience contributes to a sense of coherence, as well as self-compassion and a genuine concern for one's own and others' wellbeing. These factors have been associated with people's psychological wellbeing [18]. This could partly be understood as related to the content and its focus on mindfulness as well as different aspects of psychological functioning. However, as described by Kumpusalo and Pitkajarvi [30], there is a relationship between perceived health, self-care activities and social support. Thus, as the SC is also an opportunity to bring people together it could also be the human encounters during the SC that contribute to the findings. Nevertheless, the SC was perceived as beneficial for participants, which calls for further studies. The findings also highlight that further modifications are needed: to set off more time for each session, and add further sessions to the material, including more specific between-session homework. SC may also benefit work groups of nurses, as they do not always translate their knowledge about self-care into their own lives [16].

Another issue is that the pilot SC was led by a licenced psychotherapist. This was motivated at an early stage, but to disseminate SC there is also a need to establish a system where SCL could be recruited among people with less formal competence. One possibility is to introduce SC in primary health care as a means for health promotion, and thus assign SC leaders to professionals who are not psychotherapists, yet who are familiar with self-care issues.

##### 4.1. Methodological considerations

This study was undertaken as a pilot study, accounting for the experiences of participants and SCL in one SC. In line with Dattilio et al's [23] recommendation, we have used a mixed methods design framed as a case study. This allowed us to follow the dissemination of the SC, and to merge and reflect on different aspects related to the process. This closeness, and the fact that authors 2 and 3 were involved both in developing and disseminating the SC, is considered an advantage but also a challenge. As researchers 2 and 3 are familiar with the original CRGP [21] and previous modifications of it [22] and have implemented it in different contexts, comparisons and adjustments were facilitated. On the other hand, such closeness could bias the study. To balance this, the first author was invited to be part of the analysis and interpretation of data.

By describing participants, data collection procedures, and the analysis steps, trustworthiness was ensured in line with Graneheim and Lundman's [29] recommendations. A limitation was the low number of participants. However, the aim was not generalizability to a wider population at this stage, but rather to test the format as well as the suitability of the measures for further studies. Therefore, we claim that this pilot study can be a basis for the continuation of the project.

#### 5. Conclusions

SCs are not considered an alternative to psychiatric care for people in need of professional services. Rather SC should be understood as a possible means to support self-care and thereby promote mental health in the general population. Hence, SC can make a valuable contribution to

public health. However, in addition to modifications of the content, further research is needed on the qualifications for SCL as well as the dissemination of SCs.

**Author Contributions:** All authors contributed to the conceptualization of this study and reviewed manuscript drafts. Data analyses were conducted by BK and LWG.

**Funding:** This work was supported by Malardalen University for the research, authorship, and/or publication of this article.

**Acknowledgments:** We thank all for sharing their experiences, as well as Monika Spindler who coordinated the work at Folkuniversitetet, Vasteras.

**Conflicts of Interest statement:** None declared.

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