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Liturgical categories and ritual process⁽¹⁾.

The Nordic welfare states encounter with workplace health problems

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An anthropological approach to health in the Norwegian welfare state

This study starts out from a problem area of growing importance in the Nordic welfare states; people who do not function adequately when fitting into the system of their workplace due to what is defined as health problems. I have chosen two very different groups to illustrate my point. The first group is pupils in elementary school who have behaviour disturbances and therefore can not follow their class in the ordinary educational programme. The other group is employees with chronic, diffuse musculoskeletal pain that prevents them from functioning in their job.

My aim with the study is to see how the system deals with these problems and how the individuals themselves can be empowered to take alternative strategies to the system approach. My presupposition of the Norwegian system is that solving health problems is seen as the responsibility of the state. The state is a bureaucratic organisation that needs a set structure and routine to deal with each case. Individuals are put into categories so as to fit into the structure. These categories derive from a medical system of diagnoses. What happens when the system does not function any more because the individuals do not fit in the categories?

The two cases are chosen because they represent two very different approaches both from the welfare system and from the individuals involved, in a situation where the established concept of how the state should take on and solve people's health problems do not work. The psychologists and pedagogues working with 'difficult' pupils find more and more complex sets of problems that are not so easily solved within the established system. The employees with chronic, diffuse musculoskeletal pain have more or less been abandoned by the ordinary medical system.

I do not intend to find a solution to these problems through my study. I don't think there is just one, but many, as will be evident in the description of the rehabilitation programme for the employees with musculoskeletal pain. I only want to look at the system from an anthropological standpoint, and view the medical system and the welfare organisations as cultural systems constantly facing new complex problems and making continuous adaptations. In these adaptations there is also a power aspect that needs to be detected to make the people involved able to act according to their interests. Motivating the study lies a concern for people losing not only control over their own lives but also important life quality by being defined as 'outside' of standard normality. Empowering them requires a demasking of discursive power in the Foucaultian sense.

The Nordic (2) welfare state overflowing

The Nordic welfare systems are considered to be some of the most successful in the world. Practically all groups in society not able to support themselves are covered, in one way or another. Poverty is less frequent and class differences smaller than in most societies. After WW II the notion of the state as a home for everyone was actively used by the politicians, connotating that the state would take care of everyone's needs. This was first and foremost the programme of the social democratic parties, but gained massive support from the majority also in most of the other political parties. In spite of the changing colours of the governments in the last 30 years, the welfare state has been maintained and developed.

The 'home' as a metaphor for the state has, as I see it, had very important implications for welfare policy. From the start it connotated safety and security for the weak and support for major taxation of income from those who had work and could support themselves and their families in a notion of national solidarity. But especially over the last 20 years the aspect of the solidarity with the weak has given place to a notion of 'home for all' meaning rights for all. The state has become the 'allfather' that is obliged to solve everyone's problems. To twist the old slogan 'Do not ask what your country can do for you but what you can do for your country' – it is rather; 'Do not ask how you can help yourself, but; isn't the state going to do anything about it?'

I not aiming a critique of the Nordic welfare states here. Doing anthropology at home, I am also a member of this society, and in that capacity a strong supporter. But as an anthropological observer I see a system that has taken on too much for itself. The welfare state has become a container for problems, and it is about to overflow.

The watershed was with the massive unemployment that hit the western world towards the end of the 1980's. The number of people that could no longer support themselves grew enormously and had to be dealt with politically. The state had to take on new and costly responsibilities. To compensate – to some extent – costs were cut and services rationalised in other fields. For our purpose here, two aspects are important. The state tried to save costs in the school system by having bigger classes, effecting the possibilities for the teachers to give 'difficult' pupils extra attention. On the labour market the possibility for early retirement for those with health problems were made easy to free jobs for others. These are only two small pieces of a big picture. But they represent two important trends; the professionals producing the welfare services, like education and health are continuously being stretched to produce more. The slack that gave them time and resources to deal with the extras, like the difficult pupils, was cut. The second is the extra expenses the state has taken on through pensions. This is a major problem in Germany and France, but also an important factor in Nordic public finance.

The cultural logic of liturgical categories

As a political system with a need for legitimisation the welfare state has to be organised in a way that is seen as just by the overall majority of the population. So just treatment is an important issue. Dealing with thousands of people in a just way can only be done within a firm structure. So the welfare state has developed structures and routines that secure at least a notion of equality for people approaching with their problems. In matters of health this question also has to relate to the scientific categories of medicine.

When the MAAH-meeting sets 'liturgies and rituals in health and illness' as a main subject, new and metaphorically rich associations are given to this material. Liturgy is to me one of the main inventions by which the church maintains its continuity and legitimacy. Liturgy is a system of acts with a predefined meaning that the individual goes into and takes part in. By taking part, the individual is absorbed into the collective, the church. The liturgy is not subject to negotiation. By taking part, the individual accepts the rules, but expects salvation. Seeing the Welfare State as an organisation with a liturgy for dealing with health problems creates interesting perspectives.

When the parents or the teacher of a 'difficult' child reports problems, the 'priests' – the psychologists or pedagogues – take action. The child is interviewed and tested according to set routines, evaluated, and then sent on to medical experts to be diagnosed. If the child is found to be 'outside' normality, that 'outside' needs a categorical description accepted by the system; a diagnosis. The diagnosis will then trigger rights to special treatment both in the health and the school system.

What is striking for me as an outside observer is the variation both in concept and description of the condition of the child by the psychologists. My prior mapping of the field left a picture of a strict and well-defined system of categorisation based on ICD-10. Interviewing the leaders for the unit (3) they described a system in which the pupils were tested scientifically and followed up accordingly. When I then interviewed some of the psychologists their description varied, and they were less scientific in their language. They seemed to avoid ICD-10 terminology, and talked about 'overactive', 'reduced concentration', 'learning difficulties', 'psycho-social problems' and the like. They worked actively with parents, teachers and others around the child, and the child, to work out solutions and were not particularly quick to go for diagnoses. If they found this necessary, the child was sent on to a medical institution with the psychiatric authorisation to diagnose.

I have yet to collect significant material on the actual practice of diagnosing, but according to the professional personnel the parents often pushed for an evaluation and possible diagnoses. That would strengthen their demands for resources on behalf of the child.

The diagnostic system can well be seen as a cultural system in the Geertzian sense (Geertz, 1973) but with important modifications in practical use. Obviously knowledge of the system differs, which influences the work of the culture as Keesing pointed out (1994). But it is still a fairly complete system that can be described. Its function seems to be important for regulating the justness and thereby giving legitimisation to the whole welfare system.

The room for agency

What I see at stake here, besides a liturgy for justness, is normality. It is normal for children to be a little active and wild and lacking in concentration sometimes. And the normal must be accepted within the ordinary limits of the system. But where is the border between normality and abnormality? As far as I can see, this is negotiable. If the child can function in a way that is acceptable to the teacher and the other children, and the parents don't demand more resources, the liturgy is not carried on. But if one of the parties presses for a category that gives more resources, then the liturgy has the necessary parts for that as well.

The process that defines the child as normal or abnormal can be seen as a discursive process in the Foucaultian sense. The school system enforces a rather strong form of discipline on the children by demanding that they respect strict rules in the classroom. But the system also gives them some slack because it tolerates some degree of 'wild', 'overactive' or 'unconcentrated' behaviour as part of the normal. The teachers and the front line of psychologists work to maintain the child within the frame. But if children are seen to be too troublesome they are sent to be diagnosed and thereby labelled as abnormal. Psychologists and psychiatrists take care of that in the second line, institutionalised within the medical system. To be diagnosed is clearly stigmatised, but in a social democratic way. The welfare system takes care of the abnormal as well as the normal. The pupils get a strengthened school situation with more resources.

Following Foucault and Austin, Judith Butler points to the space for agency that is left between the illocutionary and perlocutionary aspect of a speech act in her theory of performativity (Butler, 1997). To me, a diagnosis is a very typical speech act. When the medical expert points to the child and says 'ADHD' (the most common diagnosis), he or she makes the child the diagnosis. The whole system around the child is programmed to act on this new characterisation. The diagnosis is not negotiable as it is 'scientific' and out of the hands of the child and the parents. It follows a 'divine' logic beyond the people involved. But it implies a great deal of power. This is not the power of one person over the other, in the Weberian sense, but can best be seen as a discursive power in a Foucaultian sense. It is a liturgical power. The performers only carry out the needs of the system. And not only that, they are seen as helpers. They help to find a category for the children so that they can still have a place in the system. That is the intention of the diagnosis, the illocutionary aspect of the diagnosis as a speech act.

But, as Butler points out in accordance with Austin (Austin, 1962), the speech act has an effect that is not causal to the illocutionary aspect. The object, the one addressed, can react in ways taht were not intended by the addresser. In the case of diagnoses of pupils, this happens when the parents react as activists for the pupils' right to resources. The diagnosis could illocutionarily be seen as a way of categorising the child to legitimise that the school can not educate the child adequately and has to take measures to put the child outside the rest of the class. The parents in some cases counteract this by organising themselves in national interest groups and demand far more resources. They accept the diagnosis, but turn it into a fight for more resources for the child. This was not the intention of the diagnostic liturgy, but the perlocutionary effect of the diagnosis, worked out by the addressed (or the parent on behalf of the addressed). This opening for reactions that are not intended by the speaker, and therefore can oppose the power of the speaker, or the system the speaker acts on behalf of, is what Butler would call *the room for agency.*

The need for agency

The other case history differs from the first in the sense that the welfare system *has* already overflowed. While the school system still manages to coopt the children and their demands in a – to the system – normal way, the employees with chronic, diffuse musculoskeletal pain are causing a big problem in working life and society, now also recognised by the system.

A considerable group of employees experience pain in their musculoskeletal system that causes them to take long sick leaves, and later leave their work permanently. Without going into statistical details this is the largest group for early retirement in Norway today.

The parallel to the first case is that neither group can function adequately within a work organisation and therefore needs to be categorised in a way that gives them a place in the system outside the normal. But while the school/medical system manages to do this with the pupils, the work organisation/medical system has faced greater difficulties with the chronic, diffuse musculoskeletal sufferers. The main strategy for the medical system has been to look for objective, physical causes so as to categorise the pain within the framework of well-known somatic medicine. To some extent this has been successful for problems like lower back pain, but the majority of these people cannot show these objective indications.

In the late 1980's and early 1990's substantial unemployment made it less of a problem to exclude these people from the labour market. The welfare state was made responsible for their income by giving them an early pension. In the late 1990's this was shown to be a great burden on the pension system, and resulting fiscal practice. From the mid-1990's, programmes for developing rehabilitation programmes were initiated. I have followed one such programme since 1995 to see what kind of social and cultural properties can be detected from this complex problem.

The typical trajectory for a process ending in pre-pension is people, mostly women, experiencing severe pain to the extent that they have problems in functioning in their daily activities both privately and at work. They seek medical help from a GP, are referred to physiotherapy and granted short-term sick leave. This helps and they go back to work for a short period, only to find the pains coming back and continuing. If these are persistent enough, they get the GP to refer them for more thorough medical evaluation. After some months in this process, and nothing has been found, they are back for more physiotherapy. Many of them now also start seeking help within alternative medicine. Not being able to continue working, after one year of sick leave they have to find a more permanent solution. With the help of their GP, who has now given up trying to cure them, they get the necessary medical statement to enter the pension system. They either go straight on a pension or go through a three-year programme of retraining paid by the welfare system to see if there are other job opportunities they can live with. They always have to accept reduced income and, therefore, a reduced standard of living. After years of dissatisfaction with their job situation, many can be relieved by early retirement, but many will also find that their quality of life decreases.

The rehabilitation programme I have followed[4] focuses on group therapeutic methods taken from Gestalt therapy, psychodrama and similar pedagogical ideas. But the programme is rather self-therapeutic and resembles self-help groups more than professional psychological therapy as practised within the medical system.

A group of 10-12 people come together for 4 hours every two weeks for 6 months. Two group leaders, trained health workers but not therapists, lead the sessions and direct the participants in different exercises. But most of the work is reflexive dialogues within the group.

The aim of the programme is not to cure the pain but to empower the participants to cope better with the pain. In the terms of performativity I would describe it as *activating agency*. The participant has been found unfit to function in the work organisation. But the medical system has not been able to re-categorise the person by producing an adequate diagnosis for the suffering, failing to transform the pain into a recognised disease. The work organisation/welfare system has produced a ritual in the Turnerian sense (Turner, 1967) without a structure (the workplace), or an anti-structure (the sick leave), and the new structure (the early retirement) is satisfactory neither to the system nor to the person. It is too costly for the welfare system, it does not take away the pain and it reduces the standard of living of the person involved.

What work organisation does though is to privatise or individualise the problem. The problem owner is the person, not the system. The ritual process is, therefore, not satisfactory to the person's self-image either. It places the blame on the individual.. In the medical cultural system it is usually possible to avoid this blame by getting a diagnosis, which places the blame on something outside the self, something external and objective. By not being able to produce such a diagnosis the medical system fails to establish a new structure that satisfies the self-image. Psychologically the person is left in constant liminality.

The rehabilitation programme addresses this problem by helping the participant to perform a self-reflexive process, deconstructing and reconstructing a new self-image. Analysing the possible causes for the pain and in this way identifying plausible causes outside the self does this. But, unlike the ordinary medical system, the programme does not provide any solutions to the problem outside the participant itself. He or she has to make choices, act in response to the new situation, and learn to cope in a more conscious way. In the programme this is called 'training for strengthening the self', and seems parallel to empowerment.

Liturgy and ritual

In the conceptualisation of this workshop I have described one example of diagnostic praxis as liturgical and one praxis where adequate diagnoses are absent as ritualistic. The main difference which the use of these two metaphors emphasises is that the liturgy of diagnosing is non-reflexive while the rehabilitation programme turns the failed liturgy of medical treatment of people with chronic musculoskeletal pain into a (self-) reflexive ritual.

The lack of reflexivity in the first process can be analysed as a discursive performance of power. But, as mentioned in this example, and following Foucault, there is always room for agency that can be acted on and made reflexive.

Notes

(1) This short paper is a presentation of work in progress. I am still doing fieldwork on the case concerning schoolchildren with behaviour disturbances. I would like to thank my employer, Vestfold University College for financing my project.

(2) The ethnography is from Norway and the Norwegian Welfare State. In the literature on welfare systems the Nordic countries are usually grouped as one, and especially the three Scandinavian countries. Denmark, Sweden and Norway have so many cultural, social and organisational similarities that it is reasonable to group them in one category.

(3) The unit is called 'psychological-pedagogical service' and serves one municipality. My study was done in a middle-sized Norwegian town with 15 primary schools.

(4) The programme is called 'an educational programme for people with generalised chronic musculoskeletal pain', and is described in Steen and Haugli (2000).

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