
CHAPTER 1

# Introduction

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"Maybe you should see a doctor or talk to a therapist about that." Many of us have likely given this advice to someone who has approached us with a personal problem—maybe a colleague with recurring headaches, a friend who feels overburdened at work, or a teenager in our own family who has had continued difficulties at school. Some of us may even have received this advice ourselves. Consulting medical doctors or psychologists has become a primary course of action for dealing with various problems that individuals experience in modern societies. Even in the absence of concrete problems, we draw on knowledge from medicine and psychology and on techniques for guidance regarding how to stay happy, healthy, and productive.

But it is not only individuals who turn to medicine and psychology with their personal problems. Indeed, the welfare state has also resorted to these disciplines. While both medicine and psychology have always played an important role in healthcare, their influence is not limited to this one field of the welfare state alone; rather, they are also relevant for social

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policy more generally. Welfare states enact social policies as measures to meet human needs and to respond to social problems. These social problems are not necessarily social in their causes or solutions, but the social responsibility that the welfare state takes on for an issue makes the problem a *social* one (Gusfield, 1989).

As scientific studies from medicine and psychology have accumulated evidence suggesting that many social problems (e.g., aging, poverty, unemployment, disability, low educational achievement, homelessness, and problems in childhood or adolescence) have both biological and psychological causes and consequences, the *ideas* from these disciplines influence how such problems are constructed in welfare discourses. For instance, scientific studies and governmental reports have revealed that unemployed, poor, and homeless people across Western countries are much more likely to suffer from physical or mental illness (BMAS, 2021; e.g., Dufford et al., 2020; Fazel et al., 2014; Paul & Moser, 2009; UCL Institute of Health Equity, 2013). These health inequalities are usually the result of disadvantaged material and social situations (UCL Institute of Health Equity, 2013). Nevertheless, in welfare discourses, targeting health through preventive, curative, and rehabilitative measures has repeatedly been presented as a solution to unemployment and poverty:

> **The health status of individuals strongly influences their labour market participation.** For example, early labour market exit is often the result of health-related problems. (European Commission, 2013, p. 11; bold in original)

> It is therefore possible **to boost economic growth by improving the health status of the population and enabling people to remain active and in better health for longer.** Access to quality health care is a constituent part of the maintenance of a productive workforce and an integral part of the flexicurity setup. (European Commission, 2013, p. 12; bold in original)

This example from the European Commission's communication about the Social Investment Package promotes "access to quality healthcare" as a strategy for solving social problems and achieving social and economic goals. While the example references health as a rather general notion, concrete medical and psychological concepts and theories are taken up in the discourse on social problems. Personality traits, resilience, and self-efficacy

have become popular concepts for understanding inequalities and social disadvantage from a psychological perspective (Friedli, 2015; Haushofer & Fehr, 2014). Economic Nobel laureate James J. Heckman, for instance, has advocated for early childhood programs as the most effective solution to poverty. Heckman bases his argument on the concept of character skills, which "personality psychologists have studied […] for the past century" (Heckman & Kautz, 2013, p. 10):

> The foundations for adult success are laid down early in life. Many children raised in disadvantaged environments start behind and stay behind. Poverty has lasting effects on brain development, health, cognition, and character. Gaps in skills emerge early, before formal school begins. Waiting until kindergarten to address these gaps is too late. It creates achievement gaps for disadvantaged children that are costly to close. (Heckman & Kautz, 2013, p. 7)

Over the last five decades, a large body of social science research has investigated how medicine and psychology have become more important in societies (Foster, 2016; Nye, 2003). These processes—which can be described as *medicalization* and *psychologization*—have been identified through the growing role of medical and psychological concepts in the discourses outlined above. However, the processes do not unfold in discourses alone. Indeed, it is also through *actors* as well as their promotion of and increasing use of medical and psychological practices that we can determine medicalization and psychologization. For instance, in Western countries, physicians and psychologists are often easily accessible, and it is thus in their offices that social problems frequently show up or end up. In a survey of general practitioners in one region of Germany, respondents reported that in over half of all consultations, social problems represented at least part of the reason why individuals had come into the doctor's office. However, most medical doctors in this survey had felt forced to give their patients a medical diagnosis and had been willing to give them a sick leave certificate, even if they could not identify a medical problem (Wilfer et al., 2018). This practice has even been acknowledged in the recent version of the International Classification of Disease (ICD), in which Chapter 24 now includes "problems associated with employment or unemployment," "problems associated with education," and "problems associated with social insurance or welfare" for "occasions when circumstances other than a disease, injury or external cause classifiable

elsewhere are recorded as 'diagnoses' or 'problems'" (World Health Organization, 2022).

Psychology has developed its own diagnostic tools and techniques—such as personality tests—and instruments for assessing motivation, resilience, and so on, which are regularly applied when profiling unemployed people or when assessing children with social or education problems. Not only are these concepts applied by psychologists themselves, but they have become widely diffused into various social professions, such as education and social work (Ecclestone & Brunila, 2015). Moreover, caseworkers in the welfare administration rely on these tools and techniques, as outlined in a report on youth unemployment by the International Labour Organization:

> Although screening techniques vary from country to country, the degree of risk is usually assessed using psychological models (based predominantly on unobservable characteristics, such as motivation, self-efficiency, personal behaviour and attitudes). […] Attitudinal diagnostic tools aim to identify jobseekers whose attitudes represent a barrier to finding a job, and design activities to change individuals' behaviour. Examples of attitudinal screening tools can be found in Denmark (*Job Barometer*), France (*Copilote Insertion*), Germany (*Placement Characteristics*) and Portugal (*Forecast Guide to the Difficulties of Insertion*). (International Labour Organization/European Commission, 2017, p. 15)

The influence of medicine and psychology in the welfare state is also tied to *institutions*. The institutional setup of welfare states puts physicians and psychologists in a powerful position that has received little attention in the literature on the welfare state. Indeed, medical doctors' and psychologists' opinions are central to making decisions not only about who should receive medical treatment, but also about who is eligible for long-term care, sick leave, and incapacity benefits (Aurich-Beerheide & Brussig, 2017). Medical doctors and psychologists are involved in assessing *who* is able to work, *when*, and *for how long*. They are consulted when deciding which children are ready for school, require special education, or should be exempted from certain school subjects or from receiving grades in these subjects (Ecclestone & Hayes, 2009; Harwood & Allan, 2016). In particular, the welfare state seeks the expertise of medical doctors and psychologists if claims are controversial or if other efforts fail. Thus, members of these professions are regularly involved in decision-making on social rights and obligations in the welfare state. Their role is so significant

because they are called upon to settle conflicts and controversies created by existing institutional structures:

> Since *social security between citizens* (as in labor law) and the *social benefits of the community* (such as social insurance, social assistance etc.) are all too often and to a large extent indispensably linked to treatment processes or illnesses for which the physician is the only competent assessor, the physician becomes the arbitrator in the welfare state. In contrast, employers' human resource departments—as well as social administrations, labor courts, and social courts, to name the most important examples—often perform only an executive function. (Zacher, 1985, p. 223; translated from German, emphasis in original)

## 1.1 Moving Toward a Biopsychosocial Welfare State?

Why have we chosen to study the influence of the two disciplines of medicine and psychology in the welfare state? It could be argued that science and professions in general have become more important in the organization of the welfare state. While there is convincing evidence for this hypothesis, others have in fact investigated this extensively (e.g., Blom et al., 2017; Brückweh, 2012). We focus in this book on medicalization and psychologization in the welfare state not as an example of a general scientization or professionalization of social policies; rather through our focus we aim to uncover the qualitative changes that stem from including medicine and psychology in our understanding of social problems and social policies as compared with a situation in which *social* ideas and measures guide welfare states.

The cultural narrative in which the welfare state is embedded is one in which the state deals with problems that originate in social relations and solves these problems by providing social rights and services. Our understanding of the medicalization and psychologization of the welfare state does not mean that either of these disciplines (or both together) have taken over the welfare state. However, both disciplines have indeed changed the narrative by adding ideas, techniques, and the voices of the professionals who work within them to what had formerly been considered "social problems," thereby also rendering these problems medical and psychological. Medicine and psychology, however, do not merely make

the picture more colorful; rather, their disciplinary backgrounds provide a qualitative change to our understanding of the above-mentioned problems. Since medicine and psychology focus primarily on the individual (the body, genetic makeup, thoughts, emotions, personality, etc.) rather than on the social relations between individuals (which can be economic, political, social, cultural, etc.), the medicalization and psychologization of social issues shifts the perspective to a more individualized notion of the problem.

To highlight the fact that our understanding of the medicalization and psychologization of the welfare state represents a process of growing interdisciplinarity and complexity rather than a takeover of the welfare state by these disciplines, we draw on the concept of the biopsychosocial model as a metaphor for the development we have identified. The biopsychosocial model was developed by George L. Engel in 1977 to illustrate the complex interplay of biological, psychological, and social factors in the genesis of health or illness (Engel, 1977). The model is a widely known framework that illustrates how these three factors are linked and interrelated. We can imagine the changing role of medicine and psychology in the welfare state in a similar way since the influence of these disciplines has been linked to and integrated with existing social ideas, actors, and practices.

This book was written for scholars and students of social policy who are interested in the welfare state. By including the role of medicine and psychology in our concepts and analyses, we can gain a new perspective on the institutional configurations and historical dynamics of the welfare state. This book was also written for students and researchers who are interested in medicalization and psychologization. If our goal is to understand these processes better, we must not merely consider the welfare state an abstract phenomenon, but instead deconstruct it to see how it can be an agent of for (de-)medicalization and (de-)psychologization and the concrete institutional context in which these processes unfold. Therefore, we examine three social problems in this book to see how the welfare state works through specific institutions, ideas, and actors in concrete fields of social policy.

## 1.2 An Academic Dialogue

As outlined above, examining the role of medicine and psychology in the welfare state should prove interesting to readers from two fields of academic inquiry: *medicalization and psychologization research* on the one

hand and *welfare state research* on the other hand. The purpose of this book is to bring these two fields together and to foster a lacking academic dialogue. Such an exchange of ideas can provide both fields with new perspectives on their research objects and their theoretical frameworks and can also uncover novel empirical puzzles and research strategies.

*Medicalization and psychologization research* is an interdisciplinary research area that is strongly influenced by writers from philosophy, medical sociology, cultural sociology, and critical psychology. The research we review here as medicalization and psychologization research is a large body of work that uses a variety of theoretical concepts, including "medicalization," "biomedicalization," "psychologization," "therapeutization," "therapy culture," and Foucault's concepts of "biopower" and "biopolitics" (e.g., Conrad, 1992, 2007; Nolan, 1998). What all this research includes as either a single element or a focal point is an analysis of how medicine and/or psychology—that is, the ideas, practices, and professions of medicine and psychology—have become central to how modern societies deal with problems and govern life. Some contributions to medicalization and psychologization have been critical of this development and have been concerned, for instance, with the depoliticization of social issues or the transfer of social control to medical and psy-professions. Other scholars have used the abovementioned processes as analytical concepts and aim first and foremost to describe and explain these processes.

From the beginning, the sociopolitical consequences of medicalization and psychologization have formed an integral part of this research area (e.g., Foucault, 1976 [1973]; Szasz, 1960; Zola, 1975). In works that specifically deal with the state, it is clear that medical and psychological ideas, practices, and professions have been considered to legitimize the modern state (Nolan, 1998) or to provide a form governmentality that resonates with the ideational basis of liberal democracies (Rose, 1998). However, in these contributions, the state is treated as an abstract, complex phenomenon, and little interest is paid to its specifics. In contrast, we consider the state to be an actor in medicalization and psychologization processes as well as to provide a context that impacts these processes depending on its specific institutional configuration (Bourgeault, 2017). Adding such an institutional perspective of the state provides a tool for better understanding how and why medicalization and psychologization vary across countries and over time (Olafsdottir & Beckfield, 2011). A specific analysis of the welfare state as the cornerstone of the modern state (Kaufmann, 2012; Rothgang et al., 2006) also highlights how

medicalization and psychologization are associated with the social stratification of societies. Moreover, examining medicalization and psychologization in the context of the *social* welfare state allows us to expand the ideas of simultaneity and layering. Our image of the *biopsychosocial welfare state* builds on the idea that medicalization and psychologization do not need to be conceptualized as having successfully dominated a given problem by assuming a single professional perspective; rather, they can also be conceived concurrently with other approaches in a "layering of institutional control and [an] increasing multi-institutional management of social problems" (Medina & McCraine, 2011, p. 139).

*Welfare state research* is also an interdisciplinary field that receives contributions from political science, sociology, history, and economics but that constitutes a much more coherent research discourse in comparison. The field of welfare state research theorizes, describes, and analyzes the development both of different social policy programs and of the welfare state as a coherent macro-phenomenon. This field is interested in explaining the dynamics of welfare discourses and policies and aims to establish causal relations between the welfare state and various outcomes on both the macro-level (e.g., growth) and the micro-level (e.g., educational attainment). The welfare state is not merely one function of the state; rather, it is what makes a state a modern state—that is, what distinguishes a modern state from earlier forms of statehood (Kaufmann, 2012). Integral to welfare state research is the segmentation of research into various fields, such as pensions, healthcare, unemployment protection, and family policy. As a result, the influence of medicine and psychology has been subsumed into welfare state research under the field of healthcare, where the strong influence of the medical profession has long been acknowledged (Tuohy & O'Reilly, 1992).

For welfare state research, engagement with medicalization and psychologization offers a new perspective on the wide influence of medicine and psychology on the welfare state because the concepts and involvement of medicalization and psychologization cut across various welfare fields (see Table 1.1). The social-constructivist background of medicalization and psychologization research also provides analytical concepts that respond to the cultural turn of welfare state research (Pfau-Effinger, 2005; Sachweh, 2011). Specifically, this background adds an important dimension to the analysis of changing welfare discourses and reforms within both the neoliberal era and the most recent years, which have built on the social investment paradigm.

**Table 1.1** Examples of how health and illness matter across various fields in welfare states (*unemployment* and *poverty* based on Eggs et al. (2014); *work* based on DAK-Gesundheit (2019); *homelessness* based on Schreiter et al. (2017); *families* based on AFET Bundesverband für Erziehungshilfe (2020) and Ravens-Sieberer et al. (2021); *education* based on Rommel et al. (2018) and KMK (2021); *social care* based on GBE Bund (2020))

*Box 1: Examples of how health and illness matter across various fields in welfare states*

- Unemployment and poverty: 40% of minimum-income recipients in Germany report having serious health limitations.
- Work: Sick days for mental illness have tripled over the last twenty years in Germany, with 2.2 million people taking sick leave days in 2019.
- Homelessness: 77% of homeless people in Germany suffer from mental illness.
- Families: About 3 million children (i.e., 1 in 4 children in Germany) grow up with at least one parent with mental illness (including addiction). One in five children (17.5%) is classified as having signs of psychological strain. This rate has increased to one in every three children (30.4%) since the onset of the COVID-19 pandemic.
- Education: In 2020, out of 8.83 million school children, 571,671 received special-needs education, 15% of 3- to 6-year-olds received logotherapy, and 16.7% of 14- to 17-year-olds received physical therapy.
- Social care: In 2019, 4.1 million people in Germany received social care. The need for such care is assessed by medical staff and based on medical and psychological criteria.

## 1.3 A German Case Study

This book developed within a research group entitled the "Medicalization and Psychologization of Social Problems: Challenges and Chances for Social Policy (MEPYSO)," which was funded by the German Ministry of Labour and Social Affairs. Our research focuses on medicalization and psychologization within the German welfare state. We consider an investigation into the move toward a biopsychosocial welfare state within the German context to be both innovative and theoretically fruitful. Such an investigation is *innovative* because most existing work on medicalization and psychologization has focused on either liberal or social-democratic welfare states, particularly if this work has linked these processes to social policy and to the welfare state (*Scotland*: Allan & Harwood, 2014; *England/Finland*: Ecclestone & Brunila, 2015; *England/Scotland*: Friedli, 2015; *England*: Garthwaite, 2014; *USA*: Hansen et al., 2014; *Sweden*: Holmqvist, 2009; *England*: Macvarish et al., 2015; *Norway*: Madsen, 2014; *USA*: Nolan, 1998; *Canada*: Pulkingham & Fuller, 2012; *England*: Rose, 1985, 1998; *USA*: Schram, 2000; *England/USA*: Wastell

& White, 2012; *USA*: Wong, 2016). There are good reasons for this focus: in social-democratic welfare states, medicalization and psychologization are considered to be forms of well-intentioned "generosity" and serve as an explanation for why standard social services have not yet solved existing social problems (Holmqvist, 2009). In liberal welfare states, medicalization and psychologization are instead portrayed as institutionally created necessities or last resorts, with losing a disability status, for instance, potentially meaning no longer having access to any type of benefits at all (e.g., Hansen et al., 2014; Wong, 2016). These results suggest that medicalization and psychologization can be institutionally linked both to strong conditionality (liberal welfare states) and to the universalist orientation (social-democratic welfare states) of welfare states. Therefore, a study from another world of welfare states is important to understanding whether and how medicalization and psychologization unfold in a system with a welfare orientation that includes a mixture of both elements.

As a conservative welfare state, Germany is a *theoretically interesting* case, because it has specific institutional features that could shed light on other mechanisms that pertain to how the state is involved in processes of medicalization and psychologization. Moreover, the German welfare state has experienced a strong reform dynamic over the last three decades, which allows us to investigate how medicalization and psychologization are incorporated into paradigmatic changes that are associated with ideas of neoliberalism and social investment.

In comparative welfare state research, Germany constitutes the archetype of the conservative welfare state regime (Esping-Andersen, 1990). In Germany, social policy is strongly based on social insurance systems with earnings-related contributions and benefits and with family policies oriented toward a male-breadwinner model. An important aspect of this institutional configuration is a strong demarcation between different welfare programs, which creates problems when different social problems intersect. Social policies are also strongly codified in the 12 books of the German Social Code. Benefits and services are thus institutionalized as social rights. Citizens perceive these benefits and services as individual social rights because contributions for pension, healthcare, unemployment, and social care insurance are taken directly from citizens' monthly employment income, as is visible on each individual paycheck. Another important feature of the German welfare system is corporatism. The self-governance of corporate actors grants physician organizations in Germany direct decision-making power in the public health insurance system.

Over the last few decades, Germany has borne witness to a strong reform dynamic in different sectors of the welfare state. This dynamic was influenced in the 1990s and 2000s by neoliberal thinking, and since the 2000s, it has also been influenced by the social investment paradigm. Neoliberal reforms to unemployment and social assistance programs have strongly increased the conditionality of welfare benefits and imposed work obligations on all non-employed people unless their health status precludes them from working. Social investment ideas have influenced the shift in German family policy. While Germany has long supported a male-breadwinner family model, the introduction of an earnings-related maternity leave and the substantial expansion to childcare facilities have created strong support for mothers' employment participation. Some scholars have argued that the passing of these fundamental reforms "no longer warrants labeling Germany a conservative welfare state" (Seeleib-Kaiser, 2016, p. 235), while others consider "[t]he German social insurance state [to be] alive and kicking" (Blank, 2019, p. 522). In any case, this dynamic provides an empirically interesting case for studying how medical and psychological ideas, practices, and actors have been, respectively, the fuel, catalyst, and outcome of these welfare state reforms.

The focus used in past reforms guided the selection of the social problems or social policy areas that we analyzed in our research. First, because one of the most significant transformations in the German welfare state was the reform of the German unemployment and social assistance system in the early 2000s, we studied the medicalization and psychologization of *unemployment* and *poverty*, thereby adding to an evolving body of international literature on these issues (Buffel et al., 2017; Friedli, 2015; Hansen et al., 2014; Shepherd & Wilson, 2018; Wong, 2016). We extend this work by linking medicine and psychology as two distinct yet strongly interactive disciplines and professions that have changed their role in dealing with poverty and unemployment. Second, family policy reforms—and particularly the reforms that expanded and transformed childcare in Germany—reflect the new level of attention that is paid to early childhood in German social policy. Children in families with difficult circumstances and issues of child protection constitute another area in which new policies have been enacted. Such policies include the National Initiative for Early Childhood Intervention, which was launched in 2006. Viewing difficulties in childhood as a social problem also resonates with the medicalization and psychologization literature, which has long considered the changing role of medicine and psychology in childhood to be an important research topic (e.g., Conrad, 1975; Ramey, 2015; Timimi, 2002).

## 1.4 Medicine and Psychology in Germany

Medicine and psychology are both popular academic disciplines in Germany. For years, access to the two fields of study has been restricted because demand has exceeded the number of available places at universities (Fehling, 2018). Medicine is clearly the more powerful profession in Germany as it holds a strong position in the self-governing body of the German healthcare system in the form of the Federal Joint Committee. With 4.3 medical doctors per 1000 population, Germany has a high physician density, ranking 6th in a 2018 comparison of 28 OECD nations (OECD average: 3.6) (OECD, 2021). As in many Western countries, the number of physicians in Germany has increased immensely from a historical perspective. There was one medical doctor per roughly 3000 inhabitants in 1885, one per 700 inhabitants in 1952, one per 329 inhabitants in 1991 (Busse & Blümel, 2014), and finally one medical doctor per 233 inhabitants in 2019 (OECD, 2021).

However, psychology has also grown substantially in importance. Table 1.1 illustrates this development quantitatively. Until 2007, there were about twice as many students studying medicine compared with psychology. Between 2007 and 2020, the number of students enrolled in psychology increased by 223%, and the figure fully caught up to medicine despite the simultaneous increase in the number of medical students between 2010 and 2020 (Fig. 1.1).

Psychology also consolidated its professional status in 1999 with its acknowledgment as an independent profession (psychological psychotherapist) and the right for these professionals to establish their own practices (PsychThG, 1998). In 2020, psychological psychotherapists also gained the right to see patients without a physician's referral, thereby increasing their independence from physicians in the outpatient healthcare sector (PsychThG, 2019). In light of these changes, the number of psychological psychotherapists rose from about 30,000 in 2006 to around 50,000 in 2020 (GBE Bund, 2021).

Most physicians and psychologists work in private practices, hospitals, and clinics. In their clinical practice, their diagnoses are often relevant when it comes to sick leave, social security benefits, welfare services, or exemptions from certain social obligations. Thus, many medical doctors and psychologists act as arbitrators for social problems both through their regular practice and as independent reviewers for courts and welfare

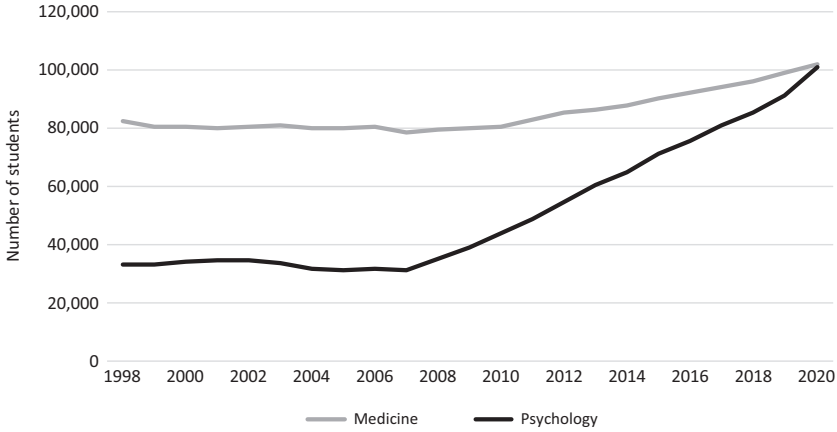


**Fig. 1.1** Number of students of medicine and psychology in Germany, 1998–2020 (Statistisches Bundesamt [Destatis], 2022, own calculations)

administrations. Moreover, German statutory health insurance, statutory pensions insurance, and the Federal Employment Agency have individual medical review boards, and the Federal Employment Agency also has a psychological review board. In these boards, employed physicians and psychologists provide socio-medical expertise, which in many cases directly translates to a legal status that either grants or does not grant benefits (e.g., disability pensions), services (e.g., rehabilitative services), and obligations (e.g., active job search). Psychologists and medical doctors are also employed in communities and work in different social settings, such as schools. However, it is not the number of physicians and psychologists who work in a field that determines their influence on the welfare state. Indeed, it may be that the rather small number of physicians and psychologists who work in the welfare administration and in the political system (compared with in clinical practice) are the most influential in the medicalization and psychologization of social problems because their work is influenced by their professional socialization and professional networks. For instance, medical doctors who work in a ministry might be more inclined to support medical explanations or to call upon medical expertise for a given problem than would someone with a different professional background.

## 1.5 The Book

With this book, we aim to integrate research agendas from welfare state studies with existing work from the field of medicalization as well as with psychologization research. We thereby investigate the following questions: (1) What roles do medicine and psychology play in the welfare state? (2) How have these roles developed? (3) What implications does a move toward a biopsychosocial welfare state have? These broad questions serve as a guideline throughout the chapters of this book.

We begin our investigation into these questions in the first part of this book by bringing the diverse lines of research together on a theoretical level: Chap. 2 lays out the primary concepts and theoretical assumptions of medicalization research on the one hand and psychologization research on the other hand and offers a systematic comparison and currently lacking synthesis of the ideas found in these bodies of research. Chapter 3 then integrates this debate using theories from the welfare state and social policy research. Using the analytical dimensions of *ideas*, *actors*, and *institutions*, we develop a multifaceted theoretical framework that provides guidance on how to trace and understand medicalization and psychologization in the welfare state.

The second part of the book applies this framework to three social problems that are integral to welfare state activity: unemployment, poverty, and childhood problems. The chapters in this part illustrate medicalization and psychologization in the respective welfare fields by combining a multitude of data sources, including analyses of legal categories, qualitative and quantitative discourse analyses, analyses of bibliographic data, and analyses of data from an experimental vignette survey that we fielded in Germany in 2019. Chapter 4 illustrates how medicalization and psychologization have unfolded in the welfare state's response to unemployment. In this highly dynamic field of activating reforms, the boundaries between unemployment and disability and the importance of illness in precluding work obligations are illustrated and discussed in terms of the relevance of these issues to individuals' social rights and obligations, the social legitimacy associated with the status of sickness, and the continuous attempts of the government to "deal with long-term unemployment." Chapter 5 illustrates the medicalization and psychologization of poverty by showing how the two disciplines have gained ground both quantitatively—in the scientific discourse on poverty—and qualitatively—through the elaboration of poverty as a multidimensional concept in which notions of health

and psychological concepts are integral. The role of scientists in the medicalization and psychologization of poverty can also be traced in the periodical governmental reports on poverty and wealth, but medical and psychological ideas are of little relevance in parliamentary debates on poverty. In Chap. 6, we turn to a field of welfare state activity that has become increasingly important over the past three decades: policies that address children and children's problems. We investigate the role of interest groups in the medicalization and psychologization of children and study institutional implications in terms of the relevance of diagnostic categories for social rights in the field of education. Finally, we describe the results from our survey, which shows the legitimacy of social rights and the obligations that the general public considers to be adequate for children with emotional and behavioral problems.

Finally, in the third part of the book, Chap. 7 discusses how the move toward the biopsychosocial welfare state can be interpreted partially as a result of how medical and psychological explanations and interventions have resonated with the two dominant social policy paradigms that have guided the transformation of the welfare state over the past decades: neoliberalism and social investment. The concern that the medicalization and psychologization of social problems is accompanied by individualization and depoliticization is visible in parts of our empirical results, particularly during the period of the neoliberal restructuring of welfare policies. However, we can also see how medical and psychological arguments have been used to argue for greater societal responsibility and social solutions, particularly in more recent years. This shift reflects a greater focus on social investment ideas as well as on learning from difficulties that stem from neoliberal policy changes. Finally, in Chap. 8, we summarize the key lessons learned from our research as presented throughout the chapters and look to the future of the biopsychosocial welfare stateWelfare state.

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