CHAPTER 8

The Biopsychosocial Welfare State: A New Perspective on Social Policy

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Throughout this book, we sought to understand (1) *the roles that medicine and psychology play in the welfare state*. Our guiding hypothesis was that both disciplines play an important role in a wide range of issues that are addressed by the welfare state in fields other than healthcare. We investigated this issue specifically for three social problems that are key to the welfare state's fields of action: unemployment, poverty, and problems in childhood. In order to grasp the role of medicine and psychology in the welfare state, we proposed a theoretical model that conceptualizes medicalization and psychologization along three levels (i.e., micro, meso, macro) and three dimensions (i.e., ideas, actors, institutions) (see Chap. 3). We employed this framework in the analyses of our three social problems, which we described throughout Chaps. 4–7. For instance, on the micro-level, medicalization and psychologization were visible in the dimension of *ideas* in terms of how individuals use information on physical and psychological health in their assessment of unemployed people (e.g., whether

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these unemployed people are blamed for becoming or remaining unemployed; see Chap. 4). On the meso-level, we discussed how social security branches use medical categories in their organizational procedures—such as "sick leave" (*institutions*)—and have their own medical service agencies (*actors*) for managing long-term unemployment (see Chap. 4). On the macro-level, which we studied most extensively, we illustrated how *ideas* from medicine and psychology shape scientific discourses and the definition of poverty in policy reports and public debates (see Chap. 5). Moreover, we showed how medical and psychological categories have become integrated into social law and thus influence access to benefits and services on the dimension of *institutions* (see the institutional analyses of medicalized benefit receipt in Chap. 4 and the analyses of learning difficulties in Chap. 6). Finally, we illustrated how medical profession associations engage as *actors* in public discourses and therein simultaneously medicalize and de-medicalize childhood (see Chap. 6). Thus, the results we found throughout Chaps. 4–7 revealed that the role of both medicine and psychology in the three problem areas is in fact quite extensive.

Nevertheless, our systematic empirical analyses also uncovered little evidence that medicine, psychology or "a therapeutic culture" have become the dominant form of legitimization or governmentality in the welfare state. For instance, some of our analyses revealed no medicalization or psychologization at all (e.g., our analysis of plenary debates on unemployment in Germany in Chap. 5), and empirical examples of de-medicalization and de-psychologization were even found, such as with the restriction of access to incapacity benefits (see Chap. 4), with policies that limit the pharmaceuticalization of ADHD, and with the resistance of German states to a medicalized/psychologized practice of dealing with learning difficulties (see Chap. 6). Moreover, medical and psychological regulation are often integrated with each other as well as with social elements (e.g., education, social work, income benefits). Thus, the notion of the "layering of institutional control and [the] increasing multi-institutional management of social problems" suggested by Medina and McCraine (2011) more adequately describes the empirical patterns of medicalization and psychologization that we found in the German welfare state. We argued that this idea can be taken a step further by viewing the medicalization and psychologization of social problems and social policies as a move toward a biopsychosocial welfare state—that is, as a move toward a welfare state

that integrates biomedical, psychological, and social ideas, technologies, and actors in addressing social problems.

Finally, we set out to explicitly compare medicalization and psychologization across social problems. While this endeavor was certainly limited by the need to use problem-specific data sources and methodological approaches, we can tentatively conclude that the influence of medicine and psychology differs across social problems. Psychology seemed to be least relevant in Germany for unemployment and most significant in the case of childhood problems, whereas medicine proved relevant to all three social problems. Despite the rapidly increasing growth and relevance of psychology, medicine has remained the more powerful profession. This finding is particularly true in the case of Germany, where the medical profession has a powerful position in the self-regulatory bodies of the healthcare system and where medical doctors represent the majority of healthcare professionals who are employed or contracted by the various branches of social security. Nevertheless, Rose's (1996) thesis—that is, that the influence of psychology unfolds not by monopolizing, but rather, by sharing its ideas and methods—was also found in our data analyses, in which, for example, psychological concepts such as self-efficacy and parenting style were important without necessarily being associated with the discipline of psychology.

A second question that we posed in this book involved (2) *how medicalization and psychologization in the welfare state have developed over time.* For all social problems, we could find historical examples of how medicine and (sometimes) psychology were relevant as early as at the end of the nineteenth century, such as in the discourses on unemployment and incapacity and in the regulation of problematic childhood behavior. This research area would certainly greatly benefit from a systematic quantitative longitudinal analysis that explicitly tests the importance of medicine and psychology in the welfare stare over time. However, in practice, such an overarching analysis is precluded by the lack of available data as well as by methodological challenges. Nevertheless, the existing literature (e.g., Furedi, 2008; Olafsdottir, 2007; Pulkingham & Fuller, 2012; Wong, 2016)—as well as our own analyses—have assessed medicalization and psychologization trends for specific issues and/or over more limited periods of time. For instance, we conducted bibliographical analyses of the share of disciplines among all three social problems (this book includes analyses for poverty; see also Brase et al., 2022; Krayter & Reibling, 2020), which revealed that poverty had become more medicalization and

psychologized between 1960 and 2019. These results and further data—such as the rising number of medical doctors and psychologists (see Chap. 1)—provide evidence of the increasingly important role that medicine and psychology play in the welfare state. However, when we take other results from our studies into account, we agree with Halfmann's (2012) observation that a more detailed analysis often reveals both medicalization and de-medicalization, which sometimes even occur simultaneously. Thus, for certain periods, we found an increasingly strong role of medicine and psychology in terms of how modern welfare states intervene in specific social problems. Moreover, medicine and psychology can certainly be seen to have become more powerful if we simply consider the increasing size of both professions (see Chap. 1). However, in addition to considering the absolute magnitude and pervasiveness of medicalization and psychologization, it is important to think about *how* and *why* medicine and psychology work within the welfare state. We suggested that the medicalization and psychologization dynamics of recent decades need to be viewed in the context of neoliberal and social investment discourses and reforms, which have influenced medicalization and psychologization processes in Western welfare states. One example is how the importance of sick leave among the unemployed changed in the context of the increased conditionality of unemployment and minimum income benefits (see Chap. 4).

Finally, we also investigated (3) *the effects of the processes of medicalization and psychologization—that is, the implications of a move toward a biopsychosocial welfare state*. These implications are both manifold and mixed (i.e., they are both positive and negative). These mixed consequences of medicalization and psychologization can be understood through Foucault's (1979) notion of power as a positive, productive phenomenon on the one hand and a negative, oppressive phenomenon on the other hand. To begin, the growing role of medicine and psychology in the welfare state has many positive, productive, and liberating implications. For instance, a medical and psychological perspective gives more attention to the perspective of individuals within the welfare state—that is, regarding how individuals experience social problems and the welfare state's involvement in these individuals' lives (e.g., Jo, 2013; Linden et al., 2018; Stenner & Taylor, 2008). Another major liberating aspect of the role of medicine is that individuals' problems and experiences are legitimized through medical and psychological diagnoses, which explains why individuals actively pursue these diagnoses (e.g., Hansen et al., 2014; Klasen, 2000). In addition, from a practical perspective, a medical (and sometimes

psychological) diagnosis is a necessary precondition for receiving certain benefits and services from the welfare state, such as incapacity benefits, sick leave benefits, or services/changed rules for learning disabilities. Moreover, medical and psychological ideas have broadened the concept of social investment by including individuals' health and psychological characteristics in the discussion (rather than only including these individuals' labor market qualifications) (Goijaerts et al., 2022). Thus, our results indicate that medicalization and psychologization can also be interpreted as a learning process that has revealed that unemployment, poverty, and childhood are complex, multifaceted phenomena that require multiple and intersectoral forms of action from the welfare state (e.g., Ariaans & Reibling, 2021; European Network of Public Employment Services, 2020). Such interventions (e.g., early childhood intervention (i.e., "Frühe Hilfen") in Germany) rely on health professionals—due to the required trust and the low-access threshold—to act as a door-opener for further welfare state interventions. Finally, as medical doctors and psychologists are regularly confronted with patients who have problems that originate from their social and economic situations rather than from their bodies, psyches, or behavior (Wilfer et al., 2018), these professionals can act as advocates for their clients. We demonstrated this finding, for instance, in our analyses of the public communication of the German Professional Association of Pediatricians (see Chap. 6).

In contrast, medicalization and psychologization in the welfare state can be oppressive and constraining. Medicine and psychology not only legitimize access to benefits/services and refrain from labor market participation, but they also legitimize the intervention of welfare organizations in people's lives. The major point of criticism of this element of social control served as the source of inspiration for the development of medicalization theory in the 1960s. Over time, as Nye (2003, p. 127) pointed it out, this critique has moved somewhat out of focus: "Scholars [who] investigat[e] […] long-term development and present [the] effects of medicalization remain warily suspicious of [the] close alliance of medical power and the state, but regularly find, in the modern welfare state at least, less cause for concern." While our results do not stand in opposition to Nye's assessment, it is important to underline the idea that the implications for the social control and surveillance of medicalization and psychologization are central when we study these processes in the context of the welfare state. Moreover, the recent restructuring of the welfare state toward more conditionality (under neoliberalism) and the resurgence of

paternalistic interventions (based on social investment thinking) reveal how significant this implication of medicalization and psychologization currently is.

Moreover, as Lupton (1997, p. 156) noted, the repressive effects of discourses (in her case, public health discourses) are not equal for all individuals but "do frequently serve to perpetuate relations of social inequality, [which are] often organized around the drawing of distinctions between gender, categories of sexual preference, ethnicity and social class." This point is also particularly relevant to our social policy perspective, and existing research has pointed out how medical and psychological ideas and technologies have been used in "the politics of tackling inequalities" (Friedli, 2015, p. 206). We also found support for this observation in our vignette study, in which citizens widely supported obligatory medical/psychological interventions for recipients of minimum income benefits with a medical or psychological diagnosis (see Chap. 4). Finally, in their current practices, medicalization and psychologization usually imply that social problems such as unemployment, poverty, or problems in childhood are individualized. This means that these problems are interpreted as problems of individual health, personal resources, actions, and so on and are therefore subject to individual, therapeutic interventions (Conrad, 2007; Madsen, 2014). In its ideal typical version, medicalization individualizes problems by pathologizing them, thereby relieving individuals of responsibility for their own state, whereas psychology holds individuals responsible for finding the solution to their problems, which is understood to lie in these individuals' thoughts, emotions, and actions (Brickman et al., 1982). In practice, both medicine and psychology contain ideas and practices that involve pathologizing and responsiblizing individuals. However, in either case, the structural, socio-economic causes of these problems—which would require macro-level political action—receive little attention in medicine or psychology (important exceptions such as social medicine and critical psychology notwithstanding). While this individualization of social problems is one of the most pertinent downsides of medicalization and psychologization discussed in the literature (e.g., Adams et al., 2019; Friedli, 2015), it is important to point out that in our analyses of the German cases (and specifically of parliamentary debates, governmental reports, and public attitudes), we found that medical and psychological measures in Germany are often discussed together with social or economic interventions or are considered secondary. However, despite the awareness of the need for economic measures, the reforms over

the last two decades have not increased social security enough to lead to reduced poverty and child-poverty rates (see Chaps. 5–6).

8.1 Medicalization, Psychologization, and Welfare State Research

The aim of this book was to trigger a fruitful academic dialogue between two research areas—namely, *medicalization and psychologization research* on the one hand and *welfare state research* on the other hand. Both earlier (e.g., Conrad, 1980; Nolan, 1998; Stone, 1984; de Swaan, 1988) and more contemporary (e.g., Buffel et al., 2017; Ecclestone & Brunila, 2015; Holmqvist, 2008; Olafsdottir, 2007) research have examined the intersection of the two fields in terms of specific social problems. In this book, however, we built on existing work and extended it through our own analyses and research in order to move toward a synthesis of how medicalization and psychologization matter to the welfare state more generally. To that end, we brought these two research areas into dialogue in several ways.

The *first synthesis* involved the level of medicalization and psychologization research, which has thus far either been studied individually or been merged into concepts such as therapeutization. In Chap. 2, we made a case for the benefits associated with studying both processes simultaneously and comparing them. To that end, we revealed that the two disciplines share many interests, subject areas, and scientific methodologies. Moreover, in practice, the two disciplines often work together professionally. However, these disciplines differ significantly in terms of their theoretical attribution of responsibility, their diagnostic and treatment techniques, the institutions in which they primarily work, their professional power, and their driving forces that have been identified in the literature.

The *second synthesis* involved linking these two processes and the welfare state. In our conceptual model of the biopsychosocial welfare state, we suggested that medicalization and psychologization in the welfare state can be understood by adapting the framework created by Halfmann (2012) by adding three commonly applied categories from welfare state research: ideas, institutions, and actors. We applied this framework in the empirical analyses in Chaps. 4–6 and revealed how it enables the versatility of medicalization and psychologization processes in the welfare state to be

measured. This framework allowed us to select the level and dimension on which the medicalization and/or psychologization of the welfare state should be studied. Our findings demonstrated that the empirical study of medicalization and psychologization processes not only is possible by using a variety of qualitative and quantitative methods, but also benefits from the use of these methods. While qualitative methods have been more common in medicalization and psychologization research, both theories formulate hypotheses that require quantification (Conrad, 2007). For instance, we showed that quantitative research methods—such as factorial surveys with case vignettes—are a fruitful method of linking both research on medicalization/psychologization (e.g., McLeod et al., 2004) and research on welfare attitudes (e.g., van Oorschot et al., 2017). Another example is our use of bibliographical methods to examine medicalization and psychologization in scientific discourses on social problems (see also Krayter & Reibling, 2020).

The *third synthesis* involved examining how medicalization and psychologization can be understood as processes in the context of welfare state restructuring based on neoliberalism and social investment thinking. While there are many examples of scholars pointing to the influence of neoliberalism for medicalization and psychologization (e.g., Adams et al., 2019; Barbee et al., 2018; Madsen, 2014), little research has been conducted on the link to social investment. Moreover, neoliberalism has been used in this work as a form of discourse, whereas we looked more specifically at the associated policy changes that resulted from these discourses in Germany and at the extent to which these changes included or resulted in medicalization and/or psychologization.

In summary, the medicalization and psychologization of social problems unfolds in, through, and due to the welfare state. Therefore, on the one hand, future medicalization and psychologization research should look more specifically at the welfare state as a concrete social entity and use theoretical and methodological expertise from welfare state scholarship, such as welfare state typologies, data on the development of social rights and services, and welfare cultures and narratives. This step would result in more detailed analyses of how institutions, power resources, and cultural narratives stimulate, shape, and inhibit the medicalization and psychologization of specific problems in the welfare state. For instance, studies from Anglo-Saxon countries have indicated that reforms that have eliminated the non-medical receipt of income benefits have resulted in medicalization processes (e.g., being sick may be the only way to access support) (e.g.,

Hansen et al., 2014; Pulkingham & Fuller, 2012; Wong, 2016), whereas in our German case, being on sick leave seems to be a solution for dealing with the conditionality of benefits and the strict activation regime that is implemented in the German minimum income system.

On the other hand, welfare state research has largely ignored the role of medicine and psychology outside the healthcare sector even though the welfare state heavily relies on both disciplines and professions in various fields of action. Our results corroborated the hypothesis that medicine and psychology matter across various social problems and are present on various levels as well as across several dimensions. Thus, future welfare state research could benefit from more explicitly studying medicalization and psychologization processes in various fields in addition to in the welfare state overall. To that end, welfare state research could draw on the rich theoretical and methodological tools applied in medicalization and psychologization research. For instance, medicalization research shows a strong link to the actor-centered perspective in welfare state theory, while psychologization research relates more strongly to the role of ideas and culture in the welfare state. Most importantly, such research could help to broaden our understanding of the changes that many welfare states have experienced since the popularity of neoliberalism and social investment began. As we showed, both paradigms are often reduced to an economic idea of human capital in social policy research even though existing discourses and policies have increasingly often included medical and psychological ideas, tools, and actors.

8.2 Policy Implications

Above, we outlined the idea that the implications of medicalization and psychologization have an inherently double-edged nature. Nevertheless, concrete policy implications can be drawn from our findings that could contribute both to supporting the productive consequences of medicalization and psychologization and to mitigating the repressive and constraining implications of these processes. In terms of the role that medicine and psychology play in social policies, three important fields of action exist: (1) *science and the use of evidence*, (2) *professions as self-reflective agents*, and (3) *solidarity and welfare state institutions.*

(1) *Science and the use of scientific evidence*: In Chap. 5 of this book, we revealed how medicalization and psychologization can be viewed quantitatively in the scientific discourse on poverty. Medicine and psychology are

not only professions, but also scientific disciplines. One important way in which medicine and psychology have become more important for social problems is by generating scientific evidence on certain topics (Bell, 2012). While an interdisciplinary perspective on social problems mostly constitutes a scientifically and socially desirable development, it is important to also consider the structural inequalities between scientific disciplines. These inequalities in both resources and prestige (e.g., perceived credibility and scientificity) likely lead to differential output and influence (both within and outside of science). For instance, there are visible differences in the resources dedicated to certain disciplines or research areas, with medicine, for instance, receiving a disproportionate share of research funds compared with the social sciences (which here include psychology) (Deutsche Forschungsgemeinschaft, 2021). Moreover, Comte's (1830) idea of the hierarchy of the sciences (i.e., the physical sciences are at the top, the life sciences are in the middle, and the social sciences are at the bottom) as well as the notions of *hard* and *soft sciences* are still used in research on scientific fields (Fanelli, 2010; Simonton, 2006). More notably, this hierarchy can also be identified in the attitudes of professionals (O'Brien et al., 2022) and students (Munro & Munro, 2014), who consider the natural sciences and medicine to be more credible and scientific than the social sciences. Thus, such conceptions could likely also shape science policy and the use of evidence in (social) policymaking. For example, medicalization and psychologization could be the result of what happens when medical or psychological evidence based on randomized clinical trials is given greater weight than sociological and economic evidence based on observational studies.

(2) *Professions as self-reflective agents*: Medicalization and psychologization within the welfare state occur due to the increasing importance of the medical and psychological profession in various fields of the welfare state. The impact of the work of these professions depends on both their professional habitus and their concrete practices. Knowledge about the existence and implications of medicalization and psychologization processes is an important prerequisite for self-reflexive professional practices (Adams et al., 2019; LaMarre et al., 2019; Madsen, 2014). In our analyses of press statements in Chap. 6, we found that on the associational level, pediatricians are aware of medicalization dynamics and act as advocates for educational policies. Aside from advocacy, scholars from critical psychology have also highlighted the way in which professional practice can take the downsides of psychologization into account, for example, by implementing a

stepped diagnosis approach and reducing pathologization (Batstra & Frances, 2012), thereby making people aware of structural limitations rather than exclusively focusing on what the individual can do (LaMarre et al., 2019). Moreover, psychological research could engage more in cross-cultural and de-colonial research in order "to *denaturalize* taken-for-granted assumptions about supposedly natural tendencies of human beings in general" (Adams et al., 2019, p. 207; italics in original). In the context of the welfare state, both professions also need opportunities to reflect on their assigned, perceived, and possible role in concrete policy contexts. However, at this point, the curricula of medical education and psychology seem to provide little opportunity for such reflection (Madsen, 2014).

(3) *Solidarity and welfare state institutions*: The medicalization and psychologization of social problems is also the result of the institutional structure of welfare states. Access to the healthcare system has a relatively low threshold and is largely free, at least in Germany. Thus, the fact that unemployment, poverty, and problems in childhood show up in medical and psychological practices indicates that alternatives are non-existent, more difficult to access, or less attractive. Considering the results of our vignette study on children in Chap. 6, medical doctors and psychologists are not generally the first or most important point of contact; rather, educational professionals fill this role. However, in the educational system in Germany both resources and qualifications to deal with such issues seem to be limited. Moreover, access to services for children with difficulties is tied to medical or psychological diagnoses in a number of instances. Thus, medicalization and psychologization might in certain areas be the result of the welfare state's restructuring toward less generosity and higher levels of conditionality. Thus, our results highlight the current critique that social investment reforms have become alternatives rather than complements to traditional social security policies (Cantillon & van Lancker, 2012; Olk, 2007). The takeaway for policymakers is that it is critical to consider that a lack of social services and shortages in the educational sector might result in a higher level of the medicalization and psychologization of problems and consequently also in higher costs for the healthcare system.

8.3 A Glance into the Future

While social crises are a general characteristic of modern, differentiated societies, recent crises—including the COVID-19 pandemic, contemporary international conflicts and refugee movements, and the progressing issue of climate change—represent crises of a new magnitude, speed, and global reach. These crises have posed—and will continue to pose—great challenges to modern welfare states that require substantial financial investments and societal efforts to mitigate the consequences for citizens' health, living expenses, social integration, and quality of life. However, at the same time, these crises can also be viewed as windows of opportunity that enable political action by giving greater attention to certain issues and that thus also offer the potential for building new coalitions and political majorities for political change. From the perspective of the biopsychosocial welfare state, the interesting question involves how contemporary crises have shaped medicalization and psychologization processes in the welfare state. As these crises developed during and after our research, our results do not directly speak to their influence. Nevertheless, we can develop some theoretical expectations as to how these crises may have impacted—or may in the future impact—medicalization and psychologization in the welfare state, and these expectations could be tested by future research.

First, as a crisis that originated due to a disease, the COVID-19 pandemic has certainly been particularly important with respect to medicalization and psychologization. In fact, societal changes related to the pandemic can be considered a momentous example of the medicalization of social life:

> Virtually our entire existence became medicalized in the spring of 2020. How we worked, shopped, washed, loved had suddenly been transformed into actions with a profound impact on our own health as well as the health of our nations, essentially into matters of life and death. Medicalization is obviously not a new phenomenon; many of the activities just mentioned have been subject to medical expertise and language. Yet the intensity and scope of the medicalization we have experienced during the pandemic is novel—at least in terms of recent history. Most of us had not known what it is like to have our public and private lives framed in terms of medicine. In some ways, we have shared what was already the reality of many chronically ill people. (Degerman, 2020, p. 61)

As the above statement illustrates, never before has social life been so heavily influenced by medicine in so many ways. In the early period of the pandemic, medicine dominated public and political discourses. Medical researchers and doctors became top-level policy advisors, and medical technologies and categories such as tests, quarantines, and immunization statuses became central to the organization of social life. While a controversial debate exists on whether this strong medicalization at the beginning of the pandemic was necessary and/or useful, it certainly put medicine in an unprecedented position as a discipline and profession. Moreover, this strong medicalization created a window of opportunity for bringing long-standing issues to the forefront, such as the need for innovation and for more resources in the public health service in Germany (Ewert & Loer, 2022). While this need resulted in new investments in the public health service, a systematic analysis of political changes in Germany after the COVID-19 pandemic by Ewert and Loer (2021) came to the conclusion that the pandemic had not led to a paradigmatic change in prevention policy. However, our focus in this book was limited to advanced welfare states in Western, democratic countries. Medicalization and psychologization in other parts of the world—that is, in places with less well-established welfare states or different political systems—might look different. For instance, the question of medically legitimized social control and surveillance caused by the COVID-19 pandemic might be of particular importance in autocratic countries, such as China.

However, the pandemic may have had an important impact in another way: namely in terms of the widespread tendency to medicalize and psychologize the negative repercussions of the pandemic and infection control measures, such as loneliness, fear, and depression (Arora et al., 2022; Ravens-Sieberer et al., 2021). Even though the experiences of the pandemic are known to have been the result both of a collective crisis situation and of specific social measures, such as school closures, these experiences have nevertheless been primarily framed and operationalized in existing research with medical and psychological vocabulary, concepts, and measurement tools (Johnstone, 2021; Rajkumar, 2021). Moreover, despite the widespread concern about the (long-term) implications of the pandemic on children, at least in Germany, resources in early childcare and schools have not been substantially increased, which suggests that many existing problems and experiences might end up in the jurisdiction of medical doctors and psychologists.

The sustainability of political changes that have resulted from the pandemic is also doubtful given that new challenges have emerged with the war in Ukraine and with the resulting levels of inflation and exploding energy crises. In the current situation, rather than health, costs of living and personal security have come into public focus. As a result, current political initiatives have re-focused on the classic welfare state function: social security. As poverty has become legitimized through an external source, various monetary payments have been administered, and political initiatives in support of increasing less conditional welfare benefits have been launched. Thus, in this constellation, the medicalization and psychologization of social policies have become less important.

While these social crises may have represented windows of opportunity for medicalization and psychologization and may have re-oriented the welfare state toward social security, the role that medicine and psychology have played in Western welfare states over the course of the last 150 years suggests that the biopsychosocial welfare state and its dynamics will continue to be a vital subject matter for years to come.

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