The role of chronic pain and suffering in contemporary society

Tidsskrift for Forskning i Sygdom og Samfund

Nr. 13, 2010

Tidsskrift for Forskning i Sygdom og Samfund

Nr. 13: *The role of chronic pain and suffering in contemporary society*

Peer review foretages af et tværvidenskabeligt panel bestående af bl.a. læger, antropologer, filosoffer, historikere, psykologer, politologer og sociologer.

Proof: Thomas Christian Mikkelsen.

Layout og prepress: Jens Kirkeby, Aarhus Universitet & Thomas Christian Mikkelsen.

Tryk: Werks Offset, Højbjerg.

Udgiver:
Foreningen Medicinsk Antropologisk Forum,
Afd. for Antropologi og Etnografi, Aarhus Universitet, Moesgård, 8270 Højbjerg.

Bestilling, abonnement, henvendelser og hjemmeside:
Tidsskrift for Forskning i Sygdom og Samfund.
Afd. for Antropologi og Etnografi, Aarhus Universitet, Moesgård, 8270 Højbjerg
Torsdag kl. 9-12, tlf. 89424597, email: sygdomogsamfund@hum.au.dk
www.sygdomogsamfund.dk
ojs.statsbiblioteket.dk/index.php/sygdomogsamfund/index

ISSN: 1604-3405

Tidsskriftet er udgivet med støtte fra Forskningsrådet for Kultur og Kommunikation.

Formål:

Tidsskrift for Forskning i Sygdom og Samfund er et tværfagligt tidsskrift, der tager udgangspunkt i medicinsk antropologi. Tidsskriftet har til formål at fremme og udvikle den forskning, der ligger i grænsefeltet mellem sundhedsvidenskab og humaniora/samfundsvidenskab. Tidsskriftets målsætning er at fungere som et forum, hvor disse fag kan mødes og inspirere hinanden – epistemologisk, metodisk og teoretisk – i forskellige forskningssammenhænge. Tidsskriftet formidler den debat og teoretiske udvikling, der foregår i de voksende faglige samarbejds- og forskningsinitiativer, der udspringer af dette grænsefelt. Tidsskriftet henvender sig til alle med interesse for forskning i sygdom og samfund og i særlig grad til sundhedsmedarbejdere i forsknings- og undervisningssammenhæng med forbindelse til tværfaglige miljøer.

Aims and scopes

The Journal for Research in Sickness and Society is an interdisciplinary journal which has a theoretical background in medical anthropology. The aim and purpose of the journal is to promote and develop research in the borderland between the health sciences and the humanities/the social sciences. The goal of the journal is to function as a forum in which these disciplines may meet and inspire each other – epistemologically, methodologically and theoretically. The journal conveys the debate and theoretical development which takes place in the growing collaboration and research initiatives emerging from this borderland. The journal addresses all with an interest in research in sickness and society and especially health professionals working with education and/or research in interdisciplinary institutions.

Contents

Marie Østergaard Møller & Lise Kirstine Gormsen
Introduction 5

Peter Conrad & Vanessa Lopes Muñoz
The medicalization of chronic pain 13

Lise Kirstine Gormsen
Pain as an object of research, treatment, and decision-making 25

Marie Østergaard Møller
Stereotyped perceptions of chronic pain 33

Claus D. Hansen
Making a virtue of sickness presence - reflections on the necessities of everyday workplace 'suffering' 69

Jane Ege Møller
Lack of motivation as suffering 89

Keld Thorgaard
The normative and epistemological status of pain experiences in modern health care 109

Anders Dræby Sørensen
The paradox of modern suffering 131

Lars Thorup Larsen
The circular structure of policy failure and learning 161

Abstracts på dansk 195

Authors 201

Vejledning til bidrag 205

Beskrivelse af nummer 14 208

Original research article

Stereotyped perceptions of chronic pain

Marie Østergaard Møller

Department of Political Science, Aarhus University
marie@ps.au.dk

Møller, M.Ø. (2010). Stereotyped perceptions of chronic pain. *Tidsskrift for Forskning i Sygdom og Samfund, nr. 13, 33-68.*

The article explores how strong social stereotypes shape social workers' approach to assistance-seeking citizens. The empirical analysis focuses on the impact of 'deservingness criteria' as well as on how paternalistic and emotional arguments are used to justify stereotyped categorizations. In addition, the article illustrates why it is important to respect the assistance-seeking citizen's own problem and health perception in order to be able to protect the citizen from vague documented and moralizing casework.

Introduction

Knowledge of human interaction in political contexts is crucial for improving public policies. Street-level bureaucracy – understood as the locus where public employees such as doctors, teachers, policemen and social workers meet citizens as patients, pupils, criminals, victims and social clients – is particularly interesting. The legitimate basis of all public policy is that it is carried out on equal terms independent of personal preferences, attitudes, beliefs etc. However, we know that the human factor adds a dimension of both sensitivity and bias in the process of determining eligibility among street-level bureaucrats (Soss 1999). Doctors treat patients differently resulting in unequal access to treatment; teachers see certain pupils' problems as self-inflicted and others as disabilities, and social workers use stricter evaluation practices on some clients and easier ones on others. This issue of discrimination is, at worst, reproduced within the political administrative categories as institutionalized bias towards certain human characteristics (Schram et al. 2009). The question in the following is how stereotyped perceptions of chronic pain affect how social workers choose to evaluate assistance-seekers suffering from either contested or non-contested chronic pain. I do so by comparing social workers' reactions to comparable stories of pain patients. The article is framed by the theory of social solidarity (Durkheim 1984), public administration literature (Lipsky 1980) and political psychology research about public attitudes to 'deservingness' and 'entitlement' to welfare (Feather 2003). The political context of the article is active social policy in Denmark.

> *I have a lot of people who come and say, 'I want to be early retired. Do you think I can?' (…) Well, just like these two here. I tell them, 'I don't know, it depends on your capacity to work (…) What is it like? In order to receive an early retirement pension, your [working capacity] must be ZERO, and there must be no treatment options'. These are the [demands]. It's really difficult to be given [an early retirement pension]. And if there are any possibilities, then they must all be tried out first, so that all of the options are exhausted – all activation options, rehabilitation and flex job options.*[1]

The quote is from a Danish social worker who administers the current law of active social policy. The quote aptly sets out the content of the present article on how social workers categorize assistance-seeking citizens. How do social workers decide when all treatment options have been exhausted, and when it is fair to claim that a citizen has zero working capacity? Earlier analyses have shown that stereotyped perceptions dominate over experience-based approaches towards social clients (Møller, 2009b: 193). These analyses show a relationship between social workers' images of societies and their categorization practice and, furthermore, how this relationship is shaped by whether the social worker administers social welfare or sickness benefits (2009b: 239). Based on these findings, I seek to demonstrate how different perceptions of chronic pain result in stereotyped categorizations. In the article, I explore the dimension of stereotyped practice by comparing the social workers' reactions to contested and non-contested stories of chronic pain, respectively, and their subsequent preferred choice of evaluation practice. Thus, the article presents an empirical based study of social workers' reaction to different social stereotypes in the process of determining eligibility to social benefits.

The effect of contested pain in the process of determining eligibility

What happens to the process of determining eligibility when the claimed pain is contested? Can society accept an invisible and exclusive private pain as a legitimate public (and social) matter? When considering a person in pain, one would expect the pain of the other to count less than if the other was 'one of us'. If so, Parson suggests a way to find out how to interpret the ethical value of pain and that is by posing the question of confidence:

> [A]re you one of us or not? Your attitude on this question decides (Parsons, 1964: 97).

In the study, I use vignettes (see appendix) describing different diagnoses of chronic pain as the predominant symptom. Studies show that people tend to favour certain types of non-contested pain, such as e.g. multiple sclerosis; while disfavoring other contested types of pain e.g. fibromyalgia (Barker, 2005; Møller, 2009b; Meershoek, Krumeich & Vos, 2007). Furthermore, Studies of deservingness support these findings; evidence here points in the same direction – in accidents where victims cannot be held responsible, they are more likely to be perceived as deserving help than 'victims' who are blamed for their accidents (Feather & Johnstone, 2001; 2007; Weimer, 1995).

The following analysis captures the defining criteria in the process of determining eligibility and the evaluative actions suggested by the social worker. The analysis identifies aspects of how perceptions of fairness affect social workers' interpretation of stories of suffering, and how these interpretations are transformed into public categories of assistance or non-assistance categories. To support the set-up of the analysis, Bo Rothstein's notion of how the public discussion of social policy often becomes a question of a general perception of fairness has inspired the research design. In accordance with Rothstein, I argue that the organization of a particular welfare program such as the active social policy reflects arbitrary perceptions of 'the truly needy'.

> Where should the line between the needy- and the non-needy be drawn and whether the needy themselves are not to blame for their predicament? (Rothstein, 1998: 159)

In this perspective, the group of chronic pain patients displays this line between 'the needy' and 'the non-needy' in the current active social policy. Hence, the group works as a de-facto boundary between those who should and should not receive public support (Rothstein, 1998: 158). Moreover, perceptions of the pain of others trigger relations and reactions to questions such as 'who should we feel sorry for and why?' Additionally, because pain constitutes this very inaccessible private experience and is at the same time an important public concern for the suffering person, who may be 'one of us'. It also illuminates – by asking social workers to relate to such examples of chronic pain – the criteria used in the process of determining eligibility; and not least it opens a window allowing us to study how the social workers reason and justify their categorizations of citizens. Which criteria provoke a 'blame-the-victim' reasoning? Which criteria lead to 'empathy' and 'self-identification'? Literature in the field suggests that medical disagreements about the nosology of an illness tend to be reflected in the public through social interpretations with a clear judgemental character (Conrad & Schneider, 1992; Conrad, 2007).

The contested label then reinforces the judgemental interpretation of the 'painbearer'. In the concrete case of fibromyalgia, the character of the dispute is, hence, that it is framed as unreal and unexplainable instead of simply 'still not explained'. By framing an illness as 'unexplainable', strong associations to malingering as the real cause are made, and consequently malingering is established as the dominating key to interpret how to relate to such persons (Birket-Smith, 1998: 229-237; 2005; Gormsen, 2005; Conrad & Schneider, 1992; Østergaard, 2005).

Data collection and analytical strategy

Literature and analyses suggest that pain is a special tracer when we study the discretionary boundaries of the street-level bureaucracy's process of determining eligibility (Møller, 2009a: 10; Østergaard, 2005; Stone, 1984: 137). The argument is that pain experience is a highly subjective and private matter because it is difficult for others to 'see'. In general, it is difficult to communicate about pain, not least for street-level bureaucrats, such as social workers, who must evaluate 'the pain of others' professionally when they, e.g., administer access to sickness benefits and social welfare.

Furthermore, a study of visitation patterns for a chronic pain patient revealed that comparable diagnoses triggered different attitudes among both doctors and social workers (Østergaard, 2005: 44). The form and analytical strategy of the current analysis of stereotypes has primarily been conducted based on the experience from this study and on part on the empirical analyses in my dissertation (Møller, 2009b: Chapter 9).

> The argument that disability is a socially created category does not deny that certain characteristics of individuals significantly limit their ability to function. But to view disability as a social constructed phenomenon is to focus on a different set of questions: one asks not what is 'wrong' with some individuals, but why social institutions respond to some individuals differently than to others (Stone, 1984: 27).

The quote illustrates a social constructivist approach as a matter of observing perceptions rather than qualities of individuals. In addition, it exemplifies the purpose and the approach of the current study. The study is based on a qualitative study of 24 social workers from 20 Danish municipalities. The method used is cross-case and within-case comparisons using an experimental design to improve the possibility of analysing the mechanisms facilitating the processes of categorization practice. In order to enhance the general study, the research design includes three cases (vignettes) describing different types of chronic pain. I have chosen the case of chronic pain because it appears to be well-suited for studying the effect of different stereotyped perceptions. The vignettes are used as randomly given 'treatments' to create the variation under study, otherwise difficult to select beforehand (see vignettes in appendix).

The selection of social workers is based on a criterion of municipality size and geographic dispersion. Both criteria seek to strengthen the selection of similar and comparable cases located in social realities expected to embrace a variety of social problems. The aim is to reduce the risk of selecting municipalities dominated by special local problems, which I expect is more likely in smaller municipalities than in bigger ones. Among the population of 44 potential respondents, 24 agreed to participate in an interview. However, some of them were located in the same division. The total number of represented municipalities in the study is 20. Besides selecting the right type of social worker, the criteria assured that those selected administer the active social policy laws on either social welfare or on sickness benefits.

The three vignettes were constructed with varying diagnoses of chronic pain. The selection criterion was recognition, and the diagnoses reflect a distinction between a contested chronic pain and two non-contested chronic pains emphasizing different aspects of non-contestedness. Consequently, the 24 respondents were exposed randomly to a combination of two vignettes. One group received vignette combination AC and another vignette combination BC. The ordering of the stimuli was thereby standardized. The constructed variation in the three vignettes A, B and C constitutes a methodological possibility to study systematically how the social workers argue they will categorize the cases. By using vignettes A and B separately, I am able to compare the two groups of social workers on the parameter for various strong stereotypes. Vignette A describes a woman with fibromyalgia, which is a recognized contested condition, and vignette B describes a woman with the non-contested disease multiple sclerosis. Vignette C, which is given as the second stimulus to all social workers, allows me to compare within and between cases.

The reactions towards C, in which a woman with phantom pain is described, can be analysed and compared to the priming vignette (A or B). Even though the substantial reason to use vignettes is to compare A and B, vignette C is included in order to achieve these different comparative advantages and to anchor the interview around certain attributive characteristics of a case. Theoretically speaking, the main difference between the three vignettes is whether or not the pain is publicly conceived as contested or non-contested.

Evaluation practices

The basis for analysing the evaluation practice used towards the vignettes was to code all statements referring to where and how the social worker suggested they would clarify the particular citizen described in the vignette. The content of the code corresponds to each evaluation practice such as a referral to particular institutions. This coding facilitated an overview of the area to which the social workers would refer the three assistance-seeking citizens described in the vignettes. Display A2 shows the results of the distribution of choice for evaluation proposals in relation to pain stereotypes A, B and C (see Appendix A2). The display indicates that the social workers suggest a range of different institutions and efforts toward the assistance-seeking citizens to be important e.g.: *evaluation seminar*; *crisis management*; *lifestyle/competence center*; *medical test center*; *motivation program*; *general practitioner*; *psychiatrist*; *psychologist*; *rehabilitation institution*; *pain treatment and management* and *evaluation of current work place* (See Appendix A2).

The display also suggests that there is no significant pattern in relation to using certain efforts towards certain assistance-seeking citizens, as otherwise expected. However, the simple fact that the different efforts are used towards all three pain-stereotypes says nothing about the aim of the particular referral. In the following, the context surrounding the evaluations is included in the analysis in order to see whether the purpose of an evaluation differs according to pain stereotype.

Evaluation practices on hard and soft terms

In the following, the context surrounding the choice of the form of evaluation is included in the analysis. This revealed a significant pattern. We can see a relationship between how the social workers perceived the assistance-seeker's own problem perception and the intention of the suggested evaluation practice related to the vignette. Sometimes the social worker expressed a supportive attitude toward the assistance-seeking citizen presented in the vignette, and at other times he or she was primarily concerned with challenging the problem perception of the assistance-seeking citizen. The difference was hence coded according to the purpose of the particular evaluation strategy as either hard or soft. The following offers an example of how a referral to a rehabilitation institution can be used in both hard and soft purposes. The example is illustrated through two quotes stemming from two different interviews:

First of all, this is one of those illnesses where I'll say it's a theory that she has this [pain]. It's not something where you can get an accurate test capable of telling you with certainty that this [the pain] is precisely such-and-such an illness (…) She may be a typical person we would refer to our competence center (…) then [to] our rehabilitation institution for supplementary exploration, also in order to obtain an interdisciplinary effort. If you can locate the right [effort] for her, then I would first of all clarify whether there's a chance for rehabilitation.[2]

This exemplifies how the rehabilitation institution and the competence centre are used to clarify the assistance-seeking citizen's own perception of her health problems. It is not possible for the social worker to avoid violating the creditability of the assistance-seeking citizen's in this case, because she estimates a reasonable doubt that there is in fact no real illness. In order to live up to the letter of the law, she therefore intervenes in the assistance-seeking citizen's self-perception of her health by e.g. using an evaluation strategy at a rehabilitation institution. This use is assigned with the attribute of hard use of an evaluation practice. The following example shows the same:

This is a pure rehabilitation [case]. In other words, a training plan in order to be able to be preventive and look forward – she shouldn't have her health condition aggravated (…) that could be one model. But her fictitious perception of an early retirement pension as it appears here (…) that makes it a long journey (…) because there's a long way until she can see herself in the labour market, because she's thinking about an early retirement pension (…) and she can't go on and her strength is running out. So this is going to be the hard way for her (…) Her model would be something like: 'It's very likely that you can't work as a social- and health assistant, but we simply document that this is the case' (…) So in this case, you should think more comprehensively about her. So no, she is not entitled to an early retirement pension. And she can't receive an early retirement pension on this basis.[3]

The social worker here refers to the assistance-seeking citizen described in vignette A (fibromyalgia). As can be seen from the quote, the intention with a referral to an evaluation institution is to challenge the diagnosis of fibromyalgia – and thereby how the assistance-seeking citizen perceives her own health. This is made very explicit because the social worker talks about the assistance-seeking citizen's perception of own health as a 'fictitious perception'.

In contrast to these two examples of a hard use of the rehabilitation institution, the following two quotes illustrate a soft use. Both of these quotes refer to the assistance-seeking citizen with MS described in vignette B:

The way she describes herself here, she's really bad. And I wonder where I should refer her to. Sometimes we simply use a rehabilitation institution, where they begin by carrying out a social and healthcare examination. They work in a labour-directed manner and they're used to work testing (…) and they [use], for example, their workshop to figure out whether a girl like this can be practically work tested at all?[4]

In this case, the social worker refers the assistance-seeking citizen to a rehabilitation centre in order to document that her perception of own health should not be challenged. She reveals how she accepts the assistance-seeking citizen's self-perception when the social worker says that the aim of the referral is to find out 'whether a girl like this can be practically work tested at all'. The reference to the assistance-seeking citizen as a 'girl' – as opposed to a 'middle-aged woman' or a 'client' – creates an association to an innocent minor; a person we should treat carefully as we do our own children. The following offers another example of a soft use of an evaluation institution:

R: First, they make a seminar for some weeks, and then you get out in practical training. Or you can stay in training at the rehabilitation institution. And she would be one of those they would keep at the institution (…) And then you would test her out and say: 'What can she do? Can she sit at a table and put stuff together?' Her hands might work fine or something like that. She's so young, damn it! ButI: But you ignore her wish to apply for an early retirement pension then?

R: NO. This is done with the intention of getting her an early retirement pension.[5]

The rehabilitation institution is clearly being used for a soft purpose in the two quotes in the sense of easing the total evaluation process of the assistance-seeking citizen with MS. The concrete mechanism justifying this approach is the social worker's recognition of the assistance-seeking citizen's perception of her own health.

The different evaluation programs can hence be used for either hard or soft purposes reflecting how the social worker judges the extent and meaning of the respective assistance-seeking citizens' problems as they appear in the vignettes. The social worker thus seems to use the evaluation for one of two aims: as a tool to either support or undermine the assistance-seeking citizen's perception of own health and statements regarding related problems; that is the assistance-seeking citizen's own perception of why she lacks the ability to provide for herself. It seems that only when health problems are perceived in identical terms by the social worker and the assistance-seeking citizen will it be possible for the social worker to respect the citizen as an autonomous person.

Based on this theoretical set-up and the identified differences in the aims of the evaluation strategies, the context surrounding each suggested referral was coded as either 'soft' or 'hard' use in accordance with the principle illustrated in the quotes above. In cases where an evaluation was being used for a hard purpose, it seemed as though the social worker followed the strict intention behind the law (or an administrative norm, as analysed in Møller 2009b: Chapter 9). Conversely, in cases where the social worker used an evaluation practice with a soft purpose, it seemed as though the social worker was frustrated with the strict demands of documentation in the legislation. This became evident when the social worker ended a statement by posing a question concerning the fairness of the intervention as for example in the last quote that displayed a soft purpose. Here the social worker asks whether it is at all possible to rehabilitate 'such a girl'. Moreover, it appears as if the social worker identifies her role as either an authority or a therapist depending on the purpose of the evaluation strategy. The social worker appears to act and identify herself as an authority when the purpose is hard, but as a therapist when the purpose is soft. Display A3 in the Appendix shows the distribution of referral options in relation to the intention of the evaluation as it has been explained and illustrated thus far. Obviously, it then becomes interesting to see whether the expected pattern between the purpose of an evaluation practice and vignette case corresponds as already indicated above.

Display 1. Stereotypes and evaluation practices

Evaluation use: pain stereotype:	Hard	Soft
A (fibromyalgia)	11	0
B (multiple sclerosis)	0	13
C (phantom pain)	14	10
Total	25	23

n = 48

Reactions to stereotypes and use of evaluation practices

How is the use of ‘soft’ and ‘hard’ evaluation strategies distributed in relation to the assistance-seeking citizen descriptions described in the three vignettes A, B and C? Can the material under study confirm that a contested diagnosis causes a hard use of an evaluation practice and vice versa if the diagnosis is non-contested? The display below relates the pain stereotypes embedded in the given vignette to the purpose of the evaluation strategies as they have been identified in the interviews:

The display shows two things very clearly: First, that the social workers’ use of evaluation strategies may vary, but when the purpose of their use is included in the analysis, the display shows that when the assistance-seek has fibromyalgia, they choose a hard approach as opposed to a soft approach when the assistance-seeking citizen has MS. Even though the two stereotypes were selected based on them being strong and distinct enough to provoke a varying outcome, the result is still very strong on this point. That which is somewhat surprising and unexpected is the pattern of the relationship between evaluation use and vignette C. This is the second observation, which becomes clear in the display: It is impossible to see what characterizes the use of evaluations towards the assistance-seeking citizen described as suffering from phantom pain. At this point, one should keep in mind that the comparative logic incorporated in the analysis, does not apply to the comparison between the two main groups. The 11 social workers receiving the vignette describing a fibromyalgia case did not at any point know of the vignette describing an MS case, which the other main group (13 social workers) received and vice versa. All comparisons are made in relation to vignette C describing the assistance-seeking citizen who lost an arm in an automobile accident. In other words, no matter what the impact of the internal comparison has been for the social workers, it has been the same for the two main groups.

Priming effect of stereotypes on the use of evaluation practice

The social workers apparently use evaluation strategies for both hard and soft purposes when suggesting evaluation practices for the assistance-seeking citizen with phantom pain described in vignette C. A plausible explanation for this (lack of) pattern relates to the institutions involved. Since this pain type is not included in the job centres general policy tools for use in the evaluation of assistance-seeking citizens with health problems (as are both fibromyalgia and MS), the social interpretation of the phantom pain may depend on other, non-institutionalized perceptions. In other words, where the perception of fibromyalgia and MS is made explicit in the political institutions governing the field of social policy, the same cannot be said to characterize pain type C, because phantom pain is not mentioned directly in any policy documents, as is both fibromyalgia and MS.

However, there is a crucial detail that marks vignette C in the study: It was always given to the social worker as the second case. In other words, pain type C was always compared to the first given vignette (either A or B). In that manner, vignette C functions as a case not only used by the social worker to compare with the other vignette, but also as a case I can use to compare the reactions between the two main groups.

Hence, vignette C serves as an indicator of the differences between the two main groups receiving either A or B. This circumstance is analysed in greater detail below. The aim is to see whether it makes a difference to the social worker's use of practice towards C if they received vignette A or B as the first case. The following display shows how the use of evaluation appears in relation to C when the former vignette case is incorporated in the analysis:

Display 2 illustrates how the 'soft' and 'hard' uses of evaluation practices relate to pain stereotype C (phantom pain) when including the basis of comparison (fibromyalgia or MS). The display also shows that the correspondence is significant. When the social worker compared vignette C to vignette A, the evaluation method used was usually soft; whereas when it was compared to vignette B, the evaluation method used was most likely to be hard. In other words, the display shows that if a social worker related to vignette A, the reaction towards C was to use a soft evaluation strategy. On the other hand, if a social worker has just taken a position towards vignette B, the tendency is to apply a hard evaluation strategy towards vignette C.

Display 2. Basis of comparison for stereotype C in relation to evaluation practice

Evaluation use: Basis of comparison for pain stereotype C (phantom pain):	Hard	Soft
A (fibromyalgia)	3	8
B (sclerosis)	11	2
Total	14	10

n = 24 cases. P < 0.005.

In addition to this finding that the first vignette primed the reaction towards C, it became evident how the social worker weighted different aspects in the vignettes depending on whether or not they believed the assistance-seeking citizen's story described in the vignettes to be true. For the further understanding of what is going on when social workers categorize assistance-seekers, it is therefore essential to study this selection of aspects or criteria of eligibility in greater detail. This is especially interesting in relation to the reactions towards vignette C, because this pain type may be representing the most common type in a job centre. Not in the sense that there are more people without arms than people with MS or fibromyalgia at the job centres seeking assistance, but in the sense that vignette C represents an under-institutionalized health perception. In practice, most people do not fit a stereotype exactly. Instead, they approach the social system with different health and social problems that may be difficult to classify 100 percent in accordance with the existing administrative categories. But as the analysis has shown thus far, it seems as though the cases, which are not described in the policy tools, are still interpreted according to the social knowledge associating them with either a negative or a positive stereotype. In the following analysis, the focal point will be to analyse the reactions as they appeared in the material. The main point is thus not primarily methodological, but a substantial conclusion regarding how arbitrary or fragile the normal category really is. The next section explores this point in further detail.

Arguments for hard and soft evaluation practices

The literature on the meaning of pain and suffering is vast in both disciplinary and historical extents. This theme unites and separates thinkers, professionals, scientists and ordinary people, because experiencing pain is a salient trait of humanity, and relieving others of their pain is a fundamental social act (as long as they are not perceived as our enemy). However, there is often disagreement concerning the meaning of pain and social interpretations of others' pain. In this section, the distributive findings are described and discussed in order to see which aspects from the vignettes decided the social workers' reasoning about the meaning of the pain and the subsequent suffering related to it.

> The amount of pain and the amount of injury are not tightly coupled. The time course of pain depends on the needs for escape followed by the needs best suited for treatment and recovery. The location of the pain may differ from the location of the damage. The public display of pain has the purpose of informing others of the patient's needs whereas the private suffering assesses the meaning and consequences of the patient's own miserable state. All pain includes an affective quality that depends on the circumstances of the injury and on the character of the victim. (Wall, 2000: 15)

A neuroscientist presents the theme here. Basically, he clarifies how pain is embedded in both a private and public 'reality' and how the expressions of pain are not easily compared in terms of treatment and recovery. The following quote displays a similar theme as seen from the social worker's perspective at the street-bureaucracy level:

R: I actually believe that there's a massive difference between whether it's something you can see or not (…) And you'd be able to see something like sclerosis to some extent. I don't *think there's much understanding for something like fibromyalgia (…) And I don't mind admitting that at the school of social work, you learn that fibromyalgia 'sits between the ears.*[6] *We've had some intense discussions about it (…) So there's still a lot of uncertainty on that one.*

I: What are you being taught then? Because even though it might sit between the ears, it still may be…

R: Certainly, well this pain is experienced as very real. But then you can say that it becomes important which diagnosis you get in relation to what assistance you can receive. That is, whether you can get a flex job or a pension, right? (…) In case each medical consultant in each municipality says that – if they have different opinions of fibromyalgia and what it is (…) then it becomes significant.

I: Oh yes, so what you're saying is that what they say depends on which diagnosis the chronic pain is attached to?

R: I think so (…) I think everybody can relate to a man with one leg. But that Jørgen[7] *over there, who goes around and we can't really see it on him… and depression (…) and back pain. We don't have much respect for this.*[8]

The conversational sequence aptly displays the ambiguity relating to the perception of pain. When the social worker says, 'Well, this pain is experienced as very real', she denotes a very refined ambiguity by using the Danish word *'reel'* (here translated as 'real'). However, even though the Danish word signifies that it is 'real', i.e. 'actual' or 'practical', another sense of the word denotes a sense of fairness and properness. By using the word *'reel'*, the social worker hence denotes two conflicts stemming from a discrepancy between the social worker's perception and the assistance-seeking citizen's perception of own health: One discrepancy

Display 3. Relations between pain stereotype and intention of evaluation practice

	Relations between stereotype and evaluation:					
	Hard A	Soft B	Hard (A)C	Hard (B)C	Soft (A)C	Soft (B)C
Distribution of vignette cases	1, 5, 7, 15, 17, 19, 25, 31, 33, 45, 47	3, 9, 11, 13, 21, 23, 27, 29, 37, 35, 39, 41, 43	8, 26, 46	4, 10, 14, 22, 24, 30, 36, 38, 40, 42, 44	2, 6, 16, 18, 20, 32, 34, 48	12, 28
Total	11	13	3	11	8	2

concerns reality as opposed to fiction, and the other concerns the reliability and fairness of the pain narrative put forward by the assistance-seeking citizen as opposed to society's perception of the same.

In the following, arguments of this kind will be analysed in relation to the findings displayed thus far. However, before presenting the hard evaluation of vignette A, the soft evaluation of vignette B and the two different main reactions toward vignette C, an overview showing the relations between pain stereotype and the intention of the evaluation practice is presented in relation to the vignette cases: The display illustrates the attributes of each vignette case. The display shows how there are very few 'outliers' in the analyses, and no matter how interesting they may be in order to further develop the theoretical understanding of categorization, the following analyses are concerned with exploring the typical relations which have been identified. These main relations are between a hard use of evaluation practice towards vignette A, a soft use of evaluation practice towards vignette B, and the primed reactions towards vignette C.

Reactions towards fibromyalgia and MS

The social workers were randomly divided into two groups, each receiving a different vignette combination. One main group received a fibromyalgia and a lost-arm description, while the other main group received an MS and a lost-arm description. There are several potential comparative advantages stemming from this set-up. Based on the analyses so far, it seems most relevant to compare the two main groups before we consider the different reactions toward vignette C. In the following, the first analysis explores the different reactions towards the first given vignette in the interviews by comparing and describing selected quotes from the coded sequences about vignettes A and B. The first section illustrates how the social workers typically evaluated and argued about the assistance-seeking citizen described with fibromyalgia, while the next section illustrates the same about the MS vignette.

[I]t has a lot do to with the will to… having the will in spite of your pain

The group of social workers receiving vignette A chose a hard evaluation practice towards the assistance-seeking citizen which can be explained by the contested value of the diagnosis; socially it is interpreted as denoting an inferior kind of suffering compared to the suffering stemming from other diagnoses, such as MS. The social interpretation of fibromyalgia was also found to be highly institutionalized; in the policy tool of the *referral guide*, it is described as a diagnosis to which the professionals should pay extra attention when clarifying whether these assistance-seeking citizens primarily 'suffer' from possible motivational barriers, which is generally associated with attempts at 'milking the system'. In order to understand the mechanism structuring the argument behind a hard practice, a number of quotes have been selected to display examples of sequences in which the social workers interpreted and evaluated vignette A with a hard purpose. Hence, each quote is chosen to display the general features behind the reactions to the vignette. The following example shows a reaction where the contestedness of fibromyalgia structures the hard approach towards the assistance-seeking citizen in vignette A:

> *Yes, well. She has been on sick-leave for six months. Yes, first, well again this is about this... First, I will have her health clarified and next in relation to the limitations. This is one of these very diffuse illnesses right? (…) 'Oh well', you can say every time it's fibromyalgia. And 'Oh no not another one'. They're difficult. They're really difficult, also because it's very subjective how people experience this illness, right? (…) And there are many medical theories about it. And some recognize it, but there are also many doctors who refuse to recognize this illness (…) She wants an early retirement pension, and that [I] know… she won't get it. No (laughing) It's simply because, it's so hard to receive a pension today, right? (…) That is, before we even get to that evaluation.*[9]

The quote reveals a pivotal point in all of the hard judgements of the fibromyalgia vignette, namely how the social worker bases his/her evaluation on the premise that fibromyalgia equals a working capacity. In other words, they do not compare fibromyalgia to the physical possibility of a reduced working capacity, suggesting that even though most of them used the discourse of 'this is a very hard and diffuse case', they all said very similar things about fibromyalgia. This indicates the opposite picture, namely that the diagnosis should be very easy to handle and interpret for the social worker.

The ambiguity and diffuseness is not a substantial problem, but instead the general frame that structures the argument for approaching the assistance-seeking citizen with suspicion – and consequently to argue for a hard evaluation practice. The following offers another example of this discursive setting, which the social worker initiates by excluding the possibility of associating fibromyalgia with a physical limitation:

Today it isn't easy to receive an early retirement pension. There mustn't be any working capacity left at all. And that is, first, everything else must be tried to see whether there isn't a chance. So this isn't exactly what she should go for. And inasmuch as she isn't very old, then the smartest thing for her would not be to go home with an early retirement pension (…) No. So, I still think she should start with this resource profile to see whether they can find something she can do, even though she has an illness (…) like fibromyalgia.[10]

In addition to showing how the working capacity and fibromyalgia are not initially perceived as negatively related, both quotes designate how the perception of the assistance-seeking citizen is ignored in favour of a social perception of fibromyalgia as a deceptive illness, which is not associated with a legitimate claim for assistance.

The legitimacy aspect is consistently hinted at in the reactions to fibromyalgia. In order to understand the scheme that structures the social workers' boundary making for what is perceived as legitimate pain and what constitutes an unfair claim for public assistance from the assistance-seeking citizens, the difference between 'our pain' and 'the others' pain' seems to be a fruitful entrance. In the examples of a hard evaluation practice toward vignette A, there was a significant framing of the pain as belonging to a different – and inferior – community than the social worker's. Next, a quote illustrates this notion. I.e., fibromyalgia pain is associated with 'the others'' pain and perceived as inferior to 'our' pain:

[T]his stinks of her having considerable barriers in relation to the labour market (…) and therefore you should not wait until she has passed 40 weeks of sickness benefits or whatever strange limits there might be. I think you should make a resource profile of such a person immediately (…) I think that she has substantial barriers – somatic, but has some cognitive difficulties it says here – and the cognitive difficulties she has are obviously caused by [she pauses, laughing] the pain she has, too (…) then I would find out what is the essential barrier here. Is it somatic or is it cognitive? And then I would gather some documents and figure out what to do.[11]

In addition to the choice of pejorative remarks and associations made in the quote, as when the social worker says 'this stinks of her having considerable barriers in relation to the labour market', the social worker expressed strong body language, signalling how she dissociated herself from the described assistance-seeking citizen. For example, she pauses, laughing, while speaking, and she uses sarcasm as when saying, 'and the cognitive difficulties she has are obviously caused by [she pauses, laughing] the pain she has, too'. She uses 'obviously' in a manner that was clearly intended to send the opposite meaning, namely that the causal relationship between the assistance-seeking citizen's difficulties and the pain is perceived to be unlikely and unfair.

This is really a diagnosis which can give a pension

All 13 social workers who received vignette B reacted towards the described assistance-seeking citizen by proposing a soft evaluation strategy. In the following sequence, the social worker picks up the diagnosis from the vignette immediately and connects it to the possibility of a pension:

This one – this is really a diagnosis that can give a pension. (I: Sclerosis?) Yes, it can. It can be very quiet for some, whereas when it hits others – BANG (…) and then you're so disabled that you can't (…) It's very different (…) But there are very good specialists within this area, right? So you can get a lot of documentation.[12]

According to the social worker, the difference in the impact this diagnosis can have on people means that it does not belong together with fibromyalgia as a contested disease; instead, it is a rather capricious disease that behaves unpredictably. Here, the disease – not the patient – is identified as the 'enemy', as opposed to what was generally the case in relation to the hard evaluations of vignette A.

The social workers reviewing vignette B generally presented the 'problem' within a discourse of a common sense perception that the assistance-seeking citizen in vignette B ought to be given a soft work test:

[B]ut she won't avoid being work tested (…) You can say that of course you will have her work tested very gently. After all, she's not going out 37 hours/week.[13]

The subscription to common-sense reasoning turned out to be a very powerful tool in these matters, because it denotes that this has to do with basic decent human behaviour. If you do not follow or agree with such common-sense reactions towards disabled people, you risk being categorized as an inhuman and a rigid-minded person. The following offers another example of the use of common-sense knowledge in connection with exempting the assistance-seeking citizen in vignette B from the normal, strict rules:

But it's also because no matter what she does or says, then it's difficult and stuff like that. So, how to put it? Well, it will always be an individual consideration, when you sit in front of people. But on the face of it, I'd say that the purpose of the work test will be to show that she can't do anything. Not that she can do something (…) if you understand what I mean – the difference, right?[14]

In this quote, the social worker accepts the assistance-seeking citizen perception of own health, because she refers to her own statement without ever questioning the reality or fairness of it. The social worker continues along the same lines in the following:

This one with sclerosis – she won't take long to clarify. That is, 'We know what we know', I'm tempted to say. She's bad. She's sitting in a wheelchair. She won't get any better (…) She'll undergo a fairly short work test.[15]

The use of the expression: 'We know what we know' may refer to both her professional community and a bigger, more abstract community including all loving, caring humans. However, the crucial point in this context is simply to illustrate the strength of a reference to a basic 'silent' knowledge as the fundamental argument for her practice.

In addition to this generally sympathetic attitude towards the MS diagnosis described in the vignette, all of the social workers also took it as 'serious', though still, always demonstrating how their soft, exempting evaluations were made within the legislative framework. This became evident when they referred to the need for a work test and at the same time expressed their sympathy for the assistance-seeking citizen. Nevertheless, in contrast to the hard reactions toward A, almost all of the social workers, who evaluated the assistance-seeking citizen in vignette B, selected the MS diagnosis and equated it with a threatened working capacity, even before suggesting an evaluation. The following example shows such an equation; here the assistance-seeking citizen with MS is categorized as having a threatened working capacity even before she has been clarified:

Well, with her there's no doubt at all. That is, I would immediately think that her working capacity is threatened. And then the resource profile must be initiated immediately in order to get it described. And particularly to have all of her health information collected (…) no doubt about it (…) when she has sclerosis, so this must be gathered right away (…) She's confined to her bed, wheelchair… this can only go one way. We know it, and it goes fast, right? (…) So in this case, I would immediately think, 'Well, I'll try to clarify her'.[16]

In this quote, the social worker draws on a deathbed metaphor and compares the assistance-seeking citizen to a dying patient. In doing so, she ascribes legitimacy to the assistance-seeker's interest in an early retirement pension, as when she gives her an exemption from the labour market, thereby giving her political and social right to an early retirement pension. Unsurprisingly, the use of a deathbed metaphor is very effective towards creating an understanding and sympathetic frame of the extent and content of the problem. Being associated with a potentially fatal illness makes it relatively easier to make the connection to social and political rights to public assistance. If you are dying, then of course you are entitled to permanent public support. In other words, the deathbed metaphor associates her with a terminal patient, which again is a good symbol to which to anchor reasoning as to why the assistance-seeking citizen ought to be exempted from the strict activation demands. In addition to this, a need for more knowledge about treatment options is also mentioned in the quote in order to signal a good, caring effort.

This is very interesting as compared to the typical reactions towards the contested fibromyalgia diagnosis, where none of the social workers mentioned a need for more knowledge about the diagnosis, despite the fact that it is unexplained and highly debated among doctors and the general public. On the contrary, the social interpretations were so strong that it may never occur as an obvious component in their casework. It seems as though no one wants to know more about it – they have already made up their minds! The opposite case applies to the reaction towards vignette B, even though the diagnosis is described clearly:

Well, first of all, that which is very evident here is her diagnosis. Because it's important that you, as a caseworker, get a feel for what it's like to have sclerosis. You must have knowledge about the area. No doubt about it. You must be sure of your support base in relation to going directly to the medical consultant and saying: 'What does this really mean?' We know where this is going.[17]

Summed up at this point, the reactions towards vignette B were generally characterized by *not* being anchored to the information of chronic pain in the vignette. Instead, the social workers paid the most attention to the diagnosis and the wheelchair together with the cognitive problems described in the vignette. These were considered as caused by – that which the social workers generally framed as – a serious disease as opposed to a contested symptom, as was the case among the social workers who reacted to vignette A. There were few differences between the two vignettes in relation to which elements varied between them (See Display A1 in appendix). However, that which did vary, namely the diagnosis and the supportive means such as the bandages and wheelchair, most likely caused the social worker not only to notice different elements in the vignettes, but also to use very different reasoning as to how to interpret and evaluate the assistance-seeking citizen.

In the final comparative analysis, the attention is focused exclusively on the reactions towards vignette C. Based on the result of the analysis, which pointed out a priming effect of the first vignette, this analysis becomes even more interesting. Not only because of the methodological aspects, but also because the substantial implication – that the 'most normal' and least institutionalized vignette – systematically provoked different reactions among the social workers. Where the first comparison between the two first vignettes can be explained precisely by their significant differences, the reactions towards vignette C reveal that something other than vignette differences caused the two predominant reactions towards the same vignette. Thus far, the explanation given has been the basis of comparison with the first given vignette. In the following, I will substantiate this result using a selection of typical quotes to illustrate the two main reactions as they have been identified. The analysis exemplifies the arbitrariness of the under-institutionalized category and shows the room of variation for the social workers' decisions, when they use a stereotyped perception to argue for a categorization practice.

Reactions towards an accidental loss of an arm

In this part, only the reactions towards the second presented vignette (C) are analysed and compared. Again, there are several potential comparative advantages stemming from this set-up, but the crucial thing to make note of in this analysis is the differences between the reactions to vignette C. In the following, the second analysis explores these different reactions towards the second given vignette in the interviews by comparing and describing selected quotes from the coded sequences about vignette C. The first part illustrates how social workers typically evaluated and argued when they argued for a hard practice towards vignette A and afterwards a soft evaluation practice towards C. The next part illustrates the opposite of the pattern as it has been analysed so far: a soft reaction towards the assistance-seeking citizen described in vignette B, which in most cases resulted in a hard evaluation practice towards vignette C.

She has lost a lot (…) so she may end up receiving a pension

If suspicion and compassion were the two words that best described the differences between the reactions towards vignettes A and B, then it becomes interesting to see whether the same two nouns can be used to describe the differences between the two reactions towards vignette C; or whether a distinct discursive setting is used when vignette C is being evaluated and interpreted. As the heading above clearly implies, the first part analyses the soft reaction towards vignette C.

The second vignette presented describes chronic pain, a feature the social workers associated with malingering in their hard reactions towards vignette A. However, vignette C also describes the problem as caused by an accident. This component of the vignette may be better compared to the impact of the MS diagnosis in vignette B. As such, it is possible that this criterion triggers a sympathetic and soft attitude towards vignette C.

In the first quote, the social worker justifies her choice of a soft evaluation referring to the traffic accident. The accident is associated with a trauma, which is how she justifies exempting the assistance-seeking citizen in vignette C from the labour market:

Again, you'll have to look into how much she has lost, right? (…) She has lost her occupation; she has lost part of herself (…) That is, find out altogether whether she has had psychological therapy in relation to the accident she experienced. It is a a trauma unto itself to have to change our lifestyle totally.[18]

However, the initial framing of her reaction is attached to a metaphor of loss; she uses the missing arm to describe other aspects of the assistance-seeking citizen's life beyond the arm.

The physical limitation of the missing arm hence constitutes a discursive frame in which she uses the same verb 'to lose' both in relation to her unemployment, her self-relation, and not least to her personality. All of these components were often present in the hard evaluation of vignette A, though always associated with a negative frame of self-responsibility and malingering. Conversely, the current framing of the expanded loss makes it easier to interpret the problem as clearly worth a soft public effort. Consequently, the interpretation of losing an arm becomes the defining metaphor, which the social worker uses in order to ascribe the assistance-seeking citizen with a disability worthy of being legitimately exempted from the general demands of activation:

I'm thinking about whether or not she's successfully treated for her post traumatic stress (…) that is, whether or not she has been successfully treated for the repercussions it has caused her. Because losing a body part is a massive trauma (…) And phantom pain, when it's described as being so strong. I think I'd contact a specialist about it, because I don't know enough about it in order to be able to evaluate how much it can disable her. So I would definitely ally myself with somebody.[19]

The same discursive setting is used in the quote below, where the social worker connects the lost arm directly with the possibility of a pension. The assistance-seeking citizen is interpreted as a person who has lost 'a lot' beyond the arm, which the social worker presents as entitling her to a pension:

[I]t's hard to tell how bad she is (…) I would say, 'Well, there is probably also a psychological aspect'. She has lost a lot (…) so she may end up receiving a pension. I wouldn't reject that at all.[20]

The next quote offers yet another example of how the accident triggers a chain of reasons for why the social worker chooses a soft reaction towards the presented assistance-seeking citizen. First the accident is connected to a 'post traumatic kind of thing' which connects to the accepted perception of the cognitive problems:

Depending on how bad she is, if she's hit hard by some post traumatic kind of thing, then she will have to… Oh, she may not necessarily have to go to a rehabilitation institution, but she may go to a private workplace with an educated mentor (…) for her. Because I could imagine that she needs, well then she has these cognitive things. She could use some support from a mentor. And if she can work with that, well, that depends on (…) what kind of a person she is (…) She could maybe benefit from being shown that she's needed.[21]

The quote shows a very compassionate reaction to how the cognitive problems become interpreted as legitimate limitations perceived as having a serious character.

The following, final quote describes another example of a soft reaction towards vignette C. Here, the pain is associated not with a contested pain but instead to neurological damage. This sort of pain is considered as more serious/salient than was the case towards the pain in vignette A.

I would be more nervous if there was neurological damage, of course (…) then she shouldn't be pushed to (…) the limit. Because that could have consequences (…) fatal consequences, right?[22]

This quote should be compared to the same social worker's reaction towards vignette A in relation to the sayings about when and why an assistance-seeking citizen should be pushed to the limit:

That is, you shouldn't do that to a person with fibromyalgia, either. That could also worsen her condition – if you pushed her beyond what you could do (…) but to begin with, I would say that she's better off being pushed (…) as much as possible.[23]

As in the previous analysis, this social worker suggests to push the assistance-seeking citizen in vignette A in order to uncover the truth about her pain. However, her opinion towards the assistance-seeking citizen in vignette C differs on this point. Here, the assistance-seeking citizen should be spared such a hard approach. For, as she says, 'that could have consequences (…) fatal consequences, right?'

Generally speaking, the soft reactions towards vignette C contain clear elements of compassion for others as well as respect for the assistance-seeking citizen's self-perception and health perception. This suggests that empathy is the basic mechanical mechanism driving the reaction; however, the acceptance of the assistance-seeking citizen's own health perception also corresponds well with the virtue of citizen's rights to autonomy. In the following, the impact of the 'idea of citizen's right to being an autonomous individual' is further discussed in relation to the hard reactions towards vignette C.

[Y]ou don't get a pension for a one-armed illness

The soft reactions towards vignette C – generally associated with a disability discourse of compassion – made it difficult to distinguish empathy and pity from one another. In contrast, the hard reactions towards C were characterized by very different reasoning. Here, the reactions were much more comparable to the reactions analysed in relation to vignette A. Not least in relation to which aspects of the vignette the social worker selected to anchor the interpretation of vignette C. As was also the case in the reactions towards vignette A, the hard reactions towards vignette C draw on the element of the vignette describing the assistance-seeking citizen's chronic pain problems.

In the first quote describing a hard use of an evaluation practice towards vignette C, headaches and back pain are mentioned; aches that constitute some of the classical elements in suspicions of malingering. In the quote, it is interesting how the interpretation of the meaning of the lost arm differs radically from the one in the soft approach, which was primed by vignette A. In this case, where the reaction is primed by vignette B, the meaning of the lost arm is perceived as nothing special that goes beyond the concrete arm. The pain described in the vignette is now being associated with the arm alone and is interpreted as normal instead of traumatic discomfort:

There's no doubt that she should be work tested within a field other than childcare. And then it might turn out that [the work test] shows that she isn't even entitled to a flex job. (…) Because – depending on how much having back pain and headaches affects her, if there really isn't that much to work with, well, then she shouldn't receive a flex job. That is because you can say that those who are born with only one arm – they don't receive a pension or a flex job for that reason. That's the way it is. But no doubt about it – she should be given some kind of help.[24]

The same interpretation of the lost arm as a condition that should not be seen as anything other than a functional challenge prevails in the following two quotes:

Yes, this [case] is definitely a bit more difficult. Off-hand, I would say that this is going to be a long haul (…) That is, you don't get a pension for a one-armed illness (…) on the face of it (…) It would depend on an evaluation and a long-term course in order to figure out her options if she can't manage it.[25]

Again it becomes evident how the interpretation of the impact of the lost arm differs from the interpretations towards vignette C suggesting a soft strategy. A one-armed illness does not constitute a legitimate exemption according to the social worker in the quote:

Here, it should QUITE SIMPLY be tried out (…) It would require a longer course, and even though a doctor says that she has chronic pain, that's not enough to say that you get a pension for a one-armed illness (…) You simply just don't get that.[26]

When comparing this quote to the aspect of the soft reaction towards vignette C, where the loss of an arm was associated with both the assistance-seeking citizen's psychological and social condition, the difference becomes quite clear. In contrast to the expanded meaning of the lost arm in the soft approach, the social worker here comes to the very opposite interpretation: 'You can't simply say that a person isn't capable of doing anything just because you've lost something'.

Even though the social worker in the following quote selects the pain element from the vignette, she does not use the term 'phantom pain'. Instead, she refers to headaches and back pain in quite the same way it was referred to in vignette A, namely as indicators of an 'illegal' pain – or at least a contested pain. The social workers suggested that the assistance-seeking citizens with contested pain should be sent to rehabilitation institutions in order for the caseworkers to determine what it is all really about:

I have a lot of clients who have – where there aren't any objective findings. But they simply have pain everywhere (…) Yes. They have headaches, back pain, pain in all the locomotive apparatus. Yes (…) [I] send them out of the house to our rehabilitation institution, where we have doctors employed, psychologists (…) occupational therapists, physiotherapists, social workers, job consultants (…) Then they get a 10-week evaluation course (…) and then they see them all (…) and find out, 'Well, what's this all about? What does it take?' (…) For example, is there some kind of psychological superstructure causing her pain? That is, maybe there's something psychosomatic, which the psychologist may contribute to clarifying, right?[27]

Again, this reaction can be compared to the typical hard reaction towards vignette A. The assistance-seeking citizen's primary problem is here conceived as being related to (a lack of) motivation and hence the reason why she prevents herself from getting a job and coping with her pain:

Well, it may certainly reduce her motivation (…) because what has to be worked with here is her motivation – and then we have something called 'Express Care[28]*'. This is quite simply an exercise – well, it's taken care of by physiotherapists. It has to do with asking whether there is some exercise, some physical training that can make – which can reduce* *the phantom pains (…) And the third and final option is possibly a referral to our rehabilitation institution here in Jarslev,[29] where you can work cognitively with motivation and with visualizing yourself back into the labour market (…) because she might not be able to hold an ordinary job. She might require rehabilitation in order to regain her total working capacity. But they can also work with how you deal with chronic pain.*[30]

This is an example of how the social worker sees her problem as primarily about a (lack of) motivation, which is assumed to be the cause preventing her from keeping a job and from coping with her pain.

This discursive setting, where motivation becomes negatively related to the length of the described sick-leave period and next to the assistance-seeking citizen's (lack of) will to work ultimately, produces a free-rider suspicion instead of recognizing the lost arm as a legitimate disability. The fundamental perception of the assistance-seeking citizen hence becomes a description of a somewhat lazy person, which again can be compared to someone who does not make the (politically expected) 'extra' effort:

That is, I'd try to motivate her, right? And to do that, I think I'll use a clarifying course, where she simply should have some long talks about where she could picture herself, where, 'What options do I have with this education?' Right? And make some phone calls to different places. Get some help to do these things. She has obviously been gone for a long time (…) The labour market has become big and frightening and really scary for her. And then it's a bit easy to say… well, that it's more pleasant to be able to simply be free of all of it (…) Because, of course she is disabled. But after all, she still has her head and she functions. And she has a life. I'd clarify her through a project, I think. And figure out her options? What could come out if it? (…) And then, of course, it would be something about helping her with some skill development of some kind. If this became necessary.[31]

In addition to the perception of the assistance-seeking citizen as being somewhat lazy and as primarily suffering from low work motivation as opposed to a reduced capacity to work, the social worker in the following quote denotes the pain as 'diffuse' and thereby associates it with a contested condition. Again, the doubt about the reality of the pain structures her approach, for example when she asks, 'what's this about?'

Moreover, the social worker clearly does not accept phantom pain as a 'real' diagnosis. She indicates as much when asking whether 'this is something you can assign some diagnosis'. The chain of reasoning hence starts by denoting a lack of (real) diagnosis, which proceeds to identify a lack of self esteem, then to a thesis about how exercise as a treatment could be part of the solution to both the described sleeping problem, which finally becomes the constituting frame of legitimizing the preferred evaluation strategy towards the assistance-seeking citizen:

Here, it's a bit more diffuse (…) and she has this pain. And you don't really know anything, 'Well, what's this all about?' Is it something you can give a diagnosis? Can it be treated? Can she gain some more self-confidence, some training or something else? (…) there's a dormant problem, I think. She – I imagine I would gather something about the treatment options – and then maybe something from a specialist in relation to the same part, namely concentration (…) and everything about how it affects her ability to function.[32]

As in the case of the evaluations of vignette A, the association with a contested diagnosis is also related to the possibility of cheating. Thus, one social worker compares the case of the lost arm to the MS case and proceeds to discuss how the evaluation of the patient will depend on her behavior, suggesting how patients with a contested diagnosis may indeed exaggerate their pain:

R: That is, a patient with sclerosis will have a totally different status (…) no doubt about it.

I: Compared to?

R: Compared to someone else with chronic pain, who says 'I'm on sick leave because of chronic pain'. It depends on how the particular citizen behaves [the respondent laughs] (…) It also depends on what kind of society you're in. And on which social class you belong to and who you associate with. What signals are you sending?

I: Could you go into greater detail about that?

R: Well, you know what it's like when you know about someone in a small community (…) right? Who has been retired because of chronic pain – and an overwork condition

I: It's not much fun?

R: No. Someone like that has, well… I know of a person like that from my earlier municipality, right? (…) And now the person is actually capable of doing a lot of things in the community since receiving the pension. And has gotten a public pension, and where one is active… that sends a very, very bad signal. There's a lot of talk and gossip. It gets really, really hard (…) There's a totally different understanding of sclerosis (…) It's a severely debilitating disease, which you know you'll die from at some point, right? (…) You'll get steadily worse. That's totally different…

I: Totally different?

R: COMPLETELY different.

I: People have another opinion?

R: Yes, they have.[33]

Thus far, the general image of how the social workers relate to the vignettes is that they draw on stereotyped perceptions in quite different ways and with very different outcomes. Sometimes the social workers suggest a hard and at other times a soft evaluation practice.

During the interviews and the development of the analyses, I sometimes wondered about what, in the eyes of the social workers, an appropriate pain perception of 'the others' looked like. Not in the sense of how they themselves experienced pain or how they related to their own pain, but exactly how they expected other people to relate to pain.

In the course of the coding process, I did find several expressions of the social workers' perception of what they thought appropriate pain-coping looked like. Even though these images of pain have not been part of the general analysis in this article, the following two quotes may contribute to the general understanding of what causes social workers to react to others' pain the way they do as it has appeared in the collected interviews. The following two quotes from Interview 8 show an example of a social worker's personal perception of the appropriate pain behaviour of 'others':

Here, in this building, we've had a colleague who lost his arm at a very young age to cancer. And who, by the way, is now dead as a 39-year-old (…) and he slaved away until the end and didn't want a pension.[34]

And she gives another example:

And Johan,[35] *who we have here, who is blind and makes a huge effort and goes out and gives talks to people about why they can't get a flex job, for example, right? Well, Johan has a personal assistant who makes sure his papers are accessible for him. But that's also the only [assistance] he gets. He takes care of everything else himself, right? (…) And what is it that makes him walk down the hall and – I'm tempted to say (…) is happy and satisfied every day. He lost his sight as a 16-year-old. Why hasn't he lost his courage? (…) This is COOL, really nice (…) And what is it that gives him the quality of life he has, in contrast to others who would sit down and not be able to do anything for the rest of their lives? (…) I think that's really interesting.*[36]

The social worker clearly raises a number of basic human questions, which most people wonder about when they hear about other people's complaints and sufferings. In the first quote, she refers to a man who 'slaved away' despite having cancer, a lost arm and probably a lot of pain.

He is obviously a hero in her eyes. Again, this is not very difficult to follow, but the standard of will and motivation to work, which she describes as appropriate through the story about the young man, may nonetheless be an unachievable standard to use in relation to assistance-seeking citizens with a poor health perception.

Conclusion

The use of vignettes in the interviews generally contributed to the understanding of what leads to variations in the categorization practices employed by different social workers. The differences in categorization practice were measured in terms of the social workers' use of hard or soft evaluation strategies towards fictive cases. The vignettes were constructed as recognizable stereotypes about different diagnoses with chronic pain as the common symptom. The social workers understood contested chronic pain as private pain, which was considered to be a normal human condition; something we all have to live and cope with. Therefore, they tended to dissociate themselves from the contested pain bearers, as they were examples of whimpering persons with a 'second agenda', implying that they were malingering in order to gain free, undeserved political and social rights. According to this understanding, pain is implicitly understood as something that 'brings us together as humans'; consequently, whoever demonstrates a wish to escape 'that which brings us together' is perceived as not wanting to belong to the designated community. The perception of the MS vignette stands in contrast to this pain perception. Here, the pain was rarely selected from the vignette as a salient feature, even though it was described using identical words in both vignettes. The social workers generally approached the MS assistance-seeking citizen with empathy and understanding, and their aim was to use an evaluation practice facilitating quick relief for the assistance-seeking citizen in the form of a pension. These two different types of reactions met the theoretical expectations very well. However, an interesting pattern emerged in relation to the reactions towards the second vignette presented to the social workers. This pattern showed that the social workers made different evaluations depending on whether vignette A or B was presented to them. In most of the cases, this priming effect resulted in the opposite reaction to vignette C as compared to the first reaction. A comparison of these primed reactions has revealed that not only the outcome, but also the concrete aspects of vignette C changed accordingly.

The analysis has opened a window for exploring how strong stereotypes shape the approach to assistance-seeking citizens. The analytical strategy was to focus on what is generally referred to as 'deservingness criteria' and what previous analyses have shown in relation to a dominating presence of paternalistic and emotional arguments for a stereotyped practice (Møller, 2009b: Chapter 7). However, the analysis has also hinted at an aspect of how individual perception and corresponding individualized practice depend on being able to hold the assistance-seeking citizen's problem and health perception 'sacred' in the sense that it must be accepted in order not to violate the protection of the citizen from moralizing interventions.

Implications

By letting stereotyped information influence the judgemental practice of our political system, we allow for arbitrary criteria and particularistic policy preferences to determine the access to fundamental political and social rights to public services. This applies because stereotypes work through over-determined associations of either positive or negative character and hence always trump the concrete experience and evaluation of the citizen. This contradicts the fundamental principles of equal access to treatments in the political system as well as an objectively based evaluation of – in this case – the assistance-seeking citizen's working capacities. When stereotyped associations take over, the eligibility to public services can no longer be based on a concrete evaluation of the citizen. In the empirical analysis, I found that social workers reproduced and reinforced the institutionalized perceptions of social stereotypes such as contested/non-contested pain to justify their reasons for categorizing assistance-seekers differently. Seen in the light of this result, one may ask how many resources society should spend not only to ensure that all citizens should work, but also the costs – not simply in respect of money, but also in respect of legitimacy – to evaluate how much assistance-seeking citizens in pain 'really' want to work. The risk of being associated with a negative stereotype is relatively high since many citizens' complaints and reasons for unemployment far from fit particular non-contested categories and their 'reality' is hard to measure. The findings from the analyses have shown that the potential consequences of being ascribed with such negative values may give the citizen quite a different course through the system compared to the course of a citizen who is disabled enough in a non-contested way to be associated with a positive stereotype.

Appendix

Display A1: Vignettes

A)Imagine a 34 year-old woman with fibromyalgia. She is married and has two children living at home. She has been on sick leave for six months from her job as a social and health care assistant mainly because of chronic pain in joints and muscles. She wants to apply for an early retirement pension, because she does not see herself as being capable of doing her job properly. She now uses support bandages almost all of the time, and she has tried all kinds of treatments without getting any better. In addition to her pain, she has trouble sleeping, together with memory and concentration problems. Her experience now is that if she goes to work or does housework, she ends up in bed for several days.

B) Imagine a 34 year-old woman with multiple sclerosis (MS). She is married and has two children living at home. She has been on sick leave for six months from her job as a social and health care assistant mainly because of chronic pain in joints and muscles. She wants to apply for an early retirement pension because she does not see herself as capable of doing her job properly. She now uses a wheel chair almost all of the time, and she has tried all kinds of treatments without getting any better. In addition to her pain, she has trouble sleeping, together with memory and concentration problems. Her experience now is that if she goes to work or does housework, she ends up in bed for several days.

C) Imagine a 35 year-old woman, who lost an arm in a traffic accident. She is married and has three children living at home. She has been on sick leave since the accident 18 months ago from her job as a childcare worker mainly because of chronic back- and head pains as well as strong phantom pain in her missing arm. She wants to apply for an early retirement pension because of her handicap. Since the accident, she no longer sees herself as capable of doing her job properly, since she generally has a lot of trouble just trying to handle the extra pain and extra difficulties in her everyday routine that stem from her lost arm. In addition to her pains she has trouble sleeping, together with memory and concentration problems.

Display A2: Social workers' choice of evaluation in relation to vignette cases

Pain stereotype	A (Fibromyalgia)	B (Multiple Sclerosis)	C (Phantom pain)
Number of vignette cases	11	13	24
Evaluation seminar	1	0	0
Means of evaluating working capacities	2	2	5
Work testing	7	7	11
Exemption from work testing	0	4	0
Home visit	0	2	0
Gathering of medical documents	3	8	8
Job advisor	0	1	2
Crisis management	0	0	4
Lifestyle/competence center	1	0	1
Medical consultant	3	3	3
Medical test center	0	0	1
Mentor system	0	0	1
Motivation program	2	0	5
General practitioner	1	3	5
Psychiatrist	1	0	2
Psychologist	4	0	5
Note reporting fit for work	0	0	1
Resource profile	5	4	4
Rehabilitation institution	9	6	9
Conversation	0	2	3
Pain treatment and management	3	0	8
Medical specialist	8	6	6
Clarification on current work place	1	0	0
Management consultant	0	1	1
Corporate trainee position	3	4	6
Total referrals	54	53	91

Display A3: Soft and hard use of clarification strategies

Use of evaluation	Hard	Soft
Evaluation seminar	1	0
Means of evaluating working capacities	4	4
Work testing	13	10
Exemption from work testing	0	4
Home visit	0	2
Gathering of medical documents	7	10
Job advisor	0	1
Crisis management	1	3
Lifestyle/competence centre	2	0
Medical consultant	3	2
Medical test centre	1	0
Mentor system	0	1
Motivation program	6	1
General practitioner	3	3
Psychiatrist	1	0
Psychologist	6	3
Note reporting fit for work	0	0
Resource profile	5	4
Rehabilitation institution	14	7
Conversation	2	1
Pain treatment and management	7	2
Medical specialist	7	8
Clarification on current work place	0	0
Management consultant	0	0
Corporate trainee position	5	2
Total referrals	88	68

Notes

1: Interview 2, vignette case 24, question 4.
2: Interview 20, vignette case 25, question 4.
3: Interview 23, vignette case 31, question 4.
4: Interview 13, vignette case 9, question 4.
5: Interview 4, vignette case 37, question 4.
6: Social workers, who were suspicious towards the intention of the citizen described in vignette A, often pointed at their heads just above the ear. I interpreted that as if the social worker wanted to underline that the character of the psychological aspects of fibromyalgia was different from non-contested psychological illnesses such as schizophrenia or manic-depression. By pointing at their heads they implicitly told me that the person was malingering and being unreliable about his or her pain condition.
7: The person has been anonymized.
8: Interview 4, vignette case BC (37 and 38), question 7.2.
9: Interview 9, vignette case 47, question 4.
10: Interview 24, vignette case 33, question 4.
11: Interview 16, vignette case 15, question 4.
12: Interview 7, vignette case 43, question 4.1.
13: Interview 7, vignette case 43, question 4.
14: Interview 10, vignette case 3, question 4.
15: Interview 10, vignette case 3, question 5.1.
16: Interview 2, vignette case 23, question 4.
17: Interview 21, vignette case 27, question 4.1.
18. Interview 18, vignette case 20, question 4.
19: Interview 16, vignette case 16, question 4.
20: Interview 11, vignette case 6, question 4.
21: Interview 16, vignette case 16, question 4.
22. Interview 17, vignette case 18, question 4.1.
23: Interview 17, vignette case 17, question 4.1.
24: Interview 10, vignette case 4, question 4.
25: Interview 7, vignette case 44, question 4.
26: Interview 7, vignette case 44, question 5.1.
27: Interview 2, vignette case 24, question 4.
28: The institution has been anonymized.
29: The city has been anonymized.
30: Interview 3, vignette case 36, question 5.
31: Interview 5, vignette case 40, question 4.
32: Interview 5, vignette case 40, question 4.1.
33: Interview 7, vignette case BC (43 and 44), question 7.2.
34: Interview 8, vignette AC (47 and 48), question 5.2.
35: The person has been anonymized.
36: Interview 8, vignette case AC (47 and 48), question 5.2.

References

Barker, K.K. (2005). *The Fibromyalgia Story. Medical Authority & Women's Worlds of Pain*. Philadelphia: Temple University Press.

Birket-Smith, M. (1998). *Somatoforme tilstande. En deskriptiv og sammenlignende undersøgelse af patienter med somatiske symptomer uden organisk grundlag.* København: Foreningen af Danske Lægestuderendes Forlag.

Birket-Smith, M. (2005). *Interview with Morten Birket-Smith*, May 2005, Bisbebjerg Hospital, Denmark.

Conrad, P. & Schneider, J.W. (1992). *Deviance and Medicalization. From Badness to Sickness.* Philadelphia: Temple University Press.

Conrad, P. (2007). *The Medicalization of Society. On the Transformation of Human Conditions into Treatable Disorders.* Baltimore: The John Hopkins University Press.

Durkheim, E. (1984). *The Division of Labour in Society*. London: Macmillian Press.

Feather, N.T. & Johnstone, C. (2001). Social Norms, Entitlement, and Deservingness: Differential Reactions to Aggressive Behavior of Schizophrenic and Personality Disorder Patients. *Personality Social Psychology Bulletin*, 27(6), 755-767.

Feather, N. T. (2003). Distinguishing between Deservingness and Entitlement: Earned Outcomes versus Lawful Outcomes. *European Journal of Social Psychology.* Vol. 33, pp. 367-385.

Feather, N.T.; N. Skinner; T. Freeman & A. Roche (2007): Stigma and Discrimination in Health Care Provision to Drug Users: The Role of Values, Affect, and Deservingness Judgments. *Applied Social Psychology.* Vol. 37, No. 1, pp. 163-186.

Gormsen, L. (2005). *Interview with Lise Gormsen*, May 2005 at the Pain Clinic, Aarhus University Hospital, Denmark.

Lipsky, M. (1980). *Street-Level Bureaucracy. Dilemmas of the Individual in Public Services,* New York: Russell Sage Foundation.

Meershoek, A., Krumeich, A. & Vos, A. (2007). Judging without criteria? Sickness certification in Dutch disability schemes. *Sociology of Health & Illness*, 29(4), 497-514.

Møller, M.Ø. Østergaard (2009a). *Hvad betyder smerte for kategoriseringspraksis i det sociale system?* Region Midtjylland, Viborg.

Møller, M.Ø. (2009b). *Solidarity and Categorization: Solidarity perceptions and Categorization Practices among Danish Social Workers,* PhD dissertation submitted to the Department of Political Science, Aarhus University, Denmark, July 2009.

Parsons, T. (1964). *The Social System*. London: Collier-Macmillian Limited.

Schram, S.; J. Soss; R. Fording and L. Houser (2009): Deciding to Discipline: Race, Choice and Punishment at the Frontlines of Welfare Reform. *American Sociological Review,* Vol. 74, pp. 398-422.

Soss, J. (1999): The Lessons of Welfare: Policy Design, Political Learning and Political Action. *The American Political Science Review,* Vol. 93, No. 2, pp. 363-380.

Stone, D.A. (1984). *The Disabled State*. Philadelphia: Temple University Press.

Rothstein, B. (1998). *Just Institutions matter. The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Wall, P. (2000). *Pain: The Science of Suffering.* New York: Columbia University Press.

Weiner, B. (1995). *Judgments of Responsibility. A Foundation for a Theory of Social Conduct*. New York: The Guilford Press.

Østergaard, M. (2005). *Visitationsveje for en kronisk smerteramt med ledighed som problem – et casestudie i Viborg amt af visitationsnormer og kategoriseringsprincipper i sundhedsvæsnet og I det sociale system.* Viborg: Sundhedsforvaltningen. Viborg Amt.