

SENSE OF COMMUNITY

Trust, Hope and Worries in the Welfare State

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Community-studies have a long tradition within European Ethnology. Almost without exception they have been neglecting the strong presence of public institutions of the welfare state – despite the fact that various social security and insurance systems are such an important factor in local life. These are the offices people turn to when they are ill, require unemployment benefits, social assistance, and early retirement or disability pensions. They often provide the foundations for people to make a go of things where they live. Local communities on the other hand are not passively receiving support, but in a most intricate practice defining the actual outcome of the workings of the institutions. In this essay remuneration for illness in contemporary Sweden is used as an instrument for putting local culture in a new light. In a joint effort the macro-perspectives of political science is combined with the detailed cultural analysis of ethnology.¹ Especially the emotional aspects of community-building are brought out.

Keywords: community, trust, social capital, bureaucracy, health, medicalisation

In spite of the long history in European ethnology of studying local communities, this tradition appeared to run out of steam at the beginning of the twenty-first century, perhaps supporting Gisela Welz's pessimistic view that "the classic approach of ethnography, the community study, turned out to be a slow and clumsy instrument under conditions of transnationalisation" (Welz 2004: 6). Describing culture as something that is bound up with place might have seemed too limiting, as other issues have manifested themselves in an era of globalisation and migration. Postmodern theories led to research more focussed

on discourse than experience and more interested in verbal representation than everyday materiality and agency. Our view, however, is that the study of cultural processes at the local level is a valuable tool in the understanding of a number of issues pertinent to how social solidarity and trust are built in a changing society. In this study we focus on the relation between the welfare state and local practices in an era the state was said to be "withering away" and the local was described as disintegrating. The study is based on one of the most important concerns in a welfare-state: people's health and well-being.

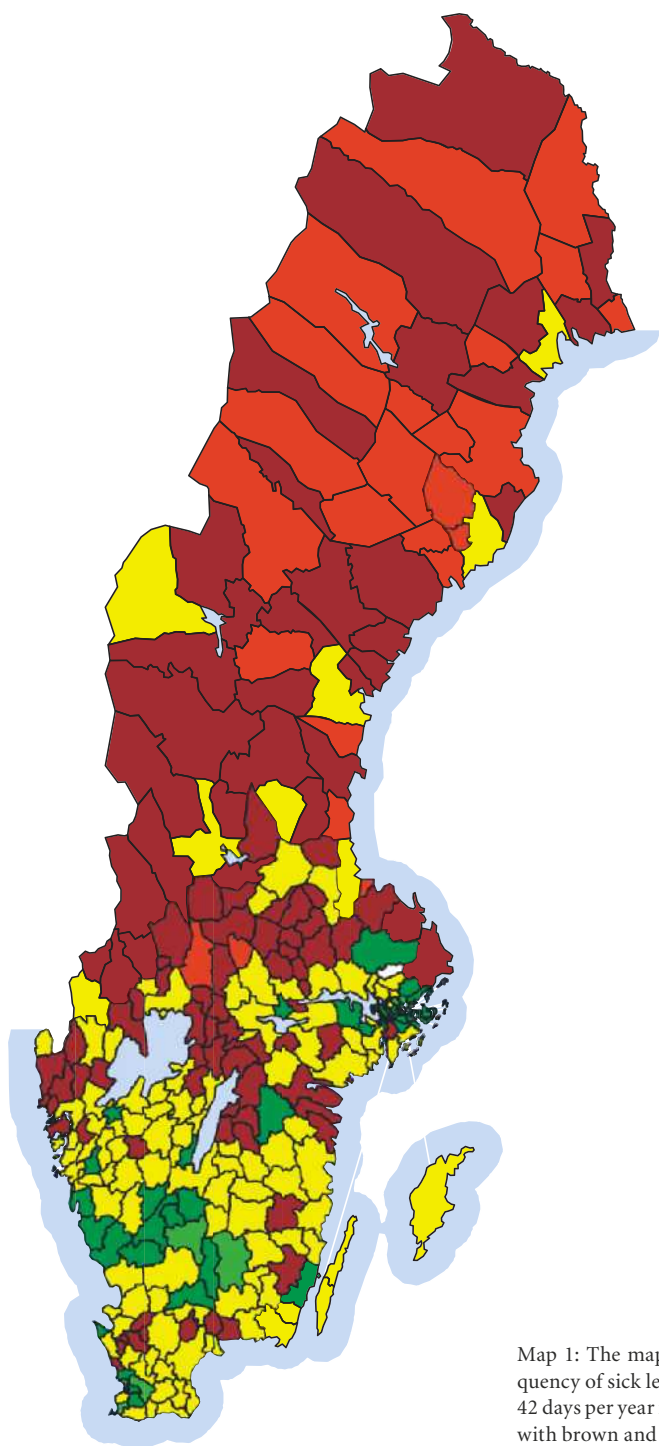
For people living in a mobile world, the local maintains its importance, even though it changes in both meaning and content. This has become so accepted and so obvious in ethnology that it has almost become invisible in theorising about the local. The “heritage crusade” has made people possessed by the past (Lowenthal 1996). No houses may disappear without being documented, 1950s kitchen equipment is deposited in a museum devoted to old homesteads, and almost every town and village feels compelled to explore its cultural heritage. Yet at the same time as ethnologists are involved in this activity, they also seem to have shifted their gaze away from the local as a functioning community. The local has become a place of narratives, commemorative research and preservation, for which theories have been developed and methods established. Some see this importance placed on the local as cultural compensation – looking for safety and security in an alien world. Others take a less moralising attitude and point to new social and economic possibilities for living locally. Human geography, sociology and political science have shown a much greater willingness to theoretically examine such local phenomena. The presence of strong public institutions in Europe has also laid foundations for the kind of trust that makes it possible for people to make a go of things where they live (Rothstein 2001). In this local context, the support provided by various social security and insurance systems is an important factor: these are the offices people turn to when they are ill, require unemployment benefits, social assistance, and early retirement or disability pensions, though in conjunction with various forms of regional support. This dimension is often neglected in ethnological research.

For many, Robert Putnam’s theories of *trust* and *social capital* have served as a reminder to include an intensive social life, in the shape of clubs and networks, in the equation; these affect communication between local and societal levels (Putnam 1993, 2000, 2007). Looked at this way, one can study trust in society from the bottom up. In communities where social capital is large and confidence strong, everyday issues like health, comfort and well-being,

the integration of ethnic groups, or the toleration of varying opinions, are affected by it. Social capital and cultural capital are concepts that have been used in ethnology for a long time, rooted in the writings of Pierre Bourdieu, but they have rarely been used to delineate the cultural and social prerequisites for local life. They have been used even less for showing the connection between the welfare state and the local community, and hardly ever for discussing health and well-being.

There is a need for a greater collaboration between different research traditions. Ethnological analyses could benefit from a focus on the state’s presence, while sociology and political science could benefit from ethnographic precision in the description of local processes. Much as ethnologists need to focus more on synchronous processes like *decision-making*, *intentions* and *conduct*, political science could benefit from ethnological expertise on how community is built around traditions, value patterns, narration and material culture. At the same time, there is a danger of focussing on what so many community studies describe: history, rituals and traditions. In this context, the “clumsiness” Welz notes can block insights into the dynamic ways people relate to the local.

Why have national institutions so easily been forgotten in ethnologists’ understanding of the local? This may have something to do with the potency of studies of individual communities and their unique traditions. Local community has often been conceptualized as having survived despite the intervention of central government. From the study of island communities and fishing hamlets, industrial communities and sparsely populated areas, ethnologists have shown that top-down power has often proved to be fumbling and tyrannical. “Government bureaucrats” quickly became a term of abuse and the state’s civil servants have been seen as “humourless automatons” and bearers of central national values and manipulation (Brox 1966; Herzfeld 1991). Such a view is more likely to result if these two levels, the central and the local, are placed in dialectic interplay. Interestingly, the aspect we regarded as being so obvious in this study had been overlooked: Everyday



Map 1: The map shows the geographical variation in the frequency of sick leave. On average people were absent from work 42 days per year in 2004. Figures above this number are marked with brown and red; below with different shades of green.

systems to ensure social security are a prerequisite for, rather than an obstacle to, local life.²

We also maintain that the local perspective holds the key to understanding the survival of communities in a globalised world; the practical workings of national regulations can be grasped best at this level. The ways in which the state creates trust and confidence – or fails to do so – manifests itself here. We also think that the strength of ethnography lies in its ability to show how differing communities adapt to the presence of institutions. As our comparative studies have shown, some local communities actively reject state support on the grounds of its deep penetration into economic, social and cultural structures. Other communities become dependent on such support, which in turn renders them unable to survive without state intervention. This does not result from top-down political governance, but can instead be explained with patterns that have developed from below that reside in the local. Showing this requires a kind of scientific double vision – a combination of ethnology and political science. Our interest in community studies had a much more prosaic background, though.

Public Health and Regional Variation

Some years ago, our research team was approached by the Swedish Social Insurance Agency (*Försäkringskassan*) to see whether we could contribute some answers to questions arising from the high sick leave figures in Sweden. At that time, the country had the highest level of sick leave in the world, closely followed by Norway and the Netherlands. On average, every citizen was absent from work for 42 days each year on grounds of ill health. Finland's figures were half those of Sweden's, Denmark's figures a third and Germany's figures a quarter (Palmer 2003). Compensation for sick leave amounted to twice the entire national defence budget or the budget for education. Confidence in the welfare system naturally weakened when more and more people seemed to be content to live on state handouts.

The questions we were faced with included why the variations in the country were so great and enduring. Some regions had very low figures while oth-

ers had double the number – and this had been the case over a considerable period of time. How could this be possible when state regulations were the same throughout the country? It was understandable that figures varied between countries – but inside the very same national system? Statisticians working with this material had examined everything that was possible to quantify: age structures, socio-economic circumstances, access to employment, etc. This produced a number of explanations, but nothing with any bearing on the local situation(s) (Palmer 2004).³ Could ethnologists and political scientists contribute deeper insights? Could we explain why the highest figures for sick leave were in *rural areas* and *small communities* rather than in urban environments? It had been thought that postmodern society, with its associated stress, difficulties in making life's jigsaw pieces fit together, and employment uncertainties, ought to create more absenteeism or illness in larger towns and cities. At any rate, that was a common assumption based on what one might term "scientific folklore". But instead it was in regions where people lived closest to nature that one found the highest sick leave figures. Might this have anything to do with culture – either bureaucratic or among the population?

Administrators had begun to suspect individuals were abusing the system, because people had been transformed into welfare state clients and become dependent on the benefits they could receive. Tighter rules and supervision were thought to be possible cures. The authorities regarded the problem essentially as moral.⁴ By contrast, we thought it more natural to ask how these figures related to people's *trust* and confidence in the welfare system, and how they used social insurance to deal with local problems. Social insurance or benefits were deeply rooted in the community in which people lived. It was also a question of individual decision and the kind of role that a state-based administration played in local problems or individual decision-making.

Local communities offer an arena for taking practice as the point of departure in analysis – by looking at how rules and systems are implemented in everyday actions. Those who make use of the services pro-

vided by the welfare state and those who administer them all live in a local context. When it comes to implementation, this is an opportunity to get a better grasp of some of the most burning issues in modern health care, namely the role local experience and decision-making plays in the understanding of overall socio-medical problems.

Two different counties were contrasted and compared in order to track the basic structural characteristics of communities and how they functioned. Our selection was determined by the differences in the sick leave figures. Jönköping County, in southern Sweden, had 34 days per year of sick leave on average, while Jämtland County had 50 (see Frykman & Hansen 2005). These were also regions with very clearly articulated and developed cultural profiles – and very familiar in the context of cultural research.⁵ Other parameters would have to be included if the study was to be made representative of urban environments, and our study should be looked upon as a model for how future analyses could be conducted.

We used familiar ethnological and political science concepts, such as trust and social capital, as analytical tools. We also tried to see how the dimensions of *hope* and *worry* acted as culturally powerful organising factors in how people related to the state's presumed ability to provide safety and create trust (Hage 2003).

Our account begins with a presentation of the two counties, followed by a discussion of trust and social capital as they are used in the political and behavioural sciences. We then turn to a cultural analysis of the regions, basing it on a renewed interest in community studies. The next section analyzes the role the local plays in what appears to be a neutral, state-run administration, and we conclude with an analysis of how medicalisation – the process by which non-medical problems and conditions are defined and treated as medical – can be understood locally. We also look at how “burnout” and other “vague diagnoses” reflect the importance of diagnoses being rooted locally. We close by linking the discussion to how hope and anxiety can be understood as constructive factors in social life, and how they are dealt with in the welfare state and in the local.

Two Counties

The places chosen in Jönköping County were the industrial and immigrant community of Gislaved (with a sick leave rate of 33.5), Mullsjö (37.1) – a suburb of Jönköping – and the classic industrial and railway junction of the Smålandian “Highlands”: the town of Nässjö (38.4). In Jämtland the places selected were Östersund (60), the regional capital, with its proliferation of national agencies, local administration and tourism, and the sparsely populated municipality of Strömsund (67.3), which among other things is famous for having had the highest concentration of opponents in Sweden to the EMU. In all areas, women over 60 had the highest proportion of sick leave. For example, in Strömsund this was on average 162 days per year, while in Gislaved it was comparatively low – 99 days per year.⁶ The variation between counties was much greater than within them.

We conducted comprehensive empirical studies, mainly through interviews with staff working in the local Social Insurance Agency offices, in local health centres, with civil servants at different municipal levels and with locally elected politicians, parish leaders, health experts and people on the street. We asked them to describe their image of the area's state of health, comment on the sick leave statistics and give us their interpretation as to how this fit with what they perceived to be the area's cultural patterns and moral orientation. Extensive statistical studies of administrators' attitudes were also conducted by means of questionnaires. A study of the diagnoses of illnesses that had led to granting sick leave during the last 30 years was also undertaken.

Understanding a society or community on the basis of its decision-makers proved to be useful, since almost all the civil servants were extremely knowledgeable about their communities and all had very clear perceptions of the problems relating to sick leave. Like the amount of taxable income, size of population or unemployment percentages, sick leave figures were part of the projected municipal image and a constant issue. High figures were a cause for concern and low figures a reason for pride. Aside from serving as an indicator of health in the local

community, such figures also measured the state of the local economy in terms of taxable income rates. Several civil servants we interviewed had lived where they worked their entire lives and were very familiar not only with local social and political issues but also with the local ethos – including how it was expressed in terms of solidarity. The administration of the welfare state was central to what was regarded as life in their community.

Although the locales we studied were relatively small, they had quite varied demographic and economic profiles. Småland regions were characterised by trade and industry, low unemployment, relatively high numbers of immigrants and definite social hierarchies, while those in Jämtland were less developed and had one relatively dominant industry, high unemployment, few immigrants and diffuse social hierarchies. The municipalities were chosen to represent a continuum between the rural and the urban and between industrial areas and dormitory towns, and thereby demonstrate the diversity of each region. Rather than standing out as separate areas, the municipalities highlight some general prerequisites for people living in inland Norrland [an unofficial name for the nine counties that make up northern Sweden, and including Jämtland] and in the entrepreneurial area of Småland. Our ambition has *not* been to produce as life-like a picture of the regions as possible, however. That would have demanded a different kind of study. Our focus is rather on the interplay between local life, health and the presence of government agencies.

Apart from the divergent sick leave figures, one reason for choosing Småland and Jämtland was that they were regions with clearly articulated cultural patterns. People talk about themselves there in cultural terms. These characterizations have, in turn, become well established public topics and thoroughly investigated both in historical and ethnological terms. Numerous studies of the culture, trade/industry and societal structures in these regions exist: what it means to be a Jamt or a Smålandian is engrained into each and every inhabitant of the respective areas.

To the external eye, the counties are covered in woodland; both have periodically been affected

by poverty. In its northern parts, Jämtland shares a mountain border with Norway, to which it belonged until 1645. The region is sparsely populated and more than half of its 130,000 inhabitants live in the only major town, Östersund. Beyond the town lie small suburbs, villages, mountains and extensive rural areas. The county has provided raw materials, such as timber, as well as electricity for industries in other parts of the country.

Småland lies in the southern part of Sweden, and from its eastern coast stretches inland towards a high plateau that is more densely populated and contains a number of towns and villages. The area we studied is either forested or barren, and since the nineteenth century, industry has been small-scale and based on iron and timber. In the last century, poverty led to people to roam about in search of work, and also led to mass emigration to the United States. Since the end of the nineteenth century, the region has been a low-church stronghold and was considerably influenced by the nonconformist movement.

On Trust and Social Capital

It is necessary to look first at how concepts like social trust, inter-human and social capital have been used in social science research, to see whether they can help us delve deeper into regional differences. An intensive discussion about the relationship between “rational” explanatory models and more culturally-determined efforts has long been underway. Should human action primarily be explained with reference to concepts such as vested interest, benefit, strategy and calculus, as one part of economic theory argues? How can this be reconciled with seeing humans as governed by specific cultural and social standards they have somehow internalised? This issue is central, for both theoretical and empirical reasons, to the extensive research on social capital and trust. Two extreme views can be identified in the discussion.

Rationalism

On the one hand, here represented by the American political philosopher Russell Hardin, inter-personal trust is understood as part of a rationalist theory based on a notion of an economic man. An individ-

ual's confidence in another actor is "encapsulated" in the assessment of the other's utility calculus with respect to trustworthiness. In this view, people only rely on each other if they believe that being trustworthy serves their own interests or purposes, and that this in turn is governed by their information about the incentive structures (Hardin 2002). This implies we can only trust a very limited number of people, since we can only deal with a limited amount of complex information about a relatively small group. In most of our contacts, we don't trust everyone in every respect but instead only in specific matters. "As a rule," Hardin writes, "we only trust those with whom we have a rich enough relationship to judge them trustworthy, and even then we trust only over certain ranges of action" (2006: 18).

This means people aren't able to generally trust *everyone*, including the staff at the Social Insurance Agency to whom they turn when in need of support, other than in their professional capacity as distributors of support. Moreover, people only trust them because they know that effective institutional punishment mechanisms are in place in case of neglect or malpractice. This implies people only trust civil servants because they consider it in the interest of these administrators to act in a responsible and reliable way when providing support in cases of incapacity or ill-health.

This rationalist ideology has little room for *community* – a "general trust in other people" in the community in which one lives – for the simple reason that no single individual can have enough information about "other people in general" and, above all, about the often complicated institutional mechanisms that regulate their behaviour. In rationalist theory, only what we call *particular* trust is possible.

Following this theory, it is logical to consider it "unrealistic" of people to entrust public bodies with something that isn't absolutely necessary, such as social insurance, and to argue that the public authorities should limit themselves to matters of law and order. This is because control and incentive systems would become too complex and make it much more difficult to judge whether public civil servants are acting in accordance with their own utility cal-

culus. Do they really have a vested interest in acting in a trustworthy way towards the individual (Hardin 1999: 35)?

This rationalist way of thinking has proved to be problematic for both empirical and theoretical reasons. Recurrent surveys have shown that people in different countries believe it is possible to trust other people to varying degrees. In Nordic countries, a large majority (over 60%) say they "can trust other people", while in countries such as Romania, Brazil and Turkey, only a small minority of people (under 20%) believe this to be the case. Faced with empirical results like this, rationalist theory has no answers since it is unreasonable to suggest there are national differences in how one makes utility calculations or creates workable incentive systems. In our own study it would be absurd to explain differences between Jämtland and Småland by suggesting inhabitants of these communities have developed different ways of making rational utility calculations.

Rationalist calculus also suggests all inter-human trust would turn into something extraordinarily uncommon. For A, a rational and egoistic actor, the best strategy would be to first appear to be trustworthy in a number of transactions of limited value, hoping Actor B would entrust him or her with something considerably more important. When this finally happens, it is rational for Actor A to betray Actor B's trust and opportunistically appropriate what B has entrusted A with. But if B has reason to suspect that A's actions are intentionally opportunistic, B will not be able to trust A at all. This kind of strategy would very quickly be detected in a local community in which people have multiple and long-lasting relations to each other. In this way a strictly rationalist theory of trust and confidence becomes too full of contradictions and almost falls apart (Rothstein 2005: Chap. 3).

Culturalism

The extreme cultural view is to regard trust as a moral quality in actors. As a result of early socialisation, some people simply "trust other people", always think the best of them and have a very optimistic view of life and other people's trustworthiness

(Uslaner 2002), while others develop a strong mistrust of “people in general”. Neither of these views is particularly fruitful for our objective, however. It is unlikely that the very large variations in the degree of inter-human trust between countries can be traced back to differences in early socialisation, and in analyses of this kind there is a danger individuals become reduced to “cultural dopes” (Giddens 1984). Ian Lustick describes the conception of actors’ actions in culture-based analyses as “behaviour without the participant making any decision or making any choice” (1997: 12). In local communities with mobile populations, long-term socialisation would be necessary in order to discover the hidden, yet evident, patterns.

There is obviously very little, if indeed any, room for such human qualities as intent, aim or strategic action – not to mention considered choice – in this perspective. If and when the world becomes “culturally formed” for actors, they will no longer be acting agents in any meaningful sense (Lustick 1997: 12). However, people in the communities we studied are influenced by their own experiences and other people’s obvious actions, and over the long run assimilate this information in ways meaningful to them. The idea that cultural order could be so strong that it results in socialisation that determines individuals’ trust doesn’t only appear contradictory, it is also difficult to demonstrate empirically – and is more akin to ideas about so-called “pre-modern” societies and other utopias.

How then are we to make sense of the significant variations in inter-personal trust that exist in different societies and communities? One clue is provided by the connection between social trust and corruption. It is well-known that there is a negative connection between the degree of corruption in a society and the degree of trust – the more corruption there is, the lower the inter-personal trust (Rothstein & Uslaner 2005). So if local government agency employees are involved in corruption, citizens will generalise that dishonesty and untrustworthiness to the rest of the community. In other words, if people cannot trust the teacher, the policeman, the doctor and the social insurance administrator in their local

community, it will be difficult to imagine “people in general” as being trustworthy – *der Fisch stinkt vom Kopf her*, the problem starts from the top (Rothstein & Eek 2009). There are also studies analysing what happens when people emigrate from countries with a low degree of trust to a country where trust is very high. The result is that after a while their trust in other people increases. One factor that affects this the most is the perception that they have been “justly” and “impartially” treated by the government agencies in the new country (Nannestad & Svendsen 2005). In several of the communities we studied, many inhabitants had been born elsewhere and a number had moved there as adults. How could they have been socialised to assimilate the *habitus* that demands the upholding of certain moral standards?

Local Approaches

Navigating between rationalism’s Scylla and socialisation’s Charybdis means trying to find entry points to take account of people as meaning-making individuals able to assimilate and assess information about people in communities where they live and work – at the same time as they are also naturally affected by that community. This implies we need to establish whether local cultural codes have anything to say about the pathways of trust. As British philosopher Bernhard Williams argued, we need a definition of confidence and trust that can neither be reduced to a question of inherent and culturally determined moral valuation, nor to a purely rationalist instrumental value (Williams 2002: 90f).

One way of understanding this is to say that when individuals make such an assessment, they are actually making a moral evaluation of the society in which they live. Trust thus emanates from a valuation of society rather than of individuals. If people entrust other people or government agencies with something (an asset, duty, or information), will they prove to be reliable or will they abuse the trust? The question is then where such “belief systems” about prevailing social morals come from. Indeed, how might they be used to explain differences between regions in a country like Sweden?

People are not simply governed by their own local

“community” or by ideas about “hyper-rationality”. Instead, individuals can never have more than patchy information about other actors in the community in which they live. They nevertheless try to form an opinion on the basis of this fragmented and incomplete picture. They observe how other actors (including civil servants from the Social Insurance Agency) function in their local community and continually update their opinions on the basis of all the different kinds of new information that reaches them.

Douglass North, an economic historian and Nobel Prize winner, tried to formalise a cultural understanding of institutions that govern people’s actions. North sees institutions as different regulatory systems that can be both formal (laws or decrees) and informal (social conventions or social standards) in setting norms about one’s own trust and other people’s (and organisations’) trustworthiness. This takes the form of “shared mental models” that affect how we act in different situations when we can choose between acting in solidarity or in our own interest (North 1998a, 1998b; Douglas 1986). North suggests that the ability to create formal, and above all informal, institutions that facilitate different kinds of “productive exchange” results in much of society’s social and economic efficiency. While formal regulations can facilitate the emergence of and strengthen such “productive exchange” (e.g., a functioning judicial system), it is the informal institutions (e.g., in the form of standards, social conventions and internalised “codes of conduct”) that are decisive (North 1998a).

Interactive Rationality

This leads us to an understanding ethnologists and political scientists can share. Trust can be seen as a flexible, interactive phenomenon, an idea put forward by Robert Aumann and others. They suggest your perception of other people’s trustworthiness (what is defined as “the moral standard of the society in which you live”) is a manifestation of *interactive rationality* (Aumann & Dreze 2005). When people decide how they are going to act, what is most advantageous for them is not always apparent from their own utility calculus. They instead start from

how other people in their local community might act if they found themselves in a similar situation. In other words, they are prepared to act in accordance with recognised standards of solidarity – if they believe that the majority of people in their *community* would do the same in a similar situation. The reverse is naturally also true. Faced with the possibility of people lining their own pockets and disregarding the accepted norms, we can argue the majority will act on the basis of similar vested interests if they believe that they cannot trust other people to act in accordance with the accepted standards. This kind of *interactive rationality* differs from economic rationality in that the actors do not automatically act to maximise their own utility. Instead, the idea becomes relational: people’s ideas about how they are going to act are based on how they think other people will act in similar situations.

This theoretical detour has been essential to highlight how different perceptions and practices can arise regarding how a social insurance system can and ought to be used in different local communities. Investigating how such perceptions about “other people” have developed, and how (and by whom) they have been formed, will be the most decisive in understanding this mechanism. Such a “shared mental model” could take the following form: “I will assume other people are trustworthy if I also believe that these other people consider that I (or people like me) can be trusted.” This subsequently means that when it comes to the significance of the local context for people’s trust in other people, the most central element is a mutual *expectation* of the other actors’ actions and expectations (Aumann & Dreze 2005: 9).

A specific example of this was an intense debate about “cheating” in social insurance matters that occurred during the period of the study (Frykman & Hansen 2008). The majority of the people in a community would not cheat if they were sure the majority of the people in a similar situation also abstained from cheating. This also implies trust in the central authorities responsible for social insurance. If they are thought to be reasonably effective in detecting and dealing with (or punishing) those who cheat, it is reasonable to assume this is why most people

decide not to cheat or even try. But if it is believed that the authorities are ineffective and lax, interactive rationality will probably lead to a different outcome in terms of personal behaviour with respect to cheating. After the debate about “over-utilisation” of sick leave had raged in the press for a year or two, and the regulations tightened, the sick leave figures were reduced by a significant amount.

By this reasoning, what people choose to do depends on how they think other people might act – and not least, act in acceptable ways. Their “feeling of community”, or in other terminology, the local community’s “ethos”, is determined by how they interpret “over-utilisation,” for example. Having confidence in other people in the community is symbiotically related to the amount of trust one has in the local civil servants in that same community (Rothstein & Eek 2009).

When it comes to our case, namely the utilisation of available benefits, the situation becomes even more complicated. The difficulty is that it is unclear what the criteria are for cheating or “over-utilisation:” there is no clear way to “measure” a person’s work capacity relative to their medical condition. Work capacity has to be determined in each case, relative to present and future work or state of health. That can be both complicated and multi-dimensional: a broken leg carries very different implications for a ballet dancer than for a teacher of philosophy. Diagnoses of psychological states such as “anxiety syndrome” or “clinical depression” are not always clear-cut either. It is thus difficult for individuals in a local community to distinguish whether the considerable increase in social insurance payments could be due on the one hand to more people acting disloyally (who therefore cannot be trusted) or on the other to the fact that society has developed in a way that leads to more illness. The latter would legitimise the increased use of sickness benefits, with people continuing to be regarded as trustworthy. Considerable uncertainty remains.

Trust and Social Capital Networks

The concept of trust is closely linked to that of social capital: “Social capital refers to connections among

individuals – social networks and the norms of reciprocity and trustworthiness that arise from them” (Putnam 2000: 19). The term “capital” refers to a kind of asset (tools, training) by which actors can acquire things they wouldn’t otherwise be able to. Social capital can be regarded as a *community’s* dynamic aspect, if not asset, since it refers to the connections between people and what activities thereby result. “Trust” can be regarded as an asset too, for if others perceive a person to be trustworthy, he or she can count on help and support from them. If the bank trusts a customer, then he or she will be able to borrow money; both sides benefit. Being regarded by others as a trustworthy person is an asset, much as it is an asset for a person to know other people he or she feels can be trusted.

Similarly, social networks are also a kind of capital. It is common for people to find new jobs through their social networks, and extensive social networks are an asset for the individual. However, this is contingent, for it isn’t only quantity that matters. Being regarded by many as an untrustworthy person, or knowing many people one regards as untrustworthy are more like liabilities than assets. While the number of social contacts (the extent of the network) can be said to be the quantitative part of social capital, the degree of confidence and trust can be regarded as the *qualitative* dimension (Rothstein 2005: Chap. 3). We can thereby define social capital as the number of social contacts “multiplied by” the degree of confidence in these contacts. This works both at the individual level, and at higher levels. Organisations and local communities where there is a high degree of interpersonal trust, and where social contacts are extensive, can also be said to have high social capital (Rothstein 2005).

Still, the social capital of organisations is not necessarily an asset to the local community. Communities may well contain extensive social capital even though it might not be used in a way that strengthens the local community itself. Like other assets (human capital, financial capital) an organisation can use its social capital either in socially destructive or constructive ways. As it is, research shows that the presence of certain types of organisations leads to

an increase of confidence in the community as well as improved social contacts between its inhabitants (scouts, parent–teacher associations, choirs etc.). A community well-endowed with organisations that are inclusive and attract active members from a broad social spectrum also contributes to an increased local social capital.

However, some organisations, though they have a high degree of internal trust, social contact and confidence, can appear exclusive to non-members and contribute to increased social mistrust in the community: examples include groups that cultivate(d) an “outlaw” image (Hells Angels) or terrorist groups (al-Qaida). Still other organisations only accept individuals with particular qualities as members, discriminating based on ethnicity, social position or religious affiliation. Consciously or inadvertently, they may foster mistrust between group members and the community through attitudes of exclusivity that in turn erode trust and confidence in the community, and people’s belief that they live in a kind of *Gemeinschaft*. In such cases trust is turned inwards and mistrust of the community at large increases: trust thereby becomes particular rather than general.

So it is an open question whether an organisation’s social capital, which serves to increase its effectiveness, can be converted into societal social capital (Rothstein 2005). Local communities can even be destroyed by conflicting networks that use their social (and other) capital to oppose each other in a variety of ways. Two local communities well-endowed with organisations and social networks can have enormously different social capital depending on the type of organisation dominating the respective community. In the regions we studied, inhabitants had built up social capital in very different ways; the confidence in their own region was often greater than that shown towards the country as a whole.

On Local Communities

We saw both advantages and disadvantages in returning to studying communities. It was rewarding in the sense that there is a solid foundation of studies of the social processes that link a community together (Daun 1969; Löfgren 1978; Blehr 1994;

Hansen 1998).⁷ But it was problematic because every place being studied also had its own “culture” and was therefore often described in terms of continuity, tradition and history, its people taken for “cultural dopes” who “lack insight into the normative underpinnings of their actions” (Garfinkel 1967: 71).

As Orvar Löfgren and others have noted, this study of communities was essentially a search for a utopian *Gemeinschaft* in contrast to the cold *Gesellschaft* offered by modern society. Studies took the form of finding what American anthropologist Kathleen Stewart aptly called “a place on the side of the road”, or a dream of a better world, “a social imaginary” (Stewart 1996). The community studies often gained strength from providing alternatives to modernisation, urbanisation, industrialisation, exploitation, alienation – and not least, the fickleness of character that was said to characterize post-modern society (Bauman 1992; Giddens 1991; Sennett 1999). The researcher more or less implicitly chose sides against modernity.

During times of change, studies like these proliferated, including during the later twentieth century when a “green” wave swept through all European societies. There was a strong longing for dynamic utopias. (In our analyses of sick leave patterns, paradoxically enough, societies most reminiscent of this type of community were those with the most ill-health and sick leave problems.) The move away from community studies in ethnology occurred gradually, then sped up as a result of postmodern theories that made them seem obsolete. The new theoretical perspectives set out to deconstruct existing structures and discourses. In addition, globalisation contributed to questioning phenomena like place, socialisation and local culture.

Most social scientists seemed to agree that in a fragmented world, individualism predominated and people’s spatial affinity became both fluid and virtual (Delanty 2003: 186ff). Place was said to lose power as a basis for human experience (Cragg & Thrift 2000: 19). Anthony Giddens (1991), David Harvey (1989) and Manuel Castells (1996) spoke about the “compression” of space; Marc Augé (2000) attracted attention by pointing to how “real” places increas-

ingly give way to “non-places” like shopping centres, airports, motorways, theme parks and places where people needed signposts and instructions about how they should orientate themselves. In looking for the local, people now have to fix their gaze on its symbolic content: “As the integrity of the local neighbourhood is assailed by state policies or globalizing forces, communality increasingly has to be asserted or imagined symbolically rather than structurally” (Amit 2002: 10). And what was the local if not something compensatory – a comforting teddy bear and cure for contemporary anxieties?

This symbolic approach made redundant social and economic processes that had previously been self-evident. *Interactive rationality*, we noted, was based on confidence in networks and attainable feelings of community, but as an idea was derived from methods other than those usually used in qualitative analyses. Was the researchers’ search for community so oriented to the past that they missed seeing new forms of societal trust that were constructed? Had they become so convinced that local disintegration was an established fact that they simply couldn’t see how central administrators – governmental or EU – interacted with local life?⁸

We found it quite natural to pit ideas about the disappearance of place against empirical studies of what actually happened in the interplay between state administration and local conditions. On the basis of sick leave statistics, we concluded that different societies offered differing choices in that they had developed differing moral attitudes about the possibility of living off social benefits. These societies were thus characterised by different forms of trust and social capital. The question was not *whether* place had significance, but *how* it had an effect.

Glocalisation

Some scholars have tried to encompass the changed importance of the local in an expanded world by speaking of “glocalisation” (Robertson 1992): “This underlines that all cultural change actually takes place, and must therefore be studied not up in the stratosphere but here on the ground among actors” in their everyday, local actions (Löfgren & Ehn

2001). What the local is can thus neither be taken for granted nor be regarded as confining or socially compelling. People think, feel and act on the basis of an affiliation that partly made the local enthralling and partly ensured basic security. They became skilful in defining a “culture” that could be spatially linked without being provincial. Places could be used for “branding”, “place-marketing” and other expressions of a “politics of place” (Harvey 1996). Coming from Östersund or Nässjö didn’t necessarily mean people came from “the country” as it did during the centralised twentieth century.

Such a “politics of difference” made people amplify certain local traits and play down others. They saw themselves in terms of distinctive characteristics relating to matters national, regional, religious, ethnic, sexual or linguistic. Sweden quickly became more Swedish, Småland more Smålandian, Jämtland more Jamtish, immigrants more ethnic or Muslims more Muslim, while municipalities, towns and cities changed and at the same time became more themselves. If one doubts this, one only need visit a local tourist information bureau, a revived rural community centre or a newly built museum.

The phenomenon called *culture* has thus left the researcher’s desk and become a popular instrument for the production of self-identity (Giddens 1991; Melucci 1992). When this happens, culture becomes filled with meanings people find important to emphasise. It is stretched according to what one chooses to put into it and becomes a kind of feeler used to grope one’s way forward. Who are we, how are we linked, how do we relate to our surroundings? How do we relate to the future and to history? Which contemporary problems can we come to grips with? How do we make ourselves visible in such a complex world? Culture has become a sensitising concept whose strength is made up of a constructive ambiguity that allows it to act as a societal platform where people can meet, air their ideas and fill up with emotional energy (van Londen & de Ruiter 2008: 9).

This is how people in Småland and Jämtland consciously created an *imagined community* (Anderson 1983). Even if all the inhabitants of a community do not know each other personally, they neverthe-

less have strong feelings about what belonging to the community means. Such obligations and rights are so obvious that they do not need to be expressed, in that everyone is already aware of them. People regarding themselves as part of a marginal group, defining their community as the country's entrepreneurial centre or the hub of wonderful experiences, or seeing the local landscape as offering liberties can then play a considerable role.

Only when we as researchers connected the dreams of community with the actual experiences of living in a place did it become possible to talk about an existing community. People were not signed off as ill in their imagined communities, but concretely in the places where they lived – Småland and Jämtland. Some kind of relationship between discourse and experience is necessary: "Community arises out of an interaction between the imagination of solidarity and its realization through social relations and is invested both with powerful affects as well as contingency, and therefore with both consciousness and choice" (Amit 2002: 18). People care about the local because they connect it with people they know or knew, and with whom they shared experiences, impressions, stories, places and actions.

The need for emotional ties to one's immediate surroundings increases as a result of globalisation, not as compensation for a sense of emptiness, but for practical reasons. Ghassan Hage argues that people ideally should be able to trust one another, have confidence that society is governed fairly and properly, and accept other people's rights and identities. One can suggest trust adds an emotional and comparative dimension to the sense of belonging, though it can be present to greater or lesser degrees. It is to do with the *intensity* with which one embraces one's local community and its inhabitants, and that intensity is graded according to the expectations for a common future, and *hope* is a decisive element if *trust* is to be kept alive. When hope dies it is easy for the opposite, *worrying*, to take over, which in turn leads to people ceasing to have trust in each other – or in the future (Hage 2003: 15f).

Jämtland – Close to Nature

Public places are places where people are *seen* – and where people can see others. Observations of how people act and move around in public spaces can provide clues to a community's cultural patterns. In both Strömsund and Östersund we were struck by how energetically the young, the old and the middle-aged moved around the streets and squares, how they greeted each other and were happy to stop and chat. The number of people of working age was not only relatively large, but was also constant throughout the day. People were seen in public on a *come as you are* basis. Here it was a matter of casual wear with reference to outdoor life.

There was an almost formalised informality about social intercourse, which also became apparent when we, as visitors, met people involved with the different service functions. They greeted us and immediately started to chat as though we were long-lost friends rather than strangers with briefcases. Friendly smiles served to transform social roles and positions into direct and personal relations. There was a willingness to include those from outside the immediate community in the fellowship, as long as the outsiders accepted the basic premise that *here we are all spontaneous and equal*.

In Jämtland's rural areas, most employment was related to primary industries, education and health care. Unemployment was high and varied seasonally. Administration, management and higher education appeared to be Östersund's main features. As a tourist-based region, Jämtland welcomes thousands of people in search of rest and relaxation every year. Here people live close to nature in a healthy environment, with fishing, berry and mushroom picking, hunting and winter snowmobiling as common outdoor activities. People live and move around in the outdoors, and are not stressed due to the high tempo of life.

Permanent residents do not have an easy time earning their living. Employment is uncertain, wages relatively low and there are few entrepreneurs. Earlier, the forest provided jobs, but today machinery has replaced manpower. Dependence on various forms of external support is high, and comes in the

form of regional political support, investment support, unemployment benefit provisions and social security/insurance. Public investments made it possible for many to earn a living, and administrative units that represented the municipality and the state in their various manifestations were important and integral aspects of life, language and habitus.

One of the most frequently expressed values was that people should “pull their weight and do their share”, unless there was a legitimate reason why they *could not*. A lack of job opportunities was the problem, though people were always *busy and occupied* with something. But being employed and having a regular wage was not a given.

Many Jamts had local cultural capital that was valuable for family and society alike.⁹ Taking a snowmobile ride in early spring was more than just private enjoyment. Fishing confirmed a sense of family togetherness and harmony with neighbours and acquaintances similar engaged and encountered in the March sunshine. For most people, doing something meant *going out*. The activities also underscored that this was a good place to live – and led to valuable contributions to the freezer. Children and old people, unable to engage in such profitable outdoor activities, were also beneficiaries.

Jämtland was an interesting example of how modern possibilities can unite a pre-industrial, seasonally-oriented *hunting and gathering culture* with strong relations to the welfare state (Frykman & Hansen 2008). Hunting, fishing and gathering wild berries or mushrooms added to the economy, but was also important in how leisure time was organised and how strong local values were maintained. One's way of life could be based on a variety of pursuits, with the premise that other income could be *added* to it, including welfare state benefits. People learned to have confidence that the state would step in when industry failed, a benefit that came to be regarded as an important right.¹⁰ It is unclear whether the causes of this are to be found in regional policies adopted by government that render people passive or in a lack of local initiative and spirit of enterprise, or in dependence on a single industry (Hansen 1999). It was in this context that remuneration from the Social

Insurance Agency acquired cultural meaning and strengthened the legitimacy of government agencies.

A prerequisite for this kind of lifestyle was that people had some way of supporting themselves. This was combined with the hope of making a *windfall* that would make it possible to live without worry until the next hunting season. It could be the dream of shooting the biggest elk, have an unbelievable timber felling season, landing temporary work as a paver during the summer months, winning the lottery – all in order to do something other than just sit around for the remainder of the year. This jackpot mentality allows people to deal with a monotonous daily round or routines, inasmuch as they are ready for adventures and challenges. At the same time, this jackpot mentality is very masculine and separates real men from office-based pen-pushers (Bringslid 1996).

An economy based on gathering was also expressed by neat or stacked woodpiles, or sheds filled with sawn and chopped timber. Cellars housed well-stocked freezers ready for a consumption that would stretch all the way to the next season's catch. The objectives had much to do with *here and now*. Hunting and fishing could supplement otherwise meagre benefits. If people were on sick leave, then it was from work – not from the rest of life. What was local shaped *when* and *how* sick leave could be taken or unemployment benefits claimed, and it was on that basis that people developed strategies in dealing with the health care and administrative systems.

A Methodical Health

The communities we visited in Småland had undergone radical changes during the last few decades. Sometimes it was in the form of relatively large immigration and the closure of factories, as in Gislaved, elsewhere it might be the wholesale restructuring of trade and industry, as in Nässjö, or it could be moving from being a rural district to a dormitory suburb for the city of Jönköping, as in Mullsjö. Despite this, these towns or areas had managed to keep the sick leave figures at a relatively low level. Our starting point was that this somehow reflected the kind of trust that people had in each other and in the welfare state. Were the forms of “shared mental models” dif-



Ill. 1: A place for everything and everything in its place. The well groomed garden with a Volvo in the driveway gives an image of a community where a sense of order permeates private and public life (Småland).

ferent here than in Jämtland? And if so, how did they relate to local welfare state administration?

To the external eye, the places we visited in Småland appeared *neat and trim*. Buildings and people were equally nicely and neatly in place – everything and everyone in their rightful place – and material culture breathed order and planning, objects constituting moulds for the mental models. People hurried across the squares and along the central streets. They weren't just out for a stroll, but were purposefully going somewhere, probably to work or recreational activities. Only pensioners – those not involved in actual production – had time to stop and chat with each other.

At the same time we continually met people who felt the order of things was threatened, and many furrowed brows were to be found behind the nice house facades. People knew society resulted from their own efforts, and that they were responsible for how their community fared. There was no lack

of self-confidence when it came to prescribing how the rest of the country ought to be run. The societal model was clearly so well formed that others could copy and use the mould! The idea of having a mission was never far away: people were keen to come to grips with deviations and discrepancies before the rot set in.

In our conversations with inhabitants we often encountered moralistic attitudes relating to the state of society. People were upset about those who called in sick because it led to conflicts at the nursery school their child attended, or because people couldn't get out of bed on Monday mornings, strains that echoed the latest heated debate about cheating, exploiting the system, or a general "anything goes" mentality. High sick leave figures were more than just a barometer of ill-health. They were also signals of a general and perplexing threat to the community: "Sick leave has now become a social problem and we all have to help to find a solution for it", one doctor said.

The revival of denominational or evangelical churches ("free churches") in Sweden has undoubtedly played a significant role in assertions made about morals and in Småland, despite energetic protests that such non-conformist influence has not been great. This moralistic attitude often involved finding a formula to transform everyday labour into something serving a higher purpose, namely putting words into action and believing in the future.

Social control was a reality in all our conversations and a prerequisite for even being able to talk about social capital. Sick leave was regarded as an anomaly, either an unlucky fate to lament about or a social handicap to ponder over. Those who were on sick leave yet nonetheless went out, became publicly visible in the wrong way – as someone standing or placing themselves outside the general community. Being on sick leave was equated with an important change in status that was similar to being unemployed, retired or divorced, a topic to discuss and get upset about as to whether it was legitimate or not, but even more lamentable when it was someone who was seen as genuinely ill.

Life in the Småland forests was characterised by a forward-looking and impatient entrepreneurial spirit. The future would be better if people planned wisely, were well prepared and hoped things were better organised. This was obvious at work, but it was also true of social and association activities that might revolve around the next competition, the next test, the next level. It is an attitude usually associated with modern times and occasionally with a Weberian protestant work ethic. Nothing unites a group of people as much as the hope of a better tomorrow, and that hope was nurtured because work was available in the area. It had drawn people here from foreign lands and it kept them there, offering them a secure future.

Signs of Trust

In the places we visited in Småland, people read the low sick leave figures as a sign of confidence and trust that reflected well on the community. Indeed, the lower the figures the greater the trust. "People keep a check on each other and watch each other. If

someone goes to a party and moves around among ordinary folk, and you know that he or she's off sick, you start to ask questions," a civil servant in the municipality said. In another area, a local government commissioner said, in reference to the Ten Commandments, that "you don't deceive your neighbour, you don't steal and you don't cheat the state. If you are off sick without actually being ill then you are breaking the seventh commandment: Thou shalt not steal. A deep-seated notion about what is right and what is wrong permeates this district."

In Jämtland's Strömsund, however, the municipality's authorities showed a certain tolerance for people who were searching for various kinds of solutions to help the community survive. It was, after all, in the general interest of the community. Stories circulated among civil servants as to how people fiddled with benefits. A man could lay asphalt in the summer, work through to the autumn, and have earned a year's wage into the bargain. He could then go to the unemployment benefit office and sign on for the rest of the year. The willingness to tell amusing stories about people's creative solutions became a kind of local narrative genre and was perpetuated with a knowing smile (Frykman & Hansen 2005: 16). It was also based on a particular local experience that legitimised the high exploitation of social benefits.

While entrepreneurship was an obvious element in Småland, access to natural resources was a prerequisite for life in Jämtland. This was a world in which people made active use of the forests and of nature. Hunting, fishing, harvesting timber, berry-picking and snowmobile-riding demanded both local knowledge and legal access to nature's rich bounty. The inhabitants also regarded themselves as marginalised relative to the rest of the country. This feeling was of long standing and was an important aspect in how people regarded their roles as citizens (Hansen 1998). The feeling of not belonging was usually expressed in spatial metaphors, with no shortage of notions about the geographical and cultural distance to the centre (Ardener 1987; Shields 1992). Those living in a "sparsely populated area" lived by different rules than those that applied to people living amidst

modern, built environments. In Jämtland people had participated in societal changes from the sidelines, and there was a strong feeling of having been wronged when it came to the distribution of society's resources. At times, it appeared as though people regarded themselves as an exploited colony (Hansen 1999) and that there was good reason to feel victimised. It served to legitimize a right to reclaim something that "society as a whole" had robbed the region of. Such stories were part of a "master narrative" that underscored a long tradition of outsidership. The local was where the narratives assumed a definite form and could be filled with moral attitudes, and thereby constituted the interface between discourse and experience.

The Power of Hope

Few things have such a societally organising power as hope. And few things structure life as strongly as the expectations of how other people might act if they found themselves in a similar situation. Trust increases when people are inspired by an expectation of the future rather than a memory of the past, at least when it comes to what people might become as contrasted to what they already are.

In Gislaved, a Småland community, people had been affected by the sudden move of the area's largest industry – Continental's tyre factory – to another EU country, aided by substantial relocation grants. It left a tenth of the population out of work. How would the community survive such a loss? Local government officers, the local employment and social security offices, and real estate agents were anxious. What happened, though, came to be described as "The Gislaved Miracle", or, as the manager of the employment office put it: "The miracle was that people were mopped up by the local labour market and didn't have to look for jobs through the employment agency. Thou shalt work! That's the spirit of things here. You have to take care of things yourself because nobody else is going to do it for you!" Needless to say, very few cases of sick leave were dealt with by the Social Insurance Agency.

In this multicultural entrepreneurial region there was strong confidence that things would work out,

and that it was important to utilise the skills found among those who had been laid off. This kind of trust is similar to the classic equation of like giving rise to like. It was thus about looking toward the future, in a situation of extreme uncertainty where there were no rational grounds for trust in it or in others. One could also say that employers were prepared to act in accordance with solidaristic norms because they believed most people in their community, faced with a similar situation, would act according to similar norms (Aumann & Dreze 2005: 9). Confidence in the future dictated work and practice in the present.

One of Jämtland's leading civil servants put it comparatively. "When a student from the motor engineering programme at the upper secondary school comes down the school steps, he looks around and asks: Who is going to guarantee me a living? But in the Gislaved area his peer asks: Where can I open up my workshop?" What is sometimes called entrepreneurship is actually having the necessary knowledge for setting up in business. But above all, it's about expectations and hope, locally administered. Hope, as Hage writes, is often as much a physical, bodily disposition as a mental expectation.

Perhaps this progressive approach was the key to a functioning social community where people could trust each other. This approach served as both a social and economic building block, and was far more important than custom or a *habitus* that was more lethargic.

The Micro-Physics of Trust

Hope based on confidence people would act in a similar way if in a similar situation easily loses substance if people ignore how this serves as social coinage in everyday social interactions. It's about how people get to know each other, which routes are available in the community and how a person injects large doses of care and trust into all this. How, for example, did those who moved into the area get involved in the local community? Examining such processes makes it easier to understand actions facilitating a build-up of trust and social capital.

Socialisation in local communities took two distinct patterns. In Småland, the route to inclusion



Ill. 2: In daytime people are at their work-place, and in the busiest streets only retired people are seen on a shopping round (Småland).

was through association activities (Gislaved: the school of music, children's and young people's sporting activities, parent-teacher associations; Nässjö and Mullsjö: sports clubs and free-church congregations). Integrating into society could revolve around joining the Salvation Army or the Swedish Missionary Society, or, equally importantly, the volley-ball or bandy team, or orienteering at weekends. These were arenas where newcomers could demonstrate they really wanted to belong. The existence of such opportunities was necessary in a community with some 60 different nationalities and all the world's well-known religions, as in Gislaved. It was not just membership that mattered, but also the assurance of kinship and a sense of solidarity available to all. It was, it was said, an easy community to assimilate into if a person had a hobby or a dog.

Association life drew children, parents and households into existing networks. Those on sick leave took their illness with them to the ice-hockey rink and the handball match stand. This is where judgments and attitudes were formed. This is where people were excluded or rejected, or conversely regarded with wonder or approval. People became morally available to each other in the community through its structured recreational activities. A special, bodily dimension contributed to this openness: sports

gave participants a natural opportunity to look forward – physical and mental concentration on the next match, the next meeting, the next performance.

Association activities were also an asset in Jämtland. Parents took their children to sports training sessions – and chatted with one another while their children practiced. Relationships formed that often led to continued and deepened friendships. Unlike Småland, where association activities were almost regarded as being out of bounds if people were on sick leave, participation was equated with rehabilitation. Common activity integrated people, and was thought to do so without reference to the participants' other social baggage. If people wanted to take part they were welcome to do so – and to come just as they were.

In Jämtland, association life reflected a context characterised by a familiarity that enveloped everyone included in the local and place-defined fellowship. People didn't need to qualify for membership, for membership meant being a member of the local community, through a kind of practice that stretched across time. It was a bit like marrying into a family. In most cases a person is initially accepted "on principle" and then later accepted as the person he or she really is. In Småland, on the other hand, it was literally like becoming a member of a club.

These two different ways of being integrated into the local scene illustrated two different ways of organising confidence and trust. The Smålandian experience pointed to a society in which trust is based on a newcomer quickly learning the accepted values, the emphasis on industriousness and diligence. The rules were easy to understand and were formalised in social life as well as in the material culture. It was upheld by the public institutions and there was little contradiction between local life and the security provided by the welfare state. Jamtish society, on the other hand, was that of a close-knit community. People, in a manner hard to explain, gradually found a place for themselves, and grew into the local context slowly. They didn't become part of local society as a result of what they *did* or due to the social position they filled, but for who they *were* as persons – and whether they could be trusted. A strong dependency on welfare system hand-outs was met with a certain amount of distrust by those administering public institutions.

On Administrators and Communities of Ill-Health

What role does the local play in the extremely centralised activity prevailing in the social insurance system? Agency employees work for a central and rule-bound governmental organisation at the same time as they are deeply embedded in local practices and culture. They are the final link in a gigantic central administrative system. The rules they apply are general, which means that their work should be carried out in a similar way in every region or place. Such a neutral and general governmental operation is believed to be a foundation stone in the bureaucratic administrative process and is regarded as creating legitimacy for the system (Gerth & Mills 1946). From one perspective, it was here, if anywhere, that “the social administration of indifference” with “humourless automatons” (Herzfeld 1991) could be expected to exist.

But the administrators also had a private life and belonged to a local culture with its own system of standards. They frequented the same shops as the insured, their children attended the same schools, and

they ate at the same restaurants. This could lead to embarrassing situations: “On Saturdays, you are reluctant to go into town if there's some event on, that is, just like you avoid the market square on Tuesdays. You meet a couple and he is reluctant to say hello and she just wants to chat.”

This potentially conflicting double allegiance may become evident in the administrators' daily routines. Their work for government is characterised by a dual pressure that issues from general and bureaucratic social insurance rules and regulations as well as from the quite varied reality of people's individual needs. This is a well-recognised dilemma, so administrators are given considerable discretion in order to be able to do their jobs as best as possible. Making decisions about benefits demands measures adapted to the specific *situation* of an individual, not only in terms of work or illness but also within a specific local context.

Some previous research suggests administrators with considerable discretion identify more with their clients than with the rules and regulations they are expected to follow. This leads to policy being formulated “from the bottom up” by administrators who encounter the clients face-to-face rather than “from the top down” by democratically elected politicians via legislation (Lipsky 1980). This creates a dilemma in legitimacy, because the administrators have no policy mandate from the population. Politicians acquire such a mandate by being voted into office, and people choose new politicians if they are dissatisfied. But administrators can't be voted out. If people have confidence in them as individuals this doesn't automatically mean they have confidence in the system they represent. It can lead to suspicions of favouritism, a general problem that affects those who administer social insurance programmes much as it affects teachers, the police and social workers.

Administrators and Communities of Ill-Health

In one sense, the central social insurance system is biased toward local variations. The present Swedish central organization has a dual cultural heritage. One lay in the “health insurance movement”, a non-profit organisation people belonged to that insured

against economic loss resulting from illness, and which was dominant in the early twentieth century. A social insurance system was created parallel with this, its roots in a more bureaucratic and centralized state organisation. During the first half of the twentieth century, both forms existed side by side.

The gradual integration of the “health insurance movement” into the state’s organisation has been well documented, and that experience had a lasting influence on the entire system. Many of the routines and much of the management came to be carried out by people involved in the health insurance movement. Its staff was a strongly local anchored and secured the population’s confidence (Lindqvist 1990: 62ff). Up to 2005, the impact of this movement was also apparent in the organization of the social insurance system in that the regional social insurance agencies were formally independent. Since 2005, however, the Swedish Social Insurance Agency has become centralised and bureaucratised in part in response to the high levels of sick leave and in part to strengthen the organisation’s uniformity and improve efficiency (SOU 1996:64).

Institutional memory exists. Standards and attitudes have a tendency to become entrenched, if not “sticky,” though the original reason why they came into being no longer applies. So even though today’s Swedish Social Insurance Agency is now a formally centralized organisation, it is clear that memories linger on in the organisation as a whole. This could be one reason why the phenomena we have identified in ill health have arisen. Attitudes and values have been generated over time in the collaboration between local communities and national institutions, with routines cultivated in conjunction with administrators’ freedom to adapt their practices. Local standards established themselves in the bricks and mortar.

If true, this calls for empirical studies to determine how the patterns were manifested in practice. We therefore conducted about sixty longer interviews with administrators in Småland and Jämtland to try to map the kinds of relations that exist between clients and civil servants. In the two counties we selected contrasting examples to establish

a clearer picture of characteristic features.¹¹ Most administrators working with sick leave issues were interviewed at the respective offices.¹² We also interviewed the associated doctors and officials reporting to the respective social insurance bodies, middle managers and unit managers, as well as those working as controllers or supervisors of their colleagues’ cases.¹³ The conclusions drawn from the material have been addressed in a separate monograph that specifically investigates the significance of organisational culture on the degree of ill health (Olofsdotter Stensöta 2009).¹⁴

The interviews in both counties showed a significant difference in questions relating to how kind or caring officials were to their clients. Jämtland administrators had an “open jacket” approach, which meant they showed considerable personal openness to the needs and situation of the individual. In Småland, on the other hand, more distance was apparent. This did not come from the civil servants but was a result of the interaction: administrators showed a stronger degree of personal restraint, making it possible for them to be “understanding” and “not too rigid” but still hand in more restrictive decisions.

The “Open Jacket” Approach

Some of the interviews were conducted in the main building of Jämtland’s Social Insurance Agency headquarters in Östersund. The offices are in the kind of informal public building that monumentalises the earlier days of the welfare state – a split-level building with a flat roof and walls of varying shades of grey. Inside, long corridors flanked by numerous offices, glass walls and closed doors, stretch into the distance. A large part of Jämtland’s social insurance administration is housed here. The offices are very small, and some of them house specialized national agencies that have been relocated here. In other words, the workplace we encountered was very large and very open.

The expression “having an open jacket” was only encountered at the offices in Jämtland; it meant the administrator didn’t set up defences against the individual’s needs and wishes. Their problems were allowed free expression in the interaction. “Many

– those with too much of a ‘helper’ in them – have an open jacket approach and take the problems to heart,” said one civil servant while unzipping his cardigan, “whereas it can often be better to let them bounce off.”

Being too much of a helper means offering extra services to the client, such as promising to phone the employment office (because the client is too nervous to do it) and discuss the matter at hand, or promising to get the extra information needed for finding rehabilitation work. Although the services undertaken are well-meaning and a sign of care, in the long run they become unsustainable for both administrator and client. “You end up sitting with a mass of Post-It stickers on the wall in front of you and feel overwhelmed,” one civil servant said. According to another, this approach didn’t benefit the insured at all: “The more I see, the more I think it’s better to stick to the rules. I had a woman client a few years ago who got very upset with me – I’d done more for her than I should but she got so angry that she reported me. It would have been much better if I’d been firm and clear. It’s important to stick to the rules even if they are cumbersome, because they provide safety and security for the individual concerned as well as for me. Then I know I’ve done exactly what is required and nothing more.”

None of the civil servants wanted to describe themselves as having “an open jacket” approach, though there was a recurring narrative of this attitude still being prevalent, and that it had been much more common in the past. “One person found it difficult to swallow ... it was too sensitive an issue. But that person no longer works here... Lots of people have left since 1997 – not many of the old hands are left. In the sickness benefits division all the old hands have gone.” Several of the people we interviewed thought that attitudes towards the insured had hardened in recent times.

Yet those we interviewed had pinboards full of yellow stickers reminding them of tasks to be undertaken. A pattern of human helpfulness and almost unlimited kindness had developed among those civil servants who perhaps inwardly felt the rules were not being properly implemented. It had developed

into a cultural pattern that was difficult to change: “Yes we felt that it was wrong, yes. But then there are still those who think that the rules were better before and feel sorry for people, but it depends on how you see your role. But as I say, there are still discussions about it. There are those who say ‘I feel sorry for him/her’. But it all depends on how you see your role.”

The person recounting this was aware that human understanding was related to geography. He had been on the job for a long time and had also worked in the more remote municipalities with the highest sick leave figures. He said it was much easier to grant early retirement pensions to people who lived out in the periphery, which would never have been approved if they had lived in the more central areas. “It was, well, call it VIP treatment or the icing on the cake. Those who lived centrally, they had less chance, isn’t that right? Those with a good or decent education, they had no chance either because we could determine that they could at least try to work. But if you had no education and lived out in the woods, you had a better chance.”

This was just one of many examples of how an administrator was obliged to compromise between his own personal views, locally established patterns and central rules. He was torn between the centrally formalised government agency logic and the attitudes that characterised the local context. Others were more focussed on following the routines that had developed over the years. One administrator had adorned her pinboard with yellow Post-It stickers. She described herself as a “caring person” and found it difficult to accept the stricter, centrally issued rules: “They don’t see people from a holistic perspective. The Social Insurance Agency has a very clinical approach to people. How can I explain it ... – they just look at the symptoms and at the diagnosis. They don’t pay much attention to the other factors in a person’s life. I think they do this because it’s very difficult to have a holistic view of people. It’s actually much easier to kick them out of the system using a medical perspective.”

She was only one of many who preferred a more care-oriented approach:



Ill. 3: At the annual fair of the patron saint Gregorius in March, people in Jämtland rally to celebrate local history and the strong link between town and country (Östersund, Jämtland).

I'm the caring type, so we prefer to drag it out and allow them to try a bit longer and perhaps let the different benefits overlap. If they have a study grant or salary or permanent employment – even if their work capacity has been verified, I don't just chop them off and expect them to fix the rest. No, I say that I'll prolong the rehabilitation by a month so that the benefits can overlap. I think it gives better contact with the insured person and I think it's more positive in the long-run. ... I don't think that there's any real check from the management or the director – they are too distant in many respects. You sit in your room and get on with your work and that's about it (laughs). It probably states in the directives that the sick leave figures should be reduced, but you just carry on as normal.

"Not being too hard"

The Social Insurance Agency in Småland was more varied. The local offices we visited were sufficiently large that they could set their own informal standards of behaviour. For example, the offices in Nässjö

have an elaborate coffee break culture governed by unwritten rules making it (socially) compulsory to take part in the 10 o'clock coffee break, and then behave appropriately: "Like the Customer Service Manager at coffee today. After she'd sat with us for five minutes she moved to another table. That wasn't very popular. When she saw that her colleagues were sitting at another table she switched over. She just switched tables during the coffee break. She didn't accept us as coffee mates. That's not on."

There was also a distinct air of competition between the offices. Vetlanda, for example, that had had to start afresh, had long been annoyed that Eksjö had been able to avoid reorganisation. Such things were kept account of. Gislaved was the "best in the province" and had secured regional development money on several occasions. This meant they had acquired more resources than the other offices though the problems they had to deal with were decidedly less than in several other areas. The employees at Gislaved seemed to enjoy their prominent standing and took it as a sign of their greater entrepreneurship.

Administrators also took a different approach to their clients. “I think that it’s better to be ... I won’t say kinder, but better to not be too hard.” “Not being too hard” meant being as kind as the rules allowed, and acting within determined boundaries. “In our job you sometimes have to deal with things that aren’t directly associated with the actual case. Then you have to set limits. You can’t just take on the role of feeling sorry for someone – empathy and sympathy. We’d never cope. We come across all kinds of tragedies in this job every day. It’s our daily bread.” This professional attitude was not the human desire to act as “helper” or have “an open jacket” orientation. What we encountered in Småland was something one could call being kind – on the system’s terms.

Such an approach was possible because there was confidence in the system and in decision-making, including making difficult decisions: “No one here is afraid of making a decision. We have plenty of support and sounding boards. We haven’t been afraid of saying ‘this is how it is’. You have to defend the social insurance system. If you don’t have the courage to make a decision, you just have so much other stuff to deal with that in the end you simply don’t know what to do.”

But it also had to do with local social mores that urged everyone to work if they were not absolutely in need of sick leave. This social control was also evident in that the value of self-discipline was regarded as more important in Småland than in any other region in Sweden. The “not being too hard” on clients could contribute to lower levels of sick leave because it intersected with the greater degree of self-discipline among citizens.

If the framework was clearly laid out, civil servants could act in a “not too hard” manner and seek solutions based on rules and regulations they were supposed to administer. This made it considerably easier to make difficult decisions, and only when clear demarcation lines were missing did the administrator have to fall back on his own feelings of human solidarity and adopt an “open jacket” approach. This didn’t benefit the client, the administrator – or the social insurance system as a whole, it was felt. To

retain a sense of self-respect, the person who signed up as sick was obliged to live up to the diagnosis.

Småland and Jämtland

In Småland, relations between government agencies and citizens were structured by clearly articulated rules as to how matters ought to be dealt with and how social roles were allocated. In Jämtland, relations were characterised by a more informal approach in which the person and his or her background was taken into consideration. The relationship was based on local knowledge and individual assessment, with the civil servant a member of a local culture inside which she or he had to implement the rules. This was a sensitive matter and at the same time created a kind of conditionality over how social insurance ought to be implemented. While trust in people was good, the system ended up somewhere in-between. The number of yellow Post-It notes indicated continuing demands and were one of the more obvious signs of how social security legislation expands and is implemented in accordance with the most pressing needs of the local community.

Office attitudes mirrored value patterns in the different communities. In Småland, there was a clearer orientation towards the future that was rooted in a simple Weberian work ethic. That was also true in Jämtland, though it was different because social solidarity and leisure time outdoor activities were highly valued, although more difficult to formalise.

In both regions we found a sympathetic, helpful and caring attitude among the Social Insurance Agency staff. The rules were applied differently, and it is noteworthy that the helpful attitude had quite different effects in the two contexts. Where the population had a restrictive attitude about taking sick leave, a helpful and sympathetic attitude could be entirely positive. But it could be devastating in a context where the population took an expansive attitude toward sick leave. If combined with consideration for the person, the effects were even more radical. One might say that a permissive attitude invited abuse of the welfare system. The sizeable variations in health figures between different parts of the country can hence be explained in part by the interplay

between civil servant's attitudes and local culture(s). Ironically, the very demonstration of solidarity, human warmth and openness by civil servants can contribute to creating a "community of ill-health".

Is Trust Detrimental to Health?

In the relatively recent discussions of the sickness statistics, higher figures are often regarded as worse than low figures. Our study indicates differing local standards for sick leave. So can one draw normative lessons from this?

The Jämtland community has many aspects modern city-dwellers yearn for, and is a place where values aren't dependent on achievement. Since the 1970s, similar ideas have underlain day nurseries and schools and they are ideas that we regard as important knowledge for our children. It is also what stressed-out city-dwellers go on expensive courses to learn. A generation of *community studies* also demonstrated that such alternatives existed.

The connections become even more interesting if we examine the general effects trust or social capital has on society. People's confidence in each other is regarded as something positive: it leads to better health and to a stronger democracy (Putnam 1993) as well as economic growth (de Soto 2001). But if low levels of sickness figures are regarded as better than high ones in a welfare state as extensive as Sweden's, then this positive relation does not hold for the social insurance system. If we compare our discussion with findings on attitudes towards trust in Swedish regions, people in Jämtland say they have more confidence in people in general than those in Småland. This is the case for both the administrators and the population at large (Olofsdotter Stensöta 2008). So is this a case where social capital is not furthering agreed-on societal benefits?

The possible dark sides of social capital have been addressed by Putnam (2000), who asks whether social capital strengthens the values of equality and liberty. His conclusion seems to be that on the aggregate level, social capital covaries positively with these values. From a rational perspective it should not be too surprising that social insurance works better, meaning it encourages less utilization, in an

environment where a certain degree of distrust exists between people. So it would be misguided to say lower sickness figures generally point to a community with a better life. It is more correct to say that sickness statistics may indicate strong community solidarity. Obviously, there are benefits in people keeping themselves healthy. For the person on sick leave, living in Jämtland was clearly an advantage.

Interestingly, it appears that a certain degree of anxiety was a prerequisite for keeping oneself in shape. Neighbourhood social control helps keep sickness figures down. Social insurance was thought to work "better" when there was a greater degree of mistrust in the population and among the administrators. After all, everyday social control, keeping an eye on one another also reflects signs of *care* and thus turns a society into a *community*.

We examined two societal types with different kinds of social capital, one that safeguarded the values to be found in the community and one that placed the community in a wider context. Confidence in the region was considerably stronger in Jämtland, though that went hand-in-hand with a high dependence on state benefits. This also meant strategies were developed which helped ensure the community's survival, so local interest determined how the rules were to be applied.

Our study shows the importance of local administrative practices and the extent to which local culture depends on state intervention. This is a contribution to de-emphasizing statements about the blessings of trust or social capital and their connections to health and well-being. The ethnological perspective indicates the importance of directing attention to what people expect from the future and their encounter with institutions, rather than what they reflexively acquire in terms of local culture.

On Medicalisation

The Social Insurance Agency's legitimacy came about as a result of cooperating with the local context. Different *communities* participated as actors in relation to the social security systems. This was not the result of deliberate strategies but the effect of innumerable decisions and contexts obvious to people

in their everyday lives and work. Would it also be possible to understand how illness was perceived from a local perspective? This demanded immersion into how health is defined in the interplay between doctors, patients and the communities themselves. It is well-known that different diseases can be linked to different epochs, but is this also the case when it comes to place?

To this end we studied a large number of case history journals in four social insurance offices in Jämtland and Småland.¹⁵ All the journals related to long-term (i.e. more than 90 days) sick leave. We examined 230 file entries from days 5, 15 and 25 (a total selection) in three time intervals from the 1970s to the end of the 1990s. We selected two indicators of medical syndromes: muscular illness (illness that results in a muscular diagnosis) and mental problems (symptoms that result in a psychic diagnosis).¹⁶ The files varied in scope, stringency and classification, both with regard to different offices and administrators, in itself an interesting observation. A demarcation was made concerning studying the administrators' journal notes and the doctors' medical reports on the basis of local context.

We attached importance to gender because this is a good way of understanding the construction of syndromes (Johannisson 1994).¹⁷ The increase in sick leave in the statistics is a decidedly female phenomenon, particularly in psychological diagnoses. The patient's own descriptions have a particular analytical value in providing the diagnosis of symptoms, for they are defined in the interaction between the medical system and the individual's need for health care. These cannot be established with the same level of objectivity as, for example, disease in the circulatory system.

Does Welfare Evoke Illness?

What can be defined as illness is subject to constant negotiation and change. Symptoms are both created and treated by the existing cultural conditions and the exercise of power at given times (Foucault 1965, 1978; Szasz 1961). Assigning names to physical disorders is a practice that occurs in interaction with the local community, its standards and its values.

The concept of "medicalisation" refers to the process in which non-medical problems and conditions are defined and treated as medical (Conrad 1992; Zola 1972).¹⁸ Medical experts are usually regarded as the most important actors in this process and medicalisation has thus been seen as a result of the medical establishment's increased influence. In recent years, interest has been directed at other actors, including patient organisations, drug companies and the psychopharmacology industry (Ballard & Elston 2005; Barsky & Borus 1995; Conrad & Leiter 2004). Interest has also increasingly been focused on the welfare state as a driving force. Medical opinion is one of the most important administrative ways of distributing welfare within the framework of different welfare state programmes (Holmqvist 2005; Schram 2000; Stone 1985) and forms the basis of an asserted right to services provided by state and society.

It is thus not the administrators within the social insurance system that have actual decision-making power. The state instead places this power in the hands of doctors and social insurance medical experts. They diagnose the illness and establish the work capacity in percentage terms that the person on sick leave has.¹⁹ Based on an assessment of physical, psychological and somatic conditions, they are expected to provide diagnoses. This delicate and sensitive interpretation is based on experience and does not adhere to a strictly scientific approach in which definite symptoms immediately lead to a clear diagnosis.

The importance of interpretation increases when it comes to different psychological conditions – as well as muscular conditions, since it can be difficult to separate back trouble and psychological problems, for example. Diagnoses thus describe something that has been culturally constructed and actually experienced. Diagnoses are born, have a career and die, appear under a new name, are claimed by other diagnoses and also disappear again. Doctors become hermeneuticists in the service of society.

Doctors are not governed by an administrator's rules and regulations, but base their professional practice on an "open jacket" approach. If they are unable to establish a relationship of trust with their



Ill. 4: Hunting is a strong cultural focus but also of immense importance to the local economy in Jämtland. Here it is depicted in the online self-presentation of the community of Strömsund.

patients, it limits their possibility of helping patients combat illnesses.

The Reliable Diagnosis

Medicalisation means non-medical problems and conditions are given labels that entitle the patient to services from the welfare state. This also means another dimension needs to be taken into account: how the diagnoses are rooted in the local environment. If they are not, this also has repercussions for the legitimacy – trust – in the social insurance system. An often overlooked “confidence-building game” takes place here between medical practitioners, the Social Insurance Agency and the local community.

A diagnosis is potent in that it points towards something that *is*, that exists and that is tangible. It is both meaning-making and classifying, which is of particular importance with respect to psychological problems. In interviews, patients often talk about

the relief they feel on being given a diagnosis. That is not because they have any doubt about their illness but because now it is legitimised in the eyes of other people and by society at large. As the person who is ill interacts with people in networks and community settings, the diagnosis has to have both authority and legitimacy. It is therefore possible to be ill in different ways in different contexts, even though the symptoms might be similar.

Another way of expressing this is that local illness concepts have to be continually elaborated if confidence in the system is to continue. Here the diagnosis, the naming of the actual condition, fills an important and general confidence-building function. Whether a patient likes it or not, the doctor is part of this cultural context, serving as a mediator in the perception of the good life and the individuals’ experience of their illness.

So-called “relay doctors” who replace each other after relatively short periods in the area were on duty in several of the communities we visited. First and foremost, the health centre where they worked had considerable influence, since the relay doctors themselves were unable to treat the patients throughout their entire period of illness, but were instead obliged to hand the patients over to the incoming doctor. This meant the local staff of nurses and counsellors provided much of the continuity in treatment. Much of the definition-power – ideas about health and illness – thus lay in the hands of the local health care experts. So diagnoses and treatment were linked to the local community.

Diagnoses in Småland and Jämtland

Which discourses did we find in the two different counties? The material points to different concepts of illness, with similar symptoms leading to different diagnoses. Our study indicated different ways of thinking about and relating to illness among doctors and administrators alike, and that these ways had a certain durability. This supports the hypothesis that medicalisation is something that occurs in intimate contact with the immediate local community. A number of empirical cases serve to illustrate these trends in the material.

In Jämtland, a male patient consulted a doctor about his lumbago and a slipped disc.²⁰ He had suffered back problems for 10–12 years, which began as pain in his spinal cord after he lifted something too heavy. He was signed off as sick, received initial treatment at a spinal-injuries unit and later returned to work. According to his social insurance journal, the doctor noted he was “mentally unstable”. He was said to be very distressed and worried about his future and was faced “with extraordinarily large economic problems”. The treatment, however, was focused on the back problems he had initially sought help for and some improvement was registered.

Before the next period of sick leave, the patient again sought medical attention for his back pain and was again signed off as sick. He was given physiotherapy, but this time the effects at providing relief were noted by the doctor as being “more or less non-existent”. At the same time, the case notes indicated he felt he had been harassed by his employer. He also had considerable problems with his partner, to the extent that she no longer wanted to talk to him. He was described as being “very unhappy, insecure and easily prone to stress”.

From the first day the case was administered, the documentation indicated a person with a mixture of physical and psychological symptoms. For five long years, the diagnosis was mainly related to his physical symptoms. The psychological symptoms that were expressed at the very beginning, which had been emphasised in the doctor’s report from the spinal-injury unit, were not included in the case study journal. This means the psychological condition was not part of a diagnosis, hence not treated during the sick leave period. Not until six years later, in the latter phase of long-term sick leave, was this psychological aspect taken into account, and it was only after this had been diagnosed and documented that the patient received treatment and work rehabilitation.

An example from Småland provides a striking contrast.²¹ A man was diagnosed as having neck problems and depression. According to an early medical report, he suffered from “pain in the neck and back” and was “easily depressed and expresses varying degrees of anxiety about the future”. In a later report,

he was diagnosed as suffering from depression; the reason for this being that during the sick leave period he had also experienced a mid-life crisis. A combination of psychological and physical symptoms had clearly motivated treatment. Even though the man had sought help for his neck problems, he was seen as warranting a double diagnosis. This was ascribed to the man from the very beginning and formed the basis of his subsequent treatment.

The two cases had much in common. Both men were described as having psychological as well as physical symptoms in the very first case documentation. They were both relatively young when they were declared sick, and in both cases the sick leave periods stretched over several years and were repeatedly extended. In the Jämtland case, relatively little notice was paid to the psychological symptoms until much later; in the other case, these were included in the diagnosis from the very beginning.

Two other cases illustrate differences in judgement. A man from Jämtland was diagnosed as having myositis (inflammation of the muscles) with pain and muscle weakness.²² The doctor reported the patient had “numbness of the hands and stiffness in the neck and shoulders and wasn’t at all well”. The notes also stated that a close family member had been admitted to hospital for treatment of a tumour; there was a waiting list for an operation, and the man “experiences these events as extremely difficult”. He was subsequently treated at a spinal-injuries unit and at the same time started job rehabilitation and physiotherapy with the intention of later “returning to work”. During a second period of long-term sick leave, the patient was “tired and worn out from work”. He also witnessed the steady deterioration of his close relative. The symptoms of pain and inflammation persisted. A change of workplace and treatment was arranged, although the focus was still on the physical symptoms relating to the pain and inflammation.

A Smålandian colleague with the same affliction had been diagnosed as having “asthma, eczema of the hands, lumbago and back problems”.²³ After many years of working in a factory, he was finding it increasingly difficult to work there with his physical

problems. The notes indicated the patient felt himself to be “out of sorts” in the workplace and was very anxious about mixing with people as a result of his illnesses. He did return to work for a brief period, however. A period of re-training was discussed prior to a second period of long-term sick leave. It had now become clear that he did not feel wanted in his present employment; his asthma and back problems were treated, and he received counselling for his psychological condition.

In the first case, there was reluctance to include psychological conditions in the diagnosis, and the focus was instead on the physical state of the patient. In the second case, both physical and psychological conditions appeared to have parallel lives and were included in the diagnosis. Similar symptom indicators, based on a classification of muscular and psychological illnesses, were dealt with following two different patterns in the local contexts.

The Significance of Gender

How was treatment manifested in the case of women, though? It seemed more important to draw a line between men and women in the north than in the south. In Jämtland, diagnoses indicating psychological problems were much less frequent.

A man from Jämtland had been diagnosed as having back pain and spinal insufficiency.²⁴ The medical report stated that “the present period of illness dates back several years, when the patient’s work situation led to considerable strain on the back”. A later report stated that “in addition to back pain, the patient also suffers from depression and chronic anxiety”. During the first long-term sick leave, the journal noted that “the insured has severe literacy problems”, which had come to light during the retraining programme that was part of his rehabilitation. This was later changed to “severe dyslexia”. Again, it was the physical symptoms that were subject to treatment and rehabilitation, despite the psychological problems named in both the medical report and the journal notes – without being included in the diagnosis.

In the case of a woman suffering from myalgia and back pain, the diagnosis of fatigue was also added.²⁵ She had initially sought help for her back

problems, though the medical and journal reports noted “a work situation with a lot of stress”. The psychological condition of the patient shaped both the indicator of the syndrome and the diagnosis.

These gender differences were discovered over and over again. Men were diagnosed as physically ill while women were treated for their psychological problems. This was particularly the case in the northern part of the country, so a regional and gender-based differentiation existed. In the later decades of the material, however, an increasing number of men received psychological diagnoses in Jämtland as well, suggesting this diagnosis has become more gender-neutral.²⁶

Local Legitimacy

The medical reports and journal notes in essence made different diagnoses, depending on gender as well as local culture, for what were similar syndromes. It wasn’t that the doctors’ assessment of a person’s work capacity differed from region to region, which one might have assumed had the actual state of the labour market been taken into account, but that the notions of illness differed between the different regions.

This was quite remarkable, in that the legitimacy of the system supposedly is based on cases being dealt with on equal terms throughout the country. Where a person lives should not make any difference whatsoever in how that person is dealt with and diagnosed. Giddiness, anxiety and back pain should all be dealt with in the same manner by the welfare state; ideally, the administration of similar cases should lead to the same result.

Civil servants are strongly influenced by the community in which they work, understandable relative to how locally socially integrated these administrators were. Evidently the doctors making the diagnoses also felt themselves bound by local contexts, probably not for fear of violating societal norms or being subject to local sanctions, but more likely reflecting how the examination of patients and their illnesses are pre-determined by the working environment. Trust and confidence in the overall system are created locally.

On Burnout and Outsiderness

We also needed to study a group of patients who, for reasons of their own state of health, found themselves in such an ambiguous position that they no longer fit into the local community's definition of health. What happened if a diagnosis wasn't accepted in the local context? The hope of improvement and the confidence things would work out was based on people's understanding of life as something definite and foreseeable, and that illness and sick leave were important parts of this process. It was therefore important that the diagnoses were tuned in relation to accepted regional indicators. The consequences of someone who previously had been included, but now ended up outside the recognised social and cultural categories, did not only create personal discomfort and anxiety – but also a feeling of social powerlessness. In this context the phenomenon of *burnout* served as a good measure of how hope and confidence worked.

Not of this World

Burnout can be regarded as an example of medicalisation. It could also be regarded as an indication of the fragility of social life. It is an illness that can dissolve a person's meaning-making network. From having been active and the centre of attention a person is now confined to the peripheries of social life (Jönsson et al. 2005). Both the sufferers themselves as well as society at large try to give this diffuse syndrome a definite shape, but also provide signposts for the way back to a functional social life.

The "burnout syndrome" was only recognised during the mid-1980s, and appeared in a variety of guises, such as overwork, myalgic encephalomyelitis (ME), stress syndrome, anxiety syndrome and fatigue syndrome. The Anglo-Saxon term *burnout* was adopted, and translated literally into Swedish as *utbrändhet*, which then became the popular name for the condition. The recommended medical diagnosis was chronic fatigue syndrome, but the sufferers often refer to themselves as being burnt out, although this is not what is actually written in the medical statement.

The diagnosis gave temporary permanence to a series of diffuse signs of illness and it expanded rap-

idly.²⁷ It was a condition medically difficult to document in physiological terms, due to it being based largely on a judgement of the patient's own experiences and descriptions. People often had strong ideas about what they might be suffering from before seeing the doctor.

The lack of physiological and measurable symptoms contributed to a general mistrust towards those suffering from the sickness: Why can't they just pull themselves together and go to work like everybody else? Aren't they making a mountain out of a molehill? Are they really ill or are they simply feathering their nests at other people's expense by claiming sickness benefits without really being ill? Fear of the unknown (e.g., what burnout actually was) was increased by the social threat it represented.

Those suffering from burnout testified about the problem of feeling terribly ill and at the same time being questioned and mistrusted. What they feared most – a lack of trust on the part of other people – was also what hit them hardest. Both the diagnosis and their state of health often led to a sense of social shame, of feeling diminished in other people's eyes. They felt guilty and embarrassed about no longer being able to perform and about having to reveal their vulnerability and dependency.

The syndrome also appeared to be profoundly mystical: memory loss, racing heart, rising blood pressure, upset stomach, lack of energy, paralysed by anxiety. In addition, having to explain – or even worse, *defend* – the situation to all and sundry hardly made things easier. The need to rest was great and days passed by in oblivion. Sufferers often avoided people altogether and stayed at home instead of going into town, thereby obviating the need to meet colleagues or neighbours and feeling obliged to respond to their embarrassing questions.

The following extract from a conversation with Maja, a burnout sufferer on long-term sick leave, describes how initial voluntary isolation in the home soon came to resemble personal and social incarceration.

"In the first year I kept out of sight, apart from when it was unavoidable."

"Why?"

“Because I no longer belonged to the world.”
(pause)

“Was that how you felt?”

“Yes, I didn’t fit in any more. I somehow didn’t fit in among other people...”

“Can you explain it in a little more detail?”

“I became a kind of alien. It felt as though I was a complete stranger in what was otherwise familiar, like my streets and my neighbourhood. I could cope with certain things, like going down to town to my aquarobics class. I drove there and back. I also managed to go to the doctor. But I think I was a bit like a zombie. I think that I encapsulated myself in a kind of protective wall.”

“Like a stranger you say...”

“Yeah, it wasn’t the others who were strangers. I was the stranger. I didn’t belong. I had no right to be there. I had no right to be on the streets or in the shops. It was all rather...”

“Did you feel ashamed?”

“Yes, I think so. I naturally felt that I had little value as a person. I felt ashamed and guilty and that everything was a mess...”

Later in the interview Maja referred to herself as “a minus sign in the government’s budget prognosis” and “a second-rate citizen”. Although this was accompanied by a twist of black humour and irony, there was a hint of painful gravity about it: Through her strange illness she had lost something of her human dignity and worth. The town that had previously been so easy to move around in and be seen in was now a place she had to avoid. The confidence she had felt in her own community had ebbed and she was now, metaphorically speaking, confined within her own four walls.

Good to Know

For many, the sense of outsidership remained after the diagnosis had been confirmed, since the condition wasn’t recognised as part of what was locally negotiable. It was comparatively easy to gain recognition for being on sick leave – but not for this! Eva, even though she had been signed off as sick for pain and burnout, described it in the following way:

“My self-esteem, which was already shaky, took a real nose-dive. You simply weren’t yourself. You’re not worth anything. You know yourself what it’s like when you meet people you know: ‘And what do you do?’ they ask. ‘Oh I’m burnt out,’ you respond. In other words you become identified by your illness, full stop. And you carry on being ill. It’s a vicious circle.”

“Does the illness become a kind of safety net?”

“Yes. Absolutely! It gives you some kind of identity that makes you feel secure and at home. And it’s easy as well because you can just let things go. You can say no to everything and everyone without having to justify anything, simply because you are ill. From being a very social person, I became completely unsociable. When you’ve been at home for a long time with a strange diagnosis that people don’t really understand, you just avoid meeting other people in the end. You just don’t have the energy to answer all their questions.”

“What does solitude come to mean then?”

“An escape from reality, from yourself. From life. I was tired of talking, tired of words, tired of always being available and tired of pretending I was happy. You go through a kind of personality change and that scares other people.”

For Eva, a diagnosis meant relief at finally, after many years of pain and anxiety, knowing what she was suffering from. At last she was regarded as really being ill and at last she had found a doctor who believed her! This is something that recurs in the sufferers’ narratives: A desire to reclaim their social face – a need to be believed, not just by friends, acquaintances and colleagues, but also by government agency representatives. The opposite, such as being mistrusted by a doctor, a person regarded as an important representative of the welfare state, is experienced as something that is not conducive to recovery. In those cases where the Social Insurance Agency’s doctor had rejected the diagnosis that the person’s own doctor had written on the sick leave certificate, the result was desperation and anger. Patients felt under suspicion, and mirrored the mistrust manifested by the authorities: A person doubt-

ed by a public servant doubts the authority that issued that declaration, creating a *double declaration of no confidence*. This also led to strong pressure on the doctors and administrators to make life more tolerable in the community in which people lived.

In such an exposed situation, the diagnosis, the name, becomes something that the patient can cling to, an admission ticket to a worthwhile social life. At the same time it steals much of people's day-to-day freedom. Eva described how she used it as a kind of exemption warrant from social demands and obligations. In the long-term, this proved to be a solution that locked her into the inferno that was her own self. The pain she suffered from gave rise to isolation, which in turn led to a fear of life itself, making her even more depressed and introspective. She said that in the end she *became* the actual illness: "I was the actual diagnosis. That might sound strange, but when you're on sick leave nothing else counts. My self-esteem, which was already at rock bottom, became even worse. You simply don't know who you are. You're worthless."

People's own Community

After several years of sick leave, Eva managed to break the vicious circle, among other things by becoming the leader of a group of women with similar problems. Eva lived in Jämtland, and in this club for people on long-term sick leave, time was devoted to information work: visiting local businesses and talking about stress and burnout and trying to motivate employers to work preventatively in such matters. The club was also involved with group rehabilitation through various kinds of artistic activity. It was obviously more acceptable for people to be on long-term sick leave in this community than in more prohibitive Småland.

A constantly recurring discussion about members' rights and societal recognition was typical for this and other associations for the long-term sick and burnout sufferers, which mainly consisted of women. The long-term sick ought to be able to enjoy respect and be dealt with in the same way as any other citizen. These associations created their own social world by challenging the prevailing order "out

there", characterised by demands, stress and speed, and very little time for rest and recuperation. They pointed out that women still assumed considerable responsibility for home and family, yet also were expected to work full-time. They claimed that psychological ill-health ought to be classified as warranting sickness benefits and be regarded as just as valid as other types of illness.

One of the club members, Sara, who had been given a range of different diagnoses, was familiar with how treatment in society varies depending on which illness people are suffering from: "When I had neck problems nobody thought it the least bit strange that I was on sick leave. It was also OK when I was later diagnosed for mouse elbow [epicondylalgia]. But when it comes to stress and pain-related depression, folks just think this is nuts."

This alienation from society, subjectively experienced and thereby also in some sense true, seemed to bring these women closer. To a large extent, burnout is about solitary confinement, vulnerability and a kind of homelessness in social space, which can help to explain why people on long-term sick leave are drawn together. However, it is nothing new that people in vulnerable positions are drawn together, and patient associations linked to almost any diagnosis attract an impressive number of members nowadays. Understanding and sympathy is expressed among people sharing similar experiences, and only here, says Erving Goffman, among kindred spirits, does the stigmatised patient feel fully accepted, included and respected:

As personal experience has taught them what having this special stigma means, some of them give him advice as to how to cope with his stigma and even put him in touch with a group of regrettably similar sufferers that he can contact for moral support and feel easy and at home with, and accepted as the person he really is, just like any other normal human being (Goffman 1963: 28).

The stigmatised person can relax and be accepted among others similarly stigmatised. An informal association like this often develops into a more formal

organisation with explicit policies, ideologies, political aspirations, representatives and publications. The process is shaped by the fact that contact with “the Other”, in this case employed and healthy individuals, becomes increasingly strained. A number of interpretations and reinterpretations of social interplay take place when the sufferer is increasingly obliged to identify with his or her outsiderhood, mainly because this is constantly endorsed by other people’s “insiderness”. Through their very existence, “the Normal” demarcates the subordinate position in society that “the Abnormal” is perceived as occupying. The stigmatised thus becomes obliged and compelled to resort to new adaptation strategies (Goffman 1963). This is visible in associations related to sick leave. They resist the world outside, they underline solidarity with their own kind and they emphasise their collective rights in society. Paradoxically, this process can also serve to increase the distance to the world outside the new community of fellow sufferers.

Vague Community

What was characteristic of those suffering from burnout was that they didn’t belong to any definite category. It was rather the sense of things having gone astray in bodily, cultural and social terms that united these people, together with an expressed feeling of no longer belonging. They suffered from the double declaration of no confidence. In many ways, their groups were *vague*, with an indistinct profile and without a common agenda or assignment. The groups themselves tended to dissolve over time, their members highly dependent on other people’s views and perceptions for their well-being and rehabilitation.

It was regarded as a poor argument that an association for burned-out people in Jämtland tried to resist societal development as a whole and argue that overload in the contemporary “information society” was the biggest cause of burnout. It was like accusing the clouds of releasing water, the counter-argument ran. The activists tried to apply pressure, but had very little chance of having a real effect, especially through groups and networks that were not granted

a high status. Instead, the local community had a lukewarm, obliging attitude to associations for those on long-term sick leave and burnt-out women.

The network meetings of fellow sufferers can be regarded as a way of trying to reproduce a sense of community by *proxy*. In that context, and in a manner similar to those who were healthy and employed, they could demonstrate that they were able to perform their duties and meet their commitments. They tried to reproduce the cultural value systems accepted by the community in which they lived, but under conditions possible for the person suffering from burnout and on long-term sick leave. It was about setting limits and defining what was acceptable and not acceptable. Quiet agreements and unspoken rules determined the type of activity the sufferer could devote time to. However paradoxical it may sound, every cultural system includes the normal, or “healthy” way of being ill, writes Arthur Kleinman (Kleinman 1988: 5). As we have already seen in this study, these normal ways of being ill vary from region to region. In some milieus, being out and about when one is off sick appears to be perfectly acceptable, whereas in other places such a thing would be unimaginable. Burnout sufferers showed how important the local rules were for social acceptance.

A woman in one of the networks briefly described her participation in association life: “Not having any work made me frustrated, and in order to feel included in some kind of social context I got involved with a number of different voluntary associations.” Her network colleagues could thus be likened to some kind of substitute workmates. She drank coffee with them, shared her burdens, arranged and developed projects. Empathy emerged within the group, and members sympathised with and understood each other’s predicaments and moods.

The participants in these networks strove to remain as neutral and normal as possible. At the same time their main objective was to manifest and maintain the distinction between illness and health, the normal and the abnormal. But abnormality had to occur within socially acceptable forms. Members were recruited from within their own category.

Communication with the surroundings mainly occurred through the channels that association life offered. Local politicians' presence in discussions, information sheets to a conference or district committees' financial support for an activity were all examples of how abnormalities fitted into established behaviour patterns. Devoting themselves to organisational activities was in every respect a socially and culturally accepted form of occupation for both those who were healthy and in employment as well as for those on sick leave. People on sick leave can use these activities to cover the superfluous cracks in their personal character, which Goffman would probably have categorised as burnout (Goffman 1963: 14).

These affiliations also became a trap for the members in that they did not clearly indicate the way back into the community at large. Something happened to those who kept company with other sick people, day after day, month after month, year after year. Katarina, the leader of one of these networks, suspected that this was not always such a good idea. There was an obvious risk of getting trapped in their own problems and developing a kind of sickness-related identity based on mistrust. "We have to take care of them so that they come here and they have to revel in their problems when they are here," she said. Discussing such matters openly with people who had been ill for a long time and whose self-esteem was at rock bottom is not easy, maintained Katarina. When identification with the illness was the only thing they had to cling to, and it hadn't yet been accepted in the local imagination, it could easily turn into general critique of society. In actual fact, confidence within the group increased the distance to the world surrounding it.

Confidence in society is based on recognising and acknowledging the social capital that exists in the community. A step away automatically becomes a step towards, such that alienation from local surroundings ran parallel with establishing strong fellowship within the support group. So some communities, Eriksen writes with humour, are like inverse refrigerators: "Their expressed aim is to create inner warmth, but in order to do this they have to, almost

unintentionally, create exterior coldness. The complete reverse of what a refrigerator does, in other words" (Eriksen 2004: 55).

Likewise, one might suppose that the feeling of solidarity that accompanies the sufferers on this journey could lead to their state of health becoming permanent. Yet it was actually a community that developed around a *lack* of confidence in the world in general, just as much as its search for a local social context. Perhaps this also reflects the dilemma people are in danger of being sucked into when the local community does not provide the basis for confidence or trust in society at large.

The Sense of Community

Our results indicate the need for studies of community that combine the rather inflexible notion of local culture with one that takes full account of making rational decisions with expectation and emotional involvement. Such engagement is not only based on common memories and narratives, but also includes knowledge of how other people in the local community might act in similar situations, in what we have called *interactive rationality*. People appear to be prepared to change their behaviour if they are convinced the majority of the inhabitants of their community will act in accordance with accepted standards in a similar situation.

The word rationality puts too great an emphasis on conscious choice, however. What we instead found was an emotional involvement that was not socialised into a form of deep-rooted societal ethos or habitus.²⁸ It rather had to do with the future-oriented expectations that newcomers to a locality could adopt and accept. A striking example of this was the two "healthy" Smålandian communities (Gislaved and Nässjö) that accommodated inhabitants from Finland, former Yugoslavia, Greece, Somalia and Iraq, and the rural commuter suburbs that had been taken over by city people with a longing to own their own houses (Mullsjö).

People fill their community with meaning on a day-to-day basis. This meaning was also easily understood by "central bureaucrats", from administrators to doctors and health care staff visiting or liv-

ing in the area. And it was to some extent formed by the presence of the very same officials. In the doctors' diagnoses and in the administrators' work we could see how sensitive they were to diagnoses that "worked" and the kinds of support that were locally acceptable.

We found the concept of hope important here. How it works in terms of daring to reach out, getting involved in networks and developing what we have referred to as social capital has been discussed with reference to Ghassan Hage (2003). Unlike Ernst Bloch (1995), he doesn't see hope as a cognitive phenomenon but more as "the perceived capacity to exercise some mastery over life, and it stands in opposition to helplessness" (Hage 2003: 25). This makes it synonymous with the kind of emotional assurance that is closely related to belief domains – or rather, to deep trust. It is also based on the insight that *I can*, rather than *I know* (Merleau-Ponty 1962; Frykman & Gilje 2003). It includes the almost physical confidence that the future will work out for the best, that things will end up right – and that there is also room for me. This kind of hope can exist in communities as something that is neither confining nor excluding; people feel that new possibilities are always available.

This was not a metaphysical hope but one that is grounded in everyday micro-processes and encounters with national institutions. The different clubs and associations gave rise, in true Putman spirit, to trust and formed the basis for the development of personalized social capital. Information about other people in the community was circulated, which resulted in insights as to what life must be like for others. But something other than the rather obvious training in the development of social capital also became apparent, namely an insight that personal opportunity was dependent on other people's opportunities, whether for neighbours, colleagues or society as a whole. It is easier to hope if surrounded by optimists. Everyone's free development is the prerequisite for anyone's free development, as Marx might have put it.

But the social insurance offices and health care centres also had valuable functions. When people

realised that these authorities were reasonably effective they also felt that society's assets were legitimately distributed. They were essential instruments for the creation of confidence at the general level and security at the individual level. They maintained an order based on rights rather than individuals. This is what Hage referred to as society's instruments for *the social distribution of hope*. Distribution has to appeal to the capacity to administer *care*, just as much as the insight that the distribution is so translucent that everyone can see through it.

The interesting thing was that actual support seldom inspired hope. It was the conviction of help *being available* if people should need it that inspired confidence rather than the receipt of benefits. Whenever such benefits tended toward becoming permanent, they produced more worries, and a sense of victimisation, than hope.

Ill-Health and Trust

In a more limited sense, our study highlights what happens when welfare policy is put into practice. The application of common regulations had differing consequences in the two counties we studied. The ideals and values welfare policy is based on were shared by most inhabitants of the different communities. But the differences became obvious when the rules were put into practice. People could simply be more readily signed off sick in some communities, and local inhabitants, administrators and doctors knew that.

In Jämtland, the locals were deeply engaged in the community they had created, although in national terms, their county was a marginalised and distressed region. Confidence in local solutions was reinforced by people having an outside power to match themselves against. Joining forces and seeking different resources for community survival were ways of trying to ensure the future; in this context, sick leave was one path taken. It made it possible for people to remain in the community and hope for a better future. In these comparatively strongly integrated communities, the high proportion of sick leave thus became something of a chimera. It testified to a culture that created its own rules and

made use of society's institutions in order to solve local problems, yet it was a form of regional support that carried the risk of people identifying with their diagnoses and thereby reinforcing their mistrust of society more generally.

Hope as Hage describes it is an emotion based both upon rational insights and a belief in the magic of increasing opportunities for the future. Strangely enough, support from the welfare state can deplete communities of their surplus of hope, because by helping it to close in on itself, worrying takes over (Hage 2003: 22f). This develops into what Robert Putnam has referred to as "bonding social capital", or what Bo Rothstein has called "particular trust" (Uslaner 2002). This is trust in a tight circle of family, relatives, or the village community. People easily lose hope if they can't control their own lives, and often mistrust social institutions if they can't see what they will gain from them. This seemed to be the case in many parts of Jämtland. By using hand-outs to uphold their community, the hope they could manage to change the future on their own diminished. In order to deserve support some preferred having a medical diagnosis than a job offer.

In Småland, the local was not formed in contrast to the welfare state. They might have regarded it as an obstacle to how their community could be run more efficiently. People regarded their community as a model for how Sweden ought to function. Modernity, entrepreneurship, flexibility, workforce migration, the ethnic and religious mix, valuable personal contacts and formalised networks seemed to form the basis for a special optimism. Here the state was present as a kind of background insurance, although the less people had to do with it, the more hope there was for the future. The local community was strong thanks to its capacity to adapt – and not strong due to its museums, reference to history and cultural heritage, long traditions or the place-marketing of striking qualities or characteristics. It was strong through economic thrift. People were also remarkably healthy here, as measured by levels of sick leave.

In Putnam's terms, this could be called "bridging" social capital. Rothstein calls it "general" in that it

fortifies the borders between the group that has capital and the rest of society. In such communities, people tend to have confidence in other people in general and that people can manage their own situations. They see "the local community in a positive way and believe that if they follow 'the rules of the game' they will also be reasonably well rewarded" (Rothstein 2003: 158).

In Jämtland or Småland such trust didn't just appear out of thin air but was the result of how people built community and filled it with meaning. People actively made use of what central administration and health care offered, merging it with what we usually claim to be local culture: history, beliefs, traditions, social forms and material traits. In one case, it developed into a reluctant dependency, in the other into an independence in line with modernity and to some extent with a state that was promoting the very same values.

The study clearly shows how a community is not simply something that *is* but something that is constantly *in the making*. Likewise, trust is not something that *is* but something that constantly *takes shape* when people dare to believe that the community has a future and direction.

Contemporary research in the social sciences contains a vast array of post-modern clichés with regard to the placeless, nomadic, fragmented and uncertain nature of society in general, along with rhetoric about "where the world is heading". European ethnology can provide a useful counter-balance to such sweeping scenarios, but that calls for a return to local empirical studies. In our project we chose to study people's relation to sick leave. Further research could analyse how this relates to other forms of state benefits, ranging from allowances for immigrants to unemployment compensation. There is no lack of hypotheses about how this creates new dependencies, new gaps, or new conflicts (Giddens 2006). But what do such processes look like from below? It is clear that studies that tackle such problems with renewed vigour and energy are needed. It is not a question about *whether* the local plays a role in today's globalised society, but *how*.

Notes

- 1 The study is the result of an interdisciplinary research project and is therefore a common effort. Bo Rothstein was responsible for the study *On Trust and Social Capital*; Jonas Frykman and Kjell Hansen for *On Local Communities*; Helena Olofsdotter Stensöta for *On Administrators and Communities of Ill-health*; Isabell Schierenbeck for *On Medicalisation*, and Mia-Marie Hammarlin for *On Burnout and Outsideness*. The translation is by Sue Glover and the editing by John Bendix.
- 2 There has also been an intensive discussion in Danish ethnology about how citizens' identity is interfered with by the state (see, for example, Højrup 2002).
- 3 Unemployment and sick leave could serve as means of communication: sick leave sinks when unemployment rises and vice versa (Goine & Edlund 2003).
- 4 At that time there was a fairly widespread perception that it was possible "that the large deviations evident in Norrland reflected a different view as to how the social insurance system ought to be used and that the high allocation of sickness benefits and disability pensions served as some kind of regional support" (*RFV Analyser* 2003:4). Special studies relating to Norrland in *RFV Analyser* 2002:11; 2002:16; 2003:4; *RFV Redovisar* 2002:8; 2003:4; RFV, Enheten för analys [Analysis Unit] 03.03.2003.
- 5 Municipal decision-makers and those engaged in medical care at polyclinics in the Swedish Social Insurance Agency, and decision-makers in the relevant employment agencies, were interviewed. Social insurance journals were studied and extensive participant observation was conducted. The study is based on a total of 4 years of – interrupted – fieldwork. The methods used varied among ethnologists and political scientists.
- 6 These figures relate to 2005. Since then these figures have decreased overall, without the relation between the regions having been affected.
- 7 The list can be extended. The majority, if not all of today's Nordic professors born in the 1940s and 1950s undertook community studies as the first assignment in their careers.
- 8 For a penetrating analysis of the importance of the EU for local communities, see Andresen & Højrup (2008).
- 9 Following local usage, "Jamts" refers to those born and bred in the region, while "Jämtlander" indicates people who have moved in and have lived there for some time (at least 15 years) and adapted to the local culture.
- 10 Paradoxically, this has led to a *race to the bottom* and competition with other regions to be the most marginalised: this would increase subsequent access to national support measures.
- 11 The offices in question are in Östersund (the largest in Jämtland), Strömsund (with a high proportion of sick leave) and Järpen (with a low proportion of sick leave). In Småland we visited Nässjö and Vetlanda (a high proportion of sick leave) and Gislaved and Eksjö (a low proportion of sick leave). In Småland the interviews were carried out in May 2004 and in Jämtland in November 2006.
- 12 For various reasons we were unable to interview all employees in a number of offices. On some occasions the staff were absent from work and we were unable to return at a later date. In Östersund access to administrators was limited due to the length of time it would take to interview everyone. Despite this, most members of staff from each office were included in the studies, so the study can be regarded as a comprehensive selection with a limited dropout rate.
- 13 This includes staff which looks after all the incoming cases of sick leave, sickness benefit administrators, rehabilitation officers and report writers.
- 14 The monograph "*Snällism*", *stränga högerattityder och sjukskrivningar. Spelar välfärdsadministratörernas attityder någon roll?* ["Kind-heartedness", stringent right-wing attitudes and sick leave. Do welfare-state attitudes play a role?"] (2009) was written by a project participant, Helena Olofsdotter Stensöta. She looks at how variations in organisational culture can help explain regional variations in health figures by using material gleaned from questionnaires and longer interviews. The questionnaire used constitutes the first extensive survey directed at administrators in social insurance offices and is therefore unique. Among other conclusions, it was found that the sickness level is lower in regions where a large proportion of the administrators are politically inclined to the right and where they are care-oriented in a project-oriented way rather than in a helpful way. The interviews resulted in identifying four "ideal types" of administrator attitudes ranging from rule-oriented to an orientation towards the insured.
- 15 After 90 days on sick leave, the Social Insurance Agency draws up a so-called investigatory act (u-act) which then accompanies the insured persons throughout their sick leave period.
- 16 Diagnoses followed the International Statistical Classification of Diseases and Related Health Problems; various editions of this classification were published during the study period.
- 17 The constructivist power perspective is suited for studying how the female body has been medicalised, by largely male-dominated medical expertise, to a greater extent than the male body (Johannisson 1994).
- 18 Medicalisation also includes "anomalies" which occur as part of the life processes. We have, for example, seen a medicalisation of childbirth, abortions, menstruation, aging, alcoholism and hyperactivity.
- 19 Work capacity is to be assessed as at 25, 50, 75 or 100 percent by the doctor writing the medical report.

20 File 13.

21 File 133.

22 File 17.

23 File 156.

24 File 86.

25 File 91.

26 This is speculative, however, as a change can be discerned in the material during the latter period, one partly supported by the Social Insurance Agency's diagnostic study from 2007 (RFV 2007:3), indicating that the number of psychological diagnoses in Jämtland has increased.

27 It is difficult to determine how common this is because different studies present varying statistical results. However, it has increased considerably since the 1990s, with more women than men affected. Illnesses relating to psychological health (psychological illnesses + burnout) account for 31 percent of long-term sick leave. Among men, this figure is 27 percent, whereas among women it is 34 percent (RFV 2007:4), and it is in this particular category that sick leave has risen. It has diminished in others, such as movement or muscular impediments (pain in the neck and back, etc.). According to another study, two-thirds of those on long-term sick leave for psychological problems are suffering from burnout (Åsberg 2001). Gender differences in burnout cases have been confirmed in a number of studies: in a comprehensive population survey, twice as many women (9.3%) as men (4.6%) were categorised as suffering from burnout (Hallsten, Bellagh & Gustafsson 2002).

28 In the humanities the word "ethos" was often used to portray society's emotional atmosphere. In this context "ethos" was seen as a cluster of attitudes that were so basic that they were shaped in the inter-subjective relation between mother and child (Bateson 1972: 108). This then presupposes that the inhabitants of the different communities must have acquired a certain habitus during childhood.

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