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Ståhl, C., (2019), The Judas kiss: On the work and retrenchment cures and the troubles they bring, *Work*. <https://doi.org/10.3233/WOR-193053>

Original publication available at:

<https://doi.org/10.3233/WOR-193053>

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The Judas kiss: On the work and retrenchment cures and the troubles they bring

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Abstract

This article uses a number of societal stereotypes related to work and welfare to problematize the relationship between work and health, and how this relates to the prevention and management of work disability. It outlines current discourses in policy and research around these issues, and discusses some of the ethical implications of these discourses. The article concludes that the current policies on work disability and sickness insurance takes their point of departure in over-simplified accounts of the relationship between work and health, and that a more critical reading of the evidence is called for. The implications for research are also discussed, where a system-oriented perspective with attention to social gradients and the various working environments is called for.

Keywords: work disability, sickness absence, health, prevention

Introduction

I will start this article by exploring a few prejudicial stereotypes, which may or may not provoke you.

A work disabled person sits at her kitchen table. She is on sick leave, which implies being, socially, in a minor place; every day is another day full of dread. Isolated from the social context of work, she will think to herself: “When I look forward I see a darkness where the future ought to be. All I am is a burden. My bed is for sleeping, so that’s what I’ll do. I am sick, and I deserve to be compensated.” This is a prejudice about people on sick leave that can be found among various professionals working in social insurance or health care systems, or among some of the public.

At the other end of the prejudicial spectrum we meet a malevolent insurance official, sorting his papers into a black folder at the end of the day, viciously chuckling: “Today I was an evil one, a real wolf among wolves”. He sings the song for the new breed, for those who are fit and healthy, where there is no room for malingerers or weaklings. The way to glory and success is to return to work swiftly and without delay, joy and jubilee, where the mere presence in the workplace will lift us up and make us recover into well-functioning workers and citizens. This prejudice about social insurance officials can be found among people on sick leave, or among some of the public.

There are other prejudices that seem to flourish. For instance, the popular tale of the physician who spreads his careless love of humanity by issuing sickness certificates to anyone who wants them, and even if love is a genuine and empathetic emotion, it may result in a hard life for the person who is medicalized, and will be slung into a strange

form of life where our sick-listed protagonist gives up on work, and the letting go results in deterioration of the person's health. This prejudice about the well-meaning but counter-productive physician is often found among other physicians, especially those who claim to represent a hard but fair approach. This, of course, is my own prejudice about that breed of physicians, of which I only have anecdotal evidence.

Prejudices shadow our sight. In the field of work disability, they exist in abundance. They can boost your self-confidence if used in argumentation, and they are certainly seductive. If you manage to wake from their night noises, at break of day you may find that your ideas are exaggerated, merely nightmares about moral hazard or the blood embrace of insurance officials.

The Sherbrooke model [1] – a central reference in the work disability prevention field which emphasizes a system perspective and to focus on workplaces, healthcare and policies simultaneously – is by now a couple of decades old. As such, it has been influential for much research and policy developments across the world. Still, we need to learn certain lessons from what's poor in many current policies and their application of the evidence spurred by the model. It is time to be clear: the seedling of Sherbrooke has in some places grown into a weed which needs attention and care. Work disability research suffers from a lack of attention on the influence of values and prejudices, not only on actors within the systems, but on ourselves. We need to examine what values that underpin current policy systems, and critically reflect on how they shape our thinking. Particularly relevant for the work disability field is how we conceptualize work, and how we perceive the role of welfare systems (in which I include social insurance and workers' compensation systems).

75

76 I will in this article ask three questions which I consider important for the future
77 development of research and policy in the work disability field:

- 78 1. What perspectives on work dominates current thinking about work disability?
79 2. What perspectives on welfare provision dominates current policy-making?
80 3. How do values related to work and welfare influence policy-making and research in
81 work disability?

82 It is my hope that these questions will spur a debate on the premises for our studies and
83 what underlying assumptions that guide our work. While we ease down the road I will
84 also briefly conclude with how these points relate to the need for theory, to inform
85 future developments in the field.

86

87

88 **The work and retrenchment cures as dominant values**

89

90 *Everyone's got to have the sickness, 'cause everyone seems to need the cure.* [2]

91

92 Although we have ample evidence of how work may fuel health problems, the majority
93 of work disability systems remain promoting return to work as the ultimate goal for the
94 work disabled. We can call this treatment the *work cure*, which is prescribed with little
95 regard toward the potential side effects.

96

97 This cure has a long history: the term “work cure” was first coined by Hall in 1910 [3]
98 in an early contribution to the then evolving occupational therapy profession, and Hall

99 was later referred to as a representative of the *religion* of work [4]. Truth be told, Hall's
100 perspective on work was a rather balanced and positive one: it was described in opposite
101 to the harsh working conditions of the industrial system and was primarily concerned
102 with helping people with nervous disorders by changing the then common "bed cure"
103 with arts and crafts, such as pottery or weaving (perhaps an explanation for the homely
104 and wholesome aesthetics of many occupational therapists, if I may let another
105 prejudice slip). This attitude toward work as helpful in curing health problems became
106 prominent in the early 1900's, and the memory remains not only in occupational
107 therapy, but the seed has also grown into policies that go far beyond what was originally
108 intended.

109
110 Today, we seem to live in a workaholic society – the importance of work is hardwired
111 into our way of thinking about the world. A book aptly titled *The Work Cure* [5], was
112 recently published which criticizes how work today is considered to be the cure for most
113 ailments and troubles. Thus, what was planted a hundred years ago may prove to have
114 been a bad seed spurring a poisonous plant to flourish, as we even in cases where we
115 can see a link between a person's work environment and their illness still choose to
116 fight fire with fire – return to work is not just the goal, but also the means toward that
117 end.

118
119 Of course, work is not all bad. The manager is not a master of puppets who keeps his
120 subjects at the frayed ends of sanity. Most workers are not treated as disposable heroes
121 of war. We know that work can give positive health effects when work conditions are
122 decent [6]. But we also know that there are examples of terrible work environments, sad
123 but true, and these are both causing work disability and preventing recovery through a

frantic work pace or other occupational hazards [7]. We also know that the increase of precarious work causes insecure working conditions which may both cause health problems and complicate rehabilitation processes. There are political and organizational means to deal with poor work environments – work inspections, for instance – and the unforgiven employees who became victims should not be allowed to jump in the fire again before a thorough investigation of the preconditions for a safe return.

What we need in this debate is some attention to situational and contextual aspects, where we need to not only consider diagnosis (yes, return to work for someone with a whiplash injury differs from someone with depression) – but what type of job, the conditions in the workplace, and what type of socio-economic position, gender or age the person has. One person’s work environment is not necessarily the same as that of her colleagues, even if in the same workplace or work group. This confusion apparent in the literature – that work may be both harmful and helpful – calls for caution when interpreting meta-reviews or research syntheses in relation to an individual case. This does however not imply that whether the work environment is good or bad is in the eye of the beholder, and we should resist considering it from an individualized perspective where we focus more on, e.g., how individuals cope with stress than the organizational conditions that produces it [5]. How I manage my work situation is not all within my hands, but must be related to who is responsible for and has the mandate to change it.

The other cure I wish to discuss is what we can call the *retrenchment cure*. In many social insurance systems, we seem to be at a point where the thing that should not be considered the problem – the existence of social security – is often seen as precisely that. We see policies being restricted across jurisdictions where generosity in terms of

monetary compensation is seen as keeping people trapped under ice by providing anesthesia where people should rather learn how to cope with their disability. Politicians have extensively referred to theories of moral hazard to implement reforms to “help” benefit recipients escape a system which makes them passive and permanently excluded. Where the system used to be seen as a security and a guarantee, it is now seen as some kind of monster, which will only make you worse. To combat this effect and to provide health and justice for all, policy-makers seem to conclude they need to restrict such ambiguous blessings as much as possible. As with the work cure, the retrenchment cure is seldomly discussed in relation to its potential side effects, which in the individual case manifests itself through harsher assessments with the potential outcome that clients will not receive the support they need.

We have many studies indicating how distrustful and restrictive systems lead to dire health consequences, where this in some cases reflect the fundamental system design [8], but in others are the result of retrenchments in previously more comprehensive and relatively generous systems [9]. In the context of a retrenched and diluted social insurance system, the hero of the day is the professional who recognizes the need for this tough treatment and promptly denies the person sickness benefits. At the end of the line, the system needs to be strict on following its regulations, with little concern whether clients are left broken, beat and scarred.

The two cures tend to go hand in hand, and when combined – that work is always the solution, and that compensation is harmful – it can result in a cyanide cocktail; the person who draws the shortest straw may be forced to return to a bad work environment because the system is geared to provide financial incentives while offering little or no

support to manage the return in a safe way. The point here is that both cures are prescribed with the best intentions – they are loosely built on evidence, but will in the individual case be a Judas kiss where the person is left to manage without the necessary support. The two cures are sometimes also communicated in a moralizing fashion, with a “holier than thou” attitude, where individuals are blamed for not understanding the virtues of work, or are deemed unmotivated in order to explain failures that more reasonably should be attributed to the system [10].

In the next section, I will discuss how these two underlying values functions as a dirty window which clouds our sight, both with regard to what questions we pose in our research and in how they are transferred into policy.

The gift of guilt

Prejudices serve as heuristic templates based on which we make sense of the world. The work and retrenchment cures, and the link often made between them, are highly influential ideas that has governed much welfare policies over the last decades, often based on a very narrow reading of research evidence.

The shooting star that many keep referring to is the Waddell & Burton report “Is work good for your health and well-being” [6], which is commonly referenced in policy documents and research studies for claiming that work is good and unemployment (or sick leave, or anything but work) is bad. Frayne [11] makes a close reading of the report and makes several points which we should consider carefully:

1. Waddell and Burton's definition of work is much broader than paid labor (including, for instance, the kinds of creative activities promoted by the early occupational therapists).
2. Whether or not work is good for your health depends on the nature of work, and where re-entering poor jobs may cause further harm.
3. Unemployment is bad for you not because you do not have a job, but because in a work-oriented society it comes with several other detrimental effects, such as poverty and having to be placed under repressive government policies.

On this last point, Frayne concludes that "worklessness is miserable because our current system is set up to make it that way" [11, p. 134].

These nuances are often not regarded in policy-making, and more often than not they are also reproduced in research articles, uncritically using the Waddell & Burton report as a standard reference to claim that work is healthy. Work is seen as the wild healer which will lower the axe on the silver cord that keeps us from flourishing.

According to Frayne, the rise of work-focused and retrenchment-oriented policies go hand in hand with the spread of neoliberal policies which individualizes social and structural problems, which Frayne calls the employment dogma, and which has its counterparts and supporting structures in the increased dominance of therapy culture. The use of cognitive behavioral therapy promises deliverance from most problems, including that of work disability, a stance that has been described as psychocentrism [12], where social problems are pathologized and where causes are placed within individuals while structural or organizational causes are disregarded. Therapy is presented as benign, but may serve to reinforce oppressive structures by taking attention away from the real causes of distress. This critique echoes Mill's classic critique of

empirically driven research, that tends to psychologize social problems into individual troubles if not sufficiently analyzed and contextualized through the use of theory [13].

It is a sight to behold how people accept the gift of guilt and attribute their disability to a lack of backbone. This is, parenthetically, in alignment with how Lewin in the 1940's described the concept of "ability" as not just "'the ability to speak French', but also 'the ability to take a beating'" [14, p. 28]. This echoes today's focus on individual resilience to endure strain and poor conditions, and where the fall into work disability is, consequently, interpreted as an individual failure.

What is the danger here? For sure, as researchers we need to be able to look ourselves in the mirror. But it is also a matter of how our research is being applied, where it may be taken hostage by policy-makers or professionals who either pray to an uncritical employment dogma, or that it is being applied in very restricted ways because the systems for managing work disability are not designed to harbor the conclusions from the research, e.g., that social insurance systems and health care have no clear communication channels to employers and no power in influencing employer behaviors. There is a vacuity to the work norm in much policy-making – it often seems empty of meaning apart from ideological positioning; this emptiness can, on the other hand, also be the result of a lack of options, due to path dependency or bounded rationality in decision-making [15].

A purposive application of the Sherbrooke model and the results of knowledge syntheses could result in employers taking responsibility for the work environment and making adequate adjustments to accommodate returning workers. But as the systems are

249 designed today, these results are introduced to a setting where their application in many
250 cases is nothing but a mirage. All the tears shed by those who get trapped in the
251 wilderness of unreasonable return to work plans lead us to question whether we should
252 keep promoting solutions that only work under ideal conditions, or if we should also
253 have an openness to choosing the lesser of two evils where the conditions for applying
254 our research are not met. For a person who is on sick leave due to a condition connected
255 to a poor work environment, returning to work will likely lead to recurring problems
256 and increased disability; here, the “evil” of continuing to grant the person benefits is
257 likely much less harmful. Ideally, such a course of action should be combined with
258 negotiations with the employer, preferably managed by a person with sufficient
259 knowledge and the power to influence the employer’s actions. Today this is more often
260 than not left to the work disabled person, who is not in a position to make demands
261 given the health condition and the dependency in relation to the employer.

262
263 So, returning to the questions posed in the introduction, we can see how current policies
264 and much research focuses work as having an almost intrinsic value, which is thought to
265 promote health and moral standing, almost regardless of the conditions. Further, the
266 perspective on welfare provision has become increasingly individualized, along with the
267 rise of therapy culture. We can see how this is reproduced in scientific studies and in
268 policies. The prejudices I repeated in the introduction are products of these values.

269
270 Wisdom comes not from the sky, but from collecting knowledge and reflecting on how
271 it should be applied for making the world to come a bit better. We need to be careful in
272 uncritically accepting the work and retrenchment cures, and we need to understand how
273 implementation of well-intended research into policy is a process which simplifies and

distorts the knowledge to fit into existing systems and ideological positions. No matter how carefully we point out that work is a mixed blessing and that decent work conditions are needed for work to actually help more than harm, our research will be read just like the Waddell & Burton report is continuously read: as a heuristic anthem praising individual recovery over structural adjustments.

Conclusions

If we consider current policy systems as badly equipped to deliver the types of support recommended in the literature, we may need to consider alternative courses of action. In order to do so, we firstly need to establish a relevant diagnosis and critique of the current state. In this article, I have aimed to diagnose dominant discourses around work and welfare, which are prevalent in research as well as in policy, and which are influenced by neoliberal ideals around the relationship between individuals and states. Next, we need theories for reasoning about ways to correct what is not functioning. It is not an uncommon claim that all we can hope for are incremental reforms of existing policies, but as Olin Wright argues, we need to develop emancipatory social sciences that enable us to explore viable alternatives to current policy systems [16]. Here, we can consider theories that explain current policy developments [15] as well as the reproduction of social values that underpin these policies [5, 16]. Such critical perspectives are needed to promote new paths for research and policy alike.

Acknowledgements

The author wishes to acknowledge Will Oldham, James Hetfield, Lars Ulrich, Kirk Hammett, Cliff Burton, Jason Newsted, Robert Trujillo, Joe Duplantier, Mario

Duplantier, Christian Andreu, and Jean-Michel Labadie for providing valuable language inspiration for this text.

References

Loisel, P., et al., *Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence*. Journal of Occupational Rehabilitation, 2005. **15**(4): p. 507-524.

Hetfield, J. and L. Ulrich, *Cure*, in *Load*. 1996, Metallica.

Hall, H.J., *Work-cure: A report of five years' experience at an institution devoted to the therapeutic application of manual work*. Journal of the American Medical Association, 1910. **54**(1): p. 12-14.

Meyer, A., *Philosophy of occupation therapy*. Archives of Occupational Therapy, 1922. **1**(1): p. 1-11.

Frayne, D., ed. *The Work Cure: Critical essays on work and wellness*. 2019, PCCS Books: Monmouth.

Waddell, G. and A.K. Burton, *Is work good for your health and well-being?* 2006, Norwich: TSO.

Harvey, S.B., et al., *Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems*. Occupational and Environmental Medicine, 2017. **74**(4): p. 301-310.

Lippel, K., *Preserving Workers' Dignity in Workers' Compensation Systems: An International Perspective*. American Journal of Industrial Medicine, 2012. **55**(6): p. 519-536.

323. Barr, B., et al., *'First, do no harm': Are disability assessments associated with adverse*
324 *trends in mental health? A longitudinal ecological study*. Journal of Epidemiology and
325 Community Health, 2016. **70**(4): p. 339-345.
3260. van Hal, L., et al., *A sociological perspective on "the unmotivated client": public*
327 *accountability and professional work methods in vocational rehabilitation*. Disability
328 and Rehabilitation, 2013. **35**(10): p. 809-818.
3291. Frayne, D., *The employment dogma*, in *The Work Cure: Critical essays on work and*
330 *wellness*, D. Frayne, Editor. 2019, PCCS Books: Monmouth.
3312. Watts, J., *Not in my name, not in my profession's name*, in *The Work Cure: Critical*
332 *essays on work and wellness*, D. Frayne, Editor. 2019, PCCS Books: Monmouth.
3333. Mills, C.M., *The Sociological Imagination*. 1959, Oxford: Oxford University Press.
3344. Lewin, K., *Frontiers in Group Dynamics: Concept, Method and Reality in Social*
335 *Science; Social Equilibria and Social Change*. Human Relations, 1947. **1**(1): p. 5-41.
3365. Ståhl, C., K. Costa-Black, and P. Loisel, *Applying theories to better understand socio-*
337 *political challenges in implementing evidence-based work disability prevention*
338 *strategies*. Disability and Rehabilitation, 2018. **40**(8): p. 952-959.
3396. Wright, E.O., *Envisioning Real Utopias*. 2010, New York: Verso.
- 340