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Breaking or reinforcing the vicious circles of class inequality? Exploring the micro-mechanisms of early interventions in preventive educational, social and health policies.

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*** Very first draft. Please do not quote. All comments welcome! ***

Abstract

Policies fighting class inequalities by early interventions in day care and schools are prominent in both Europe and USA. However, such interventions may not always be successful. By focusing on street-level implementation, this paper explores why. Drawing on the literature on street-level bureaucracy (e.g. Lipsky, Maynard-Moody and Musheno) as well as the literature on class, inequality and mechanisms within stratification (e.g. Bourdieu, Lamont), the paper discusses micro-mechanisms at work in the implementation of preventive social, education and health policies. Especially it is explored, how social class background and lifestyles of professionals may be decisive for policy interventions. Based on a qualitative research project from Denmark, with 58 interviews and vignette-experiments among schoolteachers, day-care professionals and health nurses, the paper show how there is an effect of social class background and lifestyles, and a tendency for stereotyped reasoning and class-biased conceptions of normality to influence professional intervention, thus tending to reinforce rather than break patterns of inequality. Further, it is explored, how social composition of local administrative units (i.e. social homogeneity or heterogeneity) may impact the relationship between professional social background and policy intervention. In other words it is explored, whether the tendency of reinforcing inequality is smaller in heterogeneous neighborhoods than homogeneous in neighborhoods.
Introduction: From fighting to preventing inequalities

A crucial policy agenda in most welfare states is fighting inequality and social marginalization, creating strong life chances and social mobility among all citizens. However, changing welfare policies may run the risk of reinforcing rather solving problems, due to specific micro-mechanisms within implementation, street-level bureaucracy and frontline work. In this paper, I will argue that this is the case in recent Danish preventive policies within health, child care and education. Also, I will show how mechanisms at the organizational level may prove efficient in furthering an agenda of redistribution and empowerment.

Across welfare models, a strong trend within welfare policies has been widening the conception inequality, and the kind of policy measures taken up to fight it. Following the transformation from “first to second modernity” (Beck 2002), including a different and more complex order of stratification and inequality (Bourdieu 1984), and new types of social risks (. Taylor-Gooby, 2004a, 2004b; Bonoli 2005, 2006; Armingeon & Bonoli, 2006), welfare policies has expanded from transfers to services, and from social protection to investment in health, children care and education (e.g. Esping-Andersen 2002, Morel et al. 2009). Also social investments has been accompanied by a focus on early interventions and prevention. This change may have many reasons, among them that investments in early childhood, as shown by Heckman and others (Cunha et al. 2010), will produce a higher return compared to investments in later years. Thus, as Esping-Andersen shows, high quality child care and early education polices have strong equalizing effects, and may be of special benefit for disadvantaged children (Esping-Andersen et al. 2012).

However, the increasing focus on prevention and welfare services, in the effort to fight inequality and increase mobility, also trigger new challenges for implementation and professional organizations. And even though we have some knowledge on the effects of different welfare program – for example that the quality of the programs matter – there are still many unanswered questions. This includes whether the choice of targeted vs. universal programs makes a different
(Esping-Andersen XXXX), as well as how the micro-mechanisms of implementation at the street-level and frontline of state agencies may be important.

In this paper, I focus on the last question, following the traditional insight (Wildawsky 1984, Lipsky 2010) that no material policy effect will be achieved before policies have been implemented at the front line of state agencies. This also goes for preventive efforts, and I will show how specific problems arise when frontline professionals are expected to identify and solve problems of inequality and mobility, before they arise. The paper takes its point of departure in a qualitative study of newly introduced Danish targeted programs of preventive policies within health care for families and children, child care and primary education. I begin with a brief presentation of these policies, followed by a theoretical discussion of frontline discretion within preventive policies, as well as an presentation of data and method. I then move on to present the result of the qualitative study, focusing first on the possible effect of the social class background and habitus of frontline professionals, and second on the possible effect of the organization of interventions, or more specifically whether policy agencies are organized in socially homogeneous or heterogeneous areas. Finally I draw together conclusions and suggestions that can be drawn from this study.

**Early intervention policies in Denmark: The task of identifying problems**

As shown by Esping-Andersen, Denmark presents one of the strongest cases of high quality child care and early childhood education, and comparatively speaking, problems of inequality and lack of social mobility are low in Denmark (Esping-Andersen et al. 2012). However, even in Denmark social mobility is not high, especially when it comes to education (Jæger 2009; Jæger and Holm 2007, Jæger and Karlsson 2011), and it seems to be easier to redistribute economic resources than cultural and educational resources. The fact that not even high quality programs and a high level of expenditures on early childhood education can reduce problems of educational immobility indicates that other factors, e.g. at the level of implementation, are relevant.
Within the last fifteen years, educational immobility and the emergence of new social risks has been addressed in Danish policy discussions as a problem of “negative social heritage”, and a growing consensus on the need for targeted early intervention has formed. Different reforms and policy revisions have included the fight against negative social heritage as a policy goal in polices regulating health services towards families and children, child care and education (LBK 913, LBK nr. 314 and LBK 998). As shown elsewhere (Harrits & Møller 2012; Møller & Harrits 2013), these policy revisions has resulted in an increasing focus on identifying and “correcting” small problems in the lives and behavior of children and families, expected to be signs of future problems. Also, larger problems addressed in special (and evidence based) programs such as parent education or social training programs for children, hinges upon the identification and visitation of children with problems “large enough” to substantiate intervention.

Consequently, the task of identifying (or detecting) problems has been formulated as a key task for frontline professionals. As stated for example in a guidance act on child care:

Due to their special knowledge on the child or the young person, the staff are key resource persons in relation to detecting a need for support according to the law on daycare at an early stage (VEJ 31, 2009: par. 6.2).

However, detecting or identifying problems among children installs a professional role and a type of discretion, that is not necessarily in line with the traditional role and identity of frontline professionals, or with the knowledge traditionally held by these professionals. Thus, as argued elsewhere (Harrits and Møller, forthcoming), we might see an emerging conflict between professionalism and state authority, as well as an increase in discretions build on something else than professional knowledge. To substantiate this claim, however, we need to take a closer look on theories of frontline work and discretion.

**Micro-mechanism of implementation: Discretion, habitus and organization**

Within the literature on street-level bureaucracy, it is well known that micro-mechanism of implementation may interfere and change policy intentions and
outputs to very different outcomes. These mechanisms include, for example coping, professional standards as well as personal values and policy preferences (e.g. Lipsky 2010; Winter & Nielsen 2008; Nielsen 2007; Evans & Harris 2004; Evans 2011; Hupe and Hill 2007; Ellis 2011; Prior and Barnes 2011). Understanding the micro-mechanisms involved in early interventions and the identification of problems, however, especially calls for understanding how professional discretion works, including the way in which discretion may be influenced by stereotyped reasoning, professional identity and moral boundaries (e.g. Maynard-Moody and Musheno, 2003, Holmberg 2000, 2003; Yanow 2003; Soss, Fording and Scram, 2011; Hochschild & Weaver 2007; Guetzkow et al. 2007, Mik-Meyer 2002, 2004; Carstens 2002; Møller 2009).

Discretion

Discretion, as Lipsky (2010) explains, is key to understanding the work of street-level bureaucracy for three reasons: first, street-level bureaucrats work in complicated situations that impedes detailed regulation, second street-level bureaucrats has to respond to “the human dimension of the situation” (Lipsky 2010: 15), and third their tasks includes interacting with citizens, giving them a power of the situation. Lipsky does not, however, take the role of professionalism much into account, and when he does (Lipsky 2010: 189), he mainly refers to professional norms rather than knowledge and expertise. The role of knowledge, however, is key to understanding professional discretion in the sociology of professions. Abbott (1988:35-58 ), although not using the term discretion, distinguishes three key elements of professional work, which can supplement Lipskys conception: diagnosis, treatment and inference. Thus, frontline professionals must identify human problems (diagnosis) and decide what to do about them (treatment), referring to a reservoir of professional (scientific) knowledge that can legitimate decisions.

Thus, whereas Lipsky tends to underline the formal and organizational aspects of discretion, understanding it as a freedom of regulation (and management) and a void to be filled by some kind of decision, Abbott insists on the epistemic aspects of
discretion, i.e. that professional discretion includes a specific way of reasoning about problems and solutions, that cannot be regulated in advance, but needs to be based on other sources, including professional knowledge and expertise (see also Wagenaar 2004 and Grimen and Molander 2008 for a further discussion). In our case of preventive early interventions, the formal and legal aspects do not play a very large role (Harrits and Møller 2012; Møller and Harrits 2013). Put differently, the discretionary freedom (or the void to be filled) is rather large, since specific instructions on what to consider as signs of need or intervention are sparse throughout the policy regulations. On the contrary, as shown above, it is specifically indicated that frontline professionals will “know” the children best (see also Harrits and Møller forthcoming). However, the knowledge foundation is also quite sparse, especially when it comes to the very early signs of worry. This means that the epistemic aspect and sources of reasoning besides knowledge and expertise becomes important to explore.

Following Abbott a little further, the problem of ‘diagnosis’ is particularly interesting. Diagnosis, Abbott argues, has a dual nature, consisting both of ‘colligation’, i.e. painting a picture of the client, and of classification, i.e. referring this picture to a suitable professional category that can then be handled (i.e. treated). The task of colligation thus involves the sorting of information that is relevant for the diagnosis from information that is irrelevant, but this distinction is seldom clear cut. Therefore, diagnosis “begins to assign subjective properties to the objective problems with which professions work” (Abbott 1988: 44).

In a similar fashion, Maynard-Moody and Musheno (2003) has demonstrated how frontline professionals not only work as state agents, following rules and regulations, but also as citizen agents, focusing on the concrete and acute problems of citizens facing them, and their “identities and moral characters” (Maynard-Moody and Musheno 2003: 9). Thus, the logic of the citizen agent is not deciding what rule to apply, but rather “putting a fix on people” (77) in order to decide, how to proceed, and this is an “uncertain process” (83), involving the negotiation of social relations, meanings and moral judgments.
Taken together, theories on the nature of discretion and professional work suggest that the task of identifying problems may involve a range of subjective, social and moral aspects. Hence, we need to turn to a different set of theories to understand what is going on at the front line of the new welfare state.

_Habitus_

As mentioned, theories of street-level bureaucracy has long suggested the influence of subjective factors in front line work. Of particular interest in relation to early interventions, I would argue, are theories of stereotyped reasoning, social categories and the habitus of frontline workers. Stereotypes, i.e. “ways of organizing and selecting aspects or characteristics that individuals are seen to be endowed with because they are placed or classified into a particular category” (Anthias 1998: 518) can function as important tools when faced with the task of colligation or “putting a fix on people”. As already pointed out by Lipsky, stereotyped reasoning is therefore a way for the street-level bureaucrat to handle an overwhelming task of getting to know the high number of clients faced in “mass-processing” organizations.

However, stereotypes are not necessarily universally shared, and the specific content of stereotypes or social categories may vary between people. At one (symbolic or discursive) level, social categories may be shared among social and cultural groups, whereas they at an individual level may be shaped by social experiences. The French sociologist Pierre Bourdieu has suggested that different social positions produce different “principles of vision and division” as well as “schemes of perception and appreciation”, in other words that social positions, resources and experiences will produce different social categories and stereotypes (Bourdieu 1984, 1989).

This means that in order to understand the possible use of stereotypes and social categories by frontline professionals making discretions on early intervention, we need to explore not only the legal and organizational context of the situation, but also the social position and history of the frontline professional. Here the concept of habitus is particularly useful. Habitus functions as a system of dispositions (e.g.
motivational, cognitive, aesthetic and normative dispositions), produced by the specific social conditions of the individual (Bourdieu 1990: 53, 77, Bourdieu 1984: 170-173). In the Bourdieusian tradition, such social conditions are typically seen structured by class structure, i.e. capital volume and capital composition of especially cultural and economic capital (Bourdieu 1984: 99-168, 1998: 6). In this context, capital refers to accumulated (material, embodied or institutionalized) labor (Bourdieu 1986: 241-242), and thus presents a broad and generalized conception of social power as accumulated resources. Economic capital refers to different forms of economic resources, whereas cultural capital refers to resources such as knowledge, education and high-brow cultural tastes (see e.g. Lareau and Weininger 2003).

Building partly on Bourdieu’s theory, Michelle Lamont (1992, 2000) has further demonstrated how people draw symbolic boundaries between people of “their kind” and others on the basis of both moral, cultural and socioeconomic differences. Thus, social categories are not only shaped by habitus and social class positions, they are also enacted and reinforced in social interactions, and some categories and stereotypes are hereby reified at a collective (cultural or symbolic) level.

Hence, when frontline professionals make discretionary judgments on early intervention, and especially when they sort out relevant from irrelevant information trying to assemble a picture, or putting a fix on, the concrete citizen, they may very well be drawing on social categories, as well as cognitive, moral and aesthetic schemes of perception and appreciation stemming from their habitus and social position. Also, in the concrete interactions with clients, symbolic boundaries may either be enacted or drawn upon.

Further, we need to take into consideration that the content of decisions on early interventions within health care for families and children, child care and education (at least partly) has to do with everyday behavior and lifestyles. Thus, making discretions on the possible need or problem of preventive health care in a family also has to take for instance norms, habits of food, exercise and personal hygiene
into consideration. Similarly, making discretions on the needs of children in child
care also has to consider parental values and practices, for example if the parents
are playing with the children, reading to them and giving them the care and love
they need. With weak regulations and knowledge foundation, it may be hard to
separate relevant from irrelevant information here, without referring to ones own
(private) norms and standards.

In sum, theories on social categories and the logic of habitus suggest exploring the
way in which frontline workers draw on elements of habitus (norms, moral and
cognitive schemes etc.) as well as symbolic categories, boundaries or stereotypes
when identifying problems of early intervention. Further, it leads to a hypothesis
that the social difference or distance between the habitus of the frontline
professional and the habitus of the clients (which may be seen as producing the
lifestyles practices being evaluated) is crucial to understanding discretion. Thus,
meeting a practice formed be a habitus similar (from a similar class position) to
ones own will produce a sense of normality and a tendency “not to worry”, i.e. to
refer from making early interventions. Whereas meeting a practice that is different
(from a different class position) from ones own will produce a sense of deviance
and worry, and possibly a tendency to intervene.

**Organization and social environment**

However, even though discretions are often made by individual frontline
professionals, they seldom act in isolation and solely with reference private social
experiences and norms. As already explained, there will typically be a basic
structure of legal regulation as well as a base of knowledge and expertise,
restricting (at least at the discursive level) the kind of arguments and inferences
that can be made. However, both legal regulations and the knowledge bases are
weak in the case of preventive policies.

Several other factors, especially at the organizational level, may also be relevant
though. First, professions may share norms, values and worldviews (Durkheim
1957, Parsons 1954), much similar to what Bourdieu describes as doxa, i.e. tacit
assumptions and implicit rules of conduct (Bourdieu 1990). Second, a similar set of
restrictions may stem from professional organizations and management, either supporting or counteracting professional norms (Evetts 2010; Evans 2010). In sum, both professional and organizational doxa may serve as restriction or resource for the way in which discretions are performed, and for the way in which the habitus of professionals shape such discretion. In the analysis, the impact of professional doxa will be held constant by restricting analysis to three professions: health nurses, pedagogues (i.e. teachers trained for child care for children ages 0-6 years) and primary school teachers (0nd-3rd grade). The impact of organizational doxa will not be explored here.

In stead, the analysis will focus on the impact of the organization of frontline work, or more precisely the way in which the work is organized with respect to the local social environment. As explained above, the content of discretions in preventive policies has to do with the meeting of client and professional lifestyles and habitus, and the way in which stereotypes, social categories and stereotypes may impact this meeting. However, as Allport (1979) claims, contact with different groups may impede prejudice and the use of stereotypes (see also Thomsen 2006, Uslaner 2012). Also, as Lamont shows, the use of social categories and drawing on social boundaries will not necessarily only follow private social experiences and individual social positions (as claimed by Bourdieu), but may also vary with culture. Thus, in cultural settings dominated by what Lamont calls heterachies, a pluralism of social categories may exist, and the symbolic boundaries of existing social categories may thus weaken (Lamont 1992, 2012).

Therefore, whereas the social-distance-thesis claims that social distance and private social experiences (habitus) may be important for discretion, making the use of stereotypes and the tendency to intervene larger with social distance, the heterogeneity-thesis claims that contact with social groups (as well as habitus and lifestyles) different from ones one will lower the tendency to use social categories and stereotypes when making discretions and thus lower the tendency to intervene based on social distance. This thesis will be explored by including both organizations with a homogenous (middle class) local social environment and organizations with a heterogeneous local social environment.
To sum up, the analysis will systematically explore two hypothesis in three professions, i.e. health nurses, pedagogues and primary school teachers:

1. The *hypothesis of social distance*, claiming that professionals will tend to intervene to a larger extent when faced with families form classes or social groups different from themselves, basing their discretion on a logic of habitus and private social experiences (norms, worldviews, use of social categories and stereotypes etc.)

2. The *hypothesis of heterogeneity*, claiming that contact with different social groups in the local social environment of frontline organizations will tend to hinder the use of a logic of habitus, whereas the lack of contact with different social groups (due to a homogeneous local environment) will further the use of a logic of habitus.

Before proceeding with the analysis, I will briefly explain the data and methods used in this study.

**Data and method**

As explained, the analysis is focused on the way in which discretions are made and the way in which frontline workers reason and substantiate their discretions, including the extent to which discretions are informed by a logic of habitus. Consequently, I draw on qualitative interview data from semi-structured interviews, where discourses and arguments are accessible, and where practices can be represented in a narrative but also condensed form (e.g. Kvale and Brinkmann 2008, Charmaz 2006).

Interviewees have been selected theoretically in several steps. First, as already mentioned, three professional groups are included, namely home nurses, pedagogues and primary school teachers. These professionals groups implement preventive social and health policy, and they are quite similar with regard to degree of professionalization and the way in which they perform their tasks in informal settings (the home, the day-care room and the classroom), interacting with children and families. Also, being what in Danish is sometimes referred to as
“welfare professions” or “relational professions”, we may assume professional doxa to be quite similar.

Second, interviews are performed in two local areas within four municipalities (i.e. eight areas in total). In order to test the hypothesis of heterogeneity, one area in each municipality is heterogeneous, whereas the other area is homogeneous, with mainly middle class families. The selections is based on local data and interviews with local experts. Within local areas, institutions and interviewees have been selected by criteria of convenience and accessibility. A total number of 58 interviews (teachers: 22, pedagogues: 20, home nurses: 16) have been collected, by two interviewers, lasting between appr. 1 hour and 3 hours.\(^1\)

All interviews are semi-structured, focusing on interviewees’ spontaneous discourses and reasoning. Approximately one third into in the interview, interviewees are presented with two vignettes describing the situation of a child and a family. The vignettes are designed to portray a realistic problem, which lies in the “grey area” of prevention, i.e. which arguably could both be seen as a minor problem not eligible for intervention and as a possible problem eligible for a “small extra effort” (se appendix for the wording of vignettes). First, all interviewees are presented with a case portraying a middle class family (with cues of parents occupation and the name of the child), and second interviewees are presented with either an upper class or lower class family (by random assignment within professional groups and local areas), similar in all other aspects than name and family background. Interviewees are then asked to tell, “what they think about” these cases, and how they would act if confronted with such cases. Analyses are done by qualitative content analysis, coded systematically in Nvivo.

\(^1\) Interviews have been collected by the author together with Marie Østergaard Møller.
Habitus and social distance

Testing the hypothesis of social distance involves two elements. First we need to explore whether it makes a different, if discretions are made in cases of low or high social distance, and second we need to explore if the reasoning done when making discretions reflects a logic of habitus as claimed.

Social distance

The first step of the analysis is based on the experimental element of the interviews, i.e. the vignette cases. Below, table 1 shows the results, displaying, at the level of interviewees, how respondents react to both the first case (low social distance) and the second case (high social distance, either upper class or lower class). As mentioned above, the interviewees were given two cases and asked “what they think about it”, and in each case this was followed up by probing on the extent to which the frontline professional was worried or not in the specific case, and whether he or she was more or less worried in the second case, compared to the first. The concept of “worry” is taken from the practice of the three professional groups themselves, and it proved to be a concept that spoke well to the spontaneous discourse of the interviewees. Basically, it is an indication on the key preventive task in question here, namely detecting problems before they really occur.

As is evident from table 1, most professionals indicate some kind of worry in almost all cases. Probably due to the priming of worry before and during the interviews, almost all interviewees took great care to explain, how they would of course “keep an eye” on the child and families presented in the cases. And the response of “no worry” or “they will be fine” (indicated with - ), is not frequent. However, the interviewees themselves subsequently introduced a distinction between “small worries” (indicated with (+) ) and “big worries” (indicated by + ), i.e. a distinction between being worried to the extent that the case would give rise to further attention from the frontline professionals, and being worried to the extent that this would require some kind of preventive intervention. As explained by a teacher, when asked if she was worried:
Table 1: Social distance and discretion (tendency to worry)

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Nurses

Teachers
I'm not really worried. I mean, it has to take place over a certain period, right? Before it turns into a real worry. But I'm worried in the sense that here there is something to talk to the parents about. There are some things that needs to be corrected. So in that sense, I am worried (TB10).

With this distinction between small and big worries, table 1 further indicates if the interviewee shows an increase in worries when confronted with the second case (high social distance). The cases with an increasing worry with increasing social distance are highlighted with a dark grey shading, whereas the cases showing a similar degree of worry are highlighted with a light grey shading, leaving the cases (four in total) that displays a lesser degree of worry with increasing social distance are kept without shading.

As can be seen in the table, in little over half of all cases, front line professionals tend to be more worried in the case of high social distance (nurses 10 of 16, pedagogues 11 of 20 and teachers 11 of 22). Also, for nurses and pedagogues, this tendency is more widespread where the vignette case presents a lower class family, suggesting that it may not be only social distance but social hierarchy that is important. This tendency, however, is not present among teachers.

The logic of habitus

To further explore the hypothesis of social distance, we also need to take a closer look at the way in which frontline professionals reason when making discretions, and the question of whether or not this reasoning draws on a logic of habitus. To explore this notion, we can first take a look on how frontline professionals explain, when they in their daily work will tend to make preventive interventions, i.e. when they – in general – tend to be worried. Thus, as opposed to the previous analysis, this analysis is based on the spontaneous discourse of the frontline professionals before the introduction of vignettes (see also Harrits and Møller, forthcoming).

If we first look at the content of worries, we find that frontline professionals do tend to worry about everyday behavior and lifestyle issues, and the way in which such worries are explicated indicates that discretions draw on or use both
cognitive and normative elements of habitus. As explained, for example, by a pedagogue:

She always comes five minutes before closing time [...] Running with the stroller ... and well she is actually at home all day. So it has to do with, when you pick up your child in the day-care, then you go give your child a hug, right? And things like that. She doesn't do that. She just picks up their stuff and says "now we have to go home" (Pedagogue, PB08).

Here, the pedagogue observes a behavior, finding it both "not normal" and worrying, measuring it against a quite clear conception of "how one would normally pick up a child". And even though the interaction between children and parents are within the areas of professional pedagogical knowledge, this knowledge is not drawn upon. Instead, the pedagogue refers to an implicit sharing of "normality" between the interviewer and herself.

Such references to private (or implicitly shared) norms and standards are quite widespread in the material, when frontline professionals discuss lifestyles issues. This goes for norms on friendship and social skills, daily routines and "rythms", hygiene and food:

I had a boy once, who really did not fit in. He didn't have any support from home, his father was not really there, and the mother was dyslexic, and not really interested. She made sure, that he had his fourteen yoghurts with him every day for lunch so he could get his sugar rush. He would come to school, smelling, not haven taken a bath for a long time [...] And he just had a hard time in school, because he couldn't find any friends. (Teacher, TB09).

References to social categories and stereotypes are also quite widespread. First, several "problem-categories" found also in the policy documents (Harrits & Møller 2012), such as "alcoholic father", "violent father", and "drug-abusive mother" appears, functioning as indications of typical problems, and to some extent work as stereotypes. Further, other social categories are used as indications of typical (and worrisome) behavior, for example when ethnic and religious minorities are described as tending "to keep to themselves in their culture" (teacher, TB08). Also,
an even more widespread, are references to social class in a broad sense, especially
two stereotypes: on the one hand the “weak family”, with unemployed parents
living on welfare benefits or otherwise deprived of resources, and thus lacking
certain capacities for supporting their children; and on the other hand the “career-
families” who have such a busy work schedule that they do not have the time to
care of their children. Thus, whereas weak families are typically described as
having a chaotic lifestyle, the tendency for “too much control” is also seen as a
reason to worry:

I start to worry if there are twenty-five candles and the apples are lying in
order all facing the same direction in the bowl. If it’s just too orderly. That
does not make me safe. It’s just too much control. And then my alarm bells
start ringing. (Home nurse, NC11)

Underlining the logic of habitus, is also the way in which discretions are made by
frontline professionals. Here there exist a strong tendency to describe discretions
as “seeing”, “feeling” or “sensing” what is going on, i.e. using a language that
emphasizes spontaneous and intuitive reasoning, with a widespread use of
emotions and bodily senses:

Well we are pretty good at spotting then ... it kind of catches the eye pretty
quickly who stands out from the crowd (Teacher, TA05)

And again, all senses are alert ... well most homes we visit are always
really nice and clean the first time we are there [...]. (Nurse, NB06).

However, the logic of habitus is certainly not the only logic at work, and the data
contains equally strong tendency to use systematic procedures for identifying
problems, e.g. scientific tests and observations schemas on physical or language
development, and formal procedures for handling cases of serious worry. Similarly,
it is not only lifestyles that are the center of attention for frontline professionals, as
they also quite often refer to more basic (and scientifically well described)
standards of development. Examples are nurses worrying about premature babies
and weight developments, pedagogues worried about language development,
motor skills or psychological disorders such as ADHD, and teachers worrying
about the development of reading skills or mathematical skills.
Further, many frontline professionals refer to organizational and collegiate forums for discussing and deliberating on worries, including cooperation with other professions (e.g. psychologists, physiotherapists and social workers).

In total, I do find a strong presence of the logic of habitus, combined with a logic of problem identification based on professional knowledge and systematic procedures.

**The impact of a heterogeneous social environment**

Moving on to the heterogeneity thesis, table 2 displays the same data as table 1, controlled for the heterogeneity of local social area of the front-line work. As can be seen, results are different for the three professional groups. For nurses and pedagogues, heterogeneity does seem to have an impact on the effect of social distance. Thus, as can be seen, almost all cases where the increase of social distance is followed by an increase in worry are situated in homogenous areas. Also, for both groups, all but one case in the homogenous areas shows an increase in worry with increasing social distance. However, results for the teachers show no effect of heterogeneity. This may have to do with the fact that teachers do, after all, have a different knowledge base, a different set of professional norms, or that the organizations chosen here have specific procedures or a strong organizational doxa. It may also be the case that schools are larger organizations than day care centers, and therefore are quite heterogeneous even when situated in homogeneous areas. In any case, further analysis are needed here.

[To be written: Analysis on differences in logic of habitus in heterogeneous and homogeneous areas]
Table 2: Social distance and discretion (tendency to worry) in heterogeneous and homogenous local areas

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Concluding discussion: Challenges of early targeted intervention
[Needs revision]

Policies of a new social investment state involves – among other things – an increasing focus on early, preventive interventions. However, especially targeted interventions, trying to detect and correct social problems before they arise, may face serious challenges of implementation. This paper has tried to demonstrate, how discretions made by frontline professionals, in a setting without clear rules and regulations, and without strong professional knowledge, also draws upon a logic of habitus. As was shown, this results in social differences between front line professionals and clients makes a difference for interventions.

Surely, the results here can say nothing about the effects of policies. Thus, further analysis will have demonstrate, how a logic of habitus may impact the effect of preventive, early interventions. One imaginable result could be a tendency to over-treatment, under-treatment or the wrong kind of treatment being given, based on unfounded problem-identifications. The challenges, however, may be even more serious than that.

As mentioned in the introduction, one problem with existing welfare policies seems to be that it has proven quite difficult to redistribute cultural capital and to facilitate educational mobility. Some scholars and studies (e.g. Bourdieu and Passeron 1990; Ploug 2005) has pointed to the fact, that access to educational institutions also to do with “doxa”, i.e. tacit assumptions and hidden rules of conduct, that dominates such institutions. In other words, even though access is formally possible, students and pupils with lower class backgrounds have a difficult time finding their place in schools dominated by upper- and middleclass values.

One way to evaluate the preventive Danish policies is that they try to handle this problem, by giving children the chance of learning and acquiring a “habitus” for making it in the educational system. However, when – as demonstrated – a logic of
habitus, social categories and symbolic boundaries are put into practice in institutions and policies towards families and children, this may hinder reaching this goal. In stead, such policies may run the risk of enforcing rather than breaking the symbolic boundaries hindering inclusion in the first place. That is, by trying to distribute a strong middle class habitus, front line professionals may run the risk of stigmatizing and excluding the exact same citizens that they should try to include.

Therefore, the results from the second part of the analysis are worth noticing. As was shown, nurses and pedagogues in heterogeneous areas seems to be much less affected by social distance than nurses and pedagogues in homogeneous areas. Seen in the logic of habitus and symbolic boundaries this may point to a mechanism of tolerance or pluralism that can prove to be effective for reaching the goals of welfare policies. Thus, when symbolic boundaries are weakened, inclusion can prove to be easier. Surely, analysis made here are only a very first step towards disentangling the mechanism at work. However, it points towards taking serious the challenges of implementation in a new welfare state.
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Appendix: Vignettes

**Nurse, middle class**

Imagine a visit in a family with a two-month-old child (Mads). The mother is 29 and pedagogue, and the father is 36 and teacher, and they both work at the local school. Mads is the mother’s first child, while the father has two children from a previous marriage.

You are visiting the family on an “extra visit”, because the mother has called you and asked you to come. She is worried about Mads, because he is very restless in the late afternoon and evening. Mads cries a lot and he constantly regurgitates. The mothers tells that she has difficulties succeeding with breastfeeding, and she feels like he will not accept the breast, even though she offers it to him. She is also worried hat he is not gaining enough weight.

You perceive the parents as insecure in their role as new parents. The mother asks many questions on what to do in different situations, and she has many general questions on child development, e.g.: When do children normally get a regular sleep cycle. The mother also tells you, that it is difficult for her to cope with daily practical routines, and she is upset that she has not managed to clean and tidy the house in several weeks. A week ago, the father’s two children visited the family (they do not often visit), and a lot of toys, games and cd’s are lying around the living room.

During the visit, you notice that both parents seem tired and unfocused. You also notice that the mother repeats that the family has moved to the area only a year ago. As a consequence, she has been separated from her mother and older sister, and the family has not yet made many friends in the area.

**Nurse, upper / lower class**

Imagine visiting a family with a two-moth-old child (Vitus / Mike). The mother is 32 and a MD / nursing assistant, and the father is 35 and engineer / truck driver. The mother works on a hospital nearby / is temporarily unemployed, and the father is employed in a private company / on sick leave with a back injury.

You are visiting the family on an "extra visit", because Vitus / Mike has had problems gaining weight. After a control weighing you observe that Vitus / Mike has gained some weight, but it is still not quite good.

During the visit, you notice that both the mother and father are very active with questions on Vitus’ development and they are very focused on Vitus getting enough attention, from both themselves and the nurse. The parents have a lot of (theoretical) knowledge, and several times they refer to different books and home pages on child development. / During the visit, you notice that the mother and father are very active in showing you Mike, and several times they try to make you comment on Mikes new clothes. They also tell you, how happy the rest of the family is about Mike.

You also notice that the living room is quite messy. A lot of books and stacks of paper are lying around, a laptop is placed on the dining table, and in the corner is and exercise bike and exercise equipment. / Plates are left on the coffee table, and clothes are lying around the living room. A computer is placed at the dining table, and the TV is on, even though it is muted during you visit.

Also, you notice that the mother seems tired and unfocused, and several times during the visit, she offers the breast to Vitus/Mike, without him accepting it.

You mention to the mother, that you have put together a mother’s group and would like to invite her to the first meeting. The mother replies that she does not want to participate in a mother's group. She has talked to some of her friends, who have tried being in a mother’s group, and she doesn’t feel that such a group can contribute to Vitus’ development or the fulfilling of her own needs / she can’t see the purpose of such a group. Besides, she has good support in her mother and father in law, who live close by, and who have agreed to take care of Vitus during the day, when she starts working in about five moths / who lives close by and is on permanent sickness benefit.
**Pedagogue, middle class**

Imagine a boy in your day care centre. You are his contact person. His name is Mads, he is four years old, and he started in the day care only five months ago, when his family moved to the town. The mother is 33 and pedagogue, and the father is 40 and teacher, and they both work at the local school. Mads is the mother’s only child, while the father has two children from a previous marriage.

Mads has had a fine start in the day care, and it seems as if he has adapted quickly. For example, he says goodbye to his mother very fine in the morning.

Within the last month, though, you have experienced that Mads has has been in some difficult conflicts with the other children. The conflicts have been of different character, but typically it centres around who gets to decide, and on problems sharing toys. Especially the problem has been that Mads is very aggressive. He shouts very loud, and in a couple of instances he has hit another boy. Also, you have experienced that Mads will not eat together with the other children, and that he goes out into the locker room when the lunch is served.

The parents are very upset about the situation, and they tell that Mads has difficulties finding friends. The mother tells that the family has moved to the area only a year ago. As a consequence, she has been separated from her mother and older sister, and the family has not yet made many friends in the area yet.

While preparing for a routine meeting with the parents (which is usually placed half a year after the child’s start in the day care), you have discussed with your colleagues that Mads might have some motor skill problems. For example, he has difficulties catching and throwing a ball. Also the parents have told the manager of the day care that they have tried getting Mads to play football in the afternoon, so that he could get to know some other children. But Mads doesn’t want to play football, and therefore they have stopped.

**Pedagogue, upper/lower class**

Imagine a boy in your day care centre. You are his contact person. His name is Vitus / Mike, and he is three and a half years old and is started in the day care half a year ago. The mother is 36 and a MD / nursing assistant, and the father is 39 and engineer / truck driver. The mother works on a hospital nearby / is temporarily unemployed, and the father is employed in a private company / on sick leave with a back injury.

Vitus / Mike has had a rough start in the day care centre. He has difficulties saying goodbye to his mother in the morning, and she seldom has the time to stay very long.

You experience Vitus / Mike as rather whining during the day. He is a quiet child, keeping a bit to himself, and it is difficult for him to establish contact to the other children. Also he has difficulties concentrating on collective activities, and often he leaves the room, when a collective activity begins.

During the last six months that Vitus/Mike has been in the day care, he has several times refused to eat the food served in the day care in the collective lunch arrangement, which has been democratically decided by the parents in the day care. The parents have asked if they can bring their own lunch-package, because they find the food served in the day care of too low quality, and they think that this is why Vitus will not eat it / because they think that it is too expensive now that Mike does not eat the food.

While preparing for a routine meeting with the parents (which is usually placed half a year after the child’s start in the day care), you have discussed with your colleagues that Vitus/Mike may have some difficulties with language development, especially with pronunciation. The parents have told the manager in the day care that they are worried about Vitus’ language, and that their old day care centre did not do nearly enough to support the children’s language development / that they can’t see anything wrong with Mike’s language.
**Teacher, middle class**

Imagine a boy in the second grade. You are his class teacher. His name is Mads, he is eight years old, and he started in the class just five months ago, when his family moved to the town. The mother is 38 and pedagogue, and the father is 44 and teacher, and they both work at the local school. Mads is the mother’s only child, while the father has two children from a previous marriage.

Mads has had a fine start in the class. He is a funny boy, and he has gotten a lot of attention from the other boys by telling jokes, for example from "Klovn" (a Danish sitcom primarily for adults), that he watches together with his father. In the classroom this creates some disturbances, and some of your colleagues have mentioned to you that they have difficulties getting Mads to be quiet. Also, the gym teacher has told you about some episodes where Mads has acted out very strongly, because he has felt that he has been treated unfairly.

During the last month, the parents have told you that Mads as difficulties making really close friends in the class, and often he does not have anybody to play with during the afternoon or in the weekend. The mother tells that it has been difficult moving. For example, she has been separated from her mother and older sister, and the family has not yet made many friends in the area yet, just as Mads has not yet found any after school activities that really interests him.

While preparing for a regular meeting with the parents, you have talked to the math teacher. He tells that Mads is somewhat behind in math compared to the rest of the class. Mads lacks some basic skill: he can’t tell the time, and he is not quite sure about the numbers above 20. The parents have told the math teacher that they have stopped pressuring Mads to do his homework in math, because he often gets very upset. And due to the moving and Mads beginning in a new class, they have avoided putting too much pressure on him.

**Teacher, upper/lower class**

Imagine a boy in the second grade. You are his class teacher. His name is Vitus / Mike, and he is eight years old. The mother is 40 and a MD / nursing assistant, and the father is 43 and engineer / truck driver. The mother works on a hospital nearby / is temporarily unemployed, and the father is employed in a private company / on sick leave with a back injury.

Vitus / Mike is a popular boy in the class, and he often takes a rather dominating role both in class and in the breaks. During breaks it is often Vitus / Mike who decides on the teams that will play football, just as he acts as a referee and solves conflict. In class, there is always a lot of disturbances around Vitus / Mike, and sometimes he will state, very loudly, that the activities started by the teachers are "boring" and that he doesn’t want to participate. But sometimes he will be a very active participant in class discussions.

Parents tell, that during the last six months they have had difficulties getting Vitus / Mike to do his homework. Even though the homework is not much (typically it will be reading fifteen minutes a day, and some small math assignments), they often end up in conflict. The parents have also told you that Vitus / Mike describes the homework and the activities in schools as boring, and often he ends up being allowed to play the computer. The parents think that Vitus lacks sufficient challenges, and they are considering putting Vitus in a private school with a higher academic level / … .

While preparing for a regular meeting with the parents, the Danish teacher has presented the results of the last reading test. The Danish teacher explains that the test confirms her suspicion, namely that Vitus’ / Mike’s level has dropped severely in the last six months, and that he actually has a substantially lower level of reading skills compared to the other children in the class.