Experiences of sickness absence among NHS staff: A grounded theory analysis.

Helen McFarlane

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Health Psychology

This research was carried out in collaboration with Cwm Taf Health Board

Department of Psychology, Faculty of Health and Life Sciences, University of the West of England, Bristol

June 2014

_____

Acknowledgements

_____

Contents

Chapter 3   Study 2: Experiences of sickness absence among NHS staff: A grounded theory analysis. Introduction and Methodology…………………………………………….. **72**

List of Tables and Figures

_____

Abstract

_____

Reducing sickness absence and speeding up return to work following absence is usually beneficial for employees and organisations. However, current theory on sickness absence is not sophisticated enough to meaningfully inform policies which adequately promote employee wellbeing. This research aimed to explore employees' decisions about taking sickness absence and returning to work and to identify factors which help employees to remain in or return to work. Two studies are presented. Study 1 was a systematic review evaluating the evidence that cognitive-behavioural (CBT) pain management improves work outcomes (return to work, sickness absence and hours worked) in employees with chronic pain. Fifteen studies were reviewed. A meta-analysis of a subgroup of four good or adequate quality studies showed no effect of intervention. Other high and adequate quality studies found no effect of intervention, with one exception. Lower quality studies lacked appropriate control groups, therefore conclusions could not be drawn about their effectiveness. Overall, insufficient evidence was found that CBT pain management improves vocational outcomes. Complex interventions, which target workplace and health issues, may be required. Study 2 was a grounded theory study of sickness absence among NHS staff in South Wales. Face-to-face interviews were conducted with 18 employees. Interviews were transcribed verbatim and analysed using Charmaz's (2006) approach to grounded theory. A new process model of sickness absence is presented which goes beyond established theories.

The establishment of the legitimacy of absence and its negotiation with others, particularly health professionals and managers, were core to the model. The absence process was complex, with different factors becoming important at different points in time, including the type and severity of illness; the work context; the employees' beliefs about illness and work; their values and support. Line managers had a key role in managing absence but may require additional support and training. Health psychologists should now turn their attention to understanding the specific beliefs which are relevant to absence from work in order to further develop theories of sickness absence.

Chapter 1

Introduction and Literature Review

_____

1.1 Introduction

Sickness absence is costly to the economy (Confederation of British Industry [CBI], 2011) and is therefore of interest to policy-makers, governments and managers as well as health professionals and researchers. In the last 20 years, organisational policies for managing absence have become more widespread (Chartered Institute for Personnel and Development [CIPD], 2012). Over the same time period, a number of government policies have been introduced and these have impacted on health at work. For example, the Equality Act (2010) requires employers to make adjustments for employees with long-term health conditions and provides protection for disabled people who wish to remain in work. The government aims to encourage people with long-term health conditions and disabilities to remain in and return to work, and employers are responsible for enabling this as far as is reasonable.

Whilst employers are required to fulfil their responsibilities to disabled employees, most are concerned about the cost of sickness absence (CIPD, 2012). There is therefore a potential conflict for employers between their requirement to provide support to employees who are ill and their desire to

reduce absence levels. Workplace and government policies need to be informed by an adequate evidence base. Understanding the factors which help employees to remain in and return to work may allow employers to provide policies and support which improve employee wellbeing and work attendance. However, research on sickness absence is not sufficiently developed to adequately address these issues. This thesis will explore what helps employees to reduce their sickness absence either by avoiding it altogether or by limiting its duration.

1.2 Overview of the thesis

The thesis is structured as follows: Chapter 1 reviews the background, policy, theory and other literature in the area. The rationale and aims of the research are then outlined. A systematic review of one type of return to work intervention – cognitive-behavioural pain management for chronic pain – is then presented in Chapter 2 as an addition to the evidence reviewed in Chapter 1. Study 2, a grounded theory analysis of sickness absence among NHS staff in South Wales, is described in chapters 3 and 4. Chapter 3 introduces the grounded theory method and provides a rationale for using this approach. It then describes the methods that were used in Study 2. Chapter 4 presents the results of the grounded theory analysis and discusses the findings in relation to research in the field. Chapter 5 discusses the implications of the research for policy and future research, identifies the limitations of the research and draws conclusions from the findings. A reflection on my development as a health psychologist over the last four years is presented in Chapter 6.

1.3 Literature review: overview

Research on sickness absence has been undertaken within a number of disciplines including management, economics, sociology and occupational health and providing an overview of this disparate research is something of a challenge. This chapter aims to review the policy, theory and literature most pertinent to the research question. Firstly, the prevalence and consequences of sickness absence and the importance of studying it will be outlined. Government and workplace policies which relate to absence and return to work will then be surveyed. Previous research on sickness absence will be summarised, including predictors of absence and return to work; theories of sickness absence; interventions to aid attendance at work and the role of health and illness beliefs in absence. It is argued that health psychology has the potential to contribute to this area of study. The focus of the current research is outlined following the literature review.

1.4 Background: Sickness absence in the UK and the NHS

Sickness absence cost the UK economy over £17bn in 2010 (CBI, 2011), making it a concern for government. In particular, sickness absence within the NHS has been consistently high, prompting a review by Boorman (2009) and, in Wales, a report by the National Audit Office Wales (2004). Sickness rates in the Welsh NHS have fallen but are still short of the target of 4.2 percent which was set by the Welsh Assembly Government following the 2004 report (Wales Audit Office, 2009). Boorman (2009) estimated that the NHS could reduce sickness absence by a third, with an estimated annual

saving of £555 million, suggesting that prioritising the reduction of sickness absence would be a sound financial investment for the NHS.

Most absent individuals return to work within a short period of time (CIPD, 2012). However, around a third of working time is lost to long-term absence (i.e. absence of four weeks or more; CBI, 2011). The longer employees are absent from work, the less likely they become to return to work (Waddell & Burton, 2006). Individuals who go on to claim sickness benefits are even less likely to return to the workplace and after two years on benefits are more likely to die or retire than to return to work (NICE, 2009). As well as having financial implications, worklessness has negative effects on individuals, leading to poverty, social exclusion, higher mortality and poorer general health (Waddell & Burton, 2006). These findings suggest that prevention of long-term sickness absence and early return to work is desirable for both health and financial reasons and would benefit the individual, the employer and the state.

Over the coming decades, it is likely that the number of people with health conditions in the workplace will rise for a number of reasons (Black & Frost, 2011). Firstly, welfare reforms mean there is anticipated to be a reduction in sickness benefit claims as more people with health conditions are transferred to Jobseekers' Allowance and expected to seek work (Beatty & Fothergill, 2011). Secondly, the health of the population is anticipated to deteriorate over the next two decades, due to lifestyle factors (Vaughan-

Jones & Barham, 2009) and an ageing population (Black & Frost, 2011). As the number of people in the workplace with health conditions increases, the need for adequate policies and services will become more pressing (Munir, Yarker & Haslam, 2008). An understanding of the processes underlying sickness absence is therefore needed in order to provide a basis for the development of policies and intervention strategies (Alexanderson & Hensing, 2004).

Research on sickness absence has made slow progress over many years and is not sufficiently developed to deal effectively with the complexity of the problem (Alexanderson & Hensing, 2004). Although a wide range of interventions appear to reduce absence levels (e.g. Baltes, Briggs, Huff, Wright & Neuman, 1999), there is evidence that certain workplace interventions lead to employees feeling pressured to attend work when unwell (termed 'presenteeism'; Munir et al., 2008) which may have long-term detrimental effects on health (Kivimäki, Head, Ferrie, Hemingway, Shipley, Vahtera & Marmot, 2005), however, this process is poorly understood. There is a pressing need for evidence-based policy and intervention to promote employee wellbeing and reduce absence and a multi-disciplinary approach to studying sickness absence is likely to be needed (Alexanderson & Norland, 2004). Health psychology is one discipline which is well-placed to contribute to the study of sickness absence, particularly given the projected increase in the numbers of people with chronic conditions in the workplace who may require support in managing their health. In addition, there is an increasing recognition that

work outcomes are not simply related to objective health, but that health beliefs play an important role in absence and return to work (e.g. Hoving, van der Meer, Volkova, & Frings-Dresen, 2010). The role of beliefs in health and illness is core to the study of health psychology and has been widely researched (e.g. Hagger & Orbell, 2003). Health psychology therefore has the potential to make an important contribution to theory, research and practice related to sickness absence, since research on the role of health and illness beliefs within the workplace is currently scarce (see section 1.12 for a review). Policy, both at a government level and at a workplace level, may therefore lack the insight which health psychology could provide.

1.5 Government policy on absence

The interest of government in reducing sickness absence and benefits has resulted in a number of initiatives. For example, following a review of the health of Britain's working age population (Black, 2008), changes were made to absence certification when the 'fit note' replaced the 'sick note' in 2010. This allowed GPs to recommend adjustments to working hours or duties so that employees could continue working despite illness or injury. Following a further independent review of sickness absence (Black & Frost, 2011), the government outlined plans for a health and work assessment and advisory service to be set up in 2014, aiming to help sick employees to return to work (Department for Work and Pensions, 2013). Changes have also been made to sickness benefits over the last few years (e.g. Welfare Reform Act, 2012) as Incapacity Benefit (IB) is phased out and replaced by Employment and Support Allowance (ESA), with new, more stringent,

criteria. These changes highlight the considerable investment by government into reducing sickness absence and benefits. Absence from work is a significant political issue and given the investment of public money as well as the impact that policies have on sick and disabled members of society, it is important to question the effectiveness of policies in promoting work attendance; their impact on vulnerable members of society and the quality of the underlying evidence base.

Government initiatives to reduce absence and benefit claims have not always been successful. The Department for Work and Pensions have reviewed the use of the fit note by interviewing GPs, employers and employees (Fyney, Fyney & Caveny, 2011; Lalani, Meadows, Metcalfe & Rolfe, 2012). They found that GPs were not always confident in using the fit note and were perceived by employers as not having expertise in occupational health. However, the availability of adjustments to the workplace was welcomed by employees and employers, suggesting that the transition to the fit note was seen as positive despite problems with its implementation. GPs may have required more training than anticipated or the process may have been more effective if implemented by specialists, such as occupational health nurses. The problems with the assessment process for the new ESA benefit are more worrying. The House of Commons Public Accounts Committee criticised the assessment process in a recent report, arguing that decision making was poor and the most vulnerable were disproportionately affected (Committee of Public Accounts, 2013). A lack of research on sickness absence which is of practical value

may contribute to problems with developing government policies which are fit for purpose. Without an adequate theoretical foundation, it is possible that policies may be ideologically driven rather than evidence-based. Adequate research on the causes and consequences of sickness absence, the interventions which are most effective, the effects of policies and the process of certifying absence is needed in order to develop more appropriate policies. Underlying all of this, a coherent theoretical basis for research is required (Alexanderson & Hensing, 2004).

1.6 Workplace policy on absence

Absence is also a concern to employers and in recent years there has been an increased focus on absence management by organisations (Taylor, Cunningham, Newsome & Scholarios, 2010). Average sickness rates have declined over recent years (CBI, 2011). This decline could be attributed to a number of factors, however, workplace strategies and policies for managing absence are now used by almost all organisations and the reduction in absence over time is often attributed to their wider use (CIPD, 2012). Management strategies commonly include recording the frequency and duration of absence spells; the use of return to work interviews, where employees discuss the reasons for their absence with managers and any changes that are needed; and the use of 'trigger points', where a certain number or length of absences triggers procedures such as formal interviews or referral to occupational health (Whittaker, 2001). Workplaces may also offer adjustments and support on return to work, such as reductions in working hours; amended duties; redeployment; workplace health and safety

or ergonomic assessments; physiotherapy and counselling (Franche, Cullen, Clarke, Irvin, Sinclair & Frank, 2005). There are a number of bodies which have published guidance for employers on managing sickness absence (e.g. NICE, 2009). Most guidance tends to stress the importance of workplace policies which operate on a 'trigger' basis and prompt the line manager to take action to manage the absence and support the employee.

These types of policies are standard practice, however, they are not without their critics. One review of strategies to manage long-term sickness absence concluded that evidence for the effectiveness of these trigger-based approaches in comparison to other strategies is limited and therefore the ubiquitous use of these policies is mainly based on consensus (Higgins, O'Halloran & Porter, 2012). There is also some evidence that policies based on trigger points pose difficulties for employees managing chronic illnesses, since they feel pressurised to attend work when unwell ('presenteeism') in order to avoid disciplinary procedures (Munir et al., 2008). Workplace sickness absence policies often disproportionately punish frequent, short-term illness which tends to be viewed as less legitimate than infrequent long-term illness (Taylor et al., 2010). However, this is not always the case, particularly for employees with chronic conditions (Munir et al., 2008). Grinyer and Singleton (2000) found that punitive workplace policies could lead to a fear of taking sickness absence among employees. The policies led to longer periods of absence for some, since employees did not return at the earliest opportunity out of fear that they may need another period of absence and therefore trigger disciplinary procedures. These findings

suggest that different groups of employees (for example, those taking absence when not genuinely ill; those with chronic illnesses and those with acute health conditions) are likely to benefit from different approaches to managing their absence. This may indicate that more flexible policies are needed, however, it is important to remember that policies are practised within specific workplace cultures and by specific managers. Therefore, it may be that policies need to be operationalised differently in certain settings.

Line managers play a central role in the management of absence, and positive communication between line managers and employees during absence is linked to earlier return to work (Nieuwenhuijsen, Verbeek, de Boer, Blonk & van Dijk, 2004). However, one qualitative study of the implementation of workplace policies found that line managers are often reluctant to take on responsibility for absence and may see this as the role of HR (Dunn & Wilkinson, 2002). In some companies, managers were not given adequate training on managing absence and did not know what was expected of them; some did not see it as a priority when workloads were high and others were concerned about jeopardising positive relationships with their staff. This suggests that there may be a conflict between different aspects of the manager's role, for example in the daily demands of the job; the need to support staff and the disciplinary element of absence management. To aid managers in supporting absence, a competency framework of manager behaviours for supporting return to work and a questionnaire for measuring the competencies has been developed, (British

Occupational Health Research Foundation [BOHRF], 2010), focusing on promoting communication and supportive behaviours.

Whilst most organisations have absence management policies in place, they may not be implemented in ways which benefit all staff (Grinyer & Singleton, 2000). A greater understanding of the effects of workplace absence management policies is needed, not only on sickness absence, but also on presenteeism; the management of disability in the workplace and relationships between managers and staff. Presenteeism has been linked to lower productivity (Johns, 2010) and poorer future health (Bergström, Bodin, Hagberg, Lindh, Aronsson & Josephson, 2009). Therefore, if workplace policies do promote presenteeism, they may have an unintended negative impact on employees. The increasing use of policies for encouraging work attendance highlights the importance that both government and employers place on reducing sickness absence and benefits. However, the negative effect these policies can have suggests they require review. More research is needed to identify how they can be made more effective (Alexanderson & Hensing, 2004).

1.7 Research on absence and return to work

Despite the enormous cost of absence to the economy and initiatives from government and organisations aimed at reducing this cost, academic research on sickness absence has been surprisingly poorly developed (Alexanderson & Hensing, 2004). Almost ten years ago, a systematic review

was conducted into the causes and consequences of sickness absence (Alexanderson & Norland, 2004). It concluded that there were few studies of good quality and that studies focused on a narrow range of factors. It is worth noting that there are dissenting views to this, such as Johns (2003) argument that absence research has made good progress, despite a lack of theory, due to the diversity of methodologies that have been employed in studying it. These differing perspectives may reflect the dominance of management-focused research on sickness absence as opposed to medical or psychological research, since Johns' research is in the field of management whereas Alexanderson and Norlund took a more health-focused approach.

In the early 1960s, sickness absence was described as 'a social fact in need of a theory' (Ås, 1962). The authors of the systematic review concluded that this was still the case (Alexanderson & Hensing, 2004). However, this is not because there are no theories of sickness absence - in fact, there are many (for a review see Rhodes & Steers, 1990). Rather, studies carried out in different disciplines use a wide variety of different theories (Allebeck & Mastekaasa, 2004a). The evidence found to date is very general in nature, leading to difficulties in drawing inferences about possible causal pathways, and is therefore of limited use in practice (Alexanderson & Hensing, 2004). Since the publication of Alexanderson and Norland's review, few of their concerns have been addressed, although there appears to have been progress in the understanding of the predictors of sickness absence and return to work for different medical causes of sickness absence (Shaw,

Findley & Feuerstein, 2011). One widely researched area not included in the review is the assessment of return to work interventions, which have been the subject of a number of systematic reviews (e.g. Schaafsma, Schonstein, Whelan, Ulvestad, Kenny & Verbeek, 2010). This literature review will examine the predictors of absence and return to work; theoretical debates and the effectiveness of return to work interventions. It will be argued that health psychology has the potential to contribute much more to the study of this area.

1.8 Predictors of absence and return to work

Most research on sickness absence has focused on its causes and predictors (Allebeck & Mastekaasa, 2004b) and progress has been made in summarising predictor variables for a variety of health conditions, (e.g. Huijs, Koppes, Taris & Blonk, 2012). Dozens of predictor variables have been found and there have been several meta-analyses, each finding slightly different predictors (e.g. Duijts, Kant, Swaen, van den Brandt & Zeegers, 2007). Predictors tend to fall under the broad headings of illness-related factors; job and workplace characteristics; individual differences; demographic factors; lifestyle factors and the sickness insurance system. However, despite having made some progress in identifying these factors, they do not provide an explanation of why sickness absence happens (Kristensen, 1991). The large number of predictors of absence and return to work highlights their complexity, and sophisticated theoretical models of absence and return to work are therefore needed to explain them. However, despite numerous calls for theory in this area to be improved (e.g.

Kristensen, 1991), a theory of sickness absence with adequate explanatory power has remained elusive.

1.9 Theories of sickness absence

There are a number of theories and models of sickness absence which have come from different disciplines, including management, economics, and psychology, and have focused on different elements of absence (Kaiser, 1998). This literature review will focus on theoretical assumptions and debates, as well as assessing the most popular theory of sickness absence, Steers and Rhodes' (1978) process model of absence.

Absence from work has been presented in varying and conflicting ways, including a cost-benefit analysis (Allen, 1981); a function of personal and workplace influences (Steers & Rhodes, 1978); a medical issue (Palmer, Brown & Hobson, 2013) or an outcome of workplace culture (Chadwick-Jones, Nicholson & Brown, 1982). Many of the early models of absence tended to assume that absence from work was a voluntary behaviour (e.g. Allen, 1981) and focused on job satisfaction (e.g. Steers & Rhodes, 1978) or a cost-benefit analysis of absence (Allen, 1981). In fact, where non-genuine absence has been directly studied (and researchers have not relied on assumptions that frequent absence is never legitimate) voluntary absence has been found to be taken by only a small minority of employees (e.g. Vahtera, Kivimäki & Pentti, 2001). The second Whitehall study found that measures of health at baseline were strong predictors of long-term sickness absence and, to a lesser extent, of short-term absence (Marmot, Feeney,

Shipley, North & Syme, 1995). Whilst this finding may appear rather predictable, it is in contrast to a tendency in the absence literature (and organisational policy) to treat short-term absence, particularly where it is frequent, as non-legitimate, assuming that it is not related to health problems (e.g. Chadwick-Jones, Brown & Nicholson, 1973). However, the assumption that absence is often a matter of personal choice has persisted in parts of the literature (Taylor et al., 2010). The presentation of sickness absence as a negative organisational behaviour, and even a deviant behaviour, is common in academic literature as well as in the media (Patton & Johns, 2012), despite the evidence to the contrary. Government and workplace policies can negatively affect those with chronic illnesses where they are overly punitive, by pressuring them to attend work or by disallowing benefits (Munir et al., 2008; Committee of Public Accounts, 2013). These overly punitive measures may result from the assumption that individuals taking absence or claiming benefits are not genuinely ill. It is important that theories of sickness absence acknowledge that most absence from work is due to legitimate illness in order that this mistaken assumption is challenged. The inadequacy of current theory may be one reason this misconception has persisted in the academic literature (Alexanderson & Hensing, 2004).

The best known model of absence is Steers and Rhodes' (1978) process model of attendance. This model asserts that absence is influenced by two main factors: attendance motivation and ability to come to work. Attendance motivation refers to job satisfaction (influenced by the job situation and the

employees' values and expectations) and pressures to attend (which may be internal pressures such as personal work ethic or external pressures such as group norms). This theory has been difficult to test empirically since its constructs are categories of variables rather than measurable individual variables. Additionally, the concepts included within each of these categories were often not clearly defined (Brooke, 1986). Tests of the model (as it has been operationalised to date) have found that it explains a maximum of 17 percent of the variance in absence behaviour and, in some studies, as little as 3 percent (Steel, Rentsch & Van Scotter, 2007). Sickness absence is a complex phenomenon and any testable theory would be unlikely to include every important aspect, however, we might expect the best known theory of absence to perform better than this.

There have been repeated calls for better theories of sickness absence. For example, Kristensen (1991) argued that an integrated theory of sickness absence was needed which provided an explanation of absence, rather than just focusing on predictors, and which included illness perceptions, sickness behaviours and stressors. He set out a number of criteria for an integrated theory of absence. Only one theory of note has emerged since this time: the illness flexibility model (Johansson & Lundberg, 2004). Whilst this theory does place a greater emphasis on health, it does not address his insight that sickness absence is not related directly to objective health, but is partly a function of a person's subjective understanding of their health. The role of health and illness beliefs in sickness absence, which is increasingly acknowledged as being important (see section 1.12), has largely been

ignored by theorists. This may be due to the small number of health psychologists who are involved in research on sickness absence. It is clear that a comprehensive theory of absence is still needed to underpin research and inform policy and this theory will need to include the new insights into the role of health and illness beliefs in absence as well as moving away from the assumption that much absence is voluntary.

Research on absence and return to work has progressed in the absence of adequate theory. There have been two major stands to this research: in addition to the literature already reviewed on identifying predictors of absence and return to work (e.g. Duijts et al., 2007), much research has focused on interventions to aid return to work (e.g. Schaafsma et al., 2010).

1.10 Interventions for reducing absence

Understanding the types of interventions which are effective for preventing absence and promoting return to work is essential for developing policies which can help people with health conditions to remain in and return to work. This literature review will focus on the most common causes of long-term absence which are stress (which will include the associated mental health outcomes of anxiety and depression), and musculoskeletal problems, including back pain.

There have been a number of reviews of interventions aimed at stress at work, and even a review of reviews, which provides a synthesis of eleven

meta-analyses and twelve narrative reviews, (Bhui, Dinos, Stansfeld, & White, 2012). This review of reviews concluded that organisational physical activity interventions were effective at reducing sickness absence, although for other organisational level interventions, the evidence was mixed. Whilst individual interventions, particularly cognitive behavioural therapy (CBT), led to improvements in mental health, there was no evidence that they impacted on sickness absence outcomes. However, many of these studies did not report sickness absence outcomes, leading the authors to conclude that the effect of interventions on organisational outcomes such as absenteeism was an area which required further study. Despite this, it appears that different types of intervention may be effective for aiding return to work in comparison to improving mental health. This finding could have implications for organisations in considering how they rehabilitate their employees who experience stress-related illness. It may be that changes within the workplace are needed in addition to interventions targeted at improving health. Despite the large literature on workplace stress in general, there is a greater need to focus on return to work as an outcome, particularly for interventions which aim to improve individual mental health. In addition, there is a need for further research focusing on different types of organisational level interventions, some of which appear to be effective at reducing absence.

A number of systematic reviews have been conducted on interventions for musculoskeletal problems, focusing on the effectiveness of these programmes at improving work outcomes (e.g. Flor, Fydrich & Turk, 1992).

These interventions typically focus on pain management; rehabilitation interventions, such as physiotherapy and workplace adjustments (European Agency for Safety and Health at Work, 2007). Much of the research has focused on back pain (e.g. Flor et al., 1992), although some reviews have looked at interventions for chronic pain in general (that is, pain lasting at least three months; e.g. Cutler, Fishbain, Rosomoff, Abdel-Moty, Khalil & Rosomoff, 1994). Some concluded that multidisciplinary pain management was effective for return to work, such as Flor et al. (1992), who found that employees with back pain who were treated with a multidisciplinary intervention were almost twice as likely to return to work as untreated patients or those treated with non-multidisciplinary interventions. In contrast, other reviews found that interventions were only effective for particular subgroups. In summary, it appears that high intensity interventions (of more than 100 hours) are more effective than low intensity (of less than 30 hours; Guzmán, Esmail, Karjalainen, Malmivaara, Irvin & Bombardier, 2001) and those which target changes in the workplace are more effective than those which do not (Schaafsma et al., 2010; Carroll, Rick, Pilgrim, Cameron & Hillage, 2010). In addition, employees who have been absent from work for shorter periods (Norlund, Ropponen & Alexanderson, 2009), those with back pain (Meijer, Sluiter & Frings-Dresen,1995) and those with subacute pain (that is, pain lasting between six and twelve weeks; Schaafsma et al., 2010) appear to be better candidates for intervention.

There was contradictory evidence about which approach to pain management was most effective. For example, Schaafsma et al. (2010)

concluded that the addition of CBT to a multidisciplinary intervention did not add any benefit, whereas Schonstein, Kenny, Keating, Koes & Herbert (2003) concluded the opposite. A problem in evaluating this evidence on pain management interventions is that interventions tend to be multidisciplinary, containing heterogeneous elements, which are often poorly described (Eccleston, Williams & Morley, 2009). It is therefore difficult to assess which elements of intervention are effective. Whilst it appears that multidisciplinary interventions are effective for return to work, at least for some employees (e.g. Meijer et al., 1995), it is also worth considering the individual interventions which are effective. For example, one review concluded that modified work duties reduced absence for acute (less than six weeks) and subacute back pain (Frank, Sinclair, Hogg-Johnson, Shannon, Bombardier, Beaton & Cole, 1998). A review of exercise therapies for lower back pain (Hayden, van Tulder, Malmivaara & Koes, 2005) found evidence for the effectiveness of graded activity programmes for subacute back pain in occupational settings. Multidisciplinary interventions may benefit from the inclusion of these individual interventions which are known to be effective, however, their use in combination with other intervention elements will need to be assessed. The effectiveness of CBT on work outcomes has not been reviewed and the effectiveness of its addition to multidisciplinary interventions has showed mixed results (Schaafsma et al.,2010; Schonstein et al., 2003). However, there is some evidence of its effectiveness for other outcomes such as disability, pain, mood and catastrophising (Williams, Eccleston & Morley, 2012). A review of the effectiveness of CBT pain management for vocational outcomes may be

useful to explain these mixed results. In addition, a reassessment of the effectiveness of the inclusion of CBT in multidisciplinary pain management is needed, perhaps with a focus on which elements of CBT may be most effective.

Evidence from the interventions focusing on stress management and those focused on pain management indicates that interventions with a workplace focus are more likely to be more effective than those which focus solely on health improvements (Schaafsma et al., 2010). The evidence that multidisciplinary pain interventions are more effective alongside evidence that CBT in combination with other elements may reduce stress-related absence (Murphy, 1996) suggests that interventions which focus on both health and improvements in the workplace are more likely to be effective (Flor et al., 1992). Absence from work is unlikely to have one simple cause and is therefore unlikely to have one straightforward solution (Johns, 2003) and therefore more complex interventions are likely to be indicated. The inclusion of CBT or other psychological interventions in return to work programmes may be indicated due to the importance of health and illness beliefs in absence (e.g. Hoving et al., 2010), the evidence for which will be reviewed in the next section of this chapter. However, this is likely to be only one element of an effective intervention and its value is yet to be established.

1.11 The role of health and illness beliefs in absence

In recent years, there has been an increasing recognition of the role of health and illness beliefs in absence (e.g. Hoving et al., 2010), however, research in this area is still in its early stages and few studies have been conducted to date. Whilst the impact of health and illness beliefs on health behaviours and outcomes in disease has been long recognised and widely researched (e.g. Petrie & Weinmann, 2006), the influence that these beliefs have on sickness absence is an area which has previously been neglected (Coutu, Baril, Durand, Côté & Rouleau, 2007). The evidence that health and illness beliefs are related to work outcomes will be reviewed and the usefulness of Leventhal's (1970) self-regulatory model of illness behaviour will be assessed. It is argued that health psychology has the potential to make a greater contribution to the field of sickness absence than is currently the case.

Patient expectations of return to work are some of the best predictors of how soon the individual will return to the workplace, when severity of illness is controlled for (Kapoor, Shaw, Pransky & Patterson, 2006) and are more accurate than the predictions of professionals (Fleten, Johnsen & Førde, 2004). For workers with chronic pain, fear avoidance beliefs (beliefs that activity will worsen pain) predict higher level of sickness absence (Jensen et al., 2010). Individuals who had taken time off work due to lower back pain were found to be more likely to believe that pain was directly related to activity, believed they had lower levels of control and were more likely to focus on pain compared to matched employees who remained in work

(Linton & Buer, 1995). In addition, Keller (1983) found that an internal health locus of control predicted lower sickness absence, while D'Amato and Zijlstra (2010) found that self-efficacy plays a role in return to work. These findings suggest that a number of beliefs are important in decisions about work attendance, however, most studies (although still a small number) have concentrated on Leventhal's (1970) self-regulatory model of illness behaviour.

Leventhal (1970) suggests that individuals make sense of a health condition or set of symptoms according to their common-sense beliefs about the illness and its treatment. Illness perceptions or illness representations are the terms most frequently used for these common sense beliefs. Leventhal suggested that there are five important elements of illness perceptions which are the identity of the illness based on the diagnosis or label that is given to it and the symptoms that are associated with it; the timeline of the illness (how long it is expected to last and whether it is seen as acute, chronic or episodic); the short- and long-term consequences of the illness; the causal factors contributing to it and ways to control or cure the illness. Illness perceptions are predictive of a number of outcomes such as coping, recovery, self-management, function, treatment adherence and quality of life (e.g. Diefenbach & Leventhal, 1996).

A limited number of studies have begun to look at illness perceptions and their link to return to work. A recent systematic review investigated the evidence of a relationship between illness perceptions and work

participation outcomes (Hoving et al., 2010). Four studies were included, all of which found that one or more of the illness perceptions dimensions was associated with return to work. 'Consequences' was the dimension which was most often associated with return to work outcomes but 'timeline' and 'control' were also found to have significant associations in more than one study. Two of the included studies used a longitudinal design and their findings suggest that illness perceptions are not only correlated with, but are predictive of, return to work. However, it is difficult to draw firm conclusions since these studies focused on different populations and included less than 150 participants between them.

There is some additional evidence which indicates that illness perceptions are important for work outcomes. Giri, Poole, Nightingale and Robertson (2009) found that individuals who rated their illness as shorter-lasting, more controllable and less serious were more likely to return to work within three months than those who gave themselves higher scores on these dimensions (after controlling for length of absence and type and severity of illness). Broadbent, Petrie, Ellis, Ying and Gamble (2004) asked patients who had experienced a myocardial infarction to draw a picture of their heart to estimate the amount of damage they believed their heart had sustained and to complete an illness perceptions questionnaire. They found that patients who drew more damage on their heart expected their heart condition to last longer and had less perceived control over their condition. They also took significantly longer to return to work.

There appears to be a growing body of evidence showing that illness perceptions are important predictors of health behaviours and return to work. However, results have varied between studies and it is not yet clear how strong the relationship is; which dimensions of illness perceptions are most predictive of work participation and how consistent the relationships are for different health conditions. Since health beliefs and illness perceptions are of core importance to health psychologists, it seems that health psychologists are well placed to contribute to this emerging literature on the important of health and illness beliefs to work outcomes.

At present, it is not known how differences in health beliefs and illness perceptions lead to differing work outcomes. It is also not clear whether there are additional important beliefs which may relate specifically to work attendance when ill, since the literature on absenteeism tends to rely on appraisals of the workplace, such as job satisfaction (e.g. Marmot et al., 1995) or on illness representations (e.g. Hoving et al., 2010) rather than on specific beliefs about work attendance.

To an extent, these problems have been addressed by using qualitative designs to explore the beliefs of employees about taking illness (e.g. Barnes, Buck, Williams, Webb & Aylward, 2008), however, this type of research is very limited. Several studies found that the moral aspect of absence was a common concern for employees (Barnes et al., 2008; Wynne-Jones, Buck, Porteous, Cooper, Button, Main & Phillips, 2010; Buck, Porteous, Wynne-Jones, Marsh, Phillips & Main, 2011). In particular,

employees were keen to present themselves as only taking legitimate absence and managers were concerned with establishing whether absence was genuine. Social pressures to attend work were reported, particularly feelings of responsibility towards colleagues, and presenteeism was described as common. These findings suggest that the beliefs about health and work that people hold need to be understood within their social context and within a moral framework. The popular conception of absence as deviant (Patton & Johns, 2012) may be linked to these pressures to attend work when unwell and to present any absence as legitimate.

It appears that health and illness beliefs play an important role within sickness absence and return to work. However, a fuller understanding is needed of how these beliefs are linked to absence and return to work, and how they operate within the social context where only taking 'genuine' absence is a moral imperative which is policed by managers.

1.12 Summary and rationale

Currently, the research on sickness absence and return to work is patchy and theoretically underdeveloped, despite its importance for workplace and government policy. Whilst there has been some progress in identifying predictors of absence and return to work (Allebeck & Mastekaasa, 2004b) and in establishing some effective interventions for the most common causes of absence (e.g. Bhui et al., 2012), explanations of sickness absence and return to work are inadequate. Factors relating to absence are multifaceted and occur at a number of levels (Kristensen, 1991), however,

theoretical understandings of absence have not adequately addressed these complexities. The current research will therefore attempt to address these issues by explore the ways in which employees make decisions about taking sickness absence and returning to work and the factors which may help employees to limit their absence.

Prior to conducting original research, the literature was assessed to establish whether it had been adequately reviewed. The examination of the literature (see sections 1.9 and 1.11) found that the predictors of absence and return to work have been the subject of a number of meta-analyses and broad categories of predictors have been identified (e.g. Duijts et al., 2007). The literature on interventions aimed at reducing absence has also been subject to a number of reviews and even, in the case of stress-related absence, to a review of reviews (Bhui et al., 2012). Whilst this review of reviews identified gaps in the literature, knowledge in the area can be considered to be adequately reviewed. For musculoskeletal problems, reviews have mainly focused on multidisciplinary interventions, which have been found to be more effective than non-multidisciplinary interventions (e.g. Flor et al., 1992). However, multidisciplinary interventions tend to be heterogeneous and it is not clear which elements of intervention are most effective (Eccleston et al., 2009). The review identified that whilst there is evidence of the effectiveness of CBT interventions for pain, disability, mood and catastrophising (Williams et al., 2012), their effectiveness for work outcomes has not been reviewed. Therefore, a systematic review was conducted to assess the effectiveness of CBT pain management

interventions in reducing absence from work in order to address the second part of the research question, identifying the factors which help individuals to limit their sickness absence. This systematic review is reported in Chapter 2.

A piece of original research was conducted following this which aimed to provide a more coherent and complex account of absence from work than has previously been presented. The research aimed to explore how individuals who were absent from work due to illness or injury understood and managed their health and absence from work. In order to address the identified gaps in the literature, it attempted to go beyond the existing descriptive accounts and predictors of absence and develop an explanatory model of the sickness absence process, thereby moving theory forward. It also included health and illness beliefs whilst allowing scope to explore other beliefs. By using a qualitative approach, it allowed the factors which are important to employees on multiple levels to be explored and therefore allowed for a complex, multifaceted theory to be developed. This new theory aimed to describe experiences of absence and return to work and explain the relationships between the multiple factors which are involved in absence. A grounded theory approach was chosen, which aims to develop theory from the 'bottom up'. A description of the grounded theory method and the rationale for using it in Study 2 is included in Chapter 3. The results of the study are then presented and discussed in Chapter 4.

Chapter 2

Study 1: The Effectiveness of CBT Pain Management in Improving Vocational Outcomes of Chronic Pain Patients: A Review with Meta-Analysis

_____

2.1 Introduction

A systematic review was conducted which assessed the effectiveness of CBT pain management interventions in reducing absence from work. The review strategy was adapted from the Cochrane Collaboration (2007) Handbook for Systematic Reviews of Health Promotion and Public Health Interventions.

2.1.1 Aims of the review

The overall aim of the review was to identify factors which help individuals to return to work by reviewing the effectiveness of CBT pain management for improving work attendance. In order to meet this aim, objectives were set to:

1. Locate and describe evaluations of CBT pain management interventions aimed at chronic pain patients which report vocational outcomes (i.e. return to work, rates of sickness absence, number of hours worked)

2. Critically evaluate the quality of these interventions and their evaluation and the reliability of any conclusions that can be drawn

3. Summarise the evidence that CBT pain management is effective at improving vocational outcomes of chronic pain patients in comparison to no intervention, usual care or alternative pain management interventions.

2.2 Method

2.2.1 Search

Electronic searches were conducted. More databases were assessed for inclusion than was possible to conduct full searches on due to a lack of resources. In order to maximise relevant results, databases were assessed by screening the first 100 search results. Where no relevant results were included in the first 100 results, databases were excluded. Full searches were done on seven databases and three databases were assessed then excluded. Published and unpublished studies were considered for inclusion in the review. Grey literature was searched using three databases. The databases searched for each type of literature are listed in Appendix 1. For each database, the search strategy included variations on the broad headings of chronic pain and cognitive behavioural therapy. An alternative search strategy including work as an additional heading was rejected as it appeared to exclude potentially relevant studies. The same text words were used in each database. In each database, the headings of chronic pain and cognitive behavioural therapy were mapped to the subject headings used by

that database, for example, MeSH headings in Medline. An example of the full search strategy used in Medline is included in Appendix 1.

In addition to the electronic searches, journals were hand searched to identify further relevant studies. These are listed in Appendix 1. Reference lists of included studies were searched to identify further published and unpublished research. Two experts in the field whose publications were included in the review were contacted and asked for any information on relevant studies. The experts were Prof Irene Jensen from the Karolinska Institute, Stockholm and Dr Judith Turner from the University of Washington, USA.

2.2.2 Inclusion and Exclusion Criteria

Published and unpublished studies were considered for inclusion in the review. Inclusion criteria were as follows:

- Studies of adults of working age (18-65) experiencing chronic pain (i.e. pain of over 3 months' duration).
- Studies evaluating a CBT pain management intervention
- Studies measuring a vocational outcome (return to work or sickness absence)
- Studies in the English language

Studies were not excluded due to date of publication, study design or quality of methodology.

Studies of CBT based pain management were included. For the purposes of this systematic review, CBT Pain Management was defined as follows:

1. Programme includes at least three cognitive-behavioural pain management techniques e.g. pacing, relaxation, goal setting, problem solving, cognitive restructuring or teaching of cognitive coping strategies (e.g. positive self-talk)

2. Authors report that the entire programme took a CBT approach rather than this being one discrete element of a larger programme

The features included in programmes are often poorly reported (Eccleston, et al., 2009). Therefore, it is difficult to assess the content of interventions. Some papers report "CBT" interventions, however, where very little cognitive-behavioural content is evident (for example, one follow up study reported a CBT intervention which was described as motivational interviewing in the original paper; Magnussen, Strand, Skouen & Eriksen, 2009). The inclusion of three CBT techniques was judged to be an adequate minimum standard to ensure that a true CBT approach was taken.

Studies comparing CBT Pain Management to any or no control group were included. Studies reporting return to work or sickness absence related outcomes were included.

Exclusion criteria were as follows:

- Studies focusing on patients with malignant disease

- Studies focusing on children or older patients

- Studies which did not report a work outcome

- Studies reporting on multidisciplinary interventions where CBT was only one element

- Studies reporting CBT interventions which did not include at least three CBT techniques

- Due to resource limitations, a pragmatic decision was made to exclude studies which were not published in the English language.

It was considered that interventions which may be effective for return to work following cancer are likely to be different to those which are effective for pain due to musculoskeletal problems, therefore studies of patients with malignant disease were excluded. Interventions focusing on children or the elderly were excluded since work outcomes were unlikely to be relevant for these groups.

2.2.3 Selection and Data Abstraction Process

Figure 1 summarises the selection process. Search results were screened by a single reviewer and irrelevant results were excluded by title or type of literature (for example, books, letters and reviews). Abstracts were obtained

for the remaining results and these were assessed by two reviewers against the inclusion and exclusion criteria. Full reports were obtained for the studies which were included at this stage and these were re-examined against the inclusion and exclusion criteria by both reviewers using a data extraction form devised to aid this process (Appendix 2). Any disagreement between reviewers was resolved by discussion. Full data was then extracted from the studies finally included in the review using a fuller data extraction form (Appendix 3).

2.2.4 Quality assessment

A quality rating scale specific to psychological pain management was used to assess the quality of the studies (Yates, Morley, Eccleston & Williams, 2006). This scale gives two separate scores for intervention quality (maximum of 9 points) and the quality of design and methods (maximum of 26 points). These are then added to give an overall quality score out of 35. Intervention quality was rated as adequate if a score of 5 or more was gained. Design quality was deemed adequate if a score of 14 or more was gained. Overall quality was rated as acceptable if a score of 18 or more was gained. These quality assessments are in line with those of Eccleston et al. (2009). In addition, studies were rated as being of high quality if scoring 7 or more for treatment quality, 18 or more for design and 24 or more overall. The quality rating scale is included in Appendix 4.

2.2.5 Assessment of Heterogeneity and Data Synthesis

Descriptions of studies were reviewed to assess heterogeneity of participants, interventions, comparison groups and outcome measures included in each study. Forest plots were used to map confidence intervals and Chi-squared and I-squared statistics were used to assess heterogeneity. For studies which reported return to work as an outcome (and included a control group), odds ratios were compared. For studies which reported the amount or length of sickness absence as an outcome, (and included a control group), standardised mean differences were calculated. For studies which reported the number of hours worked as an outcome (and included a control group), standardised mean differences were calculated. Where data was not available, these studies were excluded from assessment and no estimates were used. The appropriateness of pooling results in a meta-analysis was assessed. Review Manager 5 software was used for all calculations. Data was analysed by outcome due to differences in outcome measures. The results not included in the meta-analysis were assessed in a narrative synthesis and overall results were then considered.

2.3 Results

2.3.1 Search results

7929 results were found by the electronic searches. One additional study was found by the hand search. The flowchart in Figure 1 shows the inclusion and exclusion of studies throughout the review process. Following

the removal of duplicates, 665 abstracts were screened by two reviewers and assessed against inclusion and exclusion criteria. There was 97% agreement between reviewers about which abstracts met the inclusion criteria. Disagreements were resolved by discussion between reviewers and refinement of the inclusion and exclusion criteria if necessary. Disagreements were mainly due to a lack of clarity in reporting of interventions, duration of pain and vocational outcomes. Where information given in the abstract was very unclear as to whether it met the criteria, papers were obtained for review. Where papers did not mention vocational outcomes, they were excluded at abstract stage.

Full reports were obtained of 29 papers, of which 16 were included in the final review (8 studies were excluded due to patients not all experiencing chronic pain, 2 were excluded as the intervention was not CBT pain management, 2 were excluded where there was no work outcome reported). One of the included papers reported 2 separate studies, and 2 were long-term follow ups of other included studies. Therefore, the 16 papers reported the results of 15 studies. Details of included studies are shown in Table 1.

Figure 1: Flow diagram of included and excluded studies

Stage 1: Potentially relevant studies identified and titles screened N = 7930	Studies excluded on the basis of language, type of publication (e.g. letters), or title (e.g. studies of depression or insomnia)
Stage 2: Abstracts of studies reviewed by 1ˢᵗ and 2ⁿᵈ reviewer N = 665	Studies excluded if: 1. Population were children or older adults (N = 7) 2. Population was not chronic pain (N = 60) 3. Excluded patient group (N = 2) 4. Not CBT Intervention (N = 122) 5. CBT intervention was not pain management (N = 15) 6. No work related outcomes (N = 308) 7. Ineligible type of literature (e.g. review, letter) (N = 111) 8. Not in English language (N = 11)
Stage 3: Full reports of studies evaluated in detail by 1ˢᵗ and 2ⁿᵈ reviewer N = 29	Studies excluded if: 1. Not chronic pain (>3 months) (N = 8) 2. Not CBT Pain Management (N = 2) 3. No work outcome (N = 2)
Studies included in review N = 16	

2.3.2 Quality Assessment

Quality of studies was highly variable. The average overall quality score was 18.8 (range 11-30). The mean treatment quality score was 5.2 (range 3-8) and the mean design quality score was 13.6 (range 6-22). Studies were rated as poor, adequate or good according to their quality score. Studies with overall scores of 18 or more were considered acceptable and with scores of 24 or more were considered good. Treatment quality was considered adequate if it scored 5 or more and good if it scored 7 or more. Design quality was judged adequate if it scored 14 or more and good if it scored 18 or more. Quality ratings for each study are shown in Figure 2. Studies rated good are coloured green, those rated adequate are coloured amber and those rated poor are coloured red.

Figure 2: Quality ratings for included studies

	Treatment Quality	Design Quality	Overall Quality
Corey, Etlin & Miller (1987)	🟧	🟥	🟥
Dunstan & Covic (2007)	🟧	🟥	🟥
Jensen et al. (1995)	🟧	🟥	🟥
Jensen et al. (2001)	🟩	🟩	🟩
Jensen et al. (2005)	🟩	🟩	🟩
Jensen, Nygren & Lundin (1994)	🟧	🟧	🟧
Jensen & Bodin (1998)	🟧	🟧	🟧
Jensen et al. (1997)	🟥	🟧	🟧
Johansson et al. (1998) Study 1	🟧	🟧	🟧
Johansson et al. (1998) Study 2	🟧	🟥	🟧
Kendall & Thompson (1998)	🟥	🟥	🟥
Lindell, Johansson & Strender (2008)	🟥	🟩	🟧
Marhold, Linton & Melin (2001)	🟩	🟧	🟧
Richardson et al. (1994)	🟥	🟥	🟥
Schweikert et al. (2006)	🟩	🟩	🟩
Turner (1982)	🟥	🟧	🟧
White, Beecham & Kirkwood (2008)	🟧	🟥	🟥

Table 1: Summary of included studies

Study	Intervention	Study Design	Participants	Work Outcomes	How Measured	Main Findings
Corey, Etlin & Miller (1987)	Home-based CBT pain management intervention, plus work intervention and marital/family therapy for some participants. Intervention included: Education on model; identification of pain aggravating thoughts, situations and behaviours; relaxation; distraction; stress management by modifying cognitions; exercise; lifestyle restructuring; biofeedback; sleep scheduling. Delivered by: 2 nurses, 1 social worker, 1 psychology graduate. Training/Experience: trained by author Length: varied between 50 and 200 hours over 1-15 months. Setting: Patients' homes in Ontario, Canada.	Design: Before and after Control group: None Time frame for measurement: Before and after intervention. Follow up between 2 and 38 months. Quality score: Overall = 11 (poor). Intervention quality = 5 (adequate). Design quality = 6 (poor).	N: 72 Type of pain: Cervical strain = 18, Lumbar strain = 14, Mechanical low back = 16, Discogenic back = 9, Headache = 4, Other = 11. Mean pain duration: Not reported Recruitment: First 100 people referred to a pain clinic, selected by interview. Attrition/Response rate: 100% work data collected, questionnaire response rate 79.2%. Gender: 53% male Mean Age: 38.4 Origin: 58.4% North American SES: 47.3% unskilled workers	Work status (Full or Part Time, Retraining/ Job seeking, Work equivalent e.g. homemaker, vocationally disabled).	Employer or funding agency was contacted to establish work status.	Before intervention 100% of participants were vocationally disabled. Following intervention: 25% working full time, 16.7% working part time, 16.7% retraining or job seeking, 12.5% work equivalent and 29.18% vocationally disabled. At follow up: 21.9% working full time, 16.7% working part time, 11.1% retraining or jobseeking, 12.5% work equivalent, 30.6% vocationally disabled. No statistical analysis is reported.
Dunstan & Covic (2007)	A cognitive-behavioural work related activity programme aimed at rural workers. Included CBT pain management and work intervention. Intervention included: Education on pain and the biopsychosocial model; goal setting; physical upgrading including walking and exercise; activity management including scheduling and pacing; relaxation; distraction; problem solving; sleep management;	Design: Before and after Control group: None Time frame for measurement: Before and after intervention, 6 month follow up. Quality score: Overall = 12	N: 30 Type of pain: work related compensable soft tissue injury, 63% back pain Mean pain duration: 31 months Recruitment: Via a medical practice Attrition/Response rate: not reported Gender: 60% male Mean Age: 41 Origin: Not reported	Resumption of paid work, sick listing status (possible statuses: fully fit for work, fit for modified duties, partially fit, unfit)	Via sick note	Significant decrease in proportion of participants being classed as unfit for work from 30% ($n = 9$) at pre-program to 20% ($n = 6$) at six-month follow up (binomial test $P = 0.001$).

	identifying and challenging unhelpful thoughts; social skills training; relapse prevention. Delivered by: author, physiotherapists, occupational rehabilitation providers as return to work case managers. Training/Experience: author trained in multidisciplinary pain management. Length: ½ day x 6 weeks Setting: community meeting room in New South Wales, Australia.	(poor). Intervention quality = 5 (adequate). Design quality = 7 (poor).	SES: 57% unskilled workers			
Jensen et al. (1995)	Multi-modal CBT for chronic neck and shoulder pain. Intervention included: education; relaxation; physical exercise; physical therapy; health behaviour change; goal-setting; coping strategies e.g. increasing activity and cognitive distraction; problem solving. Delivered by: Physical therapists, physicians, physical training instructors, nurses, psychologists. Training/Experience: All staff trained in CBT for chronic pain. Length: 4 weeks full time Setting: inpatient orthopaedic department in North Sweden.	Design: RCT Control group: multi-disciplinary CBT intervention to improve physical fitness, health behaviour and plan for return to work (not including psychologist). Time frame for measurement: before and after intervention, 6 month follow up Quality score: Overall = 14 (adequate). Intervention quality = 5 (adequate).	N: 66 (CBT treatment group with psychologist [B]: n= 29; CBT intervention without psychologist [A]: n=37) Type of pain: neck and shoulder Mean pain duration: not reported Recruitment: Clients referred to an inpatient orthopaedic department. Attrition/Response rate: not reported Gender: 41% male in psychologist group; 30% male in control group. Mean Age: 39 in psychologist group; 40 in control group Origin: Not reported SES: 48% blue collar workers in psychologist group; 33% blue collar in control group.	Sick leave over 1 year prior to intervention and 18 months following	Information on sick leave from the Swedish National Health Insurance Authority	Sick leave data is reported in graph form only. Estimated mean days of sick leave from graph: 12-7 months before treatment A = 100, B = 85; 6 months before A = 135, B = 135; 0-6 months after A = 140, B = 140; 7-12 months after A = 105, B = 110; 13-18 months after A = 90 B = 90. ANOVA found no significant differences between groups in sick leave at 6 or 12 months.

		Design quality = 9 (poor).				
Jensen et al. (2001)	CBT alone and in conjunction with physiotherapy (Behavioural medicine [BM] intervention). Intervention included: Activity planning; goal setting; problem solving; applied relaxation; cognitive coping techniques (e.g. distracting imagery, external focusing, coping self-statements); activity pacing; vicious circles and how to break them; the role of significant others and assertion training. Delivered by: psychologist, physician, physical therapist Training/Experience: experience in pain management Length: CBT intervention: 13-14 hours x 4 weeks; BM (CBT plus physiotherapy) intervention: 33-34 hours x 4 weeks. Setting: rehabilitation clinics in Stockholm, Gothenburg, Helsingborg, and Malmo, Sweden	Design: RCT Control group: physiotherapy intervention, treatment as usual Time frame for measurement: before and after intervention, 6 and 18 month follow ups Quality score: Overall = 30 (good). Intervention quality = 8 (good). Design quality = 22 (good).	N: 214 (BM = 63, Physio = 54, CBT = 49; treatment as usual control = 48) Type of pain: spinal Mean pain duration: BM = 35.6 months, Physio intervention = 36.9 months, CBT = 22.7 months, treatment as usual = 27.3 months. Recruitment: Clients identified from health insurance register. Attrition/Response rate: Treatment drop outs n=28 (BM = 14, Physio = 6, CBT = 8). Gender: Behavioural medicine = 52% male, Physio = 32% male, CBT = 55% male, control = 42% male. Mean Age: Behavioural medicine = 43, Physio = 43, CBT = 44, control = 44. Origin: 81% Swedish SES: Compulsory education only = 57%	Sick listing plus early retirement	Information from National Social Insurance Board	At 18 months, no significant differences were found between intervention groups and control group for work absence (parameter estimates from ANCOVA for differences between treatment group versus control group with 95% CI in brackets: Women in BM group -18 [-106-70], men in BM group -58 [-159-43], women in physio group -20 [-104-64], men in physio group -50 [-167-67], women in CBT group 20 [-76-116], men in CBT group 65 [-39-169]). At 18 months, the risk of being granted early retirement was significantly lower for females in the physio and CBT interventions compared to the control group (Odds ratios with 95% confidence intervals : BM, 0.4 [0.1-1.4]; PT, 0.1 [0.0-0.6]; CBT 0.1

						[0.0-0.8].
Jensen et al. (2005) (Follow up of Jensen et al., 2001)	As above	Design: As above Control group: As above Time frame for measurement: 3 year follow up Quality score: As above	As above	As above	As above	Per protocol ANCOVA analysis found females in the BM group showed lower sick leave. No difference was found for CBT alone (Mean differences compared to control with 95% confidence intervals: BM = -201.3 [-403.9, 1.3], physio = -57.1 [-246.5, 132.3], CBT = -1.5 [-222.2, 219.5]). No significant differences were found for men (Mean differences compared to control with 95% confidence intervals: BM = -136.7 [-374.5, 101.1], Physio = 25.5 [-52.3, 303.2], CBT = 55.6 [-185.1, 296.2]). Intention to Treat Analyses found no significant differences (Mean differences compared to control with 95% confidence intervals for females: BM = -134.2 [-327.5, 59.1], Physio = -39.9 [-225.4, 145.6], CBT = -53.3 [-263.9, 157.2]. For males: BM =

						-65.1 [-290.3, 160.2], Physio = -12.6 [-273.2, 247.9], CBT = 105.6 [-124.9, 336.1].
Jensen, Nygren & Lundin (1994)	Multimodal CBT delivered as a full time outpatient group programme Intervention included: five modules: exercise therapy; cognitive behavioural modification, education; promotion of patients' interaction with their usual occupational and social milieu; and training of work supervisors to enhance re-integration into the job. Delivered by: psychologist, physician, physical therapist, nurse Training/Experience: experience in chronic spinal pain Length: 8 hours daily x 4 weeks Setting: NärRehab/Hälsoinvest (NRH), an outpatient clinic located in the centre of the city of Örebro in the southeast of Sweden.	Design: matched cohort Control group: no treatment Time frame for measurement: before and after intervention, 6 month follow up Quality score: Overall = 19 (adequate), Intervention quality = 5 (adequate), Design quality = 14 (adequate).	N: 35 intervention group, 35 matched controls, 53 unmatched patients as reference group Type of pain: neck, shoulder, back Mean pain duration: Intervention group: 44 weeks; Control group: 47 weeks Recruitment: Referrals to clinic via National Health Insurance Authority Attrition/Response rate: matched patients – 2 drop outs, 2 excluded; unmatched patients – 7 dropouts, 10 excluded; matched controls 4 dropouts, 2 excluded Gender: 26% male Mean Age: matched patients = 43, matched controls = 44, reference group = 40 Origin: not reported SES: blue collar workers treatment group = 76%, control = 69%	Absenteeism	Information from insurance agency	Mean days absence 6 months prior to treatment for matched patients = 82.6, for patient reference group = 85.6, mean days absence 6 months after treatment for matched patients = 77.9, for patient reference group = 81.7. Trend towards less absenteeism in intervention groups. A change in how the data was recorded by the insurance agency during the study meant that data from the control group was not usable and therefore no comparisons could be made.
Jensen & Bodin (1998) (Follow up of Jensen et al., 1994)	As above	Design: As above Control group: As above Time frame for measurement: 18 months	As above	As above	As above	Treatment group showed an increase in average sick-leave of 1.5 days (pre- 8.2 days, post- 9.7 days). Control group showed a decrease of

				Sick leave in year before and 18 months after	Data from National health insurance authority	2.3 days (pre- 11.1 days, post- 8.8 days). After adjustment for pre-treatment sick-leave the estimated post-treatment group difference was 1.9 days less sick-leave for the control group. 95% confidence interval for the difference between treatment and control groups = -2.4 to 6.3 which was not statistically significant according to ANCOVA (F =0.77, df =1;93, P =0.38).
		Quality score: As above				
Jensen et al. (1997)	Multimodal CBT delivered as a full time inpatient group programme Intervention included: exercise therapy; education; problem solving; goal setting; applied relaxation and self efficacy training. Delivered by: psychologist, physician, physical therapist, nurse, alcohol/drug counsellor Training/Experience: not reported Length: 8 hours daily x 5 weeks Setting: clinic in Northern Sweden.	Design: RCT Control group: 2 experimental groups of Multimodal CBT: one with specific intervention for women Time frame for measurement: before and after intervention, 6 month and 18 month follow ups Quality score: Overall = 19	N: Tailored CBT = 29, Regular CBT = 25 Type of pain: neck, shoulder, back Mean pain duration: Intervention group: 44 weeks; Control group: 47 weeks Recruitment: Referrals to clinic via National Health Insurance Authority Attrition/Response rate: 14%, 4 dropped out of treatment, 5 failed to return follow up questionnaires Gender: 100% female Mean Age: Tailored intervention: 45; regular CBT intervention: 43 Origin: not reported SES: <10 years education = 41%	Sick leave in year before and 18 months after	Data from National health insurance authority	Sick leave data is reported in graph form only. Estimated mean days of sick leave from graph: 12 months before intervention: regular CBT = 45, tailored CBT = 45; 6 months before: regular CBT = 110, tailored CBT = 100; 6 months after: regular CBT = 130, tailored CBT = 105; 12 months after: regular CBT = 80, tailored CBT = 65; 18 months after: regular CBT = 48,

				Percentage	Self-report	

		(adequate), Intervention quality = 4 (poor), Design quality = 15 (adequate).	in tailored intervention, 32% in regular CBT group			tailored CBT = 50. ANCOVA was reported to be non-significant but no more information is described.
Johansson et al (1998)	Multidisciplinary inpatient CBT Intervention included: education, goal-setting, graded activity training, exercise, muscle training, pacing, relaxation, cognitive techniques, social skills training, drug reduction techniques, contingency management of pain behaviours, planning of return to work Delivered by: Clinical Psychologist, Physiotherapist, Occupational Therapist, Physical Education Teacher, Vocational Counsellor, Physician, Nurse Training/Experience: Trained in behavioural techniques and in cognitive and behavioural foundations of the programme Length: 5 full days x 4 weeks Setting: Department of Rehabilitation Medicine in Sweden	Design: Study 1: RCT. Study 2: Before and after Control group: Study 1: waiting list. Study 2: no control Time frame for measurement: Study 1: Before, after, 1 month. Study 2: Before, after, 2 months, 1 year Quality score: Study 1: Overall = 19 (adequate), Intervention quality = 5 (adequate), Design quality = 14 (adequate). Study 2: Overall = 18 (adequate), Intervention quality = 5 (adequate), Design quality = 13 (poor).	N: Study 1: CBT group = 21, Control group = 21. Study 2: N = 85 Type of pain: Study 1: 81% in multiple sites. Study 2: 49% in multiple sites. Mean pain duration: Study 1: 11 years. Study 2: 11 years Recruitment: Referral to a rehab clinic by GP or consultant Attrition/Response rate: Study 1: 4 dropped out of treatment group and 2 from control. Study 2: 8% attrition for sick leave data. Gender: Study 1: 22% male. Study 2: 32% male. Mean Age: Study 1: 43.5. Study 2: 42 Origin: Not reported SES: Study 1: 28% elementary school only. Study 2: 48% elementary school only.	Percentage sick leave (Study 1 and 2), hours of occupational training daily (study 1 only)	Self-report questionnaires	Study 1: Mean (standard deviation) in % sick leave. Pre-intervention: treatment group = 84.3 (33.6), control group = 51.7 (48.3); 1 month after: treatment group = 80.4 (34.8), control group = 59.6 (42.5). ANCOVA analysis found no significant differences between groups: $F_{(1,33)} = 0.55$ (n.s.) A significant increase in occupational training was found in the intervention group. Mean (standard deviation) hours of occupational training. Pre intervention: treatment group = 1.2 (1.6), control group = 0.8 (1.4); 1 month after: treatment group = 2.8 (2.3), control group = 0.6 (1.2). $F_{(1,24)} = 11.24$ ($p<0.01$)

						Study 2: ANOVA found average level of sick leave decreased significantly over time from 63.8% (SD = 49.5) pre-intervention to 49.4% (SD = 43.0) at 2 months and 29.8% (SD = 39.1) at 1 year. F(2,154) = 32.6, p<0.001).
Kendall & Thompson (1998)	CBT pain management programme aimed at increasing productive activity Intervention included: Education on the physiology of pain, the nature of chronic pain and biomedical treatments; training in exercise and fitness; problem solving; effective communication and assertion; stress management; deep muscle relaxation techniques; healthy lifestyles including information about nutrition, sleep disturbance and sexual function; and medication compliance. Delivered by: clinical psychologist, occupational therapist, physiotherapist, nurse, and a medical registrar Training/Experience: not reported Length: 12 x ½ days Setting: hospital based pain management centre in New Zealand	Design: Quasi-experimental Control group: Waiting list Time frame for measurement: before, 3 month and 15 month follow ups Quality score: Overall = 16 (poor), Intervention quality = 4 (poor), Design quality = 12 (poor).	N: CBT group = 81, Control = 102 Type of pain: 52% back pain Mean pain duration: 66.5 months Recruitment: referral to public hospital pain man centre Attrition/Response rate: 0% in intervention group, 76.6% response from control group Gender: 59% male Mean Age: 41.1 Origin: 96% Caucasian SES: Not reported	Employment and compensation status	Self-report	Intervention group work status. Pre-intervention: 1.2% in f/t work, 16% in part time work, 0 doing voluntary work, study or work trial, 70.5% on full compensation, 12.3% on benefits or homemaker. 3 months after: 9.9% in f/t work, 21% in part time work, 11.1% doing voluntary work, study or work trial, 44.4% on full compensation, 13.6% on benefits or homemaker. 15 months after: 11.1% in f/t work, 27.2% in part time work, 9.9% doing voluntary work, study or work trial, 38.2% on full compensation, 13.6% on benefits or homemaker. Waiting list control

						group. Time 1: 9.8% in full or part time work, 0 doing voluntary work, 54.9% on full compensation, 35.5% on benefits or homemaker. Time 2: No change from Time 1. No statistical analysis of work data was done.
Lindell, Johansson & Strender (2008)	Cognitive behavioural rehabilitation Intervention included: Mapping of obstacles to work; graded activity; CBT for anxiety and depression; applied relaxation; goal setting; vocational conferences; CBT support for retraining. Delivered by: physician, physiotherapist, psychologist or a social worker, health-care adviser. Training/Experience: social worker had training in CBT, physiotherapist was trained in manual therapy. Other training not reported. Length: variable – average of 45 sessions Setting: rehabilitation centre in Stockholm county council	Design: RCT Control group: Primary care Time frame for measurement: 6, 12 and 18 months Quality score: Overall = 23 (adequate), Intervention quality = 4 (poor), Design quality = 19 (good). Note: Power analysis was conducted but recruitment was ceased before number of clients could be recruited therefore study lacked sufficient power.	N: CBT group (chronic pain) = 41, Control = 44 Type of pain: back and neck Mean pain duration: Not reported Recruitment: GP referral to rehabilitation centre Attrition/Response rate: All work data followed up Gender: 48% male Mean Age: 42.2 Origin: 81% born in Sweden SES: 37% primary education only	Return to work, sickness absence	Social insurance agency	Return to work share (% of patients who regained work ability for at least 30 days) was not significantly different between the intervention and control groups (Intervention group = 42 [26-57], Control group 46 [30-61]). Hazard ratios for return to work with 95% CIs: 6 months = .9 [.5-1.6], 12 months = .9 [.4-2.1], 18 months = 1.0 [.3-3.9]. Net sick days were not significantly different between groups at 18 months (Intervention group = 431 [377-486], Control group = 431 [383-478].
Marhold,	Cognitive behavioural package	Design: RCT	N: Long-term sick leave: CBT	Sickness leave	Data from	No significant

Linton & Melin (2001)	focused on coping with pain and return to work **Intervention included:** Education; goal setting; graded activity; pacing; relaxation; cognitive techniques; social skills training; stress management; problem solving; planning return to work and generalising coping skills to the workplace **Delivered by:** Clinical Psychologist **Training/Experience:** Trained in CBT and experienced in pain management **Length:** 12 x 2.5 hour sessions **Setting:** University Psychology department in Uppsala, Sweden	**Control group:** Treatment as usual **Time frame for measurement:** 6 months **Quality score:** Overall = 22 (adequate), Intervention quality = 8 (good), Design quality = 14 (adequate)	group = 18, Control = 18 **Type of pain:** 58% neck and shoulder, 29% lower back **Mean pain duration:** 48 months **Recruitment:** Register of people on sick leave **Attrition/Response rate:** 3% **Gender:** 100% female **Mean Age:** 46 **Origin:** 75% Swedish **SES:** 61% compulsory school education, 14% with degree		national insurance authority	differences between treatment and control groups were found by ANOVA for mean sick leave [F (3,99) = 0.49 (n.s.)]. Mean (SD) days sick leave: pre-intervention treatment = 52.6 (12.0), control = 53.2 (11.7); post intervention treatment = 49.9 (14.7), 51.5 (11.9); 4 months treatment = 49.4 (17.4), control = 53.7 (10.5). Separate analyses of patients on short term sick leave found a significant drop in sick leave but did not meet criteria for inclusion in this review.
Richardson et al. (1994)	Group cognitive-behavioural pain management programme **Intervention included:** Education; exercises; baseline setting and gradual increase of activity; goal-setting; pacing; work advice; relaxation; distraction; cognitive techniques; medication reduction **Delivered by:** psychologists, anaesthetist, physiotherapist, occupational therapist, nurse **Training/Experience:** No specific	**Design:** Before and after **Control group:** none **Time frame for measurement:** Before, after, 1 month, 6 months, 1 year **Quality score:** Overall = 12 (poor).	**N:** 109 **Type of pain:** 61% lower back **Mean pain duration:** 10 years, 8 months **Recruitment:** referral to programme by pain clinics, GPs, consultants **Attrition/Response rate:** all followed up **Gender:** 32% male **Mean Age:** 45 **Origin:** not reported	Number of patients in work	Self-report	26% initially in work, 30% at 1 month, 34% at 6 month and 1 year follow ups

	training reported Length: 4 weeks for inpatients, 8 afternoons for outpatients Setting: Hospital in the UK	Intervention quality = 3 (poor). Design quality = 9 (poor).	SES: not reported			
Schweikert et al. (2006)	Group CBT pain management programme Intervention included: education; relaxation; distraction; cognitive reappraisal of stress; self-confidence; mood; challenging negative thoughts Delivered by: psychologist Training/Experience: specialist in pain Length: 3 weeks rehabilitation including 10 hours of CBT Setting: 2 inpatient rehabilitation clinics in Germany	Design: RCT Control group: usual care (standard rehabilitation) Time frame for measurement: 6 months Quality score: Overall = 25 (good). Intervention quality = 7 (good). Design quality = 18 (good).	N: CBT = 200, Control = 209 Type of pain: lower back pain Mean pain duration: Recruitment: referred to rehabilitation clinic via public pension insurance Attrition/Response rate: Gender: 83% male Mean Age: 46.9 Origin: Not reported SES: Not reported	Sickness absence	Information from insurance company	Mean days off work were lower in CBT group following intervention. Mean (SD) absence at follow up: treatment = 11.4 (28.9), control = 16.8 (34.1). However, t-test showed the difference was non-significant (p=0.115).
Turner (1982)	CBT based on stress inoculation therapy (Meichenbaum & Turk, 1976) Intervention included: relaxation; goal setting; identifying cognitive and affective responses to pain; imagery techniques; coping self-statements. Delivered by: author Training/Experience: not reported Length: 5 x 90 minute sessions Setting: California, USA	Design: RCT Control group: relaxation intervention and waiting list control Time frame for measurement: before, after, 1 month, 18 months – 2 years Quality score: Overall = 18 (adequate). Intervention	N: 13 CBT, 14 relaxation, 9 control Type of pain: lower back pain Mean pain duration: 8.7 years Recruitment: referral to pain management by orthopaedic surgeons Attrition/Response rate: 32% in intervention group and 28% in control group Gender: 8% male Mean Age: 42 Origin: Not reported SES: average education high school plus some college	Hours of work weekly	Not reported	ANOVA at 18 month-2 year follow up found CBT group significantly increased the number of hours worked in comparison to control group. $F_{(2,33)} = 6.16$ (p<0.01). Mean (SD) hours worked relaxation group: pre = 23.8 (17.7), post = 23.8 (17.7), 1 month = 25.3 (17.7), 18 months = 22.8 (18.9); CBT group pre = 18.4

		quality = 4 (poor). Design quality = 14 (adequate).				(16.4), post = 18.9 (15.4), 1 month = 21.9 (17.8), 18 months = 38.0 (17.7).
White, Beecham & Kirkwood (2008)	Intensive outpatient multidisciplinary group CBT intervention encouraging family involvement Intervention included: exercise and stretch; goal setting; pacing; education; problem solving; changing maladaptive behaviours; changing unhelpful thoughts and beliefs; drug reduction; relaxation; sleep management; relapse prevention. Delivered by: clinical psychologists, physiotherapists, nurses, pain medicine specialists Training/Experience: trained in cognitive-behavioural principles Length: 3 weeks full time followed by 4 week home/work intervention Setting: hospital in Australia	Design: Retrospective comparison following intervention Control group: none Time frame for measurement: asked retrospectively about work status before and after intervention and current work status (between 2 and 87 months after intervention) Quality score: Overall = 14 (poor). Intervention quality = 5 (adequate). Design quality = 9 (poor).	N: 209 Type of pain: any chronic pain, 55.6% in multiple areas Mean pain duration: 8.5 years Recruitment: referral to hospital by medics Attrition/Response rate: Response rate 58% Gender: 26% male Mean Age: 46.2 Origin: 73% lived whole life in Australia SES: not reported	Vocational continuum scale (several increments between no intention to return to work and working full time)	Vocational Questionnaire developed by authors	50% of patients moved towards work on the continuum. 27% returned to work, 13% increased hours of work. 14% continued to work same hours, 6% stopped work, 7% reduced hours of work.

2.3.3 Assessment of Heterogeneity and Data Synthesis

Heterogeneity was assessed separately for studies with return to work, sickness absence and hours worked outcomes, since the differences in outcome meant that odds ratios and mean differences could not be

Table 2: Summary of outcomes and methods of synthesis

Study	Type of outcome and method of synthesis
Corey, Etlin & Miller (1987)	Narrative synthesis with return to work outcome
Dunstan & Covic (2007)	Narrative synthesis with return to work outcome
Jensen et al. (1995)	Narrative synthesis with sickness absence outcome
Jensen et al. (2001)	*See Jensen et al. (2005)*
Jensen et al. (2005) *(Follow up of Jensen et al., 2001)*	Meta-analysis with sickness absence outcome
Jensen, Nygren & Lundin (1994)	*See Jensen & Bodin (1998)*
Jensen & Bodin (1998) *(Follow up of Jensen et al., 1994)*	Meta-analysis with sickness absence outcome
Jensen et al. (1997)	Narrative synthesis with sickness absence outcome
Johansson et al (1998)	Narrative synthesis with sickness absence outcome for both study 1 and study 2
Kendall & Thompson (1998)	Narrative synthesis with return to work outcome
Lindell, Johansson & Strender (2008)	Meta-analysis with sickness absence outcome and narrative synthesis with return to work outcome
Marhold, Linton & Melin (2001)	Meta-analysis with sickness absence outcome
Richardson et al. (1994)	Narrative synthesis with return to work outcome
Schweikert et al. (2006)	Narrative synthesis with sickness absence outcome
Turner (1982)	Narrative synthesis with return to work outcome
White, Beecham & Kirkwood (2008)	Narrative synthesis with return to work outcome

meaningfully compared for all outcomes. Forest plots were included where more than one set of odds ratios or standardised mean differences were available. Appropriate methods of data synthesis were then assessed. The method of synthesis chosen for each study is summarised in Table 2.

2.3.3.1 Studies with a return to work outcome

Six studies reported return to work outcomes; however, four of these did not use a control group. Two studies had data that could be used to calculate odds ratios and these were entered into a forest plot (Figure 3) and heterogeneity was tested. A very high degree of heterogeneity was found between these studies ($I^2 = 92\%$) and therefore these studies were included in a narrative synthesis of the evidence.

Figure 3: Forest plot of return to work studies

Study or Subgroup	CBT Events	Total	Control Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Kendall & Thompson 1998	47	81	92	102	78.1%	0.15 [0.07, 0.33]
Lindell et al 2008	24	41	24	44	21.9%	1.18 [0.50, 2.78]
Total (95% CI)		122		146	100.0%	0.38 [0.22, 0.65]
Total events	71		116			

Heterogeneity: Chi² = 11.98, df = 1 (P = 0.0005); I² = 92%
Test for overall effect: Z = 3.54 (P = 0.0004)
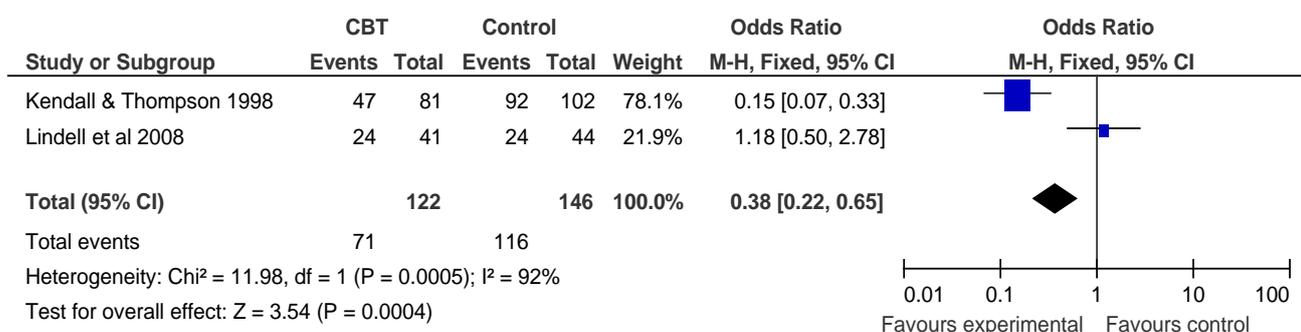
2.3.3.2 Studies with a sickness absence outcome

Eight studies measured sickness absence as an outcome. Two of these measured differences between two different CBT interventions without a further control group and only reported data graphically, therefore these

were not included in the forest plot (Jensen et al., 1995; Jensen et al., 1997). The other studies used control groups receiving usual care, no intervention or waiting list control. These studies were entered into a forest plot (Figure 4) and heterogeneity was tested. Heterogeneity in these studies was found to be low (I^2 = 10%). Johansson et al.'s (1998) study may not have a reliable outcome as measured by standardised mean difference as the control group had a lower level of sick leave at baseline (52% versus 84%) and actually found a small drop in sick leave in the intervention group and a small rise in the control group whereas the standardised mean difference appears to slightly favour the control group. When this study was excluded from the analysis, heterogeneity dropped to 0%.

Figure 4: Forest plot of studies with sickness absence outcomes

	CBT			Control				Std. Mean Difference	Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Jensen & Bodin 1998	9.7	9.5	67	8.8	10.5	28	11.0%	0.09 [-0.35, 0.53]	
Jensen et al 2005	542	446	49	572	424	48	13.5%	-0.07 [-0.47, 0.33]	
Johansson et al 1998	80.4	34.8	21	59.6	42.5	21	5.6%	0.53 [-0.09, 1.14]	
Lindell et al 2008	431	27	63	431	24	62	17.4%	0.00 [-0.35, 0.35]	
Marhold et al 2001	49.4	17.4	18	53.7	10.5	18	5.0%	-0.29 [-0.95, 0.36]	
Schweikert et al 2006	11.4	28.9	161	16.8	34.1	182	47.5%	-0.17 [-0.38, 0.04]	
Total (95% CI)			379			359	100.0%	-0.06 [-0.21, 0.08]	

Heterogeneity: Chi² = 5.53, df = 5 (P = 0.35); I² = 10%
Test for overall effect: Z = 0.87 (P = 0.39)

-100 -50 0 50 100
Favours experimental Favours control

One of these studies was conducted in Germany (Schweikert et al., 2006) and the remainder took place in Sweden. Differences between countries in treatment protocols; health, work and insurance policies and in cultures may introduce heterogeneity in participant groups. Therefore, a meta-analysis

was conducted on a subgroup of four studies conducted in Sweden (Jensen & Bodin, 1998; Jensen et al., 2005; Lindell et al., 2008, Marhold et al., 2001). Johansson et al.'s (1998) study was excluded due to the unreliability of the standardised mean difference. The excluded studies were included in a narrative synthesis of the evidence.

2.3.3.3 Studies with an outcome in hours worked

Two studies reported a change in hours worked as an outcome. One of these studies had no control group, the other used a waiting list control group in the short term and a relaxation control group which was followed up long-term. These studies are summarised in the narrative synthesis of the evidence.

2.3.4 Effectiveness of interventions

Overall little good quality evidence was found that suggested CBT Pain Management affects vocational outcomes in chronic pain patients. Data was synthesised using a meta-analysis on a subset of studies and narrative synthesis of the overall evidence. Evidence is considered according to the quality of the studies.

2.3.4.1 High and adequate quality evidence

A meta-analysis was conducted on a subgroup of four studies from Sweden. The results are shown in Figure 5. The results show no evidence that CBT

pain management decreases sickness absence in chronic pain patients in Sweden and are consistent between studies. All four studies were rated as being of adequate quality and one as good quality (Jensen et al., 2001; 2005).

Figure 5: Meta-analysis of Swedish studies with sickness absence outcomes

Study or Subgroup	CBT Mean	SD	Total	Control Mean	SD	Total	Weight	Std. Mean Difference IV, Fixed, 95% CI
Jensen & Bodin 1998	9.7	9.5	67	8.8	10.5	28	12.3%	0.09 [-0.35, 0.53]
Jensen et al 2005	542	446	49	572	424	48	15.1%	-0.07 [-0.47, 0.33]
Lindell et al 2008	431	27	63	431	24	62	19.5%	0.00 [-0.35, 0.35]
Marhold et al 2001	11.4	28.9	161	16.8	34.1	182	53.1%	-0.17 [-0.38, 0.04]
Total (95% CI)			**340**			**320**	**100.0%**	**-0.09 [-0.24, 0.07]**

Heterogeneity: Chi² = 1.45, df = 3 (P = 0.69); I² = 0%
Test for overall effect: Z = 1.13 (P = 0.26)

Std. Mean Difference IV, Fixed, 95% CI
-100 -50 0 50 100
Favours experimental   Favours control

Five studies which were not included in the meta-analysis were rated as being of good or adequate quality (Schweikert et al., 2006; Johansson et al., 1998 - Studies 1 and 2; Jensen et al., 1997; Turner, 1982). Turner's study found a significant increase in the number of hours worked in the CBT group compared to a relaxation control group. The other studies looked at differences in sickness absence between patients who had received CBT pain management and a control group. Schweikert et al. and Johansson et al. used control groups who had not received an intervention. Schweikert et al.'s high quality study found that the intervention group had slightly fewer mean sick days (11.4 versus 16.8) but neither paper reported statistically significant differences between the control group and intervention groups in sickness absence. Jensen et al. (1997) compared two different CBT

interventions. They found a reduction in sick leave in both groups post intervention, but no significant difference between groups. However, as there was no non-CBT control group, it is difficult to assess the effect of the intervention on sickness absence. Lindell et al.'s (2008) study included a measure of return to work which was not included in the meta-analysis. They found no significant difference between intervention and control groups in the percentage of patients who returned to work. Overall, most studies of high and adequate quality did not find evidence that CBT pain management improves vocational outcomes. The exception was Turner (1982) who found a significant increase in hours worked.

2.3.4.2 Poor quality evidence

Poorer quality studies found mixed evidence of the effectiveness of CBT on vocational outcomes. Of the six poor quality studies included, two studies included a control group (Jensen et al., 1995; Kendall & Thompson, 1998). Jensen et al.'s study compared two CBT interventions without a further control. Kendall and Thompson found an increase in the number of participants who were working following intervention (from 17.2% to 38.3%) whereas no change was found in the waiting list control group. However, no statistical analysis was reported. Jensen et al. found no significant difference between the two groups in sickness absence rates. Both intervention groups showed a similar pattern of absence with a rise in sick leave immediately following intervention, followed by a drop. However, as there was no non-CBT control group, it is difficult to assess the effect of the intervention from this data. Four studies looked at work outcomes following

intervention but with no comparison group (Corey et al, 1987; Dunstan & Covic, 2007; Richardson et al., 1994; White et al., 2008). Dunstan and Covic found a drop in the number of patients classed as unfit for work following intervention, however, the numbers included in this study were very small (n=30) and although the drop was 10%, this was only 3 patients. The other three studies all found an increase in the number of participants working post intervention compared to before. However, in the absence of a control group it is not possible to know whether this increase is due to intervention or is a natural progression in this patient group. The poor quality evidence overall showed an increase in work activity following intervention, but a lack of appropriate comparison groups means that there is not sufficient evidence to conclude that this was a result of intervention.

2.3.4.3 Overall evidence

Overall, there was not sufficient evidence to suggest that CBT pain management interventions improve vocational outcomes in chronic pain patients. Most studies of good or adequate quality showed no effect of intervention. Studies of poor quality did not have adequate control groups and therefore no firm conclusions can be drawn on the effects of these interventions. Good and adequate quality studies were mainly conducted in Sweden, with the exception of two (Turner, 1982; Schweikert et al., 2006), which calls into question the generalisability of the results.

2.4 Discussion

The systematic review of the evidence for the effect of CBT pain management on vocational outcomes in chronic pain patients did not find sufficient evidence that intervention is effective in these patients. Better quality studies were fairly consistent in finding no effect of intervention, however, they were mainly conducted in Sweden. Of the two exceptions to this, one found an increase in hours worked following intervention (Turner, 1982). There are a number of possible reasons for the lack of intervention effect. Previous research may give some explanations, however, more reviews and future research are needed to identify the types of pain management interventions which work for which patients and on which outcomes.

Previous systematic reviews have suggested that multidisciplinary pain management interventions are effective at improving work outcomes (e.g. Flor et al., 1992). Therefore, it may be that more complex interventions are required, which may or may not include CBT. There is a lack of research comparing different multidisciplinary interventions. Only one of the included studies in this systematic review compared more than one multidisciplinary intervention (Jensen et al., 2001; 2005). This study found that a combination of CBT and physiotherapy intervention was effective at decreasing sick leave in women. However, the effective intervention was more intensive than the alternatives and this may have affected the outcome. Further reviews of the evidence which compare different types of multidisciplinary intervention would be welcome. However, with poor reporting of

interventions (Eccleston et al., 2009) and a lack of consistency in the operationalisation of CBT interventions (Turner & Jensen, 1993), this may be difficult to do in practice.

Chronicity of pain may be a factor in patients being able to return to work. One of the studies included in this systematic review found a positive effect of intervention for patients with subacute pain on return to work and sickness absence (Lindell et al., 2008), whereas no effect was found for chronic pain patients. Similarly, Schaafsma et al.'s (2010) systematic review of workplace interventions found more evidence of effectiveness for patients with subacute pain. Similarly, another study included in this systematic review found that patients with short-term absence showed a drop in sick leave following intervention, whereas no difference was found for the patients with longer absence prior to intervention (Marhold et al., 2001). Therefore, interventions may be more effective at an earlier stage.

The fact that so many factors are involved in return to work suggests that making comparisons between interventions done in different countries may be problematic. Therefore, the reliance of this review on evidence from Sweden may not give a balanced view of the effectiveness of CBT interventions for chronic pain elsewhere in the world. Absence from work is a complex and multi-faceted phenomenon without a single cause and therefore interventions may need to address multiple factors to aid return to work (Flor et al., 1992). It is possible that CBT pain management is not

sufficient for changing work outcomes since there are likely to be many different factors involved in decision-making about work, in fact, illness-related factors; workplace factors; individual differences; beliefs and financial factors are all predictive of return to work (e.g. D'Amato & Zijlstra, 2010). Given the number of factors involved, it appears that decisions about work are complex and therefore interventions which simply focus on reductions in pain or disability may be too narrow.

The results of the present systematic review reinforce the conclusions from the literature review that reducing absence is a complex and multi-faceted issue, and despite some progress in identifying the interventions which are most effective, many questions still remain. Given the complexity of the factors involved in return to work as well as the fragmentary nature of the research in the area and underdevelopment of theory highlighted by the literature review, it is clear that further research is needed. Many studies have investigated predictors of return to work, however, little is known about how individuals with health conditions make decisions about attending work. This research aims to explore the ways in which employees make decisions about taking sickness absence and returning to work and the factors which may help employees to limit their absence. The present review has addressed one aspect of this: investigating the factors which help employees to reduce their sickness absence by focusing on one type of intervention (CBT pain management) for improving vocational outcomes. Study 2 will build on this understanding and will address the entire research

question, focusing on both how employees make decisions about attending

work and on factors which help employees to remain in or return to work.

Chapter 3

Study 2: Experiences of sickness absence among NHS staff: a grounded theory analysis.

Introduction and Methodology

_____

3.1 Introduction

Study 2 explored how employees make decisions about taking sickness absence and returning to work and the factors which may help them to limit their absence from work. A grounded theory approach was chosen for the study. This chapter will provide a rationale for the use of grounded theory and the specific approach used (Charmaz, 2006) and a description of the methods employed.

3.2 Introduction to grounded theory and rationale

The literature reviewed in chapters 1 and 2 identified that the factors associated with absence from work are complex and operate at multiple levels, whereas theories aimed at explaining sickness absence are underdeveloped (Kristensen, 1991). Research on sickness absence now needs to move towards building theories which can further our understanding of this complex phenomenon. Given the fragmentary state of

the current research, the most appropriate starting point for understanding absence is an exploratory approach.

Early research in the field of sickness absence tended to focus on absence from the perspective of the employer, particularly on voluntary or non-genuine absence, which is conceded even by employers to make up only a minority of total absence (CBI, 2011). This is likely to have hampered the development of a rich understanding of absence by its narrow focus and by perpetuating a common lay belief that absence is a deviant behaviour (Patton & Johns, 2012), leading to a lack of transparency and honesty from employees and employers about sickness absence (Johns, 2003). However, qualitative research on absence and return to work, often focusing on the perspectives of employees, has become more widespread over the last fifteen years (e.g. Barnes et al., 2008). This approach has allowed beliefs about absence to be explored in depth (Barnes et al., 2008). Some new insights on the aspects of absence which are important to employees have been gained from this research, for example, the importance of the moral aspects of absence (Wynne-Jones et al., 2010). However, there are still a limited number of qualitative studies in the area and those that exist have tended to present only descriptive themes, rather than moving on to explanation of their findings (e.g. Barnes et al., 2008). There is a need therefore for qualitative research to move from description to more complex analyses with greater explanatory power.

The lack of adequate theory in the field of sickness absence also suggests that there is a need to move towards developing explanatory models of absence from work (Kristensen, 1991). Traditional theories are based on a deductive model and aimed at generating and testing hypotheses (Glaser & Strauss, 1967). There is an alternative method, however - grounded theory is an inductive approach to theory building (Strauss & Corbin, 1990). It is assumed that "it makes no sense to start with received theories or variables (categories) because these are likely to inhibit or impede the development of new theoretical formulations" (Strauss & Corbin, 1990, p50). Since existing theories of absence have not been successful (Alexanderson & Hensing, 2004), new insights and interpretations are more likely to be generated using an exploratory, inductive approach (Strauss & Corbin, 1990). It is known that the beliefs of employees are important in predicting absence and return to work, and therefore the beliefs of individuals about health and work will need to be included in explanatory frameworks (Kristensen, 1991). A grounded theory methodology has the potential to explore the beliefs of employees and include them in a theory which aims to be 'grounded' in (or abstracted from) the data. The method is systematic and includes a number of key components such as simultaneous data collection and analysis; constructing theory from the 'bottom up', rather than from pre-existing hypotheses; using constant comparison of data, codes and categories; memo-writing to aid theory development; theoretical sampling (aimed at aiding the construction of theory) rather than representative sampling and delaying of the literature review until after the data analysis. It should be noted that 'theory' in this context should not be

seen as referring to a formal theory with testable set of hypotheses, but rather a complex analysis of data within a specific context, which provides an explanation of the phenomenon being studied (Birks & Mills, 2011).

The conception of absence as a deviant behaviour (Johns, 2003) presents difficulties for research in the field. Asking individuals about their absence from work could trigger defensive reactions, since there is a social pressure to only take absence when 'genuine' (Barnes et al., 2008). It is therefore important to research this topic in a way which is non-threatening and which provides reassurance to participants. Grounded theory was developed by Glaser and Strauss (1967) while they were researching dying in hospital, and since then has been used to study other sensitive topics such as chronic illness (Charmaz, 1983) and living with HIV (Kylmä, Vehviläinen-Julkunen & Lähdevirta, 1999). It therefore has the potential to contribute to the understanding of sensitive topics where participants may fear being stigmatised or judged (Kylmä et al., 1999). However, this depends on a careful consideration of the ethical issues involved and the specific ways this issue was addressed in the present study will be described in sections 3.4 and 3.5.6.

For the reasons described, it was decided that a grounded theory approach was most appropriate for this study. However, a previous grounded theory study of sickness absence has been conducted (Thulesius and Grahn, 2007). The authors conducted interviews with working and sick-listed

individuals, health professionals and employees of the Swedish social insurance agency and conducted secondary analyses of interviews with Swedish and American employees. They argued that work attendance is promoted by 'drivers', a combination of work capacities (health, education, etc.) and work incentives (e.g. wages, sick leave compensation). They suggested that these 'work drivers' could become 'hurt' through illness or a change in incentives, leading to absence. They argued that individuals may become 'trapped' in absence and 'reincentivising' was then needed to help them return to work by 'repairing' the 'hurt work drivers'. This theory focused mainly on procedures and ways of encouraging people to go back to work. It did not focus on the experience of the employees, and only reported three quotations from workers or sick-listed individuals. In fact, although more quotations were included from doctors and insurance agency employees than workers, the analysis was not convincingly 'grounded' in the data, with many of their categories not being backed up by quotations at all. This grounded theory analysis is therefore unlikely to provide a coherent summary of the experience of sickness absence. Additionally, it was mainly based on Swedish workers. Therefore, conducting a second grounded theory of sickness absence seemed appropriate.

In contrast to the previous grounded theory analysis, the present study focused only on the experiences of employees, rather than the perceptions of others, since the absence of others is commonly perceived as deviant (Patton & Johns, 2012) and individuals seemed best placed to comment on their own reasons for absence. The grounded theory approach was chosen

to ensure that the present study went beyond the existing descriptive qualitative accounts to develop an explanatory model of the sickness absence process which explored how individuals who were absent from work due to illness or injury understood and managed their health and absence from work.

There are several different approaches to grounded theory which vary according to the exact steps used to code the data and the epistemological assumptions of the researcher (e.g. Glaser, 1992; Strauss & Corbin, 1990). Charmaz's (2006) approach was used since it provides a clear but simple and flexible set of procedures for coding. However, insights and advice from other thinkers on grounded theory were also used where these aided the analysis, for example, Birks and Mills (2011) have set out clear quality criteria for grounded theory, which were used to improve the quality of the analysis.

3.3 Procedures to ensure rigour

Quality in grounded theory can be influenced by many factors, the most important of which were considered to fall under one of three categories by Birks and Mills (2011): researcher expertise, methodological congruence and procedural precision. The procedures for ensuring rigour in the present study are described using these categories.

3.3.1 Researcher expertise

Prior to this study, I did not have any experience of conducting grounded theory. Therefore, I needed to develop as much expertise as possible in order to improve the quality of the research. I attended training on grounded theory as well as reading a number of key texts. However, in line with Stern (2007), I found that my understanding of grounded theory mainly grew through the process of interviewing and analysis. Whilst I was a novice grounded theory researcher at the beginning of the process, and this is likely to have resulted in more mistakes along the way, Corbin and Strauss (2008) also identify the importance of personal characteristics such as self-awareness and commitment to hard work as conditions which foster quality in grounded theory. I have attempted to take on these personal characteristics by regularly putting aside time to work on the analysis and increasing my self-awareness via reflection, memoing and field notes as described later in this section.

3.3.2 Methodological congruence

Methodological congruence occurs when there is correspondence between the personal philosophical standpoint of the researcher; the aims of the research and the methodological approach employed. It has already been argued that the use of grounded theory is appropriate for the aims of the research. However, I also needed to reflect on my epistemological and ontological assumptions in order to ensure that these were in line with the approach I had chosen. My position is best described as a critical realist perspective which assumes that an external reality does exist which is

independent of thought and language, whilst acknowledging that there is a discrepancy between our understanding of the world and the world itself (Danermark, Ekström, Jakobsen & Karlsson, 2002). Therefore, all knowledge is viewed as imperfect and open to amendment, however, not all interpretations are equally valid. I assume that the analysis is my own interpretation of the data and that my own experiences and beliefs inevitably affected how I approached the analysis. However, I also assume that it was possible to remain close and faithful to the data so that the analysis remained 'grounded' in the participants' experiences. Different approaches to grounded theory exist, conducted within different philosophical paradigms. For example, Corbin and Strauss (2008) describe their work as being underpinned by pragmatism and symbolic interactionism whereas Charmaz (2006) described her approach as contructivist. Glaser has been described as taking a critical realist stance (Annells, 1996). It therefore seemed appropriate to conduct grounded theory within a critical realist paradigm. However, whilst Glaser seemed philosophically closer to my own position, the methods that he described (e.g. Glaser, 1992) did not seem to provide the clearest description of how to carry out a grounded theory. In addition, I disagreed with some of his advice (for example that interviews should not be recorded but analysis of them should depend on field notes). The method described by Charmaz (2006) provided a clearer set of steps for carrying out an analysis although the philosophical position of the author is different to mine. However, she argues that the grounded theory method is essentially neutral and "can bridge traditional positivistic methods with interpretative methods" (Charmaz, 2004, p499). Therefore, it was concluded

that it was appropriate to use Charmaz's approach, despite the differences in epistemology.

3.3.3 Procedural precision

The rigorous application of grounded theory methods is the main driver of research quality. This includes managing data and resources; maintaining an audit trail and demonstrating procedural logic (Birks & Mills, 2011). A description of how data was managed and analysed is included in the sections on data management and analysis. Decisions about data management were made based on ethical considerations around protecting participant confidentiality as well to aid analysis. Different approaches were used as needed, for example, for open coding, I found qualitative data management software cumbersome. Therefore at this stage, I coded using a simple table in Microsoft Word which was spilt into three columns: one for the transcript, one for codes and another for memos to note my initial ideas. I added a column and used a similar procedure for focused coding (see Appendix 6). However, at the later stages of analysis, I found the use of NVivo qualitative data management software invaluable as I was able to more easily compare codes and data and therefore refine my analysis.

A record of my research activities and reflections was included in a research diary. This included my memos. Memos are the most important driver of analysis and therefore quality within a grounded theory study. They are the process by which data and codes are analysed early in the research

process and allow analysis to become more abstract and complex (Charmaz, 2006). Memos are therefore the method by which theory is built to a conceptual level from the initial codes. My initial ideas about the analysis were noted in memos next to my codes. More complex memos were included in the research diary. These memos included my reflections on my philosophical position; my impressions and feelings about the interviews and research process; decisions about procedure and analysis; ideas about codes and categories and their relationships to one another, including diagrams and quotations. This diary was written by hand and was carried with me where possible. An example of a memo from this research diary is included in Appendix 7.

Procedural logic was maintained by closely following the grounded theory methods described by Charmaz (2006) although there were some difficulties with this which are described in the section on limitations. One of the keys to maintaining this adherence to the methods was maintaining a balance between working with the raw data from the participants and the more abstract levels of analysis. This was aided by the use of NVivo which stored all the relevant quotes in one place under a code and allowed codes to be clustered under more complex categories. I was also careful to include data in my theoretical memos to prevent them becoming too far removed from the data.

3.4 The impact of the role of the researcher

During data collection and analysis, I was working for the 'Worksure' employee assistance programme, which provided self-management advice to NHS employees with health conditions who were working for Cwm Taf Health Board in South Wales. I worked as a case manager, providing advice and support via telephone to employees. Employees were mainly referred to this service by their managers although some self-referred. Most employees were absent from work at the time they were contacted by Worksure. The research was conducted with employees within the same health board and therefore there was the potential for a conflict of interest and boundaries in doing both these roles. Therefore, measures were put into place to minimise this conflict. Firstly, employees who had previously received case manager advice and support from me were excluded from the study. It was also agreed with the managers of Worksure that participants who required future case manager support would be assigned a different case manager.

The development of a grounded theory requires the researcher to put aside preconceptions about the topic of study to an extent, since the theory is built from the data collected (Glaser, 1992). My role in Worksure meant that there was the risk of the analysis being overly influenced by preconceptions about sickness absence based on the work role rather than the data collected. Therefore, it was decided that the recording of interviews was important (whereas Glaser [1992] advises relying on field notes from interviews). The recording of interviews added to a robust audit trail as well as acting as a check to any preconceptions.

My association with the Worksure service may have led to defensiveness on the part of the participants and therefore this increased the need to reassure participants of their confidentiality; their right to withdraw from the study at any time and the fact that their taking part would have no impact on their job. The participants were given this information in writing in the participant information sheet and verbally prior to interview. The interviewees were given the option of where they would prefer the interview to be held, which could be at their place of work or at another venue. This allowed participants greater control over the interview and allowed them to choose a venue where they felt comfortable. I attempted to put participants at ease by ensuring that information was fully explained and by beginning the interview with more non-threatening, generic questions, prior to asking more personal questions about the participants' experiences of absence. Although the influence of my role could not be eliminated, these measures aimed to limit any negative effects on the research.

3.5 Methods

3.5.1 Participants

Participants were NHS staff working for Cwm Taf Health Board which covers the Merthyr Tydfil and Rhondda Cynon Taff areas of South Wales. This area has the highest number of deprived local areas in Wales; the lowest life expectancy in Wales and the highest number of emergency hospital admissions (Public Health Observatory for Wales, 2010). NHS employees in this area are likely to be affected by some of the health

problems experienced by the local population and the increased risks of ill health which affect NHS employees in general and has consistently had sickness rates above the average for NHS Wales since its creation in 2009 (Health Statistics & Analysis Unit, 2013).

Initially, potential participants were identified from a database used by the Worksure service (see section 3.4 for a description of the service). Grounded theory includes using a theoretical sampling strategy, and the initial aim of the sampling strategy was to recruit a diverse sample in terms of health condition, age, gender, length of sickness absence and type and area of employment in order that the experiences of a varied range of employees were included to aid theory development. Following initial interviews, it was planned that employees with specific characteristics could be sought to further develop the theory (Charmaz, 2006). However, a low response rate to the letters sent led to a different recruitment strategy being used to recruit additional participants. An advert was placed on the health board's intranet site and several of the participants were recruited via this method (see section 3.6 for a summary of how participants were recruited and section 5.5 for a discussion of the implications of these recruitment problems the grounded theory).

Inclusion criteria were that participants had to be employees of Cwm Taf Health Board who had been referred to the Worksure service by their

manager or had self-referred between July 2011 and March 2012. All causes of absence were included. Exclusion criteria were having received case management support from the researcher (see section 3.4 for a rationale); being absent under infection control policies, since these employees had no choice about taking time off; taking absence of fewer than 5 days, as it was assumed that these individuals would have less to say about their experience of sickness absence. Employees who remained absent from work at the time of recruitment were excluded to avoid participants feeling pressured to return to work and to ensure that the experience of returning to work could be discussed. However, this limited the model to being applicable only to those employees who return to work.

Eighteen participants were interviewed. Table 3 summarises demographic information from the participants and causes of absence. More women than men were interviewed, however, the proportion of men in the sample was slightly higher than within the health board as a whole (28% of interviewees versus 20% of health board staff). More than 18 absence causes are listed due to some participants discussing more than one period of absence or more than one cause of a single period of absence.

Table 3: Demographic information

Participant (n=18)

Gender	
Male	5
Female	13
Age	
Range	35-59
Mean	49
Staff group	
Clinical: registered	
Registered nurse/midwife (non-manager)	4
Medical	1
Clinical: non-registered	
Clinical support (e.g. healthcare assistants)	3
Non-clinical: non-management	
Facilities and estates (e.g. porters, cleaners, electricians)	3
Administrative and clerical	3
Specialist support (e.g. HR, Health and Safety)	1
Management	
Clinical (e.g. ward manager, senior nurse)	1
Non-clinical management	2
Causes of absence	
Physical	
Musculoskeletal	6
Planned surgery	4
Ear, nose and throat problems	3
'Flu-like illness	2
Oral/dental problems	1
Endocrine problems	1
Gynaecological problems	1
(Industrial Injuries)	*(3)*
Mental Health	
Stress/anxiety/depression	8
(Work related)	*(5)*
Psychosis/serious mental health condition	1

3.5.2 Interview Schedule

A semi-structured interview schedule was developed. Whilst the research

aimed to be exploratory, the reviewed literature provided important context

and therefore broad themes were identified from the literature and questions were developed from these themes. Identified themes were the social and cultural nature of absence (see sections 1.10 and 1.12 for a review of the relevant literature); beliefs about health and work (see section 1.12); how employees negotiate and make sense of the wide range of factors which are related to absence and return to work (see sections 1.9 and 1.12) and how employees use support to manage their absence and return to work (see section 1.6). A balance was sought between building structure to the interview (informed by previous research) in order to keep the interview focused on the topic, and the potential for spontaneity so that unexpected avenues could be explored (Kvale & Brinkmann, 2009, p131). A structured set of questions was developed, however, this was used flexibly within the interview and was simplified as the interviewer became more experienced.

From the identified themes, questions were developed. Since it was not known how comfortable the participants would be discussing their experiences, the early questions aimed to be non-threatening and put participants at ease. The schedule therefore opened with a general question about why people take sickness absence. This question was included as a non-threatening opening and also to explore perceptions of social norms around absence. A further question was included on the perceived views of others regarding absence to further explore the social and cultural nature of absence. The next questions asked about the experience of illness and the effect on work ability. These questions were included in order to explore

beliefs about health and work whilst being broad enough to elicit information which was not expected. A further question was included about the factors which are important in deciding to take sickness absence, in order to explore how the many factors which predict absence are understood by employees. The final questions asked about support that was received and additional support that would have been helpful.

The interview schedule was trialled with a member of staff from Cwm Taf Health Board who gave feedback on the questions. From the feedback, no questions were added or deleted but the wording of some of the questions was changed to make them clearer. For example, the initial question, 'What does someone needed to take into account when deciding whether they should go to work?' was reworded as, 'What type of things do you think someone needs to take into account when deciding whether they are fit to go into work?' The interview schedule was amended several times during the study as theoretical concepts began to emerge from the early interviews (see Appendix 5 for an example of an interview schedule from the start of the research process and one from near the end).

3.5.3 Procedure

Letters inviting employees to take part in the research were sent to 263 potential participants, along with an information sheet, consent form and response form. A reminder letter was sent to each employee approximately

four weeks later (excluding four participants whose original letters had been returned as undeliverable due to incorrect addresses). Ten employees responded to these invitations and took part in the study (see Figure 7). Due to the low response rate, an advert was placed on the Cwm Taf Health Board intranet site asking employees who were interested in taking part in the study to contact the researcher. A further 13 employees responded to the advert. Of these, eight were included in the final sample, but three did not respond to further contact and two withdrew prior to interview due to personal circumstances and time constraints (see Figure 8). The change of sampling strategy has implications for the building of theory, and the implications of this are discussed in section 5.5. It is difficult to assess which groups may not have responded to the invitation to take part in the study. The research and its association with the health board may have been viewed as too threatening to take part in. In this case, we would have expected to be missing employees who took absence due to reasons which were more sensitive or viewed as stigmatising. However, the participants included nine employees reporting stress or mental health conditions, which might be viewed as some of the most stigmatising conditions. Conversely, many employees may view themselves as taking little absence, due to the tendency for individuals to underestimate their absence from work (Johns, 2003). Therefore, the majority of employees may have simply seen the research as not being relevant to them and those who took part may have therefore had specific reasons to do so, for example, a long period of absence, a chronic condition or a bad experience with a manager.

Figure 6: Flow chart of recruitment by letter

- 263 letters sent to employees
  - 4 letters returned as undeliverable
  - 8 responses
    - 8 took part in interview
  - Reminder letters to 251 employees
    - 2 responses
      - 2 took part in interview

Figure 7: Flowchart of recruitment from advert

- Advert on intranet site
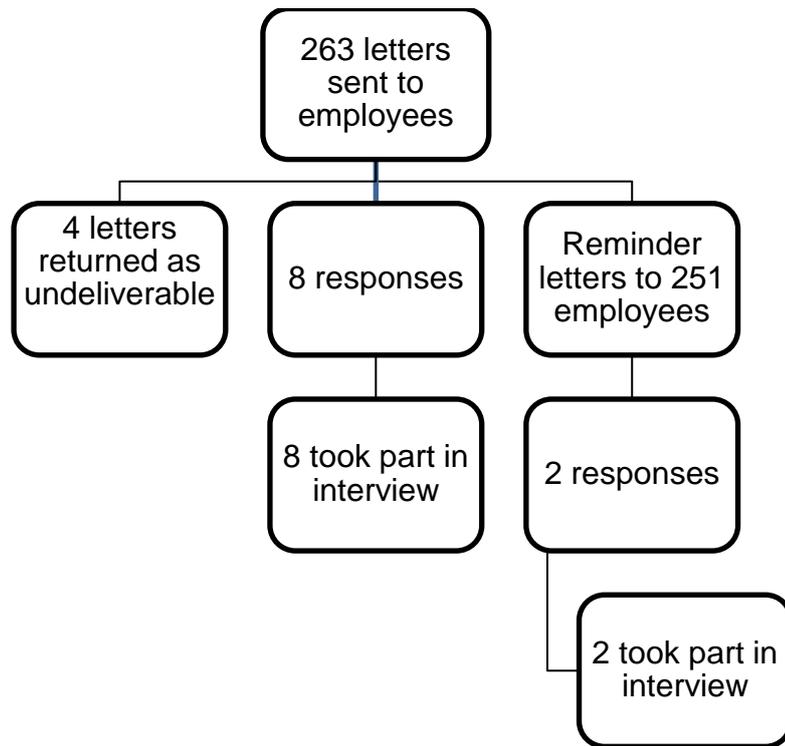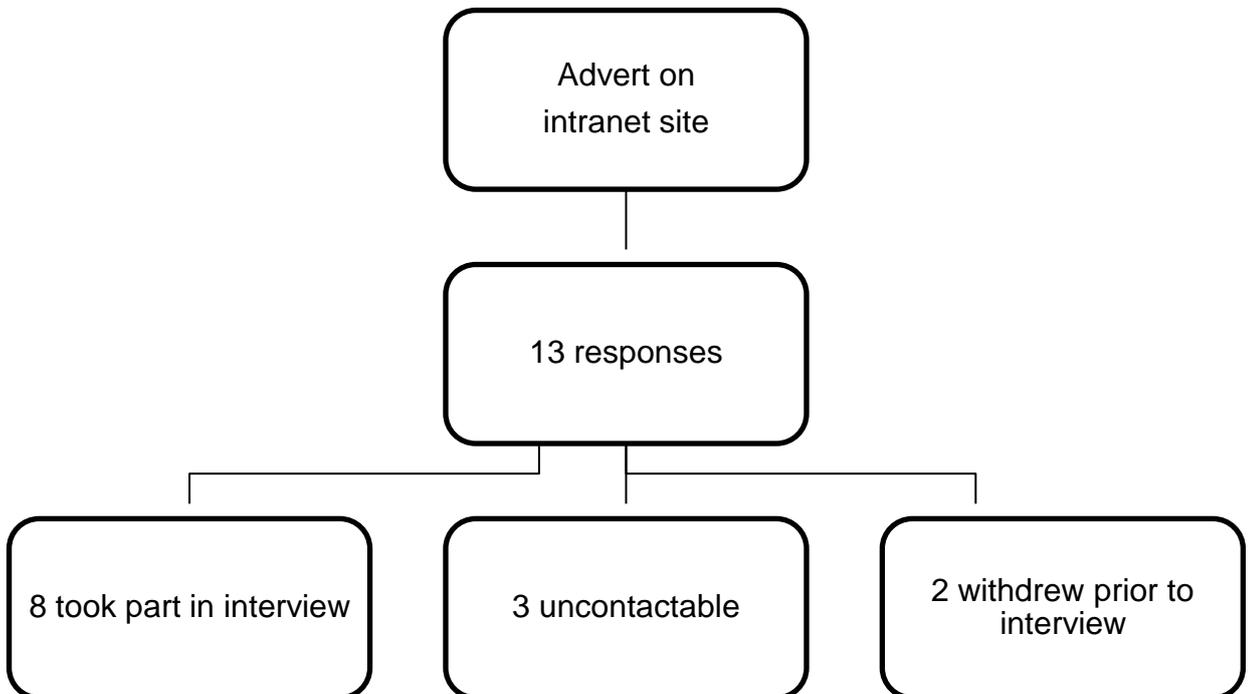 - 13 responses
    - 8 took part in interview
    - 3 uncontactable
    - 2 withdrew prior to interview

Participants were invited to take part in an interview. Interviews were either held at the participant's place of work (n=9) or at another hospital or office within the health board that was convenient to them (n=9). Participants chose the venue in order to allow them maximum convenience and comfort. However, the fact that the interviews often took place in the workplace or another health board site may have increased the level of defensiveness shown by the interviewees. Interviews followed a semi-structured format and lasted between 30 minutes and 1 hour 15 minutes. Semi-structured interviews were used to allow the interviewee to introduce topics that are important to them and so that the interviewer was able explore certain topics more deeply, whilst keeping the interview within the bounds of the topic. The interview schedule was adapted throughout the process as concepts began to emerge from the interviews (see appendix 5 for example interview schedules). All interviews were conducted by the researcher. They were tape recorded and transcribed verbatim by the interviewer within 21 days of the interview. Field notes documenting the researcher's impressions and responses were written by the researcher following each interview. One interview failed to record and therefore no transcription could be made. The researcher therefore made detailed field notes and entered these into the analysis since the interview comprised part of the process of theory generation.

3.5.4 Analysis

Analysis was undertaken using Charmaz's (2006) approach. Initial analysis was done using Microsoft Word. Early interviews were coded line by line and from these codes, focused codes were developed to code larger amounts of data. Memos capturing the researcher's initial impressions and ideas about the coding were written in tandem with the line by line and focused coding. An excerpt of one interview with open codes (line by line), focused codes and memos is included in Appendix 6. More complex theoretical memos were developed, which began with initial ideas and questions about categories and developed to fuller explanations of categories and the relationships between them. The theoretical memos incorporated raw data from the interviews as well as the researcher's interpretation of the data, developed from field notes and initial memos. An example of a theoretical memo on "genuine illness" is included in Appendix 7. NVivo software was used to aid later coding. Focused codes developed via the initial coding by hand were entered into NVivo. This allowed for the codes and the associated data to be easily compared. The focused codes were clustered to form larger categories, using a process of constant comparison of the data, codes and categories, and refining of the theory through ongoing memo writing. The categories were compared to one another and to the data and the relationships between them considered until a model of absence and return to work was developed. Data collection ended when sufficient data had been collected to build a comprehensive theory of sickness absence (Morse, 1995).

3.5.5 Data management

Interviews were transcribed using a code number for each participant to protect confidentiality. Confidential data including recordings were stored in a locked filing cabinet at the Worksure offices. These were later moved to a locked cabinet at Cardiff Metropolitan University since the Worksure service was disbanded in April 2013. Confidential data held electronically was password protected and stored in files on a Worksure computer. Following the dissolution of the service, these files were deleted from the Worksure computers and stored on a computer at Cardiff Metropolitan University. Any information that was removed from the office on memory sticks or in hard copy was anonymised. As precautions for data on memory sticks or in hard copy being lost or misplaced, information on memory sticks was password protected and did not contain personally identifiable information such as names or addresses. No confidential data was sent via networks. All information kept in hard copies was anonymised with the exception of consent forms. Completed consent forms were retained by the researcher and placed in a locked filing cabinet in the Worksure offices as soon as possible following the interview. These forms are now held in a locked filing cabinet at Cardiff Metropolitan University and will not be removed until they are destroyed following the end of the study. There was no sharing of portable data. A short report will be written for participants and other interested parties.

3.5.6 Ethical considerations

Prior to written consent being gained, participants were assured that taking part in the research was voluntary, that they could withdraw at any point, and this would not affect their work in any way or the support they received from the Worksure service. Measures to protect confidentiality were explained and contact information for support services were provided. Ethical approval was gained from the South Wales NHS Research Ethics Committee and the University of the West of England Faculty Research Ethics Committee.

Chapter 4

Study 2: Experiences of sickness absence among NHS staff: a grounded theory analysis.

Results and Discussion

4.1 Introduction

This chapter presents the results of Study 2 which explored how employees make decisions about taking absence and returning to work and the factors which help them to limit their absence from work. A model of absence and return to work was developed. Firstly, an overview of the model will be presented followed by description of the individual categories. The findings will be discussed in relation to previous research.

4.2 Overview

A process model of sickness absence and return to work was developed (see Figure 8) which could be broken down into three main sequential stages: becoming absent, being absent and return to work. It appeared that different processes operated at each stage, rather than, for example, return to work simply mirroring the absence process. While the categories in the model are presented as occurring in a specific order, this is for the sake of clarity and parsimony. Although employees all moved through the stages of

Figure 8: Model of Absence and Return to Work

Assessing Work Ability

Considering the Consequences of Absence

Avoiding Sickness Absence

Learning and Changing

Getting Back to Normal

Becoming absent

Return to Work

Deciding to Return to Work

Becoming Absent

Negotiating Legitimacy

Barriers to Return to Work

Recovering

Navigating a Different World

Negative Impact of Absence

Feeling Supported and Connected
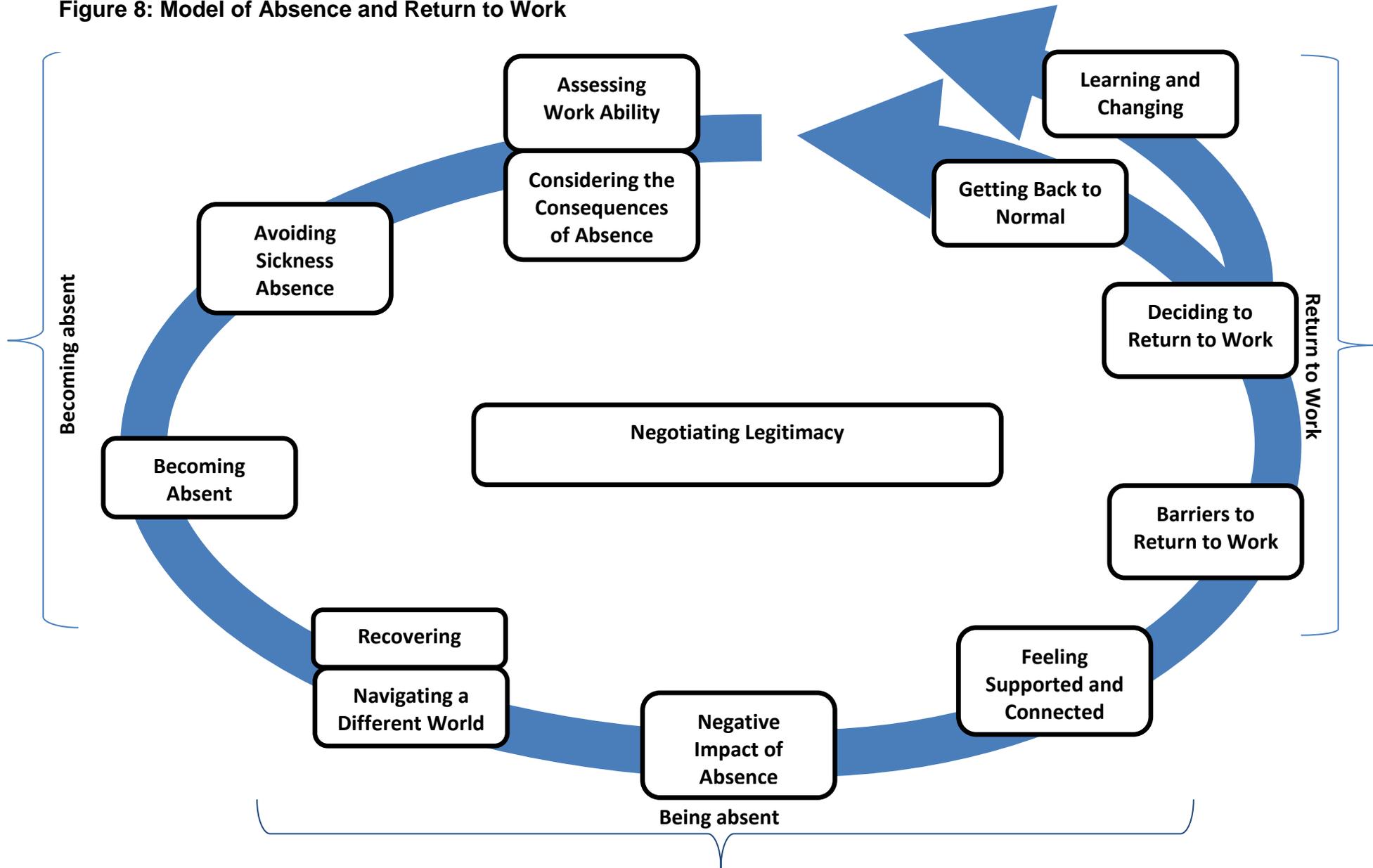
Being absent

becoming absent, being absent and return to work sequentially, the categories within each stage were interrelated. In addition, there were some aspects of the absence experience which were important at more than one point in time. For example, the idea of 'having to get on with it' was most discussed with relation to return to work and is included in this stage of the model; however, it was also associated with *Avoiding Sickness Absence*. The model should therefore be considered a simplified diagrammatic representation of a complex set of processes. The process is represented as circular since return to work is viewed as a return to normality, although sometimes the experience of absence could lead to profound change as represented by the second arrow moving past the starting position. The circular process also highlights how the experience of absence informs future absence by changing the context of future absence. For example, being absent changes the consequences of taking future absence, since disciplinary procedures are based on the number of absences taken in a given period of time.

One important feature of the model presented is the fact that return to work is not a mirror image of absence and different factors are important during the different stages. In contrast, many other models of absence (e.g. Steers and Rhodes, 1978) identify factors which lead to work absence or attendance in general, but do not distinguish between becoming absent and returning to work. The theoretical separation of absence and return to work allows absence to be seen as a process rather than a static set of circumstances. The temporal aspect of this process was important and

pressure to avoid taking absence when unwell was linked to the amount and recency of previous absence and the timing of absence in relation to what was going on at work. Similarly, the duration of absence was connected to considerations of legitimacy (the amount of time off that was seen as being reasonable) and returning to work as soon as possible was an important proof of the validity of the absence. Time was seen as a necessary aspect of the process of recovering but there was a limit to how long this could legitimately continue. The negative aspects of absence also increased with time and therefore, the costs of being absent from work tended to outweigh the benefits as the duration of absence increased. The division of absence into long- and short-term by both researchers and policy-makers highlights the implicit recognition of the importance of time in relation to absence. However, this aspect of absence has generally been ignored by theorists. A process-based model of absence is likely to be superior to a static model in explaining the changing influences of different aspects of absence over time. The current model is an important step forward in this regard.

A core category of *Negotiating Legitimacy* was identified which spanned the entire process and is shown in the centre of the model. Establishing that the absence was 'genuine' was a central concern which allowed employees to become legitimately absent from work, both from the point of view of the organisation and in the views of managers and colleagues. Employees were highly critical of those who were seen as not genuine. Absences were negotiated with health professionals and managers. This

negotiation allowed the support of the GP and manager for the absence, which was an important part of establishing legitimacy.

Stage one represents the process leading up to the employee becoming absent from work. During this stage, employees assessed their ability to work using information about their illness or injury and contextual information about work and other demands on them (*Assessing Work Ability*). A category of *Considering the Consequences of Absence* was identified, where employees considered any negative consequences that taking absence may have had on them, their colleagues or their patients. These considerations then either led directly to the absence decision, or employees first used one or more strategies for *Avoiding Sickness Absence*.

During the second stage of the process, employees were absent from work. The main purpose of this stage was *Recovering* from the illness or injury. Alongside this, employees went about *Navigating a Different World*. There were different expectations on employees during this second stage than at times when they were in work, such as behaving in a way which aided recovery and avoiding social activities. Most also had to navigate the healthcare system and workplace sickness absence procedures. For employees with little previous experience of absence or knowledge of the procedures involved, this could be a daunting and confusing experience. The amount of support received from the workplace was important in helping employees feel that they were still part of the workplace and that

they were valuable members of staff (*Feeling Supported and Connected*). The manager was a key part of this process and the support of colleagues was also important. Over time, employees were more likely to experience a *Negative Impact of Absence* as they became more distanced from work and began to lose confidence in their abilities. Some also reported feeling bored, isolated and low in mood. A lack of support from the manager exacerbated these negative effects of absence.

When there was an appropriate degree of recovery, or sometimes before where the *Negative Impact of Absence* acted to push employees back towards work, employees considered *Deciding to Return to Work,* leading on to the third stage of the model. The return to work process was sometimes delayed by *Barriers to Return to Work*, such as problems in the workplace. The decision to return to work was not always an easy one. Returning to work involved a process of *Getting Back to Normal*. This often began with a phase of reorientating where confidence was regained in the workplace. Part of *Getting Back to Normal* when in work was 'just getting on with it'. For some, the experience of absence had a long-term effect on them, resulting in them *Learning and Changing*. Changes were sometimes seen as negative, for example where confidence was never regained. Often changes were seen as positive, with employees re-evaluating their priorities or gaining empathy with others. Each category will be described in further detail.

4.3 Negotiating Legitimacy

Negotiating Legitimacy appeared to be the core category which underpinned many of the other categories. The employee attempted to show that the absence was legitimate or 'genuine' as a means of avoiding being judged by others and of being legitimately excused from work (the words 'genuine' or 'genuinely' were used 27 times in 9 interviews). It is possible that this was over-emphasised due to my role within Worksure (see section 3.4 for a description) and the participants felt they needed to justify their absence to me. However, genuine illness is the criterion that excuses the individual from having to fulfil what is normally expected of them in work (both under their formal contract with their employer and informal social contracts, for example, with colleagues). Others were sometime judged harshly for taking what was perceived as non-legitimate absence ("playing the system"), and five participants reported negative reactions to their absence from colleagues or managers, including pressure to return to work, bullying or exclusion:

> "I don't know whether {my colleagues} think that I'm trying to scam a bit of it…they don't talk to me. Only one person speaks to me."
>
> [P11, female, non-clinical, non-management]

This employee reported good relationships with her co-workers prior to a long period of sickness absence, highlighting the severe social consequences that can be experienced when others view the individual as "scamming". This suggests that the importance of establishing legitimacy was not highlighted merely due to my role. The core importance of

legitimacy in absence was also identified by the previous qualitative research in the area (e.g. Barnes et al., 2008), further suggesting that concerns about being viewed as genuinely ill are central to the experience of absence.

Despite the importance of establishing legitimacy, the criteria for genuine absence were not always clear:

> "It's also the mixed messages... if you've got a cold or 'flu stay away...but... if you have time off every time you have a sniffle ...you get sort of criticised for not being in work."
>
> [P13, female, clinical, non-registered]

Perhaps due to this ambiguity and the negative consequences of being seen as taking non-legitimate absence, the legitimacy of the absence was negotiated with others, including health professionals, managers and colleagues. This negotiation was aimed at conferring legitimacy on the absence and a number of pieces of evidence for establishing legitimacy were offered. They included a comparison with the behaviour of others; the participants' moral beliefs about absence; contextual factors; expert opinions; the lack of choice about absence and the severity of the illness. These pieces of evidence will be examined in turn.

Employees contrasted their behaviour with that of others in appealing to the legitimacy of their own absence. When participants criticised others for

taking absence which was not viewed as legitimate, they were explicit in voicing that non-serious absence was unacceptable:

"There are some that… will go on the sick for…the silliest things really. And I think, 'Oh why?'"

[P2, female, clinical, registered]

The attempts of employees distinguish between legitimate and non-legitimate absence appears to mirror attempts in the academic literature to do the same (e.g. Chadwick-Jones, Brown & Nicholson, 1973). However, these attempts could result in the bullying and exclusion reported by some participants whose absence was viewed as non-legitimate. The idea that illness needed to be serious enough to warrant absence was linked to upbringing and morality, with the avoidance of sickness being linked to positive moral values:

"I was brought up with high moral values: always get out to work and do your best, don't go sick."

[P8, male, clinical, non-registered]

The moral aspect of absence was appealed to as participants described their own absence as legitimate, often contrasting it with the behaviour of others, who would 'play the system'. The aim appeared to be to present the self as a moral, well brought up person, who would never take non-genuine absence. Phrases such as, "I am the type of person…" were frequently used, suggesting that this view of the self as a moral, hard-working person was closely related to the individual's self-concept. This can be understood within the context of the popular conception of absence

as a deviant behaviour (Patton & Johns, 2012). The participants seemed keen to distance themselves from this connotation by presenting their behaviour as beyond reproach. This was done by stressing that their absence (deviance) was temporary, out of character and unavoidable. Other pieces of evidence were presented to back up this assertion. For example, a past record of having little absence proved that the employee did not take absence lightly:

> "I've had very, very little time off sick. So I think in those circumstances, if you are off, people do realise that it's genuine."
>
> [P13, female, clinical, non-registered]

This evidence was used as confirmation of the participants' standing as a good, moral person who only takes absence when absolutely necessary. There was also an implicit assumption about the importance of time. Few absences over a long period of time established legitimacy whereas when absences came in close succession or at the 'wrong' time, legitimacy was called into question:

> "{I took absence} just as I started a new job, so I was really embarrassed about that…I thought that was terrible but…everybody was really positive, saying, 'Well, it's not your fault.'"
>
> [P9, female, clinical, registered]

Therefore, contextual factors, which are separate from the medical aspects of absence, appear to provide part of the decision making about when absence is legitimate. Patton (2011) found that workplace pressures such as tight deadlines can lead to blame and anger from colleagues,

regardless of the cause of absence. Therefore, absence which may be legitimate from a medical point of view is not always treated as such by colleagues. This highlights the conflict at the heart of absence, the conflict between being an employee who has duties to fulfil and being an ill person who can be exempted from normal duties. These conflicting roles had moral connotations –hard-working employees were seen as virtuous and deserving of praise; those who were too ill to work were seen as blameless and as deserving of support; those who took absence for minor reasons were viewed as weak and deserving of scorn and those who took absence when not ill were viewed as immoral and deserving of punishment. In response, employees tended to emphasise the severity of their illnesses when talking about their own absences but feared being seen as 'shirking' their duties.

Negotiations took place between employees, health professionals and managers, and to a lesser extent with others such as unions, colleagues and family members. In some cases, participants' reported being directly advised to take sickness absence, usually by the GP. This expert advice was used as strong evidence for the legitimacy of the absence. The GP was presented as an objective professional but also as paternalistic and directive. The individual was almost always presented as not having a choice about taking absence, and where a 'decision' was mentioned, with one exception, it was made by another person:

> "I don't think it's my fault... it actually came down to my GP who made the decision, you are not working there."

Having less choice about taking time off appeared to confer greater legitimacy on the absence. Conversely, when discussing return to work, the decision was presented as being made by the individual or as a joint decision with health professionals or managers:

"Once I was mobile, I thought, 'Right I'll be back.' And so that's how I got to that decision."

[P4, male, non-clinical, non-management]

The participants tended to present themselves as passive in the decision about taking absence, but as more active in wanting to return to work. In contrast, a qualitative study of GPs views of negotiations about sickness absence found that GPs often presented patients as demanding sick notes and in some cases having to resist these demands (Money, Hussey, Thorley, Turner & Agius, 2010). The presentation of the employees as passively accepting the pronouncements of the GPs allowed the 'blame' for absence to be attributed to health professionals whose role was not only to corroborate that the absence was genuine, but to act as authority figures, compelling employees to take time off work. This shifting of blame appeared to function as a way of avoiding judgements by others that the absence was avoidable and therefore deviant.

Negotiations became more formalised as the absence progressed, for example, with a fit note from the doctor being required after the first week

and formal meetings being held with the manager and HR representative after four weeks. When messages from the workplace conflicted with those from the health professional, participants reported distress, anxiety and ambivalence about attending work:

> "I felt pressured {by the manager}… it took me away from actually listening to what my consultant was saying because the work pressure was more."
>
> [P2, female, clinical, registered]

With the exception of those experiencing problems in the workplace, participants reported being keen to return to work and even occasionally as 'rebelling' against the GP who was advising further absence:

> "I argued with {the GP}… to say, 'Look I think I am {ready to return to work}', and he'd say, 'Well, I don't think you are'.
>
> [P7 female, clinical, non-registered]

The portrayal of the employee as keen to return to work and even as willing to flout medical advice in order to do so, appears to be given as evidence of the individual's commitment to work - a work ethic so strong that illness is stoically overcome. However, it is difficult to establish how accurate this portrayal of the negotiation is, due to the strong need of participants to present themselves as genuine.

The severity of illness was an important aspect of the legitimacy of absence. Participants' statements about the severity of their own illness tended to be implicit in the language used (e.g. "terrible", "bad", "rough"),

rather than explicit. Employees often provided long descriptions of their illness and its consequences. However, certain types of illness appeared to be viewed as more legitimate than others. Participants who reported negative reactions to their absence from managers and colleagues all experienced chronic, invisible illness, such as hearing loss, pain and, anxiety. Participants experiencing workplace stress reported feeling that their symptoms were not taken seriously; that their concerns were ignored and that they were blamed for their illness:

"If you've got a stress-related illness… people… see it as a weakness."

[P14, female, clinical, management]

The interpretation of absence as deviant or non-legitimate could lead to problems within the workplace, such as the bullying and exclusion by managers and colleagues that was described by participants. Patton (2011) found that colleagues who are impacted by the absence of others may blame and wish to punish absentees, even when the absence is medically justified. This is a concern for those with mental health problems or other chronic conditions, who may need to take sickness absence more frequently than others. Managers and colleagues who treat employees less favourably due to their health are likely to increase stress, potentially prolonging illness and absence as a result. Managers may require more information on the needs of employees with long-term health conditions in order to provide adequate support.

Employees who reported being negatively viewed because of their illness described distress and a reluctance to disclose the true nature of their illness to colleagues and managers. In particular, stress-related illness was seen as having a stigma attached. Instead, they gave reasons for absence which were viewed as more acceptable:

> "In the beginning I would put down that I would have like flu...until the point that I actually put down my reason for sickness was work-related stress."
>
> [P12, female, non-clinical, management]

The result of this may be that certain types of absence, such as stress, are under-reported. In line with this, a qualitative study of stress in teachers found a reluctance to report stress due to the stigma associated with it and the fear of being perceived as unable to cope with their job (Brown, Ralph & Brember, 2002). Work-related causes of absence may therefore go unreported and consequently remain unaddressed. Due to the high rates of stress within the NHS (Boorman, 2009), a more proactive approach to stress management may be required. Prioritising the wellbeing of NHS staff can reduce sickness absence and increase job satisfaction (Boorman, 2009). Making staff wellbeing a priority at an organisational level would therefore be of benefit to both individuals and organisations.

During the stage of being absent, individuals were expected to use their time in certain ways. The main purpose of sickness absence was for *Recovering* and employees were expected to use this time to aid their rehabilitation:

"I did…use the sick time appropriately. I kept my foot up, much to my husband's utter surprise."

[P9, female, clinical, registered]

Being seen out of the house reportedly called legitimacy into question and the employees reported behaviours similar to those identified by Parsons (1951) as characterising the sick role. He described the sick role as a social role that the individual temporarily adopts when unwell which is characterised by a release from normal social responsibilities; an exemption of blame for the illness; an expectation to seek out professional help and to comply with any advice given. In the present study, employees reported being released from their normal duties as a result of being ill and were expected to avoid social activities which were out of line with the sick role, such as socialising or shopping. However, these activities could be legitimised by someone in authority:

"I didn't go out of the house until I'd spoke to one of the girls on Worksure and she said, 'You can go out of the house'… I was thinking …What if somebody sees me?'

[P3, female, clinical, registered]

This could be another example of the way in which responsibility for decision-making was shifted from the individual to health professionals or other authority figures. Leaving the house became legitimate since the employee was able to appeal to an authority that authorised it.

Employees reported being expected to return to work as soon as possible, once a period of 'proper' recovery had passed. Genuine absence could become non-legitimate if it went beyond the point where the individual could have reasonably returned to work:

> "I was off for just less than three weeks…somebody else has the exact same thing done and you're off six weeks."
>
> [P10, female, non-clinical, non-management]

Again this highlights the importance of time in considering whether absence is legitimate. Legitimacy can be considered a fluid state requiring ongoing assessment and negotiation and can only be understood where absence is conceptualised as a social process.

It seems that negotiation with health professionals and managers is an important aspect of absence which is used to confer legitimacy on the absence. Participants tended to depict themselves as genuine and, therefore, either as passively accepting advice to become absent or as pushing to be 'allowed' to return to work. We may be sceptical about uncritically accepting these accounts, particularly as they appear to conflict with GPs' descriptions of their negotiations around absence (Money et al., 2010). However, it does seem clear that absence is more than a medical or a workplace issue, rather it is a social process where self-presentation and negotiation play key roles. When this process goes wrong, it can lead to negative outcomes. Where employees' absence is viewed as non-legitimate, punishment by their colleagues and/or managers may ensue.

The negotiations of legitimacy were ongoing and will be discussed in relation to the different stages of absence.

4.4 Stage One: Becoming Absent

The first stage of becoming absent describes the time leading up to absence and includes four categories: *Assessing Work Ability, Considering the Consequences of Absence, Avoiding Sickness Absence and Becoming Absent.* During the first stage, employees considered whether they were able to attend work. Important questions presented by employees during this stage were, 'Am I ill enough to justify taking time off?', 'Could I cope in work?', 'What would the negative outcomes of absence be?', 'Could I avoid taking absence?' The advice and support of significant others was sought at this point, with the GP's opinion being particularly important.

4.4.1 Assessing Work Ability

Participants assessed their work ability in relation to both the nature of their illness or injury and the requirements of their job. They spoke about work ability in terms of their ability to cope. When considering the illness, major considerations were severity, contagiousness, chronicity and control. More severe illnesses were, unsurprisingly, seen as more likely to require absence. However, this was only one aspect of coping, which was affected by a complex interplay of different considerations. The chronicity of the illness could affect the ability to cope with it over time:

"It just got worse over a matter of months…I stuck it until I couldn't stick it no more…I thought, well I have to phone in sick."

[P7, female, clinical, non-registered]

This consideration of the chronicity of illness seems comparable to one of Leventhal's (1970) illness perceptions constructs: timeline. The length of time the illness lasted appeared to change how it was perceived by participants, in particular how it impacted on their ability to work and the implications for their future health (the 'consequences' in Leventhal's model). However, in some cases, chronicity was linked to an avoidance of taking absence. This was linked to the employees' beliefs that there was a reduced chance of recovery and to fears about job loss, due to the amount of absence that may be needed:

"The realisation hit me…if I'm going to rest this thing long enough for it to actually heal I'm going to have to be off work for so long, I don't even know if I would still have a job at the end…So I've just rattled along since then."

[P18, female, non-clinical, management]

There does not seem to be a simple relationship between illness perceptions and decisions about work. In these examples, chronicity could lead to a decision to take absence or a decision not to take absence depending upon the circumstances. Therefore, it is important that wider workplace factors are also taken into account when trying to understand the relationship between health and work ability.

Employees' perceptions of the amount of control they had over their

symptoms also affected decisions about whether they were able to cope in work. The types of coping strategies employees were able to use to control their symptoms depended on their work context and in some cases, employees changed workplace in order to better manage their health:

"I was {working in a} unit which could sometimes be physical and now I'm in {a different area} which is less physical, apart from getting up and down, which is good for my back."

[P2, female, clinical, registered]

There was a complex interplay between health and the work environment, leading to these global perceptions of being able to cope. In addition, working was sometimes seen as harmful and sometimes as beneficial to health depending on the employee and the circumstances. Work ability beliefs appear to be related to but distinct from illness perceptions and these specific work ability cognitions warrant further investigation.

A number of aspects of the work and home contexts were important when thinking about coping, including stress (both at work and at home); the effect of work on the employee's health; workplace culture; the behaviour of colleagues and managers and the amount of support received. Fourteen participants mentioned stress as having an effect on their health. Those reporting stress often talked about the workplace having a detrimental effect on their health:

"Is it truly work-related stress?...But there was nothing else going on in my life...I could demonstrate then the effects of the working environment."

High workplace demands, low control over the work environment and a lack of support (in keeping with the Demands-Control-Support theory of stress; Karasek & Theorell, 1990) have been linked to absence from work in previous studies and those in lower grade jobs appear to be disproportionately affected (North, Syme, Feeney, Head, Shipley & Marmot, 1993). Organisations may help to reduce stress by addressing these workplace issues.

Employees with problems causing stress in the workplace all reported trying to resolve the issues first. This usually meant having discussions with the manager. The behaviour of the manager in response to this appeared to be crucial in determining whether absence was then taken:

> "I think if my manager had dealt with the situation better…I wouldn't have gone on sick in the first place."

[P3, female clinical, registered]

Seven employees reported significant health problems as a result of issues at work (two of these did not take any absence for this reason and therefore only five have work-related stress listed as a cause of absence). Of these, one felt that stressors had improved within the workplace due to the intervention of senior management and HR. The other employees experiencing stress reported feeling that their concerns were dismissed:

"I put my concerns down...{that the} job they wanted me to do would be impossible to do... I was basically told that...I had to do it."

[P12, female, non-clinical, management]

This reported unsympathetic attitude of managers to workplace stress could be a result of the attitudes to stress discussed in section 4.3 on *Negotiating Legitimacy.* It may be that beliefs that stress-related illness is less legitimate than illness with a physical cause led to concerns being dismissed. Additionally, managers may have difficulty in carrying out their conflicting roles in supporting staff; the disciplinary aspects of managing absence and managing the workloads of absent employees. In two cases, employees had taken absence which was recognised as being due to workplace problems, and were able to identify specific issues and suggest actions to ameliorate them, but did not receive the support that they hoped for:

"I went to see Occ Health, HR, the unions...everybody said, 'Yes, this will happen'... Nothing did.

[P15, male, non-clinical, non-management]

NHS organisations often have clear policies and referral protocols in place for dealing with workplace issues. However, it is important that communication between the parties involved is effective; that they are clear about their responsibilities and that action plans are followed up. Where processes are not followed through, return to work may be delayed and resources may be wasted. When managers, and sometimes the wider organisation, did not address workplace problems, employees were left

feeling powerless, isolated, angry and devalued. They were not always sure where they could go for further help and advice:

"I don't know how to take it forward. Because I've spoken to my manager about it, I just don't know where to go with it."

[P11, female, non-clinical, non-management]

Two employees felt that they had exhausted all their immediate options for support and were considering, or had been advised to take legal action against the health board. For these employees, sickness absence appeared to be a last resort in an untenable work situation. The effective implementation of workplace policies to reduce stress may have led to absence being avoided altogether in these cases. This lends further weight to the earlier suggestion that organisations need to prioritise staff wellbeing by addressing workplace issues proactively. Policies also need to be swiftly and efficiently enacted in order to reduce the need for absence as far as possible. This may require training for managers and the strengthening of communication channels.

Stress at work and stress at home were reported to exacerbate one another, for example, where pressure at work or working hours conflicted with caring responsibilities. Illness and contextual factors appeared to have a cumulative effect on employees' perceptions of whether they were able to cope in work:

P: Sometimes demands on us are very high …then of course when a period of relative ill health occurs … the two together may lead to the sort of decision not to be at work.

I: Does that imply… if your job was less demanding, you might have been able to go into work?
P: I think so, yes.

[P17, male, clinical, registered]

Chronic conditions required higher levels of coping with symptoms than acute conditions, since symptoms were always present. While there appeared to be cumulative and interactive effects of symptoms and demands, assessments of work ability often appeared to be based on a global perception of coping, rather than based on any specific criteria:

"Pain that you can cope with becomes something that you can't cope with the next day…I'll just be too tearful or perhaps it's tiredness…{which} tip me over the edge into thinking, 'No, I just can't do this today'."

[P18, female, non-clinical, management]

Chronic conditions can be variable and unpredictable, however, the policies which govern absence can be rigid and punitive, which may lead to a conflict between an employee's health needs and their need to attend work. This conflict will be discussed further in section 4.4.2 on *Considering the Consequences of Absence.*

It appeared that when staff considered taking absence, there were a number of considerations which they took into account, which is in keeping with research indicating that there are multiple predictors of absence (e.g. Huijs et al., 2012). These different considerations were weighed up as employees considered whether their illness warranted absence and how it might impact their work ability. The beliefs of employees about their illness; their ability to cope in work and whether absence was morally justified

were important in this process. Illness representations were considered but it appeared that other beliefs regarding coping, the workplace and legitimacy were also important. Further research is required to explore these work ability beliefs. However, work ability was not the only consideration in the decision about work attendance. Employees also weighed up whether taking absence may lead to negative consequences.

4.4.2 Considering the Consequences of Absence

Even where employees assessed that they would not cope well in work, this did not necessarily lead to absence. The consequences of taking absence for the individual, for colleagues and for patients were considered. Employees did not want to let others down and this was linked to their moral and professional values:

> "Even if I'd earned £20 million, I wouldn't just say, 'I can't come in now.' That would be irresponsible…There's people with mental health issues that rely on you."

> [P9, female, clinical, registered]

The consequences the absence would have on patients and colleagues was reported as depending on available resources, whether there were others who could cover the work and whether that work could be postponed. Where areas were short-staffed or employees worked in small teams, they described feeling a responsibility to try to attend work:

> "When there's only two of you, you feel a bit whatsaname then, leaving the other one down…So I'll try my best to get to work if I can."

[P4, male, non-clinical, non-management]

The amount of previous absence participants had taken was an important contextual factor, since this had implications for future sickness pay, for disciplinary procedures and eventually, for job safety:

> "We've got to wait for {a planned operation}…that's going to be more sickness…over a two year period. That's been worrying me…because you don't want to lose your job do you?"

[P6, female, non-clinical, non-management]

Potential financial consequences of absence were an important consideration for a number of employees:

> "Well you've got to {stay in work} haven't you? 'Cause I need the money, innit. Well, like it's not a lot of money innit, but I need it."

[P1, female, non-clinical, non-management]

This category appears to fit well with Johansson and Lundberg's (2004) concept of attendance requirements, which they found correlated strongly with absence and presenteeism. As noted by Grinyer & Singleton (2000), absence could be considered a 'risk-taking' behaviour, since a number of negative consequences can result. In this study, the consequences were reported to be more severe when absence was viewed as less legitimate and therefore this category links closely with the core category of *Negotiating Legitimacy.* If 'too much' absence was taken as defined by policy, employees risked losing wages, disciplinary meetings and ultimately risked losing their job. If 'too much' absence was taken as defined by

colleagues, or if the absence was viewed as non-legitimate, employees risked their relationships with colleagues.

As noted in the category on *Assessing Work Ability,* the work context, including the behaviour of managers and colleagues was reported to impact on decisions about absence. A minority of participants discussed working in environments where employees were afraid to take sickness absence, due to a culture which included bullying:

> "My previous manager… was a bully… There's still some of that residual attitude in the department that you shouldn't really take time off and, if you do, you're sort of conning people out of your time."
>
> [P18, female, non-clinical, management]

Workplace cultures where absence is punished using bullying or exclusion may increase stress and promote presenteeism among staff (Dew, Keefe & Small, 2005) which may lead to a long-term worsening of health (Kivimäki et al., 2005). Measures organisations can take to promote a supportive environment are discussed in sections 4.4.1 and 4.5.3. Where employees were concerned about the negative consequences of taking sickness absence, they were likely to consider strategies for *Avoiding Sickness Absence.*

4.4.3 Avoiding Sickness Absence

A number of strategies for avoiding sickness absence were reported by the participants. Swapping shifts and using annual leave were strategies described by employees with chronic or multiple health conditions who

were concerned about the amount of absence they had taken. Although employees would still be absent from the workplace, the financial and procedural consequences of taking sickness absence could be avoided:

> "I've taken annual leave rather than go sick…I thought, 'Oh, I can't go sick again, you know, so I'll take that leave.'"
>
> [P6, female, non-clinical, non-management]

The strategy also appeared to have some implications for legitimacy and therefore for relationships with colleagues and managers. Annual leave appeared to be seen as a right and as belonging to the employee, in contrast to sickness leave which was viewed as a privilege which should only be taken in extreme circumstances and should not be abused:

> "If you've got annual leave and you're sick… it's your annual leave, so why can't you take that annual leave?"
>
> [P7, female, clinical, non-registered]

However, annual leave when sick was not consistently granted by managers and therefore this strategy was not always available.

Some of the participants were able to adjust the way they worked in order to avoid absence. This sometimes involved formal work adjustments, but often employees made their own informal adjustments, sometimes with the support of their colleagues:

> "My partner does {the tasks I can't do}…I say, 'Oh, do you mind doing it 'cause it needs it,' and I do something for her."

It was not always clear why informal adjustments were made rather than formal ones, however, procedures for making adjustments were reported to be slow (see section 4.6.1). No participants described asking for formal adjustments proactively, and may not have been aware that they could request adjustments in the workplace in order to prevent absence. A preventative approach to absence management by the organisation may help to reduce absence for those who are less able to make their own informal adjustments.

Two employees reported avoiding taking medication they had been prescribed, since the side effects of the medication would have affected their ability to work:

> "This medication that they gave me…just knocks me… So, you can't work like that… So I'm just popping the Ibuprofen now and try and cope with that."

[P2, female, clinical, registered]

This could be a risky strategy for employees to adopt when avoiding absence, since it may have long-term implications for health. However, as noted in the category on *Considering the Consequences of Absence,* taking absence in itself can be considered risky and therefore, the consequences of not taking medication need to be weighed against the consequences of being absent from work. However, workplace adjustments should also be considered, since these may allow sufficient flexibility for employees to take prescribed medication and attend work.

Where other strategies failed, or employees did not see them as being available, employees avoided taking sickness absence by simply struggling on despite feeling unwell:

> "I would sort of struggle into work…I would spend the entire weekend practically comatose …I would do anything I could to avoid being off on the sick."

> [P12, female, non-clinical, management]

The strategy of struggling on seems to correspond to the concept of presenteeism. This strategy could not be maintained indefinitely and employees who reported struggling on often believed that taking absence sooner may have been more beneficial to their health. There is some objective support for this assertion, since presenteeism has been found to predict poorer future health as well as future absenteeism (Bergström et al., 2009). It seems that employees using different strategies for *Avoiding Sickness Absence* may experience very different outcomes. Whereas struggling on often appeared to lead to absence, employees adjusting their work did not take absence if the changes they had made were sustainable, therefore researchers studying presenteeism may need to take these complexities into account. Allowing employees greater flexibility and proactively making adjustments may be good strategies for organisations to adopt in order to prevent absence and potentially to avoid the negative outcomes associated with presenteeism. When the strategies for *Avoiding Sickness Absence* failed, employees became absent from work.

4.4.4 Becoming Absent

Becoming Absent was often presented as a difficult decision, based on a combination of the assessment of the illness; the potential consequences of taking absence; advice from those in authority and the degree to which employees viewed the reasons for absence as being legitimate. The various considerations described in the categories of *Negotiating Legitimacy, Assessing Work Ability* and *Considering the Consequences of Absence* converged as a decision was made. The decision was often not an easy one:

> "I don't take the decision lightly at all…{I} think about the implications and think about my own wellbeing. Very often I'll spend several hours thinking about it the night before."

> [P17, male, clinical, registered]

The weighing up of 'the implications' of absence and 'wellbeing' suggests that the decision about taking absence is a weighing of risks: the health risks of being in work on the one hand and the risks of being absent described in *Considering the Consequences of Absence* on the other. In some cases, the decision was less difficult, particularly when absence was planned; when there was clear advice from policy or health professionals and when attending work would have been almost impossible (e.g., when admitted to hospital). The locating of the decision with the health professional, discussed in the category of *Negotiating Legitimacy*, may have had two functions. Not only did the decision negate the responsibility of the employee for the absence, it may also have reduced the uncertainty about whether the 'right' decision had been made.

This complex decision to take absence represented the transition from stage one of becoming absent to stage two of being absent. Stage one was characterised by the assessment of the illness, the workplace factors and the consequences of absence as well as the viability of remaining in work, all leading up to this decision-making point. However, once the difficult decision to take absence had been made and the employee moved into stage two of the process, the considerations were different.

4.5 Stage Two: Being Absent

Stage two of the model describes the experiences of employees whilst they were absent. In this stage, there was a focus on recovering from the illness or injury, whilst also fulfilling expectations to refrain from certain activities, to attend medical appointments and to comply with workplace policies. Some employees experienced negative outcomes of absence, such as feeling bored or depressed, but these could be buffered by contact and support from the workplace. This stage includes four categories: *Recovering, Navigating a Different World, Feeling Supported and Connected* and *Negative Impact of Absence.*

4.5.1 Recovering

Recovering was viewed as the main reason for taking sickness absence and as being a legitimate use of time when absent from work. Taking time out rest to was an important factor of the recovery process but recovery

sometimes also involved actively undertaking activities which aided the recovery process:

> "I just had to force myself…{the doctor} would say to me, 'Try this, try that. If you can't do it, try it again in a month's time.'"

> [P11, female, non-clinical, non-management]

For some, recovery seemed to be an active decision that had to be made, particularly when absence was long-term. There was a sense that ill health could only be indulged for a certain period of time before employees needed to work harder at getting better:

> "I thought, 'Right I can't go on like this…I've got to get myself sorted.'"

> [P3, female, clinical, registered]

Time was an important factor at this stage in determining when absence became non-legitimate. Absence which was legitimate for a certain period of time could become non-legitimate when sufficient effort was not put in to recovering and the absence therefore lasted longer than necessary.

Whereas employees were keen to avoid absence in the first stage of the process and many reported 'struggling on' as long as possible, once they became absent, there was a desire to 'properly' recover:

> "Once I've taken one day off, I'm thinking I've really got to just let it rest now."

> [P18, female, non-clinical, management]

It seems that there was no simple 'cut off point' where employees believed they were fit for work. Rather, employees thought about the long-term consequences of absence or returning to work. It was perceived that sufficient recovery was needed prior to return to work to avoid the risk of needing further absence in future. Since the risky decision to become absent had already been taken, sufficient recovery was seen as mitigating further risk. Employees in this study were generally keen to avoid taking an additional period of absence. This was likely to be a consequence of sickness procedures where triggers for informal and formal interviews regarding absence are based on the number of absences employees have taken in a given time period (for example, an informal interview is triggered after three absences in the space of a year). Procedures are not related to the type of illness, but are automatic processes which are triggered regardless of how helpful they are likely to be for the employee. Several employees reported that they or their colleagues had returned to work too early at some point, with negative consequences for their health and sickness record:

> "{my manager} came back too soon and then she had to have another month off. So she was saying to me, 'Don't come back until you're ready.'"

> [P9, female, clinical, registered]

There were big differences in the expectations of managers about recovery prior to return to work. While some employees reported pressure from their managers to return regardless of recovery, others reported that managers encouraged them to stay off for longer periods to fully recover. There could be a number of consequences of this. Managers who were viewed as

supportive and did not pressure employees to return to work were talked about in more positive terms and were related to less stress. However, whilst supportive, the suggestion to remain out of work to 'properly' recover may not be beneficial for many health conditions, since remaining out of work can lead to negative outcomes (see section 4.5.4 on the *Negative Impact of Absence*).

.

In parallel with this process of recovery, the individual went about *Navigating a Different World,* where expectations about the employees' behaviour when absent from work were different to those when in work. These expectations were sometimes process-based, for example, in attending workplace sickness meetings. Others were based on behaviours which were to be avoided, such as going shopping.

4.5.2 Navigating a different world

Day to day life for employees absent from work was hugely different to the usual work routine.

> "I didn't sort of get into any routine…until just before I came back to work …everything just sort of grinded to a halt."
>
> [P11, female, non-clinical, non-management]

'Normal life' ground to a halt and many of the participants' daily activities ceased. For some, this was more extreme than others, with even basic daily tasks such as washing and dressing interrupted in some cases:

> "I couldn't function at all in the house, I didn't get dressed, my hair was breaking off in my hands."

> [P12, female, non-clinical, management]

Employees often reported a loss of social contact, since they tended to stay at home. A few participants reported feeling anxious about seeing others and for others the loss of contact with others was due to them feeling too unwell to cope with social interaction. However, as noted in the category of *Negotiating Legitimacy*, there was also a perception that social activities were not legitimate uses of their time. Consistent with descriptions of the sick role (Parsons, 1951), it appeared that the social rules about what was legitimate during sickness absence were different to the rules that applied at other times:

> "I've heard it – 'Oh I saw them shopping; nothing wrong with them'. You saw them shopping, but did you see them with a plaster on their arms and somebody else carrying the bags for them? No, you didn't see that, you just seen them shopping."

> [P2, female, clinical, registered]

Some did challenge the prescriptions of the sick role, since expectations to stay at home during long-term sickness may not be realistic and may actually be contrary to advice on recovery, for example, for back pain or anxiety where going out is likely to be beneficial. However, two participants (both recovering from surgery) described the release from normal obligations as reducing stress and promoting a period of rest and recovery:

> But I enjoyed my time off, I thought…sit down, do what you've got to do, there must be things that you haven't done for ages.

The period of recovering may potentially be easier for those recovering from surgery in comparison to those with chronic conditions for a number of reasons. Firstly, the medical nature of surgery may confer legitimacy on this type of absence. In addition, absences for non-emergency surgery can often be planned in advance and there is likely to be advice on the length of recovery time needed, meaning that these employees begin absence with a greater idea of what to expect. This may lead to a more positive and smoother period of recovery and an avoidance of the *Negative Impact of Absence.*

In addition to the loss of normal activities, employees were expected to deal with a number of agencies and processes. There was a perception that healthcare was often slow and difficult to access, which impacted on the speed of recovery:

> "It's awful hard to get in to the Occ Health…I think they should fast track it…'Cause my GPs…it takes like 3 weeks to get in."
>
> [P6, female, non-clinical, non-management]

Participants stated that NHS staff should be prioritised on waiting lists, in order to get them back to work as quickly as possible. This is a contentious issue, however, it may be worthy of consideration by NHS organisations in order to maintain staffing levels and therefore increase the capacity to treat patients.

Employees were usually expected to attend sickness meetings with their manager and a representative from HR every four weeks. In some cases, the procedure did not run smoothly, and one employee reported never having had a meeting, despite more than one episode of long-term absence. In a minority of cases, for example where employees suffered industrial injuries, there were legal and compensation-related procedures to deal with. Information on the help that was available was not always given to employees, which could have huge implications:

> I said to {a colleague}, 'I don't have no more wages...And she said...'Why haven't you got Industrial Injury?' I said, 'I didn't even know it existed.'

> [P2, female, clinical, registered]

Participants were not always clear of what was expected of them during their absence:

> "We read so many {policies}, you sign them, you read them, you sign them, but the next one comes along and fills your head up."

> [P2, female, clinical, registered]

The knowledge of policies often did not go beyond this basic requirement to read them and it appeared that they were often not embedded in daily practice. When contact between employees and their managers was not regular and when employees had not taken long-term absence before, participants were often less sure of what was expected of them and more likely to feel anxious about navigating this unknown world:

> "'Cause me not having been on sick...I didn't even know about a sick note see. I know people hand them in but I didn't know {about} the time limits."

<center>[P3, female, clinical, registered]</center>

A common wish was for more information or for guidance on who employees could contact for advice.

.

The varying absence experiences of the employees may give clues to how absence can be best managed. If employees understand how their absence will be managed at the start of their absence, this is likely to aid recovery. A lack of understanding about absence processes could lead to problems, for example, processes not being followed. Clear guidance and regular contact from managers is likely to aid the employee's journey through this unknown world. Participants reported that the absence process was made easier by support and contact from the workplace, as described in the next category on *Feeling Supported and Connected*.

4.5.3 Feeling supported and connected

The support employees received from their managers and colleagues made a huge difference to their experience of absence. Where employees were contacted regularly by their managers in a supportive way, they reported feeling more connected to the workplace, which aided return to work:

> "{My line manager} used to ring me quite regularly, just for a chat...You don't feel as if...you're coming back to a new place, a new job, because I knew roughly what was going on anyway."

In contrast, participants who had little contact from their managers while off work, felt isolated, disengaged and undervalued, although being contacted by another representative of the Health Board seemed to help:

"The only time I heard from my ward manager was when I phoned her… You feel alone… There was a big, big difference when I had that call from Worksure…It made me feel as if I was someone."

[P2, female, clinical, registered]

Support from managers was not always perceived as consistent, with some employees feeling that they were shown less support than their colleagues in the same team. Previous research found that employees taking absence due to stress, anxiety, depression and back pain tended to rate their managers as less supportive than those who were absent due to cancer or heart disease (BOHRF, 2012). It may be that these inconsistencies in levels of support are related to the differences in the perceived legitimacy of the causes of absence discussed in section 4.3.

In some cases, where employees felt unsupported by managers and colleagues, they were able to gain support from other sources, such as Occupational Health, HR, Worksure or family members, which mitigated the lack of managerial support to an extent:

"{My team at work} make no allowances for {my disability}… And I think that if I wasn't such a strong person, who's got such a strong family life, I would have gone."

However, organisations do have a legal duty to treat employees with health conditions fairly. It is important that managers are aware of their responsibilities to their staff and that a culture of supporting those with health conditions is cultivated.

In some cases, employees did not feel they were supported even when seeking help from wider sources:

> "I actually filled in an action plan... these are my stressors...It was, 'We can't support your action plan'...There was no support from managers and there was no support from HR."

[P14, female, clinical, management]

Stress risk assessments and associated action plans are now commonly used for employees reporting stress at work. However, these measures are unlikely to be of any benefit if changes are not made in the workplace as a result. This example again highlights the importance of ensuring that the policies that are in place are implemented consistently and effectively by managers. A cultural shift may be required within workplaces in order for this to happen.

In several cases, employees even reported being bullied by their manager or colleagues. The support that participants received from the workplace was associated with their feelings of being valued as a member of staff and as a person:

"I always thought I was a valid member of the team, until {my manager} sort of stamped on you."

[P3, female, clinical, registered]

Staff who felt supported and valued seemed to find returning to work easier. The variability in manager support could be due to a number of reasons. As already noted, it could be due to absence being viewed as more or less legitimate or due to the conflicting roles of managers. Managers may also vary in the amount of pressure that is on them and therefore the amount of time they feel able to give to their employees. Managers may view sickness absence as an HR issue and not see it a part of their job, as was found in Dunn and Wilkinson's (2002) study on the implementation of sickness policies. Whatever the causes of policies being poorly implemented, organisations may need to provide additional support and training for managers in order that they can more effectively support their staff. Where there was a lack of support from both managers and colleagues, employees were more likely to report a *Negative Impact of Absence.*

4.5.4 Negative Impact of Absence

As time progressed, employees were more likely to feel that sickness absence was having a negative impact on them. A number of negative outcomes were reported to result from absence including boredom, loneliness, guilt, depression, a loss of social contact and an increase in financial pressures. These negative outcomes could then begin to outweigh the benefits of being off work and having time to recover.

Boredom and frustration at being unable to do everyday tasks were commonly reported:

> "It's a long day with nothing to do… I did on the whole find it a bit boring."
>
> [P4, male, non-clinical, non-management]

For some the sick role was imposed on them by the limitations of their health, however, as noted in the category on *Navigating a Different World,* for others it was socially enforced. A number of employees reported a negative impact on their mood, and some reported that they had been depressed. Loneliness could be a problem, due to the loss of contact with others, particularly when family members were not at home. Some participants reported feelings of guilt and shame due to their absence. Guilt was often associated with concerns about letting others down whereas shame was more often reported by those experiencing stress and a lack of support in the workplace. This may be due to the need to use sickness absence for stress, which is seen as having a stigma attached and as being less legitimate than absence due to physical causes:

> "If I had to give somebody like one major feeling of how I felt being off, and it's the shame of it. That just overrides everything."
>
> [P12, female, non-clinical, management]

It is possible that greater workplace support may mitigate these feelings of shame and therefore facilitate return to work.

As employees were away from the workplace and from regular contact with others for a period of time, they reported losing confidence in their abilities and feeling less self-assured in work and social situations:

> "You lose that bit of confidence ...I went out one weekend and I was like really quiet and everybody was saying, 'That's not you.'"

> [P7, female, clinical, non-registered]

These negative changes in mood and confidence levels appeared to be buffered by regular contact with the workplace, which increased participants' feelings of being supported and valued at work (see category on *Feeling Supported and Connected)*.

Financial pressure could mount over time and the points at which pay dropped from full to half pay and from half pay to no pay, were seen as important milestones where the incentive to return to work increased regardless of the degree of recovery. In fact, all of the negative outcomes of absence could propel employees back towards work. This pressure was separate from the experience of symptoms, and like the pressures described in *Considering the Consequences of Absence,* was more akin to the concept of attendance requirements (Johansson & Lundberg, 2004). The implications of returning to work due to these pressures are unlikely to be straightforward. Participants who described returning to work too soon reported that this could have a negative impact on health and lead to further absence. However, Waddell and Burton (1996) suggest that returning to work is often beneficial to health. The experiences of employees on return to work are likely to be influenced by a number of

other factors, including the support and adjustments they receive; any barriers to returning; the reason for their absence and any ongoing health problems. The experiences of employees on return to work will be discussed as we consider Stage three of the theory: return to work.

4.6 Stage Three: Return to Work

In the final stage of the absence process, employees returned to work. The decision to return to work depended on the number of *Barriers to Return to Work*, the degree of recovery, the influence of negative outcomes of absence and the advice and support of health professionals and managers. On returning to work, employees reported two main experiences: *Getting Back to Normal* and *Learning and Changing*. Work was generally seen as representing normality. However, in some cases, it was not possible to return to how things and previously been, for health reasons or due to the experience of absence. Therefore, in these cases employees needed to adapt in order to function in the workplace. For some, there was a profound reassessment of the role that work played in their life and a decision to do things differently in future.

4.6.1 Barriers to return to work

A number of barriers to return to work were reported which could slow return to work. These included access to services, the work environment and relationships at work. Healthcare services were often seen as difficult to access and slow, which could impact on the speed of recovery and

return to work. In some cases, participants needed adjustments to be made to the workplace. These could be slow to implement or in some cases, were not implemented at all:

> "{the GP} said, 'you're not going to work unless there's workplace adaptations'…{I} went back and seen him in a fortnight... nothing done. Another paper for 3 weeks, another paper for 4 weeks, another paper for 6 weeks."
>
> [P15, male, non-clinical, non-management]

The swift implementation of adaptations in the workplace is likely not only to ensure that organisations fulfil their legal requirements, but also to speed up return to work.

The busyness and pressure of the work environment was sometimes reported as a barrier to return to work. This was particularly the case in a ward environment which was not seen as being an easy environment for staff needing adjustments:

> "{Staff members' sickness} episodes lasted quite a long time because when they came back to work the environment was so hectic…You are expected to be functioning at 100%"
>
> [P14, female, clinical, management]

The introduction of the fit note has challenged the perception that employees need to be 100 percent fit to attend work (Black, 2008). However, the concept of fitness for work appears to be context-dependent as well as health dependent (Irvine, 2011). A nurse therefore may need a different level of fitness for work than, for example, an office worker. In

addition, greater fitness for work may be required on a busy, short-staffed ward than on one which is adequately staffed. The assessment of fitness for work appears to be complex and multi-dimensional and requires an understanding of the pressures of the work environment as well as health-related factors. However, it is also possible that there is a culture of being resistant to adaptations among ward staff and this culture may need to be challenged to facilitate return to work for these employees.

Relationship problems with managers or colleagues were seen as a barrier to returning to work, with staff feeling stressed and less positive about return to work:

> "{The manager would} be quite sarcastic and nasty on the phone…I would go {back to work} not glad that I'd had the rest and recovery time, I would just be trying to keep my head down."
>
> [P18, female, non-clinical, management]

These bullying techniques were reported to reduce the positive effects of *Recovering.* This experience reaffirms the importance of employees *Feeling Supported and Connected* and the training of line managers, which may help managers to behave in a way which is congruent with the competencies for return to work (BOHRF, 2010).

When the *Barriers to Return to Work* were sufficiently overcome, in conjunction with a sufficient degree of recovery, or where the *Negative Impact of Absence* began to outweigh the benefits of absence, employees considered *Deciding to Return to Work.*

4.6.2 Deciding to return to work

As discussed in the category of *Negotiating Legitimacy*, return to work was seen being under the control of the individual, or at least as negotiated with health professionals and managers, in contrast to becoming absent from work, which was framed as being out of the control of the individual. The decision to return to work was reported as being affected by a number of factors, such as the degree of recovery and the *Negative Impact of Absence*.

Employees perceived that they needed to have recovered to a sufficient degree to be able to cope in work:

> "I can…go out then a mile or so with the dog…so I can manage a couple of miles walking round {the hospital}."
>
> [P4, male, non-clinical, non-management]

The decision to return to work was not always an easy one and employees had to weigh up a number of considerations:

> "I had a choice to make. Is it worse being out of work or is it worse in work?"
>
> [P15, male, non-clinical, non-management]

Return to work was usually, but not always, reported as a positive choice. However, in some cases the decision was made when the negative effects of being off work began to outweigh the benefits having the time off to recover:

> "Things change…when you're off for a long time. It's nice in the beginning because you've got the support of your family…when they're getting on your nerves, that tells you it's time to go back."

<p align="center">[P5, male, clinical, non-registered]</p>

However, this was not independent of the experience of symptoms. Frustration and boredom were linked to disability but were rarely reported when symptoms were acute. Therefore the impact of *Recovering* and the *Negative Impact of Absence* on the return to work decision should be considered in conjunction with one another.

In some cases there were specific reasons for wanting to return to work at a certain time. Guilt about the impact the sickness absence was having on others was sometimes a driver for employees returning to work:

> "I was supposed to have worked Christmas Day… I felt guilty then that the person that probably had to cover Christmas Day and Christmas Eve was going to come in again then New Year's Eve and New Year's Day so that's why I wanted to go back and do that shift."

<p align="center">[P10, female, non-clinical, non-management]</p>

Financial pressures were also considered by employees in their decision to return to work:

> "There was an element of me going onto half pay and also the fact that I knew the longer that I was away the more difficult it was going to be for me to go back to work."

<p align="center">[P12, female, non-clinical, management]</p>

As noted in *Negotiating Legitimacy*, the timing of the decision to return was linked to legitimacy as well as these other factors. Absence becomes non-legitimate where it extends beyond a reasonable period. Where employees were unable to return to their old post, they could apply to be redeployed to a different area. This process could present a barrier to return to work, although two participants reported being given temporary duties while they awaited a more permanent post.

The support employees anticipated receiving on return to work had an impact on their decisions to return, as did their feelings of being valued:

> "If {staff} feel valued, they want to come rushing back...If they don't feel they're valued they'll say, 'Well I'll come back at some stage.'"
>
> [P17, male, clinical, registered]

Once the decision to return to work had been made, there were two main experiences described by employees: *Getting Back to Normal* and *Learning and Changing.* Return to work was seen as a return to normality, however, in some cases things could not return to the way they were previously due to ongoing health issues or changes in beliefs and values and therefore employees had to change and adapt to their new circumstances.

4.6.3 Getting Back to Normal

One aspect of returning to work described by participants was *Getting Back to Normal*. A period of reorientating was the first step back towards normality. Employees reported feeling nervous when they initially returned to work:

> "You know when you start in a new job, that's the only way I can describe {returning to work}. The butterflies in my stomach…and your heart is racing."
>
> [P3, female, clinical, registered]

Confidence was often lowered when employees first returned to work, and part of the period of reorientation was rebuilding their confidence in their abilities:

> "Eventually you get your confidence back then…I was finding I wasn't confident in doing things in work like paperwork.'
>
> [P7, female, clinical, non-registered]

Being back to normal was seen as the end point of recovery. Whereas being off work was associated with the cessation of normality, being back in work was associated with regaining normality:

> "I felt better then back in work: back to normal."
>
> [P1, female, non-clinical, non-management]

'Having to get on with it' was another aspect of getting back to normal. There were similarities between *Recovering* and *Getting Back to Normal*,

in that there was often an active decision involved to move forward despite ill health and difficulties:

> "When you have a bereavement you either fall apart or you get on with it and I got on with it because if felt more 'me' when I was in work"
>
> [P9, female, clinical, registered]

Carrying out a work role appeared to be linked to a perception of the self as a good person, who works hard and copes with difficulties. It also appeared to represent a moral requirement to fulfil a work duty which could be likened to the description of the Protestant work ethic (Weber, 1930). This requirement was seen as having to be fulfilled in normal life, whereas absence gave a temporary respite only in extreme circumstances. The concept of having to get on with it was also discussed in relation to *Avoiding Sickness Absence,* where it could be a driver of presenteeism.

While *Getting Back to Normal* was one aspect of return to work, participants also reported being different as a result of their experience of absence as they went through a process of *Learning and Changing.*

4.6.4 Learning and Changing

Learning and Changing happened in a variety of ways. Some of the changes described by participants were practical, such as adjustments to the workplace. Others reported changes to their knowledge levels, beliefs or behaviour following absence. Sometimes these changes could be

profound and there was a sense of moving forward with a changed perspective and set of values.

In some cases, employees required adjustments to be made to aid their return to work. This was often a short-term measure like a phased return but there was sometimes a need for long-term adjustments for staff with chronic conditions. In some cases, adjustments were recommended by the GP or Occupational Health and officially agreed. However, these adjustments were not always seen as being realistic:

> "You can have a special chair…I'd have to carry that chair around with me wouldn't I? Stop people sitting on it …and that's not really feasible."
>
> [P2, female, clinical, registered]

A number of employees reported making their own adjustments on their return to work, rather than them being officially agreed:

> "I done a couple of three day weeks by using my annual leaves … but I done that off my own back…I didn't have the support from management."
>
> [P3, female, clinical, registered]

There could be difficulties with the implementation of procedures for arranging adjustments to the workplace (see section 4.6.1) leading to these informal adjustments.

For some, there were permanent changes to their behaviour or beliefs following their return to work. In some cases, this was seen as negative, for example, where staff felt less engaged with work or that their confidence

had been permanently lowered. Particularly for those who experienced stress and a lack of support from managers or colleagues, there could be a sense that they had been broken by their experiences:

"I was always a workaholic. I loved that job… But I don't feel the same about the NHS at all… it is such a shame."

[P12, female, non-clinical, management]

Other employees reported reducing their effort levels as a result of a reappraisal of the importance of work in their life. For some this was seen as a loss, however, for two participants, this was seen as a positive step towards better work-life balance. For all, however, there was a link between feelings of not being valued at work and their decision to reduce their effort levels. Whilst having a healthier work-life balance may have been a positive outcome for some staff, it does imply that they may have been more engaged and productive if they had been given more support.

Other positive changes following absence included a greater understanding of health:

"Every time is a learning experience, it's like every time I know a little bit more"

[P8, male, clinical, non-registered]

As a result of their learning, some made changes to their health behaviours, either in a general way such as eating more healthily and exercising, or specifically in self-managing their health condition:

"If I've got to over-stretch, don't do that no more. No, I'll watch my back, because I don't want to be out of work."

[P7, female, clinical, non-registered]

Manual handling training is mandatory for all health board staff, however, there was a suggestion that staff do not always see this as an important aspect of their job. For this employee, its importance was only identified after a long period of absence. This again highlights the problems that can exist with implementing policy, particularly where policy aims are not embedded in the culture of the workplace. Health and safety training has the potential to improve the health and wellbeing of staff, however, it is rarely a priority of senior managers and therefore training can become a 'tick-box exercise' (Cadman, 2013). The prioritisation of staff wellbeing requires a commitment to the prevention of injuries in the workplace and a greater emphasis on the importance of health and safety at work by managers is likely to reduce injuries at work (Huang, Ho, Smith & Chen, 2006).

Some reported that their experience of being unwell had allowed them to feel greater empathy with others who may be experiencing similar problems, particularly patients or colleagues. Greater empathy with patients was seen as a positive outcome which could increase the quality of patient care. Participants found different ways of moving forward from the absence and sometimes this included a profound change in values and outlook. It appeared that the greatest difference between those who remained distressed about the stressful experiences they had and those

who were able to look to the future with a greater sense of hope, was the ability to find some positive meaning in their experience of stress and absence. For some, there was almost a sense that the return to work could herald a new beginning, incorporating a positive identity and new meaning:

"So that's what I have learned out of it and perhaps…it might make me a better person."

[P3, female, clinical, registered]

It appears that there is the potential for sickness absence have positive outcomes where the experience of reflected on and a positive plan for change put into place. It may be possible for managers to facilitate this process in return to work planning. The identification of learning which could be useful in the workplace may help to buffer employees' concerns about having lost skills and therefore increase feelings of confidence on returning to work.

4.7 Summary

The current model provides a summary of a complex social process. Sickness absence was reported to be multifaceted, incorporating a variety of experiences. The way absence was experienced depended on a number of factors including the type and severity of illness; the work context; the beliefs of the individual about their illness and its impact on work ability; professional and moral values about absence and the support received at work. All of these were underpinned by concerns about legitimacy. The findings have a number of implications for policy and

practice. The line manager played an important role in managing absence and facilitating return to work, however, management practices were not consistent and managers may therefore require more support to implement absence policies. The early and efficient implementation of adjustments to the workplace is also likely to aid return to work and managers are able to influence this process. A culture of support which prioritises employee health is likely to be needed in order to facilitate this.

Chapter 5

General Discussion

_____

5.1 Introduction

The findings presented in Chapter 4 have a number of implications for theory, policy and practice which will be discussed in this chapter. The limitations of the study will also be examined and some directions for future research will be suggested, including the role that health psychologists could play.

5.2 The conflict inherent in absence

The central role that _Negotiating Legitimacy_ plays in the new model highlights the importance of the moral and social aspects of absence. The ongoing attempt to distinguish between legitimate and non-legitimate absence can be understood within the context of a wider question about fairness in society. The concept of 'fairness' is central to some political and media discourses about the deviance of absence, which divide people into 'workers and shirkers' (Jowit, 2013). There appears to be an ongoing tension – how to be fair to and support those who are sick whilst also being fair to those who may have to work harder to support them. This tension can be seen in the concerns of individuals about legitimacy, in their feelings of guilt and shame about taking sickness absence and their robust defence of

their absences. It can be seen in the perceived bullying of employees who have taken sickness absence which is viewed as non-legitimate by managers or colleagues and in the support provided by managers and colleagues to those who are seen as 'genuine'. The tension can also be seen in the attempts of researchers to distinguish between voluntary and involuntary absence (e.g. Chadwick-Jones et al., 1973) and in workplace and government policies which often include both disciplinary and supportive elements. This conflict arises from the assumption that the absent person may be (or may be viewed as) treating others unfairly by expecting their colleagues to cover their workload.

For employees, this conflict means that the absence decision is a difficult and risky one. The decision to take absence, particularly for long periods, may involve risks to the employee's job, relationship with others, social standing and self-worth. The employee's sense of value is eroded by long periods of absence as well as poor treatment by others at work. The perception of absence as a deviant behaviour is perhaps underpinned by the assumptions of the Protestant work ethic (Weber, 1930) – that 'good' people work and those who do not are either weak or immoral. In addition, some illnesses appear to be viewed as more 'virtuous' than others. Those undergoing surgery appeared to be viewed as more legitimate and given higher levels of support than those taking stress-related absence. Stress was often hidden by employees who feared being seen as unable to cope. Those who do not work may be seen as sick and therefore blameless; as weak-minded and therefore needing to cope better or as immoral and

therefore deserving punishment. Thus, there are strong reasons for employees to want to remain in work if possible; to return to work quickly; to avoid future absence and to defend any absence as genuine and unavoidable.

For managers, there may be a conflict between their different roles and responsibilities. Organisations often expect line managers to support employees who take absence as well as to enforce disciplinary procedures associated with sickness absence. In addition, managers may need to arrange cover for the absent employee's workload and support and motivate other members of their teams who are likely to be affected by the absence. In many cases, line managers may lack the training and resources to resolve this conflict successfully. A recent report by the CIPD (2013a) found that managers at all levels felt unable to support the wellbeing of their staff because they had to prioritise other aspects of their job. Therefore the management of absence may be viewed as a low priority. Additionally, employees with chronic conditions or experiencing stress may lack the support they need when in work. The same report found that there was a mismatch between the support that employees expected from their managers and that which was actually provided. One reason for this may be that managers lack support and role clarity. Over a third had received no training for their role as a line manager. Given the importance of the line manager in preventing absence and supporting return to work (Munir, Yarker, Hicks & Donaldson-Fielder, 2012), organisations would do well to prioritise their training and support. A range

of resources are available to support this. In supporting employees who are absent, there are several guides available on managing absence, for example from the CIPD (2013b) and Acas (2010) as well as the line manager competencies for supporting return to work (BOHRF, 2012). In addition, an e-learning intervention for managers is currently being piloted (GEM study, 2013), aiming to improve the wellbeing of staff and reduce sickness absence by training managers to better support their staff. These may provide guidance for managers in how to manage the conflict between supporting and policing absence.

In order to reduce absence, managers may be able to take proactive steps to address health and workplace issues. Considering preventative strategies may become more important as the workforce ages and chronic conditions become more prevalent. There is advice and support available to help managers. For example, as part of the responsibility deal for health at work, the Department of Health (2012) have issued guidelines on managing chronic conditions and making workplace adjustments for employees with mental health conditions. A greater awareness and understanding of chronic conditions may help to protect employees experiencing long-term ill health from being viewed as taking non-legitimate absence and, in extreme cases, from bullying and exclusion. It may also promote the use of appropriate workplace adjustments and therefore reduce future absence. A number of condition-specific guides are also available which may help line managers deal with employees' individual needs, for example, Shift (2007) have issued a guide for

managing mental health conditions at work and Macmillan (2011) have published guidelines for managing cancer at work. Another important issue which may require a proactive management approach is workplace stress. One widely used approach for addressing stress at work uses the Health and Safety Executive's management standards (HSE, 2009), which are standards of good practice associated with six aspects of work. This approach includes a risk assessment using an indicator tool questionnaire followed by action planning to address the identified stressors. A recent review concluded that the indicator tool provides a sound overview of stress at work (Brookes, Limbert, Deacy, O'Reilly, Scott & Thirlaway, 2013), however, Study 2 identified that, despite risk assessments being carried out, action plans were not always implemented. Guidance and tools for improving employee wellbeing are available to managers, however, there is a greater need for them to be used as an integral part of the management of illness and absence. In order for this to happen, the important role that line managers play in promoting staff wellbeing needs to be recognised by organisations and appropriate support provided. Line managers may require greater role clarity and greater resourcing, both in terms of time and training, in order to effectively manage absence.

The tension at the heart of absence and its management around legitimacy and fairness has a number of implications for both employees making decisions about absence and return to work and managers who are dealing with the absence. To date, these conflicts have not been adequately understood by theorists or policy-makers. The conflicts have made absence

from work difficult to study since the attempt to distinguish between 'voluntary' and 'involuntary' absence has sidetracked researchers and since the association of absence with deviance has made employees and organisations defensive about absence. Theories of absence and its management may need to take this conflict into account in order to provide a more complex understanding of absence and how it can be addressed.

5.3 Implications for theory

The present model has a number of implications for theory. Firstly, theories of absence need to include the important role of legitimacy in absence and recognise that this is negotiated within a social context. Theorists have variously seen absence as a rational decision (Allen, 1981); as relating to a number of workplace influences (Steers & Rhodes, 1978); as a medical issue (Palmer, Brown & Hobson, 2013) or as arising from workplace cultures (Chadwick-Jones et al., 1982). It is now time for more complex and nuanced understandings of absence from work, which take on board the insights of all of these perspectives as well as recognising the conflict inherent in absence. The conflicts of individuals and managers in dealing with absence from work arise from its complexity and ambiguity as well as from the questions of legitimacy and morality which underpin them.

Health psychologists have not focused on sickness absence as an area of research despite its relevance to health psychology. The current model appears to map to a number of existing models which are widely used in

health psychology. For example, the perceived seriousness and susceptibility aspects of the health belief model (Becker, 1974) appear to map onto the category of *Assessing Work Ability*. Perceived seriousness of illness was one of the main factors forming the assessment of whether absence from work was legitimate. In tandem with this process, individuals went about *Considering the Consequences of Absence*. This appears to map to the health belief model's construct of the assessment of the costs and benefits of the health behaviour. However, the health belief model does not address the core category of *Negotiating Legitimacy* and does not include the importance of the social aspects of absence. The theory of planned behaviour (Ajzen, 1985) does address the social aspects of health behaviours with its construct of the subjective norm. However, whilst this underlines the importance of other people's attitudes in the absence decision, it does not address the complexity of the social interaction that was described by employees or the reciprocal and contextual nature of the negotiation. The theory of planned behaviour's concept of perceived behavioural control (similar to the concept of self-efficacy which is also included in social cognitive theory; Bandura, 1998) could be likened to the concept of 'confidence' which could be reduced as one *Negative Impact of Absence* and was regained as part of *Getting Back to Normal*. Most social cognition models do not include the importance of time, which was identified by the current grounded theory model as being of central importance. In contrast, stage based models such as the transtheoretical model (Prochaska & DiClemente, 1982) do acknowledge the importance of change over time. However, the specific stages of change included in the

transtheoretical model (i.e. precontemplation, contemplation, preparation, action and maintenance) do not appear to map to the current model in any obvious way. It appears that the decision to take absence could be viewed as a health behaviour, and therefore theories which attempt to explain and predict health behaviours go some way towards explaining the decision-making process. However, they do not appear to adequately describe the social aspects of the decision and, in most cases, do not address the changes that occur over time. In addition, these theories appear to map to the first stage of the model of becoming absent and have less relevance to the later stages of the absence process.

Whilst absence can be conceptualised as a health behaviour, it could alternatively be viewed as a coping strategy for dealing with ill health. Therefore health psychology theories which relate to coping with illness may also be relevant to the understanding of absence. The relationship of the current model to Leventhal's (1970) self-regulatory model has already been discussed. Moos and Schaefer (1984) propose a crisis model of chronic illness. This model maps to the current model in a number of important ways. Moos and Schaefer propose that the crisis of illness leads to a number of changes in identity (e.g. from employee to patient), location (e.g. from work to home), role (e.g. from work roles to sick role), social support (e.g. via isolation from work colleagues) and in the future (e.g. with job uncertainty). These changes map to the current model's category of *Navigating a Different World* and to a lesser extent to the *Negative Impact of Absence* and *Feeling Supported and Connected*. They highlight the

reasons that illness and associated absence can be disorientating. This crisis theory proposes that coping can be divided into three processes: cognitive appraisal, adaptive tasks and coping skills. The cognitive appraisal aspect of the model maps to the categories of *Assessing Work Ability* and *Considering the Consequences of Absence* where the individual appraises the seriousness and the impact of their illness. *Avoiding Sickness Absence* included undertaking a number of adaptive tasks such as dealing with the illness and preserving competence. Employees drew on a number of problem-focused coping skills in order to do this. Coping skills were also used throughout the absence, in particular for *Recovering* and in avoiding the *Negative Impact of Absence*. In addition, the model assumes that individuals are motivated to re-establish equilibrium, which closely maps to the category of *Getting Back to Normal*. Moos and Schaefer's model appears to include a number of constructs which are very relevant for the understanding of sickness absence. It addresses the core category of *Negotiating Absence* since it recognises that developing and maintaining relationships with health professionals; preserving self-image, competence and mastery and sustaining relationships with family and friends are all important adaptive tasks. These tasks do not address all the processes which were described in the category of *Negotiating Absence*, but they do address the main concerns identified by the employees. However, whilst this theory appears to provide a relatively good description of the absence process, all of the health psychology theories are theories relating to health and illness and do not take into account the other aspects of absence.

In considering how health psychology theory relates to the current grounded theory model, we need to consider the differences in the underlying epistemological and ontological assumptions. Most health psychology theories are based upon positivist assumptions that truth is directly knowable and can be discovered through the analysis of empirical evidence. The present grounded theory is not intended to be predictive and does not include testable variables, but rather aims to conceptualise sickness absence in abstract terms, focusing on understanding patterns and connections in the data. It could be described as an 'interpretivist' theory (Charmaz, 2006; see section 5.5 for a fuller discussion of Charmaz's distinction between positivist and interpretivist theories).

The relevance of the crisis theory of illness to the current model suggests that perhaps absence from work is better seen as a way of coping with illness rather than a health behaviour in any traditional sense. It also highlights the relevance of absence from work to health psychologists and the importance of health psychologists becoming involved in the study of absence, since many concepts which already exist with health psychology are clearly important in the understanding of sickness absence. However, the present grounded theory model has identified that absence from work is not merely a health-related phenomenon. Rather, it is a complex issue which is influenced by individual differences and experiences, social factors, the workplace and wider contexts as well as illness. Health

psychologists have the potential to bring their existing knowledge to extend our current understanding of absence and to take absence research beyond the medical, business or social models via which it has traditionally been studied. Constructs from existing health psychology theory, in particular Moos and Schaefer's theory of coping with the crisis of illness, could be tested in future research in order to further develop sickness absence theory. However, existing theories are not adequate to explain absence from work, since they do not cross the traditional boundaries between health, work and social models of absence. A holistic model is required, incorporating aspects of theory from various disciplines, in order to provide a fuller understanding of absence from work.

The present model has a number of strengths. It is a complex model which includes social, medical, psychological and workplace aspects of absence. Workplace, health and social factors need to be considered in theories of absence. These may be objective health and work conditions; the beliefs that employees hold about health, work and the legitimacy of absence and the social context within which these operate. The beliefs of employees which were relevant to absence went beyond illness representations (Leventhal, 1970) to include beliefs about work ability and coping as well the morality of absence. Closely related to these beliefs was the attempt to maintain a positive self-concept as a good person who works hard unless prevented by ill-health. The beliefs which are specific to absence from work need to be better understood and incorporated into theory. This is discussed further in section 5.5. The present model also considers the

162

social aspects of absence, in particular its negotiation with others and the importance of support in return to work. The important role of the line manager in managing absence and supporting staff needs to be considered in theories of absence. The experience of absence could be positive where recovery was prioritised and sufficient support received. However, difficulties in navigating the absence process could arise when there was inadequate information and support. Employees who lacked support could become isolated and were more likely to report feeling devalued, lonely, depressed and low in confidence. This could suggest a potential process for the identified link between manager support and absence levels.

A further strength of the present theory is that it is a process model, which appears to be superior to static models in capturing the complexity and fluidity of the absence experience. The experience of absence appears to change over time and longer absences were normally reported to be more negative. However, this depended on the reason for absence and the support received from work. Theories of absence need to incorporate the importance of changes over time to the implications of illness and of being absent from work and to judgements about legitimacy.

The most important determinants of return to work were the degree of recovery; support received from managers and colleagues; the negative implications of remaining off work and any barriers to returning to work.

Recovery and the health aspects of absence are important aspects of sickness absence and should be incorporated into theories of absence. Whilst this may appear a rather obvious recommendation, many theories of absence have not given sufficient weight to the role of ill health. However, this was not a passive process. Access to healthcare and active attempts at recovering were also important factors.

The model developed in this study is not generalisable to other groups. However, this research provides important insights which could inform future formal theories of absence. These in turn can be tested with other groups of employees. The understanding of absence gained from this research also has more practical implications for policy and practice in the workplace, in healthcare and at a government level.

5.4 Implications for policy and practice

The research has a number of implications for workplace policy and its implementation. The research confirmed that workplace policies could lead to fear of disciplinary action and job loss and, as a result, could promote presenteeism. This was a particular concern for those with chronic conditions. A proactive approach to wellbeing at work may be required for these employees. As well as additional support for line managers (see section 5.2), adjustments to work tasks or being allowed sufficient flexibility to adapt effort levels to accommodate illness may help employees to remain in work in a sustainable way. A culture shift may be required within

workplaces away from punitive measures and towards prioritising staff health and wellbeing. This shift may be helped by recognition of the conflicts of employees and managers which surround sickness absence. By recognising that most absence from work is genuine and that managers are often in a conflicted role when managing it, organisations may have the opportunity to help their staff work through these conflicts and understand one another better. The change to a more supportive workplace for employees with health conditions is likely to become more important as the workforce ages and chronic conditions become more prevalent.

Vocational rehabilitation is another approach which may help employees with long-term conditions to return to work. However, the systematic review reported in Chapter 2 found no evidence for the effectiveness for CBT pain management for vocational outcomes. This suggests that more complex interventions may be required. It appears that multi-disciplinary interventions and those which include a workplace element are most effective for helping employees with musculoskeletal disorders to return to work (Flor et al., 1992; Schaafsma et al., 2010). Similarly, organisational interventions are more effective than individual ones for stress-related absence (Bhui et al., 2012). This is despite individual interventions having positive health effects for both musculoskeletal and stress-related conditions (Bhui et al., 2012; Williams et al., 2012). Occupational health departments often offer individual level interventions such as physiotherapy or counselling, however, without changes to the workplace, these interventions may not aid return to work. In addition, the evidence for

specific interventions needs to be improved so that occupational health departments and the government's new health and work assessment and advisory service can offer the most effective interventions. These departments or GPs may recommend workplace adjustments, however, these recommendations need to be implemented by managers. Study 2 highlighted that there could be problems with this happening in practice as well as with other aspects of the operationalisation of policy. Suggestions for improving the implementation of policies by managers are made in section 5.2.

A further problem with workplace policy was its tendency to be rigid and punitive. This resulted in presenteeism and delays in return to work, due to a perceived need to 'properly' recover. Policies may need to be amended in order to promote return to work when the employee first feels ready. For example, the use of phased return to work could be extended in order that more employees are given the opportunity to build their work capacity whilst in work. Employees should be given flexible working conditions as far as possible in order that they are able to adjust their work to their reduced capacity. In addition, a grace period could be introduced following return to work where employees can trial a return to work and can take further absence if necessary without it being recorded as a second period of absence. These measures may encourage employees to attend work even if not 100 percent recovered and may reduce the perceived risk associated with return to work.

5.5 Limitations and future research

There are a number of limitations to this research, in part due to the methodology employed. One limitation to the grounded theory study was the difficulty with recruitment described in sections 3.5.1 and 3.5.3, which resulted in an inability to use theoretical sampling. Since this is an important aspect of grounded theory, this could potentially have implications for the resulting theory. If it had been possible to use theoretical sampling, different groups may have been targeted for inclusion in the sample. For example, given the importance of establishing legitimacy, this element of the theory may have been furthered by including those who admitted to taking non-legitimate absence. Previous research has identified that young men are more likely to take non-legitimate absence (e.g. Barnes et al., 2008) and this group could have been targeted. However, this is likely to be a difficult to reach group and therefore it may not have been possible to include them. Other groups which would have been targeted to further the theory given early findings were those with chronic illnesses and those experiencing stress at work. Fortunately, later interviews did include these groups and therefore these aspects of the theory were developed. One group that was not considered in this study were the employees who did not return to work. These employees may have very different experiences of absence and the current research does not include these experiences. Further research is needed to understand the impact of absence for this group.

The study was conducted within a specific context and used a qualitative approach, therefore is not generalisable to other groups. However, the concerns of the NHS employees were similar to those found in previous qualitative research. Further research is needed to explore how far the present grounded theory is applicable to other groups. Specific aspects of the theory also require further study, for example, the beliefs of employees which relate to work attendance. These may include beliefs about work ability, beliefs about the workplace and moral beliefs about absence and the self. More research is needed to understand these absence-related beliefs, which appeared to be related to, but go beyond, illness representations. Given the knowledge that already exists on illness representations and other health-related beliefs in the field of health psychology, health psychologists may be well-placed to develop research on absence beliefs. At present, little research has been undertaken from this perspective. Research into these beliefs may be one step towards developing a more holistic theory of sickness absence.

The present study attempted to describe and explain sickness absence, a very complex process which includes a wide-ranging set of behaviours and experiences. Focusing on a narrower aspect of absence may have allowed a model to be developed which was more useful in terms of predicting absence behaviours. The broad aims of the study therefore inevitably limited the depth of explanatory power that the model was able to achieve. As a consequence of this broad focus, the conclusions that we can draw from the research are somewhat limited. The model can best be understood

as a high level description of a complex and multi-faceted process and each aspect requires further development in order to provide a more in-depth explanation. A formal theory of sickness absence would need to include a wide variety of variables, mediators and outcomes in order to adequately explain and predict sickness absence. Prediction of absence is something the present process model clearly should not attempt, and was not intended, to do. However, this critique can be levelled not only at the current model but at grounded theory models in general.

There has been much debate about the meaning of 'theory' in grounded theory. In their original description of grounded theory, Glaser and Strauss (1967) appear to conceptualise grounded theories as being capable of prediction and the categories included in the theories appear to be viewed as variables. If grounded theory had been conceptualised in this way (though it was not in this study), it is clear that the present model would not come close to a successful predictive model. A formal, predictive model of sickness absence would need to address a huge number of predictors, mediators and outcomes, something which the present process model is not intended to do and is not capable of doing. However, the more traditional grounded theory approach of Glaser and Strauss (1967) has been criticised for attempting to develop predictive models using a qualitative method. Some critics have argued that the limitations associated with this approach mean that grounded theory is not 'theory' in any meaningful sense of the word (Thomas & James, 2006). They argue that theory can be understood in two ways – firstly as relating to patterns found in data and secondly as

explanation and prediction. They argue that grounded theory confuses these two processes and, as a result, promises too much. Thomas and James surely make a valid point about the word 'theory' leading to confusion based on common positivist and functionalist assumptions about the meaning of theory. Charmaz (2006) offers a similar analysis, agreeing that disagreements about grounded theory often arise from differing assumptions about what theory is. She also identified two main interpretations of what theory is, which she terms 'positivist' and 'interpretivist'. Positivist theories are characterised by treating concepts as variables, specifying relationships between concepts, explaining and predicting these relationships, systematising knowledge and hypothesis testing. On the other hand, interpretivist theories emphasise understanding and focus on patterns and connections rather than causation. They aim to conceptualise phenomena in abstract terms; consider theory in terms of scope, depth, power and relevance; acknowledge subjectivity and present an imaginative interpretation. These two interpretations of what theory is map almost directly onto Thomas and James' (2006) conceptualisations. However, in contrast to Thomas and James, Charmaz views interpretative theory as equally valid.

Using Charmaz's terms, the present analysis can be better described as interpretative rather than positivist, since it aims to provide a complex analysis of how the meanings of absence are presented as well as a description of the process. In line with Charmaz, I have used the term 'theory' to describe the analysis and resulting model. However, it is

important to note the limitations of grounded theory in order to address the confusion that this terminology is likely to lead to for those who are unfamiliar with the grounded theory method. The use of grounded theory to develop predictive models seems fraught with difficulties, since the qualitative approach is, by its very nature, subjective. Rather, a grounded theory should be viewed as a complex description of a phenomenon that reaches a level of abstraction which provides it with some explanatory power (Birks & Mills, 2011).

There are a number of intervention studies which aim to promote return to work. However, there are still gaps in this literature. There is a need for further intervention studies for work-related stress, both on an individual and organisational level. These studies should measure absence or return to work as an outcome in order to better establish the interventions which are effective for these outcomes. There is also a need to compare multi-disciplinary interventions for pain management to establish the most effective elements of these interventions. This is another area where health psychologists can contribute more than they currently do. Psychological aspects of intervention are currently poorly described and often poorly implemented (Ecclestone et al., 2009). However, their inclusion in multi-disciplinary interventions may potentially increase the intervention's effectiveness (Schonstein et al., 2003). Health psychologists have the capability to design high quality psychological self-management interventions for a range of conditions. Robust investigation of these types of intervention within multi-disciplinary programmes is needed. In addition,

interventions which target managers need further study. Despite the existence of a number of manager resources for managing health (e.g. Shift, 2007), there are currently few studies which investigate the effectiveness of manager training for reducing absence, although the GEM study (2013) is an important step forward in that regard. Further research in this area is therefore needed.

5.6 Recommendations and conclusions

A number of recommendations for practice can be made based on the findings of this research. It is suggested that organisations need to provide a supportive environment for staff, which promotes wellbeing at work and encourages return to work rather than punishing absence. There are a number of ways in which this may be achieved. Line managers are likely to require more support from senior management as well as training in managing absence and in understanding stress and chronic conditions. A more proactive approach to preventing absence is likely to be useful, for example, by routinely making adjustments for employees with health conditions and by actively assessing and addressing workplace stressors. Sickness absence may be made easier and return to work promoted by providing clear information to employees on the absence process when they first become absent and by encouraging regular supportive contact from managers during absence. Return to work can be further promoted by increasing flexible working and access to workplace adjustments; by closer collaboration of health professionals with the workplace and by introducing a

grace period in which employees becoming absent for a second time are not penalised.

The implementation of these recommendations is likely to require a culture shift on the part of organisations, due to the widespread view that absence from work is deviant and the suspicion that absent employees are treating their colleagues unfairly. It will require managers to focus more on promoting wellbeing than on policing absence. This change is unlikely to be easy, given the shift in attitudes that may be required. The present model of absence furthers our understanding of absence from work by identifying the ways in which concerns about legitimacy underpin decisions about and the negotiation of absence. It has identified that there a number of beliefs which underlie employees' and managers' conflicts about absence from work which are not fully understood. Health psychologists should now turn their attention to studying these beliefs regarding illness, the workplace, coping and the morality of absence, since they may help us to understand how employees, managers and organisations can improve the management of absence and heath at work.

Chapter 6

Reflection

_____

6.1 Introduction

In this chapter, I will reflect on my development as a health psychologist over the last four years and will discuss my experiences in relation to the learning and change that has gone with them. My experiences have led to different types of learning which are broadly in line with Mezirow's (1990) concept of critical reflection. He identifies three types of reflection: content reflection, which refers to reflection on the substance of a problem (the 'what'); process reflection, which refers to reflection on procedures for solving a problem (the 'how') and premise reflection, or critical reflection, which refers to reflection on the underlying assumptions of a problem (the 'why'). Drawing on these types of reflection, I will discuss the acquisition of skills (the 'what'); the ways in which I ensured I acquired these skills in changing circumstances (the 'how') and my self-development as a health psychologist (the 'why'). I will reflect on specific skills and incidents which are relevant to my development as a health psychologist. Prior to reflecting on these subjects, I will briefly describe the roles I have worked in over the last four years to provide a context for the reflection which follows.

6.2 Context

At the time I began the doctorate, I had been in the same job for three years, working as a Cognitive Behavioural Practitioner for the Condition Management Programme (CMP), a programme which was developed by the NHS and the Jobcentre Plus. This job was mainly focused on intervention and teaching: I provided self-management advice to individuals who were claiming sickness benefits. It was also a good context for developing my professional skills, particularly in working ethically with clients, maintaining professional boundaries and working within a multidisciplinary team. A few months after commencing the doctoral programme, it was announced that the funding for CMP would be cut in April 2011. After much uncertainty, we were informed that a new redeployment opportunity was available for a small number of the team. There would be a new service known as 'Worksure', employing seven members of staff. This post would involve providing self-management advice to NHS staff with health conditions by telephone and by post. This job also focused on intervention and teaching, although the method of delivery was quite different to the one I had been used to, and therefore it appeared to be an opportunity to broaden my skills. The role also included more responsibility, since the majority of the advice would be provided by unqualified staff, and therefore my role would be relatively senior within the team (although my grade would be the same). Therefore it also seemed to offer the prospect of building on my professional skills. In April 2011, I began employment with the Worksure service. I hoped that this would mark the beginning of a more settled and less stressful period at work;

however, this was not the case. In the summer of 2011, the post of Worksure Manager was cut due to reductions in funding, and our manager was redeployed to another area. In her place, we were given another manager who was already responsible for two other services and did not have the time to fulfil the manager's role. Our team leader therefore took on most of the manager's role as well as trying to fulfil her own. As the next most senior member of staff, I picked up more clients and some of the supervision responsibilities. As time went on, I found it increasingly difficult to juggle these work responsibilities with the demands of the doctorate and also try to have time for rest and recreation. Therefore, I needed to think of strategies to ensure that I was able to develop the skills I needed as a health psychologist in addition to fulfilling the requirements of my day job. The pressure on me increased further when our team leader took long-term sickness absence due to stress. I was then the most senior member of the team, with the exception of our manager, who was not based at our site and whom we saw infrequently. I therefore had to be creative in considering how I developed in a high pressure context where I did not feel adequately supported. The strategies I used to do this will be evaluated in section 6.4. As time progressed, the difficulties I described led to me reconsidering my career path via a deeper reflection on my reasons for wanting to be a health psychologist and what I wanted from my career. As a result of this, I decided to take a different career path and began a PhD focusing on workplace stress at Cardiff Metropolitan University in January 2013. The reflection which led me to this decision is described in section 6.5.

6.3 Gaining skills and competencies

The most straightforward aspect of my development as a health psychologist has been the acquisition of certain skills throughout my training. This was the type of learning I had most anticipated and planned for at the start of the course, since the doctorate is structured in order to ensure that certain competencies are evidenced. These are fully described in the portfolio, in particular the professional skills log, and therefore will only be briefly discussed here. Some of the competencies were integral to my work roles, particularly intervention, professional skills and teaching. However, the research and consultancy competencies were additional to my work role and occasionally even appeared to conflict with it. For example, for the research I conducted interviews and therefore needed to develop my skills in interviewing. I found this difficult at first, since there were so many elements of the interview to focus on: understanding what the interviewee was saying; picking out relevant information for elaboration; covering all the questions; building a rapport with the interviewee and time management. In addition, I found that the similarity of the information given in the interview to that given to me in my work role, made it more difficult to separate the two and I had to repress the impulse to give advice. This was potentially made more difficult due to the way my work was managed, which meant I was likely to be providing advice to employees on the same day I was interviewing. One additional measure that I believe would have helped me to focus on the skills outside of my work role was setting aside a day a week to work on the research.

However, my attempts to adjust my working schedule were not very successful and my informal request to reduce or compress my hours was denied. This led me to reflect on the difficulties I was facing in a different way. I knew what needed to change, but I needed to consider different strategies to solving the problems. This was therefore a shift from Mezirow's (1990) content reflection on what needed to change, to process reflection – a consideration of how I could ensure I gained the skills I needed whilst working in a pressurised and inflexible context.

6.4 Strategies for maximising skills development

My difficulty in setting aside time to focus on the research was one symptom of a greater difficulty in managing the various demands on my time. This led to me consider how I might best develop the skills I needed across the competencies within my work context. The job within Worksure allowed me scope to develop the interventions competencies, since the role was focused on providing advice to help staff to self-manage their health using a variety of approaches. This competency built on the intervention skills I had acquired in my previous job with CMP. The role also allowed me to develop different methods of teaching and training. The advice that I provided was in the form of psycho-education and providing this at a distance via telephone and post was a new challenge which led me to develop different strategies for teaching. As I was now working with more unqualified staff, I provided more training on basic issues such as record-keeping. In addition to developing my teaching and training skills, this was relevant to the development of my professional skills. I had more

responsibility for less senior members of staff and I took on supervision responsibilities for two employees, therefore, part of this responsibility was to ensure that they were working within their own boundaries. For example, they needed to know how and when to pass on a call to a more senior member of staff; they needed sufficient knowledge to give basic advice on health conditions; they needed to understand that only approved and evidence-based advice could be given and they needed to maintain clear and neutral records of their conversations with staff and the advice they gave. However, I was aware that the pressures on me could be a problem for me professionally. In line with Karasek and Theorell's (1990) theory of stress, I felt that the high demands on me coupled with a lack of control (for example, in adjusting my working hours) were leading me to feel under strain. I therefore needed some strategies to combat this in order to ensure that I was competent to continue doing my job. This led to me considering the resources that I needed to function at work; the number of demands I took on and the support I needed.

Karasek and Theorell's (1990) theory suggests that stress can be reduced by reducing demands, increasing control and receiving support. I attempted to address the problem by using a combination of these strategies. Simply making a plan increased my feelings of control over the situation. I considered where I could reduce demands and concluded the main opportunity for doing this was in the work I did with employees. However, I still had a professional responsibility to provide support to staff. Therefore, I began to provide more advice about other support services

and provide more written information to employees. This allowed me to reduce the number of staff members who I was providing more in-depth intervention to, while still ensuring they had appropriate support, and to maintain more appropriate boundaries in terms of what I was able to provide. I believe attempting to do more than this would have stretched me too much and would have therefore compromised my professional responsibility not to go beyond my competence. Secondly, I considered the support that I had for doing my role. Given the demands on my line manager, I felt that I needed additional professional support. Therefore, I got in touch with the Head of Psychology and asked for additional supervision. This was a long process and it took around six months to arrange a supervisor, but finally I was contacted by a Clinical Psychologist who offered me some supervision. This was a huge help as I was now offered empathy, support, helpful suggestions and insightful questions which led to me feeling that I had more of a sense of direction and control. This support allowed me to remain professional and to provide support to the clients of the service and my supervisees.

Whilst these strategies helped me to maintain and develop my professional skills, I also needed to consider how to develop my consultancy and research competencies within the Worksure context. This was more difficult, since, unlike the other competencies, they were an added extra rather than an integral part of my job. This problem required a consideration of how I could manage my time. My first strategy was to ask for a reduction in my work hours, since I felt that the most effective way for

me to manage my time would be to dedicate one day per week to working on my consultancy and research skills. However, I was informed that reducing or rearranging my working hours was not an option and that I would only be allowed one hour per day away from my substantive role. Taking this time in one hour chunks did not appear to allow me sufficient periods of time to develop the skills I needed in depth. Therefore, I structured fewer longer periods of time at the middle or end of the week, when the Worksure service was quieter. I took these at the end of the day, which allowed me to continue working beyond the end of the working day. However, this strategy was only partially successful since the demands on me did not always allow me to take this time and I was prone to being interrupted by telephone calls or queries from my supervisees. Although this strategy allowed me to develop the skills I needed to a certain degree, I was not entirely successful in integrating the competing demands of my work life and I noticed that I was becoming exhausted. This realisation led me to a deeper questioning of my role as a health psychologist within the NHS and in general. The nature of my reflections on what I was doing changed from questioning how I could develop as a health psychologist within my work context to deeper questions about why I wanted a career in health psychology at all. In Mezirow's (1990) terms, I had moved from process reflection, to the deepest type of reflection, premise reflection, where I began to question my underlying assumptions about where the path I had chosen was taking me and whether I wanted to go there.

6.5 Rethinking what is important

Mezirow (1990) argues that premise reflection or critical reflection is the type of reflection which may lead to profound, transformational learning. However, it is also the most difficult since it stems from questioning some fundamental assumptions. I had begun the doctorate assuming that I would continue to work in the NHS in the field of health psychology and I assumed that I would continue to work directly with clients, using a range of interventions. However, due to the difficulties I had experienced, I began to question this and I began to ask myself whether I wanted to continue working in this field. This led me to question what it means to me to be a health psychologist. I felt that the basis of what a health psychologist is could be found in a careful consideration of the competencies, in particular, those relating to professional skills. To be a health psychologist is to be a professional who works ethically; who provides psychological advice to others and who continues developing. These were ideals which still resonated with me. I wanted to provide help and guidance to others through my psychological knowledge; I wanted to work ethically and professionally and I wanted to continue to develop myself to do these things to the best of my ability. However, I concluded that my desire to work to the best of my ability may not be compatible with the context I was working in, since self-development and working ethically did not appear to be seen as priorities by those working in senior positions in my department.

Although I concluded that I was committed to a career in health psychology, it was time to use the skills and competencies that I had acquired to do something different. The opportunity arose to undertake a PhD in the area of workplace stress. This appeared to offer me the chance to use some of the knowledge I have already gained in workplace health and research skills whilst also developing in some of the areas which I used less in my previous roles: research and academic teaching. I was excited about taking on this new challenge but still unsure of what this move would mean for my career. However, the learning and change I have experienced over that last four years has changed my expectations about my future career. Health psychology does not have a clear career structure, and working contexts can change over time. My experience means that I am now prepared to be more flexible in my career plans and expect that I may need to alter my plans to accommodate changes at work. However, in the fundamentals I am less prepared to be flexible. I now feel I have a clearer perspective on the things which are foundational to health psychology. I am less willing to accept working environments which do not place a high value on the development and wellbeing of staff and on providing high quality advice to clients. I feel that by reflecting at a deeper, more critical level on what it means to be a health psychologist, I have gained a new perspective on what really matters. This perspective will underpin the career decisions I make in future. More importantly, it will form the foundation of the health psychologist that I am becoming.

References

_____

Acas (2010). *Managing Attendance and Employee Turnover,* Acas.
Retrieved 10/8/13 from www.acas.org.uk

Ajzen, I. (1985). From intentions to actions: a theory of planned
behavior. In J. Kuhl and J. Beckman (Eds.), *Action-control: From
cognition to behavior.* Retrieved 9/2/14 from
http://people.umass.edu/aizen/publications.html

Alexanderson, K. & Hensing, G. (2004). More and better research
needed on sickness absence. *Scandinavian journal of public health,
32(5),* 321-323.

Alexanderson, K. & Norlund, A. (2004). Sickness absence: causes,
consequences, and physicians' sickness certification practice. A
systematic literature review by the Swedish Council on Technology
Assessment in Health Care (SBU). Preface. *Scandinavian journal of
public health, 32(Suppl. 63),* 3-4.

Allebeck, P. & Mastekaasa, A. (2004a). Swedish Council on Technology Assessment in Health Care (SBU). Chapter 5. Risk factors for sick leave - general studies. *Scandinavian journal of public health, 32(Suppl. 63),* 49-108.

Allebeck, P. & Mastekaasa, A. (2004b). Swedish Council on Technology Assessment in Health Care (SBU). Chapter 3. Causes of sickness absence: research approaches and explanatory models. *Scandinavian journal of public health, 32(Suppl. 63),* 36-43.

Allen, S.G. (1981). An Empirical Model of Work Attendance. *The Review of Economics and Statistics, 63(1),* 77-87.

Annells, M. (1996). Grounded theory method: Philisophical perspectives, paradigm of inquiry and postmodernism. *Qualitative Health Research, 6,* 379-93.

Ås, D. (1962). Absenteeism – a social fact in need of a theory. *Acta Sociologica, 6,* 278 – 86.

Baltes, R.B. ,Briggs, T.E., Huff, J.W., Wright, J.A., & Neuman, G.A. (1999). Flexible and compressed workweek schedules: a meta-analysis

of their effects on work-related criteria. *Journal of Applied Psychology, 84*, 496-513.

Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology and Health, 13,* 623-649.

Barnes, M.C., Buck, R., Williams, G., Webb, K. & Aylward, M. (2008). Beliefs about common health problems and work: A qualitative study. *Social Science and Medicine, 67(4),* 657-665.

Beatty, C. & Fothergill, S. (2011). *Incapacity Benefit Reform: The Local, Regional and National Impact,* Sheffield, CRESR.

Becker, M.H. (1974). The health belief model and personal health behaviour. *Health Education Monographs, 2,* 324-508.

Bergström, G., Bodin, L., Hagberg, J., Lindh, T., Aronsson, G. & Josephson, M. (2009). Does sickness presenteeism have an impact on future general health? *International archives of occupational and environmental health, 82(10),* 1179-90.

Bhui, K.S., Dinos, S. Stansfeld, S.A. & White, P.D. (2012). A synthesis of the evidence for managing stress at work: a review of the reviews reporting on anxiety, depression, and absenteeism. *Journal of Environmental and Public Health, 2012,* Article ID 515874, 21 pages doi:10.1155/2012/515874

Birks, M. & Mills, J. (2011). *Grounded Theory: A Practical Guide,* London, Sage.

Black, C. (2008). *Working for a healthier tomorrow,* London, TSO.

Black, C. & Frost, D. (2011). *Health at Work- An Independent Review of Sickness Absence,* London, TSO*.*

Boorman, S. (2009). *NHS Health and Well-being – Final Report,* London, Department of Health.

British Occupational Health Research Foundation [BOHRF] (2010). *Managing Rehabilitation: A Competency Framework for Managers to Support Return to Work*, BOHRF. Retrieved 10/04/11 from http://www.bohrf.org.uk/projects/rehabilitation.html

Broadbent, E., Petrie, K.J., Ellis, C.J., Ying, J. and Gamble, G. (2004). A picture of health - myocardial infarction patients' drawings of their hearts and subsequent disability: a longitudinal study. *Journal of psychosomatic research, 57(6),* 583-7.

Brooke, P.P. (1986). Beyond the Steers and Rhodes model of employee attendance. *Academy of Management Review, 11(2),* 345-61.

Brookes, K., Limbert, C., Deacy,C., O'Reilly, A., Scott, S. & Thirlaway, K. (2013). Systematic review: Work-related stress and the HSE Management Standards. *Occupational Medicine, 63,* 463-472.

Brown, M., Ralph, S. & Brember, I. (2002) Change-linked work-related stress in British teachers. *Research in Education. 67,* 1-12.

Buck, R., Porteous, C., Wynne-Jones, G., Marsh, K., Phillips, C.J. & Main, C.J. (2011). Challenges to Remaining at Work with Common Health Problems : What Helps and What Influence Do Organisational Policies Have? *Journal of Occupational Rehabilitation, 21,* 501-12.

Cadman, C. (2013). Employee training: ticking the box or building business competence? *Industrial and Commercial Training, 45(1),* 32-35.

Carroll, C. Rick, J., Pilgrim, H., Cameron, J. & Hillage, J. (2010). Workplace involvement improves return to work rates among employees with back pain on long-term sick leave: a systematic review of the effectiveness and cost-effectiveness of interventions. *Disability & Rehabilitation, 32(8),* 607-621.

Chadwick-Jones, J.K., Brown, C.A., Nicholson, N. (1973). Absence from work: its meaning, measurement, and control. *International Review of Applied Psychology, 22,*137–55.

Chadwick-Jones, J.K., Nicholson, N. & Brown, C.A. (1982). *Social Psychology of Absenteeism,* New York, Praeger.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis,* London, Sage.

Charmaz, K. (2004). Grounded theory. In S.N. Hesse-Biber & P. Leavy (Eds.). *Approaches to Qualitative Research: A Reader on Theory and Practice*, Oxford, University Press.

Charmaz, K. (1983). Loss of self: a fundamental form of suffering in the chronically ill. *Sociology of Health & Illness, 5(2),* 168-95.

Chartered Institute for Personnel and Development [CIPD] (2013a). *Real Life Leaders: Closing the Knowing-Doing Gap.* CIPD. Retrieved 26/9/13 from http://www.cipd.co.uk/hr-resources/research/real-life-leaders.aspx

Chartered Institute for Personnel and Development [CIPD] (2013b). *Absence measurement and management.* CIPD. Retrieved 11/08/13 from http://www.cipd.co.uk/hr-resources/factsheets/absence-measurement-management.aspx

Chartered Institute for Personnel and Development [CIPD] (2012). *Absence management: annual survey report 2012*, CIPD. Retrieved 16/10/12 from https://www.cipd.co.uk/hr-resources/survey-reports/absence-management-2012.aspx

Cochrane Collaboration (2007). *Handbook for Systematic Reviews of Health Promotion and Public Health Interventions*. Retrieved 11/10/09 from http://ph.cochrane.org/resources-and-guidance

Committee of Public Accounts (2013). *Department for Work and Pensions: Contract management of medical services. Twenty-third Report of Session 2012–13*, London, TSO.

Confederation of British Industry [CBI] (2011). *Health Returns? Absence and Workplace Health Survey,* CBI. Retrieved 11/10/12 from http://www.cbi.org.uk/media/955604/2011.05-healthy_returns_-_absence_and_workplace_health_survey_2011.pdf

Corbin, J. & Strauss, A. (2008). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques (3rd Edition),* London, Sage.

Corey, D.T., Etlin, D. & Miller, P.C. (1987). A home-based pain management and rehabilitation programme: An evaluation. *Pain, 29,* 219-229.

Coutu, M., Baril, Durand, R., Côté, M. & Rouleau, A. (2007). Representations: an important key to understanding workers' coping behaviors during rehabilitation and the return-to-work process. *Journal of Occupational Rehabilitation, 17(3),* 522-44.

Cutler, R.B., Fishbain, D.A., Rosomoff, H.L., Abdel-Moty, E., Khalil T.M. & Rosomoff, R.S. (1994). Does nonsurgical pain center treatment of chronic pain return patients to work? A review and meta-analysis of the literature. *Spine, 19*, 643–652.

D'Amato, A. & Zijlstra, F. (2010). Toward a Climate for Work Resumption: The Nonmedical Determinants of Return to Work. *Journal of Occupational and Environmental Medicine, 52(1),* 67-80.

Danermark, B., Ekström, M., Jakobsen, L. & Karlsson, J.C. (2002). *Explaining Society: Critical Realism in the Social Sciences,* Abingdon, Routledge.

Department of Health (2011). *The Public Health Responsibility Deal.* DOH. Retrieved on 30/7/13 from https://responsibilitydeal.dh.gov.uk/wp-content/uploads/2012/03/The-Public-Health-Responsibility-Deal-March-20111.pdf

Department for Work and Pensions (2013). *Fitness for work: the Government response to 'Health at work – an independent review of sickness absence',* London, TSO.

Dew, K., Keefe, V. & Small, K. (2005). 'Choosing' to work when sick: workplace presenteeism. *Social Science & Medicine, 60,* 2273–2282.

Diefenbach, M.A., & Leventhal, H. (1996). The common-sense model of illness representation: Theoretical and practical considerations. *The Journal of Social Distress and the Homeless, 5,* 11-38.

Duijts, S.F.A., Kant, I., Swaen, G.M.H., van den Brandt, P.A. & Zeegers, M.P.A. (2007). A meta-analysis of observational studies identifies predictors of sickness absence. *Journal of Clinical Epidemiology 60,* 1105-1115.

Dunn, C. & Wilkinson, A. (2002). Wish you were here: managing absence. *Personnel Review, 31(2),* 228-246.

Dunstan, D.A. & Covic, T. (2007). Can a rural community-based work-related activity program make a difference for chronic pain-disabled injured workers? *Australian Journal of Rural Health, 15,* 166-171.

Ecclestone, C., Williams, A.C. & Morley, S. (2009). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews, Issue 4.* Art No: CD007407. DOI: 10.1002/14651858.CD007407.pub2.

Equality Act 2010. Retrieved 3/08/11 from http://www.legislation.gov.uk/ukpga/2010/15

European Agency for Safety and Health at Work (2007). *Work-related musculoskeletal disorders: Back to work report,* Luxembourg, Office for Official Publications of the European Communities.

Fleten, N., Johnsen, R. & Førde, O.H. (2004). Length of sick leave – Why not ask the sick-listed? Sick-listed individuals predict their length of sick leave more accurately than professionals. *BMC Public Health, 4:46* doi:10.1186/1471-2458-4-46

Flor, H., Fydrich, T. & Turk, D. (1992). Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. *Pain, 49,* 221-230.

Franche, R.L., Cullen, K., Clarke, J., Irvin, E., Sinclair, S. & Frank, J. (2005). Workplace-Based Return-to-Work Interventions: A Systematic Review of the Quantitative Literature. *Journal of Occupational Rehabilitation, 15(4),* 607-631.

Frank, J., Sinclair, S., Hogg-Johnson, S., Shannon, H., Bombardier, C., Beaton, D. & Cole, D. (1998). Preventing disability from work-related low-back pain. New evidence gives new hope--if we can just get all the players onside. *Canadian Medical Association Journal, 158(12),* 1625-31.

Fyney, B. Fyney, F. & Caveny, L. (2011). *An evaluation of the Statement of Fitness for Work: qualitative research with GPs (RR780),* Sheffield, Department for Work and Pensions.

GEM Study (2013). The GEM Study. *www.gemstudy.net.* Retrieved 12/09/13 from www.gemstudy.net

Giri, P., Poole, J., Nightingale, P. and Robertson, A. (2009). Perceptions of illness and their impact on sickness absence. *Occupational Medicine, 59,* 550-555.

Glaser, B. (1992). *Emergence v Forcing: Basics of Grounded Theory Analysis.* Sociology Press, Mill Valley, CA.

Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory,* London, Aldine.

Grinyer, A. and Singleton, V. (2000). Sickness absence as risk- taking behaviour: A study of organisational and cultural factors in the public sector. *Health, Risk & Society, 2(1),* 7-21.

Guzmán, J., Esmail, R., Karjalainen, K., Malmivaara, M., Irvin, E. & Bombardier, C. (2001). Multidisciplinary rehabilitation for chronic low back pain: systematic review. *BMJ, 322(7301),* 1511-1516.

Hagger, M.S. & Orbell, S. (2003). A Meta-Analytic Review of the Common-Sense Model of Illness Representations. *Psychology & Health, 18(2),* 141-184.

Hayden, J., van Tulder, M.W., Malmivaara, A. & Koes, B.W. (2011). Exercise therapy for treatment of non-specific low back pain. *Cochrane Database of Systematic Reviews 2005, Issue 3.* Art. No.: CD000335. DOI: 10.1002/14651858.CD000335.pub2.

Health and Safety Executive [HSE] (2009). *How to tackle work-related stress: A guide for employers on making the Management Standards work.* HSE. Retrieved 10/9/13 from http://www.hse.gov.uk/pubns/indg430.pdf

Health Statistics & Analysis Unit (2013). *Sickness Absence in the NHS.* Retrieved 14/0613 from http://wales.gov.uk/topics/statistics/theme/health/nhsworkforce/nhssickness/?lang=en

Higgins, A., O'Halloran, P. & Porter, S. (2012). Management of Long Term Sickness Absence: A Systematic Realist Review. *Journal of Occupational Rehabilitation, 22(3),* 322-332.

Hoving, J.L., van der Meer, M., Volkova, A.Y. & Frings-Dresen, M.H.W. (2010). Illness perceptions and work participation: a systematic review. *International archives of occupational and environmental health, 83(6),* 595-605.

Huang, Y.H., Ho, M., Smith, G.S. & Chen, P.Y. (2006). Safety climate and self-reported injury: assessing the mediating role of employee safety control. *Accident Analysis and Prevention, 38(3),* 425-33.

Huijs, J.J.J.M., Koppes, L.L.J., Taris, T.W. & Blonk, R.W.B. (2012). Differences in predictors of return to work among long-term sick-listed employees with different self-reported reasons for sick leave. *Journal of occupational rehabilitation, 22(3),* 301-11.

Irvine, A. (2011). Fit for Work? The Influence of Sick Pay and Job Flexibility on Sickness Absence and Implications for Presenteeism. *Social Policy & Administration, 45(7),* 752-769.

Jensen, I.B., Bergstrom, G., Ljungquist, T. & Bodin, L. (2005). A 3-year follow-up of a multidisciplinary rehabilitation programme for back and neck pain. *Pain, 115,* 273-283.

Jensen, I.B., Bergstrom, G., Ljungquist, T., Bodin, L. & Nygren, A.L. (2001). A randomized controlled component analysis of a behavioral medicine rehabilitation program for chronic spinal pain: are the effects dependent on gender? *Pain, 91,* 65-78.

Jensen, I. & Bodin, L. (1998). Multimodal cognitive-behavioural treatment for workers with chronic spinal pain: a matched cohort study with an 18-month follow-up. *Pain, 76,* 35-44.

Jensen, I.B., Dahlquist, C., Nygren, A., Royen, E. & Stenberg, M. (1997). Treatment for "helpless" women suffering from chronic spinal pain: A randomized controlled 18-month follow-up study. *Journal of Occupational Rehabilitation, 7(4),* 225-238.

Jensen, I., Nygren, A., Gamberale, F., Goldie, I., Westerholm, P. & Jonsson, E. (1995). The role of the psychologist in multidisciplinary treatments for chronic neck and shoulder pain: a controlled cost-effectiveness study. *Scandinavian Journal of Rehabilitation Medicine, 27,* 19-26.

Jensen, I., Nygren, A. & Lundin, A. (1994). Cognitive-behavioural treatment for workers with chronic spinal pain: a matched and controlled cohort study in Sweden. *Occupational and Environmental Medicine, 51,* 145-151.

Johansson, C., Dahl, J., Jannert, M., Melin, L. & Andersson, G. (1998). Effects of a cognitive-behavioral pain-management program. *Behaviour Research and Therapy, 36,* 915-930.

Johansson, G. & Lundberg, I. (2004). Adjustment latitude and attendance requirements as determinants of sickness absence or attendance. Empirical tests of the illness flexibility model. *Social Science & Medicine, 58(10),* 1857-68.

Johns, G. (2010). Presenteeism in the workplace : A review and research agenda. *Journal of Organizational Behavior, 31,* 519–542.

Johns, G. (2003). How methodological diversity has improved our understanding of absenteeism from work. *Human Resource Management Review, 13(2),* 157-184.

Jowit, J. (2013) [8 January]. Strivers v Shirkers: The language of the welfare debate. *The Guardian Online.* Retrieved 15/9/13 from http://www.theguardian.com/politics/2013/jan/08/strivers-shirkers-language-welfare

Kaiser, C.P. (1998). What do we know about employee absence behavior? An interdisciplinary interpretation. *The Journal of Socio-Economics, 27(1),* 79-96.

Kapoor, S., Shaw, W.S., Pransky, G. & Patterson, W. (2006). Initial patient and clinician expectations of return to work after acute onset of work-related low back pain. *Journal of Occupational and Environmental Medicine, 48,* 1173–80.

Karasek, R.A. & Theorell, T. (1990). *Healthy Work— Stress, Productivity, and the Reconstruction of Working Life*, New York, Basic Books.

Keller, R.T. (1983). Predicting Absenteeism from Prior Absenteeism, Attitudinal Factors, and Nonattitudinal Factors. *Journal of Applied Psychology, 68(3),* 536-40.

Kendall , N.& Thompson, B.F. (1998). A Pilot Program for Dealing with the Comorbidity of Chronic Pain and Long-Term Unemployment. *Journal of Occupational Rehabilitation, 8 (1),*5-26.

Kivimäki, M., Head, J., Ferrie, J.E., Hemingway, H., Shipley, M.J., Vahtera, J. & Marmot, M.G. (2005). Working while ill as a risk factor for serious coronary events: the Whitehall II study. *American journal of public health, 95(1),* 98-102.

Kristensen, T.S. (1991). Sickness absence and work strain among Danish slaughterhouse workers: an analysis of absence from work regarded as coping behaviour. *Social Science & Medicine, 32(1),* 15-27.

Kvale, S. & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing,* London, Sage.

Kylmä, Vehviläinen-Julkunen & Lähdevirta, (1999). Ethical Considerations in a Grounded Theory Study on the Dynamics of Hope in HIV-Positive Adults and Their Significant Others. *Nursing Ethics, 6(3),* 224-239.

Lalani, M., Meadows, P., Metcalfe, H. & Rolfe, H. (2012). *Evaluation of the Statement of Fitness for Work: qualitative research with employers and employees (RR797),* Sheffield, Department for Work and Pensions.

Leventhal, H. (1970). Findings and theory in the study of fear communications. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 119–186), New York, Academic Press.

Lindell, O., Johansson , S. & Strender, L. (2008). Subacute and chronic, non-specific back and neck pain: cognitive-behavioural rehabilitation versus primary care. A randomized controlled trial. *BMC Musculoskeletal Disorders*, *9*, 172.

Linton, S.J. & Buer, N. (1995) Working despite pain: factors associated with work attendance vs. dysfunction*. International Journal of Behavioral Medicine, 2(3),* 252 – 62.

MacMillan (2011). *Managing cancer in the workplace: An employer's guide to supporting staff affected by cancer,* Retrieved 31/5/13 from http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Workandcancer/Supportformanagers/Employersguide/Employersguide.aspx

Magnussen, L.H., Strand, L.I., Skouen, J.S., Eriksen, H.R. (2009). Long-term follow-up of disability pensioners having musculoskeletal disorders. *BMC Public Health, 9,* 407.

Marhold, C., Linton, S.J. & Melin, L. (2001). A cognitive-behavioral return-to-work program: effects on pain patients with a history of long-term versus short-term sick leave. *Pain, 91,* 155-163.

Marmot, M., Feeney, A., Shipley, M., North, F. & Syme, S. (1995). Sickness absence as a measure of health status and functioning: from the UK Whitehall II study. *Journal of Epidemiology and Community Health, 49(2),*124–30.

Meijer, E.M., Sluiter, J.K. & Frings-Dresen, M.H. (1995). Evaluation of effective return-to-work treatment programs for sick-listed patients with non-specific musculoskeletal complaints: a systematic review. *International Archives of Occupational and Environmental Health, 78,* 523–532.

Mezirow, J. (1990). *Fostering Critical Reflections in Adulthood: A Guide to Transformative and Emancipatory Learning,* San Francisco, Jossey Bass.

Money, A., Hussey, L., Thorley, K., Turner, S. & Agius, R. (2010). Work-related sickness absence negotiations: GPs' qualitative perspectives. *British Journal of General Practice, 60,* 721-8.

Moos, R.H. & Schaefer, J.A. (1984). The crisis of physical illness: An overview and conceptual approach. In R.H. Moos (Ed.). *Coping with Physical Illness: New Perspectives, Vol 2,* pp. 3-25. New York: Plenum Press.

Morse, J.M. (1995). The significance of saturation. *Qualitative Health Research, 5,* 147-149.

Munir, F., Yarker, J. & Haslam, C. (2008). Sickness absence management: Encouraging attendance or 'risk-taking' presenteeism in employees with chronic illness? *Disability & Rehabilitation, 30 (19),* 1461-1472.

Munir, F., Yarker, J., Hicks, B. & Donaldson-Fielder, E. (2012). Returning employees back to work: developing a measure for Supervisors to Support Return to Work (SSRW). *Journal of occupational rehabilitation, 22(2),* 196-208.

Murphy, L.R. (1996). Stress Management in Work Settings: A Critical Review of the Health Effects. *American Journal of Health Promotion, 11(2),* 112-135.

National Audit Office Wales (2004). *The Management of Sickness Absence by NHS Trusts in Wales,* Cardiff, National Audit Office Wales.

NICE [National Institute for Health and Care Excellence] (2009). *Managing Long-term Sickness and Incapacity for Work [PH19],* London, National Institute for Health and Care Excellence.

Nieuwenhuijsen, K., Verbeek, J.H.A.M., de Boer, A.G.E.M., Blonk, R.W.B. & van Dijk, F.J.H. (2004). Supervisory behaviour as a predictor of return to work in employees absent from work due to mental health problems. *Occupational and Environmental Medicine, 61(10),* 817-23.

Norlund, A., Ropponen, A. & Alexanderson, K. (2009). Multidisciplinary interventions: review of studies of return to work after rehabilitation for low back pain. *Journal of Rehabilitation Medicine, 41,* 115-121.

North, F., Syme, S.L., Feeney, A., Head, J., Shipley, M.J. & Marmot, M.G. (1993). Explaining socioeconomic differences in sickness absence: the Whitehall II Study. *BMJ, 306(6874),* 361-6.

Palmer, K.T., Brown, I. & Hobson, J. (2013). *Fitness for Work: The Medical Aspects,* Oxford, University Press.

Parsons, T. (1951). Illness and the role of the physician: a sociological perspective. *American Journal of Orthopsychiatry, 21(3),* 452-460.

Patton, E. (2011). The devil is in the details: Judgments of responsibility and absenteeism from work. *Journal of Occupational and Organizational Psychology, 84(4),* 759–779.

Patton, E. & Johns, G. (2012). Context and the social representation of absenteeism: Absence in the popular press and in academic research*. Human Relations, 65(2),* 217-240.

Petrie, K.J. & Weinmann, J. (2006). Why illness perceptions matter. *Clinical Medicine, 6*, 536–539.

Prochaska, J.O. & DiClemente, C.C.D. (1982). *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy.* Homewood, IL: Dow Jones Irwin.

Public Health Observatory for Wales (2010). *Health needs assessment support 2010: key small area indicators. Cwm Taf Health Board,* Public Health Wales. Retrieved 15/8/11 from http://www.wales.nhs.uk/sitesplus/922/page/49835

Rhodes, S.R., & Steers, R.M. (1990). *Managing employee absenteeism,* Reading, Addison-Wesley Publishing Company.

Richardson, I.H., Richardson, P.H., De Williams, C.A.C., Featherstone, J. & Harding, V.R. (1994). The effects of a cognitive-behavioural pain management programme on the quality of work and employment status of severely impaired chronic pain patients. *Disability and Rehabilitation, 16(1),* 26-34.

Schaafsma, F., Schonstein, E., Whelan, K., Ulvestad, E., Kenny, D.T. & Verbeek, J.H. (2010). Physical conditioning programs for improving work outcomes in workers with back pain. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD001822. DOI: 10.1002/14651858.CD001822.pub2.

Schonstein, E., Kenny, D., Keating, J., Koes, B. & Herbert, L. (2003). Physical conditioning programs for workers with back and neck pain: a Cochrane systematic review. *Spine, 28*, E391–E395.

Schweikert, B., Jacobi, E., Seitz, R., Cziske, R., Ehlert, A., Knab, J. & Leidl, R. (2006). Effectiveness and cost-effectiveness of adding a cognitive behavioral treatment to the rehabilitation of chronic low back pain. *Journal of Rheumatology, 33(12),* 2519-2526.

Shaw, W.S., Findley, P.A. & Feuerstein, M. (2011). Twenty years of multidisciplinary research and practice: the Journal of Occupational Rehabilitation then and now. *Journal of occupational rehabilitation, 21(4),* 449-54.

Shift (2007). *Line Managers' Resource: A practical guide to managing and supporting people with mental health problems in the workplace*, Department of Health. Retrieved 10/06/13 from

http://www.hse.gov.uk/stress/pdfs/manage-mental-health.pdf

Steel, R.P, Rentsch, J.R. & Van Scotter, J.R. (2007). Timeframes and Absence Frameworks: A Test of Steers and Rhodes' (1978) Model of Attendance. *Journal of Management, 33,* 180-195.

Steers, R.M. & Rhodes, S.R. (1978). Major influences on employee attendance: A process model. *Journal of Applied Psychology, 63(4)*, 391-407.

Stern, P.N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz (Eds.). *The Sage Handbook of Grounded Theory,* London, Sage.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques,* London, Sage.

Taylor, P., Cunningham, I., Newsome, K. & Scholarios, D. (2010). 'Too scared to go sick'—reformulating the research agenda on sickness absence. *Industrial Relations Journal, 41(4)*, 270–288.

Thomas, G. & James, D. (2006). Reinventing grounded theory: some questions about theory, ground and discovery. *British Educational Research Journal, 32(6),* 767-795.

Thulesius,H.O. & Grahn, B.E. (2007). Reincentivizing--a new theory of work and work absence. *BMC Health Services Research, 7,* 100.

Turner, J. (1982). Comparison of Group Progressive-Relaxation Training and Cognitive-Behavioral Group Therapy for Chronic Low Back Pain. *Journal of Consulting and Clinical Psychology, 50(5),* 757-765.

Turner, J. & Jensen, M.P. (1993). Efficacy of cognitive therapy for chronic low back pain. *Pain, 52,* 169-177.

Vahtera, J., Kivimäki, M. & Pentti, J. (2001). The role of extended weekends in sickness absenteeism. *Occupational and Environmental Medicine, 58(12),* 818-22.

Vaughan-Jones, H. & Barham, L. (2009). *Healthy Work: Challenges and Opportunities to 2030.* BUPA. Retrieved 11/01/13 from http://www.theworkfoundation.com/assets/docs/publications/216_bupa_report.pdf

Waddell, G. & Burton A.K. (2006), *Is work good for your health and well-being?* London, TSO.

Wales Audit Office (2009). *The Management of Sickness Absence by NHS Trusts in* Wales – Follow up Report, Cardiff, Wales Audit Office.

Weber, M. (1930). *The Protestant Ethic and the Spirit of Capitalism,* London, Routledge.

Welfare Reform Act 2012. Retrieved 14/01/13 from http://www.legislation.gov.uk/ukpga/2012/5

White, D.C., Beecham, R. & Kirkwood, K. (2008). The Vocational Continuum: How to Make Sense of Vocational Outcomes After Group Cognitive Behavioural Therapy for Chronic Pain Sufferers. *Journal of Occupational Rehabilitation, 18,* 307-317.

Whittaker, S.C. (2001). The Management of Sickness Absence. *Occupational and Environmental Medicine, 58,* 420-424.

Williams, A.C.D.C., Eccleston, C. & Morley, S. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews 2012, Issue 11.* Art. No.: CD007407. DOI: 10.1002/14651858.CD007407.pub3.

Wynne-Jones, G., Buck, R., Porteous, C., Cooper, L., Button, L.A., Main, C.J. & Phillips, C.J. (2010). What happens to work if you're unwell? Beliefs and attitudes of managers and employees with musculoskeletal pain in a public sector setting. *Journal of occupational rehabilitation, 21,* 31-42.

Yates, S.L., Morley, S., Eccleston, C. & Williams, A.C. (2006). A scale for rating the quality of psychological trials for pain. *Pain, 117,* 314-325.

_____

Appendices

_____

Appendix 1: Systematic Review Search Strategy

Databases and journals searched

Full search	Assessed and excluded	Grey literature	Hand searched journals
Medline,	Biomed Central	SIGLE	The Journal of Occupational Health Psychology 1996-Jan 2010
PsycINFO	Cinhal	ETHOS	Pain 1996-Jan 2010
Pubmed	Emerald	Conference Proceedings Citation Index-Science (CPCI-S)	Disability and Rehabilitation 2007-2010
EMBASE			
Web of Science			
Business Source Premier			
Cochrane Library			

Medline/Pubmed search strategy

1. Chronic Disease/

2. exp Pain/

3. exp Musculoskeletal Diseases/

4. Occupational Diseases/

5. Occupational Health/

6. (pain or chronic pain or chronic disease$).tw

7. (physical suffering$ or ache$).tw

8. discomfort$.tw

9. (musculoskeletal disease$ or musculoskeletal disorder$).tw

10. (chronic$ adj1 ill$).tw

11. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10

12. Cognitive Therapy/

13. (cognitive therap$ or cognitive behavio?r$ therapy or cognitive-behavio?r$ therapy).tw

14. (cognitive psychotherap$ or cognitive behavio?r$ psychotherap$ or cognitive-behavio?r$ psychotherap$).tw

15. (cognitive intervention$ or cognitive behavio?r$ intervention$ or cognitive-behavio?r$ intervention$).tw

16. (cognitive counsel?ing or cognitive behavio?r$ counsel?ing or cognitive-behavio?r$ counsel?ing).tw

17. cbt.tw

18. 12 or13 or 14 or 15 or 16 or 17

19. 11 and 18

Appendix 2: Data extraction inclusion and exclusion criteria

Data Extraction Sheet 1

Record number:……………………………………………………..

Other records in same study:……………………………………….

Researcher performing extraction:………………………………….

Date of extraction:……………………………………………………

Chronic pain (>3 months, all patients or analysed separately)	Yes	No
Excluded patient group	Yes	No
Adults of working age	Yes	No
CBT pain management*	Yes	No
Work attendance outcome	Yes	No
Include in review?	Yes	No

Study design:

RCT/Controlled Trial	☐	Before and after	☐
Quasi-experimental	☐	Case study	☐

*Definition of CBT Pain Management:
1. Programme includes cognitive-behavioural pain management techniques e.g. pacing, relaxation, goal setting, problem solving, cognitive restructuring or teaching of cognitive coping strategies (e.g. positive self-talk)
2. Authors report that the entire programme took a CBT approach rather than this being one discrete element of a larger programme

Appendix 3: Data extraction sheet (full)

Record number:……… ………………………………………………..

Other records in same study:…………………………………………..

Researcher performing extraction:…… …………………………………..

Date of extraction:…… …………………………………………………

Full reference:…………………………………………………………………….

Type of literature: _Published article _Report _Unpublished article

_Abstract/presentation _Book/chapter _Other………….

Design of study: RCT Non-randomised trial Cohort

Before and after Other………………………..

Study date:……………………………………..

Intervention: CBT Pain man only CBT Pain man & work intervention

CBT Pain man & other (describe)…………………………..

Description of CBT…………………………………………………………..

……………………………………………………………………………………

Part of larger intervention? No Yes (describe)………………

…………………………………………………………………………………..

Population (describe age, gender, ethnicity, SES etc)………………………

……………………………………………………………………………………

How recruited?...

How randomised?...

Inclusion/exclusion criteria…………………………………………………

N …………………………………..

Type of pain……………………………………………………………………..

Duration of pain………………………………………………………………..

Any comorbidities?..

Setting of intervention…………………………………………………………………

Length of intervention…………………………………………………………………

Multidisciplinary?   Yes   No

Treatment manual used?   Yes   No

Who was CBT delivered by?...

Experience/training of practitioner(s)…………………………………………

Intervention for control group……………………………………………………

Outcomes measured: Work…………………………………………………

                          Other…………………………………………………

How was outcome measured?...

Where was outcome measured?...

Timeframe for measurement…………………………………………………

Loss to follow up……………………………………………………………

Was adherence measured?...

Results: Summary of work related findings………………………………

……………………………………………………………………………………

Summary of other findings……………………………………………………

Statistical analysis used...

……………………………………………………………………………………

Adequate sample size?   Yes   No   Unclear

Power calculation reported?   Yes   No

Ethical issues/approval reported?   Yes   No

Details...

Costs reported?   Yes   No

Details...

Funding source..

Conflict of interest?...

Notes...

……………………………………………………………………………………

……………………………………………………………………………………

Appendix 4: Quality Assessment

Rater...

Author/Year.............

Title......

Treatment Quality

Item #	Question	Item	Response
1	Has a clear rationale for the treatment been given and adequate description of its content?	Treatment content/setting	0 1 2
2	Has the total treatment duration been reported? If so: No sessions_____ Duration_____ Total hours_____	Treatment duration	0 1
3	Is there a treatment manual that describes the active components of treatment?	Manualisation	0 1 2
		Adherence to manual	0 1
4	Have the therapists been appropriately trained in the relevant procedures for this trial?	Therapist training	0 1 2
5	Is there evidence that patients have actively engaged in the treatment?	Patient engagement	0 1

Total score for section_____

Quality of Study Design and Methods

Item #	Question	Item	Response
1	Are the inclusion and exclusion criteria clearly specified?	Sample criteria	0 1
		Evidence criteria met	0 1

2	Is there evidence that CONSORT guidelines for reporting attrition have been followed?	Attrition	0	1	2
		Rates of attrition	0	1	
3	Is there a good description of the sample in the trial?	Sample characteristics	0	1	
		Group equivalence	0	1	
4	Have adequate steps been taken to minimise biases?	Randomisation	0	1	2
		Allocation bias	0	1	
		Measurement bias	0	1	
		Treatment expectations	0	1	
5	Are the outcomes that have been chosen justified, valid and reliable?	Justification of outcomes	0	1	2
		Validity of outcomes for context	0	1	2
		Reliability and sensitivity to change	0	1	2
6	Has there been a measure of any sustainable change between the treatment and control groups?	Follow up	0	1	
7	Are the statistical analyses adequate for the trial?	Power calculation	0	1	
		Sufficient sample size	0	1	
		Planned data analysis	0	1	
		Statistics reporting	0	1	
		Intention to treat analysis	0	1	
8	Has a good, well-matched, alternative treatment group been used?	Control group	0	1	2

Total score for section_____

Total score_____

Comments:

Appendix 5: Interview schedules

Interview Schedule 1: Early version

Opening
Introduce self to participant. Give a reminder of the information sheet. Check consent before proceeding.

Introduction
We have asked you to take part in this interview because we want to find out more about people's experiences of sickness absence. This interview will not influence anything in your workplace and all the results will be anonymous. The information will be held in a separate place to any other information about you and it will only be held for the purposes of the research. What we want are your honest thoughts and feelings about work and illness and this is not about checking up on you. Do you have any questions or worries before we begin?

Interview

1. **What do you think are some of the reasons people take sickness absence from work?**

   (Prompts: Can you think of any examples of colleagues or friends or family? Are there any other reasons you can think of? What do you think are the most common reasons for taking time off?)

2. **Can you tell me about what happened when you went off work?**

   (Prompts: What happened leading up to you going off? What happened when you actually went off work? How long did it last/has it lasted and do you expect it to last? What kind of illness/symptoms did you have? How did it affect you in general e.g. ability to function, mood, family life, social life etc? What do you think caused you to become ill? How did you manage it? Who did you speak to about it? Are there any ongoing effects?)

3. **How did your illness/injury affect your ability to work?**

   (Prompts: How long were you off work? How did you know you were unable to work? Were you affected when in work? How did you decide when you were ready to go back?)

4. **How do you think other people saw your absence from work?**

   (Prompts: Think about friends, family, colleagues, management, GP/clinicians, Occupational Health, Counsellor, Physio, Worksure, Union reps. How accurate were their perceptions?)

5. **What type of things do you think someone needs to take into account when deciding whether they are fit to go into work?**

(Prompts: How would you decide not to go into work? How would you decide you were ready to go back? Can you think of any examples of a time you or someone else made the wrong decision? Are there things which affect your decision which are not health related?)

6. **What support did you receive when you were absent from work?**

(Prompts: Think about GP/NHS services, private healthcare, manager, colleagues, Occupational Health, Worksure, Human Resources, Union, Mediation service. How appropriate was the support you received? How fast did things happen?)

7. **Would anything have helped you to return to work sooner?**

(Prompts: Was there any support that might have helped you? Was there anything you might do differently next time? Were there any changes in the workplace that may have helped?)

8. **What do you think would help support staff health and wellbeing?**

(Prompts: What do you think of the help that is currently available? What is working? What could be changed?)

9. **Is there anything else you would like to discuss today?**

Closing
Thank participant. Ask if they would like to receive a short report of the results.

Opening

Introduce self to participant. Give a reminder of the information sheet. Check consent before proceeding.

Introduction

We have asked you to take part in this interview because we want to find out more about people's experiences of sickness absence. This interview will not influence anything in your workplace and all the results will be anonymous. The information will be held in a separate place to any other information about you and it will only be held for the purposes of the research. What we want are your honest thoughts and feelings about work and illness and this is not about checking up on you. Do you have any questions or worries before we begin?

1. Could you tell me a bit about your absence?

2. How did your illness affect your day to day life?

3. How did your illness affect your ability to work?

4. Have you ever gone to work feeling unwell?

5. Who did you discuss your absence with/take advice from?

6. How did others see your absence?

7. What was the experience of being off work like?

8. What support did you receive while off work?

9. Did being off work change your perspective on work/yourself?

10. How did you decide when to RTW?

11. What happened when you decided to RTW?

12. What was it like when you returned?

13. "You just have to get on with it when returning to work." Do you agree with this statement and why?

14. Would anything have helped you to RTW sooner?

15. What would help support staff health and wellbeing?

16. Is there anything else you would like to discuss?

Closing

Thank participant. Ask if they would like to receive a short report of the results.

Appendix 6: Example of open and focused coding with concurrent memoing

Transcript	Open Codes	Focused codes	Memos
P04: Yeah, yeah. I feel fine now; it's just this problem with my eyes like. And with the steroids, the side effects, you know, constantly boiling, put on weight. So I joined a gym now: go to the gym, go swimming couple of times a week like - try to keep it down. I only put on about half a stone since November, since I've been on them so it's not too bad like. But I love going to the gym now, I don't know why I didn't join it years ago. Yeah, yeah. I: So maybe something good's come out of it?	Feeling fine Having problem with eyes Having side effects Putting on weight Joining a gym Swimming Trying to keep symptoms down Putting weight on Not being too bad Loving the gym	Managing health	Having health problems/side effects has impacted on general management of health?
P04: Yes, yeah I suppose that's good, a good part of it. But I'm only like five minutes away from the gym - just drive up there, hour or so in there and I enjoy that. But yeah, that's about me done. I: Yeah, okay. And the thyroid problem	Being good Being five minutes from gym Driving up Enjoying the gym		Something good can come out of the experience of illness, cf, interview 2, showing patients skin condition, interview 3 being a better person. Is this my view or his?

Appendix 7: Theoretical memo

"Genuine" absence

Absence is portrayed as either:

1. Genuine (not the person's fault)
2. Trivial (poor coping)
3. "swinging the lead", "taking advantage of the system" (wanting more time off as extra leave, using inappropriately e.g. for childcare)

2 or 3 lead to anger – letting down the team, letting down patients. This is morally wrong (unfair). There are social sanctions against those who are seen as letting down the team. In some areas of work the onus is on the sick person to prove genuineness – seems to depend on the workplace culture? There is a fear of being seen as non-genuine and more suspicion in some workplaces than others. Where does this come from? Management? The employee's perceptions/moral values/previous experience?

Consider the experience of ps who reported prior negative experience with managers:

> P02: I think it's me... my ward manager and the senior staff above her, I've talked to them both and they're absolutely brilliant, whatever we can do for you, you know what I mean? … It's just the experience I had with my previous ward manager is, it puts the fear of god into you, you know, your job and whatever... I can't afford to get sacked. Nobody can these days can they? I think it's just the fear of losing my job is keeping me from really.

> P18: My previous manager…wouldn't give you the time of day if you took half a day off… he was a bully… There's still some of that residual attitude in the department that you shouldn't really take time off and, if you do, you're sort of conning people out of your time or something

Genuine illness is seen as affording certain rights to support and flexibility. Non-genuine absence flouts this system, asks for rights without being entitled to them, hence it is unfair to others.