Encouraging Encounters

Experiences of People on Sick Leave in Their Meetings with Professionals

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"Det finns saker som man måste vara fackman för att inte förstå."
Hjalmar Söderberg
CONTENTS

ABSTRACT .................................................................................................................. 5

LIST OF PAPERS ........................................................................................................ 7

TERMINOLOGY ......................................................................................................... 8

INTRODUCTION ....................................................................................................... 9
  Studies on sickness absence .............................................................................. 10
  The sickness benefit system .............................................................................. 11
  Health ..................................................................................................................... 12
  Health promotion ................................................................................................ 13
  The importance of work ..................................................................................... 14
  Return to work .................................................................................................... 15
  The perspective of the person on sick leave ................................................... 16
  Encounters with professionals .......................................................................... 17
  Background of the project and the author ...................................................... 18

AIMS OF THE THESIS ............................................................................................ 19

METHODS ................................................................................................................. 20
  Qualitative and quantitative methods ............................................................. 20
  How the studies are related ............................................................................... 21
    The interview studies ...................................................................................... 23
    The questionnaire studies .............................................................................. 26
    The theoretical study ...................................................................................... 28
  Ethical considerations ......................................................................................... 29

RESULTS .................................................................................................................... 30
DISCUSSION .......................................................................................................................................................... 35

Methodological considerations ......................................................................................................................... 35

Discussion of the results ..................................................................................................................................... 39

Experiences of positive encounters ..................................................................................................................... 40

Encounters and demographic variables ............................................................................................................. 41

Encounters and groups of professionals ............................................................................................................. 42

Encounters and RTW ........................................................................................................................................ 44

A model of theoretical relationships between emotions, empowerment and RTW .................................................. 44

Implications for practice ..................................................................................................................................... 47

Needs for future research .................................................................................................................................. 47

General conclusions ......................................................................................................................................... 48

Svensk sammanfattning ...................................................................................................................................... 49

ACKNOWLEDGEMENTS ...................................................................................................................................... 52

REFERENCES ...................................................................................................................................................... 54

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ABSTRACT

Background: The recent increase in long-term sickness absence both in Sweden and many other countries has been met with various attempts to intensify the use of rehabilitation measures in order to prevent people from remaining long-term sickness absent. Several actors, among them professionals in healthcare, occupational health services, and social insurance are involved in handling issues related to the sick leave of an individual, and in providing measures to promote return to work (RTW). Identification of the factors that are related to RTW of the individual is a multifaceted task; therefore to meet the individual in this process is an essential challenge for many actors involved. Knowledge is needed about factors that might promote RTW in order to facilitate future research aimed at designing effective rehabilitation programs. Such information is of great importance to improve the work situations of the professionals, to decrease the cost for society, and to improve the situations for people on sick leave.

Objectives: The overall aim of the work underlying this thesis was to ascertain whether contacts between professionals and persons on sick leave might be one factor that can promote RTW, and also to identify different aspects of how such encounters are experienced by those who are sick listed.

Material and methods: Five investigations were conducted using different study designs, data, and methods of data analysis. The first two (papers I and II) concerned interviews with persons with experience of being on sick leave about positive encounters with professionals. The third study (paper III) was based on four questions about encounters, which were included in a questionnaire that was administrated to people who were on sick leave. The fourth study (paper IV) used a broad questionnaire to examine experiences of positive encounters, and the final study (paper V) proposed a model of possible effects of the contacts on RTW.

Results: The first studies (papers I and II) identified different aspects of positive experiences of encounters. For example, it seemed that important qualities included being treated with respect, feeling supported, establishing a personal relationship, and participating in decisions regarding RTW measures. Several of the interviewees stated that RTW might be promoted by positive
encounters. The investigation described in paper III showed that perceptions of interactions varied with the type of professionals, as well as with demographics. The respondents perceived their consultations with professionals within healthcare as most positive, followed by social insurance, and lastly occupational health services. In general, females, people born in Sweden, and those who were older, and had a higher education rated their encounters with professionals as more positive. The main finding reported in paper IV was that the majority of the participants had experienced being positively encountered by professionals. Three aspects of such encounters were stressed, namely being treated with “competence”, “personal attention”, and “confidence and trust”. The results related in paper V indicated that theories about empowerment and social emotions could be successfully applied in this area, after they were specifically adapted to some unique features of the interactions between sick-listed persons and rehabilitation professionals.

Conclusions: This thesis emphasizes that being positively encountered by professionals can have a beneficial impact on RTW after a period of sickness absence. More research is required to elucidate the interaction between sick-listed persons and professionals who are involved in their cases. Further studies should focus on how the professionals can be provided with methods that will help the clients increase their own ability to mobilize and develop their resources. Moreover, additional knowledge is needed to extend professional treatment strategies that enhance self-confidence and empowerment of individuals during sickness absence.

Key words: encounters, sickness absence, sick leave, return to work, client perspective, health promotion, work.
LIST OF PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals I-V:

PAPER I

PAPER II

PAPER III
Müssener U, Person A, Alexanderson A. A population-based questionnaire study of how people on sick leave perceive contacts with professionals in healthcare, occupational health services, and social insurance. Submitted 2006.

PAPER IV

PAPER V

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TERMINOLOGY

Sickness absence and sick leave: used as synonyms for temporary absence from work due to reduced work capacity caused by illness, disease or injury.

Sickness certificate: document issued by a physician to confirm reduced functional work capacity due to illness, disease or injury.

Disability pension: temporary or permanent disability pension granted to a person who is insured and has a permanent or prolonged reduction in work capacity.

Sick leave period: a continuous period of sick leave days for which a sickness certificate is issued.

Sick leave spell: can include one or more consecutive sick leave periods.

ABBREVIATION
RTW: return to work
INTRODUCTION

Sickness absence varies among different groups in society and over time. In the last few decades, long-term sickness absence has increased markedly in Sweden and other countries (1), both with regard to the number of people on sick leave and the length of sick leave spells (1-3).

In the 1980s, the levels of sick leave in Sweden increased during a period of strong economic growth, low unemployment, and high sickness benefits (4). In the 1990s, many countries carried out reforms in attempts to reduce costs related to sickness absence and to achieve equal and fair use of sickness insurance. The sick leave is still high in Sweden. This seems paradoxical, bearing in mind that, relatively speaking, the Swedish population has good health, a high standard of living, good working environments, and considerable longevity (indeed, among the longest life spans in the world) (5). The consequences of sickness absence are related to human suffering and loss of welfare, which have an economic impact on individuals and society, and this complex phenomenon is highlighted in research as well as in the media and politics.

Back and neck disorders represent one of the most common causes of both short-term and long-term sick leave and disability pension in Sweden and other nations (6). In recent years, the levels of sick leave related to psychiatric diagnoses have increased considerably in Sweden, and this constitutes the second largest diagnostic group for both sickness absence and disability pension (7). Cardiovascular conditions such as coronary artery disease and stroke represent the third most common cause (8). Furthermore, women have a higher level of sickness absence and disability pension than men (1, 9).

The dramatic rise in sick leave during the later parts of the 1990’s in Sweden, and the subsequent increase in costs have drawn attention to the issue of sick leave, and several reports have been published on this subject (4, 10-19).
Studies on sickness absence

Studies of sickness absence and disability pension have been conducted from different perspectives, for example, that of society, the insurance authorities, the health services, the employers, and the individuals on sick leave (4). Moreover, most scientific studies have been performed within the fields of medicine, sociology, or economics (Table 1). Sick leave is influenced by factors at different structural levels (for example national, local, or individual), although published studies have mainly addressed those at the level of the individual or the workplace (4). The factors that have been considered include for example health status, gender, satisfaction with work, motivation, and physical and psychosocial work environment (1, 9, 10, 20). So far, we lack the knowledge needed to understand the complicated associations amongst these elements (4), although we can conclude that single factors cannot explain the increasing levels of sickness absence.

The majority of the studies conducted thus far have dealt with risk factors for sick leave (4), and some have examined physicians’ sickness certification practices (12, 13, 21), the practice of social insurance officers (22, 23), whereas few investigations have focused on the consequences of being on sick leave (24, 25). Furthermore, a number of studies have analysed factors that might hinder or promote return to work (RTW), and the research underlying the present thesis belongs to that group. More precisely, the focus here has been on one factor that might promote RTW among persons on sick leave.

Table 1 summarizes the various aspects of studies on sickness absence (4, 26) and the aspects that are relevant to the subject of this thesis are indicated in bold type, that is, the thesis focus on one factor that might effect RTW among persons on sick leave (how persons experience they have been encountered by professionals) and this is studied from the perspective of the sick-listed person.
Table 1. Aspects used to classify studies of sickness absence according to the Swedish Council on Technology Assessment in Health Care (SBU) (4) and further developed by Alexanderson (26).

<table>
<thead>
<tr>
<th>Perspective taken in the study</th>
<th>Scientific discipline</th>
<th>Focus of the study</th>
<th>The structural level of factors included in the analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Society</td>
<td>• Medicine</td>
<td>• Risk factors for sickness absence</td>
<td>• Individual</td>
</tr>
<tr>
<td>• Insurance office</td>
<td>• Sociology</td>
<td>• Sickness certification practice</td>
<td>• Family</td>
</tr>
<tr>
<td>• Health services</td>
<td>• Psychology</td>
<td>• Factors that hinder or promote RTW</td>
<td>• Workplace</td>
</tr>
<tr>
<td>• Employer</td>
<td>• Economics</td>
<td>• Consequences of being sickness absent</td>
<td>• Local</td>
</tr>
<tr>
<td>• Sickness absentees</td>
<td>• Law</td>
<td></td>
<td>• National</td>
</tr>
<tr>
<td></td>
<td>• Public health</td>
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</table>

The sickness benefit system

To be able to understand the complexity of sickness absence, it is necessary to have some knowledge of the sickness benefit system.

The Swedish sickness benefit insurance is part of the social insurance system, which also includes family insurances, old age pension, and unemployment insurance. The insurance is public and comprehensive, that is everyone is insured, regardless of their state of health (4). The sickness insurance is intended to compensate for loss of income and offer some degree of economic security when a person has a disease or injury that leads to reduced work capacity in relation to demands of the tasks done at the workplace (4, 27).

Other European countries have stipulated a clear maximum length of a sick leave spell, (often 12 months), whereas Sweden has no such limit. The number of days that a sick leave period can be self-certified varies between countries; for instance, a sickness certificate is required from day 4 in Germany, Denmark, and Norway, but from day 1 in France and day 8 in Sweden (17). In some countries, for instance France, Belgium, and Germany, a medical officer makes the formal decision as to whether a person has met the requirements for sickness benefits (17), whereas such judgements are made by social insurance administrations in Sweden. Although the certifying physicians do not decide
whether a person is entitled to sickness benefit, the suggestions they include on the sickness certificates have a substantial impact on the judgements made by social insurance offices (4, 19, 22).

The benefit can be paid for full or part-time absence (100%, 75%, 50%, or 25%), depending on the degree of work incapacity. The first day of sick leave is a qualifying day. An insured person is entitled to compensation if her/his annual benefit-qualifying income is more than 9,500 SEK (in 2005) (1,000 EUR). If it is prognosticated that a person’s work capacity will be reduced for at least one year, she/he can qualify for disability pension.

The population of Sweden is approximately 9 million, and around 5,76 million of those people (64%) are of working age; 16-64 years old. In 2006, around 800,000 persons were receiving sickness benefits, of which 300,000 persons were on short-term or long-term sick leave, and 500,000 persons were on disability pension. The expenditures for sickness benefits, including disability pensions, amounted to approximately 90 billion SEK (9,800 billion EUR).

Health

A person’s health status is considered highly relevant when assessing her/his work ability. Discussions of health include some basic concepts; such as health, illness, sickness, and disease (28). Illness refers to symptoms that are experienced by individuals themselves. Disease refers to conditions that medical science, at a specific time, can diagnose.

According to Boorse (29), health can be described as the absence of disease, where disease is seen as a dysfunction within an organ or a system in the body. This biological discourse can be viewed as a reductionist characterization of health. Opposing views take a broader perspective and are not anchored in a biomedical context. Pörn (30) and Nordenfelt (31) have proposed ideas about the concept of health, often referred to as holistic theories, in which the notion of ability is crucial. It is the relationship between a person’s abilities and her/his vital goals that determines her/his health status. Pörn (30) suggests that we should speak of health when a person’s repertoire, that is the sum total of her/his abilities, matches her/his profile of goals. Nordenfelt defined health as when it is possible for a person to realize vital goals (31). In line with these views, disease is a type
of internal circumstance that may reduce a person’s health.

So, health is something that can be discussed in a wider context than the mere absence of disease, since health might also be compatible with some degree of disease in an individual. In other words, a person can have a disease and still be healthy in terms of attaining vital goals.

Nevertheless, disease is not an either–or term, instead it can be felt and diagnosed as more or less serious on a continuous scale ranking from “not at all” to “very ill” (28). The issue becomes more complicated when sickness absence and sickness certification are taken into consideration, because then the need for definite delineation arises. In this context, a person’s work capacity is either not decreased or it is reduced to a specific degree, and in the latter case it is also necessary to determine the extent of incapacity (for full- or part-time sickness absence). Sickness can be viewed as the social role that is assigned to, or taken by, a person who has a disease or illness in a certain culture and at a certain point in time. Both disease and illness concern symptoms and/or conditions in the body either experienced by the individuals themselves or diagnosed by medical science. This is not the case for sickness. Sickness is a social position, which involves rights and obligations, and is part of the relationship between an individual and her/his environment. Sick leave can be seen as a typical example of sickness and the sick role, and it gives the sick person a completely new legal status and a new role with the formal right to be absent from work (32).

This thesis uses a holistic view of health, in other words, health is not considered to be the opposite of disease, because a person can have a disease and still be healthy.

**Health promotion**

Ideas originating from the salutogenic model (33) were applied in all five studies underlying this thesis. This model was developed by Antonovsky (34), who used a salutogenic perspective rather than a pathogenic perspective. The latter is often applied in medical practice and concerns the causes of disease, whereas the former focuses on factors that lead to or induce health. According to the original ideas of salutogenesis, in order to promote health, it is more important to consider peoples’ resources and capacities than to concentrate on
risks, poor health, or pathology. The focus is not on what causes disease, but instead on how people, despite strain or stress, can be healthy. How an individual feels depends on how that person can handle or control the world. Furthermore, it is not a question solely for the individual, because the interaction between people and the structures of society are also important aspects of health promotion (35).

Research on sickness absence should investigate salutary factors, which are elements that can promote health, rather than simply involving low risks, for example studies of risk factors for being sick listed. Any effort to enhance a persons’ ability to work, including attempts that are not directed at curing the diagnosed disease, can be seen as an action to promote health. The rehabilitation of sick-listed persons can be viewed as a health promoting activity, and such a perspective is applied in this thesis, in particular considering one factor that might help these people RTW, namely how they experience the way they are encountered by professionals.

The importance of work

Participation in work life has an impact on the biological and psychological health of an individual, and paid work is often claimed to be essential for well-being. Work is a complex and important feature of our lives, from which we draw not only an income, but also social interaction and relationships, the feelings of belonging to a group and being needed, and achieving increased self-esteem (36-39). Since most of us spend a large portion of our time working, work has a substantial impact on the organization of our daily lives (36). Although work is something we actively seek, it is also a source of injuries and illness or disease (36, 38). However, in the present studies, work was seen as an activity that makes positive inputs in peoples lives (40), a viewpoint that has also received considerable attention in research (39, 41).

Working life entails continual and rapid changes (42), which can have a negative effect on the health of employees and therefore render them at greater risk of sickness absence. One of the basic ideas when starting this project was that long-term sick leave can lead to negative social, medical, and/or psychological consequences for the individual who is sick listed (4), for example, in the form of loss of income, life structure, social contacts, and social status.
Notwithstanding, inasmuch as participation in work is claimed to be essential for the well-being of the individual (36, 39), we obviously need to gain a deeper understanding of factors that promote RTW.

**Return to work**

The recent increase in long-term sickness absence has been met with various attempts to intensify the use of rehabilitation measures in order to prevent people from remaining long-term sickness absent (43-45). It is well known that the longer someone stays away from work, the more difficult it is for them to return to the workplace and the higher the risk of entering the disability benefit system after a period of sick leave.

Promoting RTW is an urgent issue from the standpoints of both costs and public health, and in most cases the primary aim of rehabilitation measures for people on sick leave has been to restore or improve the persons’ ability to work (4). The processing of sickness absence and the provision of RTW measures involve several actors, such as professionals in healthcare, occupational health services, and social insurance. Research has been performed to elucidate the practices of these actors with regard to making decisions about the right to sickness benefits and measures aimed at promoting RTW (19). Identification of factors related to RTW by an individual is a multifaceted task, and thus handling contacts with the person is an essential challenge for the actors involved in this process. Therefore the scientific knowledge base concerning management routines and interactions between all people involved needs to be extended (19).

On the whole, knowledge of what makes rehabilitation measures effective and of what factors that affect RTW is scarce (23, 45-48). RTW is influenced by numerous factors at different structural levels, such as the characteristics of the employee, the job, the workplace, and the insurance and healthcare systems (12, 49, 50). Unfortunately, few rehabilitation programs have proven effective in the long run (51-53). No clear determinate for the successful completion of a program can be generalized to the public at large (54). In fact, in some cases people long-term sickness absent who have not started any rehabilitation measures actually have a better prognosis for RTW than those who have taken part in rehabilitation programs (55, 56). To understand this situation, it is
essential to consider the effects of selection: people who do not take part in rehabilitation might be healthier than those who do.

It is also important to point out that RTW does not necessarily indicate the degree of successful rehabilitation. Nevertheless, it is of great interest to identify the factors that hinder or promote RTW in order to facilitate development of treatment strategies for those persons for whom RTW actually is considered. As Hansen et al (57) have described it, early discovery of individual possibilities for and obstacles to a RTW are important as a foundation for planning rehabilitation measures. Professionals should, for instance, also pay attention to the individual’s well-being and life situation when evaluating rehabilitation and RTW measures. An assessment of the efficacy of rehabilitation for vocational outcome should consider not only work return, but also stability during follow-up.

To sum up, more knowledge is needed about factors that might promote RTW so that at a later stage we will be able to proceed with research aimed at designing effective rehabilitation programs. Such knowledge is of importance to improve the work situations of professionals, to decrease the cost to society, and to promote RTW among people on sick leave. The object of the present studies was not primarily to identify factors that affect RTW, but instead to ascertain whether encounters between professionals and people on sick leave might be a factor that can promote RTW, and especially to identify different aspects of the way such interactions are experienced by the client.

**The perspective of the person on sick leave**

As mentioned above, most medical research in the area of rehabilitation and sickness absence is conducted from the perspective of the professional, the workplace, or society, and rarely from the standpoint of the sick-listed her- or himself (58). Some studies have illuminated individuals with regard to their experiences of, and view on, sickness absence, rehabilitation, and factors that they feel might promote RTW (12, 59, 60). Knowledge is needed from both the view of professionals and that of the sick-listed person concerning rehabilitation (58), to be able to understand why so many persons do not RTW as expected, and also to identify factors that promote RTW.
Listening to the individual’s own accounts might give us new angles on what they perceive as worthless or as successful measures. Furthermore, collecting data on these experiences can provide a new knowledge base (61). Such information can complement the previously accumulated research results concerning other structural levels, such as among employees and in society (62), and it will establish the importance of considering the experiences of sickness absentees, when attempting to identify factors that can promote RTW.

In all five studies included in this thesis, the individual was seen as an expert on her/his own experiences of a specific phenomenon, in this case being on sick leave, and thus the experiences are discussed from that perspective.

**Encounters with professionals**

A factor that might promote RTW is how persons on sick leave experience their encounters with the professionals that are involved in their rehabilitation, in other words, the quality of the actual meeting between the professional and the client.

During the preparation for the studies, it was found that very little is known about the specific qualities of encounters sick-listed persons experience as positive, or about how such encounters might be promoted. In a previous study (63) it was found that it is not mainly the type of rehabilitation measures, but rather how the person on sick leave experience being encountered by the professionals that is of importance for RTW. Based on this knowledge, the choice was made to focus on the individual’s experiences in this context; more specifically, the opinions of sick-listed persons regarding their encounters with professionals are studied.

Previous studies (64, 65), described and analysed expressions of negative and positive experiences of encounters with rehabilitation professionals. The present investigations were conducted from the perspective of health promotion and therefore focused on how people on sick leave experience positive encounters with professionals within healthcare, occupational health services, and at social insurance offices. The main interest was not whether positive encounters might promote RTW, but instead to investigate what qualities of the contacts with professional were considered to be positive by the clients. Few studies have considered this topic, and, to our knowledge,
only those cited above, have previously dealt with experiences of such encounters.

Background of the project and the author

At the end of the 1990s and the beginning of the new millennium, while I was working actively as an occupational therapist, I became increasingly interested in the idea of studying the contacts between patients and professionals, as well as the feelings associated with such contacts and how they might affect the clients themselves. In work with patients, it became apparent that people are affected in different ways by how they are encountered by professionals, and the outcome of rehabilitation is largely determined by the interactions between patient and caregiver. My interest in this subject continued to grow when I worked with young people who had undergone extensive trauma that had changed their life situation. In this later phase of their rehabilitation, the question of employment arose and along with that the issue of their ability to RTW after a long period outside the labour market. It became clear that the possibility of being able to go back to employment depended on, among other things, how these individuals had been encountered by professionals that had been involved in their cases, that is, professionals within healthcare, social insurance offices, employment offices, insurance companies, and other organizations. A few years later, I had the opportunity to study this phenomenon on a more scientific level, when I embarked on the research studies that led to the writing of this thesis. The focus on experiences of interactions with professionals remained, although the subjects of interest were no longer patients, but instead people with experience of being long-term sickness absent. The outcome no longer concerned the effects of rehabilitation, but rather entailed RTW in the long run.
AIMS OF THE THESIS

The overall aim of the research was to investigate how persons with experiences of long-term sickness absence experience their encounters with professionals in the areas of healthcare, occupational health service, and social insurance.

The specific aims for the studies were as follows:
- To identify and analyse statements about positive encounters with professionals made by persons who had been or were long-term sickness absent (papers I and II)
- To analyse sick-listed persons’ experiences of encounters with professionals and possible associations of those experiences with some demographic variables (papers III and IV)
- To suggest and discuss hypothetical relationships between the experiences of encounters with professionals, health, and RTW during sickness absence (paper V)
METHODS

Qualitative and quantitative methods

Since little research has been done regarding sick-listed persons’ experiences of positive encounters from professionals, first smaller interview studies were done, and, thereafter larger questionnaire studies. Both qualitative and quantitative methods were used to analyse the data. The last study was based on discussions on theoretical aspects of encounters, and on how positive encounters might affect RTW.

It was appropriate to combine qualitative and quantitative methods to obtain further information about the various aspects of contacts, particularly in light of the very limited number of investigations, and accordingly the inadequate basic research, conducted in this area. To begin with, interview studies were done in order to be able to pose detailed questions to fewer individuals about their experiences of interactions with professionals. Analyses of these interviews provided a basis for constructing questionnaire items. It was essential to perform quantitative studies of the mentioned experiences to be able to collect data from a larger group of persons on sick leave. This method was also suitable for analysing differences in the perceptions of contacts with professionals in relation to variables such as gender, age, country of birth, marital status, level of education, and self-rated health.
How the studies are related

The study reported in paper I examined the issue of whether people on sick leave might emphasize their experiences of positive encounters with professionals in relation to RTW. The study was explorative and descriptive, and no specific questions on encounters were asked during the interviews. Statements about positive encounters with professionals were found in all groups, which indicate that the interviewees regarded those experiences as an important factor for RTW.

Based on these initial findings, individual interviews were performed in which more direct questions were posed regarding experiences of encounters with professionals (paper II). An inductive and descriptive approach was used to analyse the data, and a clearer picture of the importance of the contacts appeared.

In the third study (paper III), four comprehensive and broad questions concerning encounters with professionals were constructed and included in a large questionnaire that was sent to 10,000 people on sick leave as part of a survey initiated by the National Social Insurance Board. Analyses of the collected data suggested that it is possible to use a questionnaire to obtain answers to queries about the interactions of interest, and they also revealed associations with gender, age, country of birth, and level of education.

Based on the results presented in papers I-III, a more comprehensive questionnaire was constructed that focused on the experiences of interactions with professionals. The analysis showed that the majority of the respondents felt they had been positively encountered. The study gave a more detailed picture of different aspects of such positive experiences, and possible associations with gender, age, marital status, country of birth, level of education, part- or full time sickness absence, self-rated health, depressed during the past year, and reason for sick leave.

Paper V presents theoretical aspects of encounters, along with a comprehensive model of how positive contacts can affect RTW that is based on the discussions from the findings described in papers I-III.
Figure 1 summarizes how the studies included in this thesis are related.

Figure 1. The relationships between the studies included in this thesis.

Paper I
Focus group interviews
5 groups

Paper II
Individual interviews
11 interviewees

Paper III
Questionnaire survey
6,171 respondents

Paper IV
Questionnaire survey
5,802 respondents

Paper V
Theoretical study
Study design, participants, and collection and analysis of the data

The interview studies

*Paper I*

Paper I is based on data from five focus group interviews that were conducted as part of a large interdisciplinary research project comprising an 11-year prospective cohort study being conducted by the Division of Social Medicine and Public Health at Linköping University. That project included investigation of factors that hinder and promote RTW after long-term sickness absence (66).

The interviewees
Interviewees were strategically chosen from a cohort of all 213 individuals in a Swedish city, who, in 1985, were 25–34 years of age and had a new sick leave spell that was due to back, neck, or shoulder disorders and lasted at least 28 days. Interviews with members of the cohort were conducted in 1998. For the focus group interviews, which provided the data used in the present investigation, an introductory letter about the project was mailed to 84 strategically selected persons. Sixty-three of those individuals could be reached by phone and were asked to participate in the study. Thirty-three persons agreed to take part and were assigned to one of five focus groups. In all, 18 persons were interviewed.

Drop outs
Thirty of the 63 persons contacted by phone declined to take part, because they had not had a back disorder for many years, they lacked the time, or they had other engagements on the dates of the five interviews. One person refused due to shyness. Fifteen of the 33 persons that agreed to participate did not show up at the actual interview due to acute illness, or because they could not get away from work or had forgotten the appointment.
The interviews
An interview guide was used that focused on factors that hinder or promote RTW after a period of sick leave. The interviewer did not initiate discourse about contacts the interviewees had had with professionals. The task of the interviewer was to introduce new topics related to factors that affect RTW, to balance the participation of talkative and quiet interviewees, and to continually summarize what was said during the interviews. All interviews were conducted in a public school building and lasted approximately one and a half hours, and they were audiotaped and transcribed verbatim.

Analysis
A tentative, descriptive and explorative qualitative approach was applied to analyse the data (67-69). That strategy was considered appropriate because little work had been done to elucidate the experiences of encounters with professionals during sickness absence, and hence few definitive hypotheses existed and not much was known about the nature of the phenomenon (68). The analysis was performed at the group level, and the object was not to identify individuals who made certain statements or to note the frequency or intensity of specific comments.

The three authors individually read and analysed all five transcribed interviews several times. Each author independently identified statements about positive encounters with professionals, in other words, interactions that had led to positive emotions or that were described by the interviewees with positive words or emotions. The chosen quotations were then compared and discussed in the group until agreement was reached concerning which statements to include. Thereafter patterns were searched for in the identified quotations, categories were formed, and boundaries for categories were established based on several discussions.

Paper II

Paper II is based on data from 11 individual interviews designed especially for this project to discern additional aspects of positive encounters.

The interviewees
The interviewees were strategically selected from records at the regional social insurance office. The inclusion criteria were as follows: persons living in the municipality of Linköping, who, in May 2002, were 20–60 years of age and had
been on sick leave for at least 90 days. In August 2002, an introductory letter containing information about the project was mailed to 31 persons, and nine of those agreed to participate. Two other persons who had had long periods of sickness absence and had heard about the project contacted the research group and were also included. All 11 of the selected interviewees were between 28 and 59 years of age, and they reported that they had been issued sickness certificates due to musculoskeletal disorders, mental health problems, or other disorders.

Drop outs
Of the 31 persons who met the inclusion criteria, 22 chose not to participate. Among these persons, five women were sick listed due to musculoskeletal disorders, five women and four men due to mental disorders, and one woman due to meningitis. Diagnoses were missing for the remaining five individuals (three women and two men).

The interviews
The 11 participants were interviewed individually in their homes or at the university. An interview guide containing open-ended questions was used. The participants were asked to talk about their own positive and negative experiences of contacts with professionals during their sickness absence and to explain and describe how they perceived such encounters, i.e. “How were you encountered?”, “What happened?”, “How did that make you feel?”. They were also asked in what way positive and negative encounters might affect the likelihood of their RTW. The introduction and the interview lasted approximately one hour. The interviews were audiotaped and transcribed verbatim.

Analysis
An inductive and descriptive qualitative approach was used to analyse the data (67-69). The inductive strategy was chosen to discover important patterns, themes, and interrelationships. This method first entails exploring and subsequently confirming, guiding by analytical principles rather than rules (68), and it was applied to detect additional aspects of experiences of positive encounters.

The authors read the interview transcripts independently several times, and identified statements indicating positive and negative encounters with professionals, or more precisely, interactions that the interviewees had
perceived as positive or negative, or had described in positive or negative terms. The respondents tended to talk about negative encounters to illustrate their positive experiences by way of contrast. Some expressions describing negatively experienced encounters were therefore included to better illustrate the contacts described as positive and to account for contrasts, although the focus was still on positive encounters. The selected statements were compared and discussed by the researchers until agreement was reached about which comments should be included. Thereafter, patterns were searched for in the identified quotations, categories were formed, and boundaries for the categories were established.

The questionnaire studies

Paper III

A comprehensive 50-item questionnaire concerning health, work environment, life situation, sickness absence, and perceptions of interactions with professionals was constructed by the National Social Insurance Board. Our research group was allowed to include four questions about perceptions of encounters with professionals.

The study population and the participants

The study population consisted of a random sample that included 10,781 of the total of 26,067 people in Sweden who, in 2002, were 20-64 years of age and had a new sick leave spell that started during the period 14-27 January and exceeded 14 days. The sample was drawn from a register of all people on sick leave compiled by the National Social Insurance Board. The questionnaire was sent by mail to the home addresses of the participants in May 2002. Data from 6,171 respondents (57%) were available for the analyses.

Drop outs

The external dropout rate was 43%. The number of internal dropouts for the four questions about encounters was low (4-5%).
Analysis
In this study the responses to the following four questions concerning perceptions of contacts with professionals in healthcare, occupational health services, and social insurance, respectively, were analysed:
(1) My health problems have been taken seriously by professionals.
(2) Professionals have a correct conception of my health problems and my life and work situation.
(3) Encounters with professionals have been reinforcing and supportive.
(4) Encounters with professionals have been offensive.

Each of these items (1–4) had four response options: strongly agree, agree, disagree, and strongly disagree. Respondents were asked to choose one of the four alternatives to express the degree of concordance. Logistic regression analysis was used to model the probability of positive perceptions of contact. Associations with the following demographic variables were analysed: gender, age, country of birth, and level of education.

Paper IV
Paper IV is based on a questionnaire survey concerning the experiences of encounters with professionals. The questionnaire was designed for this project.

The questionnaire
A comprehensive questionnaire about perceptions of encounters with professionals was constructed, based on the results reported in papers I-III. The questionnaire included questions on experiences of positive and negative interactions with healthcare and social insurance professionals, what emotions such encounters evoked in the respondents, and whether positive and negative encounters might promote or hinder RTW. The respondents were first asked if they had been positively encountered by these professionals, the alternatives were “yes” or “no”. Those who answered “yes” were asked: “To what extent do the following statements describe how the professional encountered you?” followed by 19 statements, for example: “She/He treated me with respect”. Respondent were asked to choose one of four alternatives to express the degree of concordance between each statement and her/his own perception, ranging from “to no extent” to “to a great extent”.
Study population and the respondents
The study population consisted of a random sample of 10,100 persons in Sweden aged 20-64, who had an ongoing full-time or part-time sick leave spell that had lasted for between 6 and 8 months as of 31 January 2003, but were not receiving disability pension. The sample was drawn from a register of all people on sick leave according to the mentioned criteria compiled by the National Social Insurance Board. The questionnaire was sent by mail to the home addresses of the participants in April 2004.

Drop outs
The external dropout rate for the questionnaire was 42%. Among the participants who stated that they had been positively encountered, 20% had not responded to all 19 items under the relevant question for healthcare, respectively 20% for social insurance.

Analysis
Factor analysis was used to identify factors underlying positive experiences of contacts with healthcare and social insurance professionals. Multiple logistic regressions were applied to identify possible associations between the individuals’ scores for each factor and demographic and other variables.

The theoretical study

Paper V

Paper V presents theories of social emotions and expounds upon the concept of empowerment in relation to sickness absence and RTW. The notions of pride/shame and empowerment/disempowerment are elucidated and discussed, and how these terms can be related in the context of sickness absence. A simple model of hypothetical relationships between pride/shame, empowerment/disempowerment, work ability, health, and RTW was developed to gain a better understanding of how encounters with professionals might affect RTW.
Table 2 summarize information about the participants, and collection and analysis of the data for paper I-IV. The fifth study (paper V) represents discussions of social emotions and empowerment, and is further described in Figure 2 in the result section.

Table 2. Characteristics of the data and methods used in paper I-IV.

<table>
<thead>
<tr>
<th>Paper</th>
<th>n</th>
<th>Age Duration of sick leave spell</th>
<th>Sick leave diagnoses</th>
<th>Geographical area</th>
<th>Methods of data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>18</td>
<td>25-34 &gt;28 days</td>
<td>Musculo-skeletal disorders</td>
<td>Municipality of Linköping, Östergötland</td>
<td>Focus group interviews</td>
<td>Qualitative, explorative and descriptive</td>
</tr>
<tr>
<td>II</td>
<td>11</td>
<td>20-60 &gt;90 days</td>
<td>All</td>
<td>Municipality of Linköping, Östergötland</td>
<td>Individual interviews</td>
<td>Qualitative, inductive and descriptive</td>
</tr>
<tr>
<td>III</td>
<td>6,171</td>
<td>20-64 &gt;14 days</td>
<td>All</td>
<td>Sweden</td>
<td>Questionnaire</td>
<td>Logistic regression analysis</td>
</tr>
<tr>
<td>IV</td>
<td>5,802</td>
<td>20-64 6-8 months</td>
<td>All</td>
<td>Sweden</td>
<td>Questionnaire</td>
<td>Factor analysis, multiple logistic regression analysis</td>
</tr>
<tr>
<td>V</td>
<td>Theoretical study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ethical considerations**

All studies were approved by the Research Ethics Committee of the Faculty of Health Sciences of Linköping University, and the Sick Leave Registration Project of Östergötland was also authorized by the National Data Inspection Board.
RESULTS

Paper I

The first study dealt with the way that long-term sick-listed persons described their experiences of positive encounters with professionals. Such descriptions were recorded in all the five focus groups, and were made by all but two of the interviewees. One of the main findings was that, when asked about factors that hinder or promote RTW, the participants actually mentioned the importance of being positively encountered.

A general observation from the analyses was that interviewees frequently attributed their positive experiences of contacts with rehabilitation professionals to sheer luck. More specifically, some participants stated that they had gone through periods of interactions with various professionals that had not been helpful in solving their problems, and then, purely by chance, they met a professional who they experienced as providing a positive encounter.

Respectful treatment appeared as one of the main categories of positive encounters. Being believed in, being taken seriously, being acknowledged as being in the right and being listened to were pointed out by the interviewees as essential elements of high-quality interactions with a positive emotional content. Moreover, the participants emphasized that it is important that a professional believes in and shows respect for the client’s problem, and also believes in her or his capacity to solve or handle the difficulties at hand.

Supportive treatment, the second major category of positive experiences of encounters, involves the importance of being strengthened and encouraged by the professionals. This included showing personal interest, that is, when a professional provided treatment beyond expectations. Another aspect was when professionals took an advocate or a spokesman role in conflicts with other professionals or with relatives, or was easy to get an appointment with.
Paper II

In the study described in paper II more directed questions about interactions with professionals were posed, and the results gave additional and more detailed knowledge about various aspects of the encounters.

Being treated with respect, feeling supported, establishing a personal relationship, perceiving demands as well-balanced, and having participated in decisions regarding rehabilitation appeared to be important qualities. The interviewees indicated that when professionals treated them in a respectful and supportive manner, they felt relieved, strengthened, improved, and helped.

A further dimension of the results concerns the issue of whether the contacts might affect RTW. Several of the interviewees believed that RTW might be promoted by positive encounters and hindered by negative encounters. Some of them claimed that if professionals did not listen, it might have a detrimental impact on the individual’s self-confidence, which in turn might delay RTW.

Paper III

The study discussed in paper II was a first attempt to use a questionnaire to investigate a larger population with regard to the ways that people on sick leave experience their interactions with professionals. An important finding was the fact that most participants answered the type of questions included in the questionnaire and the answers clearly varied.

The analysis showed that the perception of contacts varied greatly with type of professionals and with demographics. The respondents perceived their encounters with professionals within healthcare as most positive, followed by those in social insurance and occupational health services. In general, females, people born in Sweden, those who were older, and those who had a higher education rated their interactions with professionals as more positive than did males, people born in other countries, and those who were younger, had a lower education, and a lower income.

The results of this investigation were very useful when preparing for the next questionnaire study on this subject.
Paper IV

In this study (paper IV), a broad questionnaire was administered to a large sample, and this survey represents the largest that has been performed thus far in this area of research. The majority of the respondents had experienced being positively encountered by professionals.

The factor analyses identified three factors, namely, being treated with “competence”, “personal attention”, and “confidence and trust”. “Treated me with respect”, “listened to me”, and “was nice to me” were the items that most of the respondents agreed with to the largest extent. Results from the multiple logistic regressions analyses indicated that women, people born in Sweden, and those with good self-rated health who had experienced their encounters as positive did so to a greater extent than did men, people born in other countries, and those with low self-rated health. The largest differences in the ways the participants perceived positive encounters from professionals were found in relation to country of birth and self-rated health.

Paper V

In paper V an effort was made to propose a model of how encounters with professionals might influence RTW. Furthermore, concepts such as social emotions and empowerment were discussed in the context of rehabilitation of persons on sick leave. Social interaction that induces positive self-evaluation contributes to the emotion of pride; pride contributes to empowerment; and empowerment contributes to enhanced work ability and thereby to strengthened health. Contrariwise, social interaction that induces negative self-evaluation contributes to the emotion of shame; shame contributes to disempowerment; and disempowerment contributes to weakened work ability and to ill health (Figure 2).

It is suggested that the emotional dimensions involved in meetings between people on long-term sick leave and professionals may be more important variables in the rehabilitation process than has previously been recognized.
Figure 2. A simple model of hypothetical relationships between social emotions, empowerment/disempowerment, health, and RTW.
Table 3. Research questions, object of the analysis, and general results of the five studies.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Research questions</th>
<th>Focus in the analysis</th>
<th>Results in general</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Do persons with experience of sickness absence mention positive encounters with professionals when asked about what effects RTW? If so, what types of positive encounters do they talk about?</td>
<td>All statements about positive encounters with professionals.</td>
<td>Positive encounters were mentioned in all groups. Important aspects included being treated with respect and given support.</td>
</tr>
<tr>
<td>II</td>
<td>What aspects of positive and negative encounters do persons with experience of sickness absence emphasize when asked about their meetings with professionals? Do sick-listed persons believe that such encounters might affect RTW?</td>
<td>Statements about how they experienced positive encounters from professionals, and whether positive encounters might affect RTW.</td>
<td>Experiences of positive encounters were categorized as follows: being treated with respect, feeling supported, establishing a personal relationship, perceiving demands as well-balanced, participating in decisions about rehabilitation.</td>
</tr>
<tr>
<td>III</td>
<td>How do persons with experience of sickness absence answer statements on encounters with professionals? Do experiences of encounters differ between groups of professionals? Are positive and negative encounters associated with demographic variables?</td>
<td>Differences between professionals within healthcare, occupational health services, and social insurance. Associations with gender, age, country of birth, and level of education.</td>
<td>Sickness absentees experienced encounters with professionals most positive in healthcare, followed by social insurance offices, and occupational health care. Females, people born in Sweden born, those who were older, and those with a higher education were most positive about their interactions with professionals.</td>
</tr>
<tr>
<td>IV</td>
<td>What aspects of positive encounters with healthcare and social insurance do persons with experience of sickness absence emphasize? Are there relationships between experiences of positive encounters and demographic and other variables?</td>
<td>Experiences of positive encounters with healthcare and social insurance staff. Associations with gender, age, marital status, country of birth, education, part- or full-time sickness absence, self-rated health, depressed during the last year, reason for sick leave.</td>
<td>Three important factors of positive encounters: being treated with competence, personal involvement, and confidence and trust. Women, people born in Sweden, and those with good self-rated health had higher odds of rating positive items more positive.</td>
</tr>
<tr>
<td>V</td>
<td>To discuss aspects of pride/shame and empowerment/disempowerment in the context of encounters with professionals during sickness absence and importance of this for RTW.</td>
<td>Relationships between social emotions and empowerment in the context of being on sick leave.</td>
<td>Development of a model of how social interaction with professionals might affect sickness absentees’ self-evaluations and RTW.</td>
</tr>
</tbody>
</table>
DISCUSSION

This thesis discusses the experiences of people on long-term sick leave in regard to positive encounters with professionals. The results of the first study (paper I) showed that positive encounters are an important factor when persons who have been on sick leave are asked to identify factors that promote RTW. Further work provided more detailed information about the different aspects of interactions with professionals (paper II), and also showed that the way the contacts were perceived by people on sick leave varied in relation to demographics, and group of professionals (paper III). The factors underlying the positive experiences of encounters and associations between those perceptions and demographic and other variables are presented in paper IV. The results reported in paper V point out some theoretical relationships between social emotions and empowerment in the context of rehabilitation during sickness absence.

Methodological considerations

Two of the strengths of the approach used in the current research were that several different types of data collection were used, and the analyses were both qualitative and quantitative in nature. This design was chosen to gain a broader understanding of how people on sick leave experience their encounters with professionals. Among others, Krause (70) has indicated that it will probably be necessary to combine qualitative and quantitative research methods in order to bridge the knowledge gap in this area of research. The methodology used in the present studies was elected in an attempt to narrow that gap.

Another advantage of the design was that the studies were conducted from the perspective of people on long-term sick leave (61). It has been maintained that the experiences of the individuals, also called lay knowledge, are underutilized in research on the RTW process, and most earlier studies have often not employed this potential knowledge base (70). Thus, by using such perspective, we have contributed important data to this field.
The study related in paper I included statements also about employment agency and social welfare staff. That was done because statements about interactions with these groups of professionals had been made in some of the focus groups, and, at that stage in the project, interactions with all types of professionals were of interests. The later studies (papers II and IV) were limited to healthcare and social insurance professionals. The work described in paper III, also included occupational health services.

An additional strength of the present approach was that, instead of starting from a formulated hypothesis, we studied a phenomenon (sick-listed persons’ experiences of encounters with professionals), without making any prior assumptions (paper I). When prior knowledge is lacking within an area of interest, the researchers’ expectations can be less biased with regard to the findings (68).

It seemed that the interviewees frequently recognized each other’s experiences and could associate them with similar perceptions, which also led to a willingness to share personal experiences. To obtain more explicit data on that topic, we used more direct questions in the second study. The approach in that case was to identify aspect that appeared to be important for RTW, rather than to analyse detailed aspects of positive encounters. Furthermore, the communication within the focus groups encouraged the interviewees to share and discuss their own experiences, and to remember events that had occurred many years ago. This strategy provided helpful information, and the results were also used to construct more directed questions on encounters with professionals (paper II).

Individuals with shorter sickness absence (>14 days), as well as persons with long-term sickness absence (>6 months) were included. This was done to ensure that there would be contrast and variation in their experiences of being on sick leave and factors affecting RTW.

Validity in qualitative studies is closely associated with the choice of design and with the method used to collect data (68). The validity, meaningfulness, and insights generated by qualitative inquiry have more to do with the richness of the information held by the people being interviewed and the analytical capabilities of the researcher, than with the sample size. Therefore, it is difficult to choose the number of interviewees. That selection can be guided by time and resources, together with the quality of the information received (68). The data obtained in the present interviews were of good quality and
gave a broad and distinct picture of the situations of the interviewees. Several steps were taken to ensure the validity of the results (71). The interview guides had previously been tested in a pilot study (72) and one other investigation (not published) to confirm that the questions were correctly understood. Moreover, the interviewers were trained group leaders and had experience of working with both individuals and groups of persons suffering from pain disorders, and had also conducted field investigations of clients receiving healthcare.

Use of an interview guide in semi-structured interviews (paper II), provided a satisfactory framework that proved useful in that it helped the discourse towards positive and negative experiences of contacts with professionals, but still allowed the interviewees to express themselves in their own ways. In both paper I and II the authors read the interview transcripts independently many times. Quotations were first selected separately and then compared and discussed by all authors. Statements for which consensus could not be reached as to whether they indicated positive encounters were excluded. Quotations were also excluded if they expressed satisfaction or dissatisfaction with having been given a medical examination or treatment, such as X-rays or surgical procedures. This was done so that the focus would be on encounters with professionals, not the evaluation of the results of medical treatments. For the same reason, experiences from meetings with employers, colleagues, friends, and families were also excluded.

The authors differed with regard to age, gender, and educational background. During the project, several seminars were held to discuss the data and the results of the analyses in order to enhance validity.

An advantage of starting with small samples was that the results could be used to construct questions about contacts with professionals (paper IV). As mentioned, the purpose of study III was to use a questionnaire to investigate experiences on encounters in a large sample (10,000 persons). The questionnaire was developed by the National Social Insurance Board, and it included 50 items and was designed for analyses of work environments, life situations and sickness absence. Our research group had the opportunity to add four questions about perceptions of encounters with professionals, and these questions were based on the results of our previous studies (papers I and II) and another investigation that addressed the same area (63). The survey had two particular advantages: a large and population-based data set was
available for the statistical analyses, and the four items that were analysed were included in a larger questionnaire. Therefore, it is not likely that the dropout rate was systematically related to the items evaluated in the present work. The design was useful to find differences between how the sick-listed persons experienced being encountered in relation to both different groups of professionals and demographic variables. Such knowledge can not be obtained by qualitative methods. Another asset of our approach was that it facilitated further development of the questionnaire items described in paper IV.

The strengths of the study reported in paper IV include the substantial size of the sample, which, to our knowledge, represents the largest and most comprehensive study thus far to examine how sickness absentees experience their interactions with professionals. Another strong point is that the sample was based on a population, not on a specific diagnosis, occupation, geographical area, workplace, or clinic, as is often done in studies of this type. The sample was drawn by the National Social Insurance Board, which has years of experience in the area and compiles highly accurate data registers.

Face validity can be claimed, since the questionnaires was developed by professionals and researchers who have worked for many years with people who are on sick leave or undergoing rehabilitation, and/or have investigated sickness absence. In addition, the questionnaire items were constructed on the basis of previous findings of qualitative (64, 73, 74) and quantitative studies (65), and clinical experiences and theoretical considerations (75). Early versions were tested in small pilot studies and then further developed after discussions with other researchers in the area. It is difficult to say whether the use of more directed and specific questions concerning encounters is the best method to gain knowledge in this area. We posed questions about one meeting during which the respondents experienced being positively or negatively encountered, instead of asking how often they had experienced such interactions. Thus, our interest was focused on what they actually experienced during the meetings, rather than on how common those experiences were.

A limitation to the project design was that the dropout rate was relatively high (around 42%) in the questionnaire studies (papers III and IV), which, unfortunately, is now a fairly widespread phenomenon in large questionnaire surveys.
Factor analysis is an explorative method that is in some ways similar to a qualitative approach, since it is possible for the researchers to categorize recurrent patterns in the material. This methodology was suitable for further development of our earlier interview studies. The multiple logistic regression analysis helped ascertain how the individuals scored each factor in relation to demographic and other variables.

Aspects of time can constitute problems in both interview and questionnaire studies, and the current results might have been affected by recall bias. In the first study (paper I), the interviewees were chosen from a cohort defined for the year 1985. In 1998 the members of the cohort were asked about factors that they thought might affect RTW. Some of these individuals were not on sick leave at that time, and they talked about meetings with professionals that happened many years ago. It may have been difficult to remember what had occurred during the meetings and how they had perceived the interactions with the professionals in 1985. However, the discussions in the interview studies (papers I and II) did not indicate that they had difficulties in recalling the meetings. Instead it seemed that even though some of the consultations had occurred many years ago, they still evoked strong feelings and were well recollected. The same was probably true for the respondents in the questionnaire studies (papers III-IV). In the focus group interviews (paper I), the group interaction encouraged the interviewees to share and discuss their own experiences, and also to remember events that had taken place long ago.

Although the studies varied in terms of the participants and the methods used to collect and analyse data, the results they provided are in several ways similar and thus support each other. Because of the different study designs, it is difficult to directly compare the findings, but then again that was not the aim of the research. Instead, each investigation had a specific objective, and each study was constructed based on the results of the previous work.

Discussion of the results

Past experiences and expectations, along with other circumstances, such as family issues or how clients are able to deal with situations, might influence how clients experience their contacts with professionals. However, the purpose of the studies included in this thesis was, specifically to illustrate the personal accounts of encounters with healthcare and social insurance
professionals reported by people on sick leave, not to identify or discuss the reasons why they perceived the encounters in a certain way.

Experiences of positive encounters

The results indicated that interactions with professionals induce either positive or negative emotions in the client. The interviewees described how important they felt it was to be respected, listened to, taken seriously, and encouraged and supported by professionals. Another element of high quality encounters that they looked upon as essential was that the professional should believe in the client’s capacity to solve and handle the problems in question. It was also considered to be important that professionals played the role of an advocate or a spokesperson in conflicts with other professionals or with relatives. Moreover, the participants used positive words to describe professionals that departed from their roles as experts and talked about things other than medical problems and thereby became involved in a more personal way. In addition, some of the interviewees stressed that it was vital that professionals encouraged them to take part in making decisions regarding rehabilitation, and made well-balanced demands.

The importance of interaction in healthcare is often emphasized, although most studies have been interested in interactions between physicians and patients or nurses and patients (76-85). In these studies the subjects mentioned being taken seriously and believed in (83, 86), and listened to and given information (78, 84) as features of positive contacts. Studies have also found that good qualities of the professional might influence the feeling that the medical condition has improved (85), and in that way lead to more effective treatment (78, 84).

Many studies on this topic have used the term satisfaction as the primary outcome when analysing the ways that clients/patients rated the quality of interactions or medical treatments. Furthermore, degree of satisfaction has often been measured soon after the encounters. Our results indicated that rehabilitation efforts and interactions between professionals and sick-listed persons are complicated matters that require substantial skills and knowledge on the part of the professional. To consider only, for example, client’s satisfaction is not enough when trying to identify important aspects of interaction with professionals and effects on RTW.
It should also be mentioned that analyses of the contacts between patients and physicians or nurses cannot always be compared with studies of encounters between people on sick leave and professionals, due to the different perspectives and objectives. The current studies explored the way that people perceived positive encounters also with other types of professionals whom they have met during their sickness absence, and the sick leave spell covered periods of at least 14 days up to eight months. The purpose was to provide a picture of the way the participants themselves described their positive encounters.

**Encounters and demographic variables**

In the first questionnaire study (paper III), contacts with professionals were rated as more positive by women, people born in Sweden, older persons, and those with a higher education than by men, younger people, and those with a lower education. Östlund et al (65) found that women with experiences of being on sick leave perceived their contacts with both social insurance officers and healthcare professionals as more supportive than did men. However, Ahlgren et al (87) observed quite the reverse: compared to men, women more often felt that they were distrusted when asked about their experiences of rehabilitation during sickness absence. By comparison, Bäckström (11) studied people on sick leave and found that women more often experienced being ignored, whereas men felt that they were offered relevant measures.

The results regarding gender-related experiences of contacts found in the investigations included in the present thesis are not completely comparable with the findings of previous studies. The main reason is that some of our findings (papers I and IV), concerned only those who had had positive encounters (i.e., negative experiences were not analysed), whereas the other studies mentioned above considered both positive and negative aspects of such contacts. Irrespective of the research methods used, it is difficult to determine whether women and men are actually treated differently, or if and how these issues affect each other. The same is true for age differences. The older respondents were more positive about their encounters with professionals than the younger ones were. Again varying expectations might be an explanation for this finding, and it seems likely that younger individuals will have comparatively higher expectations and make greater demands.
Respect for the professionals is another factor that might have an impact on how contacts are perceived. Older people probably have greater respect, and thus the participants in that age group in our studies may have reported their experiences as more positive because they did not question the treatment they received. It is difficult to explain the finding that people with a higher education perceived interactions with healthcare professionals as more positive compared to what was indicated by those with a lower or average level of education. Presumably, educated people might find it easier to communicate with healthcare professionals, who are also more educated. The fact that contacts with professionals in general were rated as more positive by native Swedes might be due to language difficulties, meaning that native Swedes are actually treated more congenially (88).

Encounters and groups of professionals

More persons stated that they had experienced positive encounters with healthcare professionals in both studies where that question had been placed (paper III and IV). The results given in paper III showed that, in general, interactions with professionals were experienced as most positive in healthcare, followed by social insurance and occupational health services. Also, the investigation described in paper IV indicated that more individuals had experienced positive encounters with healthcare professionals than with social insurance officers. Moreover, the mean rating was higher for each item concerning positive contacts with healthcare professionals in that study. Only those who stated they had had positive meetings were included in the analysis reported in paper IV, which is why it is not possible to compare the results with the findings related in paper III.

It is, however, notable that the people on sick leave generally responded in more positive terms with regard to healthcare compared to occupational health services. Logically, the staff of occupational health services should have a comparatively better understanding and a more comprehensive picture of the situations of their clients, since they follow the individuals in their workplaces and, hopefully, they know more about those environments.

In the investigation discussed in paper IV, a relatively large number of the participants did not respond to the question concerning experiences of positive encounters with social insurance staff. We do not know whether this
partial non-response rate was due to the participants never having been in contact with such staff, or if they had met them but the contacts had not been positive. 

Healthcare and social insurance professionals have rather different roles in their contacts with sick-listed persons. The staff in the latter organization serve as gate-keepers that are supposed to determine whether clients fulfil the requirements for receiving benefits and additional RTW measures (89). Healthcare professionals on the other hand help and treat their patients and sometimes also play the role as the patient’s advocate (21). The expectations and previous experiences of different individuals vary, and they might also affect how interactions are perceived. Furthermore, even though a long sick leave spell (in paper IV at least six months) was used as an inclusion criterion in order to increase the chances that the respondents would have met with social insurance professionals, it is possible that not everyone had had such contact, and therefore did not answer the question. Another reason why the probability of having experienced a positive interaction appeared to be greater within healthcare is that all people on sick leave meet this category of professionals more often (e.g., to obtain a sickness certificate).

In an investigation of being on sick leave (90), it was found that professionals’ attitudes and behaviour were important for RTW. The interviewees indicated that they were dissatisfied with the treatment and support they had received from many professionals, such as the social insurance staff. In general, the participants implied that they were satisfied with the medical treatment provided by healthcare professionals, but they felt they had to wait too long for those services (90). Again, the term satisfaction was used. The behaviour of work supervisors has also been mentioned as a determinant of RTW, and a recent study indicated that supervisors should communicate more frequently with employees during sickness absence, and also hold follow-up meetings more often (91).

Our results can not be used to discuss the behaviours of the professionals in question, because they can only account for and be used to deliberate about the way the study participants experienced their meetings with the professionals.
Encounters and RTW

The primary aim of this research was not to investigate how encounters might promote RTW, but to identify different experiences and aspects of positive encounters with the professionals. Nevertheless, the issue of improving RTW can be further elucidated by using some of the questionnaire data compiled in paper IV, along with other methods and participants who have actually returned to work. When interviewees were asked what they felt hindered or promoted RTW, they mentioned the importance of contacts with professionals (paper I). They also indicated that when they were treated with respect and support by professionals, they felt relieved, strengthened, improved, and helped. Several of the interviewees stated that RTW might be promoted by positive encounters and hindered by negative interactions. Also, some felt that professionals who did not encounter their clients in a positive manner might have a negative impact on the individual’s self-confidence, which in turn would affect RTW (paper II). Hansen et al (90) explored what sick-listed persons perceived as important in the process of RTW, and they found that support and participation in the sick leave process were considered to be essential. They also concluded that the professional’s ability to discover the individual’s need for support is very valuable in that context (90).

Of course RTW is as mentioned also influenced by several other factors at different structural levels. However these factors are not further described here.

A model of theoretical relationships between emotions, empowerment and RTW

When starting the research leading to this thesis, it became apparent that more basic knowledge was needed to be able to construct theoretical frameworks. Therefore, the first studies included in the project were descriptive, inductive, and exploratory in nature, and were not based on specific theories or theoretically derived hypotheses. Nonetheless, it is obvious that more work is required to develop theoretical contextualization in this area, and that theoretical concepts have to be elaborated and applied in order to improve our understanding of what psychological and social processes and mechanisms that might be involved. For example, it would be relevant to answer questions concerning the way that the contacts with professionals affect the persons’
self-image and self-evaluation. While conducting the present studies, it became clear that little is known about the long-term social and psychological consequences of sickness absence.

The first investigations (papers I-II) indicated that how sick-listed persons are encountered by professionals is of great importance, and that those clients may experience such encounters as positive or negative, which may influence the outcome of the rehabilitation process. Discussions and research concerning such social and psychological aspects of interactions would therefore be improved by theoretical contextualization, which in turn would guide empirical research.

We found that theories on social emotions, (e.g., pride and shame) and on empowerment could be fruitfully applied in our research. However, such general theories may have to be specifically adapted to some unique features of interactions between people on sick leave and professionals, and thus it is somewhat difficult to apply existing theories. An attempt was done to examine and apply such theories (paper V), and the following discussion is based on the assumptions that were made.

Pride and shame are emotions that are claimed to be of particular importance in interactions with others. Shame tends to make us want to hide, to withdraw from social interaction, to be alone, and to refrain from displaying our emotional state, whereas pride makes us want to be seen and heard, and to come closer to and increase our interaction with others (92).

The terms pride and shame have been highlighted in discussions by our research group. In this thesis, instead of pride, the broader term positive emotions is used, and thus the opposite term is negative emotions, here used instead of shame. Since a salutogenic perspective was applied in our studies, the following discussion concerns positive social emotions.

According to Scheff (93, 94), feelings of pride can occur only in social contexts, when you are evaluated in the eyes (real or imagined) of others, and those feelings are very closely linked to your self-perception and self-esteem. Therefore, it seems plausible that social emotions will be more readily evoked, and more deeply felt, in interactions with those on whom you depend, or who have some measure of power over your future or well-being, such as the various kinds of professionals you meet when you are on sick leave. These
professionals often have a decisive influence over the course and the outcome of the rehabilitation process, and hence are therefore important actors in the proceedings related to sickness absence.

The notion of empowerment has gained an ever-widening area of application in recent decades. It has come to be regarded as a method or strategy or remedy that is applicable in almost each and every part of social life where there is a desire to in some way improve the situation of some group or category of individuals. The term empowerment can thus be found in contexts involving specific categories of human beings, such as blacks (95), gay people (96), people with AIDS (97), students (98), nurses (99), women (96), the elderly (100), patients (101), employees (102), and many other groups.

After further theoretical development, empowerment can be used to point to some dimensions of what seems to be necessary to enable people to find the strength and control that is required for RTW after a prolonged period of sickness absence (75). It is important that professionals within healthcare, occupational healthcare and social insurance, not only help the sick-listed person capable of RTW in a physical sense, but that they also make her/him want to achieve that goal and perceive RTW as a meaningful option. Therefore, it is highly important to strengthen the sense of control of the client, and contribute to a raised level of self-esteem and self worth, and thereby enhance empowerment. The relationship between positive emotions, empowerment, and health are apparent. The ways a person is encountered by professionals might have an effect on how that individual uses her/his internal resources in a wider sense.

To summarize, social interaction that induces positive self-evaluation might contribute to the social emotion of pride, (here called positive emotions). Furthermore, positive emotions might add to empowerment, and empowerment might lead to enhanced work ability and along with that improved health.

The term empowerment has, as mentioned earlier, been used in studies on barriers and facilitators of RTW. Friesen et al (45) found in interviews with stakeholders that interactions that allow and encourage worker participation and empowerment are vital to the well-being of the worker and her or his ultimate RTW. This might be achieved by improved communication and should be a goal for many professionals. Millert et al (42) raised the question
of whether empowerment can be a solution to meet the perils of modern day working life, and they concluded that empowerment and individual control are key factors in the concept of successful rehabilitation. By mobilizing clients’ internal resources, the individuals are better equipped to face the challenges that arise during the rehabilitation process, and, if better prepared, they are more likely to return to the work force. A number of studies have also measured empowerment in working life. Arnesson et al (103) identified and described such questionnaires, and they concluded that research is required to better explain the interplay between conditions at work and empowerment and health.

**Implications for practice**

This thesis highlights the importance of being positively encountered by professionals during sickness absence. In particular, the results suggest that professionals need to respect and encourage their clients in order to establish a relationship that can promote the sick-listed persons’ ability to RTW. When working with persons who are on sick leave it may be beneficial for professionals to consider that they have a responsibility in that the way they act towards their clients can affect the ability of those individuals to manage RTW. Professionals need to develop their awareness of, and skills in, stimulating their clients to develop their own plans to improve their situation. A clinical implication elucidated in this thesis is the need for professionals to be conscious of, and further develop, their communication skills. The client should be given information, and be treated with respect and concern according to current healthcare legislation (104). The role of the client, her/his responsibility and own participation in treatment should be better clarified (105). Professionals involved in the rehabilitation process related to sickness absence should encourage their clients in this matter.

**Needs for future research**

More research is needed to elucidate the interactions between people who are on sick leave and the professionals involved in their cases. Further studies should focus on how the professionals can be provided with methods that can help increase the clients’ own ability to mobilize and develop internal resources. Additional knowledge might facilitate the design of treatment
strategies that will enhance self-confidence and empowerment during sickness absence.

The hypothetical relationships between empowerment, work ability, and health in the context of work-oriented rehabilitation should be investigated in depth and theorized, and also tested empirically. Should these relationships prove to be true, the information obtained could be effectively incorporated into the organizing and structuring of rehabilitation efforts and in the training of professionals.

Additional research should also be performed to determine how experiences of encounters with professionals might affect RTW.

**General conclusions**

Information about the factors that might promote RTW should be collected so that it can later be used in research projects and to design effective rehabilitation programs. Such knowledge is highly important for improving the work situations of professionals, helping people on sick leave to RTW, and decreasing the cost to society. The present studies were not focused primarily on identifying factors that affect RTW. Instead, the objective was to determine whether interactions between professionals and people on sick leave might be a factor that can promote RTW, and, in particular, to identify different aspects of how such encounters are experienced by sick-listed persons. For example, being supported, believed in, taken seriously, and treated with respect are important qualities exhibited by the professionals during meetings with their clients. Several of the interviewees believed that such encounters might have a positive impact on their self-confidence, which in turn might promote RTW. Perceptions of contacts varied with the type of professionals and with demographics and other variables. In general, women, people born in Sweden, individuals with good self-rated health, those who are older, and those with a higher education and income rated their encounters with professionals as more positive than did males, people born in other countries, individuals with low self-rated health, those who were younger, and those with lower level of education or lower income. Moreover, encounters with healthcare professionals were rated as more positive than interactions with social insurance staff.
Svensk sammanfattning

Sjukfrånvaro är ett komplext problem med många konsekvenser för både individen och välfärden, relaterat till mänskligt lidande såväl som till nationella ekonomiska aspekter. Sjukfrånvaron har ökat både i Sverige och i andra länder och vi behöver mer kunskap om vad som främjar återgång till arbete bland sjukskrivna personer. Tidigare studier om sjukfrånvaro har mestadels fokuserat på riskfaktorer för sjukskrivning såsom kön, sjukdom, arbetstillfredsställelse, motivation, psykisk och fysisk arbetsmiljö, försäkringssystemets och arbetsmarknadens utformning etc. Faktorer som påverkar den sjukskrivne att återvända till arbete är inte studerade i samma utsträckning. En aspekt som kan ha betydelse för detta är hur professionella personer bemöter den sjukskrivne.

Syftet var att identifiera och analysera sjukskrivna personers upplevelser av positivt bemötande från professionella inom hälso- och sjukvård, företagshälsovård och försäkringskassa. Syftet var vidare att analysera om upplevelser av positivt bemötande kan vara relaterat till kön, ålder, civilstånd, födelseland, utbildningsnivå, hel- eller deltidsjukskrivning, självskattad hälsa, depression under det senaste året samt orsak till sjukskrivning. Ett ytterligare syfte var att få kunskap om sjukskrivna personer upplevt sig blivit mer eller mindre positivt bemötta beroende på vilken grupp av professionella man träffat.

I avhandlingen ingår fem olika studier som baserats på data från fyra olika datainsamlingar. Två av dessa (delstudie I och II) är intervjustudier och två är enkätstudier (delstudie III och IV). Den sista (delstudie V) är en mer teoretisk studie där sociala emotioner och empowerment diskuteras i kontexten sjukskrivning, samt i hur man som sjukskriven upplever att man blivit bemött och dess relation till återgång till arbete.


Resultaten visar att positivt bemötande från professionella har många olika dimensioner, och att möten mellan sjukskrivna personer och professionella är en komplex process. Att t.ex. ha blivit respekterad och stöttad av professionella framkom som betydelsefullt. Fynden är av central betydelse för att få en ökad förståelse av hur bemötandet från professionella kan påverka
sjukskrivningsprocessen och återgång i arbete för sjukskrivna personer. Kunskapen kan vara värdefull för att utveckla de strategier, färdigheter och attityder som krävs av både professionella rehabiliteringsaktörer och sjukskrivna personer för att påverka klienter att bemästra sin omgivning och därigenom främja deras återgång i arbete. Ökad kunskap kring detta kan ligga till grund för preventiva åtgärder t.ex i form av utbildningsinsatser till professionella, och därigenom en förbättrad arbetssituation för dessa och som tidigare nämnts, främja återgång i arbete för sjukskrivna personer.
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