Impact of Changing Social Structures on Stress and Quality of Life: Individual and Social Perspectives

Work Package 7
Family Study

Finland

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1 Introduction

The Family Study forms the third main aspect and study of the Stress Impact project and was undertaken in Austria, Finland, Ireland, the Netherlands and the UK. This study undertook interviews with a sub sample of respondents who took part in the main study – a longitudinal study about their experiences during long-term absence from work (WP5).

This section is divided into three main topics

- Background on work and families
- National system for absence management
- Innovative nature of the study

1.1.1 1.1 Background on work and families

There is increasing evidence suggesting that today more than ever before, employees are working in an atmosphere of anxiety and stress. The contributing factors are the many and rapid changes taking place in the workplace and in society at large. Factors such as the globalisation of finance and trade, the rise in service industries, the increased use of ICTs, the increasing knowledge content of work, the intensification of work, the liberalisation of labour markets, the current flexibility of labour, the increased participation of women in the workplace; the ageing of the workforce and the population, dislocated social supports, later family formation practices and increasing care demands have all contributed to a radically different work and life situation for many people.

These changes are all implicated in the stress process. The negative impact of stress can be observed in the wide range of conditions that are associated with it. Stress has been associated not only with a variety of psychological conditions including anxiety and depression, but also with a number of highly prevalent cardiovascular conditions including heart attack and stroke. While evidence of the role of stress in cardiovascular conditions has been controversial, recent longitudinal research in the UK, with 10,000 plus participants, has demonstrated the biological plausibility of the link between psychosocial stressors from everyday life and heart disease. (Chandola et al., 2006). Stress is also considered to be a contributing factor to lower back pain and repetitive stress injuries (Power et al, 2001, Carragee, et al 2004).

The World Health Organisation predicts that by 2020 (WHO 2001), mental illness will be the second leading cause of disability world-wide, after heart disease. It is already recognised as one of the three leading causes of disability in the EU, where mental health disorders are a major reason for granting disability pensions. The most recent research from the UK shows that mental health problems now account for more Incapacity Benefit (IB) claims than back pain and that 10% of GNP in UK is lost each year due to stress. This research also shows that stress is the highest cause of absence among non-manual workers and an estimated 12.8 million working days were lost in Britain in 2003/2004 due to stress and depression or anxiety ascribed to work related stress (MIND, 2005). Over 35% of Incapacity benefit claims in the UK are made because of mental health conditions (Department of Work and Pensions, 2005).

Evidence from the literature suggests that workers on long-term absence as a result of stress are less likely to return to work than those with physical injuries or illnesses (Watson Wyatt, 2002). In the UK 3000 people each week become eligible for long-term sickness benefits having been off work for six months. Practical experience in the UK, shows that 60% of people who are absent from work for longer than 5 weeks do not return to work at short notice, and 80% of LTAs who move onto Incapacity Benefit do not re-enter the workplace within 5 years (www.workplacelaw.net).

The Department of Work and Pensions (DWP) 2002 parliamentary report entitled 'Pathways to Work' states that once a person has been on Incapacity Benefit for 12 months, the average duration of their claim will be eight years. Figures released by the DWP indicate that incapacity benefit has the most costly budget of any benefit in the UK (The Times, May 18, 2005).

Research has shown that coping with job loss is a dynamic process that changes over time and is associated with a host of negative and psychological outcomes (Kinicki, Prussia & McKee-Ryan, 2000). The social consequences of unemployment (or joblessness i.e. time out of the labour force) include its negative impact on the mental health and well being of not only on the unemployed but also their spouses and children (Vinokur et al., 2000). Long-term absence from work due to sickness has considerable negative effects for employees and employers as well as society (Nielsen et al, 2004) and has been shown to be a strong predictor of disability pensioning (Brun et al., 2003) as well as morbidity and mortality (Kivimäki, et al., 1995). Being out of work long-term damages a person's perception of self worth, significantly harms self-esteem (Goldsmith et al., 1996) and is likely to impact on future plans, motivation and attitude towards future reemployment.

Jahoda's (1982) latent needs theory has been developed to help us understand the negative relationship between job loss and psychological health. It is based on the idea that psychological distress in the unemployed is due to the deprivation of the latent (meeting psychological needs) functions of work. This theory proposes that 5 main psychological needs go unmet when the individual is not working. These are the need for time structure, social contact outside of the immediate family, being part of a collective purpose, being engaged in meaningful activities and having social status. Work provides people with both the obvious e.g. income and the latent sources of satisfaction. Although redeployment reverses the negative impact on the mental health and well being of the unemployed persons (Vinokur et al., 2000;), high levels of social support may encourage people to stay at home when they are ill; and more social obligations at home can also prolong sickness absence. (Kivimaki et al., 1997).

As well as changes in structure and nature of work and workplaces, in the last number of decades, traditional family structures and roles have changed significantly. The numbers of single parent families and 'blended families' (parents with children from different relationships) have increased, as have the percentage of women participating in the labour force. The percentage of women in the labour force in western countries has doubled in the past 50 years (ILO, KILM 2004). Increases in female labour force participation have consequent implications for the care responsibilities for young children, dependant disabled relatives and older family members and the division of labour within the household. Taken together, these factors have changed the work / home interface and the factors which affect individuals and families considerably. It is anticipated that these trends are likely to increase

over the coming years, which will in turn impact on and exacerbate stress related problems within society (Mead et al. 2000).

Research into the consequences of long-term absence on families and the role of the family in the process of absence and work resumption has not been the main focus of absence research. Brooke (1986); Steer & Rhodes (1978); Rhodes & Steer (1990) process models of absenteeism have been criticised because they are weighted towards organisational influences tending to believe that family responsibilities moderate but do not directly affect the relationship between attendance motivation and absenteeism. Whereas Erickson, Nichols & Ritter (2000) testing an expanded process model of absenteeism found that family conditions, responsibilities and attitudes significantly influenced employee absence through interactive means. Professionals and services also have an effect on the tenure of sickness absence. Allegro & Veerman (1998) believe that the traditional organizational-psychological approaches of sickness absence do not adequately explain sickness absence.

A recent study on the impact of long-term absence on the absentee (Floderus, B., et al 2005) found that negative consequences were more common than positive ones. Besides reduced financial resources, a large number of individuals experienced negative effects related to leisure activities, sleep and psychological well-being. Women and older workers experienced more positive consequences of long-term absence than men and younger workers, attributable for example, to relationships with children and partner, sleep and psychological well-being. Benefits as well as adverse effects differed depending on age, gender and health problems which shows the influence depends on the individual situation. This study also found that a high proportion of respondents experienced feelings of guilt for example due to perception of leaving colleagues and employer in the lurch, failure to fulfil their own expectations and demands.

It is recognised that men and women are increasingly sharing in the responsibilities for paid and unpaid work. Studies however, looking at the division of labour between spouses / partners have found that men are still typically the main bread winners and that working wives and mothers still retain the major responsibilities for child and family care. Also, overall working wives and mothers work more ‘total hours’ than their husbands / partners do (Suave,R 2002, Mead, R et al 2002).

Research indicates that young working mothers do the most ‘juggling’ between work, home, family and other activities (Suave,R 2002). . They are more likely to work part-time, to engage in other non standard employment for family reasons, to have work interruptions for family reasons, to stay out of the labour force for family reasons and to take time off from their jobs for family reasons (this includes elder care). Studies looking at stress and the impact on working families have found that there are gender differences in the experience of stress in working families. Female employees with caring responsibilities (for either children, adults or both children and adults) report higher levels of stress and strain than other employed groups (Mead, R et al 2002)..

The impact of work on family can be measured in terms of work-family conflict or spillover. Work-to-family spillover occurs where, demanding jobs and un-supportive workplaces lead to spillover from the job into workers’ personal lives. The impact of work-family conflict is

circular: if demanding work situations push workers to the limit, spillover results in high stress, poor coping skills, and insufficient time with family and friends, which in turn undermines work performance (Sauve, R. 2002). The consequences of this work-to-family spillover is not confined just to the individual workers who are trying to meet competing demands on their time and energy. Long hours spent at work and the demands of the workplace are felt by all members of the family, as well as by employers and others in the community.

All families or households are not affected in the same way, however. The experience of work-family spillover in a lone-parent family, for instance, will differ from the experience of a two-parent family. Similarly, the perception and experience of conflict in families that have a strict division of labour by gender will be quite different from the perception and experience in families where men have taken on more of the domestic and caring labour.

Negative family experiences, such as relationship difficulties or bereavement can impact on an employees performance at work. However, research suggests that work-to-family spillover is more prevalent than family-to-work spillover (Grzywacz et al 2000, Kinnunen, U et al., 2005).

Work-to-family and family-to-work spillover can be positive as well. Employees who experience autonomy and control on the job, support from supervisors and complexity in their jobs are more likely to transfer these positive experiences from work to home. Employees who receive family support or feel confident in their family responsibilities and have happy marriages transfer those positive experiences to their work which, in turn, increases their job effort and satisfaction (Kinnunen, U et al., 2005, Butler, A.B. et al 2005)).

Family-friendly work programmes, for example alternative work schedules, flexible working times and parental leave have been introduced to try and improve positive work-family spillover. Many qualitative and quantitative benefits have been associated with family-friendly work practices. The quantitative benefits include employee time saved, increased output due to increased focus and motivation, increased employee retention, increased income, decreased expenses, decreased health-care costs and stress related illnesses, and reduced absenteeism. The qualitative benefits include improved employee morale and loyalty, enhanced employee recruitment, and enhanced public and community relations (Mead, et al 2000).

Sickness absence is a ‘complex and heterogeneous phenomenon’ (Allegro & Veerman, 1998, p. 121) combining as it does, physical, psychological and social aspects. By looking at the social construction of long term absence (LTA) and work resumption, and examining the factors involved in the experience of LTA, it was the aim of this research to describe how those individuals on LTA and, where appropriate, their significant other (i.e. husband/wife/ partner) make sense of their experiences, to describe and explain what it is like, how they feel and cope with regard to being long term absent from work and overall what could help or is potentially hindering work resumption. Although there has been some research investigating the transference of one persons job characteristics, stress and experiences on their cohabiting partner (Morrison & Clements, 1997) to our knowledge this is one of the first research studies to explore the experience of being LTA on the significant other in the life of the absentee.

1.2 The national system for absence management

The Finnish sickness insurance system is controlled by the state through the Social Insurance Institution (SII) and basically covers all the persons in Finland through some form or another. Therefore, eligibility for sickness allowance does not vary e.g. depending on companies, occupations or employment. Municipalities have the responsibility for the arrangement of public healthcare for which all Finnish residents are entitled. Public health care also includes specialized medical care and treatment of mental health. Guidelines for occupational health and safety are defined in the legislation and monitored by the Health and Safety Inspectorate. The employers must also provide occupational health services for its employees. The Finnish pension system is comprised of two parts: earnings related pension and national pension. The pension system requires the cooperation of several private pension institutes, which manage the earnings related pension schemes obliged by law and the SII, which provides the national pension. The system is regulated by many pieces of legislation regarding e.g. different occupational groups. Disability pension can be granted if a person has lost his/her working ability due to an illness, defect or injury.

The daily amounts of sickness allowance are dependent on annual earnings and are calculated by specific formulas for different income groups. All in all the income during absence is about 2/3 of the previous salary income. The lower the salary income the higher the absence income is compared to it. Because of progressive taxation the net income would be slightly higherin relative terms due to a lowered tax percentage. The formulas are same for both the annual income from work and annual income from pension insurance. The benefits are paid to the employer for the period the absent employee is still receiving salary. After that the allowance is paid straight to the absentee. Sicness absence allowance is paid for 300 days 6 days a week by the SII for the same illness. The claim must be made within four months of the start of the absence. The Employment Accidents Insurance Act governs sickness absence and disability resulting from occupational accidents or occupational illnesses. The compensation for occupational accidents and illnesses differs from other forms of sickness absence compensation schemes, because they are compensated through a separate accident insurance policy obligated by law for the employer. The income compensation during sickness absence is well organised and has adequate coverage. At the moment the system is passive with strict limits. It does not include any incentives or schemes that would help the reintegration of the absentee.

Rehabilitation can be provided from many sources and for different purposes. Medical rehabilitation tries to improve or maintain the physical, psychological and social functioning of the person. There are different forms of medical rehabilitation, e.g. physiotherapy, speech therapy, treatment in a rehabilitation facility, adjustment training, psychotherapy, and neuropsychological rehabilitation or vocationally oriented advanced medical rehabilitation courses (ASLAK). The municipalities have the primary responsibility for medical rehabilitation as all medical treatment. However, the SII also arranges or compensates medical rehabilitation as a discretionary function, i.e. based on the evaluation of the need and coverage of rehabilitation. If the rehabilitation is for an occupational illness or injury, it will be provided through the accident insurance described previously. Vocational rehabilitation aims to improve and maintain the rehabilitated person’s working capacity and abilities to earn a livelihood. In practise, it can be e.g. work training, work experimentations, a rehabilitation examination, courses related to work, education for a new profession or financial support for self-employment. The responsibilities for providing vocational rehabilitation are divided based on

the employment status of the individual. One key element of a new law governing rehabilitation is that an employee has the right for preventive vocational rehabilitation, if his/her working capacity is threatened. Also, part-time rehabilitation allowance is introduced to allow continuing work while receiving rehabilitation.

Table 1.1. Time schedule for absence

Time schedule	Assessment	Intervention	Income	Legislation
preceding factors	-Caring physician: OHS/ Public/ Private	-Maintenance of Work Ability (TYKY) -Preventive and supportive rehabilitation (TYK / ASLAK) -Work arrangements	-Salary -Rehabilitation allowance paid to the employer	- Primary Health Care Act -Occupational Health Care Act -Occupational Safety Act -Law on Rehabilitation Arranged by SII -Earnings Related Pension Acts - Law on Rehabilitation Allowance
day of complaint	-Caring physician: OHS/Public/ Private	-Sick leave (A-statement) -Medication -Treatment	-Salary	-Sickness Insurance Act - Employment Accidents Insurance Act - Occupational Illness Act
1+9 days of sickness absence		-Medication -Treatment -Rehabilitation	-Salary	-Law on Rehabilitation Arranged by SII - Earnings Related Pension Acts - Law on Rehabilitation Allowance
60 days	-Caring physician: OHS/ Public/ Private -Rehab evaluation centre	-A rehabilitation plan required (B-statement) -Medication -Treatment - Rehabilitation	-Salary (sickness/rehabilitation allowance paid to the employer for the time the employer pays salary)	-Law on Rehabilitation Arranged by SII - Earnings Related Pension Acts - Law on Rehabilitation Allowance
150 days		-Reminder for rehab or pension application -Medication -Treatment - Rehabilitation	-Sickness allowance - Rehabilitation allowance	-Law on Rehabilitation Arranged by SII - Earnings Related Pension Acts - Law on Rehabilitation Allowance
After 300 days of absence		-Medication -Treatment -Rehabilitation by the SII or the labour administration	- Disability pension - Rehabilitation allowance - Unemployment benefit	-Employment Contract Act -National Pension Act -Earnings Related Pension Acts

1.3 Innovative nature of the study

1.3.1 Aims of the study

The main objective of the family study is to elaborate at a detailed level a representation of stress development from a whole family unit perspective. This study also aims to characterise the impact of stress on the social and family networks of study participants.

These general aims subsume a number of subsidiary aims. These are:

- To examine the differential impacts of stress and absence on different types of family units
- To obtain multi-perspective information on the experience of stress and absence
- To explore the factors that inflence the decision to become absent and the decision to return to work
- To examine the role of the family and wider social networks in these decisions
- To identify wider general issues in relation to the impact of changes in society on quality of life in general and on work and absence in particular

1.3.2 Why adopt a family perspective?

Family studies in the area of work absence are unknown to date. The family perspective is considered important as family members typically support and are directly affected by the actions of their members. The families study is exploratory in nature and was formulated from the idea that families might play a significant role in either supporting the return to work of the absent worker, or else in maintaining their absence. It was anticipated that long term absence would have both positive and negative impacts on families, on relationships between members, on the division of labour and various other aspects of family life.

In addition, it was conjectured that the role of families might vary according to the reason why the person was absent from work, with people with stress related or mental health problems being different in their family interactions than those with physical impairments. Furthermore, the family study aimed to investigate the proposal that the absence of people with stress related or mental health problems had qualitatively different impacts on other family members when compared to people with physical complaints

In relation specifically to the stress aspect of this study, stress theory has focused its investigations on the rage of environmental (work or non-work related) factors which may generate stress for the individual. While some investigations do identify outcomes of stress outside of the individual, these tend to examine elements such as organisational outcomes as being and ignore the effects stress may have on people other than the individual.

In addition, the vast bulk of investigation into stress focuses almost exclusively on sources of stress to be found in the workplace. Though theory (and some research) acknowledges that stress may emanate from areas other than the workplace, there are relatively few investigations which systematically examine stress from non-work sources.

By contrast, clinical practice indicates that the effects of stress and stress related mental health disorders are not confined to the individual. Where the individual is a member of a family unit, the impact which stress related breakdown may have can be profound (regardless of whether the source of stress is work related, non-work related or due to some combination of the two). Such impacts may include disruption to primary relationships with adults and children, failure to adequately fulfil family and social roles and may ultimately lead to family breakdown. On the other hand, there is also reason to believe that the acknowledgement by the individual of a psychological problem may lead to an adjustment in family interactions which be an improvement on what went before.

For these reasons, it was decided to undertake a study which investigated the experience of absence in more detail and which focused on the impacts which the absence period may have on both the individual and the family. In addition, the methodology adopted for this study (which involved the use of interviews) offered many other potential benefits to the study in terms of providing additional complex and rich information to help interpret the main survey findings.

1.3.3 The process of becoming absent and returning to work

The standard register data available on absence from work generally provides only limited insight into the processes whereby someone becomes absent from work or returns to work. Typically, the data will provide information about medical cause of absence, length of absence and some background information on demography. Even data from survey studies such as those conducted within the Stress Impact project provide only an incomplete view of process related issues. One of the strengths of the methodology used in the families study is that it can gather rich data on process related issues in ways that survey or register data cannot. Specific issues which may of interest in the current context include:

- Factors influencing the decision to become absent - while register data indicates a cause of absence in terms of a medical cause, the families study will allow the identification of factors from the workplace and from home and social life which may also contribute to the absence decision
- Factors influencing the decision to return to work – These factors may emanate from the individual, the family, the range of services available to the person or from the workplace

In addition to only identifying such factors, the data from the families study will also help to identify linkages between these factors and to obtain ideas about their relative strength. Such insights are especially important when designing the mix of return to work services which may be needed, particularly in relation to factors which are neither work nor health related.

1.3.4 Generating hypotheses for further analyses

The methodology adopted for the family study, that of face-to-face or telephone interviews using semi-structured interview techniques, was designed to allow for the acquisition of in-depth information on a range of issues relating to the absence experience. Coupled with the fact that the study is the first of its kind and with the relatively small samples used, the families study should be viewed as being mainly exploratory and heuristic in nature, rather than being concerned with the gathering of evidence for specific hypotheses.

However, the richness of the data to be gathered using this methodology will allow new insights to be generated regarding the experience of absence. Two of the most important aims of the families study relate to describing the processes of becoming absent, staying absent or returning to work, and also to examining the influences and impacts of being absent on the family unit. In addition, the data gathered in this study will generate insights into the development of symptomatology over time, both from before the absence period and during absence. The data will also provide useful insights into the relationships between the illness related causes of absence and other non-illness related factors.

Specifically, the findings from the families study may be used to generate new hypotheses which may be tested on the survey data in relation to:

- Interactions and relationships between different types of symptoms
- Interactions and relationships between health symptoms and other causes of absence
- The role of positive and negative factors within the family in relation to the decision to become absent and the decision to return to work
- The efficacy of interventions to promote rehabilitation and return to work
- The role of the employer in promoting return to work
- The role of the individual in relation to services and the decision to return to work

There will also be other issues around which hypotheses may be generated.

2 Methodology

This study is based on interviews of a sample of Long Term Absent Employees (LTAs). The interviewees had already replied to two questionnaires (T1 and T2) and had agreed to take part in a further study. We also interviewed some of the LTAs' partners. The aim of this study is to gain an in-depth understanding of the experience of long term absence by talking to people who have experienced it.

The study was coordinated by the Work Research Centre (WRC), Dublin by Richard Wynne and Nadia Clarkin. WRC proposed methodological aspects of the study, the procedure for conducting the interviews, and semi-structured interview protocols for both LTAs and their significant others (SOs). Both protocols addressed similar themes. The questions dealt with the issue of long time absence and its impact on LTA and his/her family, and covered their experiences before, during, and after the absence. (See table 2.1).

Table 2.1 Interview Themes

Section	Questions/Themes for LTA	Questions for Significant Other
Section 1- Absence Threshold	Factors that prompted to report sick Problems just before absence Who was involved in the decision	Factors that prompted to report sick Problems just before absence Who was involved in the decision
Section 2 - Prevention of Absence	What could have been done to prevent the absence Who did the LTA consult before absence	What could have been done to prevent the absence Who did the LTA consult before absence
Section 3 - Impact of Absence on Individual and Family	Impact of absence on family Changes in that impact over the period of absence	Impact of absence on family Changes in that impact over the period of absence
Section 4 - Return to Work/ Still Absent A. Questions for those who have returned to work	Factors that influenced return to work (RTW) Who was involved in the decision Issues faced on RTW Who provided support on RTW Suitability of RTW strategy used Reception at workplace What could have been done to help the LTA return sooner Impact of RTW on family	Factors that influenced return to work (RTW) Who was involved in the decision Issues faced on RTW Who provided support on RTW What could have been done to help the LTA return sooner Impact of RTW on family
B. Questions for those who have not yet returned to work	What is preventing RTW How could RTW be best promoted What may help LTA to RTW Contact with workplace during absence	What is preventing RTW How could RTW be best promoted What may help LTA to RTW
Section 5 - Rehabilitation	Has rehabilitation been offered What does the programme involve Usefulness of RTW/ rehabilitation programme	Is LTA involved in RTW/ rehabilitation programme Usefulness of programme
Section 6 - General	The impact of changes in culture and society on quality of life and absence Factors affecting absence in own workplace	The impact of changes in culture and society on quality of life and absence Factors affecting absence in own workplace

The goal was to interview 20 LTAs with physical health complaints, 20 LTAs with mental health complaints and 10 LTAs with co-morbid health complaints, as well as the LTA's partners, if available. Efforts were also made to include a wide range of types of people (e.g.

male and female; single and married; people with and without children; people who have and have not returned to work, and people of various ages).

Filling up the sample proved challenging. First of all, in the group of people who had agreed to take part in the study, there were very few SOs. In the end we only conducted 9 interviews of significant others. Secondly, during the process of acquisition of interviewees, it soon became clear that it was difficult to get enough interviewees who had returned to work. When contacting LTAs, we found out that most of them were still absent or on disability pension. However, we succeeded in reaching our goal to have half of the interviewees returned to work.

We contacted the LTAs by phone and asked them if they were still willing to be interviewed. If they were, we made an appointment for the interview. The LTAs were willing to cooperate in this part of the research and had altogether a very positive attitude towards it. Only one LTA refused to be interviewed. The reason for it was the fact that his illness had got dramatically worse and he was in a very bad condition.

We started by contacting LTAs in Helsinki and areas around it, and conducted face-to-face interviews in the premises of FIOH. After that we arranged to carry out interviews at the Regional Institutes of Occupational Health in three cities, Tampere, Turku and Lappeenranta, and contacted people living in or near them. Finally, in order to reach enough interviewees who had returned to work, we arranged telephone interviews with people who were not able to reach any of the above mentioned locations.

Eventually we conducted 51 LTA interviews and 9 SO interviews. Of the LTAs, 20 were absent from work for physical, 20 for mental, and 11 for co-morbid reasons. At the time of the interview, 25 of the LTAs had returned to work even partly or completely, whereas 25 of them were still absent. 13 of the LTAs were male and 38 female, 26 of them were married or cohabiting, and 24 were single. (See table 2.1). The interviews were carried out during the period of six months between 1st October 2004 and 21st March 2005. Majority of them were face-to-face interviews and an average interview took about one hour. The shortest one lasted only 20 minutes, whereas the longest one took nearly two hours.

The interviews were mini-disc recorded and notes were also taken by the interviewer. Afterwards they were transcribed into electronic files. After completing all the interviews we transformed them into a data matrix to be able to compare the answers question by question, also by meaningful groups or information (e.g. illness type, RTW, income, family type) separately if necessary.

We have made sure that issues of ethics are appropriately adhered to in our study. The study was planned and undertaken in accordance with standards of good research practice, such as beneficence, non-malfeasance, informed consent, confidentiality and anonymity. All confidential details as well as mini-discs containing recorded interviews were strored securely and only accessible to members of research group. The findings of the study are reported in a way that ensures complete anonymity of the respondents. Therefore any details that might help to identify any individuals are disguised or lost in the reports.

Table 2.2.1 Number of conducted interviews with LTAs with physical, mental and co-morbid health complaints and their partner, and general characteristics of the interviewed LTAs

	Main reason for current absence:			
	Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
Number of interviews:				
- LTA	20	20	11	51
- Partner	7	1	1	9
Return to work LTA:				
- Not	10	11	5	26
- Partly	1	3	-	4
- Completely	9	6	6	21
Family type:				
- Couple	10	3	5	18
- Couple with children	4	3	1	8
- Single	3	11	4	18
- Single with children	3	3	1	7
Income:				
- Single income	9	15	7	31
- Dual income	11	5	4	20
Gender LTA:				
- Male	7	2	4	13
- Female	13	18	7	38
Average age LTA in years	49,7	49,5	55,1	51,4
Education level LTA:				
- Up to lower professional education	4	2	-	6
- Intermediate general and professional education	5	5	2	12
- Completed high school	2	1	1	4
- Higher professional education	7	6	5	18
- Academic education and higher	2	6	3	11
Work sector LTA:				
- Agriculture, fishing and forestry	1	-	-	1
- Manufacturing	3	-	-	3
- Building & construction	2	-	-	2
- Trade (retail & wholesale)	1	1	-	2
- Hotels & restaurants	2	-	-	2
- Transport, storage & communication	4	5	2	11
- Banking, insurance & financial services	-	1	-	1
- Public administration	1	1	4	6
- Education	-	3	1	4
- Health & Social work	4	4	3	11
- Other community, social and personal activities	-	3	1	4
- Recreational, cultural and sporting activities	2	2	-	4

Table 2.2.2 Average scores of the interviewees on CES-D, Exhaustion, Disengagement, and General self-efficacy Scale

	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
Average score on CES-D scale; 10 items; 0=not 30=highly depressive	10.31 (SD= 4.97)	16.25 (SD= 6.46)	15.64 (SD=5.24)	13.86 (SD= 6.23)
Average score on Exhaustion scale; 8 items; 1=not-4=highly exhausted	2.68 (SD= 0.44)	3.29 (SD= 0.47)	3.17 (SD= 0.76)	3.03 (SD= 0.59)
Average score on Disengagement scale; 8 items; 1=not-4=highly disengaged	2.39 (SD= 0.46)	2.82 (SD= 0.40)	2.66 (SD= 0.64)	2.62 (SD= 0.51)
Average score on General self-efficacy scale; 10 items; 10=low-40=high	29.32 (SD= 4.01)	27.34 (SD= 4.13)	26.09 (SD= 6.95)	27.82 (SD= 4.90)

3 Findings

3.1 Absence threshold

In this section we describe the LTAs' experiences of the period prior to the absence. We describe the factors that prompted them to take absence from work, how long they considered taking leave of absence, problems the LTAs experienced immediately before becoming absent, and who were involved in the decision to take absence from work.

Main findings

- The main factor prompting absence was simply becoming incapable of work because of ill-health
- Most LTAs with mental health problems considered ill-health caused by work, whereas the LTAs with physical health problems usually did not.
- When absence was caused by a mental health problem, it was usually considered in advance, while LTAs with physical problems did in most cases *not* consider the absence.
- A wide range of problems were experienced by absentees immediately before their absence. These closely reflect illness type.
- Main person influencing the decision of going absent was occupational health physician.

3.1.1 Reasons for absence and factors that promted absence

In the first section of the interview, we asked the LTAs and their significant others about the factors that were responsible for taking absence from work. As mentioned above, 20 of the LTAs interviewed reported sick due to physical, 20 due to mental, and 11 due to co-morbid condition.

LTAs with physical health problems went absent when they became incapable of work

> "*The absence was the only option. Because of the illness, there was no choice.*" (ID 612)

All LTAs in the physical group stated that the factor that prompted them to take absence was the fact that they were simply incapable of work. In their statements, certain main reasons for the incapability can be distinguished: illness, injuries, pain, tiredness, and undergoing severe treatments. The most often mentioned factor was simply the ill-health; nine of the 20 LTAs told us that continuing work was impossible because of their illness. In some cases they were in such a poor condition that going to work was simply not an option, whereas some of the LTAs had physical problems or injuries that inhibited them from performing their tasks. In one LTA's case, for example, she got permanent vision disability after a brain surgery, and in another case the LTA's hand stopped working properly. Four LTAs said that the factor preventing them from working was constant pain, and one LTA reported that she was so tired that she had no energy for working. Four of the LTAs stated that the main factor that prompted them to take absence from work were the severe treatments for their condition. All

of these LTAs suffered from cancer. Treatments such as chemotherapy are extremely hard on the patient: "*During the treatments, I was in such pain that there were times when I didn't even know what day it was, or where I was*". (ID 579) Continuing work during these treatments would have been impossible.

LTAs with mental health and co-morbid health problems: Absence was a sum of several factors

> *"Finally I got too tired. I had to get out."* (ID 709)

When looking at the LTAs with mental health problems, it is not as easy as above to categorise the interviewees according to the factors prompting to take absence from work. Contrary to the physical group, in this group it was typical that there was not just one, well-defined reason for the absence. Instead, the absence was often a sum of several factors. Furthermore, these factors were not as clear and unambiguous as the factors in the physical group.

Similarly to the LTAs with physical problems, the LTAs with mental health complaints often stated that they reported sick because they simply became incapable of work. But the reasons that lead to this were more complex than in the physical group. Inability to work was the outcome of several factors. These factors can be divided into six groups: (1) work conditions/ problems in the workplace, (2) workload, (3) going to overdrive/ working too much, (4) exhaustion, (5) illness/ incapability to work, and (6) issues in personal life.

The factors that the interviewees with mental health problems referred to most often were related to work conditions. Nine interviewees mentioned poor work conditions or issues in the workplace as one of the main reasons that lead to absence. They talked about fast pace of work, conflicts in the work community, bullying, changes in the workplace, organisational issues and weaknesses in management. Other clearly work-related factors mentioned were workload and working too much or "going into overdrive". Workload was mentioned by five interviewees and working too much by three. In these cases it was not actually the management or work place that demanded the LTA to work too much, but the LTA him/herself. They just wound up working "*constantly 150 per cent, like a machine"* (ID 499).

Also frequently mentioned were different issues in LTA's personal life, which were referred to by seven LTAs. The issues mentioned were various, but they all contributed to becoming incapable of work and ending up taking absence from work. Unfortunate life events such as death or serious illness of a family member were mentioned by three interviewees. Similarly three LTAs referred to difficulties with children as a factor prompting to report sick.

In the co-morbid group (LTAs who had reported sick due to both physical and mental reason), there also emerged several factors that prompted the LTAs to report sick. In some cases the factors prompting them to take absence were clearly work related, in some cases the absence was caused by work and other factors together, and in some cases factors behind reporting sick were not work related at all. In the co-morbid group, roughly one half of the LTAs stated that there was one clear reason for the absence, whereas the other half had several factors prompting them to take absence from work.

Similarly to LTAs in the mental health group, the LTAs with co-morbid complaints also most often referred to problems in the workplace as factors prompting them to report sick. Like the LTAs with mental health problems, they mentioned factors such as heavy workload, poor

climate, bullying, bad working conditions, changes and problems in management. Almost all of the 11 LTAs interviewed, who had co-morbid complaints referred to such factors; four of them referred to issues in the work place as the only factor prompting them to report sick, whereas three LTAs mentioned these as one of several factors leading to absence. Other factors the LTAs in this group referred to, were issues in their personal life (mentioned by four LTAs), exhaustion (three LTAs) and somatic symptoms such as pains (three LTAs), and simply becoming incapable of work, which was cited by two interviewees.

In some cases the LTAs in co-morbid group told us how they first had a physical condition, and these troubles later lead to mental distress. Finally the physical and mental difficulties lead to becoming unable to work and going absent from work. So, in many cases the absence was a sum of several factors. Some LTAs said that they first had physical symptoms which poor work conditions made worse. On the contrary, in some cases the problems in the work place themselves caused physical and mental problems: "*I had to work too much; I had to do the work of other people, too. This got on my nerve. The relationships between people in the work community were extremely bad. The employees got no support from the management. Working too much caused pain in my shoulder and back and exhaustion, which eventually led to burn-out.*" (ID 1551). In some cases all the difficulties just overlapped: "*I suffered from tiredness and depression symptoms for a long time. I also had physical symptoms; I went to see a doctor a lot because of different ailments. Besides that, absence was caused by changes at workplace and my child falling seriously ill. Being older also affected, and so did worries about my health.* "(ID 1148).

When comparing physical, mental and co-morbid groups, certain differences can be distinguished in their views. Firstly, most LTAs in the physical group stated one clear reason for the absence, whereas most LTAs in the mental health group reported several factors that lead to absence. In the co-morbid group, some people cited one reason and some people described the situation as a sum of several factors. Secondly, when it comes to the work-relatedness of the absence, there is a difference between the groups. In the physical group, absence is typically not caused by work, while in the co-morbid and especially mental health group reporting sick very often had something to do with work conditions or stress caused by work. However, there is some similarity between the groups, too. All three groups have in common the fact that most of them pointed out that they had to take absence from work because they simply were not able to work. When comparing the LTAs view on what caused the absence with the view of the significant other, we found no differences or incongruities in none of the three groups.

3.1.2 Consideration of taking absence leave before absence depends on the nature of health problem

Before taking absence leave, some LTAs considered it for some time, while for others going absent happened more or less suddenly. Out of all the LTAs interviewed, about 60% considered taking absence leave before going absent, and about 40% did not.

In some cases the reason for not considering going absent was the nature of the condition that caused the absence. For instance, one LTA in the physical group had an accident at work, which caused her several serious injuries and led to a long-time absence. Some of the LTAs received a medical diagnosis which required instant treatment. In one case, for example, the LTA acted as a subject when testing new MRI equipment at his wife's workplace. Several weeks later he received an invitation to further examination. It came out that he had a brain

tumour, and an operation had to be performed immediately. Thus, the illness and the absence were not expected and it all became as a total shock. In some cases, however, the illness did not come as a surprise, but the LTA still did not consider going absent. In these cases the LTAs had had symptoms and problems for a relatively long period of time, but despite that they didn't consider going absent. Some people just wanted to continue work regardless of the problems, and did not see absence as an option. They kept working as long as they possibly could and did not report sick until it became impossible to go on working.

On the other hand, some LTAs *did* consider reporting sick for some time before going absent. That was the case especially with the LTAs suffering from mental health problems. In mental health group, in most cases the difficult situation had been going on for quite some time before the absence. In some cases the situation got worse by the day and the LTA thought about going absenct, *"whether or not to give up"* (1832P), as one significant other put it. Most of these LTAs stated that they had considered going absent for some months. Three interviewees in the mental health group reported that they had been thinking the issue over for about six months. One LTA in co-morbid group even told us that he had considered going absent for more than two years. There were several reasons for continuing work despite these thoughts. Some LTAs just did not have the courage to report sick. In some cases, the LTA did not want to admit him/herself that he/she was so ill that he/she could not work. Some LTAs said that they had to get used to the idea of being absent before actually reporting sick.

There is a clear difference between the three groups of LTAs in the consideration of absence. Out of the LTAs who were absent due to a physical condition, about 60% cited that they had not considered reporting sick in advance, while 40% said that they had. In the group of LTAs who were absent due to a mental health problem, 70% had considered going absent, while 30% had not. In the co-morbid group about one half of the LTAs reported that they had considered reporting sick and the other half cited that they had not. So, it seems that when absence is caused by a mental health problem, it is usually considered in advance, whereas in cases where the LTA has a physical problem, the absence is more often *not* considered. The difference is probably mostly explained by the different nature of mental and physical health problems. A physical problem can come as a total surprise to the LTA (e.g. accidents), while mental health problems usually develop slowly during a long period of time. However, that is a rough generalization and this is not always the case. Several LTAs with mental health problems also stated that falling ill and/ or going absence came as a total surprise.

In sum, there are two different types of processes of going absent. Firstly, absence can be caused by an unexpected health problem or accident, and in these cases the LTA does naturally not consider absence before going absent; it is not a question of making a decision. The second type of process involves considering reporting sick before actually doing it. In these cases, going absent is an individual decision making process that is affected by several factors (personality, culture in the workplace, family situation etc). Making a decision of reporting sick is definitely not an easy one. The following quotation of a LTA in the co-morbid group illustrates the severity of this decision: *"I considered it for a long time. The situation was so bad that I thought that I had to take sick leave, quit my job or commit suicide."* (ID 730). It can be assumed that it is not just a question of whether or not to go to work, but whether or not to admit oneself that you are not well. Thus, deciding to go out absent from work can be thought of as one kind of a dividing line between one's health and illness.

3.1.3 Problems faced before absence reflect the nature of illness

Within the LTAs in the physical group, the main problem faced before going out absent was definitely pain. Four out of five interviewees in this group mentioned pain as a problem experienced prior to leaving work. Most of these LTAs described how pain went worse and caused several further problems, ending up affecting the whole life of the LTA. Pain easily created a vicious circle: *"Pain was continuous, working was painful. This worried and caused sleeping problems, which stressed me out at work as well."* (ID 261) Having sleeping problems because of pain is something that LTAs with physical problems reported very often. Pain did not affect the LTAs alone, but also the SOs: "*Pain stresses out; it is on my in mind all the time. It keeps me up at night. It affects everything, like hobbies. It inflicts pressure at home, and that way affects my wife as well.*" (ID 833). Similarly, the significant others of the LTAs with physical problems reported pain having a widespread impact on the life of the LTA, as well as the life of the whole family: "*There was pain, tiredness, angriness and bad mood. Pain affected sleep and work; reflected in everything. It was mentally and physically rough"* (ID 1832P). In addition to pain, a few LTAs with physical complaints described experiencing other somatic symptoms before the absence, such as trembling or joint problems. Tiredness was also mentioned by some of the LTAs.

While the LTAs in the physical group were often able to describe the problems prior to absence in a few words, the situation with the LTAs in the mental goup was more complex. Unlike LTAs with physical problems, they often reported experiencing several problems and symptoms before reporting sick. In fact, all the interviewees in the mental health group referred to more than one problem when describing their situation before going out absent.

All the problems of the LTAs with mental health complaints can be counted as typical symptoms of depression. Most LTAs listed several symptoms, such as anxiety, loss of appetite, irritation, and lack of concentration. The factor most often referred to was tiredness, which was cited by 12 of the 20 LTAs in the mental health group. Sleeping problems and low spirits were both mentioned by six LTAs, and problems with memory by five LTAs. Besides psychological problems, five LTAs reported also having physical ailments before going absent, too. The symptoms they referred to are also typical for depression patients: high blood pressure, muscle tension, and pains.

The LTAs in the co-morbid group had faced very similar problems than the LTAs in the other two groups. An issue most often referred to by them was tiredness, which was cited by seven of the 11 LTAs with co-morbid health complaints. Several physical symptoms were also mentioned; LTAs reported having problems like pain (cited by four LTAs), nausea, and high blood pressure. Four LTAs told us they had problems with memory prior to the absence, and three LTAs had suffered from sleeping problems.

3.1.4 Medical professionals as the most important persons involved in the decision to take absence

A clear majority of the LTAs interviewed stated that there was at least one person besides themselves who was involved in their decision to take leave of absence from work. Only two interviewees told us that they made the decision on their own and there was no one else involved in this process. Naturally, most LTAs stated that there was a medical professional

involved in the decision process. Apart from few exceptions, all the LTAs interviewed told us that an occupational health physician was involved in making the decision. That was the case regardless of the reason for reporting sick. Some of the LTAs with mental health and co-morbid problems also stated that occupational health psychologist or psychiatrist was involved in the decision. Only three of all the LTAs referred to someone else in the workplace besides occupational health care being involved in the decision. The persons they referred to were supervisors and work mates.

Outside the workplace, it was also most often a medical professional that was involved in making the decision. That was the case in all three groups of LTAs. Some of them mentioned private GPs, but most of them referred to specialists. In the mental health and co-morbid groups that specialist was in most cases naturally a psychiatrist. Psychologists were also mentioned. Only three LTAs stated that there was someone other than a medical professional involved in the decision outside of work. They mentioned friends and family (spouse).

Becoming burned out over a long period of time

Heli did not notice herself what was happening to her until it went too far. Over a period of three years, she took on more and more tasks and responsibilities at work and regularly worked overtime. When she came home from work on nights she quickly grabbed something to eat and continued working until she went to sleep. At weekends, she went to work in secret from her colleagues. Everything else in life was left out. Finally, one night she had a fit. After that, the OHP stated that she was seriously burned out and made her take sick leave regardless of her resistance.

3.2 Before taking absence from work

In this section, we cover the issue of preventing absence from work. First, we describe the LTAs' views on what could have been done to prevent absence. In the interview we asked them to look back on what has happened, and think about what could have been done to prevent the absence by themselves, by their workplace, and by others, e.g. family. We also look at the actions the LTAs had received in order to prevent the absence. We discuss the helpful and supportive actions, both at work and outside of work.

Main findings

- Most LTAs with physical health complaints stated that the absence could *not* have been prevented. The LTAs with mental health problems felt that there *was* something that could have been done by themselves or by the workplace.
- Most LTAs discussed health issues both at and outside work before the absence. The most important contact persons were colleagues, friends and family members. Majority of the LTAs agreed that the support they received was definitely helpful.

3.2.1 Actions for preventing the absence

Actions by the absentee

In the interview, we asked the LTAs if there was anything, in their opinion, that could have been done to prevent the absence. We started by asking them to think about what could have been done by themselves. In the answers, there was a clear difference between the three groups of LTAs.

Out of the LTAs who were absent due to a physical condition, 80% stated that there was nothing that they could have done to prevent the absence, while only 20% felt that something could have been done by themselves. In most cases, the LTAs' reason for feeling that they would not have been able to prevent the absence was very simple: *"Because of the nature of the disease it could not have been prevented"* (ID 406). However, that was not the case with all the LTAs with physical problems. Some of them see that they could have done something to prevent the absence. Two LTAs stated that they should have realized the situation at an earlier stage. That way they could have sought help earlier. One of them noted: *"If I had known in time what was wrong, I could have changed work methods"* (ID 1708). One LTA with physical complaints said that she should have been more lenient on herself and taken it easier on herself at work. But she admitted that it was a question of nature; she felt so important at work that she did not want to work less or take a shorter absence leave early enough. That way it was not easy for her to do anything to prevent her absence.

Out of the LTAs who were absent due to mental health problems, as many as 70% felt that they could have done something to prevent the absence, whereas 30% stated that there was nothing they could have done. Of the LTAs who felt that there was nothing they could have done, about one half stated that falling ill and going absent was simply unavoidable. The other half told us that they had tried to do something, but in the end, the absence could not be prevented. They often referred to their own disposition as something that could not be affected: *"There was nothing I could have done. I tried to leave my job and look for a new one. I don't know if I could have done more. I can't help my disposition."* (ID 1065). However, most of the LTAs in the mental health group felt that there *was* something that they could have done to prevent the absence. The factor most often referred to was realizing the situation and acting on it at an earlier stage. These LTAs said that they should have realized the severity of the situation earlier, instead of letting it go too far: *"At least I could have realized earlier that it was more than just autumn-tiredness"* (ID 945). Several LTAs were of the opinion that they could have prevented the absence by setting the limits, or, overall, working less: "*I should have said what I can and cannot do, and what I have and do not have time to do*" (ID 709). This issue is, however, also a question of one's character: "*I was too nice and that's why I got too much work"* (ID 279).

So, compared to the LTAs with physical health complaints, the LTAs in the mental health group more often held the view that there was something that they could have done to prevent their absence. The majority of them saw that they could have prevented themselves from falling ill, or at least done something not to let their condition get that severe. When talking to LTAs with mental health problems, it seemed that some of them held themselves responsible for the absence. Some LTAs seemed to have regrets and even guilt for not being able to prevent the absence. They had an idea of several things that they *should* have done, but did

not: *"I was far too dutiful. I knew all along that I should do something but did not know how. I should have shared work but had no one to share it with. I know I should have sought help earlier, I should have taken time off" (*ID 916). These ideas and regrets may have burdened and stressed the LTAs who were already extremely stressed out.

In the co-morbid group, 40% of the LTAs said there was nothing they could have done to prevent the absence; it was simply inevitable. However, 60% of them felt that there *was* something they could have done. The ideas of what they could have done were very similar to the ideas of LTAs with mental health problems. The LTAs in the co-morbid group also referred to realizing the situation and seeking help earlier. Some of them also mentioned changing jobs as an action that could have prevented the absence: *"I should have sought help a lot earlier. I should have left my job 15 years ago"* (ID 972). Like the LTAs in the mental health group, they also mentioned setting the limits and working less. Also, they stated that their own disposition affected their way of working, and that is why it was difficult to break the habit of working too much: *"I took too much responsibility and could not say no. I have such low self-esteem*" (ID 1148). In this group of LTAs, the attitude towards work also came up. A partner of one LTA put it like this: *"His own attitude affected him. He is a workaholic. He should draw his own lines; no one else will do it. (…) He should admit that work is not the most important thing in the world"* (ID 38P).

Actions by the workplace and other persons

We also asked the LTAs if there was anything their workplace, or anyone else, could have done to prevent their absence. Most of the LTAs stated that there was nothing their family, friends, or anyone else outside of work could have done. Only three LTAs felt that the medical professionals could have done something to prevent the absence. In the LTAs' views on the role of their workplace in preventing the absence, there was again a significant difference between the three groups. In physical group, 80% of the LTAs said that there was nothing the workplace could have done, while 20% saw there was something they could have done. These LTAs stated that their working conditions could have been improved, or some work adjustments could have been done. The majority of the LTAs with physical problems, who said that there was nothing the workplace could have done, referred to the nature of their illness. Some of them pointed out that it was not possible to prevent the absence because of the nature of their work: *"Absence was the only option because my tasks could not be shared*" (ID 1659). Many LTAs in this group stated that their work was not the main factor that lead to reporting sick. However, many of them admitted that there was something in their work that affected the absence: *"Maybe busy and physically hard work affected me, but it was not the main reason for falling ill."* (ID 1949).

On the contrary, in mental health group 80% of the LTAs said that there *was* something the workplace could have done to prevent the absence, while only 20% felt that there was nothing they could have done. The actions by the workplace they would have hoped for included lightening the work load or making other work adjustments, dealing their situation more efficiently, and generally treating them better. The views of the LTAs in the co-morbid group were again similar to the views of the LTAs with mental health problems. Only 10% of the LTAs with co-morbid complaints felt there was nothing the workplace could have done to prevent the absence. 90% of the LTAs in this group stated that the workplace could have done something. The factor most often referred to were work conditions*: "There should have been a total change of work conditions"* (ID 972). It should be pointed out that the role of the superiors came up repeatedly in the views of the LTAs in co-morbid group. The problem that they most often referred to was the fact that the supervisors did not listen to the employees.

One of the LTAs stated: *"The nature and conditions of work affected getting absent. You are left alone a lot, training is insufficient. There are problems in the management. I was not listened to"* (ID 1148). Another LTA even said: *"My illness was caused by the behaviour of my supervisor. There was a lack of encouragement, bullying, bad treatment, and accusations. He did not listen"* (ID 795).

The most important explanation for the difference between the answers in the three groups is naturally very simple. It, again, comes down to the different nature of the physical and mental health problems. Physical conditions often came as a surprise to the LTAs, and in many cases they fell ill and had to go absent from work very suddenly. Whereas when it comes to mental health problems, they often evolved during a longer period of time and the LTAs considered reporting sick for some time before the absence. Also, some physical conditions, such as brain tumour, are something that can not be prevented in any way. With mental health conditions, such as depression, it is always possible to speculate what may have caused it, or at least contributed to it. In some cases, for example with work-related burn-out, it is even possible to state precisely, what was the main reason for falling ill.

3.2.1 Before Absence: Actions Received at and Outside Work

Most LTAs discussed health issues at work before the absence

In the interviews, we asked the LTAs if they had discussed their health problems with anyone at work before the absence. Four out of five LTAs answered that they had discussed these issues with someone, while one out of five stated that they had not talked to anyone. Some of these LTAs did not *have* anyone with whom they felt they could discuss these issues with, while others stated that they did not *want to* talk to anyone at work about their health problems. The reasons for not wanting to discuss these issues at work were several. For example, one LTA did not want to be treated differently, and that is why she kept her health problems to herself. Another LTA referred to her own character as the reason for not talking about her health issues: "*I am not a complainer. I rather carry my worries alone*" (ID 1267). Some LTAs felt that the work climate in the workplace did not encourage discussing personal issues with anyone. A few LTAs in the mental health and co-morbid groups stated that they neither could nor wanted to talk about their health problems at work.

Majority of the LTAs, however, did discuss their health problems with someone at work. In most cases they had talked to one or several co-workers. The second most frequently mentioned was the supervisor(s). Some LTAs had also talked to someone in the occupational health services. When comparing the three groups of LTAs, slight differences can be found. In the physical group, there were only two LTAs who had not discussed their health problems with anyone at work. So, the majority of LTAs who were absent due to physical problems had someone to talk to before going absent. Most of them had talked to their co-worker(s), superior(s), or "everyone at the workplace". Some of them also mentioned talking to occupational health practitioner or nurse. In the mental health group, 25% of the LTAs had not talked to anyone, while the remaining 75% had talked to their colleague(s), superior(s), and/ or occupational health services. It is noteworthy, that in this group, no one stated that they had talked to "everyone at work". In the co-morbid group, one third of the LTAs had not discussed their health problems with anyone at work, whereas two thirds had discussed them with someone. Similarly to the other two groups, the LTAs with co-morbid health problems had most often talked to their co-worker(s). Some of them had also talked to their superior

and/ or occupational health physician or nurse. In this group, three LTAs stated that they had discussed their health problems with "everyone".

So, according to these answers, it is slightly more common to discuss health issues with someone at work when one has physical health problems than it is when one has mental or co-morbid health problems. Out of the LTAs in the physical group, only 10% stated that they had not discussed their health problems with anyone at work before the absence. In the mental and co-morbid groups the equivalent proportion was 30%. It can be assumed, that it is generally more difficult to talk about mental than physical health problems.

Helpful actions at work: Support, empathy and someone to talk to

"*If I was not able to talk to him, the situation would have been horrible.*" (ID 406)

We also asked the LTAs what kind of support did these persons offer them. Their answers varied quite a lot across all interviewees. The answers can't really be categorised into groups, because the main point in most of them was that these persons simply offered the LTA support, empathy and someone to talk to. There were only some differences in their choice of words. In the physical group, the LTAs most often referred to support and encouragement by their contact persons. In this group, it was also stated by some LTAs that they received help in practical things. Within the LTAs in the mental halth group, it was most often mentioned that the contact persons simply offered them the chance to have a conversation with somebody. The factor that was also mentioned often was advice given to them by these persons. The LTAs in the co-morbid group referred to encouragement and conversation. In both mental and co-morbid groups there were also a small group of LTAs who stated that they were not offered any kind of support, despite the fact that they *did* talk to their co-workers, superior or occupational health services about their health problems.

Majority of the LTAs agreed that the support they received at work before the absence was definitely helpful. They stressed the importance of the support, understanding and encouragement they received from their contact persons. They told us it was nice and made them feel better. Many of them pointed out that it often helped just to have someone to talk to. The LTAs experienced the support as extremely important; some of them felt it was even vital to them: *"It was good to know I was not alone. I could not have made it without my work mates"* (ID 709).

However, there were some LTAs in each of the three groups that did *not* feel that the support they received was helpful. The reasons varied, and can be categorised into three groups: (1) some of the LTAs felt that the support was unhelpful because the contact persons could not change things: "*She was powerless; she could not do anything about the situation"* (ID 1413). (2) Some LTAs felt that the support they received was insufficient. It was mentioned that sometimes, like in these two cases, the LTA was disappointed, because the support they received was just talk, not action: "*My colleagues did not speak up for me in public. That annoyed me, and soon I did not want to talk to them at all*" (ID 1065). "*They said that they were going to do something, but did nothing*" (ID 730). (3) Some LTAs felt that the contact persons were totally unhelpful and unsupportive. One of the LTAs in this group stated that he was not understood, and two LTAs even felt betrayed by their contact persons: "*My supervisor was a back-stabber. He betrayed my trust*" (ID 322).

Most LTAs discussed health issues outside work prior to absence

Most interviewees had discussed their health problems with someone outside work before they became absent. Only five LTAs stated that they had not talked to anyone about these issues. When it comes to the LTAs' contact persons outside work, there were no significant differences between the physical, mental health, and co-morbid groups. In all three groups, more than half of the LTAs reported that they had discussed their health problems with friends. Also, more than half of them had talked to their family. Family members that were mentioned often were spouse, children, siblings and parents. Most LTAs simply referred to "family". Some of them also referred to "relatives" as contact persons. Besides friends and family, LTAs had discussed their health problems with (medical) professionals. They were referred to by eight LTAs, and the professionals they mentioned were physician, psychiatric nurse, therapist, and rehabilitation instructor. More than half of the LTAs in all three groups had talked to several people.

Helpful actions outside work: informational, instrumental and emotional support

> *"It felt good that I was never left alone"* (ID 276).

The kind of support the LTAs received can be divided into three groups: informational, instrumental, and emotional support. In all three groups of LTAs, the most important support type was the emotional one, which was referred to by almost every other LTA interviewed. In this type, we have included conversation or listening, as well as encouragement and general compassion. The LTAs told us that the support that their contact persons offered was most often just being there for them; listening, understanding and conversation.

The second most important type of support the LTAs received was informational support, e.g. advice. This kind of support was mentioned by about one third of the LTAs. Majority of these LTAs told us that they were adviced to seek help and take leave of absence from work. The friends and family of the LTA sometimes expressed this advice in a very frank, even harsh, way: *"My friends told me: Don't go to work anymore, it will kill you"* (ID 1551). But that straightforward advice was in many cases the factor that encouraged the LTA to seek help.

The third type of support the LTAs reported to have received was instrumental support, i.e. practical help. This kind of support was mentioned by three LTAs in the physical, and two LTAs in the mental health group. In three cases the LTAs referred to the fact that the support person took them to see a doctor. The remaining two LTAs did not specify the type of practical help they received.

Majority of the LTAs valued the support they received outside work: 80 % of the LTAs who stated they were offered support also said that it was useful. There is a difference between the three groups of LTAs in this matter. In the physical group, only one interviewee stated that the support he received was not useful: *"My husband offered no support, he did not listen. There was no use talking to him"* (ID 805). On the contrary, in the mental health group, four LTAs felt that the support was useless. All these LTAs felt that the persons they talked to did not understand them. The LTAs told us that it was difficult for their friends or family members to understand the nature of their illness. One of the LTAs who suffered from depression described the situation like this: *"My husband and children did not understand. They kept wondering why I only lazed about all day*" (ID 945). Another LTA said that for her mother, it was difficult not just to understand, but also to acknowledge her illness. In the co-morbid group there were three LTAs who considered the support they received as useless.

Unlike the LTAs in the mental health group, they did not refer to their contact persons' lack of understanding. Instead, one of them noted: *"Things had gone so far that talking did not help"* (ID 702).Another one admitted that the problem was actually himself: *"I did not listen to my wife's advice that much"* (ID 38). The third one of these LTAs was disappointed in the professional help she received: *"I did not get any constructive or long-term help. Exhaustion was considered my personal problem, the reasons behind it were not discussed, and solutions to work situation were not looked for"* (ID 1148).

However, most of the LTAs were satisfied with the support they received, and felt that it was extremely helpful. We also asked the LTAs to describe *how* was the support useful. Most of the LTAs in the physical group did not specify why they felt the support was useful. Instead, they simply stated that the support was "very important" or that it "felt good". One LTA within the physical group, however, brought up the importance of discussion for both parties; the LTA and the contact persons: *"Talking supported all of us, because my illness was upsetting my friends and family, too"* (ID 406).

In the mental health group, the LTAs were more verbose about the usefulness of the support they received. Basically, they all expressed in different words how important it was to have people who supported them and who they could to talk to. As one LTA put it, *"It is good to have people who care, also outside of work. It was good not to be left alone"* (ID 709). Most of them felt that talking to someone itself helped. Others pointed out that the conversations lead to further help. For example, one LTA stated that she went to see a doctor after discussing her health problems with her daughter. Some of the LTAs also emphasized the impact that talking with someone had on their own way of thinking: *"Through them I gave myself permission to be absent and take care of myself"* (ID 1625).

Family member's advice to seek help

Irmeli had felt down before, but this time she did not realise that she was depressed. Her daughter was the first to say: you will kill yourself if you keep working. She advised Irmeli to go and ask for a sick leave. Because of her daughter's words she finally went to see a doctor. She had been afraid of falling ill and she was nervous to go and ask for help. She would not have done it without her daughter's encouragement.

3.3 Impact of absence on individual and family

It can be presupposed that a long absence from work is something that has a strong impact on the life of both the LTA and his/her family. The interviews proved this assumption to be correct: according to the LTAs and SOs, a long absence from work had various consequences for the individual and family. In this section, we examine these consequences. We start by viewing the impact the absence had on the LTA personally, and after that we discuss the affect it had on the family of the LTA. We also cover the views of the LTAs and SOs on how the impact of absence changed over the period of absence.

Main findings

- For LTAs in the mental health group, the absence was a more positive experience than to the LTAs in physical and co-morbid groups.
- In all three groups, the most important personal impacts of absence on the LTAs were the mental consequences which included positive impacts such as relief and sense of growth and negative impacts such as depression on some of the LTAs who were absent due to physical and co-morbid reasons.
- The LTAs reported several negative financial, emotional and practical impacts of absence on family.
- The most important consequences for spouses were emotional.
- The most important impact on children was the fact that LTA had more time for them.

3.3.1 Consequences of absence for the individual: Emotional, financial, practical and health effects

We have divided the personal consequences the LTAs named in the interviews in positive and negative impacts. Furthermore, we grouped the negative consequences in three subcategories: financial, emotional and practical effects. Respectively, we also divided the positive consequences in emotional, practical and health effects.

There was a clear difference between the experiences of the LTAs with physical, mental, and co-morbid health problems. Out of the LTAs with physical complaints, 45% stated that the absence had only positive consequences, while 35% referred only to negative impacts. 15% of the LTAs stated that there were both positive and negative impacts, and 5% (one LTA) had not noticed any impacts whatsoever. In co-morbid group, 36% of the LTAs stated that the absence had positive consequences, 18% referred to negative impacts, and 45% to both negative and positive impacts. When it comes to LTAs who were absent due to mental health problems, as many as 65% stated that the absence had only positive consequences, 35% referred to both positive and negative impacts. None of the LTAs in the mental health group claimed that there were only negative impacts. So, according to these answers, long-time absence is generally a more positive experience for LTAs who are absent due to mental health problems, than it is to LTAs who have physical or co-morbid health problems.

Absentees with physical health problems experienced more negative consequences than others

> *"I am depressed, and the absence has lowered my self-esteem. I am so frustrated, I feel useless. I also miss my work mates"* (ID 1270).

In the physical group, almost half of the LTAs had experienced positive consequences of the absence. However, compared to the other two groups, the number of LTAs who stated that the absence had only negative impacts was rather high, 35%. In the physical groups, the negative consequences that the LTAs most often referred to were various emotional impacts. Almost half of the LTAs in this group told us that they felt lonely, depressed or worried during the absence. Some of them also underwent feelings of quilt. The next most often mentioned negative factor caused by the absence was the financial impact. It was referred to by one third of the LTAs with physical problems. One fifth of the LTAs told us about practical difficulties that the absence induced. These difficulties related to difficulties in dealing with for example insurance companies, and to a changed daily routine; some LTAs had trouble getting used to the situation in which they had no regular routines.

The LTAs with physical complaints also listed several positive consequences the absence had on them. We have divided these consequences into three groups: emotional impacts, impact on spare time, and physical impacts. The positive consequences most often referred to were increase in spare time, and emotional consequences, which were both mentioned by one third of the LTAs. The positive emotions that the LTAs most often referred to were relief and a sense of growth. In some cases, the difficult situation had been going on for some time before reporting sick. The LTA had had physical problems which made working hard and finally going out absent was a great relief to the LTA. Some LTAs told us that they felt that the absence made them grow as a person. For example, sometimes the absence generated a change in the LTA's views on life and work. The LTAs also often referred to the fact that because of the absence they had more time for themselves, hobbies, and family. Some of them remarked that because of that time they got closer to their family members and relatives. Thus, the absence had a positive impact on their relationships, too. The LTAs quite often also referred to physical impacts of the absence. By physical impacts we refer to the positive change the absence had in their condition. One fifth of the LTAs stated that because of the absence, they started to feel better and to recover. For some LTAs in the physical group, the absence had an undoubtedly positive impact on the whole life. For example, one LTA who had hip problems and felt that poor working conditions made them worse, described his situation like this: *"The sick leave has been the best time of my life. Going out absent from work had such a positive impact on my life. It was such a relief. I am feeling better, my blood pressure has lowered, use of alcohol has decreased, there is no more stress"* (ID 1708). These LTAs also claimed that the absence had no negative consequences on them. In some cases, on the contrary, the LTAs admitted that absence was very hard on them, but even so, they realized that it had a positive impact on their life: *"Although absence has been mentally and financially tough, it has altogether made life clearly better"* (ID 406).

Absentees with mental health problems had the most positive experience of absence

> *"I am relieved and feel wonderful."* (ID 322)

As stated above, when it comes to consequences of absence, the experiences of the LTAs with physical problems again differed from the ones of the LTAs with mental health problems. As many as 65% of the LTAs in the mental health group referred only to purely positive impacts, while 35% of them mentioned both negative and positive impacts. One of the LTAs did not see the absence having any consequences. But what is interesting is that none of the LTAs in this group felt that the absence had only negative consequences.

We have divided the positive impacts in three groups: practical, emotional and health impacts. The consequence most often referred to by the LTAs with mental health problems was the effect that absence had on the emotions, which was mentioned by almost half of the LTAs in this group. Similarly to the physical group, the emotion most often mentioned was relief, which was mentioned by one third of the LTAs. Some LTAs also mentioned experiencing a sense of growth: *"Before, I always went to bed feeling anxious and worried. Now I am calm and relaxed. I have more time to myself, and I value taking good care of myself. The absence has changed the way I lookedat the world"* (ID 47). This quotation illustrates very well the wide affect that going out absence can have on the feelings, attitudes, values, and the whole way of life of the LTA. 15% of the LTAs stated that the absence has made them feel closer to their family, which we have also included in the group of emotional consequences.

It also came up repeatedly that absence had practical consequences on the LTAs, too. 25% of the LTAs in the mental health group stated that they had more time, and 10% mentioned finally getting help as the main impact of absence: *"Through sick leave I got a diagnosis, which made life easier"* (ID 807). Impact on health was referred to by one third of the LTAs. They pointed out that having the chance to rest and not having to stress about work made them feel better: *"It feels wonderful that I do not have to go anywhere; there is no hurry. I have more time for my family"* (ID 322).

When we talked to the LTAs with mental health problems, it was notable how many LTAs described the absence as an extremely positive experience. For them, the absence often had a broad impact on various aspects of their life. Sometimes, the absence led to positive changes in the LTA's life and was the beginning of something new. For some LTAs, for example, going absent was the end of their working life. They knew they were not going to return to work and had accepted that fact. These LTAs enjoyed their absence and did not experience feelings of guilt for not working. *"I do not miss work. For me, absence has been easy; there has been no panic reaction. I do not feel like a loser; I have done my part in work life"* (ID 332). On the other hand, the absence could also lead to a new phase in the working life. Our youngest interviewee was only 23 when she reported sick because of burn out and depression. This is how she described the experience: *"Sick leave was a jackpot. Without falling ill I would not have got out of the horrible work place. After going out absent I have received professional help, which I really need. Now I have time to think about things and what do I want to do in the future."* (ID 499). Besides professional help to her illness, she had received professional help in planning her career.

So, in many cases the absence had several positive consequences on the LTAs' life. Nonetheless, some of the LTAs experienced negative impacts as well. A few LTAs mentioned absence having a negative financial impact and a few told us about practical consequences, such as having no daily routine. 30 % of the LTAs referred to negative emotional consequences. In their views these impacts were, however, bonded with positive consequences; the absence appeared as a process that included both positive and negative feelings: *"On the one hand it was liberating, on the other hand it was difficult to admit myself that I was incapable of work and needed to concentrate on recovery"* (ID 1625). *"I am relieved and feel wonderful. But I miss my work mates, I feel sad"* (ID 322). For some LTAs, the absence meant experiencing extremely negative feelings besides the positive ones: *"It was a horrible experience, like a small death. I felt guilty and depressed"* (ID 1065). However, a typical experience of a LTA who was absent due to mental health problems is summed up in the words of this LTA: *"It was quite hard, but it was definitely the best time of my life"* (ID 99). It might seem peculiar at first that sickness absence is considered as the best time of someone's life. However, these LTAs had, in most cases, suffered from mental health problems for a long time before finally going out absent. Also, in some cases the LTAs felt that these problems were caused by work. Regardless of what caused the problems, all these LTAs faced a situation in which working was extremely inconvenient, even impossible. When these factors are kept in mind, it is not suprising that the absence is regarded as an extremely positive experience by the LTAs.

Absentees with co-morbid health problems: Emotional consequences were most important

> *"It it easier to breathe when I don't have to care about the problems at work."* (ID 1551).

The experiences of the LTAs in the co-morbid group are again quite similar to the ones of the LTAs with mental health problems. However, the experiences of the LTAs with co-morbid complaints were not as positive as the ones of the LTAs in the mental health group.While 65% of the LTAs in the mental health group had experienced only positive consequences of absence, the corresponding figure in the co-morbid group was 35%. 45% of the LTAs in this group mentioned both positive and negative impacts, whereas 20% of the LTAs only referred to negative consequences. Like in the mental health group, the positive impact most often referred to was the emotional impact such as relief, decrease of stress, and a positively changed attitude towards work. Besides emotional impacts, a few LTAs mentioned practical impacts (more time) and impact on health (feeling better). Like in the mental health group, these aspects of being absent were often combined; having more time and less stress factors lead to feeling better: *"I did not have to do anything. That way I had more time and I could empty my head"* (ID 1011). *"There has been time to go through things, which has made me feel better. I am happy to have gotten out of work. Now I live the best time of my life"* (ID 702). As the latter quotation demonstates, some LTAs in the co-morbid group also described the absence as the best time of their life, similarly to the LTAs in the mental health group.

Besides the positive consequences, LTAs in the co-morbid group also named some negative impacts of absence. As mentioned above, we have divided the negative consequences into three groups: financial, emotional and practical impacts. In the co-morbid group only one LTA referred to financial impact, and practical impacts were mentioned by none of the LTAs. So, the most important consequences of absence on the LTAs with co-morbid complaints were emotional, which were referred to by 60% of the LTAs in this group. The negative feelings that came up in the interviews included anxiety, guilt, uncertainty, anger, sense of failure, and sadness. It seems that for most of the LTAs in the co-morbid group the absence was a hard process. However, despite the negative feelings, most LTAs felt that the absence was ultimately an experience that was necessary for them: *"It was difficult. I felt that I had failed. But it was necessary for me to stop"* (ID 1148).

Differences between the physical, mental, and co-morbid groups

To conclude, it is clear that there is a definite difference between the three groups when it comes to the personal consequences of absence. When comparing LTAs with physical, mental, and co-morbid complaints, the LTAs have experienced the absence quite differently. In the physical group, the LTAs named more negative impacts of absence than the LTAs in the other two groups. Whereas the LTAs with mental health problems had the most positive experience of absence; more than a half of them could name only positive impacts and none of them referred to negative impacts alone. One likely explanation for this distinction is the fact for the LTAs in the physical group going out absent often happened unexpectedly. Therefore they were not mentally prepared for the absence and it could come as quite a shock for them. So, it propably took some time for them to adjust to the situation and in many cases this adjustment proved difficult. Whereas for the LTAs with mental health group it was a relief to get time to rest from the often difficult situation at work and concentrate on themselves. Another possible explanation to the difference between the groups is the fact that, unlike in the other two groups, in the physical group the absence was in most cases not caused

by work. Therefore these LTAs were supposedly more satisfied with their work and enjoyed going to work more. That is why it was propably more difficult for them to stay home. On the contrary, the LTAs in the co-morbid and especially in the mental health group often felt that the absence was caused by work. That is why they naturally felt better not going to work.

There is also one clear similarity between the groups. In all three groups, the most important impacts of absence on LTAs were the mental consequences. The impact on the emotions was the consequence most often referred to in all groups, and that was the case with both positive and negative impacts. The feelings that the absence generated seem to be similar to LTAs in spite of the reason for reporting sick. When it comes to the emotional impacts, going out absent can be seen as an experience that is, in a certain way, quite universal. It often inflicts negative feelings, such as depression, guilt, and sorrow, but also strong positive reactions. Most LTAs in all groups told us that, after going out absent, they had experienced relief. Many of them also referred to a sense of personal growth.

3.3.2 Consequences of absence for the relationships with partner

In the interviews, we also asked the LTAs to consider consequences of absence for the relationship with partner, children and other dependants. None of the interviewees had other dependants in the same household, so in the follwong two sections we discuss the impact on LTA's partner and children. Out of the 51 LTAs we interviewed, 25 were married or cohabitating , and 15 had children in their household. Despite the fact that half of theLTAs interviewed had a spouse, only nine SOs agreed to take part in the interview study. Therefore we unfortunately do not have as much information about the impact of absence on the SOs' point of view as we would have hoped for.

When it comes to the consequences of absence for partner, the experiences of LTAs divide similarly to the personal impact discussed above. That is, the LTAs with physical problems referred to negative impacts more often than the LTAs in the other two groups. Again, the LTAs with mental health problems had the most positive experience of the impact of absence on partner.

LTAs with physical health probmlems: The impacts of absence on partner was often negative

> "*My husband is down when I am ill. Life is not joyful."* (ID 261)

About two thirds of the non-single LTAs with physical health complaints stated that the absence had solely negative consequences for partner. One third of the LTAs referred to positive impacts alone, and according to one LTA the absence had both positive and negative impacts on partner. The negative consequences can be divided into three categories: financial, emotional, and practical impacts. Out of these categories, the LTAs referred most often to the emotional impact. The emotions they stated their partner experienced included worries, difficulties in accepting the situation, and depression. In some cases, the absence also had a negative impact on the relationship between the partners*: "It definitely impacted on family life. I had fights with my husband almost every day"* (ID 1512). Like the quotation above demonstrates, the absence often caused tension between the partners. That tension could be caused by practical circumstances such as the LTA staying home all day or the worsening of the financial situation. In some cases it was inflicted by the negative impact that the absence has on the LTA: *"It has strenghtened our relationship. Absence has affected sex life. When*

you are not working your self esteem goes down and you just feel so useless. It's not easy to feel attractive; you are not interested in sex" (ID 1270). The second most often referred to was the financial impact: *"It had a really strong impact on the financial situation of my family. It was a catastrophe"* (ID 406). Two LTAs mentioned practical consequences. Both of them referred to the fact that the LTA stayed home all day, which generated problems. The partners had difficulties in adjusting to the new situation, and they also found it inconvenient that the daily routine was different for the LTA and the spouse that was working.

According to 40% of the LTAs with physical health problems, their absence had some positive impacts on their partner. Some of of them referred to practical impacts: LTAs had more time for the family and also to take part in domestic work more so than before. Some LTAs stated that absence had positive emotional impacts. They told us that they were simply happy about the fact that their partner was absent and did not have to struggle at work.

When it comes to the impacts of absence, the views of the significant others were quite analogous with the views of the LTAs. More than half of the SOs of LTAs with physical complaints stated that the absence had only negative impacts on them, while one third of the SOs felt there were both negative and positive impacts. Only one SO in this group referred to positive impacts alone. The negative consequences can, again, be grouped into three categories: practical, emotional, and financial impacts. Financial impact was mentioned by one SO, practical impact by two, and emotional impact by seven SOs. The practical impact the SOs referred to was the fact that LTA was at home all day. They claimed that it was a bit stressful for them, and that there was more bother from the LTA now that he/she stayed at home. The emotional impact that was mentioned most often was the worry that the LTA's illness and absence inflicted. Absence also affected the relationship between spouses. Some SOs told us that it created tension in their relationship: *"It tensed the atmosphere at home. The reason for problems was the fact that one of us worked and the other one didn't. We had rows quite often"* (ID 1512P). The SOs also referred to the problems caused by the different daily routine or life style of the spouses, All positive impacts mentioned by the SOs can be labelled as practical consequences. The SOs referred to the fact that the LTAs now had more time, and that they were less stressed, which eased up the tension caused by the LTA's work trouble.

LTAs with mental health problems: The impact of absence on partner was mostly positive

As mentioned above, the LTAs in the mental health group had a more positive experience about the impact of absence on their spouses than the LTAs in the physical group. Of the non single LTAs with mental health problems, one half felt that the absence had only positive consequences for their partner. One third of the group referred to negative impacts only, and one fifth claimed that the absence had no consequences for their partner. The negative impacts mentioned included financial and emotional impacts. Some LTAs stated that their partner was troubled or frustrated because of the absence: *"It was a difficult thing for him as well. Sometimes he was troubled because he could not do anything"* (ID 1065). Some of the LTAs who stated that the absence had a positive impact on their spouses did not elaborate on this statement, but just said that the impact was altogether positive or that the situation at home better. Some LTAs referred to positive emotional consequences such as the relationship between the partners getting better: *"My boyfriend has been so sweet, he has taken care of me and helped me a lot. We have gotten so much closer. We got engaged during my absence"* (ID 499). Some LTAs stated the absence also had positive practical impacts: *"My husband is pleased; everyday routines are now better taken care of"* (ID 807). Among our interviewees,

we have only one SO of a LTA with mental health problems. He felt that the absence had a strong impact on him. It led to changes in his way of thinking and behaviour at home: *"I became more cautious and tried to support my wife as much as possible. I have tried not to talk about work and have done more household duties so she could rest. Because of the absence, I have started to think more about our common issues"* (ID 1065P).

LTAs with co-morbid health problems: Positive impacts on partner were as important as the negative ones

In the co-morbid group, about one half of the non single LTAs stated that the absence had only positive consequences for partner while the other half felt that the consequences were purely negative. Both negative and positive impacts can be divided into two groups; practical impacts (e.g. the inconvenience caused by the LTA staying home all day) and emotional impacts (e.g. stress). In the co-morbid group, half of the LTAs felt that the absence had a positive emotional impact on their partner. They referred to relief and amended relationship between the partners. One of them summed this affect up like this: *"The issue became something that united the family"* (ID 730).

We interviewed two significant others of the LTAs in the co-morbid group. Both of them had experienced only negative consequences of the absence. They both referred to the inconvenience caused by the fact that LTA was at home and that there was more hassle from the LTA:"*My husband was used to getting served at home, that was difficult for me. Now I had to cook for him during daytime, too. (…) Situation was very hard and pressuring"* (ID 38P). Also, both of the SOs described that their whole lifestyle changed when their partner went out absent; they felt that they too had to stay at home all day. One of them referred to another type of change as well: *"I have practically lived alone for the last few years. My husband has just slept"* (ID 1128P).

3.3.3 Impact on children

Physical group: The most important impact was having more time for children

Of the LTAs in the physical group, seven had children living in the same household with them. In addition, four LTAs commented on the consequences of absence for their adult children. Out of these LTAs, 60 % referred to positive, 20 % to negative impacts. According to 20 %, absence had no impact on their children. The impact most often referred to was clearly the fact that the LTA had more time for children while being absent from work. This factor was mentioned both by the LTAs who had children living at home, and the LTAs who had adult children. One LTA with adult daughter stated: *"I had more time to take care of grand children. My daughter enjoyed the fact that I was at home during day time and could chat on the phone with her"* (ID 1949). Besides having a positive impact on children, having more time for children or grandchildren could have a positive affect also on the LTA him/herself: *"My adult daughters are happy. I now have more time to take care of grandchildren, which makes me feel important"* (ID 1723). In addition to having more time for children, absence also meant more time for domestic work: *"My son thought it was nice to have mother at home, maintenance worked better"* (ID 579). Other positive impacts mentioned were emotional: children were happy and relieved to have their parent going absent.

The LTAs in the physical group that named negative impacts of absence on children, referred to emotional impact. They told us that their children were troubled and confused because of the absence. The SOs of LTAs with physical complaints also noticed absence having positive impact on the relationship between LTA and children: the LTA now had more time for children and they had become closer with adult children.

Mental health group: Emotional impacts were the most important consequences for children

Similarly to the LTAs with physical problems, the LTAs in the mental health group also pointed out more positive than negative impacts of absence on their children. However, it is noteworthy that in this group, the LTAs mentioned slightly more negative impacts than in the physical group. In the mental health group 45 % of the LTAs named only positive and 20 % only negative consequences. 35 % of the LTAs in this group referred to both negative and positive impacts. This point is interesting, because when it comes to the impact of absence on the LTA and on the significant other, the situation was quite the contrary; the LTAs with mental health group had clearly more positive experiences of the consequences of absence than the LTAs in the physical group.

The positive impacts of absence on children that the LTAs with mental health complaints mentioned were quite similar to the ones the LTAs in physical group named. Some of them referred to practical impacts: children were happy because the LTA had more time for them and because they were now home all day: *"Absence has impacted motherhood and taking care of my daughter. My daughter sees absence as a good thing. She is happy to have mother at home. It makes her feel safe, it is a stable thing"* (ID 1372). Some LTAs told us about the emotional impacts: their children were happy because of their absence.

All of the LTAs' referrals to negative impacts on children related to emotional impacts. They told us that their children were worried. However, in some cases the worries were caused by the illness, not the absence itself: *"My daughter was frightened to hear the diagnosis but happy for sick leave"* (ID 637). Sometimes the children had difficulties adjusting to the new situation: *"My son opposed me being on sick leave. He has maybe adapted himself to the situation now, but it has been very difficult for him"* (ID 279). Besides having a hard time accepting the absence, some children had difficulties adapting to the thought of their parent's illness: *"My son was very worried. He wanted me to return to work; he wanted things to get back to normal. I don't know, maybe he denied the thought of his mother being mentally ill"* (ID 99). Unlike in the physical group, in the mental health group there were also a few LTAs that stated that they had not told their children that they were on sick leave. The reason for not telling them was the fact that they did not want to worry their children: *"My children were not at home during daytime. I did not want to tell them I was on sick leave, so I told them I was on a holiday. I didn't want to burden them"* (ID 1095).

Co-morbid group: The impact on children was mainly positive

In the co-morbid group, the LTAs named mainly positive consequences of absence on children. 60 % of the LTAs mentioned only positive, 30 % only negative, and 30 % both positive and negative consequences. Like in the other two groups, the positive impacts mentioned can be divided into practical and emotional impacts. Similarly to the other groups, the only practical impact referred to was the fact that the LTA was at home and had more time for children and grandchildren. The emotional impacts named included relief, understanding,

and positive changes in the relationship between LTA and children. The LTAs that said the absence had negative impact on children referred to worrying.

3.3.4 Changes in impact over time of absence

Almost half of the interviewees could not name any changes in impact over the time of their absence. Of those who *did* experience change a clear majority stated that they experienced a change to the better. Out of all the 30 LTAs that told us about change in consequences of absence, about 70% referred to positive, 10% to negative, and 20% to another kind of change. There was no significant difference in these figures between the physical and mental health group: in both groups, 60% experienced positive changes. Out of the LTAs with physical problems, 10% (one LTA) experienced a change to worse and 30% other kind of changes. In mental health group, 20% referred to change to worse, and 20% to other kind of changes. In the co-morbid group, the LTAs had more positive experiences of the change: 90% referred to positive, and 10% (one LTA) to negative change.

LTAs with physical health problems often experienced a change to better

In the physical group, more than one half of the LTAs had experienced a positive change in the impact of absence. A typical story was that at the beginning, the LTA was too tired to do anything but rest, but later started to have energy and started to do nice things. Also, the LTAs often had negative feelings in the beginning of absence: some of them experienced depression, fears or uncertainty about the future. They started to feel better when these feelings vanished; some of them felt relief, and one of them even referred to a change in the view of life: *"In the beginning of absence it was more dramatic, I had fears about survival. Now I have new perspectives on life and an appreciation of life"* (ID 1059). Some of the LTAs told us that it took a while to adjust to being absent from work: *"At first it was difficult for me to accept my absence. I wanted to go to work. But soon a new schedule started to form. I also understood that I am no longer capable of work"* (ID 1723).

Mental health group: Approving and adjusting to the absence was important

Among the LTAs in the mental health group, the most typical experience was the feeling that the absence got better after accepting and adjusting to it. However, this change was not easy; the LTAs had a hard time accepting being absent: *"It took me months to realize and admit that I am allowed to be absent. This process has been slow and made absence longer"* (ID 1320). They had to go through a rough process thinking the situation over, but in the end, they started to feel better: *"I needed to do a lot of work with myself to accept the situation. Now I accept it. Now I can see the positive sides of absence, and now I can enjoy it. I do not miss work anymore"* (ID 1372).Two thirds of the LTAs in this group also experienced feelings of guilt in the beginning of their absence. They did not start to feel better until admitting themselves they had a right to be ill and absent from work. Some of the LTAs stated that in the beginning of the absence they also missed work. Some of them referred to missing work mates and some of them reported missing the routine of going to work. Respectively, some LTAs told us that after a while they found a new daily routine and new things to do while being absent. One third of the LTAs in the mental health group had difficulties detaching themselves from work. They could not sleep , they worried about tasks that were now left undone, and were troubled about the substitute arrangements. Some of them even ended up going to work after reporting sick. This was, however, not unexpected, because most of the LTAs in the mental health group reported sick because of burn out. Therefore it was natural

for them to be overly attached to work and have a sense of being indispensable to their workplaces.

Co-morbid group: There were often negative emotions in the beginning of absence

In the co-morbid group, similarly to the other two groups, most LTAs stated that there was a change for the better during the period absence. This was the view of all but one of the LTAs that told us there was some kind of change in impact of absence. Most LTAs in this group stated that at first they experienced negative emotions such as anger or anxiety. Some of them were very tired during the first period of absence, and for some it was difficult to accept the idea of not being able to work. In this group, there was also one LTA who referred to worrying about work issues during absence: *"The first weeks I thought about work. I had to convince myself that the town will not fall apart without me. My psychiatrist had to convince me that this is what I need to do. But slowly I began to recover"* (ID 38). Like in the case quoted above, the LTAs with co-morbid complaints told us about going through a difficult process during absence. The beginning of absence was hard for them, but slowly things started to get better. Sometimes this process was quite concrete: *"At first I had pains and nightmares, but soon I felt how my body began to clean and the situation started to unravel"* (ID 1011). The LTAs told us that after a while they started to feel better and recover both mentally and physically. Some of them referred to finding a new daily routine, some to relaxing and starting to enjoy life. Some LTAs stated that they even found a new view on life.

Experiences of negative change in the impact of absence

Of theLTAs that told us that there was a change in the impact of absence, 10% stated that this was a change for worse. One of them said it was hard for her to fall into the sickness benefit of Social Insurance Institution. In contrast, one of the LTAs particilarily expressed that falling to the sickness benefit made her feel better. This is a good example of the fact that the processes and experiences of absence from work are extremely individual.Some LTAs referred to the impact of absence on daily life style: *"Lately, my life has been nothing but sleeping. Because I do not go to work, it doesn't really matter how I spend my days. I never go anywhere"* (ID 807).

Some of the LTAs told us about changes in impact over the period of absence that could not be classed as either positive or negative development. In some cases, the LTAs stated that the stage of the illness affected feelings: *"When I am better physically I feel frustrated, but when I am very ill, it is better that I am on sick leave"* (ID 1659). Some LTAs also referred to the clear impact that the stage of paper work in different offices had on their feelings. The proceedings they mentioned included applying for pension, processing application for sickness benefit of Social Insurance Institution, and disagreements with the insurance company. A couple of LTAs were not able to define the change in impact as either positive or negative. Instead, they cited that their feelings still kept changing.

Absence that started bad but ended well

Marja became absent because of mental illness. The beginning of absence was a nightmare. She was depressed and frustrated, and she experienced serious feelings of inferiority and uselessness. It was impossible for her to admit that she was incapable of work. After four months of absence she was diagnosed with incurable cancer, which changed everything. It gave her new values in life and made her realise that work is not the most important thing in life. Paradoxically, the cancer diagnosis made her life happier. "It was my rescue! I am so happy that I have gotten out of work and have time to enjoy other things. I now live the best time of my life", she says.

3.4 Perceptions and experiences of people who have returned to work

At the time of the interview, 50% of the LTAs interviewed had returned to work (see table 2.2.). In this section we discuss their experiences of returning to work. We start by going through the factors and people that were involved in the LTA's decision to return to work (RTW). Secondly, we look at the issues and problems the LTAs faced on the RTW. Thirdly, we review the conditions the LTAs returned to and their experiences of the suitability of the RTW option in question. After that, we discuss the reception the LTAs got from their colleagues, supervisors, and management when returning to work. Then, we present the LTAs' views on the question of if there was anything that could be done to make them return sooner. Finally, we discuss the impact of the RTW on the LTAs and their families.

Main findings

- The most important factors influencing RTW was feeling better and the LTA's own will to return.
- Work adjustments were important for LTAs with mental health problems.
- In most cases, medical professionals were involved in making the decision of returning to work.
- The LTAs in the physical group reported facing more problems when returning to work than the others. Issues faced included factors such as learning new tasks, workload, exhaustion, and different types of changes.
- The LTAs were very happy with the reception they got when they returned to work.
- The most important persons that provided the LTAs support in the RTW process were people at the workplace.
- The RTW had various financial, emotional, and practical impacts on LTA and family members. The LTAs referred to negative consequences as often as to the positive ones.

3.4.1 Factors and People involved in the RTW decision

Main factors influencing the decision: Having the will to return, feeling better, and work adjustments

Among the LTAs who were absent due to physical problems, most LTAs told us that the main factor influencing RTW was their own desire to return. Also, it was often stated that the reason for returning was simply the fact that the time period defined by their physician for their sickness absence came to an end. A few LTAs said that one factor that influenced RTW was the possibility to get a new job, and some LTAs referred to financial issues. In the mental health group, there were two factors influencing RTW that were mentioned as often by the LTAs: recovery of the LTA, and work adjustments made in the work place. Like in the physical group, financial issues were referred to by a few LTAs. In the co-morbid group, most LTAs referred to their own will to return or better health condition as the main factor influencing RTW.

So, it appears that for the LTAs in the physical group the decision to return to work was often quite simple; the absence period their physician had defined came to an end, and the LTA wanted to start working again. The same pattern seems to apply for the LTAs in the co-morbid group. In this respect, there is a slight difference between the mental health group and the other two groups. Among the LTAs in the mental health group, it was often stated that the reason for RTW was recovery. However, for the LTAs with mental health problems, it was more important to have some changes made in the work place before returning than for the other LTAs. This difference is naturally understandable, because among the LTAs in the mental health group, the absence was considered work related more often than in the physical group. It is interesting also that in none of the groups, not as many LTAs as expected used arguments concerning the financial issues.

Most important people involved in the decision were medical professionals

A majority of the LTAs returned to work stated that there was at least one person besides themselves involved in the decision to RTW. In most cases, this person was a medical professional: two thirds of them referred to the involvement of a physician or specialist in their decision. However, in the mental and co-morbid groups there were also some LTAs that stated that someone at the work place was involved in the decision. The persons they referred to included superiors and HR-managers. OHPs were also mentioned, but in this case, we have included the OHPs in the group of medical professionals. We also asked the LTAs to describe in which way were these people involved in the decision to RTW. Most LTAs stated that they discussed the issue of RTW with the person(s) in question. It was often important for them to hear the views and opinions of a professional. Some of them got practical advice from these person(s), and some even claimed that the person made the decision to return on their behalf.

When asked to consider what could have been done to return them to work sooner, all the LTAs gave us the same answer: nothing. The LTAs that gave reasons for this answear simply stated that they were not ready to return earlier because of their illness. A few LTAs in the co-morbid and mental health group thought that they should, instead, have returned a bit later.

3.4.2 Issues faced on RTW

LTAs with physical health issues faced more problems than the others

The LTAs in the physical group reported facing more problems when returning to work than the others. In the mental and co-morbid groups the LTAs referred to positive experiences as often as to the negative ones, whereas more than half of the LTAs that answeared this question in the physical group stated that the experience was negative. When the LTAs in the physical group talked about the problems faced on RTW, three main issues came up: learning new tasks, workload, and exhaustion. It was common for several LTAs that they found the RTW more difficult than they had expected. In some cases, the LTAs received new tasks, or there had been some changes in the work place, and it was difficult for them to learn the new things. Furthermore, some of these LTAs did not receive proper introduction. Also, some LTAs referred to the problems caused by the expectations of other employees: *"It was rough, especially during the first week. It was busy and I was tired. People thought I would manage well, but in fact I didn't* (ID 1832)". The fact that work mates assumed the LTA to be fit to work right away could lead to a workload that was excessively heavy. In several cases, the LTA felt tired during the first weeks at work. Some LTAs reported having difficulties adjusting to the new situation. However, in most cases the situation got easier little by little, and at the time of the interview all these LTAs were more or less contented with being back at work.

In both co-morbid and mental health groups, there were as many positive as negative experiences of RTW reported by the LTAs. In both groups, the most common reason for facing problems on RTW were different kinds of changes. The LTAs felt that the workplace, they themselves or the work culture had changed during their absence. These changes caused difficulties in adjusting to working. Sometimes the changes only related to work tasks but in some cases the LTAs referred to more profound changes. This was how one LTA in the mental health group described her situation: *"I am thinking about quitting my job. The return did not go as well as I had expected. Something has changed. Work is not satisfying anymore; I feel like I have changed myself"* (ID 1095). Another LTA referred to a change in work pace and culture: *"After returning to work, I realized that I can't keep up with young, quick colleagues. I was so sad to realize changes in work culture. These young people don't have the same ethics; their ways are so different from mine"* (ID 1426). However, we should note that sometimes the situation was quite the contary; changes could be positive, as well: *"I did not face any problems except slight confusion. My work place had changed in a good way"* (ID 38). Some LTAs stated feeling stressed on their return to work.

Positive experiences of RTW

Not all the RTW experiences were negative, however. Some LTAs in all three groups had both positive and negative, and some LTAs purely positive experiences of RTW. They felt good to be back at work and did not face any noteworthy problems. There was a certain interesting difference between the groups in this respect. In the physical group, the LTAs that claimed that the RTW was mainly a positive experience referred to the fact that nothing had changed: *"It was just like returning from a vacation, after first day it felt like I was never away"* (ID 1267). *"I had no problems. It was nice to return. Everything is fine and back to normal"* (ID 276). On the contrary, the LTAs in the mental health group stated that the reason for a successful RTW was the fact that things were *not* back to normal. They commended the work adjustments and changes that had went on in the workplace during the period of their absence. This distinction is, of course, not surprising. Among the LTAs in the mental health

group the absence was often caused by the circumstances in the workplace, whereas in the physical group the work place or work itself had, in most cases, nothing to do with the absence.

RTW options and their suitability

Due to the above mentioned distinction in the work relatedness, it is also natural that there is a difference in the work conditions the LTAs in different groups returned to. In the physical group, most LTAs reported returning to same job with same employer. In this group, none of the LTAs referred to work adjustments. In the co-morbid group, all the LTAs who had returned to work had returned to work with the same employer; most of them continued in the same job, and a few started in a new job. So, most LTAs in this group had also returned to the same job. But the difference with the physical group is the fact that in this group, all these LTAs told us about work adjustments. There had been changes in the content of work or tasks, and some LTAs started with a work trial period. In the mental health group, half of the LTAs returned to work had returned to work in the same job as before the absence. Some of them had had some work adjustments done and one of them now worked only part-time. The other half of the LTAs in the mental health group started a new job with the same employer or had a whole new job with a new employer.

We also asked the LTAs to evaluate if the conditions they returned to were suitable for them. Apart from a few exceptions, all the LTAs felt that the RTW option in question was the most suitable one for them. There was one difference between the groups in the LTAs' arguments for this suitability. The LTAs that returned to the same job they had left when they went out absence, said that this was the best option for them, in both mental and physical group. However, the way that they talked about this issue was different. A typical example of a LTA with physical complaints explained his feelings like this: *"There were no problems. It felt good to return to do the same familiar tasks"* (ID 1832). The views of the LTAs with mental health complaints was different: *"Yes. But if I was younger, I would definitely have considered changing job. And if money was not an issue, I would really like to work part-time*" (ID 709). "*It was the best option in my current situation. Other options were considered, but in the end, I felt that I could not manage learning new tasks right now. My psychiatrist suggested partial disability pension, which I now have applied for*." (ID 1426). It seems that while the LTAs in the physical group were actually happy with their old job, the LTAs in the mental health group were not that contented with their situation. Instead of being truly satisfied with their RTW option, they have chosen the lesser of two evil.

Apart from this difference, the LTA's views on the suitability of the RTW option chosen were quite similar in all groups. The LTAs that had changed workplace altogether were happy that they did not have to return to the same job. The same applied for the LTAs that returned to new job with the same employer. The LTAs in the mental health group used quite emotional choices of words when describing their situation. For example, they referred to the new tasks as "rescue" and "blessing". Two LTAs in the physical and as many as six LTAs in the mental health group, felt that they would not have coped if they had stayed in the same job. Naturally, for the LTA in the physical group, the reason was often related to physical issues: *"My old job was very hard; I would not have been able to manage it with these injuries"* (ID 1512), and in the mental health group, the reason was related to mental health issues: *"If I had returned to the old job, my old routine and ways would have remained unchanged. I probably would have fallen ill again"* (ID 872). The quotation above is a very typical example of the views of LTAs that were absent due to burn-out. Many of them believed that staying in the same job would have lead to a relapse. LTAs were also pleased with the work adjustments

and the changes made were welcomed:"*It was great that I did not have to follow the old footsteps. I had needed this kind of development for a long time"* (ID 38).

3.4.3 Reception at the workplace

The LTAs were very happy with the reception they got when they returned to work. The LTAs were especially pleased with the reception from their colleagues. The interviewees told us that their co-workers were happy to have them back and treated them well. It made them feel welcomed and expected. That was the case when returning to the same job, as well as when starting a different job or unit with the same employer, and when starting a whole new job with a new employer.

Similarly, the reception the LTAs got from supervisors was considered very good. According to most LTAs, the supervisors understood their situation and were happy and relieved when they returned to work. There were only a few exceptions from this trend. Two LTAs would have hoped for more orientation, and one LTA was upset because she was not welcomed by the head of her department. However, all these LTAs pointed out that their closest superiors treated them well.

3.4.4 Provided Support in the RTW Progress

Persons that provided the LTAs support in the RTW process included people at the workplace, medical professionals, and friends. The latter two groups were only mentioned by 10 % of the LTAs returned to work. People at the workplace were referred to by 50 % of the LTAs, and the remaining 40 % did not mention who (if anyone) provided them support. Within persons at work, the most important support provider was the superior. The second most important groups were the occupational health services and colleagues.

The types of support these persons provided can be divided into two groups: practical and emotional support. Emotional support included mainly encouragement and general concern. For example, a LTA with physical problems said that the occupational health nurse asked him every now and then how he was doing, and that felt good. A LTA in the mental health group told us that her work mates watched her and did not let her do any extra work. In the case of two LTAs, meetings with the management and superiors were organised to discuss their situation. Practical support included help with practical issues such as ergonomics, computing, and paper work concerning the absence and RTW. All the LTAs that told us about support were happy with it and felt that it was important.

3.4.5 Changes since work resumption

In the interviews, we asked both the LTAs and the SOs to estimate the impact of RTW on their household. The consequences can be divided into three groups: financial, emotional, and practical changes. The LTAs mentioned both positive and negative impacts on household. It is interesting that they referred to negative consequences as often as to the positive ones. Therefore, it should be kept in mind that the RTW, as well as going out absent, has several aspects to it and is not always a purely positive or negative thing. Also, it certainly affects the life of the whole family. The impacts of RTW that the LTAs and SOs referred to were naturally mainly opposite to the impacts of going out absent.

The most important positive impacts the LTAs mentioned were the emotional ones. RTW reduced tension between the family members: *"It was a positive thing. Now that we both go to work, we don't have to fight. There is no longer all that unnecessary nagging"* (ID 1512). The SO and children were relieved and happy to see the LTA return to work. For the family members, the fact that the LTA was capable of work again meant that he/she had recovered. In most cases, the whole family was pleased about things getting back to normal. Also, some LTAs said that the SO was happy to have more own time and space now that the LTA was not home all day. One LTA also referred to financial impact of RTW.

We divided the negative impacts of RTW into practical and emotional consequences. According to the LTAs, the most important change since the RTW was practical: there was less time for family and doing housework. There had to be changes made in the work distribution between family members and they all had to adapt to the new situation. That sometimes led to emotional cosequences, too: *"They were upset. My wife had gotten used to me being at home and I could help with the children. When I went to work, my daughter kept asking my wife: When is daddy coming back?"* (ID 1832). Also, some LTAs stated that the family members were generally not pleased with the idea of them returning to work: *"They told me I was crazy to return"* (ID 38).

We also asked the significant others of the LTAs to tell us about their experiences on partner's RTW. The experiences of the SOs were mainly positive. When it comes to consequences of RTW for the LTA, all but one SOs felt that the impact was purely positive. They stated that their partners felt better after returning to work. The experiences were especially positive when the LTA returned to a new job. Some SOs emhasized the mental impact of returning to work:*"After getting better he started to miss work. Work is very important for him, he needs action. Returning to work was extremely important for him"* (ID 1832 P). All the SOs interviewed held the view that their partner managed RTW well. According to the SOs, the impact of RTW on themselves was positive as well. Only one SO referred to a negative change since partner's RTW: partner now had less time for the family. The most important impacts were emotional. The SOs told us that the situation at home got better and there was less tension after partner returned to work. The SOs were relieved to see their partners feeling better again and enjoyed the fact that life got back to normal.

Return to work was a crisis

Reino was excited to return to work after a long absence. He felt he was ready for it and was happy to see his work mates and finally get life back to normal. But, in reality, the RTW was a shock for him. The first weeks were extremely rough both physically and mentally. He was exhausted and upset; he thought he would not make it. He was disappointed at himself. Also, there were problems in work climate and relationships between certain employees. As a superior, Reino was expected to come and fix it all. Things were poured over him during first days; he was not given any time to adjust to being back at work. It was hard.

3.5 Perceptions and experiences of people who have not returned to work

At the time of the interview, 50% of the LTAs interviewed had not returned to work so far (see table 2.2.). In this section we discuss their views on returning to work. We start by going through the factors preventing return to work .After that, we look at the LTAs' views on what could help work resumption. Finally, we review the contacts the LTAs reported having with persons at the workplace during the absence.

Main findings

- In most cases, the factor preventing RTW was ill-health.
- Most LTAs did not believe there was anything they or their families could do to help work resumption.
- The role of the workplace is extremely important when it comes to RTW.
- When askesd how companies could better facilitate work resumption, LTAs with physical health complaints concentrated on practical changes in work environment and tasks and the LTAs with mental health and co-morbid problems stressed the importance of changes in attitudes and behaviour.
- Most LTAs had contacts with workplace during absence.

3.5.1 Preventing the RTW process and what could help the work resumption

The factor that the LTAs most often mentioned as preventing RTW was naturally ill-health. It was referred to by all the LTAs who had not returned to work in the physical and co-morbid groups and almost half of the LTAs in the mental health group. Other factors mentioned by the LTAs with mental health complaints were also mainly related to health issues: The LTAs stated that they did not want to return to work because it would make them feel worse again or that they felt that they would not manage work.

It seems that most of the LTAs that had not returned to work at the time of the interview were not planning to RTW either, at least not in the near future. Several LTAs had retired or were going to retire soon because of their illness. However, there were also LTAs, especially in the physical group, that were hoping to return to work as soon as they started to feel better. In some cases, the possible RTW depended on rehabilitation or treatment, e.g. surgery.

The interviewees were also asked to consider what could be done to help them RTW by themselves, their family or others. Most LTAs stated that there was nothing they could do to help themselves getting back to work. Only one LTA in the physical and three LTAs in the mental health group felt that there was something they could do. They all stated that they could help RTW by "getting better". All the LTAs agreed that there was nothing their families could do to help them return to work. Among the LTAs in the physical group, that was also the case when asked if there was anything anyone else could do. However, most LTAs in the mental health group and one third of the LTAs in the co-morbid group felt that there *was* something that could be done. In all of these cases, the LTAs stated that work adjustments could help them to RTW. The adjustments they referred to most often were part-time work and moving to easier tasks. These views once again point out that the role of the workplace is extremely important when it comes to RTW.

Because of the important role of the employers, we also asked the LTAs to think over the question of how companies can better facilitate RTW, in general. There was a clear difference in the answears of the LTAs between the three groups. While the LTAs with physical health complaints concentrated on practical changes in work environment and tasks, the LTAs with mental health and co-morbid problems stressed the importance of changes in attitudes and behaviour. In the physical group, all but one of the LTAs referred to making work adjustments as an action that would facilitate RTW. In the mental health group, 60% of the LTAs stated that the most important factor is conversation between the employer and the employee. One LTA also pointed out that the employees should be listened to properly, and another one suggested that there should be more communication training for the management. In the co-morbid group, the factors that were clearly most important to the LTAs were the attitudes; they were referred to by all the LTAs in this group. The LTAs remarked, for example, that the employers should have more patience and respect towards the employees. One LTA stated that personal relationships at the workplace should be improved altogether. Another LTA remarked that RTW should be thought of as a common issue at the work place and everyone should support the returnee.

3.5.2 Company contacts

80% of the respondents who had not yet returned to work reported that they have had contact with someone at their workplace during the absence. In all of these cases, the persons that they had contact with were work mates(s) and/or superior(s). The contact persons kept in touch with the LTAs by phone calls and the LTAs often also visited their work places. They discussed practical issues of the absence and how things were going at the workplace, as well as how the LTA was doing. Some LTAs told us that they were friends with the work mates also outside the workplace and met them regularly. Apart from two LTAs, all the interviewees that reported having had contact with the workplace considered the contact helpful. In the two cases in which the contact was regarded as unhelpful, the LTAs felt that they did not get peace from the workplace and work issues because of the contact.

When asked what would be the ideal type of contact with the employer, most LTAs agreed that any kind of positive contact would be nice. The types of contact they preferred can be divided in two: sharing information, and showing general interest and concern over the well-being of the LTA. Three LTAs stated that they do *not* wish for any contact whatsoever with their employer. The reasons for that were quite similar in all three cases: the LTAs simply did not want to have anything to do with the workplace because of the negative experiences connected with it. This is how one of these LTAs expressed her feelings towards the workplace: *"I don't want to keep in touch. I feel that by doing that I would get stuck with my failure. I don't want to think about anything related to work. At the beginning of the absence it was so hard that I couldn't even look at the workplace"*.

Workplace is doing nothing to help the LTA to return to work

Tellervo is absent due to chronic shoulder pains. She believes there are work-related issues in the background. She has not returned to work because she has not been able to overcome the mental barrier related to RTW. The fact that no contact whatsoever has been made by the workplace has certainly not helped. She is disappointed because no one at her workplace has been interested in how she is doing and is she willing to return to work. She feels that work adjustments or new tasks could have helped to prevent the absence in the first place or at least make it shorter. She fought for changes in her job for ages but finally got too tired and gave up. It made her depressed.

3.6 Rehabilitation

In this chapter, we cover the LTAs' experiences and views on rehabilitation programmes and other activities aimed at RTW.

Main findings

- 50% of the LTAs had been offered an opportunity to participate in a rehabilitation programme and most of these LTAs also took part on it.
- LTAs attended rehabilitation courses in rehabilitation centres and spas. LTAs with mental health problems often referred to therapy, too.
- Most LTAs found the rehabilitation useful.
- Besides rehabilitation courses and therapy, other factors that contributed to the rehabilitation included physical treatments (e.g. physiotherapy), LTA's own activities (e.g. exercise), peer group support, and alterantive medicine.

3.6.1 Participation in programmes

One half of the LTAs stated that they had been offered an opportunity to participate in a rehabilitation programme, while the other half had not been offered such opportunity. There were no significant differences between the groups of LTAs in this respect. The person who discussed this opportunity with the LTA was in most cases a medical professional, such as OHP or medical specialist. A clear majority of the LTAs who had been offered rehabilitation had also taken part in it. Only three LTAs had turned the offer down. One of them felt that she did not have the strength to take part in rehabilitation programme, while the other two were not able to arrange it in practice, e.g. could not find the time for the programme.

In the physical group, in most cases where the LTAs had taken part in rehabilitation programme, the programme took place in a rehabilitation centre. In few cases it was held at a spa hotel. The rehabilitation period usually took from one to two weeks, and included discussion, treatments, exercise, and lectures. The persons involved in the programme were in most cases medical professionals such as special nurses and specialists, as well as rehabilitation instructors.

In the mental health and co-morbid groups, the form of rehabilitation most often referred to was therapy. Some LTAs had taken part in a rehabilitation period or course, which included

physical and mental activites, such as exercise, group conversations, discussions with professionals, and lectures. These periods took for 2-3 weeks and the persons involved in the rehabilitation period included rehabilitation instructors, psychologists and psychiatrists, psychiatric nurses, physicians, and physiotherapists.

3.6.2 Usefulness of RTW programmes and other contributions

Most of the LTAs that took part in rehabilitation activities found the participation useful. Only a few LTAs stated that the rehabilitation was not useful or only partly useful. The factors most often referred to by the LTAs in the physical and mental health groups referred to were getting support and advice. The LTAs with co-morbid group most often mentioned receiving professional help. For example, some LTAs in this group told us that the therapy was essential for their recovery: *"The therapist was very skilled; he helped me to understand things. Therapy helped me to change my attitude towards life, to cut the negative spin. I would not have made it without the therapy"* (ID 38). In all three groups, some LTAs emphasized the importance of peer group support in particular.

The LTAs that did not think the rehabilitation was useful simply stated that it did not help, or that the positive impact of rehabilitation did not last. Some of the LTAs that found the programme useful, also found some negative sides to them, e.g. that the programme in particular was not suitable for them or that the timing was not that good. When asked about how the rehabilitation programme could have been more useful, timing was in fact the factor most often referred to by the LTAs. However, most LTAs could not name anything that could be improved in the programme. One of the LTAs was happy with the programme itself, but pointed out that *"rehabilitation is useless unless things change in the workplace"* (ID 1065).

Rehabilitation programmes were not the only services that contributed to the rehabilitation of the LTAs. Some of the LTAs referred to other factors besides, or instead of, rehabilitation programmes that were helpful. These factors can be divided into four groups. The first group includes physical treatments, such as physiotheraphy. The second group consists of own activities of the LTAs. For example, some LTAs with physical health problems found exercise the best rehabilitation of all. The third group includes peer group support, such as attending meetings of support groups. The final group of factors that contributed to rehabilitation consists of alternative medicine. Some LTAs in the co-morbid group had found help in alternative treatments, such as homeopathy and zone therapy.

Positive rehabilitation experience

Eino has attended a rehabilitation course of two 14 days periods in a rehabilitation centre. The programme included physical and mental activities, such as lectures and therapy, and it was attended by 10 people suffering from burn-out. He has been happy with the rehabilitation; it felt good to get away from everything for a while. The most important thing for him was definitely peer group support. It was good to meet other people who were in the same situation. The group conversations were extremely helpful.

3.7 General

In the final part of the interview, the LTAs and SOs were asked some more general questions relating to their perception of changes in society and the consequent impact on their quality of life and levels of stress. They were also asked what they considered as the main factors influencing absenteeism in their own workplace and what their opinions were on the impact of changes in society on absenteeism more generally. We were happy to have very diffuse and profound answears for these questions. Most of the LTAs seemed to have thought these issues over, and they were eager to share their views about changes in society and in the workplaces. Lately, there has been a lot of public discussion about these issues in Finland, too, which the interviewees have propably followed with interest.

Main findings

- The LTAs agreed that changes in society have an impact on their quality of life and stress levels, as well as on absenteeism in general. They referred to a variety of changes. Most of them were related to work culture and demands in the workplace.
- The LTAs strongly criticize the emphasis on financial issues (profit responsibility) in work life.
- Most interviewees listed several issues that affected well-being of the employees and affected absence in their workplace: demanding work, relationship/ climate issues, work load, problems in management, and working environment.
- Poor climate and/or management stood up as the central problem faced in the workplaces of the LTAs.
- According to the LTAs the values of our society are becoming tougher and life is becoming more and more demanding, which has a strong influence on worklife and absenteeism.

3.7.1 Changes in society and the impact on quality of life and stress

"Changes in society have definitely had some part in my exhaustion". (ID 1011)

Apart from two exceptions, all the interviewees shared the view that changes in society have an impact on their quality of life and stress levels. A variety of changes that have this impact were named by the interviewees and all of these changes were related to demands in the workplace. All the changes actually come down to one thing: the interviewees feel that profit motives leads to doing *"as much as possible for as little as possible"* (ID 1512P), as one of the SOs put it. This goal naturally puts more pressure on the employees and speeds up the work pace, creating constant hurry and stress. Some LTAs felt that the work culture of today has changed so much that it does not follow their ethics, or that they find it impossible to adjust to it for other reasons. As discussed above, not all the LTAs considered their absence caused by work. However, it is interesting that in this part of the interview some of the LTAs stated that if they had suffered a non-work-related illness or injury, they would probably, sooner or later, have fallen ill because of the work.

3.7.2 Main factors affecting absence in respondents' workplaces

"Things seem to be out of control." (ID 99)

Most interviewees listed several issues that affected well-being of the employees and affected absence in their workplace. These factors fell into five categories: demanding work, relationship/ climate issues, work load, problems in management, and working environment. So, the factors can be roughly divided into two main groups: issues related to personal relationships (relationship/ climate issues and problems in management), and issues related to work itself (demanding work, work load, and environment). There was one clear difference between the three groups of LTAs: in the physical group, the factor most often referred to was demanding work, while in the other two groups the most important issues that came up concerned relationships in the workplace. However, poor climate and/or management were often mentioned in the physical group, as well, and therefore these issues stood up as the central problem faced in the workplaces of the LTAs.

Issues related to relationships

The most often mentioned factor affecting absences in the workplace was unsatisfactory management, which was referred to by half of the interviewees. It was often cited that management did not care about the employees and did not respect them. In some cases, the supervisors treated the employees badly; one LTA told us that their behaviour could even be labelled as bullying. Also, almost one third of the interviewees pointed out problems in the general climate at the workplace, as well as the relationships between the employees. They reported problems of a different level, varying from lack of team spirit to an atmosphere that became totally unbearable: *"There is no open discussion about problems; everyone talks behind each others' backs. Being different is not tolerated and no one is respected by colleagues, not to mention supervisors. The work place is a battlefield, and people are interested in nothing but their own advantage"* (ID 795). Naturally, as one of the LTAs remarked, *"poor atmosphere affects coping at work"* (ID 261).

Issues related to work

When it comes to factors related to the work itself, the issue most often referred to by the LTAs was demanding or hard work. Work could be hard physically and/ or mentally. LTAs referred to physically hard tasks,such as being on your feet all day, and tiredness caused by shift work. Mentally demanding work included issues such as dangerous and sometimes terrifying tasks, too much responsibility, or job being generally stressfull. Another factor related to stressfulness that also came up frequently was work load. One fifth of the LTAs stated that the work load was too much, and it caused faster work pace and long work days. Some LTAs also pointed out that there was too few staff, which increased the work load from before. In some cases, the working environment affected absence at their work place. These issues included lacks in safety, poor work premises, working outdoors, and overall unsatisfactory conditions.

3.7.3 How have changes in society impacted on absenteeism

"When capitalism is the only thing thought of, everything goes wrong." (ID 972)

The interviewees listed several changes in society that they considered having an impact on absenteeism. A clear majority of these factors were changes in work culture and work places, while minority of them were more general societal changes. The bottom line was the fact that our culture has definitely changed, and not in favour of the employees. There have been changes in ethics, values and attitudes, and these changes have a strong impact on today's work life.

General societal changes

We will start by discussing the general societal changes referred to by the LTAs and SOs. First of all, several interviewees mentioned the fact that overall, nowadays everything is in a stage of constant change. This generates uncertainty and insecurity in people's life. Secondly, the interviewees held the view that our way of thinking has definitely changed. For example, several interviewees felt that nowadays effectiveness is highly valued and there are more demands on people *"Hurry is in fashion; if you are not busy all the time, you are lazy and a loser"* (ID 322). *"There is an irrational attitude towards weakness and imperfection* (ID 1148). The interviewees also pointed out that there are serious social problems: *"Living conditions have gone worse and basic security has weakened. Mental health problems have increased"* (ID 1148). They also saw flaws in health care and education system. One important point made was that people don't get help early enough, which for its part impacts absenteeism: when they finally gett help, employees are in a very bad condition and absences tend to belonger. According to the interviewees, the most significant societal issue affecting absenteeism is, however, unemployment. The following quotation sums up the thoughts of several interviewees: *"employees feel insecure and unsafe, anything can happen. Unemployment touches many people"* (ID 614). So, besides possibly leading to other social problems among the unemployed, unemployment generates insecurity in those who are in working life. *"Insecurity about jobs causes stress, which lead to falling ill. (…) People have to stick to most dreadful jobs" (*ID 1325). There is also more temporary employment than before and employment periods tend to be shorter. This insecurity leads to fears of unemployment, and one side-effect of these fears is the fact that employees don't dare to go out absent when they are ill. This, again, naturally causes the situation where employees are in a bad state when they are finally forced to go absent. One LTA also brought up another important consequence of short employment periods: *"It follows that some employees do not become a member of any group. Belonging to a group is very important"* (ID 38).

Changes in work culture and workplaces

"Fast pace, stress, demands… Nothing is enough!" (ID 1095).

As mentioned above, most of the LTAs' comments regarded changes in work culture and workplaces. The majority of the interviewees stated that work life has become more and more demanding for the employee. Work load is enormous and work pace keeps getting faster. According to the intervewees, employees face more expectations than before and, overall, work is more stressful. Some LTAs also expressed dissatisfaction with the fact that employees lack autonomy in their work: *"I hate the feeling of not being able to have control over my own work. Decisions are made somewhere far away, which causes obscurity*" (ID 1011).

Also, few LTAs cited that employees are treated badly and are not respected: *"No one cares for employee's well being anymore"* (ID 322).When discussing treatment of employees, the terms 'machine', 'slave' and 'pawn' were used in the interviews more than once. The LTAs also named other flaws in today's management, e.g. lack of strong leadership, and lack of positive feedback and open discussion in their workplaces.

Several LTAs expressed their concern about changes in ethics and values in today's work culture. Overall, the way of thinking has changed, which worries the interviewees. One issue that strongly emerged in the interviews was criticism of profit motives and the general emphasizing of financial issues in the worklife, as well as in the society more generally: *"Work is done for owners; work only has an instrumental value. All work is rated by the terms of economy"* (ID 1625). *"Making profit impacts more than before. We try to do as much as possible for as little as possible. There is faster pace, not enough staff and tighter deadlines, and work load increases all the time"* (ID 1512P). As the latter interviewee quoted , seeking profit leads to a vicious circle, and, eventually, the employees are the ones who face the consequences. Several LTAs pointed out that demands for profit take the joy out of work, and it starts to feel meaningless. The interviewees agreed that the emphasising of financial side does not always fit well to work life: *"Everything is measured by efficiency, money, savings and schedules. When working with people, measures should be different"* (ID 1426). A common view was that humanity and communality have disappeared from workplaces, and tough values have emerged instead: *"People only care for their own advantage, they don't help each other anymore- the world has become tougher"* (ID 38P). The LTAs and SOs were not happy with these changes: *"Interaction skills, communality and respect should be valued"* (ID 1065).

As we can see in the above quotes, the interviewees were generally worried about the trends of work culture of today. They had detected several changes in the society that definitely have an impact on absenteeism. The main point that the interviewees made was the fact that our values are becoming tougher and life is becoming extremely demanding. Eventually it all leads to exhaustion, tension and stress. As one of the LTAs summed it, *"people are worn out"* (ID 332).

4 Discussion

In this chapter, we discuss the main findings of our study. We consider the improvements that might be warranted at the workplaces and draft recommendations of actions that could be made around the issues of absence and work resumption.

Succesful absence and return to work - Important factors

- **Timely and safe absence and RTW**
- **Open communication and interaction in the workplaces**
- **Rising awareness levels on health issues and their work-relatedness**
- **Identifying indicators of absence**
- **Work-life balance**
- **Improving awareness on rehabilitation possibilities**
- **Work adjustments**
- **Improving cooperation and interaction between different actors**
- **Clear policies and practices on absence and RTW in workplaces**

4.1 Absence threshold

According to the LTAs, the most important reason for going absent was simply becoming incapable of work. The process of going absent was naturally strongly related to the nature of illness. There were two main types of absence threshold: immediate/ spontaneous absence leave and absence leave contemplated over a period of time. In the case of the latter type of absence threshold, the LTAs considered reporting sick before actually doing it. The period of thinking about reporting sick can be seen as a period of preparing oneself for the absence as well as admitting oneself that you are not well. In many cases, this period was quite long. Thus, it is important to make employees aware of the dangers of delaying seeking absence. It is important to note that the delay can make the illness more severe and impact negatively on recovery time. Therefore, attempts should be made to lower the barriers - both practical and mental - to seek help. When it comes to employers, awareness of how work-related issues have an impact on mental and physical health should be improved. Also, employers should be provided with information of more general awareness of mental health issues. It is also important to help the employers, as well as the employees, to learn about signs to assist in recognising onset of both physical and mental health problems. The employer should also gain clear information about where to refer employees with mental health problems to. Supervisors should regognize the importance of taking an interest in employees' health and wellbeing.

4.2 Prevention

According to our data, there is a clear "underusage" of strategies to prevent absence in the workplaces. This issue is evident when comparing the LTAs' answers to the question of what could have been done to prevent the absence with the experiences of what actually *was* done before the absence. Although the LTAs did not undertake any actions to prevent the absence, a number of them listed actions their workplace could have undertaken to prevent the absence.

Thus, the impact of the workplace on the health of the employees should not be underestimated. However, it should also be noted that in some cases the LTAs admitted not asking the employer for these actions, or even informing them about their health problems. So, the employer did not have knowledge about the wishes of the employee and therefore they lacked opportunities to undertake any actions to prevent the absence. This suggests that there are gaps in the communication in the workplaces. In these cases some actions should be made to improve the atmosphere and possibilities to communicate so that the climate at the workplace would be more open and bringing up these issues would be easier for the LTAs.

Health promotion programmes would be useful in all workplaces. The issues such as mental and physical health and how work-related issues affect them, questions of successful absence management, RTW, and rehabilitation should be discussed and access to information about these issues should be provided to both the employees and employers. One of the most important issues is gaining awareness of timely treatment to prevent more serious illnesses. Also, the families of people with stress-related health problems often lack information about the illness. Therefore, it is important not to leave the families out when discussing these issues.

4.3 Decision making and support around absence

In the interviews of LTAs, occupational health practicioners emerged as the main professionals involved in making the decision to become absent. This result points out the importance of training of occupational health care professionals around dealing with work absence and also their role in the return to work process. Within the workplace the main support prior to absence came from colleagues, supervisors, and managers. The many examples of positive support contributing to the LTA seeking help suggests that employee awareness of illness as well as management and supervisor awareness of the indicators of illness are important.

4.4 The effect of long term absence on mental health

Long term absence had both a positive and a negative impact on the mental health of the LTAs. Several interviewees that were absent due to physical health problems reported that they were experiencing psychological distress. The main symptom reported in these cases was depression. Also many of those who classified themselves as absent due to co-morbid illnesses reported that their physical illness came first and was followed by the mental illness after a period of absence. On the other hand, some of the respondents absent for mental health reasons, particularly stress and anxiety, reported feeling much better mentally when they stopped working. From the interviews, it was apparent that accepting being on sick leave and adjusting to it often took quite a while. For some LTAs admitting oneself being incapable of work and being ill was difficult and time consuming. This process made the beginning of absence hard and set back the recovery. But once the LTAs adjusted to the idea of being ill and the necessity of absence, they often started to feel better. So, settling on sick leave can be seen as the first step in being rehabilitated. Therefore, it is arguable that the LTAs should receive support especially in the beginning of absence. It would be well-grounded to remind them of the importance of absence in order to get better. Also, in many cases it should be stressed to the LTAs that there is no need to experience guilt about being absent.

4.5 Impact of absence on families

The LTAs reported several positive impacts of absence on families. The main impacts included improvements in relationships and more time to spend with children and take part in domestic work. It should be considered how these positive effects could be maintained. Are there possibilities to develop more family friendly work practices? The positive outcomes of absenteeism suggest that in some cases, there is a need for more work-life balance and flexibility in the workplaces.

The main negative impacts of absence on both the individual and families were emotional. Negative impacts on the household were mainly experienced as increased tension due to illness or due to household and family routines being altered by the newly absent person. These findings suggest that more support targeted at the psychosocial aspects of LTA is required during the absence process. According to the interviews, the family also has an essential role in the LTA going out absent and work resumption. The main factor is support. It is important for the LTAs that the family members understand their situation and support them in their decisions. Therefore, it is arguable that the families of the LTAs should receive information on health issues, particularly on mental health issues, and different factors concerning absence. The experience of absence can also be quite demanding for the family members of the LTAs. This finding suggests that attempts should be made to provide support to the families, too.

4.6 Return to work

The majority of LTAs who had returned to work stated that they returned when they were ready to do so. The main reason given for RTW was improved health status, and, conversely, the main reason for not returning was continued illness/ incapability of work. It should be kept in mind that work ability consists of both capacity (being able to work) and motivation (wanting to/ having to work). Therefore, it should be considered what factors promote the sense of work ability of the employees and attempts should be made to improve these factors.

A variety of actions were perceived by the LTAs as important in their motivation to return to work. A number of LTAs suggested that ongoing contact with the company was important and that the nature of this contact is critical. According to the interviewees, employer's genuine concern about the employee is likely to encourage an earlier return to work. Also, importance of supervisor contact when the absentee returns to work should not be underestimated. Therefore awareness of these issues should be improved and guidelines on how to handle the absences should be developed where possible. It would also be helpful to have a list of appropriate referrals or contacts available to both the supervisors and the employee on issues concerning RTW. The importance of interventions such as reduced working-time, altered work arrangements and gradual return to work were also emphasized by the LTAs. Thus, it seems that the employers' awareness about the crucial role of such actions and arrangements should be improved. In many cases, there is a need for more flexibility and openness around the idea of making adjustments in the workplaces.

Most LTAs reported that they had support at workplace when returning to work. Colleagues and supervisors were the main source of that support. The importance of support and of how RTW is generally handled by the employer and the workplace can not be overemphasized. It

might be a good idea to brief the supervisors and colleagues of the LTA before the RTW about limitations that might appear in the work ability of the LTA, and how the transition could be made easier for him/her. As in the decision to go absent, the OHPs emerged as critical people involved in the decision to return to work, too. Again, this has implications for OHP training to ensure that when they are engaged with LTAs they have sufficient knowledge and are aware of appropriate actions and practices about RTW.

When it comes to RTW, the importance of work adjustments and the important role of the employee can not be overemphasized. Before RTW, it is a good idea to arrange a meeting with management, supervisor, representative of HR department, representative of occupational health services and the LTA. The range of options and interventions to return the absentee to the workplace should be discussed when necessary. Several LTAs suggested that a gradual return to work might be the best option; in their opinion, the LTA should work fewer hours for the first few days or weeks. Also, the possibility of the LTA to move to a more suitable job should be considered when required. Overall, the interviewees stated that the employer should attempt to make the adjustments needed to make the RTW as successful as possible. Interviewees reported that employers often lacked a coherent RTW process. Also, in many cases the role of professionals in this process was unclear. Thus, it is arguable that there is a need for designing guidelines on RTW process in many workplaces.

The role of the workplace is extremely important in RTW. It is noteworthy, as well, that when we asked the LTAs who were still absent about the factors that could help them RTW, they were not able to name anything besides themselves getting better and the employer making work adjustments. This result reveals that there are gaps in the knowledge of these issues among the LTAs, too. For example, it is clear that many of them were not familiar with rehabilitation facilities. This factor also came up in the part of the interview in where rehabilitation programmes were discussed and other actions aimed at RTW. We also noted that in most cases, the rehabilitation was quite “basic”: when it comes to rehabilitation, there seemed to be a lack of certain comprehensiveness, persistence, and well-organized systems in many cases. Perhaps the rehabilitation programmes available for absentees should be charted. It can be assumed that LTAs are not necessarily able to demand rehabilitation activities, either, because they do not know what is available. Thus, we believe that the awareness level on different rehabilitation possibilities should be raised. Furthermore, it might be useful in many cases to try and improve coordination between organisations or groups providing rehabilitation activities.

4.7 Push and pull factors

Certain push and pull factors relating to absence and RTW can be identified in the interviews. We have divided them to four groups: (1) push to absence, (2) pull to stay at work, (3) push to RTW, and (4) pull to stay absence. The factors in the first two groups are related to the process of going out absent. (1) Factors that pushed the LTAs to absence include issues that are illness-related (e.g. incapability of work because of the ill-health, pains, tiredness) and other personal issues (e.g. problems with children, relationship difficulties) and work related issues such as problems at the workplace, poor climate/ relationship problems, rough work, poor work conditions, workload, and working too much. (2) On the contrary, factors that the LTAs named as pulling them to stay at work include realising the situation and getting help early enough. Actions of the employer were also considered important. Improving work conditions, making work adjustments, dealing with the situation of the LTA more efficiently ,

and overall treating the LTA better were mentioned as factors pulling to work. Also, support from colleagues was pointed out.

The factors in the latter two groups are related to the process of returning to work. (3) The main factors that pushed the LTAs back to work include recovery, own motivation to return, and work ability, financial issues, and getting life back to normal. Other factors that pushed the LTAs to work include work adjustments, contact from the workplace during the absence, and both emotional and practical support from superior, colleagues and health care professionals. It can be assumed that rehabilitation could contribute to RTW more than it did according to the interviews. Therefore improvements in this respect would be desirable. In contrast to these factors, the main issue that pulled the LTA to remain absent was ill-health. Also, some LTAs who had started to feel better during their absence stated that they did not want to endanger their health or wellbeing by returning to work. Therefore, it should be considered how to maintain the wellbeing of LTAs after RTW. Other factors pushing the LTAs to remain out of work include poor work conditions and other problems at work. When problematic situations in the workplace were not dealt withand the employer refused to make adjustments the LTAs were often not willing to return. Also, lack of contact from workplace during absence and lack of support, altogether, were issues that pushed the LTAs to remain absent.

It should be noted that the role of the employer is extremely important in both preventing the absence and promoting RTW. Also, an issue that we wish to stress is right timing in both going out absent and returning to work. Factors supporting successful processes of going out absent and RTW should be strengthened when possible. That way the absence can in some cases be prevented or made shorter, and the RTW can be promoted and made as smooth as possible. Such factors include work adjustments, supporting the LTA before, during and after absence, and rehabilitation programmes. Another factor that can not be overemphasized is open communication in the workplaces. Finally, we wish to add that when discussing possible intervention actions there should be an assessment of whether the actions will be sufficient to rectify the situation, which is establishing and maintaining work ability.

4.8 General comments

The LTAs agreed that changes in society have an impact on their quality of life and stress levels, as well as on absenteeism in general. They referred to a variety of changes. Most of them were related to work culture and demands in the workplace. Most of all, they strongly criticized the emphasis on profit motives in work life. We believe that the employers should take notice of these views. According to the interviewees, there are some serious problems and weaknesses in the workplaces and these factors strongly affect the wellbeing of the employees and thus increase absenteeism. The main issues that the LTAs referred to include relationship and climate issues, heavy work load, demanding tasks, problems in management, and poor working environment. Troubles in climate and/or management stood up as central problems faced in the workplaces of the LTAs. According to the interviewees these issues should be dealt with in the workplaces. It might be well-placed to include discussing wellbeing of the employees as well as relationships in the workplace in supervisor training. Also, programmes and actions aimed at improving climate and work environment should be planned when necessary.

In the interviews, some of the LTAs expressed critique against the Social Insurance Institution and private insurance companies. Several LTAs reproached them for complicated practices

and their bureaucratic nature. In some cases, the LTAs had serious problems in following through the process of applying for sickness allowance or disability pension. These difficulties sometimes lead to severe financial difficulties. It should be pointed out that the LTAs are often in a very poor health, tired, and not able to carry out even their normal everyday tasks, not to mention managing the lengthy and complex bureautic processes. Therefore, we think that it would be arguable to consider developing a system of authorized spokesmen or representatives for the LTA to assist them in handling these issues. However, none of the interviewees criticized the health care or rehabilitation systems. In fact, most of them expressed general satisfaction with the services and treatment they had received.

References

Allegro, J.T., & Veerman, J.T. (1998). 'Sickness Absence'. in P.J.D. Drenth, H. Thierry and C.J. de Wolfe (eds), Handbook of Work and Organizational Psychology Vol 2:Work Psychology. (2nd Ed.), Hove: Psychology Press/Erlbaum (UK). p. 121-144.

Brooke, P.P. (1986). Beyond the Steers and Rhodes model of employee attendance. Academy of Management review, 11, p. 345-361.

Bulter, A.B., Grzywacz, J.G., Bass, B.L. Linney, K.D. (2005). Extending the demands-control model: A daily diary strudy of job characteristics, work-family conflict and work-family facilitation. Journal of Occupational and Organizational Psychology, Vol. 78. No. 2. Pp 155-169

Brun, C., Bøggild, H., & Eshøj, P. (2003).Socio-Economic risk indicators for disability pension within the Danish workforce: A register based cohort study from 1994 to 1998. Ugeskrift for Læger, 195, 19, p. 297-312.

Carragee, et al (2004). Psychological stress better predictor of back pain than standard techniques. Journal of the Spine, May 15th 2004.

Chandola, T., Brunner, E., Marmot, M. (2006). Chronic stress at work and the metabolic syndrome: prospective study. British Medical Journal, Jan 2006. BMJ, doi:10.1136bmj.38693.435301.80

Department of Work and Pensions (2005) Benefit payment of incapacity payment: percentage claimants with mental and behavioural disorders. F00 - F99

Department of Work and Pensions (2002) Pathways to work: Helping people into employment DWP

Erikson, R., Nichols, L., & Ritter, C. (2000). Family Influences on Absenteeism: Testing and Expanded Process Model. Journal of Vocational Behavior, 57 (2), p. 246-272.

Floderus, B., Goransson, S., Alexanderson, K & Aronsson, G. (2005) Self-estimated life situation in patients on long-term sick leave. Journal of Rehabilitation Medicine. Vol 37 p291-299

Fullerton, H.N., Jr., "Labor force participation: 75 years of change, 1950-98 and 1998-2025," Monthly Labor Review, December 1999.

Goldsmith, A.H., Veum, J.R., & Darity Jr., W. (1996). The impact of labor force history on self esteem and its component parts, anxiety, alienation and depression. Journal of Economic Psychology, 17, p. 183-220.

Grzywacz, J.G. (2002) cited in Handbook of Mental Health in the Workplace. By Michel Hersen, Sage Publications Inc.

Grzywacz, J.G. Marks, N.F. (2000). Re-conceptualising the work-family interface: An ecological perspective on the correlates of positive and negative spillover between work and family. Journal of Occupational Health Psychology. Vol 5. No. 1. pp111-126

ILO. (2004) Key Indicators of Labour Market. ILO

Jahoda, M. (1982). Employment and unemployment: A social-psychological analysis. London:Cambridge University Press

Kinicki, A.J., Pruyssia, G.E., & McKee-Ryan, F.M. (2000). A Panel Study of Coping with Involuntary Job Loss. Academy of Management Journal, 43 (1), p. 90-100.

Kinnunen, U., Feldt, T., Rantanen, J & Pulkkinen.L. (2005). Work-family interface: a measure for identifying negative and positive spillover between work and family. Psykologia 40: 43-52. Vammala ISSN 0355-1067

Kivimäki, M, Head, J., Ferrie, J. E., Shipley, M.J., Vahtera, J., & Marmot, M.G. (2003b). Sickness absence as a global measure of health: Evidence from mortality in the Whitehall II prospective cohort study. British Medical Journal, 327, p. 362-368.

Kivimäki, M., Vahtera, J., Thomson, L. Griffiths, A. Cox, T., & Pentti, J. (1997). Psychosocial Factors Predicting Employee Sickness Absence During Economic Decline. Journal of Applied Psychology, 82(6), p.858-872

Krause, N et al (2001) Determinants of duration of disability and return-to-work after work-related injury and illness: Challenges for future research. American Journal of Industrial Medicine Vol 40: p 464-484

Mead, R.J., (2000). The Struggle to Juggle Work and Family. Centre for Labor Research and Education. Institute of Industrial relations School of Public Policy and Social Research. UCLA

Morrison, D.L., & Clements, R. (1997). The effect of one partner's job characteristics on the other partners distress: A serendipitous but naturalistic, experiment. Journal of Occupational and Organisational Psychology. 70 (4), P. 18-

Nielsen, M.L., Rugulies, R., Christensen, K. B., Smith-Hansen, L., Bjorner. J.B., & Kristensen, T.S. (2004). Impact of the psychosocial work environment on registered absence from work: A two-year longitudinal study using the IPAW cohort. Work & Stress, 18 (4), p. 323-335.

Power C. (2001) Low Back Pain Linked to Stress in Young Adulthood. American Journal of Public Health. Vol 91:1671-1678.

Rhodes, S. R., & Steers, R.M. (1990). Managing Employee Absenteeism. Reading, MA: Addison Wesley.

Robertson Cooper (2005) Stress and Mental Health in the workpace. MIND Week Report. MIND UK. May 2005.

Sauve, R. (2002) Connections: Tracking the links between jobs and family. Job, family and stress among husbands, wives and lone parents. From 1990 - 2000. The Vanier Institute of the Family, Canada

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

Vinokur, A. D., Schul, Y., Vuori, J., & Price, R.H. (2000). Two years after a job loss: Long Term Impact of the JOBS program on re-deployment and mental health. Journal of Occupational Health Psychology, 7, p.5-19.

Watson Wyatt (2002) Integrated Disability Management around the World 2000/2001. Watson Wyatt Worldwide and Washington Business Group on Health

WHO: The World Health Report (2001), Mental Health: New understanding, new hope. WHO.