



UniS

Work Package 5
Impact of changing Social Structures on
Stress and Quality of Life:
Individual Perspectives

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STRESS IMPACT 

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SECTION 1 INTRODUCTION

IN-

1.1 AIM OF THE STUDY

Long term sickness absence has become a key issue in many European countries. Of particular concern has been the increase of the proportion of mental disorders in long term absences. Across Europe it appears that stress and burnout are amongst the most frequently mentioned work related health complaints (*Paoli, 1997; Merllié & Paoli, 2001; Weiler, 2004*). Stress and burnout are a major cause of absenteeism from work, costing society a substantial amount of money and causing people a great deal of worries and problems. The increase of mental disorders as a reason for absence and disability is particularly interesting, because the prevalence of mental disorders in the entire population has not increased (see. Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2000).

It is generally acknowledged that our society has changed considerably over the past few decades. In particular structural changes, such as changing social and working contexts and the introduction of new technology are believed to be important change agents. These societal factors play a major role in the background contributing to the stress process, in the sense that these factors often constitute demands that exceed people's capacities to cope. There are a substantial number of long-term absentees across Europe; information concerning this group is scarce. Yet in order to develop adequate return-to-work-policies information concerning these peoples' present living conditions, health, future perspectives and other factors that might influence their decisions concerning absenteeism and work resumption is required. (Henderson, Glozier, & Holland Elliot, 2005).

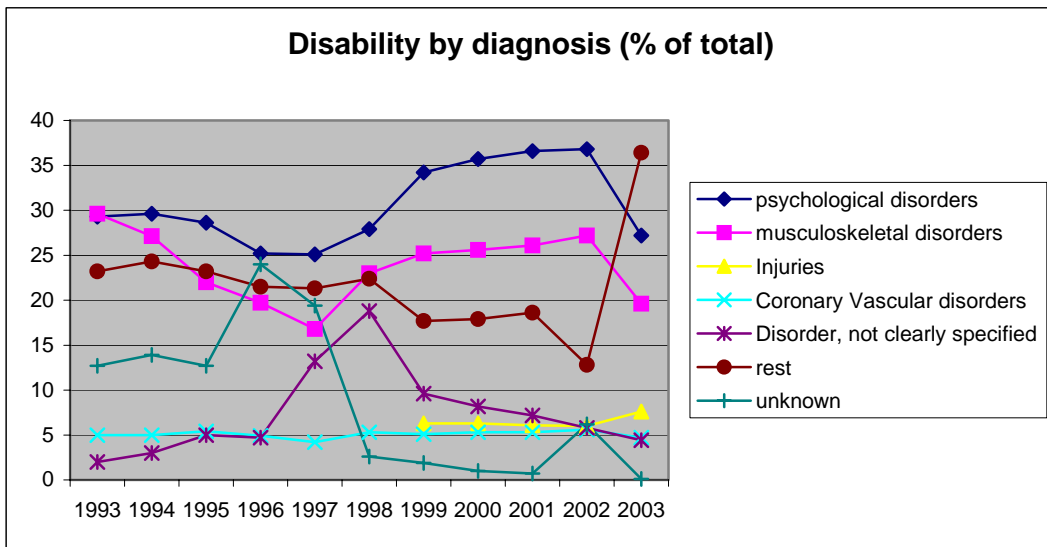
This project's aim is to fill part of that gap in the knowledge base on long-term absenteeism. One study within this project is a survey of LTA's enquiring after their experiences on being absent from work, their current health and living conditions, their job(s) before becoming absent, and future perspectives.

This report describes the main findings of the UK survey.

1.2 LONG TERM ABSENCE AND INCAPACITY BENEFIT

In the various EU-countries the percentage of people claiming Incapacity Benefits (IB), or the national equivalent, has been on the rise over the last decade, leading up to almost 10 % of the working population in 2002 in the UK. Around 30 % of this group of people on IB has been diagnosed with ‘mental and behavioural disorders’. In most West-European countries it has become the major reason for receiving incapacity benefits. Figure 1 shows the development in The Netherlands. The incidence of stress accounts for over 30 % of all absence from work and is the most frequent cited reason for absence from work, followed by musculo-skeletal problems. In 2003 there was a noticeable decline in the numbers. However, in hindsight this was attributed to a technical change in the assessment criteria which took effect in 2002 – 2003. This explanation is supported by the steep increase in the category ‘rest’ which coincides with the decline in ‘psychological disorders’. Other EU countries show a similar picture (Bergendorff et al., 2002). Some studies suggest that mental health problems are under-represented in the official statistics because they remain unrecognised or are ‘disguised’ by somatic complaints (Hensing & Spak, 1998; Stansfeld et al., 1995); there still seems to be a taboo on mental health problems and/or psychological disorders.

Figure 1.1. The Netherlands (source: Ministry of Social Affairs)



Governmental organisations in various countries have estimated that between 30 – 60 % of all sickness absence is related to ‘mental or emotional disturbances’. Therefore it is assumed that the majority of the people with mental and behavioural disorders actually have stress-related complaints. However, ‘stress’ is not an official diagnostic category, and therefore it is difficult to make an exact assessment of the number of Incapacity Benefit recipients who actually are suffering from stress. Since registration systems for sickness absence and long term absence in various countries are not comparable, cross-national studies on this topic are difficult and only feasible by collecting specific information.

There is little information available on long-term absentees. It appears that when people are absent from work, they disappear from all kind of statistics. In order to be able to formulate adequate policies on return to work, it is necessary to ‘know’ who the people are who are absent, what kind of jobs they had, et cetera. Most literature on intervention and rehabilitation strategies focus on people with physical health (injuries, cardiovascular) problems, yet it is the group of people with mental health problems that has been growing in the last decade and this is the group that we know least about. Thus with the aim of rectifying this situation this study is justified. This means that we need to have information: demographic information and information on current health status, life style, and what kind of jobs they were employed in, what characteristics these jobs had, etc. Jobs with particular characteristics apparently imply a higher risk for (long term) absenteeism compared to other jobs (cf. D’Amato & Zijlstra, 2003).

Absence from work can signify many different problems, and therefore usually a distinction is made between frequency and duration of absence. Absence *frequency* has been associated with a ‘voluntary’ component of absence, indicating that the medical condition is a less compelling reason for absence, whereas absence *duration* has been seen as a measure of involuntary absence, which can be attributed to an illness or injury. Therefore, it is argued that long spells are better measures of health status than short spells, which are often also influenced by a number of other factors (Marmot et al., 1995). There, indeed, are differences between the determinants of short and long spells of sickness absence. For example, socio-economic class seems to be a strong correlate for long but not for short spells of absence (e.g. Vahtera et al., 1996). This is why in many studies short and long spells are studied separately. However, the cut-off point is usually somewhat arbitrary and depends on the registration policy of the country or the company studied. Some of the studies are not clear on their definition of absence, concentrating mostly on short leaves of absence, or use only spells of absence, without referring to their length, which makes the in-

formation of these studies difficult to incorporate into models of long term sickness absence.

In this study we are primarily interested in long term absence, which we have defined as at least lasting 6 weeks. However, due to the differences in national registration systems, that have been used to recruit participants for this study, the actual length of absence can be substantially longer.

1.3 CHANGING WORK LIFE, STRESS AND LONG TERM SICKNESS ABSENCE

From a review of the literature (cf. D'Amato & Zijlstra, 2003) it became apparent that work related factors can constitute a particular risk for mental health problems, such factors can include the organization of work, productivity issues, and personal relationships at work. A number of models and theories have been developed to describe and explain the etiology and epidemiology of stress (Cooper & Payne, 1988; Hobfoll, 1989; Holt, 1982; Kahn & Byosiere, 1992; Karasek & Theorell, 1990; Lazarus & Folkman, 1984; Sauter & Murphy, 1995). The most prominent of these nowadays include the job demands-job decision latitude model (Karasek, 1979), the Person-Environment fit model (French et al, 1982), the 'Transactional model' (Lazarus & Folkman, 1984) and the Effort-Reward Imbalance model (Siegrist, 1996). In particular high work demands, job insecurity, and low level of job control seem to be risk factors for mental health problems.

A variety of instruments have been developed to explore how these operate within a particular workplace (see e.g. Cox and Griffiths, 1994; Cox, Griffiths, & Rial-Gonzales, 2000; D'Amato & Zijlstra, 2003).

Various parameters of stress, e.g. somatic, behavioural, emotional and cognitive are all moderately correlated to sickness absence (Nielsen et al., 2002). Psychological distress, both general and job related, predict increased absences irrespective of demographic variables (Hardy et al., 2003).

Health status and life style

Some of the strongest predictors of sickness absences are previous spells of absences and previous ill health (Andrea et al., 2003; Farrel & Stam, 1988). Self-rated health status is a good predictor of sickness absences (Marmot, 1994). Lifestyle factors, such as overweight, smoking and sedentary lifestyle are strongly associated with sickness absence, but not alcohol consumption (e.g. Kivimäki et al., 1998; Ala-Mursula et al. 2002). Sleep appears to have a beneficial effect on recovery from ill-

ness, in particular quality of sleep appears to be associated with good health (cf. Groeger, Zijlstra, & Dijk, 2004).

Demographic aspects

Various demographic aspects have been found to be associated with sickness absence. In general there is a clear relationship between age and health: older people have more health complaints. However, in the workforce this relationship is not always clear, due to either sampling strategy, self-selection of 'healthy workers', but the general tendency is that age increases the risk for long-term absenteeism (Bergendorff et al., 2002).

Also socio-economic class is related to sickness absence (e.g. North et al., 1993; Fuhrer et al., 2002), sickness absence rates are lower for people with a higher education (Ala-Mursula et al., 2002). The greatest divide seems to be that white-collar (non-manual) workers are less absent than blue-collar (manual) workers. This trend can be seen in many European countries and in various sectors of employment (Alexanderson et al. 1994; Benavides et al., 2003; Fuhrer, et al. 2002). However, there seems to be a relationship with the type of the complaints. Psychological problems seem to be over-represented among white-collar workers, whereas blue-collar workers have more physical problems (Riksförsekrinsverket, 2002). Public sector workers have a higher ratio of long-term absences than private sector workers (Riksförsekrinsverket, 2003; Bergendorff et al., 2002). There is some evidence that large organisations have higher rates of absence than smaller ones (Voss et al. 2001; Vahtera et al. 1997).

According to a number of European studies women have a higher level of absence due to sickness than men (e.g. Bergendorff et al., 2002; North et al., 1993; Niedhammer et al., 1998; Voss et al., 2001). However, no satisfactory explanation has been found thus far.

There seems to be very little evidence that the so-called double burden of family and work increases sickness absences in general (Mastekaasa, 2000; Ala-Mursula, 2002; Sonnentag & Zijlstra, in press). Having a family, and number of children do not seem to be risk factors for absenteeism as such. It should be noted, however, that most studies are cross-sectional. Hardly any longitudinal studies have been performed. Also, self-reported absence has been associated with having young children (i.e. under six years) and with difficulties with childcare (Erickson et al., 2000). These factors also moderated the association between burnout and absence. This suggests that having a family has both positive and negative effects on sickness ab-

sence and that excessive strains due to family responsibilities may result in absenteeism or at least increase the risk of stress related illnesses.

This question, whether (or to what extent) stress arises from work or from other life domains, has been a topic of debate among policy makers, employers and trade unions for some time now. The answer to this question would have implications for determining the level of responsibility of various parties, and therefore also for their costs to solve the problem, and the policies to be put in place. However, it may very well be that this question can, as a matter of principle, not be answered. The various life domains (work and non-work) constitute different kind of demands, and it will be very difficult to assess which factor contributes at a particular moment to peoples' levels of stress. Moreover, the relevance of the various factors/demands will vary over time, and be related to peoples' career and stage of life.

This can probably best be illustrated by using the metaphor of a bucket that is filled with water from different taps. At some point the bucket will be full and the water will spill over if no water is taken out. It will be difficult to assess which tap (or even which drop) actually causes the bucket to spill over. It will be equally difficult to ascertain, when people are confronted with various demands (from different life domains), which of the demand(s) is most responsible for the stress. In fact all demands contribute to the stress and if there is no alleviation in one of the life domains it is likely that the demands will exceed the person's capacity to cope with these demands and they are likely to be perceived as a threat.

However, the most constant and notable demand across the board are the demands from work. Work demands are aspects from the public domain for which an employer has a responsibility, in contrast to aspects of the private life domain. Moreover, work demands can be changed, but many stressors from daily life (divorce, bereavement, etc.) can not be prevented. Nevertheless, the issue of stressors from work and private life domains will have to be addressed in this study; therefore, from a conceptual point of view, aspects of various life domains need to be included in the conceptual framework for this study.

Another reason to look into the topic of 'return to work' is that the work force in Europe is ageing and in order to sustain the productivity at work in Europe, and retain the level of welfare for all Europeans, as many workers as possible should be retained for work. Also the costs for the social security system in most European countries need to be reviewed in order to be sustainable. This means that from the economic perspective our society cannot afford to leave people standing aside. Also

for individuals the psychological costs of being excluded from participating in society are unacceptable.

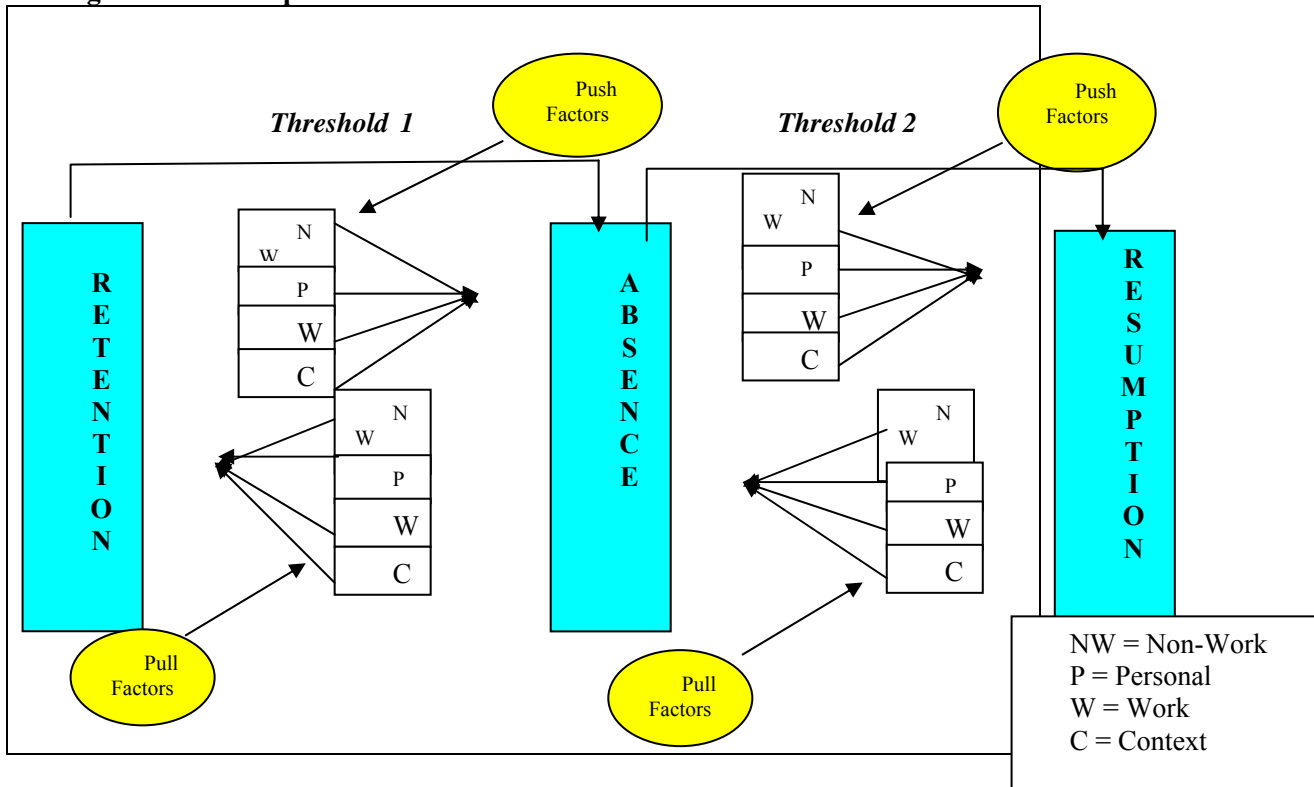
This project has arisen from the acknowledgement that we do not sufficiently understand the general process that affect workers' decisions to either report sick or resume work again. Hence a better understanding of the influence of the national systems and their (in) effectiveness to make people return to work (and thus retain workers for the labour force) is required.

1.4 THE CONCEPTUAL MODEL FOR THIS STUDY

Sickness absence, but also work resumption, can be conceived of as the result of a decision making process. People decide to stay at home and not go to work for a particular reason; they might feel that they are unable to work, or to deal with the demands of work. This decision making process can be conceived as passing a threshold (cf. Allegro & Veerman, 1998). Our expectation is that there will be a variety of factors influencing this decision. Evidently people's health will be one but probably not all of the factors. Other factors that might be relevant are the 'opportunity' to be absent (or the necessity to go to work – feeling indispensable), but also the 'necessity' to stay at home (family situation) may also play a role. Likewise people need to make a decision (i.e. pass a threshold) in order to return to work again. And again a variety of factors are believed to influence this decision, amongst which is health.

This project aims to explore what factors influence peoples' decision to pass the threshold of reporting absent, and resume work again, and also what is the relative importance of these factors in this process. This evidently includes looking into work-related factors and personal circumstances, and also into what kind of interventions have taken place. The conceptual model that has been developed can provide some guidance here.

Figure 1.2: Conceptual model of threshold



The conceptual model represents the various classes of variables that need to be taken into account. There are factors related to the personal characteristics (personality, health situation, life style, social economic class), to people’s work situation (type of organisation, job characteristics, social support, etc.), the non-work domain which includes the family situation and social network, context variables such as financial situation, geographic location, and also the type of services available e.g. health.

The model is presented as a ‘push and pull’ model, indicating that some factors will ‘push’ people away from work (into absence) and other factors will ‘pull’ people into work (away from absence). In some instances, whether a particular factor will actually work as a ‘push’ or a ‘pull’ factor will not always be clear. Whereas other factors e.g. poor job characteristics and unhealthy work situations, will be more clear cut, because they obviously contribute to people becoming absent from work i.e. they ‘push’ people away from work and factors such as interesting and satisfying

work and feeling valued and being indispensable will generally help people to stay at work, i.e. ‘pull’ them to work. When an individual has to make a decision concerning staying at home (i.e. reporting sick) or going to work it makes sense that various factors will exert different influences upon that individual. These factors will originate from the various life domains and will affect the threshold people will have between work and absenteeism. Of course, peoples’ estimate of their own working capacity to deal with the demands of work is relevant as well with respect to their decision, and this, together with their motivation, is likely to affect their future perspectives. Therefore these elements need to be included in the survey.

The main goal of this survey is to provide a description of the most relevant characteristics of the group of people who are long-term absent from work for stress-related reasons. Implicit in this aim is to make a comparison between the groups of people with (stress-related) mental health problems and those absentees that have other than mental health (i.e. physical health) problems, or the group that has both type of problems (co-morbidity).

A second aim is to determine which factors are likely to influence the decision to report absent from work and/or to return to work.

1.5 MENTAL HEALTH AND STRESS RELATED DISORDERS

The first aim of this study implies that a distinction needs to be made between ‘mental health’ versus ‘non-mental health’ problems. However, first it is necessary to clarify the distinction between ‘stress’ and ‘mental health’. ‘Mental health problems’ refers to psychological disorders of a clinical nature (more or less severe), and includes a much wider group of ‘patients’ than we are targeting for stress impact. The problems these people have are not necessarily stress-related, and may be dispositional, or resulting from a trauma. On the other side of the spectrum are the mental health problems related to stress and burnout. Stress and burnout are closely related constructs and the distinction between them is somewhat unclear. Nevertheless, they both relate to situations in which people have been over-stretched for a long period without sufficient opportunities to recover from the strains that have been put upon them. This results in a dysphoric and dysfunctional state in individuals often without major psychopathology (Bril, 1984; Schaufeli & Enzmann, 1998). Typical characteristics include high levels of (emotional or psychological) exhaustion, and feelings of reduced personal competence, or self-efficacy, accompanied by depressive feelings. This prevents people from functioning adequately in their job, and from using ap-

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appropriate coping strategies, thus causing a negative spiral. People are at risk when they perceive a chronic imbalance between their input (effort, time) and the output (material and immaterial rewards) in their work (Siegrist, 1996, Schaufeli, Maslach, & Marek 1993) and usually do not recover from this situation without outside help or environmental rearrangement (Brill, 1984). Part of the aim of this survey is to make an inventory of the services that these people know of and to what extent they are being used. And subsequently what services and/or interventions are helpful in people returning to work.

This study takes place in the six different EU countries involved in this project. In each of these countries the same methodology and instruments have been employed. A questionnaire has been designed of which the raw skeleton would be applicable and useful in each country. When necessary, country specific (minor) amendments to the questionnaire have been made.

To summarize, the key questions to be answered in this survey are:

- 1) To what extent people who are absent for mental health problems can be differentiated from LTA for physical ill health? This comparison should include demographic factors, life style, general health, job characteristics, psychological aspects, system-related situations, etc.
- 2) To what extent people who present a high level of stress be differentiated from people presenting a medium or low level of stress? This comparison should include demographic factors, life style, general health, job characteristics, psychological aspects, etc.
- 3) Which of the previous mentioned variables as well as system related factors (including availability and use of services, interventions at the workplace, etc.) contribute to predicting work resumption?

SECTION 2 RESEARCH DESIGN

THE

2.1 OVERALL DESIGN OF THE STUDY

To fulfil the aims of the research it was decided that a postal survey was the most appropriate method for data collection. A survey has several advantages:

1. A survey allows the researchers to collect a large amount of data nationwide in a standardised way.
2. A survey allows comparisons to be made between subgroups of the participants.
3. The content of this research involves personal opinions and attitudes to many sensitive issues e.g. income levels, health issues. The relative (or feeling of) anonymity of a survey encourages open, honest and valid responses to such questions because surveys are often perceived as less personal and threatening. More so than a face to face interviews where interviewer effects might well inhibit responses.
4. A survey is a relatively low cost, speedy method of data collection.

In order to track any changes or developments over time, e.g. attitudes to work resumption, improvement or decline in health, a longitudinal design was adopted; after six months a second questionnaire was sent to all those who participated in Time 1 of the research study. This type of design does risk sample attrition and it also means that it is not possible to claim complete anonymity of response because researchers need to have some way of identifying their respondents in order to be able to re-contact them (Fife-Shaw, 2000). However the benefits of a questionnaire as a research tool means that the data they provide 'are of a good enough quality to test hypothesis and make real-world suggestions' (Fife-Shaw, 2000. p. 157).

In sum, well constructed questionnaires are reliable, cost efficient and a good means of communication and interaction (Lindstrom et al., 1995). Therefore a questionnaire was developed and administered in all participating countries to a sample of Long Term Absentees (LTA). For each country the objective was to collect information

from a national representative sample of LTA's. The national registration system was addressed.

2.2 THE SAMPLE

This research required a nationwide sample of participants who were long term absent from work. More specifically it was necessary to contact those people who had been in paid work prior to their period of sickness absence who not been off work receiving incapacity benefit for more than 12 months.

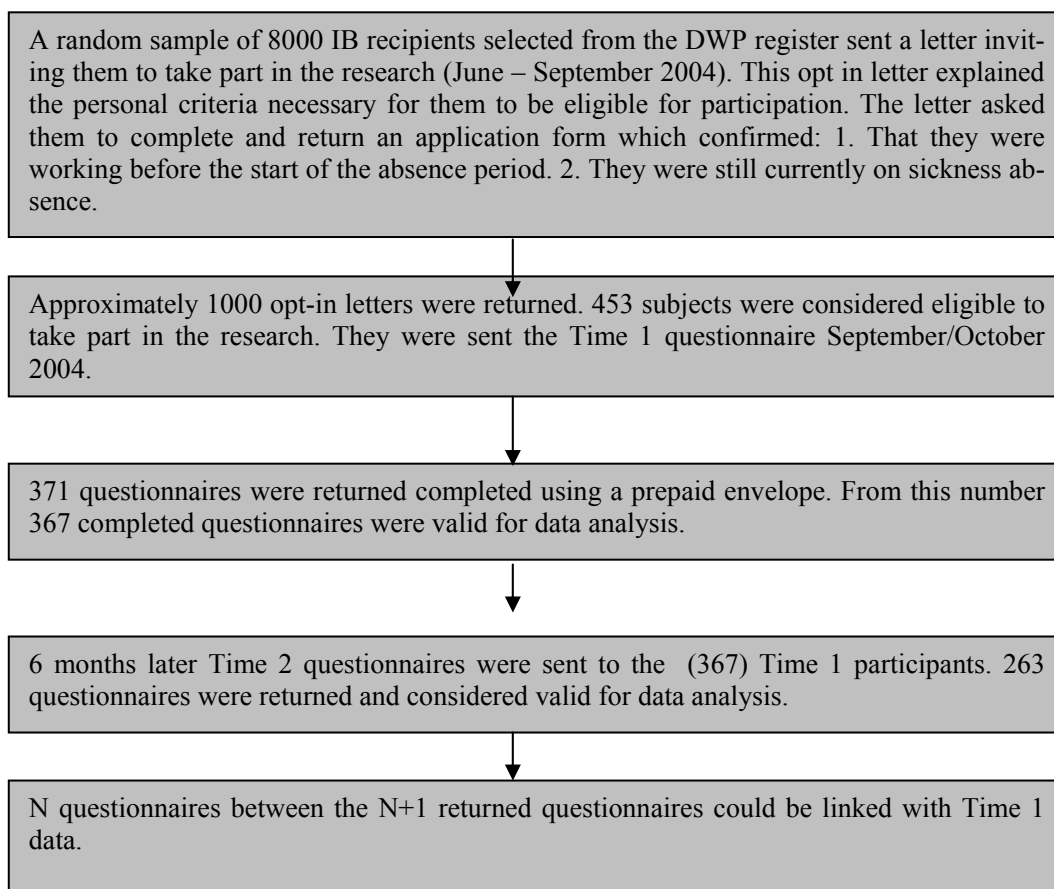
Participants were contacted from the National Register of Incapacity Benefit recipients via the Department of Work and Pensions (DWP), London. However it proved difficult to single out those individuals who met with the research criteria from the DWP database because such specific information is not coded by the DWP and thus not accessible. In the event 8000 opt in letters were sent by the DWP to benefit recipients.

Nearly 1000 people replied directly to the researchers indicating their willingness to take part in the research. From this number 453 met with the research criteria and were eligible to take part. They were all sent the Time 1 questionnaire. 367 questionnaires, or the 81% of the eligible subjects, were completed and returned using a pre-paid envelope. As a token of appreciation for their time, those people who returned the completed questionnaires were sent a £20.00 cheque.

An extra 600 subjects showed interest in the inclusion in the study returning the opt-in form, but they did not match the criteria of the research. Those respondents who did not fulfil the research criteria i.e. they had not been in paid work, they had been out of work for more than 12 months, were sent a letter which thanked them for their interest and graciously explained that their participation was not required at this stage of this research.

Because of the national register criteria and the lack of match with the inclusion's criteria of the study, it is not possible in UK to define an exact response rate and to perform "non-response analysis".

Fig. 2.1 – Summary of Sampling Procedure

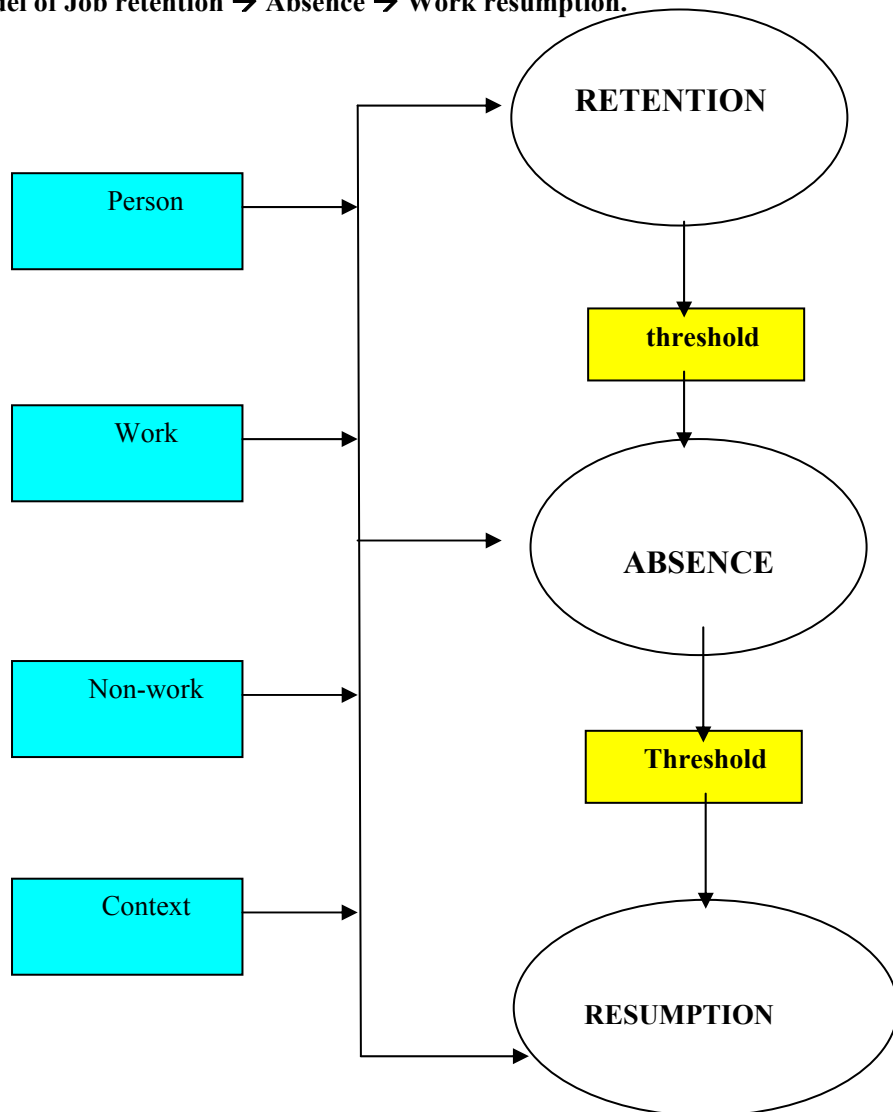


IB recipients were contacted from the DWP regardless of their status (workers or not) previous to the inclusion in the IB recipients register, information not included in this national register.

2.3 WORK ABSENCE AND WORK RESUMPTION: A COMPREHENSIVE MODEL

As a structure for the questionnaire, the conceptual model presented below has been used.

Fig. 2.2. A model of Job retention → Absence → Work resumption.



In order to assess the factors influencing, firstly the absence threshold period, secondly the period of sickness absence and finally the critical period from absence to work resumption, specific information needed to be gathered from each participant. This included variables concerning individual circumstances (health, financial circumstances), life-style, and personality. As well as variables referring to work (job characteristics, type and tenure of employment) variables relating to non-work situations (family details, marital status including elements of their work–family balance) and other context related variables (knowledge and use of available services, interventions and programmes).

Building on this, the threshold from work retention to decision to be absent can be assessed as well the intervening factors in the next critical threshold from work absence to work resumption.

The complexity of this model was necessary in order to gain a true measure of the sickness absence and the work resumption process. The topics under discussion can be categorized first of all as individual variables; they need to be assessed in order to understand which individual factors affect the absence process.

Individual characteristics interact with the social context to provide a basis for the expression of the personal decision making process. Therefore the social context needs to take into account as well (e.g., work characteristics, family-work balance, etc.). But other than the social context, also the general context needs to be specified. In fact it is suspected that social services availability and the contextual variables have an effective impact on the individual decision making related to absence as well as work resumption.

The individual and the social context are strictly embedded in the infrastructures available in the country or in the area where the person is living. A comprehensive model needs to take in to account the context and social policies, because it is suspected that they have a significant part in the individual decision making process relating to absence and work resumption.

Other variables that needed to be taken into account were at a more abstract level and constitute the specific society and the social policies. They can be categorized as legal (health and safety, social security, labor law, public health, insurance laws, equality employment law), sector and national agreements, labor market, economic activity and policy and national demographics.

2.4 THE VARIABLES

The following table (Table 2.1) shows how the variables form the basis for a comprehensive model of work absence and work resumption.

Tab. 2.1. Variables in the survey.

Category	Variables
Demographic Background	Gender, Age, Education, Family Circumstances
The Individual his/her career their work characteristics their financial circumstances	<ul style="list-style-type: none"> - Career-related information – i.e. type of organization and sector, including organization-related benefits; - Individual/psychological constructs (e.g. level of burnout, job demands, support, control, work-family and family-work balance, job satisfaction) - Organisational policies, health programs and services - Individual economical situation (e.g. income, savings, investments, benefits)
Lifestyle	<ul style="list-style-type: none"> - Sport/Physical activity - Sleep habits. - Leisure Activities
Perceptions	<ul style="list-style-type: none"> - General Self-Efficacy - Family/work life balance - Life-events perception.
Current health and situation	<ul style="list-style-type: none"> - Health and diagnosis - Mental health - Perceived work ability.
Crossing the Absence Threshold: Push and Pull Factors	<ul style="list-style-type: none"> - Type of contract/hours worked; - Previous absence history; - Diagnosis and causes; - Levels of rehabilitation support.
Life and Experiences during the absence period	<ul style="list-style-type: none"> - Changes during the absence; - Sources of income; - Treatment/interventions.
Work Resumption	
Perceived Threshold to Resumption	

In order to avoid ambiguity or misunderstanding and to enhance the accuracy of responses a great deal of attention was paid to the wording and content of the items within the questionnaire. In particular the use of unfamiliar words, technical jargon, complicated wording, double-barrelled, leading and sensitive questions were avoided. The questions were either 'closed' or based on the Likert type rating scale.

There were a large number of questions required in order to tap into all the topics presented above. The lay out of the questionnaire was clear, it was divided into sections which was hoped would help to maintain the respondent's interest and thus encourage them to answer all the questions.

In each country the questionnaire – translated into the native language, was piloted with a small number of respondents. The ensuing feedback and proposed changes discussed within the research team. A common code-book for data analysis was produced in conjunction with the formulation of the questionnaire. Common quality control procedures were implemented after the survey administration and data coding.

In short Berry & Houston's (1993) classical eight-step process for survey development has been followed throughout this research. This included the following steps: (a) planning; (b) developing; (c) pre-testing; (d) revising; (e) processing; (f) analyzing; (g) reporting. This process, although linear in appearance, has been elaborated and has a satisfactory result for the purpose of the research and the six partners involved. After the survey administration and data coding, common quality control procedures have been implemented.

The whole information requested through the questionnaire was easy for the respondent to access because was strictly related to their personal condition (e.g. attitudes or feelings) or situations (e.g. health conditions or use of services).

2.5 INSTRUMENTS

The full version of the questionnaire (appendix B) contains demographic information, psychological scales as well as questions concerning the use of services and all the other references requested. Standardised scales have been used to measure psychological constructs throughout the questionnaire when available.

Job Stress

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To measure job stressors, seven key scales were available. The first four, from the Job Demand/Control Support questionnaire (Karasek et al., 1998) were: demands (4 items); control (7 items); co-worker and supervisor support (4 items each). Over-commitment (6 items) and reward (8 items) were taken from Siegrist (1996). Job insecurity has been measured with the single item technique (Nagy, 2002). Furthermore Job Demands were specified in physical, cognitive and emotional demands (3, 3 and 4 items respectively) (Kristensen, 1996,).

All items are on a 4-point Likert scale where 1 means “Strongly Disagree” and 4 “Strongly Agree” (*Example: My job requires me to work very fast*).

Work family balance/ Family work balance

Work family balance (3 items) and family work balance (2 items) were selected from the Bristol Questionnaire (cf. Smith et al., 2000).

These items were presented on a 5 point Likert scale, ranging from 1 ‘Not at all’ to 5 ‘Exactly true’. (*Example: Your job reduces the amount of time you can spend with your family*).

Sport & Physical Activity

Sport and physical activity items (6 in total) were presented on a 5 point scale ranging from ‘3 or more times a week’ to ‘Never/Hardly Ever’

Job Satisfaction

Two items (Koys, 2001, D’Amato & Majer, 2005) were used to measure Job satisfaction. These were presented on a 5 point Likert scale ranging from 1 ‘Not at all true’ to 5 ‘Exactly true’ (*Example: Compared to most jobs mine is a pretty good one and All in all I am satisfied with my job*).

Sleep habits

Information about sleep patterns and perceptions was collected through 11 items from the Pittsburgh Sleep questionnaire (Buysse, et al., 1989). These items were presented as either categorical response questions (e.g. during the past month when have you usually gone to bed at night?) or as a 5 point rating scale ranging from very bad to very good. (*Example: During the past month how would you rate your sleep quality overall?*)

Self-Efficacy

For perceived levels of self efficacy the General Self-efficacy 10 items scale was used (Schwarzer’s, 1993). Responses were on a Likert-type scale ranging from 1 “Not at all true” to 5 “Exactly true” (*Example: I can always manage to solve difficult problems if I try hard enough*).

Burnout

The construct of Burnout and its two dimensions – Emotional Exhaustion and Disengagement – have been measured through the Oldenbourg Burnout Inventory (Demerouti, et al, 2001; Demerouti et al., 2003). The two factors are represented by 8 items each. Items are expressed on a 4-point Likert scale from “Always” to “Never” (*Example: I always find new and interesting aspects in my work*’).

Depression

Depression has been measured through the CES-D, a 10-item scale; items are expressed on a 4-point Likert scale from “rarely” to “all the time” (*Example: ‘I was bothered by things that usually don’t bother me.’*).

Life Events

An original scale has been used to collect information about life events, taking into consideration finances, health, relatives, living conditions, and relationships with spouse/partner, job, children, friends/relationships, sleep, death/mourning, feeling of loneliness. These factors were selected from the literature and considering the *Impact of Event Scale* (Horowitz et al, 1979;). The items were presented on a 4 point scale, ranging from ‘not at all’ to ‘a lot’ (*Example: Would you say any of these events, now or in the past 3 months are causing you (or have caused you stress)?*

Work Ability

Three single items were collecting information about work ability: general work ability, mental work ability (*Example: how would you rate your current ability to work with respect to the mental demands of your work*) and physical work ability (*Example: how would you rate your current ability to work with respect to the physical demands of your work*). The General Work Ability is measured on a continuum from 1 to 10 (from *completely unable to work* to *work ability at its best*); mental work ability and physical work ability are presented on a 5 point Likert scale ranging from ‘very poor’ to ‘very good’.

2.6 STATISTICAL ANALYSIS AND OUTCOME VARIABLES

To answer the key questions presented at page 12 descriptive analyses are presented in which three variables are used in the breakdown tables as divisional variables.

1. The first *breakdown* variable is the self-reported main reason for sickness absence. The respondents were asked whether the main reason for their absence was a physical illness, a mental illness or a combination of a physical illness and mental illness.
2. The second variable is “stress” or general psychological morbidity, which was constructed on the basis of three individual factors: 1. Emotional exhaustion. 2. Depression, 3. General self-efficacy.
3. The third breakdown variable ‘return to work’ has been used as the dependent variable in the Logistic Regression. The respondents were asked to indicate whether they had (a) returned to work completely; (b) returned to work partially or on a therapeutic basis; (c) not returned to work.

The significance of the variables in the breakdown tables (see next section) is marked so that if the difference is statistically significant the estimate for effect size $r > .1$ there is a triangle next to the category that differs. All comparisons are made ‘horizontally’ i.e., per row. The direction of the triangle indicates the direction of the difference. Every marked group is significantly different from the other and/or the comparison group(s), ▲: $p < 0,05$ for significantly high 'scoring' groups; ▼' for significantly low 'scoring' groups.

i. Independent variables

A comprehensive list of all the variables in the questionnaires is located in the appendices.

Three different types of variable are used in the breakdown tables and the logistical regression:

1. Nominal categories (e.g., gender).
2. Yes/No dichotomies (e.g., do you have children under 18 living in the household?)
3. Trichotomies (e.g., Low/Medium/High) have been introduced for the scales and other continuous variable – such as depression – and are based on the tertiles of the total sample of the 5 participating countries.

ii. Variables For Multivariate Analyses

Multivariate logistic regression and univariate analysis have been chosen to identify the significant predictors of return to work at time 2.

The predictors were entered in *four* blocks, as detailed later in the next chapter.

SECTION 3

RESULTS

3.1 STRESS: TEST OF A MODEL

One of the most relevant topics of the survey was the measurement of wellbeing or strain, as an outcome of stressful situations. This study has initially focused on its nature and operationalization, setting up a model which built on both current and traditional literature as well as the experience of the research group.

In the original model developed stress is explained as a composite construct mediating between individual and environmental factors. Central issues of this model are the individual's perception and appraisal of the situation as well as their coping abilities and strategies.

From a theoretical point of view stress/strain emerges from the combination of the self appraised mental health (depression) and personality, or the self-appraised self-efficacy experienced at work or for work-related matters; a third factor is the feeling of emotional exhaustion deriving from the job.

The scientific literature has widely recognized Depression and Emotional Exhaustion as part of the work stress process and outcomes (Duquette, Kerouac, Sandhu & Bedaut, 1994; Rahim & Psenicka, 1996; Rout, Cooper & Rout, 1996 ; Corrigan, Williams & McCracken, 1998; Vilhjalmsson, 1998 ; Vinokur, Pierce & Buck, 1999; Ito, Kurita & Shiiya, 1999; O'Connor, O'Connor, White & Bundred, 2000a; O'Connor, O'Connor, White & Bundred, 2000b; Mackie, Holdhan & Gottlieb, 2001; Tummers, Janssen, Landeweerd & Houkes, 2001).

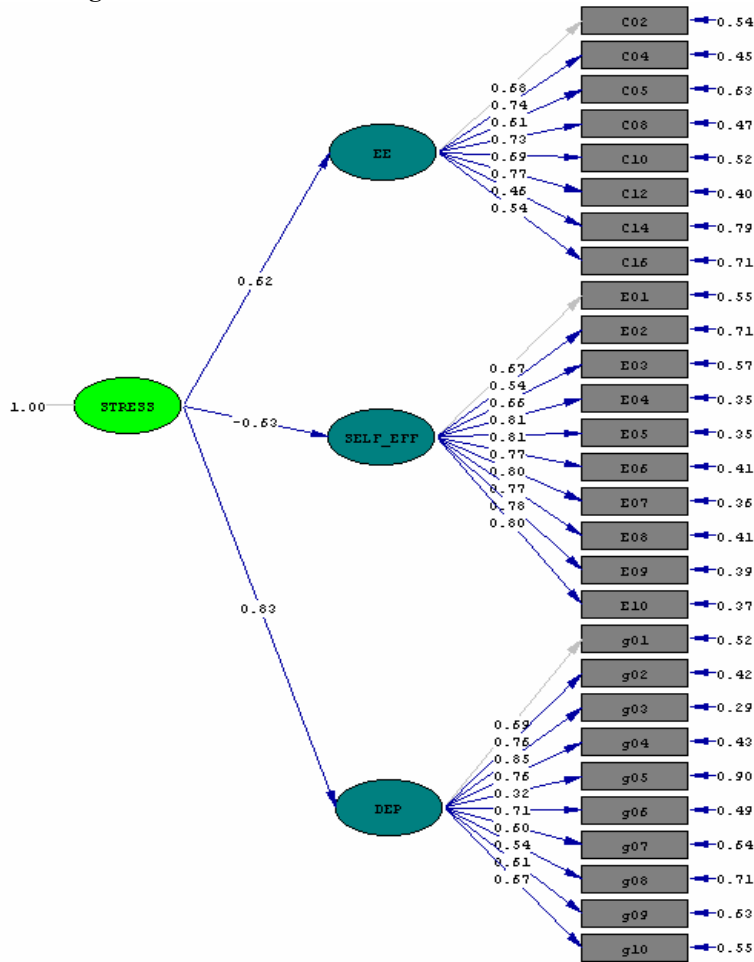
Only a few studies have seriously considered Self-Efficacy when studying occupational stress. Self-efficacy refers to the confidence in one's ability to behave in a way to produce desirable outcomes; perceived self-efficacy affects how people feel, think and behave (Bandura, 1977). In the case of setbacks, it has been found that people with higher levels of self-efficacy recover quickly and maintain commitments to their goals (Schwarzer, 1992). Although there is scant research on the social determinants of self-efficacy, it has been shown that this concept has an a significant effect in active coping and work-stress models (Gerin, Litt, Deich & Pickering,

1995) and thus may be an integral part of the coping process. In the present model, following Gerin et al, (1995) suggestion, Self-Efficacy has been assessed in terms of a specific situation

A tri-factorial model of stress has been empirically assessed and confirmed using Confirmatory Factor Analysis (CFA) (Joreskog & Sorbom, 1993) (fig. 3.1) and the population of the present study (total sample N= 1994 – Austria = 364; Finland = 492, Ireland = 366, The Netherlands = 405; UK = 367; Italy = 0).

The weights of the general model have been used for the analysis in this present research because they are more stable and therefore reliable.

An original model of stress



Chi-Square=2379.82, df=347, P-value=0.00000, RMSEA=0.058

From organizational factors to organizational outcomes: further goodness of Fit indexes.

χ^2 /df	EA	RMS	R	S	G	A	C	N	C
			MR	RMR	FI	GFI	FI	NFI	N
2379.82/347	58	0.0	0.0	0.0	0.9	0.9	0.9	0.9	32
			36	47	1	0	2	1	0.42

The model fits the data both in the combined sample and in the country-specific sample. It can be concluded that the three selected variables – depression, emotional exhaustion and self-efficacy – are part of a latent factor explaining their variance.

3.2 DEMOGRAPHICS AND OCCUPATIONAL CHARACTERISTICS

Demographic variables

Background characteristics of the sample are given in table 3.2, 3.3 and 3.4.

56.6% of the sample is male. 59% ranged in age between 50 to 60 years old. 26% had only been educated to elementary level. 45.8% were married. 80.4 % had no children under 18 living at home. 26% of the sample had a personal average income of £800 or less and 73% no higher than £1200 before the absence. These values grow respectively to 82% and 96% when the income level has been asked for the absence period.

These and other details are in table 3.2.

Tab. 3.2. Demographic characteristics of the sample (N=367).

		Freq.	Valid %
Gender	Male	207	56.6
	Female	159	43.4
	Missing	1	
Age	30 and younger	40	10,9
	31 to 40	67	18,3
	41 to 50	97	26,5
	51 and older	162	44,3
	Missing	1	
Education	Up to lower professional education	97	26.4
	Intermediate general and professional education	170	46.3
	Completed high school	63	17.2
	Higher professional education	28	7.6
	Academic education and higher	9	2.5
	Missing	-	-
Marital Status	Married	167	45.8
	Cohabiting	39	10.7
	Single	76	20.8

Work Package 5: Survey on LTAs

	Divorced	74	20.3
	Widowed	9	2.5
	Missing	2	
<hr/>			
Adults in the household	1	106	29.3
	2	180	49.7
	3	47	13.0
	4	17	4.7
	5	8	2.2
	Missing	9	
<hr/>			
Children under 18	NO	295	80.4
	YES	72	19.6
<hr/>			
Income	Less Than 600 £	52	26,0
	601 – 1200 £	97	48,5
	1201 – 1500 £	18	9,0
	1501 – 1800 £	14	7,0
	1801 – 2100 £	9	4,5
	2101 – 2400 £	3	1,5
	2401 – 2700 £	5	2,5
	2701 – 3000 £	2	1,0
	3001 £ or more	1	
	Missing	102	
<hr/>			
Dual income	NO	142	45.8
	YES	168	54.2
	Missing	57	1.1
<hr/>			
Care for elderly/ disabled	YES	66	18.2
	NO	295	81.3
	Missing	6	

67.6 % of the sample had a permanent job contract. 31% of the respondents used to work more than 40 hours a week. 31.9 % of the employees worked in organisations with less than 11 employees and 29.6 % worked in organisations with 11 to 50 employees. 14% had worked 10 years or less and 17% more than 40 years. These details are shown in table 3.3.

Table 3.3. Job characteristics: sample distribution (N=367).

		Frequency	Valid %
Job type/contract	Permanent	248	67.6
	Temporary	39	10.7
	Self Employed	72	19.7
	Other	6	1.6
	Missing	2	
Work hours/week	12 or less	20	5,7
	13 to 24	55	15,7
	25 to 40	161	45,9
	More than 40	115	32,8
	Missing	16	
Size of the workplace	1 - 10	111	31.9
	11 – 50	103	29.6
	51 - 100	38	10.9
	101 – 200	21	6.0
	201 - 500	25	7.2
	More than 500	50	14.4
	Missing	19	
Job tenure	10 or less	52	14,9
	11 to 20	74	21,1
	21 to 30	81	23,1
	31 to 40	82	23,4
	41 and more	61	17,4
	Missing	17	

Work sector characteristics

Work sector, occupational and industrial classifications are described in table 3.4.

Tab. 3.4. Work sector characteristics: sample distribution (N=367).

		Frequency	Valid %
Work sector	Private	259	67.9
	Public	65	19.2
	Non-profit	14	4.1
	Missing	29	
Occupation	Legislators, senior officials and managers	25	7.0
	Professionals	61	17.0
	Technicians and associate professionals	41	11.5
	Clerks	47	13.1
	Service and shop and market sales workers	54	15.1

Work Package 5: Survey on LTAs

	Skilled agricultural and fishery workers	4	1.1
	Craft and related trades workers	49	13.4
	Plant and machine operators and assemblers	34	9.3
	Elementary occupations	43	11.7
	Armed forces	9	
Industrial classification			
	Agriculture	11	3.1
	Manufacturing	46	13.0
	Building	50	14.2
	Trade	52	14.7
	Hotels & restaurants	28	7.9
	Transport	48	13.6
	Banking	9	2.5
	Public administration	15	4.2
	Education	23	6.5
	Health	38	10.8
	Other community	21	5.9
	Recreational	12	3.4

68 % of the sample worked in the private sector and 18% in the public sector, which corresponds with the division in the national labour force (see table 3.5).

Tab. 3.5. Binomial test for sample distribution in work sector

Category	N	Observed Prop.	Test Prop.	Asymp. Sig. (1-tailed)
Yes, private	259	,77	,76	,422(a)
No, other	79	,23		
	338	1,00		

The hypothesis that the distribution of the sample reflects the distribution of the working population is supported by the data with regard to the private and public sector. There is no difference between private and public organization with reference to the proportion of LTAs in our sample.

The result was the same when the analysis was performed using gender (tab. 3.6).

Tab. 3.6. Binomial test for sample distribution and gender

Category	N	Observed Prop.	Test Prop.	Asymp. Sig. (1-tailed)
Male	207	,57	,54	,176(a)
Female	159	,43		
	366	1,00		

I think you could drop this table and describe the test only in text

3.3 ABSENCE DIAGNOSIS AND STRESS: RESULTS FROM THE SURVEY

3.3.1 Demographic characteristics

There were significantly fewer men with a mental health and more with a physical diagnosis than women.

Participants 35 years old or less had significantly lower levels of physical illness, but reported significantly higher levels of co-morbid, i.e. physical and mental illness together. This group is also most likely to be in the low stress group. Participants 36 to 45 years score significantly higher for mental health diagnosis, compared to the other age groups. Participants aged 55 years or more, are significantly less likely to have a mental health diagnosis; they are more likely to have a physical health complaint as the reason for being absent from work. It is interesting to note that participants in this age range, compared to the other participants, are most likely to be in the low stress group. In other words the likelihood of them reporting high levels of stress is low.

Looking at education, those who have been educated to high school level score significantly higher in level of stress.

Married people are the most likely group to report a physical ailment and least likely to have a mental or a co-morbid (i.e. physical and mental) health problem. They are also less likely to report high levels of stress. People who are cohabiting or single are least likely to have a physical health diagnosis. Single people are more likely to have a mental health complaint, while those who are cohabiting, a co-morbid one. Being widowed suggests a person is more likely to have a co-morbid health complaint.

A single person living alone, male or female, is more likely to report a mental health diagnosis, and least likely to report a physical health diagnosis. When more than one

adult live in the same household it is more likely that the study participant is absent for physical health problems.

Participants in the low income group (i.e. a personal average monthly income of less than £600), are likely to have a physical health complaint and high levels of stress. Very often this group has a combination of Physical and mental health complaints: i.e. a co-morbid diagnosis.

The same situation has been found regarding average household income except for low level of stress where no significant differences have been found. Participants in the average income groups i.e. a personal average monthly income between £600 and £1200, are most likely to have a physical health complaint and high levels of stress. Participants in the high income group i.e. a personal average monthly income equal to or over £1200 are less likely to be in the high stress group. There are no differences with regard to diagnosis.

When the personal income is equal or higher than £1200 (e.g. high income group), people are less likely to be in the high stress category. No difference is associated with diagnosis.

When asked about the chances of making a living without returning to work, those who replied NO scored lower in the physical health group and higher in the co-morbid, and those who replied YES score higher in the physical condition and lower in the co-morbid condition. People who respond NO have a higher chance of being in the high stress group; people that say that they could make a living without returning to work are less likely to be in the high stress group.

3.3.2 Job Characteristics

Job characteristics divided by diagnosis and level of stress are displayed in table 3.8. When the reason for absence is concerned, significant differences are shown for job title, extra hours, job tenure and work sector. The only significant difference related to stress has been found for work sector: people working in the recreational sector score highest in the medium category of stress.

Table 3.8: Job characteristics by reason for absence and high, medium or low stress. (See Appendix A)

Clerks are more likely to have a mental health illness and less likely to have a physical health problem, while craft and related trades workers are less likely to have a mental health illness diagnosis.

People declaring to have worked less than 3 extra - hours per week before being absent from work are more likely to have a physical health problem, and less likely to report a co-morbid diagnosis, When people report to have worked more than 3 extra-hours, or in other words the actual time-schedule is higher than the contractual one, they are less likely to report a physical health illness and more likely to report a co-morbid condition.

Those who have worked for less than 20 years are less likely to report a physical health illness and more likely to report a co-morbid. Those who have worked for more than 31 years are less likely to have a mental health or co-morbid illness and are more likely to have a physical health illness.

Respondents who work in hotels or restaurants record a higher incidence of mental health illness and a lower likelihood of physical illness. Those who work in banking and in the community sectors have a high likelihood of a co-morbid condition.

3.3.3 Psychosocial work factors

Psychosocial work factors variables were analyzed by the diagnosis and level of stress. The results are displayed in tab. 3.9. Significant differences have emerged for the majority of the variables. Although the factors are considered as independent, they are, according to Karasek Job-Demand/Control Support model, Siegrist Effort-Reward Imbalance model and the Kristensen's CopSoq, (1996) all part of a comprehensive construct.

Table 3.9. Psychosocial work factors by reason for absence and stress level. (See Appendix A)

The empirical analysis confirms the discriminant validity of this set of factors in understanding the reason for absence i.e. type of diagnosis and the role of stress. The result in term of *strain* (e.g. the outcome of stressful working conditions) is the outcome of the joint influence of several stressors – as demands – or protective factors – as support.

Significant differences were found for both diagnosis and stress levels with regard to family-work and work-family balance.

3.3.4 Life-style: Changes in lifestyle and behaviours during the absence period

The respondents were asked whether the following nine aspects of their lives had changed during their period of absence: spouse's work hours, household duties, social/leisure activities, alcohol consumption, smoking habits, eating habits, contacts with extended family and friends, and the experience of the quality of social relationships within the family. The results are reported in tab. 3.12.

Table 3.10. Life-Style by reason for absence and stress level. (See Appendix A)

Participants reported a 71% decrease in social/leisure activities, a 40% decrease in both alcohol consumption and in eating habits and a significant decrease of 40% in levels of household duties.

Those who report that their partner is not working are more likely to be in the mental ill health group, not in the physical ill health group.

Those who report an increase in household duties are more likely to be in mental health group and less likely to be in the physical ill health group. A 'not applicable' response, regarding household duties is significantly associated with the co-morbid condition.

When social and leisure activities remain unchanged, participants are most likely to have physical problem. When these activities have increased respondents are most likely to have a mental health illness.

Respondents who report that their alcohol consumption has decreased are less likely to have a mental health illness and are more likely to have a physical health problem. If they report that their alcohol consumption has stayed the same they are more likely to have a mental health complaint. If alcohol consumption has increased these respondents are most likely to have a mental or co morbid health complaint not a physical one.

As far as eating habits are concerned it appears that many people have indicated that their appetite has decreased. People with physical complaints indicate more frequently that there has been no change with respect to eating habits. And some people with mental health complaints indicated that they have started eating more.

People with mental health complaints indicated that their social contacts have decreased (54 %). People with both mental and physical health complaints (Co-morbidity) indicate that the quality of social relationships within the family (household) has decreased. These findings indeed suggest that the social relations and contacts are affected by people's present status. When a mental health component is in-

volved people report reduced contacts. This means that they could run the risk of social isolation.

The only significant difference found when looking at ‘involvement in voluntary work’ is for those who report that their involvement has not changed. These respondents are most likely to have a physical illness.

Those participants who report medium level of sleeping problems are most likely to have a mental health complaint.

When people report a low level of activity they are less likely to be in the group with low stress, and more likely to be in the high stress group. Their level of exercise does not alter during their period of absence.

3.3.5 Health characteristics

Health variables divided by the main reason for absence and low, medium or high stress are presented in Table 3.11.

Table 3.11. Health characteristics by reason for absence and level of stress. (See Appendix A)

Having a mental health diagnoses suggests a higher chance of being in the high depression category and less in medium or low. Participants with a diagnosis of physical illness are more likely to be in the low depression group and less likely to have high depressive feelings. Those with a co-morbid diagnosis are comparable to those with mental health problems which is not unexpected if we remind ourselves that a co-morbid condition is typically used to disguise mental ill health (cfr. also D’Amato, Pierce, Zijlstra, 2005).

Participants with a mental ill health diagnosis have a high chance of high levels of burnout (both emotional exhaustion and disengagement); workers absent for a physical complaint are less likely of having high levels of burnout and more likely to have low burnout. No differences were detected in the co-morbid group.

A mirror image is obtained when general self efficacy is analyzed. Mentally ill workers have higher chances to be in the low GSE group and are less likely to be in the high GSE group. The opposite is found when physical ill health is the diagnosis.

Those with a low level of work ability are more likely to be in the low stress category and less likely to be in the high level of stress category. On the other hand,

when the work ability is high, people score higher in low stress and low in high stress.

3.3.6 Absence

The history of absence is displayed in Table 3.12.

Table 3.12: Absence by reason for absence and level of stress (See Appendix A)

Workers with a mental health complaint are more likely to have been absent in the previous working period. Those on IB for physical reasons are more likely to report that they have no record of prior absence.

There is no significant difference between the three categories of health complaints or levels of stress regarding the tenure of any past or indeed the current absence.

There were no significant differences when evaluating the complaint as a sudden event or as having been a gradual process. However those with mental health problems are less likely to say that the onset of their illness was sudden. They are more likely to report that their problems were foreseen. Those with a physical health complaint are more likely to report that their problems had a sudden onset, and were unexpected.

Those who experienced a sudden onset of their sickness absence are more likely to report low stress levels. Those whose period of absence had a more gradual onset are more likely to have high levels of stress.

Participants with a mental health diagnosis are more likely to have high stress levels. When the diagnosis is physical participants are more likely to have a low or medium level of stress and less likely to have a high level of stress.

3.3.7 Services and interventions

In table 3.13 use of services and interventions are analyzed with regard to diagnosis and level of stress.,

Table 3.13: Use of services and interventions by reason for absence and level of stress. (See Appendix A)

The diagnosis as well as the level of stress seems not to discriminate between visiting GPs, rehabilitation professionals or occupational health physicians.

IB recipients with a mental health diagnosis or co-morbid condition are more likely to have seen a psychiatrist and/or a psychologist. Those with a physical health problem are more likely to have seen a physiotherapist or sport physician. A person with a mental health problem is more likely to have used alternative medicine than those with a physical health problem.

Participants reporting high levels of stress are significantly more likely to visit psychologists or psychiatrics, and significantly less likely to visit physiotherapists or sport physicians.

3.3.8. Interventions at the workplace

The incidence of work place interventions on level of stress and diagnosis is detailed in tab. 3.14.

3.14: Interventions at the workplace by reason for absence and level of stress. (See Appendix A)

No significant differences were reported with regard to interventions in the workplace, except for vocational rehabilitation where people with low levels of stress are more likely to have used these services and less likely not having used them.

3.3.9 Contacts with workplace and between professionals during absence

Information on contacts between professionals and with managers as well as direct contacts with the LTA's were asked. Details are in Table. 3.15.

Tab.3.15. Contact with workplace and between professionals during absence by reason for absence level of stress. (See Appendix A)

IB recipients with a mental health complaint are more likely to report that there has been no contact between the professionals working on their case. Those in the low stress group report claim ignorance on the matter.

There are no differences between the groups with regard to contact between managers and professionals. As far as contact between the organization and the absentee during the sickness period is concerned, no differences are reported.

Participants with a mental health complaint appear less likely to have contact with their colleagues. Those off work with a physical health problem are more likely to have had contact with their colleagues.

As far as level of stress is concerned no significant differences have been detected with regard to the “contacts” variable.

3.3.10 Expectations on return to work

At two different points in time participants have been asked about their expectations with regard to work resumption, or in other words return to work. Information collected at “time 1” has been reported in tab. 3.16).

Tab. 3.16: Return to work variables by reason for absence and stress’ level. (See Appendix A)

When respondents are asked at Time 1 whether they expect to return to work, it appears that people with Mental Health problems have a more optimistic outlook for the future than those with Physical health problems; although only 20% expect to go back to work in the near future (within coming six months). Return to work is forecast at Time 1, the only variable with a different score regarding the issue of returning to the same job in the same organisation is for those in the low stress level group who are more likely to report that they would go back to their previous job. Most people (about 90 %) do not expect to go back to their old job, although. Yet to return to the same employer seems to be a considered option for many more people with mental health problems than those with physical health problems.

Those with a mental health complaint are more likely to report that they expect to return to work in the next 6 months and report that overall they expect to return to work eventually. Those with a physical health problem also expect to return to work one day but not necessarily in the next 6 months.

People with a mental health complaint are more likely to predict that when they return to work they will work for a new employer in a different job. Those with physical health complaints are less likely to make the same claim.

Time 2

After a period of about 6 months, another assessment with regard to work resumption was undertaken. Details are in table 3.17.

The vast majority of respondents (more than 80 %) have not returned to work at the time of this second assessment. There is no difference between Mental Health and Physical Health when the two groups are compared, but it appears that significantly more people who have ‘low’ stress-complaints have returned to work.

Table 3.17: Return to work variables by reason for absence and stress level (T 2). (See Appendix A)

Respondents who report that they are still not fit enough to return to work are most likely to be in the medium level stress group.

Those with a mental health diagnosis who have returned to work are most likely to be found working in a different job with a new employee. Those with a physical health complaint who have returned to work are more likely to be working in their previous job.

People who have a co-morbid health complaint are most likely to have returned to work for financial reasons.

3.4. RETURN TO WORK FROM LONG TERM ABSENCE

Four blocks of variables were taken into consideration when looking at the issue of work resumption. In particular it was important to identify the characteristics of the participants who have returned to work and the factors that were deemed either as helpful or as a barrier to work resumption

The four blocks of variables can be described as follow:

1. Personal factors, a combination of demographic variables (gender, age, education, marital status, income level and number of people in the household working), life-style (exercise, sleeping problems), health (general health, self efficacy, depressive feelings, emotional exhaustion), absence history (frequency of previous absence, length of previous absence);
2. Work/job characteristics and include economic factors (sector of the activity – private or public), psychosocial factors (job demands, job control, job satisfaction, job insecurity, over commitment);

3. Non-work conditions (work-family balance, number of adults in the household and number of children);
4. System-related policies (return to work policies, sickness absence policies) and organizational-related policies and interventions (work arrangements, contact with case manager, person responsible for RTW, position kept open).

Because of the small sample, the “highway” for investigating the impact of each of these blocks on the decision to return to work – the logistic regression analysis – could not be performed. Thus the “second best” option was used; a univariate analyses has been run. Results are displayed in the tables 3.18, 3.19, 3.20 and 3.21 below.

The impact of each of these blocks of variables has been assessed with regard to having resumed work or not.

Tab. 3.18. Personal factors and Return to Work. (See Appendix A)

Tab. 3.19. Work factors predicting Work Resumption (See Appendix A)

Tab. 3.20. Non work factors predicting work resumption. (See Appendix A)

Tab. 3.21. Contextual factor predicting work resumption (See Appendix A)

The majority of the personal factors show an influence on both work resumption and the decision to remain out of work.

If you are 55 years or older the likelihood of being out of work is high. Those with a low level of education are less likely to have returned to work part time. Single participants are more likely to have fully resumed work.

Personal income is a significant factor when work resumption is under scrutiny: participants that are still out of work are more likely to have had an income of less than £600 and less likely to have a higher income. Participants who have resumed work are less likely to have had an income at Time 1 of less than £ 600 and more likely to have had an income higher than this.

This could be an effect of the British benefits system in which people often feel penalized financially when they resume work, even partially, because they lose access to many benefits. In the UK loss of benefits is not related to amount of earnings and as such becomes a major obstacle to work resumption; many people becoming worse off working than when at home receiving benefits. Presently the UK benefit system does not offer any incentive to return to work.

The level of physical exercise has a relation with work resumption, as does reported level of health and the feeling of general efficacy. People who have resumed work are not surprisingly likely to report a higher level of perceived self-efficacy as well as be in good health. Those who remain absent from work are likely to be in the medium stress group and less likely to be in the low stress group. Those who have resumed work are less likely to be in the low stress group. Also the history of absence is related to work resumption.

As far as work characteristics are concerned, only work sector, over-commitment and rewards show a significant correlation with return to work. Participants who are back to work are more likely to report low levels of over-commitment and to have perceived a medium level of reward previously. Those who are still out of work are more likely to have experienced a high level of reward. This is actually against expectations. Apparently the level of reward at work has no effect on the decision to resume work. The best seems to be when levels of commitment of workers are in the medium range. Neither 'over'-commitment or low levels of commitment seem to be helpful for returning to work. Respondents working for non-profit organizations are more likely to have resumed work partially or on a therapeutic basis.

In the block of non-work factors variables (e.g. external work factors), only a medium family-work balances discriminates between work resumption or remaining on sickness absence.

As for contextual variables, those who have resumed work are less likely to declare having had contacts with rehabilitation advisors or case manager and less likely to say that they had contacts with those professionals. These respondents are more likely to say that there has been contact between their supervisors or managers and professionals.

Those who have not returned to work claim that some adjustments to work arrangements were made to their workplace prior to their absence but that none have been made during their absence. Whereas those who have returned to work are claiming that work place arrangements were not made before or during their absence or upon their return to work.

Conclusively, the above mentioned variables are revealed as the main factors affecting the decision to resume work or to remain absent. These factors also appear as influential in the decision making process with regard to work resumption or continuation of absence in the five partner countries. Thus they should be taken into account when considering policies, procedures and practices for work resumption.

As already stated, Logistic Regression Analysis could not be performed because there were too few respondents who have returned to work. This is a reflection on the English sampling strategy i.e. the LTA's were recruited via the database of Incapacity Benefit recipients in the UK a prerequisite of which is that they are long term sick unable to work. People are eligible for IB AFTER 26 weeks of sickness absence. The literature clearly indicates that when absenteeism takes longer than 12 weeks the chances to return to work are indeed very slim. This means that when people finally enter IB, they are not likely to return to work within the next 5 years.

SECTION 4 TOWARD A THEORY OF ACTION

This research has been designed to enhance the knowledge base on long-term absenteeism and work resumption. It has concentrated on the experience of being absent from work, health and living conditions, the job prior to absence, factors helping or hindering work resumption and future perspectives. In particular comparisons were made between those absent from work for mental and/or physical health problems and levels of stress.

Epidemiological studies indicate that in a one year period, approximately 28% of the adult population has a mental or addictive disorder (Milazzo-Sayre, Henderson & Maudersheid, 1997) and the national and international statistics point towards the increase of the proportion of mental disorders in the labour force, causing long term sickness absence. Mental health is second only to coronary vascular disease as a causal factor of work absence.

In the workplace being absent because of mental health problems and stress is notable; work stress can be also an issue when physical health is the reason why the sickness is signed or granted. Stress is a cause of clinical documented mental disorders and distress can have physiological consequences, such as coronary hearth disease, skin condition, ulcers, hypertension, asthma, and not just (Siegrist, 1996).

Mental health and stress are often used synonymously in organisational literature. Although stress is not recognised as a formal medical diagnosis, there have been legal cases were the courts have upheld employees claims regarding work related stress. Yet, by defining stress as a normal part of working life and the ability to cope with stress an essential function of any job, there have also been cases were the courts have ruled against worker's claims that the stress of the job caused their illness or disability. (see Bernardin & Lee, 2002)

Ultimately the aim of this research was to provide a framework of mental and physical absentees' conditions and level of stress with regard to: demographics; job characteristics; work characteristics; health; absence history; services and interventions; contacts and expectations to return to work.

These blocks of variables have been explored with regard to absence diagnosis, level of stress and return to work.

4.1 SICKNESS DIAGNOSIS AND LEVEL OF STRESS

4.1.1 Demographics

According to a number of European studies women have a higher level of absence due to sickness than men (e.g. Bergendorff et al., 2002; North et al., 1993; Niedhammer et al., 1998; Voss et al., 2001). However, to date, no satisfactory explanation is available for this finding. The results of this study do not support this claim. In fact the proportion of men and women receiving IB in this research reflects proportionally the gender difference in the UK working population.

This research confirms previous studies insofar as women tended to report higher rates of psychological distress and men are prone to severe physical illness. Gender comparisons often ignore differences in background variables (Kinnunen, Geurts & Mauno, 2004). Reported gender differences in the stress phenomenon have been explained by identifying specific stressors and individual coping mechanisms (Narayan, Menon & Spector, 1999). The findings of our study lend support to Carayon et al. (1995) who found that gender as well as other demographic variables were not related to worker strain caused by job stress and also to Lazarus & Folkman (1980) where very few gender differences emerged in relation to stress and coping strategies. The results of this research do not support past research which claim gender differences in levels of stress e.g. Maddock & Parkin, 1993.

The results with respect to age do not reveal anything unexpected. The general trend seems to be that young people have less physical complaints. Young people are more likely to be absent from work for reasons other than physical ill health.

Younger workers also report high levels of stress as they often perceive a mismatch between the skills and knowledge they have acquired and the career path they pursue. Often their career path is partially or even completely different from their career expectations. This is particularly true for those who have completed further education. Younger workers often have the additional burden of trying to juggle the demands of work with the responsibilities of a young family, and seem to have difficulties in finding the correct balance.

A higher level of education (high school) tends to lead to a job with increased responsibility, longer working hours, pressure or less boundaries between work and life outside of work. Having a good level of education but being employed in a job that does not allow an individual to use their skill and knowledge and pays a meagre wage is stressful.

People in the lowest income group are most likely to have a co-morbid health condition and a high level of stress. The threat of not being able to work, and losing albeit a small salary, because of poor physical health is stressful and often leads to a decline in mental health. Mental health disorders can trigger or exacerbate physical health problems.

This situation highlights the complexity surrounding work related stress. Work is often viewed as threatening and a causal factor in the onset of absence and yet when absent, work, employment is viewed as essential for survival, hence high levels of stress.

The results presented here lend full support to the extensive literature on marital status and mental health (Kirkcaldy, Cooper, Furnham & Brown, 1993; Eastburg, Williamson, Gorsuch & Ridley, 1994; Kirkcaldy & Furnham, 1995; Kirkcaldy, Cooper & Brown, 1995; Rout, Cooper, Rout, 1996; Vinokur, Pierce, Buck, 1999; Grassi, Magnani, 2000; Ito, Kurita, Shiiya, 1999) which demonstrate that being married acts as a buffer against mental health complaints compared to those who are co-habiting or single.

In the UK dual income families are the rule rather than the exception to family life (Kinnunen et al., 2004). Only 20% of the sample had dependent children but this was not shown to be related to the type of diagnosis or levels of stress, contradicting previous studies (cf. Erikson et al., 2000).

To sum, demographics are a good indicator of the type of sickness absence and level of stress.

4.1.2 Job characteristics

Past research has shown that different levels and causes of stress were reported by specific groups of workers, because jobs with particular characteristics or demands constitute a higher risk for stress (and long term absence) than other jobs (cf D'Amato & Zijlstra, 2003). In particular jobs in which people are dealing with customers (service oriented jobs) seem to be quite stressful, and this may result in mental health complaints. This study indicated that people working in a hotel or restaurant have a higher likelihood to have mental health complaints than physical health problems. Also clerical workers who are in frequent contact with clients and customers seems to have substantial higher risk for mental health problems (Narayanan, Menon & Spector, 1999) While, on the other hand it appears that manual workers (craft and trade workers) are more prone to physical health problems.

Job tenure appears to be related to reason for absence. Although tenure is usually correlated with age, these aspects are not the same. The continuous exposure to working conditions can have an effect on health that is independent of age.

The contractual working time does not discriminate between the categories of morbidity. Working extended, long hours is commonly cited as a major cause of stress, yet this research has shown that even working a few hours more than contractually obliged can lead to physical health problems.

Only a few job characteristics surveyed in this research appeared to be relevant in relation to differences in levels of stress and diagnosis.

4.1.3 Work characteristics

Sickness absence for mental health reasons is primarily associated with low levels of control, high level of job commitment, having a job with low level of demands – both physical and cognitive but high emotional demands. It is also characterised by a low level of job satisfaction and low work-family balance.

Physical ill health is related to low general job demands, high control, medium supervisor support, low commitment, high physical demands, low emotional demands, high job satisfaction, high work-family balance and medium family-work balance.

LTA's claiming low level of job stress appraised their job as characterised by low demands, high control, medium to high co-worker support, high supervisor support, low level of over commitment, high reward, low job insecurity, and emotional de-

mands, medium cognitive demands, high job satisfaction, high work-family and family-work balance.

High stress is characterised by high job demands (both emotional and cognitive demands), low control, low co-worker support but high supervisor support, high over-commitment, low reward, high job insecurity, low job satisfaction and low family-work as well as work-family balance.

Work-family conflicts or balance is a form of inter-role conflict in which the role pressures from the work and family domains are mutually incompatible (Greenhaus & Bertelle, 1985). Work-family balance and its relation with job satisfaction as well as stress have been extensively studied. From the results of this study it is apparent that a poor balance between work and family increases levels of stress as well as reason for absence.

When people have difficulties in finding an adequate balance between work and family life, they are more likely to have mental health problems. LTA's who indicate that they have an appropriate work-family balance are more likely to have physical health complaints. This is in line with past research. For example Allen, Herst, Brock & Sutton (2000) reported in their meta-analysis a weighted mean correlation of 0.29 between work-family conflict and general psychological strain measures. Frone (2000) showed that employees who often experienced work-family conflict were more likely to experience a clinical diagnosed mental health problem.

The profiles of high/low stress and mental/physical ill health are very similar. Two points are of interest here, one theoretical and one practical. The first point is that our results seem to be in line with Karasek's job-demand-control/support model (Karasek & Theorell, 1990; Karasek et al., 1998) and also with the general work stress literature (cf. D'Amato & Zijlstra, 2003). Throughout the literature there are many studies demonstrating the influence of stressors on wellbeing or psychological illness.

The second point is that absence because of a mental health condition appears to be associated with high levels of work stress.

Most people (65 %) indicated that their absence was due to physical health problem, while 19% of the participants declared that their sickness absence was due to a psychological/mental health problem; a ratio of 1 to 3. About 15% reported they had both, physical and mental health problems, i.e. a co-morbid condition.

The co-morbid group raises an interesting issue. They usually report a physical problem followed by a decline in mental health. Further research (D'Amato, Pierce, &

Zijlstra, 2005) demonstrated that in many instances the physical label is a more acceptable diagnosis and is used to disguise mental health problems. It seems that psychological problems are still associated with stigma.

The psychosocial working environment gives a clear indication of the nature of the diagnosis as well the level of stress.

4.1.4 Life-styles: changes in lifestyle and behaviours during the absence period

Stress is defined as a mismatch between the perceived demands and the perception of one's ability to meet those demands. The responses refer to short term as well as long term consequences. Short term, maladaptive coping strategies include such things as lighting another cigarette, having a drink or taking a sleeping pill. Torkelson & Muhonen, (2004) found that the use of alcohol and drugs to deal with stress was associated with more symptoms. Banyard, Berman & Graham (1993) found that smoking was a way to cope with stress. However, used long term, maladaptive coping strategies can lead to life threatening illnesses such as ulcers, certain types of cancer and hearth diseases. So a method of coping with sources of stress can ultimately become the source of stress itself (Sutherland & Cooper, 2002).

Alcohol consumption, smoking and eating habits seem to change, often for the worse, when mental health is the reason for absence. They do not appear to change or only change for the better when people have a physical ailment.

Those with mental health illness have a medium level of exercise, high levels of exercise is associated with low levels of stress. Household duties seem to increase for those off work for mental health reasons, but not for those with physical health problems. This finding suggests that people with mental health problems are keen to have a role to fulfil, to appear useful, and to have a purpose to their day; they do not want to be isolated or feel useless.

Mental health is reported to be associated with an increase in social and leisure activities and a decrease in contacts with existing family and friends. Extrapolating from this it is possible to suggest that people with a mental health illness seek new contacts and experiences where they will have no history; avoiding old contact means not having to face any perceived stigma associated with their illness. Those with physical illness do not report any change in their leisure or social activities.

High level of stress is associated with sleeping problems. In particular problems with sleep onset are well-known for people with stress problems. People with stress com-

plaints tend to worry a lot and ruminate about their problems which prevents them from falling asleep (cf. Cropley, Dijk & Stanley, 2006).

Furthermore, it appears that poor quality of sleep is associated with stress and health problems, rather than length of sleep per night. The length of sleep varies per individual and is dependent on many variables. However, the quality of sleep seems to be more important than the length of sleep to make people feel refreshed in the morning. When people feel they are not refreshed after a night's sleep most of their day time activities become a burden. Sleeping problems is also associated with feelings of depression and mental health problems.

From these findings it seems that life style is largely affected by diagnosis and level of stress.

4.1.5 Health characteristics

Clinical depression appears to be one of the main causes of absence, therefore a correlation between reason for absence and general feeling of depression was expected. Yet the experience of being LTA for physical reasons can in the long term also elicit or enhance these feelings (cf. D'Amato, Pierce, Zijlstra, 2005).

Burnout appears with stress amongst the most frequently mentioned work related health complaints and a major cause of absenteeism from work. Burnout, as a construct is not officially recognised as an illness. However, the present findings show a clear association between emotional exhaustion and disengagement, the two dimensions of burnout, and the diagnosis for mental health illness.

People with a high level of stress usually rate their workability as low, in particular their mental capacities to work. These people will in general also assess their self-efficacy as quite low, which illustrates the close relationship between self-efficacy as a psychological construct, with the rating of workability.

Mental health or physical health illness are strongly correlated to level of stress, where strain and mental health have a huge overlap.

The high stress condition is strongly related to a mental health diagnosis and comorbidity. From a diagnostic point of view the level of stress is associated with the majority of physical diseases mentioned in the questionnaire; a few exceptions are birth defects, injury from accidents, problems at the lower extremities and blood diseases, which cannot be reported as somatization.

4.1.6 Absence history

Work absence history appears to be a good indicator of mental and physical morbidity. There is a high likelihood that acute mental illness will have been preceded by a few short spells of absence. An urgent physical impairment is often sudden, unexpected and any early signals or warnings (if there were any) often ignored, because they do not result in a short term spell of absence. However, a work absence history including frequency and tenure is not an index of stress.

There is a lack of significant differences between mental and physical ill health diagnosis and the evaluation of their complaint as being a sudden event or a gradual process. From a clinical point of view a heart attack or an accident are sudden while developing a depression is a slow process. It seems that the participants do not recognise this difference.

Most mental health absentees acknowledge that (in hindsight) they felt that their health was declining. A physical problem is usually unexpected, and appears to be associated with low levels of stress. High levels of stress occur when absentees recognised that they were unable to cope with their situations and helpless to take any preventive actions leading to a state of cognitive dissonance.

4.1.7 Services and interventions

Mental health absentees make the most use of psychological services. Alternative medicine is also popular for mental health absentees. This could indicate that people already have been shopping with the regular health services without success, or it might indicate that people feel that traditional medical services are not adequate in dealing with mental health issues.

Lack of trust in psychological and psychiatric services could be attributed to:

1. Psychological treatment is by its nature longer (usually) than treatment for physical illness and requires active involvement of the 'patient' rather than passive
2. The amount of time that doctors, mainly in public health services, have available for a consult is considered to be insufficient.
3. Psychological therapy/intervention can be rather abstract of nature, and it maybe difficult to see, for laymen, what it aims for.

Only with respect to the use of 'vocational rehabilitation services' a difference can be noted, in that people with low levels of stress are more likely to have used these services.

4.1.8 Interventions at the workplace

The lack of interest and involvement of the workplace in order to help facilitate work resumption is apparent when participants have been asked about the kind of arrangements undertaken by the workplace. Also there are no differences with regard to diagnosis or level of stress and the involvement of the workplace in facilitating work resumption, which is mostly reported as poor or non-existent.

4.1.9 Contacts with workplace and contacts between professionals

When people are absent from work for mental health reasons it appears that they prefer to have no contact with the workplace. However, people, absent for physical health reasons usually indicate that they had contact with the workplace.

The mental health absentee might well actively avoid all contact with work during their absenteeism. The contacts with work seem to be particularly problematic for people with mental health problems. They perceive these contacts more often as intrusive, and feel they have difficulties justifying their absence since there is no clear and evident physical problem. Sometimes people feel these contacts are more aimed at a speedy return rather than enquiring after their well-being.

The lack of awareness with colleagues concerning mental health issues often causes those with such problems to retreat into social isolation in order to avoid unpleasant and awkward confrontation. Similarly colleagues, managers and co-workers are at a loss as how best to deal with, talk to and support their sick colleague and therefore find it easier to avoid all contact and thus exacerbate the problem of social withdrawal.

A lack of communication between professionals involved in the process of LTA is raised by the findings of this research. Mental health absentees report that as far as they know there has been no contact between professionals involved in their case. A lack of synergy between the health professionals and the workplace seems to inhibit the process of work resumption.

4.1.10 Expectations On Return To Work

Expectations prove to be an influential predictor for situations in the future. According to the goal-setting theory (Taylor et al., 2006) when actions are taken and the goals are clearly specified, results follow. In this study the individual's estimate at Time 1 proves relevant for work resumption.

Some differences have constantly emerged in our study when LTA for physical and mental health complaints were compared. LTA's with physical health problems are more likely to predict that they will never return to work. Those with psychologi-

cal/mental problems indicate a higher likelihood of returning to work in the future, although not within the next 6 months.

4.1.11 Conclusions

Work related mental illness is a hectic topic. Many conflicting explanations have been proposed to help us understand this state of affairs.

Work can be the cause of mental illness particularly when there is lack of fit between the person and the position. When the absentee mentions such issues as too much pressure from the work or high job demands, even after a period of recovery or work absence, they are not likely to return to the same job. In circumstances where the job characteristics have been identified as causing ill health and where the absentee is expecting to resume work this will be to a different job in a new setting

In light of these findings LTA for mental health reasons, often cite work as a causal factor in the onset of their absence and express no intention to return to work for their previous employers, it is reasonable to suggest that effective intervention and treatment should deal with the root cause of the workplace problems and not just focus on the individual. This is not meant to suggest that organisations are not willing to cooperate and facilitate work resumption for their LTA, this highlights the fact that there seems to be a distinct lack of knowledge, awareness and policies on the part of employers of how best to deal with long term absentees, including its prevention. Advice from a Return to Work, Occupational health advisor even government recommendations on best practices for absence management is often all that might be required. Effective intervention will facilitate successful work resumption thus the employer will retain the valued experience and knowledge of their employee, avoid the costs of hiring and training a replacement member of staff and the employee will benefit from the latent and manifest benefits of work; a 'win-win' situation for all.

Disability, a common consequence of mental illness, is expensive to employers, those who are disabled and society at large. Gabriel (2001) indicates that, out of 10 common medical applications, mental illness is second only to ischemic heart disease in total costs.

Mental health absentees who return to the same job to their old employers have the lowest level of stress. This could be because the job was not considered as a causal factor in the onset of the absence, in other words there was no 'bad' history. Even in the event that the job was a contributory factor in the onset of the illness, perhaps

they returned to the same job because of feeling of comfortable about returning to a job which is a known quantity, with no surprises.

Physical absentees do not generally regard their job as a causal factor in their illness and therefore express an intention to return to work for their old employer, if they have not already done so.

Another observed difference in the results concerns the factors that have influenced work resumption. Respondents with a co-morbid complaint are most likely to have resumed work for financial reasons.

To remain off work with no imminent prospect of returning can be distressing, and worsens an already, for most, unpleasant situation. The mental health for all absentees deteriorates by extended periods of joblessness affecting their ability, self esteem and attitudes towards work resumption.

Employers are sceptical about retaining or hiring workers with a mental health disability. Bernardin & Lee (2002) have mentioned the following reasons used by employers as an excuse to terminate the employment of people with mental health problems or to explain their poor performance:

1. These employees are most difficult or even impossible to accommodate, compared to other disabilities;
2. They are problematic in a team work setting;
3. Their ill health can interfere with capacity to perform essential functions on the job.
4. They present an undue hardship on the employer.

Employers also cite difficulties with supervisors and co-workers, attitudes to work and absence frequency as other sources of problems.

4.2 RECOMMENDATIONS

Adequate organizational practice appears to be very important for the mental health of employees. Therefore organizational theory and mental health can be considered as bedfellows (Thomas & Hite, 2002). Employees' psychological health is largely

affected by interpersonal factors – such as relations with co-workers and management – work content, organizational and structural aspects, society and social aspects – such as prestige and status of the work role (Kasl, 1992).

This study provides support for the claim that IB recipients become lost in the system after they have entered it, and their chances to return to work appear very slim. Based on this study we can conclude that recommendations concerning ‘Return to Work (RTW) should include various aspects, such as legal aspects, financial aspects, aspects of organizational change, and organizational climate, life style, et cetera. Starting point should be the position of the LTA him/herself. Information concerning the target group is therefore essential (see also Henderson, Glozier, & Holland Elliot, 2005). In order to develop adequate return-to-work-policies information concerning the LTA present living conditions, health, future perspectives and other factors that might influence their decisions concerning absenteeism and work resumption is required. Since work can also have a therapeutic effect the importance of Return to work should not be underestimated. Consequently, LTA’s should be activated to work on their return to work, in order to participate actively again in society (Thomas & Hite, 2002).

An initial list of recommendations based on the present findings is presented below. These will have to be developed and elaborated and synchronized with other national reports.

National level

- Implementation /development of a national registration system for sickness absence. This will help with information provision with respect to the target group, and policy development.
- Develop specific policies and initiatives to stimulate people to return to work: focussed on organizational and individual level. Prevention and retention of absentees.
- Make clear where the responsibility lies with respect to sickness absence AND return to work. Sectoral and organizational financial arrangements (i.e. the introduction of a so-called Bonus/Malus system for organizations/branches with high level of sickness absence, cf. Dutch system) should be considered.
- Facilitate communication between professionals in this field, if necessary legal blockades (i.e. privacy law) should be reconsidered or amended.

- Review GPs role as gatekeepers to long term sickness absence and the benefit system. Increased guidelines and training for GPs on assessing fitness for work. Increase awareness of latent and manifest benefits of work.
- Promote multi professional/disciplinary collaboration regarding RTW options to include GPs, employers and specialist benefit and/or disability advisors via RTW or occupational health specialist
- Increase access and availability to rehabilitation services, return to work programmes and health focused interventions including behavioural interventions and access to mental health services. Return to work support offered from the start of sickness absence.
- Review (Overhaul) of Benefit system – people need to have financial incentives to RTW instead of financial penalties.
- Encourage positive media image regarding IB claimants to avoid dominant negative stereotypes.
- LTAs on IB should have a program rather than being left alone – active involvement in return to work should be the goal (i.e. have requirements to see a counsellor to assess fitness to work).
- To substitute RTW with RWGH – or return to work in good health, taking into account work status, functional limitations and number of days of work absence.

Organizational level

- Mental health problems are very often triggered by work-related problems. Stimulate prevention of absenteeism, through a) periodic screenings in organizations for psycho-social risks at work; b) develop/introduce stress awareness programs via provision of information on stress and stress-related health problems; c) introduction of stress management programs.
- Policy and guidelines to manage LTSA – including training in effective communication and increase knowledge regarding mental health illness. And workplace factors influencing LTA
- Develop a return to work policy, which includes provision of an individual return to work plan; appointment of contact person with absentee (training); inventory of need for work arrangements.
- Use follow-up standardize procedures upon work resumption.
- Encourage organisations to link up with an Occupational Health service to

provide knowledge and advice and regular screening of the organization.

- Keep position open for absentee for at least a year (return to work guarantee); Train supervisors in ‘people skills’; should be integral part of leadership/management training.
- An active policy with respect to Human Resources Management. Stress prevention and return to work should be integrated in this policy.
- Early interventions are important, make adaptations to work arrangements as soon as first signals are observed.
- Introduce health education programmes together with arrangements for work resumption after a period of sickness absence.

Individual level:

- Maintain a healthy life style: sleep, socially active; maintain adequate work – non-work balance; keep focused on ‘return to work’, and try to find professional support
- Up date employability, look for (re)training opportunities to enhance or extend skills and abilities.
- Utilize health education programmes offered by the organization.

Contacts and social support:

- To encourage a policy of ongoing contact between management and employee on LTA.
- Give to the supervisor/line manager the responsibility for work resumption, providing them with the adequate knowledge and suggestions. Promote, where practical, follow-up meeting with LTA and professionals to facilitate return to work. Supervisors who were responsible for return to work in their organization were more likely to communicate better and to consult more often with other professionals –after work resumption regular meeting between the supervisor and the therapist or other health professional should be scheduled to ascertain the appropriateness of the accommodation or whether changes should be made.
- Encourage social support within the organization that has been found important in the amelioration of sickness absence granted to musculoskeletal ill-health. Colleagues with whom the person has to deal with constantly

should be made aware of the situation. In this way frictions caused by perceived unjustified favouritisms are avoided improving climate and effectiveness.

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