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Work Package 7

The Family Study: Exploring the Experience of Long Term Sickness Absence and the Process of Work Resumption.

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STRESS IMPACT

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INTRODUCTION

1.1 Background

In the UK 3000 people each week become eligible for long-term sickness benefits having been off work for six months; 80% of those will not go back to a job within 5 years (www.workplacelaw.net). An EEF/IRS 2004 joint survey (www.eef.org.uk) of long term sickness absence (LTSA) undertaken in 896 manufacturing workplaces representing all regions of the UK found the following common outcomes for LTSA:

- In smaller manufacturing companies (less than 200 employees) long term absentees (LTAs) are mostly rehabilitated over time and return to their previous job.
- The second most common outcome for long-term absence is the termination of employment.
- LTA ended with early ill health retirement on a pension.
- LTA remains ongoing and not resolved.
- Those nearing retirement are left off sick until pension payable
- LT absence staff move onto permanent health insurance (PHI) or other long-term income protection arrangements.

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

Jahoda's (1982) latent needs theory has been developed to help us understand the negative relationship between job loss and psychological health. It is based on the idea that psychological distress in the unemployed is due to the deprivation of the latent (meeting psychological needs) functions of work. This theory proposes that 5 main psychological needs go unmet when the individual is not working. These are the need

for time structure, social contact outside of the immediate family, being part of a collective purpose, being engaged in meaningful activities and having social status. Work provides people with both the obvious e.g. income and the latent sources of satisfaction. Although redeployment reverses the negative impact on the mental health and well being of the unemployed persons (Vinokur et al., 2000;), high levels of social support may encourage people to stay at home when they are ill; and more social obligations at home can also prolong sickness absence. (Kivimaki, Vahtera, Thomson, Griffiths, Cox & Pentti, 1997).

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

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

1.1.1 Statutory Sick Pay and Incapacity Benefit

In order to have a comprehensive model of sickness absence the national welfare system as well as related professionals and services has been taken into account throughout this research.

The Department of Work and Pensions (DWP) 2002 parliamentary report entitled 'Pathways to Work' states that once a person has been on IB for 12 months, the average duration of their claim will be eight years. Figures released by the DWP indicate

that incapacity benefit has the most costly budget of any benefit in the UK (The Times, May 18, 2005). Further more John Hutton MP, the Secretary of state for Work and Pensions, delivering his speech, about the future of welfare (Monday 16 January, 2006) said 'While 80-90 per cent of people coming onto the benefit expect to get back to work – many never do. After two years on the benefit, someone is more likely to die or to retire than to find a new job.' 'Empowerment' (John Hutton) is the theme running through the government's proposed whole reform programme. The primary objective of the reform being to provide incentives and support those with work potential

For example, as part of their NHS duties GP provide medical advice to their patients on fitness to work which often initiates most periods of sickness absence. Their official statements i.e. sick notes, are used by patients as evidence to support claims for financial benefits as well as by employers to support claims for company sickness benefits or Statutory Sick Pay (SSP)and have implications for insurance companies; medical statements form a key part of the claim process for state incapacity benefits.

In the UK Statutory Sick Pay (SSP) is paid to employees who are unable to work because of sickness by their employer for up to a maximum of 28 weeks. Incapacity benefit (IB) is paid when Statutory Sick Pay has ended. It is not paid if a person is over the state pension age when they became sick. IB is a benefit that gives working-age people a replacement income when they become sick or disabled and stop working or looking for work as a result. This benefit is paid at various fixed rates, the amount dependent upon such things as individual circumstances such as age, dependents, length and nature of illness and national insurance contributions. Regular Sickness notes are not required once you are being paid LT IB and individual circumstances may affect the amount received. If the relevant medical test has been satisfied then there is no requirement to look for work in return for benefit. However, without affecting benefit, it is possible to work for earnings up to £20.00 a week for an unlimited period or for less than 16 hours a week, on average, with earnings up to and including £78.00 for a 26 week period. Voluntary work can also be undertaken (see www.dwp.gov.uk for further details).

1.1.2 Aim of the Study

In order to truly understand the factors that influence LTSA and work resumption, this research considered the role of macro (societal), micro (personal characteristics and living conditions) and organizational level determinants. This study, one of three interrelated studies within a 3 year pan European project into LTSA from work, was designed to advance understanding on the processes of absenteeism and work resumption. Starting with their decision to take absence from work this qualitative study explored the impact of LTSA on people's social and economic situations, it examined

how long term absentees (LTAs) view their current functional limitations and finally how they perceive their future perspectives and options regarding return to work.

The question this research considered is:

What factors influence the processes of LTSA and work resumption for both physical and mental ill health?

More specifically it explored

- Factors that prompted the decision to take LTSA from work
- The impact on the absentee and their significant other as a result of this period of not working
- Factors that hinder or enhance work resumption.
- Differences and similarities between the experiences of physical, mental or co-morbid LTAs with regard to the absence threshold and process of work resumption.

The findings from this study will help to fill the gap in the knowledge base with respect to the experience of LTSA. It will also assist in providing recommendations to help this substantial minority of the workforce currently at risk of social exclusion a realistic chance to participate fully in society rather than being written off as incapacitated. Ultimately this research will contribute to the development of a theory of action, to new policies and practices in guiding interventions to reduce LTSA and enhance the process of work resumption.

1.2 Methodology

The research has been designed as an inductive qualitative study according to the recommendations for qualitative studies of Silverman (1993) and Hammersley (1992) and thus is making no predictions being theory generating rather than hypothesis, theory testing (Silverman, 1993). It is inextricably linked and follows on from an earlier quantitative study within Stress Impact Project (**http://www.surrey.ac.uk/Psychology/stress-impact/**) which collected information from 373 LTA claiming sickness or incapacity benefit.

This earlier study was a cross national survey of LTA for medical reasons (both physical and mental) designed to identify the factors that might influence decisions with respect to absence and work resumption, document health, social, economic and practical impacts of being off work long term and to describe the participant's personal circumstance, their experiences of interventions and rehabilitation programmes. A subsample of the participants from this earlier research, having already consented in principle to participating further in this study, were approached and invited to be interviewed with respect to their experiences of being long term absent from work. Where

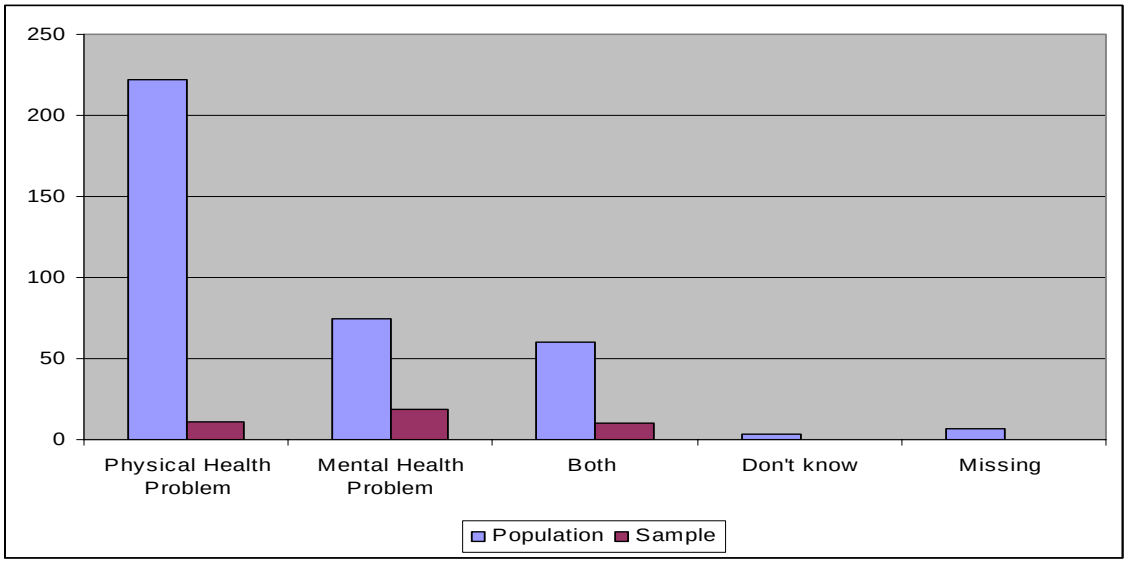
appropriate the husband/wife/partner of the absentee was also invited to take part in the study by being interviewed with respect to their experiences in relation to their partner's sickness absence.

It is the aim of qualitative research to 'give voice' to those whose accounts tend to be marginalized or discounted and can be designed, as in the present case, to capture the subjective 'feel' and insiders perspective of a particular experience and help identify any recurring or common patterns among a group of people (Willig, 2001). Qualitative research is interested in meaning, i.e. how people make sense of the world and their experiences and as such, and in contrast to the earlier research design, the researchers are implicated in the research process because of the role they play in interpreting the data. Lee, Mitchell & Sablynski (1999) suggest that qualitative research is particularly well suited to studying process and Smith (1995) for exploring complex and personal experiences. So rather than try and identify the cause-effect typical of quantitative research, it is the aim of this research to retrieve the subjectivity lost by other methodologies and explore the experience of being LTSA and bring about insight.

1.4 The Sample

From the original population of 367 LTAs, 40 LTA and 12 significant others were interviewed for this research; a total of 53 interviews. 27 interviews were conducted face-to-face in the participant's homes and the remaining 26 interviews were conducted on the telephone. Those not interviewed face-to-face were contacted and interviewed by telephone. This meant it was possible to involve participants from all over the UK making the research more representative of the general population by avoiding a geographical skew. The socio-demographics variables taken into account also included gender and family composition, being single or married, living in a single or dual income household and etiology of illness i.e. physical, mental or co-morbid ill health. Participants of all ages were contacted. Everyone who was contacted agreed to be interviewed. All the participants were on certified sickness absence.

Fig. 2.1. Distribution of the population and the sample with regard to diagnosis.



40 LTAs were interviewed; 19 were LTA for Mental Health (MH) reasons (10 female, 9 male), 11 for Physical Health (PH) reasons (7 male, 4 female), 10 had both physical and mental health illness (i.e. co-morbid) (8 female, 2 male). 12 significant others were interviewed; 9 (3 female, 6 males) had partners LTA for physical health problems, 3 (2 males 1 female) had partners off work for mental health problems. The ages of the participants ranged from 23 – 66 years. The sample was deliberately *selected* to include representation from the three categories of LTSA i.e. physical, mental or co-morbid (C-M). This allowed the researchers to identify and compare similarities and differences within the sickness absence phenomenon.

Further information about the sample is displayed in table 2.1 below.

Table 2.1. Profile of the Sample

	Main reason for current absence:			
	Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
Number of interviews:				
- LTA	11	19	10	40
- Partner	9	3	0	12
Return to work LTA:				
- Not	10	10	8	28
- Partly	1	4	1	6
- Completely	0	5	1	6
Family type:				
- Couple	5	6	2	13
- Couple with *dependent* children	4	3	4	11

	Main reason for current absence:			
	Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
- Single	2	9	4	15
- Single with *dependent* children		1		1
Income:				
- Single income	5	11	5	21
- Dual income	6	7	3	16
- Unknown	0	1	2	3
Gender LTA:				
- Male	7	9	2	18
- Female	4	10	8	22
Average age LTA in years	52	44	39	45
Education level LTA:				
- Up to lower professional education	1	2	1	4
- Intermediate general and professional education	6	6	4	16
- Completed high school	3	5	3	11
- Higher professional education	1	5	2	8
- Academic education and higher	0	1	0	1
Work sector LTA:				
- Agriculture, fishing and forestry	1	0	1	2
- Manufacturing	1	1	0	2
- Building & construction	3	1	2	6
- Trade (retail & wholesale)	2	3	0	5
- Hotels & restaurants	0	2	1	3
- Transport, storage & communication	1	3	1	5
- Banking, insurance & financial services	0	0	1	1
- Public administration	1	1	0	2
- Education	1	2	2	5
- Health & Social work	1	3	0	4
- Other community, social and personal activities	0	1	1	2
Average and standard deviation score on CES-D scale; 10	1.08 .915	1.78 .70	1.69 .65	1.57 .79

	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
items; 1=not-4=highly depressive				
Average score on Exhaustion scale; 8 items; 1=not-4=highly exhausted	2.29 .55	3.11 .54	2.78 .44	2.81 .61
Average score on Disengagement scale; 8 items; 1=not-4=highly disengaged	2.02 .49	2.82 .44	2.32 .26	2.49 .53
Average score on General self-efficacy scale; 10 items; 10=low-40=high	2.84 .78	2.18 .68	2.05 1.01	23.21 .85

1.5 The Interviews

Face to face and telephone interviews were conducted

The face to face interviews were conducted with participants accessible within a day's travel of the researcher's work place. Those participants living further away were interviewed by telephone. This helped to avoid a sample that was geographically skewed. At times, when both the LTA and their significant other had agreed to be interviewed face to face, each interview was conducted concurrently in different rooms of their home. The same two researchers conducted all the interviews.

Willig (2001) reminds us that the success of semi-structured interviewing depends on the rapport that is established between interviewer and interviewee and, furthermore, how tenuous this rapport can be. With this advice in mind concerns can be raised about the two different interview methodologies. Whereas the face-to- face interview is a valuable research tool because helps in building a relationship, rapport and confidence between the interviewer and the interviewee, the use of the telephone as an interview tool has the advantage of anonymity which can reduce the likelihood of any power differentials thus making the interviewee more relaxed and therefore often more willing to be honest and open with their responses.

A standardised interview schedule, developed from an extensive literature review and the results of past research were used to guide each interview. The interview schedule allowed each individual to 'include their reasons for their acts as well as the causes of each happening' (see Sarbin,1986, p.9). The majority of the questions were open ended and designed to encourage the participants to speak freely and openly. This design is said to enhance the emergence of new and unanticipated data because qualitative techniques tend to be participant-led in that they allow participant-generated meanings and experiences to be heard (Willig, 2001). At the same time the interview

schedule helped to ensure that the researcher stayed on course and did not deviate too far from the original research question. Each interview was recorded and then transcribed using a standardised reporting template.

The interview schedule (see appendices) was divided into 6 sections:

- Section 1 Absence Threshold
  This section was designed to prompt the participants to talk about the reasons for their absence and to shed light on the decision making process, including the factors that influenced the absence decision-making process both inside and outside the workplace.

- Section 2 Prevention of Absence.
  The interviewees were asked if they felt that anything might have been done to prevent their absence and to reflect upon the support received from their workplace, their societal structures and their family.

- Section 3 Impact of Absence
  The impact and the consequences of work absence on both the LTA and where appropriate their families was explored in this section.

- Section 4A : Return to Work.
  Participants who had returned to work were encouraged to talk about their experience of work resumption and were asked to describe factors that facilitate this process including support, either from the community or from work or rehabilitation they may have been offered. They were also asked about the reception they received from their superiors and colleagues.

- Section 4B: Not yet Returned to Work
  Participants who had not yet returned to work were asked to talk about factors that were hindering their return to work. They were asked to speculate upon whether or not there was anything that could be done either by themselves, their families, their workplace of community to encourage the work resumption process.

- Section 5 Rehabilitation
  In this section participants were asked to talk about any rehabilitation programme they have participated in. In particular they were asked to describe how helpful or not this programme was and to suggest possible improvements.

- Section 6 General

> This was a general section asking the participants for any further comments on issues not raised during the interviews. . Participants were encouraged to voice their opinion about the effects of societal changes on the quality of life, with particular reference to work absence

The same basic ethical considerations, as in quantitative research, applied to this research including the participant's right to withdraw, informed consent, no deception, debriefing and confidentiality. In some incidents it is fair to say the interview process for many participants was deemed to be beneficial, in that it provided them with the opportunity to talk about and share their stories.

Qualitative research does not work with representative samples, thus raising the question of the transferability of the findings. However if we assume that the participants experiences are at least partially socially constructed, then once we have identified a particular experience (s) through qualitative research then we know it is available within a culture or society (Willig, 2001). Validity can be promoted on the grounds that the findings, the arguments and the themes presented in this research are supported by evidence grounded, consistent and true to the data (see Crossley, 2000). Furthermore because there is no extrapolation from an artificial setting to the real world; the data has high ecological validity.

SECTION TWO
FINDINGS

Throughout this report every attempt has been made to uphold each participant's right to anonymity and confidentiality. Every name is a pseudonym and all identifying features have been removed.

This research has been designed to capture the deep meaning of the process from work to sickness absence and from absence to work resumption or the decision to remain absent from work i.e. to make sense of the 'stories' people tell about their experiences. From the previous knowledge and the meagre literature on this subject, it is clear that several factors, listed below, concur in work absence and work resumption.

2.1 Absence Threshold
This section reports on the factors that prompted the LTA to take sickness absence. It also reports on the time scale prior to the absence, any problems the LTA were experiencing and the influence of other people in the decision to report ill from work.

2.1.1 Causes of Sickness Absence
Sickness absence for physical reasons is generally described as a sudden decision. In the majority of cases the individuals have an acute or chronic problem e.g., stroke, heart problem, arthritis or cancer, have had an accident or are recovering from an operation and after consultation with their medical expert /GP been signed off sick. Absentees with chronic health problems refer to a period of contemplation prior to their sickness absence.

Absence from work for mental health reasons is frequently triggered by workplace stressors. Many MH absentees have been able to fulfil exacting and demanding job roles despite a history of MH problems, until the nature and conditions of their job changes i.e. new line manager, new technology, change to working hours. They admit to being vulnerable to unhealthy work environments and struggle with change. The narratives suggest that those with MH problems allow their problems at work to fester fearful of living up to the stigma of their MH label. So although these absentees demonstrate insight and self awareness they appear reluctant to seek help from inside or outside of their workplace. For some work place problems are the sole cause for the onset of sickness absence typically they are exacerbated by personal issues as well as the behaviour associated with the illness such as drinking or drug taking.

Personal issues in isolation are seldom enough to initiate a period of absence. However many MH absentees referred to issues outside of work acting together with issues at work to bring about a period of sickness absence.

> Beverly was trying to cope with massive restructuring and redeployment at work, in a job that involved dealing with complaints from members of the pub-

lic. At the same time she had desperate family problems – her daughter ran away from home. 'I could have coped with one situation without the other; the two together were devastating. I would go to work and people would shout at me and be so rude, at the same time I was waiting for news about my daughter. I am very fragile now and cannot face crowds of people. It has really changed me.'

Another participant talked about the difficulty of working and being a full time carer for her invalid mother, another spoke about her inability to cope after the sudden onset of diabetes and her demanding job, another suffered post-natal depression and the demands of her job. One man suffered severe depression primarily as a reaction to the breakdown of a long-term relationship fuelled by the changing conditions and increased pressures at work.

For MH absentees the decision to take sickness absence is protracted particularly when compared to those absentees with PH complaints. MH absentees often work longer than perhaps is medically desirable, sometimes to a point where their problems intensify and worsen until eventually the person is in a state of crisis and no longer able to function (see Allegro & Veerman 1998). This in turn can lead to an even longer instance of sickness absence.

Charles, is a man in his early thirties with a history of addiction, both drug and alcohol related, worked in a jewellery shop having successfully stopped using and drinking. His employers were fully aware of his medical history. He proved to be very popular at work, was reliable, worked hard and was promoted. However, this promotion meant he had to work longer and more unsocial shifts. Consequently he was not able to attend his once weekly evening AA (alcoholic anonymous) meetings, which provide essential ongoing support for recovering alcoholics such as this man. His employers were not willing or able to accommodate his request to have this evening free. He battled on because he did not want to publicly admit that he was not coping for fear of losing his job nor did he want to let his colleagues down by taking time off work.

As the pressures of work continually increased, so his ability to cope decreased. Without the specialist support he needed, Charles 'inevitably' turned to drugs and drink. In his own words ' everything became a vicious circle, I became unreliable, did not turn up for work, was rude and bad tempered, antagonised my colleagues my bosses until one day I just blew up, and that was that really.' He left work and spent the next 6 months in rehab.

In this story there were no winners; the store lost a fundamentally able and valuable employee and Charles lost his job. In hindsight Charles believes he should not have battled on without adequate support. His employers were short-sighted and played a direct role in his break down. Charles did return to work full time but not to this job.

For those who claim they are suffering from 'both' mental and physical ill health, the physical ill health is usually the primary reason for the onset of the certified sickness absence. So in several cases, one of two things is apparent. Either the physical ill health complaint is used as a socially acceptable sickness label, to mask MH problems and/or the physical ill health, often chronic, has in fact triggered MH illness.

> Sally worked as a pre school leader, a job where the pressures, responsibilities and demands continually increased. Although she enjoyed the content of her work her immediate line manager was obstructive and unhelpful. She asked for time to be scheduled into her working day for her administration work, her boss agreed in principal but practically nothing was done. Every evening she took work home and worked until well past midnight. Exhausted she fell ill and was signed off sick. Although she had suffered from clinical depression in the past, this was under control and not the reason for her absence. During this time she received constant phone calls from her line manager. She worked from home during this period of certified sickness absence. 'All I needed was a little support, they knew my history but they never took this into account. It is no wonder I fell ill, now I am depressed because of not working for so long.' Sally is still not well enough to seek employment. Although she resigned from her job she feels that it was more a constructive dismissal. 'This was nothing short of harassment.'

2.1.2 Others Involved in The Decision To Take Sickness Absence

For the majority of interviewees a GP and/or medical specialist are the only people directly involved in the decision to take sickness absence. Only in a couple of isolated cases do partners or other family members play a central or instrumental role in the decision making process.

> Cathy's husband Peter began to experience severe pain in his knees. His job involved long hours lifting and carrying heavy weights. His company i.e. his 'psychotic' line manager was not willing to alter his work schedule to make life easier for him. 'I could not bear to see him in so much pain to see him struggling and carry on with his job and at the same time cope with his psychotic manager. He began to suffer panic attacks and I decided enough was enough. I made him see a specialist – we were lucky at this time that we had private medical insurance. I went with him to the appointment. I urged him to take some time off work and he agreed – his knees were so bad that the specialist told him that he would have to have his knees replaced.

Audrey's husband Chris, was clear about the role he played in the onset of his wife's sickness absence. I could see that she was just taking on too much, that it was making her ill. With her history of depression I knew that if I did not put pressure on her she would soon be very sick. I tried to calm things down, tried to protect her take on more responsibilities at home but she just became more anxious. It was obvious that she could no longer cope but she was so worried about letting her patients and partners down, she is so professional that she just battled on. In the end I went to see her partners. They were very good and immediately took the decision away from her – they told her that she had to take time off.'

By definition all the absentees have consulted their GPs or a medical specialist in order to become certified sick from work. Some LTAs did confer with their workplace prior to taking sickness absence e.g. talking to their line manager or, in a couple of cases, an occupational health consultant. Mostly there was little active work place input, mainly they were advised to see their GPs.

The information gathered on the problems LTAs experience immediately prior to their absence – needs to be included. This list of information can be useful in developing 'signals for awareness of health issues'.

2.1.3 Summary

Typically the onset of LTSA for acute physical health reasons is sudden. The decision is made between the absentee and their GP or medical expert. Those with chronic physical health complaints talk about an irresolvable incompatibility between the demands of their job and their physical capabilities as being a contributory factor in their decision to take certified sickness absence.

The absence threshold for those with mental health complaints is high compared to those with physical health problems. Mental health problems can be exacerbated by a combination of workplace stressors, personal issues as well as the behaviours associated with the nature of their illness. However workplace issues alone e.g. issues with line manager, changes to working condition are often enough to bring about sickness absence. The point being personal issues can act as a catalyst but do not seem to act exclusively in the onset of LT absence for these absentees. Medical advice is only sought when mental health has critically deteriorated. Nearly all those with MH problems refer directly to their employers as being part of the decision making process.

Significant others have little if any direct input in the tenure of the absence threshold, although they provide much needed support in the decision outcome. The role of the GP is critical in advising patients on their fitness for work and the onset of certified sickness absence.

2.2. PREVENTION OF ABSENCE

This section describes factors, which might have prevented the period of sickness absence.

2.2.1 Physical Illness

For the overwhelming majority of those LTA off work for PH reasons, there was nothing that could have been done to prevent their sickness absence.

> For the past seven years Mary worked, part time, in a job she loved. Three years ago she discovered a lump in her breast but both her Doctor and her specialist assured her that there was nothing sinister. She remained at work, felt fit and well and never had a day off sick. Then suddenly she noticed that the lump had changed and she began to experience a great deal of pain in her arm. She returned to her GP and.'...from that moment on my life fell apart, I was diagnosed with breast cancer and within 3 days was in hospital undergoing major surgery.' There was no warning, one day she was at work and the next day absent.
>
> Her employers, a small company, offered her overwhelming support, her job was kept open indefinitely. When the interview was conducted, almost 18 months after her operation and extensive chemotherapy, she was returning to work albeit on a reduced number of working days.

On the contrary chronic ill health although not caused by work is often made worse by the nature of the job, such as the long hours spent driving, the lifting and carrying of heavy equipment, having to stand all day. Despite please to their employers the absentees believe that because no reasonable changes were made to ease the physical demands of their job their health worsened until they had no choice but to be absent.

2.2.2 Mental Health and Co-Morbid

For those who have MH or C-M sickness absence the story is different. In many instances the long term sickness might well have been prevented by prompt, early intervention; the majority of these sickness absences triggered by work place factors. People with MH problems seem reluctant to bring to the attention of their employers problems they are having at work. For those that do speak up, many do not seem to have the strength to pursue the issues until they reach their rightful conclusions, many feel that they are not listened to. Perhaps this is because for many their problems start with their line manager.

> For 20 years Ann worked for a family run retail business. As a manager she had a responsible senior position within the firm. Her boss was the owner. Two years ago her boss's wife began to work for the business. 'The husband and wife did not get on. They rowed and argued all the time, threw things at each other and made my life hell. One was always moaning to me about the other, blaming

me for their mistakes.' The situation for Ann was intolerable but there was no one she could turn to. Her colleagues at work began to leave, which meant an increase work load for her. She believed it was easier to keep quiet; it was obvious they were not willing or prepared to do anything to improve the situation. Ann's MH began to deteriorate. She went to her GP who prescribed medication which she decided not to take because they made her feel worse.

Seeing how unhappy and miserable she was, Ann's husband encouraged her to quit, but she felt unable to leave during the very busy Christmas period. 'I had a sort of misplaced loyalty to them despite everything; in hindsight I guess this was because I felt a failure for not being able to cope.' Furthermore she did not believe she would be able to get a job anywhere else because by now her confidence was destroyed, she had no self esteem 'I had been utterly destroyed.' Ann suffered a nervous breakdown, was signed off from work and eventually resigned from her job.

Others experience chronic workplace stressors over which they have no control.

Hilary was made redundant 3 times during 6 years. After each redundancy she retrained and got a new job. She had a past history of depression but this had not interfered with her life for years. However having been in her latest job for 2 years, a large national employer, the company underwent radical change, which led to office closures, redundancies and relocations. She was offered redeployment to a location 40 miles away. 'I liked my job; I enjoyed what I was doing. This was a big knock back for me and I never really got over it. I became depressed and took everything personally. I believed it was me they did not want, which I know sound so stupid but that is how I felt.' Hilary was signed off sick with depression, then they discovered she had high blood pressure. She decided to take redundancy. At the time of the interview Hilary still did not feel well enough to consider returning to work.

Many MH absentees feel that their period of absence was avoidable had they been consulted about their workplace changes, been listened to and treated with respect. A large part of absence prevention for those with MH problem should focus on early intervention, ensuring that there are systems in place to allow employees to raise issues that are troubling them, in a safe environment before their problems escalate; this is about effective management and communication.

John, despite a history of MH problems, John worked for 3 years as a cashier at his local county council offices. His symptoms were successfully controlled by medication; his employers were aware of his medical conditions. The conditions at work were tough, the equipment was unreliable, the computers regularly crashed (which meant everything had to be entered by hand and then later re-entered into the data base thus there was with a high probability of error) and he had to work in a bullet proof cubicle isolated from this colleagues. Finally the

council introduced a new intranet system which required instant responses to queries whether or not you were dealing with a customer. 'I never knew what each day would bring which was not good for me because I like having the security of routine. People like me do not like the unexpected. I do not like to be put under undue pressure because I know that I am not good at coping. This was a very busy office and I knew I could not cope with the pressures for long. I spoke to my line manager they tried to make adjustments but in the end they argued that the problems I was encountering were intrinsic to the job and there was nothing they could do – it was a question of liking it or lumping it'

Eventually the stress and the worry related to the job became too much, John did not want a sever relapse of his ill health – so he went to his GP and was signed off sick. He did not return to this job.

Hester admitted that with hindsight she was not best equipped to work in a pub where the hours were long, the job demanding, her boss unpleasant and the customers, especially after a few drinks, prone to aggression and drunken antics. She knew with her history of depression that she was vulnerable and one day after suffering verbal abuse from a customer she resigned from work never to return. 'My boss thought that mental health problems meant you were either an addict or an alcoholic. The thing is I knew what he was like before I took the job on – I was stupid really to put myself in this position, I knew that one day things would get out of hand and that would be that. This is exactly what happened.'

Neither John nor Hester returned to work for their previous employers. John is now happily working in a new job with a new employers; Hester is currently looking to to start afresh by moving to a different area of the country and has plans to embark on a college course.

The narratives suggest that MH & C-M absentees have a propensity to believe that they have a limited ability to cope with the demands imposed by workplace factors such as structural changes to job characteristics, interpersonal conflict and lack of control, Any form of social support from colleagues or management - might well have acted as a buffer against the negative consequences of stress.

Early interventions, redeployment, job redesign or sensitivity from line manager are proposed as measures that might have prevented the sickness absence. Although early intervention is ideal this can prove problematic because often the absentee does not want their workplace to know they are not coping. In many cases having clearly identified the source of their stress, employees find that their organisation is unwilling or unable to make any changes.

2.2.3 Comments by significant others on the handling of the onset of the sickness absence

Ryan worked for a multinational company. For 3 years he witnessed illegal activities at work by his line manager such as stealing, using company equipment for his own private work. He refused to become complicit in these deeds and as a result became the victim of harassment and bullying campaign. He resigned when the situation, which was making him ill, became in tolerable. His company did not want him to leave and asked him to explain the reasons behind his resignation. He told them everything.

After 3 months in his new job he was contacted by his original employers who invited him to return to work for them now that the line manager had been fired. He returned but the conditions of his employment had changed dramatically which meant that the structure of work was de motivating, de moralising, insecure and payment based on a bonus scheme no longer on a steady salary. He approached the management to tell them how unhappy he was because the conditions of his employment had changed so detrimentally. The management had nothing to say, nor were they willing to make any changes. Life became unbearable, his holidays were cut, he could not cope and he felt things were alarmingly out of his control, he was full of despair. His GP signed him off sick as he was suffering from anxiety and stress related depression. Since taking sickness absence his health has deteriorated dramatically and he has had no contact with this employers.

Ryan's partner Kate is not the only partner convinced that ill health resulted from work. Several believe that their partners were treated appallingly and that part or even the entire situation might have been avoided if only the employers had really listened, acted accordingly and changed the conditions of the employment.

'This entire mess, the life we have to lead now is their fault. I blame them entirely. Ryan was fine until all this happened – now look at us' (Kate)

Kim talking about her husband Michael, who was forced into early retirement having worked for 18 years as a primary school teacher, had this to say. 'From the moment the new head arrived I knew Mike was in trouble. This new head wanted to make radical changes and these changes would not include people as old as Mike. He wanted Paul out and made his life a misery. Gave him more and more work, constantly undermined him, and made life as difficult for Mike as he could. Paul was exhausted, his confidence went, his self esteem was none existent – life was unbearable. Yes, without doubt I blame his work; more specifically I blame that man.'

2.2.4 Summary

Nothing can be done to prevent absence for acute physical illness. Reasonable adaptations to the work environment might have helped those with chronic physical ill

health. For mental and co-morbid interviewees sickness absence might have been avoided with ongoing workplace support including early intervention. Primary interventions targeted at cultural change i.e. changing the very nature of the job such as improving communication and reducing job demands were suggested as suitable absence prevention measures.

There is a noteworthy lack of reference to any support received from colleagues, managers or employer representatives during the period prior to absence i.e. the absence threshold.

2.3 IMPACT OF ABSENCE

This section describes the impact of LTA on the lives of the absentees, and where appropriate, their significant other, children and/or dependents.

2.3.1 Finances

The financial implications of being LTA from work are paramount for the majority of the interviewees. Whether they are single, married, with or without dependents, off work for PH, MH or C-M reasons coping with a loss of earnings, is associated with practical and emotional negative outcomes; the two being inextricably linked.

> Rachel's binge drinking associated with her depression was getting out of control – she decided to leave work before she was, in her own words 'found out.' She was signed off work with depression; her alcohol problems remained off her sickness record. Rachel, who lives alone, was asked to talk about the impact of her absence on her everyday life. This is what she had to say with regard to the financial implications. 'I am off work, obviously not well trying to get better. The benefit money I receive is just enough to survive, not enough to live on. For example, I know that I need to eat healthily but I just can't, fruit and veg are so expensive, so I end up buying cheap crap: it is a vicious circle. I used to love a certain type of perfume, now all I can do is walk through the perfume section of department stores and spray some on there. I do not like having to struggle; it is humiliating, I have such little self- respect.'

Mathew was earning a 'really good, decent wage' as a subcontractor for a large building company when suddenly and avoidably he had to be signed off sick from work. Eventually, after months of tests and treatment, he was informed by the medical experts that as a result of his blood disease there was nothing that could be done now or in the future to restore his eyesight; he was registered blind. Mathew lives with his wife and two children. His wife, Tracy, talked about the financial implications of their new situation. 'Initially it did not really hit us, it was great having him home, like being on holiday. His employers were fantastic and we knew that he could go back, whenever – they had so much work for him. Now I have had to become realistic, we have had to make significant changes. I now work; obviously we don't go on holiday. Christmas was hard, especially for the children. The children have been brilliant, although I don't think the younger one really understands why she cannot have the same things as her friends. Although the children are now entitled to free school meals they won't let me take this up because it means having to line up for their lunch in a separate queue. I can't force this on them. It is really desperate at times making ends meet, I get angry and it puts such a strain on us.'

The narratives are littered with stories of the hardships imposed trying to survive on IB. Some interviewees talk about having spent all their savings, cashing in their pension and insurance policies. The interviewees talk about major changes to their lifestyles and the humiliation of having to rely on hand outs or borrowings from friends and family, including in some instances, their non dependent children. Many talk about the worry and feelings of helplessness associated with their inability to pay bills and anxiety with respect to their mounting debt. Significant others refer to the practical and emotional impact resulting from the sudden loss of income.

2.3.2 Emotional Health and Well-being

Many PH talk about a deterioration in the state of their emotional health using words like 'depression', 'miserable', 'despondent', 'unhappy' and 'helpless' to describe how they are feeling as their absence from work continues.

I feel such a loser.' (Katie)

I felt a burden on everyone but at the same time I felt responsible for everyone and everything. I feel a nuisance, worthless and I have no confidence' (Natalie).

Other negative emotions, such as anger, frustration, disappointment, embarrassment, resentment are also mentioned.

'The longer I am off work the more frustrated and angry I become. I am not getting

> any better, in fact as you can see, I am now bedridden. I am short tempered with everyone. I feel ashamed that I cannot provide for my family anymore. I feel that I have let them all down. The thing is what I can do about it – if I think about it for too long it makes me so depressed and miserable. I just can't see an end to it all.' (Frank)

> Things have worsened for me. I have become depressed and now have to take anti-depressants on top of everything else. I have always worked and provided for my family – I loved my job and earned a good wage. I worked long hours, often 6 days a week. To go from that sort of time commitment and money to nothing represents a huge loss to me – I have been really feeling it.' (Sam)

Much of the reported negative psychological effect appear linked to continuing ill-health; the longer a person is off sick from work for physical health reasons the more their mental health seems to decline.

Conversely, there are a handful of interviewees, off sick for PH reasons, who have a different experience. They talk about feeling relieved that they no longer have to face and cope with the pressures and stress of work. They talk happily about having time at home, seeing their families, taking up new interests and generally improving the quality of their lives. Not surprisingly many of these respondents have decided to take early retirement.

> Harriet has been on LTSA for nearly 2 years during which time she was made redundant from work. 'I have actually enjoyed being at home. I have worked nearly all my life and now I have had a chance to spend more time with my husband, play bowls, think about moving and take up new hobbies. If it wasn't for the pain in my leg (she broke her hip as a result of a fall), life would be just about perfect.' (Harriet)

> Hilary talked about being able to take up an art course 'This is something I have always wanted to do and I am enjoying it so much. It is a great opportunity to meet new people and get out and about.' (Hilary)

> Philip, after 27 years of loyal service was suddenly made redundant form work and as a result suffered from severe depression. 'Although I was not at my best there were some things I loved about being at home, especially seeing my children, taking them to school, doing their home work with them, having supper with them – these were things I was just not around to do when I was working.' (Philip)

Almost unanimously those sick with C-M reasons talk about the negative emotional reaction to being off work. Although the 'physical' symptoms of their illness might improve, this is at the expense of their mental health which worsens. Various emo-

tions merge into a general feeling best described as depression or psychological distress. The C-M respondents talk about now being treated for their depression rather than their physical complaint. They refer to a decline in their self esteem and self efficacy. Low-levels of self esteem seem to be associated with a lack of desire to pursue reemployment. Many respondents talk about feeling trapped, helpless to change their situation.

The story for MH patients is somewhat different. Mostly their job loss does not seem to aggravate the state of their mental health – probably because it was in a poor state at the start of their absence. For mental health absentees sickness absence seems to offer a period of respite. For this group of respondents workplace stressors are unequivocally cited as triggering the mental health illness. Hence it is understandable why many claim that they felt relief at not having to face these stressors.

> 'I can't describe the relief I felt waking up the first morning after I had been signed off knowing I did not have to go to work. For the first time in ages I was not overwhelmed with feelings of despair.'' (John)

Without the added complications of conflicting time restraints because of work commitments, many of those with addiction problems are able to successfully embark on treatment, counselling and addiction related programmes.

> By the time Charles was signed off he was 'in a bad way' but the fact that he was absent from work meant he was able to receive rehab much earlier than otherwise. He believes that things, including his health, improved over the period of his absence. He has had 6 months of rehab, 3 months of primary care treatment, been to a satellite home for recovering addicts like himself to develop their social skills, prepare them for community integration and confidence building. 'Because I was not working, the pressures in my life that were making me ill have gone. I could go to the clinic, to AA. I was now in control of my life – I had taken charge. My self esteem has improved and I am proud of myself.' I got better, I received fantastic care in the community and I got my life back on track.' Charles has returned to work full time running his own business designing jewellery.

> Hester talks about having lost nearly all of her 'self worth and self esteem' and admits to feeling inadequate and a failure and believes that she has yet to fulfil her potential. However she is clear that these feelings are for the most part due to the numerous 'hideous' jobs she has been employed in over the years. Her present period of sickness absence has provided her with a chance to re evaluate her life, to see her counsellor, regain her strength 'in fact, in spite of my poor finances, I actually feel better off, better within myself.'

To summarise, the onset of sickness absence is a bleak time; the absentees' first priority is recovery. By definition the fact that MH are on sickness absence means their

MH is in a fragile state – even at this early stage many MH realise that RTW to the same employer is unlikely but see work resumption as their goal. Many MH absentees talk about their distress lessening as the period of their absence extends. They view this time positively, as a time to recover, to receive appropriate medical care and re-assess their life priorities.

For PH and C-M absentees, the impact of being LTA is progressive. It is only when it becomes apparent that their absence is going to be prolonged does the negative impact on their psychological well being increase. Larger, negative mental health effects resulting from extended sickness absence for the PH and C-M absentees compared to MH problems were observed.

2.3.3. Self Esteem

As the duration of the sickness absence increases, levels of self esteem fall. The implication of being off sick, being on IB is a frustrating, humiliating time; this reaction is common to all absentees.

> 'It is not only the lack of money I find hard to cope with; I also feel that because I am not working that I have lost a part of my identity, that I am a nobody and have nothing to contribute. Why would anyone be interested in me?' (Sally)

2.3.4 Social Isolation

Feelings of isolation are commonly referred to as a negative impact of LTA; irrespective of whether the absentees live on their own or not. Many absentees miss the opportunity that work provides for social interaction outside of the home.

> 'I do not feel part of life anymore. I feel that not working means I have nothing to contribute to society to conversation. I feel completely cut off from the real world. There is such a void in my life.' (Sally)

Bert worked for the same employers for over 30 years. This was a physically demanding job and when his knee began to deteriorate and cause him great pain he knew that he could not continue to work for much longer. He had no idea how long he would have to wait for a knee replacement operation.. At the same time the company lost a major contract and the majority of the workforce faced redundancy. Bert was asked to stay on as he had such experience and knowledge of the company. The fortunes of the company continued to decline and eventually it had to close. In fact for Bert this was in some ways a blessing in disguise; his knees were now so bad that he was happy to be made redundant.

Bert had this to say about the impact of being LTA. 'I live on my own; I really miss going to work because I hardly see anyone now. My colleagues at work were my friends too, we used to go out together, go for a drink on a Friday. I lost more than just the money when the company closed. My knees meant that I could not drive to see anyone; I live a very quiet life and would like to have a chance to be part of life again.'

Adam's wife Fiona took an early ill health retirement package. This is what he had to say about his wife's present circumstances 'She has no life now, no interests. I hate to see her sitting here day after day never going out. I go out with my mates after work sometimes I feel guilty as I am having a good time and she isn't but on the other hand I have to have a life too. I worry about her lack of social contact; it is so frustrating. I really want her to get some part-time work but I doubt I will be able to persuade her.'

2.3.5. Impact on Partner

The stories regarding the impact of their sickness absence LTA on their partner were diverse. Many with PH acute or life threatening health problems talked about their experiences in terms of the support and caring they have received from their partner and of a strengthening in their relationship. They talked about how much they enjoy each other's company and were grateful that their period off work has given them a chance to be together. Some MH absentees feel that their partners were relieved to have them at home rather than at work.

'Although I was not in a good state when I finally went sick from work, I think that Kim was relieved to have me at home, where she could keep and eye on me. It was one less thing for her to worry about – it was like things were getting under control again. I admit to being pretty useless in the beginning but now as I get better, it is so nice to see her smile and laugh again. It was too much for her when I was so unhappy.' (Paul)

When health problems are less threatening, the tone of the stories suggest strain and tension.

Hilary had to undergo three operations in 2 years for different medical conditions. Although her job was kept open, this was a small company who could not really afford to have her job filled by part-time temporary staff. When she realised that there was no chance of her returning to work in the foreseeable future she decided to resign. She has been off work for nearly 2 years. 'I think my husband is pretty fed up with me now. He has had to increase his hours at work, do the shopping, look after our little girl and generally run the house. I feel guilty that I am not doing my bit am not able to contribute to the household either financially, emotionally or practically. He has not said anything but I know that this whole situation is putting a real strain on our relationship both emotionally and physically.'

The impact of their partner's sickness absence often means a dramatic life-style change as they i.e. the significant other, become the sole bread winner while, often, at the same time having to become the carer for their husband/partner/wife and juggle the normal demands of domestic life.

Kate, Ryan's wife explained what it has been like for her since Ryan went off sick 'There has been so much tension between us. He is bored, depressed, fed up and angry with everyone – as I am the only person he sees, I am the one he takes everything out on. So I have to put up with his crap, I need to go to work, which he resents. We have no money and we are reduced to relying on hand outs from our families but I can't leave him on his own. He needs constant care and attention; I do love him but it has been tough.' (Kate)

He is jealous that I go out to work, he would love to be able to work again and misses all the contact he had at work. Sometimes I get back from work and he demands his dinner and generally makes my life miserable. It isn't like I necessarily wanted to work but now I am glad I do because it gets me out of the house and away from him. Now that he is able to be involved more in the business things have got better.'' (Kim)

2.3.6 Workplace support

Mostly there seems to be little if any contact or ongoing support from the workplace during sickness absence – for many the only contact they have had was solely to inform them that either they were to be made redundant, to be offered early retirement or they were asked to predict when they were likely to return to work. Apart from a few isolated cases, contact from their employers was described as nothing short of harassment and consequently being detrimental to their health.

'He rang me all the time. He knew that I was not well; he just would not leave me alone. He was rude and aggressive to me over the phone and wanted me to carry on working, albeit at home, even though I was on sick leave. He kept asking me when I was going back, how

much longer I would be off.. The crunch came when he actually gave some reps my address and told them to come and see me at my house.' (Ann)

I have not received any support from my line manager. When I was at home he started to call me being abusive demanding I worked from home chasing me for deadlines. I was badgered constantly had unreasonable demands placed on me and when I tried to explain why I was not able to do this or that he just swore down the phone. In the end I had to refuse all contact with him as the pressure was making me ill. (Peter)

Within two weeks of starting a new job, Shelly's husband suffered a major heart attack leading on to heart bypass surgery. If this had happened while still working for his previous employers (where he had been employed for 18 years) he would have been entitled to generous benefits and support; in the event he was not eligible for any company financial entitlements. His new employers kept his job open and after 15 months off work, he did return. However there was no graduated return or reduced hours, from the moment he resumed work he was expected to travel long distances and work long hours. It did not take long for him to realise that he was not able to cope physically and mentally with the demands of his job; he had not choice but to leave. 'We knew he was taking a risk health wise returning to work but someone had to pay the bills, and the money from my part-time job came no where near.'

Some interviewees had positive experiences.

Mary, was working as a shop assistant for a small local boutique selling designers hats, when she was diagnosed with breast cancer. She went off sick for the duration of her treatment. She has returned to work part-time for the same employers. Talking about the support she received from her colleagues she had this to say. 'They were fantastic, so kind and supportive. They even arranged a rota of people to take me to the hospital for my treatment so that my husband did not have to keep taking time off work. I could not have got through all this without them – they have been wonderful.'

Lotte had been suffering with a chronic painful illness since her teens. For many years it has been kept under control. Her employers were fully aware of her health problems. However her illness is susceptible to and aggravated by stress. Her job which she loved involved long hours managing a large number of people and constant deadlines. 'It was a really tough job but I was so involved that I did not realise that I was making my self sicker and sicker – one day when I literally could not move, I realised that something was seriously wrong with me.' Her chronic debilitating physical illness led to a decline in the state of her mental health. Over the past 3 years Lotte has had to take sickness absence from work many times for extended periods. 'They have been fantastic, they have been so supportive, letting me work from home, allowing me to return to work on a gradual reduced hour's basis. I have had private medical health care; they have done everything they possibly can to help me; they even bought me a really expensive specialist chair for me to use at work.'

2.3.7 Impact on children

Eight interviewees had dependent children. Their parents spoke sadly about their children not being able keep up with the latest trends, fads and fashions. They talked about having meagre Christmases and birthdays. Many explained that they had gone to great lengths to maintain normality at home making sure that their children remained unaffected, ignorant by their family's financial downturn.

> 'The kids have been great but I know that they look at the brand new things their friends bring to school which they would like but know they can't have at the moment. Because of our circumstances they became entitled to free school dinners but they begged us not to make them take this up because they would have had to stand in a separate dinner line; they did not want their friend and class mates to see them.' (Tracy)

> 'It is the christening of my first grandchild in a month's time – I really want to be able to buy something really nice but I just don't have the money at the moment.' (Shelly)

Generally, it seems that older children were not affected by their parent's sickness absence.

> 'The only thing my son was concerned about was how this would affect his life at university, which of course it didn't.' (Chris)

Some interviewees referred an unexpected positive impact on their relationship with their children as a result of spending more time at home. They talked about how much they enjoyed seeing their children, being able to collect them from school and help with the homework.

2.3.8 Summary

The experience of LTA is associated with negative impacts on the mental health and wellbeing for the majority of the absentees and their significant others; the size of the negative effect varies between the groups of absentees. The financial implications resulting from the loss of income dominate the narratives.

Many respondents talk about feelings of isolation and a loss of meaningful purpose or goals in their lives. They refer to a loss of status and identity; reaction to sickness absence is influenced by many factors. Social support and individual differences appear to mediate the experience and impact of LTA. There are generic differences between and within the groups of absentees. PH and C-M absentees refer to a decline in their

mental health as the tenure of their absence increases, whereas some MH patients talk about positive reductions in their levels of distress as a direct result of having time off work and being able to receive proper and appropriate medical intervention.

2.4. WORK RESUMPTION

This section of the report describes the findings relating to the process of work resumption including factors that are hindering a return to work and the factors that facilitated a successful return to work.

From this sample twelve interviewees had returned to work. Only one LTA had returned to work for the same employer, the others had new jobs and new employers. Six were employed full time; the remainder were working either on a therapeutic or part-time basis. Nine who returned to work had been signed off sick with MH problems; one had been off work for PH problems and two for C-M problems. There is no notable difference in terms of marital status, being with or without dependents relating to those who return to work and those who do not.

2.4.1 Factors Inhibiting Return to Work

Once a period of sickness absence commences a number of factors, including finances, feelings of job satisfaction, lack of interest for the 'sick' colleague by colleagues and managers, ageism and a deterioration in mental health, influences both the duration of sickness absence and attitude to work resumption. Many of those who have not returned to work at the time of the interviews expressed an intention to return; work resumption is viewed positively.

i *Termination of original employment*

During their sickness absence the majority of LTA's have chosen to permanently exit the labour market. For many the choice to return to their previous job is not an option because:

1. They have resigned.
2. Taken early retirement on the grounds of ill health
3. Their employment has been terminated by their employers as they are unable to fulfil their contractual obligations.
4. They have been made redundant.

> Frank has been bedridden for the past 4 months having been absent from work for nearly 18 months as a result of two prolapsed disks. He briefly returned to work a year ago but this only lasted for 3 days. His job as a car mechanic requires mobility; his level of fitness is poor and being in constant pain means he is unable to cope with the demands of the job. His job was kept open for 4 months and his line manager kept in regular contact. However this is a small company who simply

could not afford to employ someone on a temporary basis to do Frank's work - indefinitely. As his health continued to deteriorate he was told that he needed a major operation but that he is not fit enough to undergo surgery. So he is not able to give his employers any indication of when he will be fit to return to work. Not long ago he received a letter terminating his contract of employment on the grounds that he is unable to fulfil the contractual obligations and the conditions of his employment.

ii *Stressful Conditions of Past Employment.*

Many MH absentees resigned from their jobs to avoid returning to the very environment they believed caused their illness.

Jane's job involved dealing with members of the public. A very stressful job. The company experienced major change, restructuring, reallocating and reshuffling 'they change my hours without telling me, increased my work load without talking to me and set unrealistic targets, there were so many additional things that kept putting me under further continual stress. We all worked in isolation; there was no one to talk, not that anyone would have listened. I knew with my history that I was vulnerable.' It was not long after her hours had changed and increased that her health deteriorated. She went to her GP who signed her off sick with depression. After further discussion Jane and her GP decided that it was best that she did not consider returning to this job. 'The management were unapproachable; the changes and conditions at work were non negotiable There was no point in even considering returning'

Jenny worked in a special school for children with severe and challenging behaviour. She was highly experienced and a valued member of staff. Two years ago Jenny returned from holiday to face allegations made by a colleague of gross professional misconduct. The allegations were made through official channels which meant they had to be dealt with at an official hearing. Jenny had to wait 8 weeks for the court hearing during which time she worked under constant supervision. She was completely exonerated of all charges her reputation remained unsullied and there was no listing in the official records. Her employers were delighted and expected her to return to exactly the same job working alongside the very colleague who had falsely made these accusations. 'I loved my job. Even though I would often come home from work covered in scratches and bruises, there were nothing else I would have rather been doing. This entire incident has been horrendous. This colleague was someone I regarded as a friend we use to socialise together. It was like having my life taken away from me; I collapsed and could not stop crying. I caved in on myself. I felt that I could not trust anybody. I went to my GP and was signed off sick – there was no way I could return and work alongside that person. They could have easily offered me a different position. I have since been seeing a psychologist who has given me the strength to move on which does not mean exposing myself to the same situation that caused me all this distress in the first place. I am not sure I will ever get over it.

iii *Early Retirement*

Some LTA for PH reasons found their new 'job-less' way of life a blessing in disguise, a chance to have a complete break and a change in lifestyle.

> Harriet suffered a complicated fracture of her leg and hip as a result of a fall. She had worked for 17 years in a job that was challenging and rewarding. During her absence she learnt that her employers were making cuts within the organisation and proposing a series of redundancies. 'It was at this point I realised that actually, despite the fact that I was still in pain and not recovered from my accident, I really liked being at home. I enjoyed seeing my husband and enjoyed taking up new hobbies.' Harriet decided to opt for redundancy rather than return to work. Although still not fully fit she was thoroughly enjoying her new found freedom and 'life of leisure.'

Others were attracted by early retirement packages.

> Fiona worked for a large national company. She suffered from osteoporosis in her knee which led to a knee replacement operation. Her recovery was not good and she suffered many complications, thus prolonging her period of absence. Although she wanted to return to work, her employers were not able or willing to redeploy her in order to accommodate her physical needs. After discussion with both HR, occupational health, Fiona was offered an early retirement package which the company rushed through in less than 2 months.

iv *Lack of organisational and societal support*

Many of the LTAs commented that they had had no contact from their employers during their absence. A lack of willingness on the part of the employers to actively promote work resumption for those employees who have been long term sick by, for example, making appropriate work place adaptations, is for many a barrier to resume work. Participants talk about feeling abandoned and trapped in the benefit system. As a result of being out of work so long, many LTAs felt that they were lacking in confidence, vulnerable and in desperate need of support and guidance before commencing the process of work resumption.

v *Financial Considerations*

The structure of the benefits systems in the UK means that for many absentees work resumption, particularly if part-time, would leave them in a worse state financially. Social security arrangements influence the work resumption threshold in that they can reduce the impact of financial incentive associated with work.

> 'It is a ridiculous situation, I have been offered part time work but I can only take this on for therapeutic reasons. I have reached a point where I would like to take on more work but actually I would lose out on so many benefits and other forms of support that it is not worth my while. The thing is I really want to go

back to work but I know that I have to do this gradually.' (Natalie)

Many commented that they cannot afford to look for work e.g. pay their travel expenses, or attend an interview e.g. how would they pay for a new suit. Furthermore even if they were successful in gaining employment they do not know how they would survive the period between the end of their benefit and their first pay packet.

vi *Health*

Many PH LTA's remain 'sick', unable to meet the physical and psychological demands of a job. Some off work with PH illness expressed feelings of frustration at the lack of control they seemed to have over their situation. Mentally they claim fitness to work but remain physically not. Their future lies with successful medical intervention; in the meantime many feel powerless to do anything to promote the work resumption process. MH absentees do not seek to blame and appear quite candid about the state of the mental health. Many participants admitted feeling better but not 'fit' enough to work.

vii *Stigma*

PH, MH & C-M absentees are worried that their medical history will be detrimental to their employment prospects.

The sudden onset of epileptic seizures was the first indication Simon had that there was anything seriously wrong with his health. He has recently been diagnosed with a brain tumour. Simon worked as a scaffolder on building sites. 'The longer I am off work the more frustrated bored and depressed I become. I would dearly love to go back to work but until I get the all clear from my Dr's then there is no way anyone is going to employ me with my history as I am a total liability.'

viii *Worry*

Many absentees displayed elements of negative affectivity with regard to work resumption. The narratives contain cynical ruminations about why they cannot return to work, why no one will want to employ them, the problems they might encounter should they be re-employed, and anxiety that history might repeat itself.

'Why would anyone want to employ me now? I have a medical history; I am probably too old now to try something new, I don't really know where to begin. I am worried that I might encounter the same problems I had before – I think that the chances of being reemployed are slim.' (Hilary)

'At the moment there is no way I can go back to work, I cannot face having a boss again. I cannot risk exposing myself to the same type of situation or circumstances again – it would probably kill me.' (Ann)

ix *Job Availability*

Many commented that they there were no job opportunities for them. They feel that there is a mismatch between the jobs available and their skills, experience and qualifications.

x *Ageism*

A number of respondents felt that their age was a barrier to work resumption. They believed that their age would be viewed unfavourably by future employers who would be reluctant to employ them based on the assumption that they would not be a worth while investment, prone to sickness absence or not able to learn.

xi *Confidence*

Low levels of confidence were referred to as an obstacle to work resumption. For those who have been out of labour market the feeling of detachment or isolation adds to their doubts about their employability and in turn this seems to dampen their motivation to search for a job.

xii *Influence of significant others*

Kate's husband Chris definitely does not want her to return to work because he does not want her to be exposed to any stressful circumstances. He believes that she cannot cope with the inherent stressful nature of her job, if she were to return, even part time it will not be long before she is ill again.

Conversely there was an element of social undermining. Many partners felt that their partner would not be able to get a job for any number of reasons e.g. they are too old, too ill, not skilled enough, have nothing to offer, are not able to learn new skills, or are just generally unemployable. Some blamed more global issues such as poor economy and unemployment issues for their low expectations of their partners work resumption prospects. Such undermining seemed to fuel a self fulfilling prophecy that their partners are indeed unemployable. This attitude seemed to hinder even deter the efforts of their partners to find a job.

2.4.2 Factors that Facilitated Return to Work

i *Health*

The primary factor coinciding with the initiation and pursuit of work resumption is a return to normal levels of physical health and/or mental health. Recovery from illness seems to bring about a positive and optimistic view of the future including thoughts about re-employment.

> 'It was such a relief to feel normal again. I felt so much better about everything; the first thing I had to do was get back to work, back to normality. As much as I enjoyed being with the kids, I still felt that not working was such a big hole in my life that the only thing I could do was to get back' (Philip)

Medical confirmation that an individual is fit and able to return to work is generally the first step in work resumption.

ii *Individual Differences: Self-esteem & Self efficacy*

The participants who were successfully reemployed display favourable self-efficacy beliefs and high, yet, realistic levels of self-esteem.

> 'I was fully aware of my limitations and my vulnerabilities but I also knew that I was a good worker with plenty of experience. As long as I took on a job that was within my capabilities, I knew that I would be successful and that my employers would be happy. I felt so much better and in control, there was nothing to stop me getting a job.' (John)

Furthermore self-efficacy beliefs seemed to influence the participant's determination to overcome obstacles and barriers in pursuit of re-employment. These participants invest a great deal of effort and perseverance to attain their goal.

> 'I was determined not to give up or be put off if I was rejected – I think this is where my counselling has helped. I was so determined to move on – I knew I had the skills and could do it. That is why it has taken me a while – but here I am running my own business, really happy and feeling the best I felt for a very long time.' (Charles)

Individual characteristics appear to have a considerable moderating effect in the successful outcome of the work resumption process.

iii *Positive Attitude and pre-employment schema*

Some participants viewed their future prospects positively, determined that past adverse job experiences would not bias their attitude or expectations towards future, new, employers.

> Jenny, who was falsely accused of gross misconduct at work, explains this well. 'If I had gone back to work thinking that my new employers were going to behave like my old ones then how would that have worked out? I had to put this behind me and move on. I had to be positive, not cynical, and trust that would be decent and treat me fairly. Which of course they have – I love my new job and being able to work again. If I had not approached my new job with this positive outlook then my old employers would have won the day – I could not have that.' (Jenny)

iv *Social Support*

Many absentees who had returned to work (bear in mind that these are mostly MH absentees) valued the tangible support they have received from their community both formally via medical support and groups such as AA and drug rehabilitation programmes and informally via their church community or families throughout their absence and during the process of work resumption. Overwhelmingly this was portrayed as positive and something which significantly contributed to their reemployment.

> Bill, has a history of serious mental health disturbances, was sectioned as a result of a catastrophic mental break down. He now works part time and is also studying for a degree. He knows that he would not be where he is today without the help and support of the mental health team, his GP, his personal tutor at University and boss at work. 'Everyone knows my history; they are all here to help and take away any unnecessary worry I might have. Although I am better, I know that I am vulnerable, the support I have access to keeps me on track and has helped me to get my life back on track' (Bill)

Ongoing medical and therapeutic support for those with a history of Mental Health illness is paramount in 'getting back to normal' (Bill).

> 'I have had fantastic, ongoing support including financial and legal advice about setting up my business. I receive advice and bonuses for staying at work. With this and my GP's input I have returned to normal, people keep their eye on me and was not lost in the system. I have received practical advice, been sent on courses which has helped me build my confidence and had really motivated me to believe in myself that I can do this.' (Charles)

John talked about a local charity specifically designed to help those with mental health problems get back to work.

> 'They helped me with writing my CV, set up mock interviews, contact local employers on my behalf, helped me with travel costs, they even bought me a new suit!' (John)

v *Realistic Expectations*

Having realistic expectations about their employment prospects was a factor that helped many gain employment.

> For example, Bill felt that working part-time in a local supermarket was the perfect option for him because he knew that it would not present him with any new challenges that 'were likely to freak me out' (Bill). He felt that it was best to

start small and work up in terms of hours and job role and as a result feel positive that things were seen to being moving forward.

Philip knew that the job he took on would probably mean that his skills were under utilised. However he explained that he did not know what it would be like for him returning to work after being off sick with depression. 'I felt that it was best that I tried things out to see how I got on, it is different to what I have been used to but then again I'm a different person now too.' (Philip).

vi *New Beginnings*

Future situations that might have negative associations or where there might be a 'history' with regard to their medical record were avoided, particularly for those where work place triggers were cited as the main catalyst in the onset of sickness absence. The majority of those who have returned to work have started new jobs with new employers often in completely different job roles.

Alice returned to work having suffered a nervous breakdown caring for her terminally ill mother and working full time. Having recovered she was determined to go back to work and initially found a job as a carer. 'It did not take me long to realise that I had made a big mistake, I had put myself right back into the same situation that made me ill in the first place. It was awful, my fault completely.' Alice left this job after 3 months. She found another job and is now working full time in a completely new career as a professional seamstress.' I have never been happier, I feel as if I have been offered a new beginning, a chance to put the past behind.'

Molly, was working full time as a contract manager for retail outlets, a very stressful job, when she was diagnosed with diabetes. 'This came out of the blue; it was such a shock. I did not handle it very well and became anxious and depressed. I could not handle the pressures of work and this.' Thanks to the support she received from her GP and local community diabetes nurse, Molly learnt how to manage her diabetes and received counselling to learn how to deal with the negative impact of her illness. 'My physical and mental health went hand in hand'. After 4 months she was ready to go back to work 'I wanted to keep active, and get back.' She decided to apply for something completely different. 'Although I was better and my old company wanted me back, I was not ready to return to the same stresses and pressures. I wanted a job with no stress to see how I got on. My line manager understood and said that I would always have a job with them. So that left me free to do whatever I wanted.' (Molly)

Work resumption is viewed as a chance for a new start and a new beginning.

Michael left teaching forever and now works full time running a holiday letting and Bed & Breakfast business from home. Sinead, who suffered from post natal

depression, returned to work as a swimming instructor having worked for 15 years in catering. Jane is now designing websites having worked for a local newspaper.

vii *Graduated Return*

Only one absentee returned to work full time from the outset of work resumption. The remaining absentees returned to work part-time with reduced hours, gradually building up as both their confidence and health continued to improve.

viii *Latent and Manifest Benefits of Work*

The latent and manifest benefits of work provide a hugely influential motivating drive behind the pursuit of reemployment. Interestingly it is not just the financial implications that the participants talk about, they also refer to wanting to return to the normal world, wanting to feel good about themselves, to have something 'to hang the week on' (Jenny).

ix *Workplace Support*

Two absentees enjoyed constructive and helpful contact from their employers (both working for smaller companies less than 200 employees) during their absence which they suggested made them feel valued as an employee and enhanced their perceptions of job satisfaction; instrumental in their decision to return to their previous job.

2.4.3 Impact of RTW on Family/Significant Other

Apart from the obvious financial improvements work resumption seems to make little impact on the family unit of the absentees. Significant others of those who had returned to work were not available to be interviewed.

2.4.4 Summary

Many respondents felt so detached from the labour market as a result of their period of joblessness that they have come to believe they face significant obstacles apart from their health, in returning to work. Many felt trapped in the benefit system; their perceived future employment prospects, bleak. This is compounded by the fact that firstly, vocational goals are not a key element of the healthcare or benefit system and secondly, many employers do not have policies or best practices in place to proactively manage sickness absence. Access to any form of occupational health expert was rare.

Mental health absentees make up the majority of those who have successfully returned to work. These absentees respond well to effective support and medical intervention. Work resumption i.e. the termination of sickness absence is influenced by many factors. Recovery from illness from either a medical point or a personal point of view is

important with respect to work resumption. The decision to return to work is initiated in the first instance by the absentee and then proceeds with the support of others such as medical professionals, the community or their families. GPs are not best placed or qualified to offer advice or to be involved further in work resumption other than assessing fitness for work.

The most common employment scenario for work resumption is to work for a new employer often in a completely new field of work. The rewards of reemployment extend beyond the obvious financial improvements. Work is viewed as the ultimate goal to mark a return to normal and healthy levels of functioning.

2.5 Rehabilitation

Participants were asked to describe any return to work, rehabilitation services, programmes activities they had been offered or undertaken since becoming absent from work.

Mathew was the only PH absentee (onset of sudden blindness) who took part in a rehabilitation programme; the content of which was designed specifically for the blind. It seems that there is limited access or availability to employment programmes or rehabilitation support for those who are sick with non serious physical health problems.

Many MH absentees have been offered and successfully taken part in ongoing support, rehabilitation and employment programmes. Those with drug and alcohol related problems took part in support groups organised by their local community health centres such as AA. People with depression, found counselling as well as CBT (cognitive behavioural therapy) helpful.

> 'If it had not been for the fact that my specialist Diabetes nurse was also a trained counsellor, I am sure that I would not have been fit enough mentally to take up the challenge of getting better and returning to work. (Molly)

Charles, Bill and John benefited from the services of voluntary organisations whose aim is to help people get back to work after mental health illness. This support is active and ongoing even after work has been resumed. Others had benefited from employment programmes offered by their local job centre designed to retrain and reintegrate them back to work.

Many participants talked enthusiastically about the support and help they had received from their church. Although strictly speaking the church is not a community service or programme, it does seem to provide a vital and realistic form of social support, both emotionally and practically in the lives of many who would otherwise have remained in social isolation.

> ‘My friends from the church have been fantastic. They have supported me and kept me sane. I do not know what I would have done without their fellowship or my faith to sustain me. How do people cope without having faith and the church? (Penny)

> Jane now works for a Christian Charity. ‘The money is not important to me, my faith and the rewards I get from my job matter more then what I am paid. I thank my friends in the church for the fact that my life is back on course; they are the ones I thank. I would not be where I am now without them.’

Some people create their own therapy or rehabilitation such as keeping a personal diary to record their experiences, thoughts and feelings. Others have taken up new creative hobbies such as painting or card making. Some have embarked on educational programmes, for example, Tim retrained to work in IT, Bill has gone back to University, Ed has gone to college and Emma is doing a course to learn to design web sites. Others do voluntary work such as working for Citizens Advice Bureau.

2.6 GENERAL COMMENTS

The interviewees were invited to comment on any other issues either related to their experiences or about changes in society such as new technology, work-life balance, changes in their quality of life and the impact of these generally on levels of absenteeism. They were also asked about the main factors related to absence in their workplace.

Many interviewees declined to comment further.

The following is a summary of their responses:

- The Benefits system is designed to leave people in the system rather than encourage them back to work. The financial implications of the benefits system are viewed as a major obstacle to work resumption.
- Access to benefits system is described as complicated; time consuming, distressing, degrading and exhausting. Benefits are often paid in arrears heightening the distress of those who are already vulnerable and suffering both emotionally and financially being absent from work.
- The stigma towards mental health was an issue raised by many absentees. Many employers are ignorant or display stigmatising attitudes towards people with mental health problems. Those who declare mental health problems at work feel they are discriminated against. There is little awareness of mental health issues at work. This is viewed as ironic bearing in mind that for many respondents work related stress is the root cause of their mental ill health.
- Employers i.e. line managers are ill equipped to manage or prevent long term sickness absence. Generally there seems to be a lack of people skilled enough to effectively handle long term sickness absence and facilitate work resumption.

Many employers seem to offer early retirement deals or terminate a contract of employment, rather than actively facilitate work resumption.

- There seems to no effective or on going support to help people find work. People on IB do not seem to be aware of or how to access re employment programmes.
- The media portrayal of those on IB as 'malingerers' is distressing. The media attention is viewed as detrimental to those on IB because they believe it contributes to the discriminatory attitudes of future employers employing those with a medical history of long term sickness absence.
- It is a substantial waste of resources including knowledge and experience to leave people in the IB trap. Employers need to be encouraged to make changes to the workplace be it changes to working hours, the organisation of work, job content or even redeployment in order to provide a suitable and healthy environment for employees. This will help employees to utilise their skills and abilities and allow them fulfil their potential.
- Increase knowledge and awareness of mental health issues in the workplace.
- Increase in knowledge and awareness of the detrimental impact on emotional health and wellbeing of those on long term sickness absence.

SECTION THREE
DISCUSSION AND RECOMMENDATIONS: TOWARDS A THEORY OF ACTION

In order to help make sense of the research outcomes and to bring a sense of credibility to the findings and interpretations, the results are now discussed in the light of and compared to relevant existing research; this comparison is not intended to be exhaustive.

The findings from this research suggest that the experience of sickness absence differs greatly according to the reason for and the consequences of the absence; sickness absence and the process of work resumption appears as a multi factorial phenomenon. Worryingly, for many, the experience of sickness absence is associated with worsening mental and physical ill health. Despite a desire to return to work many absentees perceive a range of obstacles hindering this process. Family responsibilities i.e. significant other and/or dependents do not seem to directly influence the decision to start or terminate sickness absence. Although GPs play a critical role in the start of any certified period of sickness absence they are not necessarily experts in or integral to, the process of work resumption.

In the face of much evidence that GPs are either too busy or insufficiently trained to recognise that it is better to stay in work, David Blunkett (UK Work and Pensions Secretary speaking ahead of the governments green paper on welfare reform) said 'Once people are put on sick, they tend to stay sick. We need to persuade GPs it is in the interest of the patient, and not just in the interests of the state or agencies, to help them.' (The Guardian, London, August 11, 2005

3.1.1 Absence Threshold and Prevention

Absence for certified, clear cut cases of physical medical incapacity is unavoidable and the threshold low. Absence for C-M and MH reasons is not so clear often the absence threshold is high; these absentees often stay working when not well. C-M absentees tend to use their physical complaint to legitimise the onset of their sickness absence; chronic PH conditions exacerbate poor MH. However each C-M absentee admits to psychological distress and emotional problems. Thus it remains unclear whether the psychological distress precedes or follows the diagnosis of the physical symptoms and the ensuing period of joblessness.

Somatization (a denial of the significance of psychological distress) is not new to the psychological or medical literature. These narratives reflect past research findings which conclude that many patients have difficulty or may hesitate to disclose psychological symptoms for a variety of reasons, such as feelings of embarrassment, feeling that the problem is trivial or for fear of stigmatization (Cape & McCulloch, 1999) or to

avoid emotional expression or behaviour that could possible be perceived as pathological in order to remain socially acceptable (Kinman & Jones 2005).

Workplace stressors play an integral role in the onset of MH sickness absence. The concept of stress cannot be ignored when talking to the MH interviewees about their experiences. There is a common tendency to attribute the onset of their present illness to stress – more specifically defined as intolerable work demands characterised by a feeling that they can no longer cope, heightened by a lack of support at work both socially and in terms of resources. It is not unreasonable to suggest that for some absence is the only way to cope with the excess of demands and problems they are experiencing at work.

**** These findings lend support to Harkness, Long, Bermbach, Patterson, Jordan & Kahn (2005) who suggest that the language of stress provides workers with a socially acceptable label to talk about negative feelings or discomfort thus silencing any talk that might run the risk of being perceived as a weakness by others or being labelled as 'mentally ill.' The absence threshold for MH absentees is high and the absence often avoidable. The lack of understanding, respect, compassion or effective communication blamed for the deterioration of their working relationships and levels of job satisfaction.

The experiences of the absentees highlight a dearth in organisational knowledge about how to manage negative emotion i.e. 'stress', at work. Psychological theories of stress all seek to explain how stressors at work may produce a variety of negative emotions and in the long run impaired health. There has been much debate about the usefulness of the concept of stress (Doyle, 2003) and there is little doubt that the notion of coping resources is critical to the outcome of any 'stress' reaction. Any number of negative emotions, such as depression, burnout psychosomatic complaints and impairment of physical health (to name but a few) constitute a major feature of stress (Gaillard & Wientjes, 1994). Empirical evidence from past research suggests only a weak association between psychosocial stressors and health complaints because research is complicated by a range of dispositional and individual differences that may impact the relationship between stressors and strains (Jones & Bright, 2001). Nonetheless job characteristics such as long working hours, job insecurity, training inadequacy, low levels of job autonomy, increased workload i.e. 'occupational stress' leads to a wide range of negative outcomes. Steers & Rhodes (1978) model of sickness absence remind us that there is clear evidence that company and organisational factors are of significant importance in explaining sickness absence.

The need to be heard, improved communication, respect and even compassion in the workplace were suggested as simple solutions to alleviate problems at work; hence the recommendation for primary interventions, that is interventions directly aimed at the

culture and climate of the organisations to reduce potential stressors at their source, reduce anxiety and increase perceptions of social support and thus facilitate a change in employers views and attitudes about how they can help and support their employees.

3.1.2 Impact of Absence

It is clear from the narratives that a period of joblessness resulting from LTSA harms the health, psychological well being and self esteem of the absentee and is associated with negative social and psychological effects for their families.

Financial strain is the first, foremost and enduring consequence of leaving work and moving onto incapacity benefit. Financial strain is a multi-dimensional construct and is quite different to chronic poverty. It brings about a spectrum of deprivations ranging from a lack of resources to meet basic needs such as food, shelter and heat to the loss of less essential material resources (Price, Choi & Vinokur, 2002). Maslow's (1954) classic need theory helps us to understand the observed negative affect on mental health brought about by a downturn in financial fortune. Maslow (1954) supposes that people have 5 types of needs that are activated in a hierarchical manner, a lower-order need must be satisfied before the next higher order need is activated. Physiological needs are the lowest-order most basic, vital needs and refer to the need for food, air, water and shelter; if a need is not satisfied then it generates tension and a drive to act, until that need is satisfied. Money is the obvious route to satisfy the basic and in fact it has been argued potentially all the hierarchy of needs; the more fundamental the deprivation the more substantial the impact on mental health. Hence a loss of income, financial strain, a lack of money affects subjective well being through its potential to allow an individual to purchase goods and services to enhance ones life and provide pleasure (Warr, Butcher, Robertson & Callinan, 2004).

Much of past research is devoted to highlighting the critical role played by financial strain when talking about the experience of joblessness including Fryer's (1986) agency restriction model. Critical of Jahoda's Latent Needs Theory, Fryer (1986) argues that a loss of income is the main negative consequence of being out of work and plays a more important role in the decline of wellbeing in the unemployed than the loss of latent work benefits. Creed & Watson (2003) testing for interaction effects between manifest and latent benefits of work also highlight the importance of financial strain in predicting wellbeing in the unemployed.

Although this research found, in agreement with Fryer, that, unemployment 'generally results in psychologically corrosive experienced poverty' (Fryer, 1995. p.270) the loss of latent work benefits, particularly social isolation, made an important contribution to feelings of self esteem and self efficacy and attitudes towards work resumption.

Standing against the norm, is a subset of those with mental health problems who experienced a decrease in their levels of depression and an increase in levels of emotional and personal functioning - largely attributed to participating in successful medical and therapeutic interventions as well as respite from stressors. Past research has found that social contact and social activities, has a positive effect on psychological well being and depression. Group therapies such as Alcoholics Anonymous (in which some of these participants were involved) provide an opportunity for social contact, to those who might otherwise remain in social isolation. Seemingly an outcome of this improvement is the capacity to engage in active job search.

Overall these theories are representative and enlightening of the samples' experiences. For some there are positive outcomes such as being able to spend more time with their families, an improvement in domestic relationships a time to re evaluate life priorities. However the range of negative consequences is extensive and generally caused by missing out on the latent and manifest benefits of work.

3.1.3 Work Resumption

The process of work resumption is also multifaceted. The first and ostensibly the most important factor to prompt the job search process is related to recovery and good health which in turn is linked to a marked decrease in psychological distress and an increase in self esteem and self efficacy. The latent and manifest of work are paramount to feelings of well-being. For those who are fit and looking to rejoin the workforce being employed in any job is seen as preferable to not having a job at all. A return to work is viewed as the optimal outcome to their sickness absence.

Reemployment of course, almost without doubt, will reduce the effects of financial strain on the mental health and well being of the absentees (Price et al, 2002; Hamilton, Hoffman, Broman & Rauma (1993) findings that unemployment was associated with depression and that depression is associated with subsequent unemployment, helps us understand why it is that the longer the tenure of the sickness absence the more difficult it becomes to rejoin the workforce; the longer a person is not working the more their health, physical and mental seems to decline. Poor mental and physical health impairs job-seeking behaviour reducing the likelihood of an imminent return into the workforce. Psychological distress is a major barrier to work resumption for many absentees. 'Thus the chains of adversity are clearly complex and may contain spirals of disadvantage that reduce the life chances of vulnerable individuals still further.' (Price et al., 2002, p. 309).

Apart from ill health there are many other perceived barriers to work resumption. Age discrimination is not a new phenomenon. There has been much recent publicity associated with the increase in ageing populations in industrialized economics. Ageism is

evidenced in many ways in the work place and 'is a process of systematic stereotyping and discrimination against people because they are old.' (Butler, 1987: 22). Attitudinal baggage' (see Brief, 1998) is something new employers might face employing people who have had negative past experiences.

The narrative clearly highlight how differences in levels of self esteem and self efficacy, conceptually distinct constructs, mediate successful work resumption. Self esteem refers to an individual's degree of like or dislike of themselves – it is a self judgement. Self efficacy is concerned with an individual's beliefs about whether or not they have the capacity to successfully deal with tasks required in a given situation (Bandura, 1977). It is possible for an individual to be low in self-esteem but hold favourable efficacy beliefs and vice versa (Brockner, 1988).

Whilst it is not within the scope of this research to report on individual cases, it is worth noting how common it was for employers to bring about an end of the working contract either via early retirement package, redundancy or dismissal rather than actively facilitate a return to work. For many the option to return to work for their previous employers simply did not exist. They commented that they had had little if any contact from their employers during their absence from work. This highlights the need for well founded absence management policies to deal with the challenges faced by both employer and employee during LTSA. This will ensure that employees who do intend to return to work receive the ongoing managed support they need. Allegro & Veerman (1998) predicted that with good guidance, the duration of sickness absence might, for some, be shortened. Pre-employment schemas are particularly relevant for new employees because they provide a lens through which workers 'view employment experiences and the obligations they create (Rousseau, 2001 p.515.). A schema is a cognitive organisation or mental model developed from past experiences and used to guide future actions. Individuals run their own mental models to form amongst other things future expectations and explanations. In the event a lack of guidance or support either from employers or other advisory bodies prolongs the absence.

Despite ongoing Government initiatives such as 'Pathways to work', New Deals and Jobcentre Plus, introduced to provide a single work-focused point of access to benefits and return to work support (www.dwp.org) – it seems that more still needs to be done to help those with potential to get back to work and fulfil their aspirations. One of the main themes to emerge from these narratives is the potential for interventions or rehabilitation services to facilitate successful work resumption particularly if this support is offered at the start and throughout any period of incapacity. The majority of the interviewees had not been offered any support or advice to help them in the work resumption process and felt that they had no option but to remain on benefits. This type of support was identified as one of the major factors facilitating a successful return to work.

3.2 Study Limitations

The present study has a number of limitations that need to be mentioned in order to qualify these findings.

- Many of the MH absentees were single, therefore there was limited access to significant others of MH absentees.. There was also a dearth of families with dependent children. The narratives do not reflect a cross section of the three groups of absentees and therefore questions of representative and generalizability of the findings could be raised.

- The design of this research means no causal inferences can be made.

- The sample was restricted to those receiving IB therefore it is not possible to make direct inferences about the effects of long term sickness absence to those who are certified sick from work but do not claim or receive this benefit, for example those with private health insurance or private wealth who chose not to make a claim.

3.3 Recommendations

The following recommendations are based on the findings of this research:

- Review of the benefits system to encourage people back to work. Individuals need financial incentives not penalties to initiate the first steps in the work resumption process.

- 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.

- Raise awareness of employers in the successful management of long term sickness absence.

- 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, the process of work resumption and increased knowledge of the importance of latent and manifest benefits of work

- Employers need policy and guidelines to learn how to manage LTSA – including training in effective communication and increase knowledge regarding metal health illness. They need to be aware of the workplace factors that influence LTA and the process of work resumption.

- Increase knowledge of Primary stress management interventions.

- 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

- Encourage positive media image regarding IB claimants to avoid dominant negative stereotypes.

3.4 Final Thoughts

In conclusion this research has furthered our understanding into the experience of certified long term sickness absence in the UK and enhanced the findings of past research. Long term sickness absence affects absentees, their families, their employers and the state. Encouragingly and somewhat contrary to the common populist belief surrounding the recipients of IB, these participants would like to work again but perceive many, often surmountable, obstacles in their way. These findings suggest that with collaborative inter professional support, proper incentives, policies and guidelines based on the recommendations such as these, a working future should be a viable option for a substantial number who might otherwise unwillingly find themselves trapped in the benefit system.

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