Project Title

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

Project Acronym/Logo

STRESS IMPACT

Work Package 7

Family Study: National Report of Austria

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Hopefully we can provide some new insights and aspects for all interested people.

Gert Lang, Astrid Grant Hay
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1 Background

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

This section is divided into three main topics

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

1.1 Background on Work and Families

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

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

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

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

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

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

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

As well as changes in structure and nature of work and workplaces, in the last number of decades, traditional family structures and roles have changed significantly. The numbers of single parent families and 'blended families' (parents with children from different relationships) have increased, as have the percentage of women participating in the labour force. The percentage of women in the labour force in western countries has doubled in the past 50 years (ILO, KILM 2004). In Austria, women's participation in the labour force was over 75% in 2001 (OECD, 2004). A large proportion of these are women with children under 18 years of age and also women who are lone parents. Increases in female labour force participation have consequent implications for the care responsibilities for young children, dependant disabled relatives and older family members and the division of labour within the household. Taken together, these factors have changed the work / home interface and the factors which affect individuals and families considerably. It is anticipated that these trends are likely to increase over the coming years, which will in turn impact on and exacerbate stress related problems within society (Mead et al. 2000).

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

Allegro & Veerman (1998) believe that the traditional organizational-psychological approaches of sickness absence do not adequately explain sickness absence.

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

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

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

The impact of work on family can be measured in terms of work-family conflict or spillover. Work-to-family spillover occurs where, demanding jobs and un-supportive workplaces lead to spillover from the job into workers' personal lives. The impact of work-family conflict is circular: if demanding work situations push workers to the limit, spillover results in high stress, poor coping skills, and insufficient time with family and friends, which in turn undermines work performance (Sauve, R. 2002). The consequences of this work-to-family spillover is not confined just to the individual workers who are trying to meet competing demands on their time and energy. Long hours spent at work and the demands of the workplace are felt by all members of the family, as well as by employers and others in the community.

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

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

Work-to-family and family-to-work spillover can be positive as well. Employees who experience autonomy and control on the job, support from supervisors and complexity in their jobs are more likely to transfer these positive experiences from work to home. Employees who receive family support or feel confident in their family responsibilities and have happy

marriages transfer those positive experiences to their work which, in turn, increases their job effort and satisfaction (Kinnunen, U et al., 2005, Butler, A.B. et al 2005)).

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

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

1.2 The National System for Absence Management

It is important to be aware of the national context in which absence takes place in order to understand the results which have been obtained from the Families study. Of particular relevance are:

- elements of the social security system as they relate to income replacement
- the rehabilitation system as it relates to the provision of treatment for people who have become absent
- the statutory and voluntary role of the employer in relation to return to work practices and systems
- the role of occupational and public health systems in relation to the absence process
- the role of labour market agencies in relation to retraining and job placement

Each of these elements can play a crucial role in affecting the initial decision to become absent, what happens when the individual becomes absent and the decision to return to work, should that happen. For example, low levels of sickness benefits act as a disincentive to become absent in the first instance and as an incentive to return to work, regardless of the health condition of the individual. Also, gaining access to the appropriate medical and rehabilitative services can considerably shorten the period of absence, while having a responsible and supportive employer also aids in the return to work process.

The national systems in relation to these services and provisions are described in detail in Workpackage 2 of the Stress Impact project. However, it is worthwhile to recall some of the main elements of the Austrian system here in order to support the interpretation of results form this part of the study. (e.g. HBV, 2005; Woerister, 2003: 47f.)

- Income replacement policies – In Austria, the most important income replacement policies in case of illness are income replacement / continued pay from the employer, the sickness benefit from social insurance agencies (health insurance), and (temporary) invalidity pensions. In case of illness or accident, workers are entitled by law to continued payment by the employer for a certain period. Blue-collar and white-collar workers have more or less uniform regulations but there are still differences: white-collar workers are again fully entitled to continued pay six months after their last period of sick leave; blue-collar workers are only entitled to continued pay again before a year has lapsed if they have not yet used up their maximum entitlement. However, the length of continued pay depends on how long an employer has been employed in the company. The longer the period, the longer the entitlement of continued pay. After the full continued pay, employees can claim four additional weeks which are then payed half by the employer and half by the insurance company (sickness benefit). In case of inability to work due to a work related accident or a work related illness there is a minimum entitlement of eight weeks full continued pay (not depending on the length of service in the company). After the continued pay, workers can claim sickenss benefit from the social insurence agency (granted for minimum 26 weeks up to one year). The minimum level of sickness benefit is 50% of the previous gross wage (and after the 43rd day of inability to work it is 60%).

- Rehabilitation system – In Austria, pension and work accident insurance systems provide rehabilitation services for people with earning incapacities and reduced work ability. The work accident insurance scheme concentrates on cases of work related accidents and illnesses and aims at the reintegration of people into work life mainly. Additionaly, the rehabilitation system in Austria distinguishes between medical, occupational and social rehabilitation. For instance, the health insurance companies initiate actions for long-term absentees after 3 months of absence whereas occupational actions are normally planned in cooperation with the Public Employment Service (*Arbeitsmarktservice* or *AMS*).

- The role of the employer and labour legislation – Labour legislation is an important part of social policy. In Austria it contains social welfare in case of absence due to sickness, dismissal protection for groups in need for protection and dismissal periods, and working rules and recreational periods. In case of sickeness absence of the employee, the employer only gets the information of this fact without the concrete medical certificate or diagnoses of the general practitioner or the medical specialist. As already mentioned, the employer is obliged by law to pay the continued pay for the sick employee for a certain period.

- Occupational health and safety – In Austria, the Employee Protection Act (*ArbeitnehmerInnenschutzG*) is, despite many other rules, important to mention because it concerns occupational health and safety. It is mainly to prevent accidents at work and work-related illnesses, protection from exploitation, and life threatening dangers in the work environment. Addionally, it deals with compulsory information of new employees about job safety, expert inspection of the work field for security reasons, industrial medical and psychological checks, rights and duties of employers and employees, description of work resources, the premises and working materials. Moreover, the protection of the employee through specialists such as Occupational Health Physicians and Psychologists (OHPs) and Health and Safety Representatives (HSRs). The prevention period is based on the number of employees and the character

of work. It is worth mentioning that these representatives are only obligatory with a certain number of employees in the company.

- The role of labour market agency – the Public Employment Service (*AMS*) in Austria is defined with prevention and abolition of unemployment, grants the benefit of the unemployment insurance system, and provides a wide range of training and retraining for people who are unemployed (maybe after a period of long-term sickness absence).

- Reintegration into workforce – Additionally, the Act on Employment of Persons with Disabilities (*BehindertеneinstellungsG*) should be mentioned as a significant factor in the Austrian system. This Act tries to reintegrate persons with disabilities into the workforce.

1.3 Innovative Nature of the Study

Aims of the study

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

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

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

Why adopt a family perspective?

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

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

In relation specifically to the stress aspect of this study, stress theory has focused its investigations on the rage of environmental (work or non-work related) factors which may

generate stress for the individual. While some investigations do identify outcomes of stress outside of the individual, these tend to examine elements such as organisational outcomes as being and ignore the effects stress may have on people other than the individual.

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

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

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

The process of becoming absent and returning to work

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

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

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

Generating hypotheses for further analyses

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

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

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

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

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

2 Methodology

The family study was planned as a qualitative study. This intention was realised with an in-depth approach with semi-structured interview protocols. The family study was coordinated by the Work Research Centre, Dublin, by Richard Wynne and Nadia Clarkin mainly.

WRC proposed methodological aspects of the study, the procedure for conducting the interviews and interview guides for both, long-term absentees (LTAs) and their significant others (SOs). These guides were discussed and refined in the consortium meetings in Bari and Amsterdam 2004 by all partners.

All partners agreed to have a convenient sample drawn as a sub-sample from the main study (first wave). We also agreed to interview 50 persons who were long-term absent from work due to a medical reason (LTA) in each country and, in order to allow the aims of the study to be answered, we decided to interview 20 LTAs due to mental, 20 LTAs due to physical and 10 LTAs due to both, physical and mental (*so-called*: co-morbid), reason. Because the study has a clear family unit approach, the requirement was to interview 50 LTAs *plus* their SOs, if available (singles were also included in the study because this is a meaningful contrast group). To allow the comparision to the subgroups concerning the main reason for taking the sickness absence (or crossing the sickness absence threshold) we came

to the decision to over-sample the mental group[1]. Another meaningful decision was to include a wide range of types of people too, including returnees and non-returnees, two types of household income (single vs. double), different family types, age, gender and occupation. Last but not least the study was a mixture of face-to-face and telephone interviews with tape recording or taking notes[2] of people who participated in the study.

The final version of the interview scheme included several areas and issues which could be best described by enumeration of the parts: Absence threshold (Section 1), prevention of absence (Section 2), impact of absence on individual and family (Section 3), return to work or still absent (Section 4), rehabilitation and reintegration programmes (Section 5). Additionally, section 6 covered a very general section where interviewees were asked about their quality of life and levels of stress, about the main factors of absence in the workplace and about society changes and their impacts on absenteeism in general. The core of the questions was the same for LTAs and SOs, but some questions LTAs and some SOs were asked only.

The final version of the interview guides was in English and had to be translated into the languages of the partners. Hence, in Austria the interview guides were translated into German. Based on the guidelines, recommendations and agreements, the *Forschungsinstitut des Wiener Roten Kreuzes* (FRK) – *Research Institute of Viennese Red Cross* planned to conduct the national realisation of the study. Therefore five interviewers were trained in the methodology and especially in the interview schemes and basics of qualitative empirical research if necessary. Mainly two of the interviewers were also responsible for fulfilling the sample requirements of the study and they also had to make the acquisition of the interviewees, both LTAs and SOs.

During the process of acquisition of interviewees, it very soon became clear that it was unexpectedly difficult to get enough LTAs who were absent from work due to a mental reason. The difficulties were based on the fact that the sample size in the main study of this subgroup was not very high. Only 31 respondents of the quantitative study (first wave) or about 9% stated that their sickness leave was based on a mental problem. Another reason was that many of them had not noted their telephone number on the questionnaire. Another plausible reason for the difficulties to assure a participation in this group could be that they did not want to be contacted due to their health reasons (e.g. depression).[3] In the end we did not reach the exact sample requirements (20 physicals, 20 mentals, 20 co-morbids) but we could "substitute" the mental group by over-sampling the co-morbid group.

At last we conducted 53 interviews, 24 in the physical, 12 in the mental, and 17 in the co-morbid group. 18 interviewees had returned to work (completely or partially) and 35 interviewees had not returned to work at the interview date. 21 LTAs lived in a single and 25 in a double income household (unknown = 7). 10 respondents were singles, 4 were single parents, 19 lived with a partner/spouse in the same household and 20 respondents had both, partner/spouse and child(ren). (*See table 2.1 and 2.2*)

As already mentioned above we interviewed 53 LTAs, as well as 33 SOs. Six SOs did not want to take part in the study and the remaining 14 LTAs are singles or singles with children under the age of 18.

It is also noteworthy that in an early stage of the study procedure the FRK contacted LTAs (and their SOs) in Vienna and near/easyly reachable areas closeby first in order to conduct face-to-face interviews. After we could not gain any interview partners there anymore, we

[1] Explanation: In the Austrian mainstudy, we only had 9% of people whose main reason for sickness absence was a mental reason. If we had drawn the same proportion of LTAs in the family study, we would have had only five interviews with mentals. In order to make comparisons between different illness types possible we decided to aim to interview 20 instead of 5 LTAs due to a mental reason.

[2] When interviewees did not agree to the tape recording or when it was a telephone interview.

[3] Due to these difficulties we decided to change the strategy and we loosened the sample requirements a little bit. So we also used the depression score of the quantitative results as predictor for a mental health problem. With this strategy we could count more respondents for the mental group.

started to call people outside of Vienna. These interviews were conducted as telephone interviews.

The interviews were conducted from 2nd December 2004 to 11th of Mai 2005 within a time period of more than five months. 33 interviews (38%) were conducted face-to-face and 53 (62%) were telephone interviews. The earliest interview started at 8:40 a.m. and the latest interview was over at 9:00 p.m. The mean interview started at 1:53 p.m. and in the mean the interviews ended at 2:40 p.m. The shortest interview was 17 minutes, the longest was 120 minutes, but these are extreme values because 95% of the interviews were between 39.7 (*lower bound*) and 47.5 minutes (*upper bound*). Because the LTA and the SO interview schedule has a different number of questions, the mean length of the LTA interviews was 47 minutes (95% CI: 41.4;51.9 min.) and the mean length of the SO interviews was 39 minutes (95% CI: 32.8; 44.4 min.).

The interviews were transcribed into an electronic file by the interviewers themselves. Afterwards we transformed them into a data matrix to be able to compare the answers question by question, also by meaningful groups or information (e.g. illness type, RTW, income, family type, etc.) separately if necessary.

Table 2.1 Number of conducted interviews with LTAs with physical, mental and co-morbid health complaints and their partner, and general characteristics of the interviewed LTAs

	Main reason for current absence			
	Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
Number of interviews:				
- LTA	24	12	17	53
- Partner / Significant Other (SO)	16	8	9	33
Return to work LTA:				
- Completely	6	3	5	14
- Partly	2	2	-	4
- Not	16	7	12	35
Family type:				
- Couple	9	4	6	19
- Couple with children	9	6	5	20
- Single	5	1	4	10
- Single with children	1	1	2	4
Income:				
- Single income	10	4	7	21
- Dual income	11	6	8	25
- Unknown	3	2	2	7
Gender LTA:				
- Female	13	7	12	32
- Male	11	5	5	21
Average age LTA in years	47.17 (SD=9.44)	44.33 (SD=8.79)	46.59 (SD=9.03)	46.33 (SD=9.05)

Table 2.2 Number of conducted interviews with LTAs with physical, mental and co-morbid health complaints and their partner, and general characteristics of the interviewed LTAs

	Main reason for current absence			
	Physical (N)	Mental (N)	Co-morbid (N)	Total (N)
Education level LTA:				
- Compulsory education	6	2	6	14
- Lower professional education	13	5	9	27
- Completed high school	1	-	2	3
- Professional education	-	1	-	1
- Higher professional education and higher	4	4	-	8
Work sector LTA:				
- Agriculture, fishing and forestry	1	-	-	1
- Manufacturing	4	-	-	4
- Building & construction	-	2	1	3
- Trade (retail & wholesale)	9	2	4	15
- Hotels & restaurants	3	1	-	4
- Transport, storage & communication	-	1	-	1
- Banking, insurance & financial services	-	-	1	1
- Public administration	2	1	1	4
- Education	-	-	-	-
- Health & Social work	3	2	4	9
- Other community, social and personal activities	1	1	3	5
- Recreational, cultural and sporting activities	-	-	-	-
Average score on CES-D scale;	10.25	15.25	22.13	15.19
10 items; 1=not - 4=highly depressive	(SD=7.58)	(SD=7.05)	(SD=5.83)	(SD=8.57)
Average score on Exhaustion scale;	2.24	2.82	2.83	2.55
8 items; 1=not - 4=highly exhausted	(SD=0.68)	(SD=0.70)	(SD=0.65)	(SD=0.73)
Average score on Disengagement scale;	2.19	2.54	2.37	2.32
8 items; 1=not - 4=highly disengaged	(SD=0.48)	(SD=0.49)	(SD=0.62)	(SD=0.54)
Average score on General self-efficacy scale;	31.46	27.55	25.75	28.77
10 items; 10=low - 4=high self-efficacy	(SD=6.31)	(SD=6.91)	(SD=6.37)	(SD=6.84

3 Findings

3.1 Absence Threshold

The first chapter is about the factors, problems, considerations, and the involvement of other people in the process to go out absent from work due to medical reasons. In sum, 24 people were interviewed who went absent due to a physical problem, 12 had a mental problem and 17 interviewees went absent due to co-morbid reasons. The problems they faced before going absent from work were different, depending on the absence reason, but in the mental and co-morbid group it became obvious that describing mental health problems was not easy at all. Despite severe health problems, four out of ten LTAs delayed their decision of taking an absent leave, sometimes for a meaningful period of time. The reasons for longer considerations were individual reasons and also reasons due to family, finance and environmental affairs. Additionally, about 60% of all interviewees mentioned that another person was involved in the decision to take absence leave.

3.1.1 Factors for Reporting Absent from Work

In the first section of the interview, we asked the person who was long-term absent from work due to medical reasons (LTA) and his/her partner/significant other (SO) about the reasons for reporting sick or which factors were responsible to take absence from work.

In total 24 LTAs reported sick due to a physical problem, 12 because of a mental problem and 17 persons because of both (co-morbid). At least, these were the statements of the interviewees of the first questionnaire survey in the quantitative approach. In the interview situation the interviewees had the possibility to refine their statement. The interviewed 24 persons who reported themselves absent due to a physical problem can be categorised in several groups. Six persons had an accident at work or in their leisure time (e.g. skiing, skating, car accident etc.). Four LTAs reported a tumour/cancer diagnosis, four reported a cardiovascular disease and most people who reported sick due to a physical problem reported muscular-skeletal problems. Nine people told us about such problems and reported about herniated discs mainly but also about problems with the shoulder, legs, hip, and muscles.

The mental group reported several events as main factors for going out absent from work. One interviewee reported depression symptoms after the suicide of a family member combined with problems at work (work climate) or a case of a deadly accident and suicide as well. In one case the main reason was a muscular-skeletal problem and in another case it was a cardiovascular disease as a consequence of manpower shortage at work. This led to an influenza infection, breath shortage and in the end to a cardiovascular disease. Another person reported exhaustion and fatigue, sleeping problems and back pain. After that the LTA had severe depression symptoms and psychosomatic troubles. Another person reported stress at work and pressure from others, two other LTAs said that they also suffered from depression symptoms and burn-out. In the interview sample we also had cases of mobbing because of the sickness absence followed by a dismissal. Two persons reported alcohol problems in combination with partner problems and work stress.

In the co-morbid group also several cases emerged. Some only reported physical problems which were the main reason for reporting sick. Other people also said that they had physical problems first (e.g. consequences of an accident, tumour or cancer, back pain, arm or leg problems, skin disease, etc.) and then mental problems such as exhaustion, depression symptoms, stress and mobbing. Another LTA reported depression symptoms because it was nearly impossible to get a job as a single parent with children. After this experience he/she

could not stand the situation emotionally, depression symptoms emerged, a psychological treatment was necessary.

So, many people reported a physical problem first and then a mental problem also occured. Other LTAs reported contrary cases where a mental problem appeared first and then a physical problem emerged. For instance one LTA reported a dismissal. After that he/she was unemployed and looked for another job without success. He/she was depressed and the consequence was a heart attack. But in the mental or co-morbid group these cases were more seldom than those cases in which a physical problem arose first.

In sum only one person of the physical group, which means having a physical reason as the main factor for the sickness absence, reported a cancer diagnosis as output of stress. One significant other of an LTA with a coronary heart disease and bypass also reported that his/her partner's heart problems could also have been a consequence of family or work stress. It is easy to argue that more physical problems could occur in connection with stress symptoms but most of the interviewees did not mention this source-effect-chain. So most cases of the physical group only mentioned physical problems/diagnosis as main factors for reporting absent from work. As stated above, the mental and/or co-morbid group is different to the physical group in this respect. Just some LTAs reported physical problems being the main factor for the sickness absence, whereas most cases reported depression symptoms, sleeping problems, exhaustion, work pressure, burn-out, feelings of fear, mobbing in combination with a physical diagnosis or problem. In this respect differences to the co-morbid group could not be found in the analysis of the interviews. Also different mental problems were stated by the co-morbid interviewees.

3.1.2 Consideration of taking Absence Leave before Absence

About 40% of the LTAs have considered taking absent leave before (*See table 3.1*). A rough categorisation of the answers concerning the period of time before the LTAs considered to go absent looks like the following: On the one hand they had no time to think whether or not to go absent from work, whereas on the other hand more or less long considerations took place. In the cases in which they had no time, this was because of an unexpected event like an accident or something similar. Some LTAs simply had no possibility and no need to think about going absent because their health situation changed from one day to the other and they were forced to go. But there are also many interview cases where they had had pain or symptoms for a relatively long period of time but they had not thought of taking sickness leave at first.

Table 3.1 Number of LTAs that considered to take leave of absence by main reason for current absence

Considered taking absence leave:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	12	8	13	33
Yes	12	4	4	20

For instance two persons with shoulder problems had thought of a sick leave 10 years before they actually went absent. Basically, these cases are exceptions, but periods of half a year to one year or even longer (e.g. LTAs also mentioned three to four years) were not only mentioned once. The reason for thinking about it for such a long time without going absent often was that the LTAs thought it would be possible to work even with problems and pain.

They worked as long as they could, even with severe pain until they could not work any more because of their health problems.

Some examples for sickness absence delays
- A woman who was absent due to mental reasons explained the situation before going out absent due to their medical reasons: She worked until she just could not work any more. "*Ich habe gearbeitet bis ich nicht mehr konnte. Ich habe mir gedacht, es geht schon irgendwie*." (A01/F02, ID10291/LTA, p. x),
- Due to her problems, a female blue-collar worker recognised her ill health without thinking about it. She did not want to stop working. After some time it was no longer possible: "*Vorher habe ich nicht darueber nachgedacht. Ich wollte auch nicht aufhoeren zu arbeiten, aber es ist nicht mehr gegangen*." (A01/F02, ID10320/LTA, p. x)
- A women with physical and mental problems also had not thought of a sickness absence due to her problems. She tried to work as long as she could, even with severe pain in her back. So she worked for two and a half months under pain with the consequence of an herniated vertebral disc: "*Zweieinhalb Monate habe ich mit Schmerzen gearbeitet. Dann habe ich gesagt: 'Jetzt geht es nicht mehr'*." (A01/F02, ID10040/LTA, p. x)

Another dimension for protracting the sickness absence is the already mentioned situation where people had an individual responsibility for other persons. The feeling of responsibility for others was mentioned as the main reason for not going absent. For example one LTA, who was in a higher position in a company, wanted to set a good example for the whole staff, and that is why he/she first did not go absent, not even with years in pain: "*Die Schmerzen sind schon seit eineinhalb Jahren da, aber ich habe immer gedacht 'es geht schon'. Irgendwann habe ich dann gemerkt, dass es nicht mehr geht und ich bin in den Krankenstand gegangen*." (A01/F02, ID10089/LTA, p. x) A single parent told us about the responsibility for his/her children and the fear of the financial loss when absent from work: "*Sicher habe ich schon vorher nachgedacht, mit drei Kindern und mit nur einem Lohn, da geht man nicht so einfach in den Krankenstand*." (A01/F02, ID10122/LTA, p x)

These cases indicate that going out absent from work due to a medical reason is often very individual, depending on the individual case and strongly depending on the surroundings. An example for this was the statement of a partner of one LTA who spoke about this fact and his/her spouse said: "*Nachgedacht hat (er/sie) weniger. (Er/sie) ist so lange arbeiten gegangen, bis es nicht mehr gegangen ist. (Er/sie) geht nicht so leicht in den Krankenstand. (Er/sie) geht so lange arbeiten, bis es nicht mehr geht*." (A01/F02, ID10235/SO, p x)

There were also other cases in which people had a longer therapy without going absent and without any improvement of the medical situation and another person said that he/she had thought of a sickness leave but he/she did not want to be judged as a hypochondriac by other people in his/her environment.

All these mentioned cases, except the cases where the sickness absence was an effect of an unexpected accident or a physical problem, are examples for an individual decision making process. The decision depends on the individually defined situation concerning family, financial situation, individual norms and environment (e.g. work duties).

3.1.3 Problems faced before going out Absent from Work

Also the descriptions and experiences of LTAs concerning problems they had before going absent from work due to a medical reason can be divided up into groups representing people who only had physical problems and a group of people who (also) had mental problems.

Some of the cases, where an accident was the sickness absence event, reported no problems at all – no symptoms and problems before the event. Some people said that they had

had pain shortly before the decision to take the absence leave. It is also interesting to look at a case where the person had some late effects of an accident. The LTA could not hold things any more, had pain in the arm and the head and also pain while performing easy tasks (e.g. moving hand over one's head, (un)dressing oneself, lifting something, operating the gears in the car, etc.). The LTA had lived with these symptoms and problems for a longer period of time. After a while the LTA decided to go out absent from work.

An example for an unexpected event
One stroke patient reported an unexpected event without having faced any problems before. For him it was a very sudden and striking event and he significantly explained it as follows: "*It* (the stroke) *was so suddenly. – It was like a hammer, a hammer that knocks on your head. With such an event, nowbody would expect this. A healthy person would not understand this*." (A01/F03, ID10109LTA, p. x)

Conversely, some cardiovascular patients reported several problems they had had before the sick leave. Some had had pain in their chest and their arms followed by cramps, breathlessness and heavy sweating, resulting in physical exhaustion. Sweating was also stated by other LTAs combined with heart problems (e.g. pressure in the chest), problems with the stomach and headaches, feelings of not getting enough air or breathlessness, faintness, low productivity and that everything was a burden for these persons. One stated that he/she could hardly fulfill tasks, everything was a burden: "*(Ich) konnte kaum eine normale Taetigkeit ausfuehren. Alles war eine Belastung.*" (A01/F03, ID10291LTA, p. x)

Because of the high incidence of muscular-skeletal problems in Austria as well as in the sample, we got many statements about problems from this group of people (e.g. herniated disc). They faced severe back pain, leg and arm paralysis and problems while moving as well as problems with lifting heavy objects. One person reported that he/she could only lie down on one side of the body and that the person woke up very often during the night because of the pain which persisted the whole day. One LTA reported that only medical therapy helped to stand the pain, and in this respect it was helpful but the therapy did not solve the problem for long. Consequences also stated very often were faintness and exhaustion, bad eye sight, dizziness and headaches as well. As another consequence, not only noteworthy for this group of LTAs, people also had many worries about their own health situation.

A lung disease patient reported about problems with breathing (e.g. the need to pause while climbing stairs, etc.). Some tumour and cancer patients and the patient mentioned above had not interrupted their work process at first. One person interrupted work for the medical therapy (e.g. chemotherapy) only. But knowing of their diagnoses, stress at work was a direct consequence for one LTA, apart from the disease based problems. This was not only the consequence of these tumour/cancer patients. Similar statements were made by other persons.

In the mental health group it is interesting to see that some LTAs could not describe their problems very well, but many others reported their problems before going out absent in detail. One LTA said something like 'I had no problems at all – only things like pressure at work and problems with my supervisor'. So, not all could express the problems they faced at that time. On the other hand people with mental health problems (or both, physical and mental health problems) stated their problems before the absence step with severe sleeping problems (also while on sleeping pills) and obscure dreams followed by shivering, fear, nervousness, and faintness and also being unable to work under pressure.

Some also felt drained, one reported fever (sometimes lasting several days), many faced fatigue and headaches. A person with depression and burn-out symptoms said that he/she always wanted to shout and cry and in these situations he/she was not him-/herself at all and he/she did not want to have any social contact: "(Ich) *haette nur noch schreien und weinen koennen;* (Ich) *war nicht mehr ich selbst und keiner konnte mehr an mich heran.*" (A01/F03,

ID10037LTA, p. x) Another work and family impact was that the depression symptoms and feelings of fear had the consequence that the LTA could not cope with the duties posed on him and responsibilitiesany more: "*Objektiv haette ich die Voraussetzungen, aber meine Seele hat nicht mitgespielt.*" (A01/F03, ID 10240LTA, p. x) Not only in this case but also in others the cause was that they had problems with their supervisors. In one case mobbing by one colleague was the result.

Other problems of mental LTAs were health related problems like vomiting, agitation, fatigue and exhaustion with pain in the whole body. One of these LTAs simply described his/her problems with stress ("*Na ja, es war schon sehr, sehr viel Stress*." [A01/F03, ID10102LTA, p. x]) and related problems (e.g. total exhaustion and concentration problems because of the weekly amount of working hours or because of work load) and therefore sleep was very often necessary (they often needed more sleep) to be accessible for others. The partner/spouse of this LTA described in a similar way how the LTA could hardly do anything else but sleep: "(Er/sie) *war dann depressiv* (und) *hat nur noch geschlafen. Es war auch so wenn* (er/sie) *zuhause war nach der Arbeit, quasi nichts mehr mit* (ihm/ihr) *anzufangen, also* (er/sie) *war wirklich erledigt*." (ibid./SO, p. x). Another LTA with depression and physical problems described his complaints, his pain and the depression as a vicious circle: "*Mit den Depressionen ist das dann so ein Teufelkreis: Umso mehr Schmerzen, umso mehr Depressionen.*"[4] (A01/F03, ID10119LTA, p. x) Another LTA with not further defined mental problems illustrated the symptoms like being in a cage without a way out[5] and another person said that nothing worked well and in the end he/she was overloaded with his/her own kid.

Two cases with mental health problems

- One interviewee reported that a suicide in the family was the beginning of mental health problems. But there was also a very bad working climate with depression as a consequence. At that time she was exhausted and fatigued very fast and he/she suffered from shiver, fear, and nervousness. And "(…) *somebody just had to look at me in the wrong way and I had to start to cry."* (A01/F03, ID10017LTA, p. x)
- A man with mental health problems reported his work situation before the absence. He worked for a company where he got a job dismissal due to company reorganisation. After some months he was reemployed and during a sickness absence dismissed again. His doctor diagnosed stress and mobbing. When he came home after work he needed one hour of sleep because of fatigue, dizziness, chest burning and muscle pain. After sleeping he was approachable for others again. "*Wenn ich am Abend nach Hause gekommen bin, war ich eigentlich so muede, dass ich meistens im Wohnzimmer schon eingeschlafen habe und eine Stunde geschlafen habe und dann erst wieder so richtig ansprechbar war*." (A01/F03, ID10102LTA, p. x)

In sum we may conclude that the impact of the problems faced before the individual's decision of the sickness absence period had very different effects. On the one hand some LTAs only had physical problems they had to cope with. But on the other hand many people also had other problems to face. These problems could be the source or the consequence of other health problems, but in many cases the picture of the vicious circle can be found: LTAs are facing health related problems which as a result produce problems in the work place or in their own family. Stress is therefore a consequence of this and again has an impact on the LTA´s health. This vicious circle goes on and on and many interview cases reported this. After a while the list and the impact of problems was so long and severe that sick leave was the last consequence.

[4] Translation: „*The depression is a vicious circle: The more pain the more depression*."

[5] „*Ich habe mich wie gefühlt wie in einem Kaefig aus dem es keinen Ausweg gibt*." (A01/F03, ID10305LTA, p. x)

3.1.4 Involved Persons in the Sickness Absence Decision Process

An interesting point concerning the individual decision to cross the sickness absence threshold is the question whether or not other persons were involved in this process. Overall, the answers of the LTAs show that the majority had at least one other person who had been involved in the decision to take sickness absence. Approximately 6 out of 10 LTAs mentioned the involvement of another person while around 40% said that they had made their decision on their own and that nobody else had been involved in this process. (*See table 3.2*)

Table 3.2 Number of LTAs who mentioned someone was involved in their decision to take absence leave by main reason for current absence

Someone else involved in LTAs decision to take absence leave:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No	7	3	6	16
Yes:	12	8	3	23
- someone at work	*1*	*3*	*1*	*5*
- someone outside work	*12*	*8*	*2*	*22*
refused	5	1	8	14

In the group of LTAs who had had an involvement of others for the decision, it was clear that most of the people mentioned a medical professional being there. Also the LTAs own family was involved very often, and within the family members his/her own partner or spouse was most frequently mentioned. Especially the SOs mentioned that their own kids had also been part of the decision to go absent from work and also other family members were sometimes mentioned by the interviewed family unit.

Less often mentioned were other people from the individual´s social net. For example friends had been involved in the LTA's decision but it is to highlight that the interviewees mentioned this group less often than family members.

Concerning people within the work place, supervisors and colleagues were most often mentioned and one LTA mentioned the workers' council. The answers across all groups of LTAs (illness type, family type, etc.) indicate that the involvement in the decision to go absent from work of people from the work place is not very highly represented. As mentioned above, medical specialists had most often been involved and then in the second position family members, especially the partner or the spouse if available/existing.

The result that the proportion of LTAs with no involvement of other people is significantly higher among singles including single parent households is very interesting. This is true especially for the availability of close relationships like partner/spouse, but also concerning other people in the social net as opposed to LTAs who live in two or more person households. So, singles do not have the same personnel ressources in this respect.

The result when comparing the LTAs who are absent from work due to a physical health problem to the group who are absent because of mental reasons only or both, physical and mental reasons is also significant. The result was that there is no difference between the groups mentioned above in respect to who was involved in the process of going out absent from work. The answers vary only in the frequency of the statements "General Practitioners" or "hospital doctor", because significantly more physicals mentioned these people. One would expect that mentals and co-morbids would have mentioned mental health professionals (e.g. medical specialists, psychotherapists, psychiatrists and psychologists, etc.) more often than physicals would have. But this was not the case.

3.2 Before taking Absence from Work

About one fifth of the LTAs mentioned factors that could have helped them and which could have prevented illness and absence in the last consequence. Individual and work place factors were mentioned more often in this respect and people of the mental and co-morbid group stated preventative factors more often than people from the physical group did. Before absenteeism, half of the persons reiceived supportive actions from the workplace (colleagues, supervisors) and about six out of ten interviewees stated support from outside the workplace (partner, relatives, friends; professionals) as well.

3.2.1 Factors for Preventing the Absence from Work

About preventing factors of sick leave:
"*Es haette schon – klar! Ich glaub' vermeidbar ist eine jede Krankheit.*" [6]
(A02/F01, ID10026LTA, p. x)

The question about what could have been done to prevent the absence period from work was a real challenge for the interviewed LTAs. The citation above does not reflect the majority of answers of the interviewees, because more than half of the statements said that the interviewees could not mention one single suggestion what could have prevented the absence and therefore these people answered with "*no, nothing could have been done for prevention*". Approximately one third of the statements also said "nothing", but the difference to the first group mentioned above is that one third also could not explain why nothing could have been done for prevention, whereas approximately one fifth of the LTAs answered positively to the question and in most of the cases they explained what could have been done to prevent the sickness absence.

Table 3.3 Number of LTAs who mentioned preventive measures which could have been done by themselves, work place or someone else by main reason for current absence

Measures to prevent LTA from taking absence taken by:		Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
LTA	Yes	1	5	7	13
	No/d.k.	23	9	9	41
Work place	Yes	0	3	7	10
	No/d.k.	24	9	10	43
Someone else	Yes	4	0	1	5
	No/d.k.	19	10	14	43

One explanation for this answering pattern is that the sample also includes people who were absent from work due to an accident: "*Also, es war ein Freizeitunfall und das kann man nicht vorhersehen.*" (A02/F01, ID10261LTA, p. x) This was an event that had not been foreseeable for them, therefore nothing substantial was mentioned for prevention.[7] The other explanation is also because of the answers of the physical group. They mainly suffer from physical problems and sometimes they interpret their physical condition as a long-term effect of their work.

In the analysis we counted all interviewee statements and coded them into "do not know", "no" and "yes" answers and also separately for the illness types. In sum only one out of five

[6] Translation: "It could have been – for sure! I think any disease is avoidable."
[7] The exception was that one LTA said that it would have helped if he/she had cancelled going out skiing.

answered with "yes". But by categorizing the answers in the three illness types, divergences in the answering patterns emerged. Only 7% of the physicals answered with "*yes, something could have been done*" whereas 22% of the mental group and 31% of the co-morbid group answered that way. So, what could have been done is associated with the reason why LTAs were absent from work.

LTAs which were absent from work due to a mental reason for example said that they should have listened more to themselves or that they should have seen the symptoms earlier. One LTA also stated that he/she should have said "*No!*" "*Ich haette mehr nein sagen muessen, mehr abgrenzen – schon in den Jahren davor*." (A02/F01, ID10037LTA, p. x) or should have been more restrictive or should have limited-down bad influences.

Early action would have helped in one mental case, but the LTA had not listened to him-/herself and had ignored the fatigue symptoms: „*Ich haette das schon viel frueher erkennen muessen – frueher darauf reagieren. Ich bin immer muede geworden, aber ich habe mich nicht mehr erholt.*" (A02/F01, ID10160LTA, p. x) Even relaxation interventions had not helped in one case: "*Nein, das glaube ich eigentlich nicht. Wir sind regelmaessig, alle zwei Jahre, auf Kur gefahren. Das war auch fuer* (ihn/sie) *sehr gut, weil es* (ihm/ihr) *Erholung gebracht hat*." (A02/F01, ID10194SO, p. x) Significant statements about the LTAs' own steps which could have prevented the illness and as a result the absence period of the co-morbid group were: to take another job, to reduce self-made pressure or to listen more to one´s inner voice. Two other statements from this group also were that they could have seen the doctor earlier[8], gone to the hospital or the supervisor. LTAs of the physical group answered, in this respect, things like healthier life-style (e.g. regarding smoking, eating, drinking, etc.): "*Gesuender leben haett' ich muessen*." (A02/F01, ID10331LTA, p. x), "(Er/sie) *hat einfach ein Leben gefuehrt, das krank gemacht hat*. (Er/sie) *hat* (Krankheit) *kriegen muessen, dass* (er/sie) *erkennt, dass* (er/sie) *ein Leben fuehrt, dass nicht gut ist.*" (A02/F01, ID10338SO, p. x.) One LTA mentioned the use of protection and safety equipment[9] which could have prevented absenteeism.

About what a LTA could have done to prevent absence
One LTA, who was absent due to mental health problems, said concerning his/her specific case that it would have been wise to attend a psychiatrist or a psychologist. She was not aware of this and she had only suppressed the signals of her health problems. Now she is sure that these professionals could have prevented something: "*Ich haette eher einen Psychiater oder einen Psychologen kontaktieren sollen.* (Ich) *habe mir das nicht bewusst gemacht, habe alles verdraengt.* (...) *Ich haette da sicher frueher einen Therapeuten aufsuchen sollen, der haette einiges abfangen koennen*." (A02/F01, ID10017LTA, p. x)

Other LTAs also explained why there had not been a chance to prevent the absence period. One LTA said that he/she could not have addressed the supervisor, another LTA said that he/she could not assert his-/herself due to the own depression feelings. Another person explained that he/she had worked very monotonously. He/she could not change these work characteristics and in the long run health problems had started and had become worse. One LTA who was absent due to physical problems only stated that he/she was used to working hard even under stressful conditions and that relaxation from stress based reactions was not possible.

Evidence about preventing factors from persons at the work place was also collected by the interviewees. Three LTAs from the co-morbid group mentioned that job rotation and another job position within the company would have helped or that the supervisor would have had other possibilities, not only the job dismissal due to the illness. One person from the mental

[8] "Zum Doktor gehen und zwar frueher." (A02/F01, ID10189SO, p. x)
[9] This LTA did not use the protection and safety equipment provided by the company.

group stated that his/her supervisor had not trusted the burn-out symptoms of the LTA and that the supervisor should have listened more to him/her: "*Man haette mehr auf die Beduerfnisse der Arbeitnehmer legen koennen*." (A02/F01, ID10017LTA, p. x) Some other LTAs interpreted the conditions in a similar way but concluded that there had not been any possibilities for prevention. Some of the reasons which were also mentioned were that work pressure had been very high[10], that another job within the company would have helped but the support from leading persons had not been given or that the LTA had not been taken seriously.

Statements about work place measures to prevent LTAs from taking absence were:
- "*The boss ought to have listened to me more*." (A02/F01, ID10240LTA, p. x),
- "*The boss ought to have taken the problems more seriously. He did not trust my diagnosis*." (A02/F01, ID10077LTA, p. x)
- "*Maybe it would have helped – at work, of course. Too much work is distributed to fewer people. There is definitely a shared guilt of the employer*." (A02/F01, ID10240SO, p. x)
- "*My boss should have provided a better atmosphere*." (A02/F01, ID10357LTA, p. x)
- „*For sure it was because of the company. If the company had shown any kind of intention to help…*" (A02/F01, ID10305SO, p. x)

It is interesting to note that possible preventions by other persons were only mentioned from absentees due to a physical health problem. These people stated that the diagnoses from a medical professionalist had not been the best, had been wrong years ago or that they had undergone a wrong medical treatment. One LTA also stated that his/her GP should have made a referral to a medical specialist: "*Also wenn dieser* (Arzt), *bei dem ich vor drei Jahren war, als diese Zustaende zum ersten Mal aufgetreten sind, das sofort oder sagen wir nach einem Jahr richtig diagnostiziert haette, dann waere es vielleicht anders ausgegangen*." (A02/F01, ID10148LTA, p. x) This would have helped at that particular stage and another LTA said that the application of a new medical method of treatment would have helped to prevent the worsening of the illness.

From the partners and spouses of the LTAs we also got useful hints of factors which could have prevented the LTA's sickness absence. The SOs mentioned that their partner/spouse should have seen a doctor earlier, should have gone out absent much earlier or would have needed more time to relaxe from all duties. One SO also mentioned that he/she should have just discharged because the work stress had been too high and there had not been a possibility for a fast change. Other work related statements were that the LTA had wished for less stress at that time and another SO stated that there had been too much work for too few people in the company. That was the main reason for the illness and his/her employer should have recruited more people than had actually been there. This was also the main argument of another SO who argued that the employees had not had any employer support at all and that sometimes the employer had behaved regardless of the employees' needs. Similar to the answers of the interviewed LTAs, their partners and spouses also said that the sickness absence had occured due to a wrong diagnosis of a doctor and that one hospital doctor might not have chosen the best treatment strategy: "*Vielleicht haette der Arzt oder das Krankenhaus bessere Beratungen, bessere Therapien machen koennen*." (A02/F01, ID10160SO, p. x)

[10] "Wenn weniger Stress in der Firma gewesen waere. (…) das ist einfach gefordert worden. (…) Der Stress und Druck war enorm." (A02/F01, ID10148SO, p. x)

3.2.2 Before Absenteeism: Measures taken in and outside Work

"*Wenn ich Depressionen hatte – das haben sie* (die Kollegen) *sofort gemerkt,* (und) *wenn es mir nicht gut ging – da sind sie sofort vor der Tuer gestanden.*" [11] (A02/F02, ID10056LTA, p. x)

Approximately half of the interviewees could talk to somebody in the company they worked for before they went absent from work due to medical reasons. The other half could not or did not want to talk to anybody. Almost three out of four LTAs who had talked to somebody in the company also mentioned the social role of that contact person within the company. On the basis on these answers we may conclude that the colleagues of the LTAs were the most important people they could talk to. About every other interviewee told us that he/she had talked to one or several co-workers if available. In the second position of often mentioned people was the company boss or the supervisor one step up in the company hierarchy. The staff manager and the occupational health and safety representative where also mentioned sometimes.

Some slight differences can also be seen when comparing the answers on the basis of the illness type and due to which reason they went absent from work. If the LTA went absent due to a physical reason, the most frequently mentioned answer (about two of three) was that they had talked to somebody about their problems or ill health. The distribution within the mental and co-morbid group was more balanced. About half of the people had talked to somebody, but the other half had not. To whom they had talked to only differed to a small extent, and again they most frequently told their colleagues and their supervisor about their health . (*See table 3.4*)

Table 3.4 Number of LTAs who discussed health problems with people at work by main reason for current absence

	Main reason for current absence			
LTAs discuss health problems with someone at work:	Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	10	7	10	27
Yes:	14	5	7	26
- with supervisor	*5*	*4*	*2*	*11*
- with colleague/s	*10*	*2*	*5*	*17*
- with someone else (OHP, HSR, etc.)	*4*	*2*	*1*	*7*

But what did they talk about at this stage before the absence began? Well, the answers varied very much among all interviewees. The categorisation of the statements about this issue signalised that the kind of contact was simply about discussing the problem with somebody. About one third of the LTAs' answered that they had addressed the contact person with the aim to talk about their problems, their symptoms and about work in general. It is also very important to mention that these kinds of contacts also had the output of offering people with physical problems pratical support from their contact persons, e.g. one LTA could not lift heavy things and some colleagues helped. "*Die Kollegen haben Aktenkisten fuer mich getragen*." (A02/F02, ID10008LTA, p. x) Mainly co-workers offered help with their daily work to release the individual from work burdens (e.g. lifting of heavy things). Many LTAs also said that they had taken advice from their contact persons on what to do and what to

[11] Translation: „*When I had feelings of depression – They* (colleagues) *noticed this instantly,* (and) *if I wasn't well they offered support immediately.*"

disregard. "(Er/Sie) *hat gesagt, dass ich schauen soll, dass ich die leichteren Sachen mache. Die Kollegen haben mir die schwere Arbeit abgenommen. Sie haben gesagt, 'warte bis wir da sind*!' " (A02/F02, ID10144LTA, p. x) The kind of advice had different content, e.g. because of their health problems some had said that they should consult a doctor[12], undergo a therapy or they had been advised to get in touch with the supervisor of the company. Another reason to take up contact with somebody was to get information about the right doctor or other medical institutions with the aim of getting a feeling for the best action for the LTA to take. Two single answers were also about future action with very specific content, i.e. about sickness absence, pension system or part-time employment in general.

As expressed by the interviewed LTAs, the effects of these statements at that moment were that they received appreciation, consideration and verbal/practical assistance from their counterpart. The LTAs articulated that this had been very important for them at that particular moment in which they had mainly suffered from severe health problems. Additionally, two other LTAs simply stated that the dialogue about their individual situation had helped them[13]; and in some cases they mentioned that they became more self-secure and more secure about their future. The outcome on the basis of contact with people in the work place of three LTAs was that they went to the doctor or to a hospital.

Categorising the contacts at the work site, the interviewees talked more about personal problems, about work in general, practical day-by-day support and the search for adequate information with co-workers. One significant example for colleague support was that they told the LTA only to do those tasks which were compatible with his/her health: "*Die Kollegen haben gesagt, ich solle nur die Arbeiten machen, die mit der Gesundheit vereinbar sind.*" (A02/F02, ID10146LTA, p. x) The contact with the supervisor or human resource managers was more shaped by future action like taking sickness absence, other health advice but also by discussing the problem. Health and safety representatives helped with diagnosis and treatments but also with medical advice.

Helpful and supportive supervisor action
One supervisor was very supportive. The LTA reported that his supervisor advised him to continue on his 'way', to continue the therapy and said that he should take a time out or a longer sickness absence until his health situation had improved.

Beside these positive cases mentioned above, there were also some other cases which we want to mention here. Not many but some mentioned that they had not wanted to talk to anybody about their health situation at that moment. For instance one LTA said that you should not discuss these kinds of problems with anybody: "*Nein. Man sagt nicht, dass man gesundheitliche Probleme hat.*" (A02/F02, ID10343LTA, p. x) Four LTAs also mentioned that they had not talked to anyone because they had feared a job dismissal and one person said that he/she had talked to his/her supervisor about his health problems but after some days he/she had received the letter informing him/her of the job dismissal. Other negative reactions about the results of talking to people in the company could be put into practice. The advice had a good content but it was not practical at all. Another LTA reported that he/she had got no support at all and he/she had not been taken seriously.

These results also show that not all contact within the work site had a positive end and some had no benefit for the interviewees at all. The answers also give some indication that some contact attempts were contra productive for the individual and maybe also for their health situation. These cases exist but on the other hand it is good to know that these cases

[12] *„Die Kolleginnen haben zu mir gesagt: ‚Lass dir das anschauen*!'" (A02/F02, ID10165LTA, p. x)
[13] *"Ihre Hilfen war sehr wichtig, weil die mir soviel Halt gegeben haben.* (…) *Die haben mich immer sehr aufgebaut."* (A02/F01, ID10056LTA, p. x)

seem to be exceptions from the rule. Contrary to that, most of the interviewees emphasised the social contacts at the workplace were very helpful and supportive.

Additionally, the interviewees had had a lot of contact with persons outside their work place. In sum, the majority of interviewees (six out of ten) mentioned at least one contact person before absence from work. These people had had contact with persons outside work to whom they spoken about their health problems. By comparing the type of illness which their absence was based on, the ratio of answers of LTAs who had had contact and LTAs who had had no contact slightly alternated. The ratio of "*yes, had contact(s)*" to "*no, had no contact*" in the physical group is 9:1, in the mental group it is 8:2 and in the co-morbid group it is 7:3. Persons with mental health problems had slightly less contact with persons outside of work than physicals had, and people with both, physical and mental (co-morbid) problems, had fewer contact than persons from the physical and mental group. (*See table 3.5*)

Table 3.5 Number of LTAs who discussed health problems with people outside the workplace by main reason for current absence

	Main reason for current absence			
LTAs discuss health problems with someone outside workplace:	Physical (N)	Mental (N)	Co-morbid (N)	Total
No/n.a.	8	3	10	21
Yes:	16	9	7	32
- with partner/spouse	*10*	*5*	*6*	*21*
- with family members and relatives	*13*	*6*	*7*	*25*
- with friends and acquaintances	*7*	*5*	*7*	*19*
- with medical professionals	*5*	*11*	*12*	*28*

Mostly mentioned by the interviewees were their relatives, friends and acquaintances, with the individual's relatives making up the biggest proportion of answers (approx. three of four) followed by his/her friends (approx. one of four answers). Less often mentioned were professionals. But this was only true in the total sample, because the vast majority in the physical group in this respect only mentioned their relatives, whereas the proportion of friends was higher in the mental and in the co-morbid group. So LTAs due to physical problems addressed relatives about their health problems more often than the other two groups did. The most important group is the one of the relatives and approximately one third of the mentioned contacts were close friends.

Among the contacts to relatives their own partner or spouse was the most relevant person to whom the LTAs talked about their problems. Secondly, the "family" in general was stated without mentioning the concrete relationship or social role. Within the family, the most important persons were their own mother (or mother-in-law) or father (or father-in-law), their own siblings (sisters and brothers) and their own children (daughters and sons) as contact persons in the LTAs' social network.

The contact structure concerning professional groups outside work in this critical situation at that time was also very interesting. Whereas LTAs from the physical group only mentioned GPs and other physical oriented specialists like orthopaedics, the mental and co-morbid group additionally had contact with psychologists, neurologists, psychiatrists and therapists, too.

The kind of support they received at that particular moment was structured into different types in the analysis. First of all the interviewees got a lot of informational support from their network. They gathered all kinds of information, advice and tips. Some advised them to go to the doctor or that they should take a sick leave from their work. Other network persons said that they should work less or should only work what their body could cope with. Others advised the interviewees to just live healthier (e.g. quit smoking, eat healthier). But on the other hand, instrumental support was also very important for the interviewees. And they often received practical help in everyday life by their contact persons such as support in domestic

chores, personal transport and also instrumental support for their own health (e.g. massage)[14]. And last but not least emotional support was a central point in the personal contacts to people outside work. They talked a lot about their health problems and other relevant aspects. They often had the possibility to talk about their concerns and they received understanding from their counterpart and could exchange opinions and experiences and they found comfort. Some pointed out that somebody had been there and that this had been essential for them and therefore very helpful[15].

> *About the importance of partners help and support*
> One co-morbid LTA reported of the importance of her partner. She had extreme pain and was always in the mood of crying. She reported that her partner gave her a secure feeling, the feeling that he was there for her: "*Everything will be allright and we will manage the situation together!*" – And then he embraces her. (A02/F03, ID10056LTA, p. x).

Also the kinds of supportive actions varied across all types of contact types. Informational, instrumental and emotional support was given to people with health problems from many types of contacts and very often family members (partner/spouse) and friends were involved.

The professional support was also provided and the kinds of supportive actions varied as well. Professionals such as GPs as well as other specialists made medical checks but also gave advice (e.g. change of eating behaviour). They also provided treatments and medications to fight the symptoms with the aim of improving their health situation. When they had a mental problem, some interviewees pointed out the helpfulness of the contact with a mental health professional. One interviewe stated: "*Ich habe mit Psychologen gesprochen, das war sehr wichtig*." (A03/F03, ID10056LTA, p. x).

The vast majority of interviewees categorised the kinds of support they got at that time as useful. The usefulness of the received support was rated differently, but we can conclude high importance due to the answers. Based on the advice and support from their social net, some interviewees consulted the health care system (doctor, hospital). This signalises its significance because this effected an attitude change. Some also said that this step was really important because their life was in danger. Some LTAs gave the helpfulness a different weight, but the support was also very important for them (e.g. domestic tasks). But most of the answers were that the individual interaction helped a lot. It gave them the opportunity to get rid of some problems just by talking about them. It was important for some interviewees because there was somebody there to whom they could address something. They had the feeling of not being alone and it helped that somebody was all ears and maybe gave verbal support. They could draw strength from that.

But some other interviewees who had mental problems at that time also highlighted that sometimes it had been very difficult to talk about the mental problems. Sometimes it had been that way because the interviewees could not make clear which problems or feelings they had, but also the contact persons had problems giving support and they could not really help them. One interviewee talked about his/her depression. The LTA mentioned that many people would not understand what was going on when somebody had a depression or depressive feelings. Many people would not understand what it means to have a depression: "(…) *aber wenn jemand nicht weiss, was das ist* (eine Depression), *versteht er es sowieso nicht*. (…) *andere verstehen nicht wirklich was es heisst, eine Depression zu haben.*" (A03/F03, ID10235LTA, p. x).

[14] "*Im Alltag haben sie* (die Familie) *geholfen.* (…) *Sonst haette ich fuer alltaegliche Dinge die dreifache Zeit benoetigt.*" A02/F03, ID10015LTA, p. x)

[15] "*Es wird weitergehen. Wir werden zusammenhalten und das miteinander schaffen.*" (A02/F03, ID10305LTA, p. x)

Not all supportive actions were adequate
One LTA reported that support is not necessarily supportive every single time. The opposite is sometimes true. In this case, a female co-morbid had work related problems and her family tried to advise her to change the work place. But for her the advice was not adequate because it created some kind of pressure. It was pressure for her, because at her age it was not easy to get a job again. The result was that she felt misunderstood by her family members and therefore caused depressive feelings. The words of this LTA were: "*Aber die Gespraeche, dass ich mir einen anderen Job suchen soll, waren auch ein Druck, weil ich mit meinem Alter sowieso nichts mehr finden kann. Da habe ich mich dann unverstanden gefuehlt und das war dann wieder ein Teufelskreis wegen der Depression*." (A03/F03, ID10119LTA, p. x).

Another important result was that singles who do not live together with a partner or a spouse, had significantly less contact to persons outside work when comparing the answers with those of couples. One could argue that singles substitute the partner/spouse, who is not available for singles, with other family members or friends, but the interviewed cases do not support this assumption. This is a strong indicator that singles have fewer people to talk to about their health problems and therefore are more likely to receive less informational, practical and emotional support as well.

A single person who didn´t want to stress her own children
A woman with physical health problems had no possibily to discuss her problems with others. Not even with her children because she did not want to stress her children with her issues and therefore she bottled her things up. In this respect, she was completely alone: "*Ich habe es in mich hineingefressen. Meine Kinder habe ich nicht belasten wollen. Also war ich in dieser Beziehung immer komplett allein.*" (A02/F03, ID10018LTA, p. x).

3.3 Impact of Absence on Individual and Family

The impact of absence is enormous. About nine out of ten LTAs stated individual consequences such as financial problems, emotional, depressive feelings or lowered self-esteem. But having an absent partner at home also impacts the whole family unit, the partner and the children as well. The partner also feels the financial and emotional pressure. The same is true for the children in the household. There were also changes over time of absence for LTAs personally but also for the partner/spouse and the children who live in the same household. All in all, the impact on the household and the family was negative in 19 cases only and 7 stated that negative and positive impacts appeared together.

3.3.1 Consequences of Absence for the Individual

"(…) *ich muss jeden Tag weinen – ich weiss nicht wieso*." [16]
(A03/F03, ID10332LTA, p. x)

Due to the different situations in medical terms as well as concerning the social circumstances, one might assume that there are many different consequences for the LTAs and their SOs – and indeed, the long term absence of the LTAs had various effects.

[16] Translation: "I have to cry every day – I don't know why."

In most cases, namely 34 out of 53, which means about two thirds, the LTA stated a negative financial effect. This effect can be found in the group of single income households as well as in the group of double income households, because of course in both cases the household had to deal with less money than normally. The personal impact of the financial aspect, however, varies from LTA to LTA, depending on personal savings, financial support through others, monthly expenses (including therapy) or debts. (*See table 3.6*)

Another factor often stated by LTAs is the influence on one's self-esteem and depressivity. 17 out of the 53 interviewed LTAs said that they felt useless, helpless, not needed, depressed, ashamed or something similar.

Statements about the lack of self-esteem and feelings of depressivity
- "*I appear a little useless to myself.*" (A03/F01, ID10016LTA, p. x)
- "*I feel like a piece of dirt.*" (A03/F01, ID10198LTA, p. x)
- "*Emotionally, I have fallen into a deep hole.*" (A03/F01, ID10072LTA, p. x)
- "*One loses self-confidence.*" (A03/F01, ID10144LTA, p. x).

Again no major differences between the different groups could be found concerning their self esteem and depressivity, but looking only at words such as "*unnuetz*, *unnoetig*, *nutzlos*" (useless), more single LTAs (with or without kids) mentioned feeling useless than LTAs with partners did. This supports the hypothesis that being in a relationship helps keeping up the feeling of being needed.

Table 3.6 Consequences of absence for LTA personally by main reason for current absence

Consequences of absence for LTA:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No/d.k.	2	1	2	5
Yes:	22	11	15	48
- Financial	*16*	*7*	*11*	*34*
- Emotional	*8*	*4*	*6*	*18*
- Self-esteem, depressity	*9*	*6*	*8*	*17*
- Physically restraint	*5*	*0*	*1*	*6*
- Relationships	*0*	*0*	*5*	*5*

To a smaller degree but still often stated was also the fact that the LTAs felt (physically) restrained in their usual habits. About ten percent complained that they were not able to do what they normally did or wanted to do[17] or that many things were physically strenuous if at all possible[18]. Especially interviewees from the physical group can be found stating these impairments, but also a few people from the other two groups experienced this effect.

About one third of the LTAs stated another negative emotional consequence too: worries about the future or worries about their/a job. In addition to the financial loss, losing the job meant or would mean a decrease in self confidence and psychic stress, according to the LTAs answers: "*Vor allem wie das Dienstverhaeltnis aber dann sogar wegen dem langen Krankenstand aufgeloest worden ist, da ist es mir psychisch sehr schlecht gegangen.*" (A03/F01, ID10291LTA, p.x); „*Dann ist die Sorgen um die Existenz dazugekommen, In der Firma haben sie gesagt, ich soll nicht kommen, die Chefaerztin wollte, dass ich wieder arbeite. Es war eine grosse psychische Belastung.*" (A03/F01, ID10069LTA, p.x).

[17] "*Dass ich nicht das machen hab koennen was ich wollen haette*." (A03/F01, ID10338LTA, p. x.)
[18] "*Es ist schon schlimm, wenn man ploetzlich auf Null zurueckschrauben muss. Ich habe sogar den Toilettenbesuch als beschwerlich empfunden.*" (A03/F01, ID10192LTA, p.x)

On the other hand, some LTAs experienced the lack of work as a positive consequence, since they now had time to finally relax and think their whole life over. These positive effects can be observed in the group of the physicals as well as in the other two groups.

Positive consequences for the individuals
- *"For the first time I was happy to have time to relax.*" (A03/F01, ID10016LTA, p. x)
- "*I have dealt a lot with questions about my whole life, with questions about the meaning of life. I read a lot and dealt with myself.*" (A03/F01, ID10338LTA, p.x)
- "*I am human being again – I am feeling myself again!*" (A03/F01, ID10037LTA, p.x.)

From the SOs' point of view, again the major impact of the absence was the financial aspect: Sixteen of the SOs stated financial changes for the worse, but again the actual degree of the loss depended on circumstances such as support from others, savings, debts or expenses (including therapy).

Other negative consequences stated in the interviews were the worries about their partners' health and life: "*Es war einmal eine irrsinning schwierige Zeit da, wo ich (ihn/sie) einfach da g'habt habt, (er/sie) furchtbar krank war, ich nicht g'wusst hab, ob er am naechsten Tag wieder aufwacht im Bett.*" (A03/F01, ID10338SO, p. x); „*Ich habe Angst gehabt, dass (er/sie) die Operation gar nicht ueberlebt*" (A03/F01, ID10148SO, p. x). Such examples can be found in all three groups of illness types.

Some SOs also experienced emotional stress. They felt tense, down, some even depressed: "*Wir hatten Angst, dass (er/sie) es nicht in den Griff bekommt. Das ist eine Belastung.*" (A03/F01, ID10160SO, p.x); „*Es war sehr schwer fuer mich. Bis man sich daran gewoehnt. Und du darfst nicht viel sagen, ein falsches Wort….*" (A03/F01, ID10305SO, p.x); „*Ja, da geht das rauf und runter, das ist manchmal Wut und Frustration oder auch Angst, weil ich nicht weiss, wie's dann weiter geht oder was die Zukunft bringt… .*" (A03/F01, ID10102SO, p.x); „*Wie er das erste Mal in den Krankenstand gegangen ist, denk ich, bin ich mit (ihm/ihr) abgestuerzt …*" (A03/F01, ID10240SO, p.x).

As another difficult result of the LTAs impairments, some SOs had to work more than they usually did, in the household as well as in their company. For some this was not a problem, especially for people who were at home, had no children and were used to doing the housework, for others it was a major change: "*Den Haushalt habe auch ich gemacht, obwohl (er/sie) da immer zustaendig war.*" (A03/F01, ID10192SO, p. x).

As a positive consequence, some SOs said that they enjoyed having more time with their partner and/or help at home[19]. This position could be detected in all different groups.

3.3.2 Consequences for the Relationships with Partner, Children, and Dependants

From the interviewees with partners in the same household, most of them, 25 out of 39, said that their partner experienced negative consequences. These consequences were more or less the ones stated in the previous question: financial loss, worries about the LTAs health, worries about the future and an increase in work. Typical statements in this context were: „*Wir haben finanziellen Druck.*" (A03/F02, ID10056LTA, p.x)[20]; "*(Der/Die) hat nur Sorgen gehabt um*

[19] "*Auf der anderen Seite is es schoen, wenn ich ihn laenger habe - also auch ein Vorteil.*" (A03/F01, ID10073SO, p. x)
[20] Translation: "We have to deal with financial pressure."

mich. Nur Sorgen.“ (A03/F02, ID10013LTA, p. x)[21]; „*Es hat (ihn/sie) vielleicht ein bisschen verunsichert, was denn da noch kommen wird.*“ (A03/F02, ID10122LTA, p. x)[22]; „*Der Druck ist bei (ihm/ihr) groesser geworden.*“ (A03/F02, ID10115LTA, p. x)[23]. (*See table 3.6*)

Table 3.6 Consequences of absence for partner by main reason for current absence

Consequences of absence for partner:	Main reason for current absence			
	Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	7	4	8	19
Yes:	10	8	7	25
- Financial	*5*	*4*	*3*	*12*
- Emotional	*8*	*4*	*5*	*17*
- Domestic/more work	*2*	*6*	*1*	*9*
- Relationships	*2*	*1*	*2*	*5*

Some LTAs, however, mentioned also a positive consequence, namely more time with each other. As a result, in some cases, the SO actually had less work to do at home, because he/she got help from the LTA: *“Ich hatte mehr Zeit fuer (ihn/sie). Ich konnte den Haushalt ganz alleine machen.”* (A03/F02, ID10086LTA, p. x); *„(Er/Sie) ist gluecklich darueber, dass sie mich zu Hause hat.*“ (A03/F02, ID10264LTA, p. x).

In a few cases, one or two within each illness type, the LTA said that the long absence had no consequences for their partner what so ever. For this question, no differences between the groups could be found.

Similar to the LTAs or the SOs, according to their parents also many children experienced consequences in both directions: the positive and the negative. From the positive point of view, which was stated by 15 interviewees, many children were glad to be able to spend more time with the LTA than normally. After school, they now had somebody waiting for them at home, having somebody to play with or talk to or to be helped by with their homework, as the parents told the interviewers: *“(Das Kind) hat sich da eigentlich sehr wohl gefuehlt, dass (der/die LTA) mehr fuer (das Kind) da war, als vorher, wo (der/die LTA) berufstaetig war.*” (A03/F03, ID10072SO, p. x); “*Naja, fuer die Kinder, ich habe mehr Zeit fuer die Kinder. Zum Beispiel fuer die Hausaufgabe, Hausaufgaben machen tun wir.*“ (A03/F03, ID10331LTA, p. x); *„(Die Kinder,) die waren natuerlich zufrieden, wenn sie einen Ansprechpartner gehabt haben, zu Hause, nach der Schule.*“ (A03/F03, ID10261LTA, p. x).

Many other children, however, experienced mainly negative consequences (n=18), according to their parents. Similar to the adults, they worried a lot about their parent’s health.[24] In many cases they also noticed the financial change.[25] For some children it was especially difficult to be away from their parent for the first time/for a long time, when the LTA was in hospital: “(…) *(die Kinder) haben (ihn/sie) eigentlich drei Monate nicht gesehen*“ ((A03/F03, ID10338SO, p.x); “*Aber fuer die Kinder war’s sicher schwierig dieses staendige Hin und Her, von einem Leben ins andere gerutscht irgendwie, einmal war (er/sie) da und furchtbar krank, dann war (er/sie) weg und gar nicht sichtbar, es war immer eine andere Situation.*” (A03/F03, ID10338SO, p. x). Some children reacted in their own way to the new

[21] Translation: “He/She worried about me.”
[22] Translation: “What the future might bring maybe made him/her a little bit insecure.”
[23] Translation: “The pressure increased within her/him.”
[24] “*Es war natuerlich auch emotionell schwierig, weil sie sich Sorgen um mich gemacht haben.”* (A03/F03, ID10016LTA, p. x)
[25] “*Und dann sind wir in die Situation gekommen, dass wir nicht mal Geld hatten, um die Schulbuecher fuer (den Sohn/die Tochter) zu kaufen oder die Kleinigkeiten, die (er/sie) gewohnt war zu bekommen, von frueheren Zeiten.*“ (A03/F03, ID10343SO, p. x)

stressful situation: one child cried very often and needed to sleep in the other parent's bed, one child only played on the LTAs bed during his/her stay at the hospital, another one started wetting his/her bed, one developed an alcohol problem, one had difficulties at school concerning his/her marks and one child quit school.

Table 3.7 Consequences of absence for children by main reason for current absence

Consequences of absence for children:	Main reason for current absence			
	Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	17	7	11	35
Yes:	7	5	6	18
- Financial	*3*	*0*	*2*	*5*
- Emotional	*6*	*4*	*3*	*13*
- Domestic/more work	*1*	*0*	*0*	*1*
- Relationships	*1*	*1*	*2*	*4*

Although one might expect differences between the group of single parents and the group of couples with kids, these differences could not be found. Maybe this, just like the great number of different reactions of the children to the situation, is partly due to the children's age as well, not only the number of parents in the same household.

Between the mentals on the one hand and the other two groups on the other hand, it looks like there is a small difference in how the children accept the illness. In the mental group, there are children who had difficulties in accepting their parent´s illness, simply because they could not see it. The children did not see that the LTA was not stress-resistent, because they thought, he/she was at home, so why could not he/she do things at home. To "see" a physical impairment seems to be simply easier and therefore it is also easier to accept the illness.

The accaptance of mental health problems by one´s own children
A mother talked about the problems her children had with the mental health desease of her partner: "*Partly lack of understandning of the children because it is not a visual desease.*" (A03/F03, ID10102SO, p. x) Another partner of the LTA expressed this relationship with: "(…) *they do not understand because the desease simply is not apparent to them.*" (A03/F03, ID10102SO, p. x)

Only two LTAs stated another person in their household as being dependants, in both cases it was their mother. Also both LTAs said that their relative enjoyed spending more time with the LTA: "*Meiner Mutter ist es recht, dass ich nicht arbeite, weil da bin ich mehr da.*" (A03/F04, ID10079LTA, p. x). Over time, in one of the two cases the positive aspect got even more positive due to the effects of the therapy, in the other case no changes were detected.

3.3.3 Changes in Impact over Time of Absence

The majority of the interviewees (36 out of 53) experienced a change of the consequences over the period of time of their partner's absence. Those who did experience changes can be devided into two groups: the first group experienced only/mainly changes to the better (50%), the second group experienced changes only/mainly to the worse (30%). (*See table 3.8*)

In the group of the positive statements, the LTAs and SOs mainly stated that on the one hand the health of the LTAs improved over time and on the other hand they got used to the situation and could deal with it more easily. Conversely, in the group of the negative statements, the LTAs and SOs mainly stated medical problems (not getting better), emotional stress and pressure.

Interestingly, differentiating between the three illness types (taking only the ones into consideration that experienced changes), mentals stated mainly positive changes. Within the seventeen physicals, however, only seven called their experienced changes positive, for five they were only/mainly negative, for six persons the changes were unclear. Differences between single households and households with partners could not be found, nor regarding the RTW factor.

Table 3.8 Changes in consequences of absence for LTA personally over the period of absence by main reason for current absence

Have consequences for LTA changed during period of absence:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	7	2	8	17
Yes:	17	10	9	36
- Improved	*7*	*7*	*3*	*17*
- Got worse	*5*	*2*	*4*	*11*
- Unclear	*6*	*1*	*2*	*9*

Negative changes over time of absence
- A partner stated that the situation of the LTA was getting worse over time: „*I do have the feeling that his mood is getting worse and worse*." (A03/F01a, ID10064SO, p. x)
- An LTA describes his personal impact: „*I do have an enormous psychological pressure. I want to resume work but I can't*." (A03/F01a, ID10056LTA, p.x)

Some positive statements
- "*The recovery from illness can be noticed*." (A03/F01a, ID10192LTA, p. x)
- "*The fear diminished. From health perspective there is now no danger any more* (…)" (A03/F01a, ID10148SO, p. x)
- "*It continuously improved. He has accepted the situation* (…)" (A03/F01a, ID10072SO, p. x)
- And a LTA also recognised positive changes because "(...) *now I can help her sometimes practically and sometimes we have some time to sit down and have a coffee. Then we have time to chat a little bit.*" (A03/F02a, ID10102LTA, p. x)

From the 21 LTAs who answered the question about the consequences for the partner/ spouse over the whole absence period with yes, twelve said that the situation changed to the better, 6 thought that it got more difficult for their partner and in three statements it did not become clear what the change was about (unclear change over time; *See table 3.9*).

Table 3.9 Changes in consequences of absence for partner over the period of absence by main reason for current absence

Have consequences for partner changed during period of absence:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	15	6	11	32
Yes:	9	6	6	21
- Improved	*6*	*3*	*3*	*12*
- Got worse	*1*	*3*	*2*	*6*
- Unclear	*2*	*0*	*1*	*3*

The changes to the better can, similarily to the question above, be summarised as "better health condition – less worries" on one hand, as one LTA said: "(...)*(er/sie) ist nicht mehr so*

besorgt um mich.“ (A03/F02a, ID10148LTA, p. x)[26]. On the other hand, it can also be described as “better health condition – less work”. That means that over time the situation for some partners seemed to gradually go back to normal from the LTAs’ point of view: “*Es ist ein bisschen normaler geworden*” (A03/F02a, ID10148LTA, p. x). The LTAs who mentioned negative changes, did not explain this comment further, unfortunately; both just said that it got more negative or more difficult. From those LTAs who did not think there had been changes for their partners, no further conclusions can be drawn.

Similar to the previous issue, it seemed that the interviewees also had difficulties in answering the question about the consequences for the own children living in the same household. From those who did answer (n=14), however, seven interviewees said that there had been improvements, four stated that there had been negative consequences over the time of absence for the children. (*See table 3.10*)

Table 3.10 Changes in consequences of absence for children over the period of absence by main reason for current absence

	Main reason for current absence			
Have consequences for children changed during period of absence:	Physical (N)	Mental (N)	Co-morbid (N)	Total
No/not applicable	19	8	12	39
Yes:	5	4	5	14
- Improved	*2*	*3*	*2*	*7*
- Got worse	*1*	*1*	*2*	*4*
- Unclear	*2*	*0*	*1*	*3*

Of those who could see changes to the worse: his/her child had insight to the LTAs bank account which led to an increase in worries for instance. The other interviewees, who talked about changes to the better, either said that the situation for the children got easier, because they got used to it[27] or that it got easier because the LTAs health condition had improved, leading to less work at home[28] and/or more activities together. The aspect of spending more time together sometimes also ment an improvement of the relationship between LTA and child/children, according to their parents: “*Die Beziehung zu den Kindern ist besser geworden, weil sie (Anm.: LTA und Kinder) mehr Zeit miteinander verbringen koennen.*” (A03/F03a, ID10115SO, p. x). Sometimes, however, the children were looking forward to having their parent work again in order to be less “controlled” at home: “*Und die zwei grossen Kinder freuen sich schon (Anm.: wenn der/die LTA wieder arbeitet), weil sie nicht mehr so viel Kontrolle zuhause haben.*” (A03/F03a, ID10261SO, p. x).

Again, no big differences between the groups could be found, partly probably due to the small sample, but partly probably because of the different ages of the children involved too.

[26] Translation: „(He/she) no longer worries so much about me.”
[27] “*Dass sie sich daran gewoehnt haben, dass (er/sie) krank ist.”* (A03/F03a, ID10064SO. p. x)
[28] “*Die Haushaltsbelastung ist zunehmend weniger geworden (...).”* (A03/F03a, ID10016LTA, p. x)

3.3.4 Positive and Negative Impacts on the Household and Family

"*Dass die Familie zusammenhaelt, zusammenwaechst* (...)." [29]
(A03/F04, ID10160So, p. x)

Unfortunately, 19 people could not list a single positive consequence of their partner's absence. This means that these people only recognised negative impacts on the household and family. The other interviewees, however, experienced combined, positive and negative effects because there was no single case with only positive impacts. But positive effects can be summarised as "more time", "better relationship" and "help in household". (*See table 3.11*)

Table 3.11 Positive and negative impacts on the household and family by main reason for current absence

Impacts on household and family:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
No impact/not applicable	7	4	4	15
Only positive impacts	0	0	0	0
Only negative impacts	3	7	9	19
Both, positive and negative impacts	5	0	2	7
d.k./n.a.	8	1	2	12

In most cases, the negative aspect concerned the relationship to their partner: Some LTAs and SOs felt tension, some argued more often, some even desired to "break out". It was not only difficult for some to be together "all the time", but the LTA was characterised as at that time being "choleric", "difficult", "impatient" or "cranky". Some examples for this effect are: *"(Er/Sie) ist schwierig geworden.* (...) *Es ist schwierig geworden."* (A03/F04a, ID10064SO, p. x), *"(Er/Sie) geht gleich in die Luft. Man muss so aufpassen, was man sagt.*" (A03/F04a, ID10146SO, p. x), „*Ploetzlich ist man 24 Stunden zusammen, das war sonst ja nicht. Es gab Reibereien. Ich habe oft die Tuer zugesperrt und gesagt jetzt will ich nicht mehr.*" (A03/F05a, ID10040LTA, p. x), „*Das staendige Beisammensein war auch nicht positiv, so dass man den Wunsch hat, auszubrechen.*" (A03/F04a, ID10160SO, p. x).

Another factor stated was the surplus load at home. Many SOs did not only have to do more in the household, but also nurse their partner[30]. This was the case in each group of illness and also each type of family.

Finally, the last impact stated was the factor "worries". LTAs as well as SOs were worried about their (partner's) health and /or their job situation. Some examples are: "*Die Existenzsorgen, das Bangen um die Zukunft.*"[31] (A03/F05a, ID10291LTA, p. x), "*Negativ ausgewirkt hat sich die Angst und das Ungewisse.*"[32] (A03/F05a, ID10037LTA, p. x), „*Naja, wenn (er/sie) vielleicht Schmerzen hatte oder es (ihm/ihr) nicht so gut gegangen ist und (er/sie) nicht darueber gesprochen hat und ich wusste auch dann auch nicht, was los ist.*"[33] (A03/F04a, ID10073SO, p. x). Again, in all illness groups and in all family groups there were interviewees who had had this experience.

[29] Translation: "In order for the family to grow strong, to grow together (…)."
[30] "(...) *dass (er/sie) ein bisschen mehr Pflege gebraucht hat, was ich nicht gewohnt war, weil ich nebenbei hab arbeiten gehen muessen.*" (A03/F04a, ID10126SO, p. x.)
[31] Translation: "Worries about one´s existence, fear about one´s future."
[32] Translation: "The negative effects were fear and insecurity."
[33] Translation: "Well, when (he/she) had pain or when (he/she) didn´t feel well and (he/she) didn´t talk about it and I didn't know what the matter was."

Being asked about the main effects of the long term absence on family life, a few SOs said that there had not been any effects on the family; the majority, however, mentioned impacts – either due to the absence or due to the illness/the accident –, which could be summarised into three categories:

The first category, into which four answers fall, can be called "change in priorities". That means that the SOs had rethought and/or changed the meaning of such things as health, money, work etc. in their life. They appreciated health more than they had used to, whereas material things had lost importance, according to their answers: "*Man hat andere Prioritaeten, man sieht alles anders. Durch die Krankheit hat ein Umdenken eingesetzt. Was das Geschaeft betrifft, haben materielle Sachen nicht mehr die Bedeutung.*" (A03/F05, ID10030SO, p.x), „*Zu Wissen, dass Gesundheit und zur Arbeit zu gehen nicht selbstverstaendlich ist.*" (A03/F05, ID10160SO, p. x).

The second category could be called „finance", and again four answers fall into this category. For those four SOs, the (negative) financial aspect was the main impact of the absence. Interestingly, all four SOs who stated this were partners of LTAs who had not returned to work.

Into the third category three answers appeared which can be called "slowing down". All three SOs in this group, one physical, one mental, one co-morbid as a partner, said that they, as a family, slowed down or tried to do so due to the absence/illness of their partner and that they tried to have less stress in their life: "*Es laeuft jetzt ruhiger ab, nicht mehr so auf Druck und auf Stress, wie mit der Arbeit.*" (A03/F05, ID10072SO, p.x), "*Wenn wir es schaffen (...) es (Anm: das Leben) langsamer zu machen, wenn man krank ist, auch zu Hause im Bett zu bleiben, … dann kann es durchaus was Positives gehabt haben.*" (A03/F05, ID10291SO, p. x), „*Es ist ruhiger als vorher. Es ist nicht so stressig vorher. (Er/Sie) ist ruhiger.*" (A03/F05, ID10214SO, p.x).

Finally there were five more main implications for the SOs, each mentioned once or twice. Two said that as the major effect there had been a restructuring of the household duties, with the LTA now being at home and the SO going to work or having to work more. Another person said that it was a good feeling to realise what one can endure[34]. A third person named the impairment as the main factor, not to be able to do things or go on holidays, which was not possible due to the LTAs pain[35]. Somebody else talked about the uncertainty, the worries about the future as the main impact, and one person stated the time together as the major effect[36].

Positive statements were for example the fact of having more time at home. This was stated many times. LTAs and SOs both said that they enjoyed being together more often than before the absence and that they did more things together such as going to a café or the movies. This effect was mainly stated by persons who have not fully (only partly or not at all) returned to work (or by their SO).

> Typical statements in this context were
> - "*We have more time for each other now.*" (A03/F04, ID10343SO, p. x)
> - "*Yes sure. Now I can do more with my younger daughter* (…)" (A03/F05, ID10064LTA, p. x)

The second positive factor was 'having a better relationship' (with the partner, with the children). In some cases the development in the relationship occured due to the time factor,

[34] "*Insgesamt ist es schoen, wenn man sieht, dass man wieder eine Krise, teilweise zumindest, ueberstanden hat und dass man das aushaelt.*" (A03/F05, ID10240SO, p. x)
[35] "*Dass wir wenig oder fast nichts unternehmen koennen. (...) Das ist aufgrund (seiner/ihrer) Schmerzen nicht moeglich.*" (A03/F05, ID10056SO, p. x)
[36] "*Zeit fuer uns und Zeit fuer die Kinder war waehrend der Arbeit keine. (...) Bei letzten Kind hat (er/sie) dann gutmachen wollen, was (er/sie) bei den anderen versaeumt hat.*" (A03/F05, ID10264SO, p. x)

but many interviewees said that it was not only because of the LTAs time at home but also because of the new, "extreme" situation. The effect of the relationship between the LTA and his/her children might also be influenced by the age of the children or what they did during the day. In the cases where the children were at school all the day, the influence might not have been as great as for children at a younger age, being at home.

Inmproved relationships due to LTAs absence
- "*Relationships have improved, especially with our children. Also our relationship has improved*." (A03/F04, ID10030SO, p. x)
- "*Due to the sickness we have advanced personally a lot and cohabiting has improved too*." (A03/F04, ID10338SO, p. x)
- "*We calmed down.*" (A03/F05, ID10072LTA, p. x)

The third factor, help in household, was not only mentioned by SOs but also by LTAs. When mentioned by a SO, it ment that he/she had less work to do, since the LTA helped. In those cases in which the LTA mentioned it, it ment that he/she was glad not to get help from the SO or children and that therefore he/she had less to do than normally. Also, for some LTA´s helping in the household ment being (physically/mentally) able to help, this was another positive effect. This third category of answers was mainly used by people who not fully returned to work (or their SO); other differences between groups could not be found.

3.4 Rehabilitation Programmes and Activities aimed at RTW

From the 53 interviewees only 16 LTAs participated in a rehabilitation or return to work programme. The rest of the interviewees stated that there was no participation in any kind of programme. Most of the participants rated the involvement in these programs as 'partly helpful' only but they made many suggestions for improving the system.

3.4.1 Participation and Involvement in Programmes

From the group of LTAs, the majority, namely 34 people, stated that they have not participated in any kind of rehabilitation or return to work programme. Unfortunately, for most of the individual cases the reason for this remains unknown. Only in a very few cases the LTAs or their SOs explained the situation: in two cases the LTAs argued that they had not known whom to turn to or that they had not known about programmes. In one case only, the SO stated that his/her partner, the LTA, did not need rehabilitation or a return to work programme.

Two negative experiences
- "*I don't know any contact person. They don't really care about it. There is not the need that somebody gives attention to you there. Nobody has the time - nobody takes the time. There is nobody who would say: ‚Let's try with this or that'. That's not the case*." (A05/F01, ID10122LTA, p. x.)
- "*Was I supposed to get something like that?*" (A05/F01, ID10037LTA, p. x)

From the 16 LTAs who did participate in rehabilitation or return to work programmes, 13 participated in a physical rehabilitation only, two in a return to work programme only and one in both. Interestingly, only in one case did the LTA who said he/she participated in a return to work programme actually work. In the other two cases the LTAs participated in different courses (e.g. computer courses) in order to increase their chance to return to (not necessarily

their former) work one day. In all but three cases it was a doctor who helped the LTAs getting into a programme, in two cases it was possible with the help of the Public Employment Servce (*AMS – Arbeitsmarktservice*) and in the one case, in which the LTA started working within a return to work programme, it was due to a private initiative. Due to the small sample, no differences between the illness types or the return to work types could be observed.

Most physical rehabilitation programmes took place in a health resort (and not a rehabilitation centre!) and involved physiotherapy, spas, gymnastics, coordination exercises and similar activities for groups or individuals.

The return to work programmes, which took place at different institutions, involved computer courses and trainings for saling as well as psychological subjects (not further specified), coaching, career counselling and soft skills such as trainings for social interactions. In one case the LTA also explicitly mentioned help with bureaucracy, and in one case the LTA worked together with people with similar handicaps and therefore experienced help by talking to others.

Corresponding to the specific types of programmes, the people involved in the rehabilitations were physiotherapists, GPs and the hospitals, whereas the returns to work programmes were conducted by special trainers (e.g. IT trainers) or psychotherapists.

3.4.2 Usefulness of RTW Programmes and other Contributions

Most LTA who participated in a return to work programme or underwent rehabilitation said it was at least partly helpful, only three LTA said that the programme was not helpful at all, since they could neither participate due to their high qualification nor could they see or feel any success, and only one SO thought the programme was not going to help his/her partner at all. For the group of physicals the main positive effect was the physiotherapy and the accelerated healing process.

For the mentals and the co-morbids the most important thing was having somebody to talk to, either somebody with similar problems and/or a specialist: "*Er/Sie freut sich darauf. Er/Sie findet dort neue Kolleg/Innen. Es sind dort auch Maenner/Frauen, die aehnliche Situationen erlebt haben und die gleiche Krankheit haben. Die reden dann darueber. Das tut ihm/ihr gut. Seit er/sie die Kurse macht, geht es ihm/ihr besser*." (A05/F04, ID10240SO, p. x.)

People from all groups mentioned that it just was not intense enough as a negative aspect and that they would want/need further help; in one case the SO reported that his/her partner did not like the structures of the programme (e.g. having to sign in and out each time you want to go somewhere else and come back later): "*Die Strukturen haben ihm/ihr nicht gefallen. Wenn man rausgehen will, muss man sich abmelden und so, das ist wie in einer Volksschule gewesen*." (A05/F04, ID10192SO, p. x.)

Concerning what could have been more useful, interviewees mentioned the lack of information – that is what many LTAs and SOs stated as their main problem. What they wished for was more legal advice as well as more information about what was going to happen during their absence.

Besides general information many SOs also desired more psychological counselling/ psychotherapy for LTAs and financial help in this regard, since a long term absence from work often means financial difficulties.

Programmes which allow LTAs to graduately go back to work are definitely needed, said the SOs. How these programmes should actually be designed seems to depend on the type of work you do, according to the SOs. Some, however, stated that they wished to have regular conversations with supervisors to prevent many problems and long term absence, if possible. The situation can be summarised as follows: "*Sie (Anm.: die LTAs) sollten beschaeftigt,*

unterstuetzt und betreut werden, damit sie sich langsam wieder eingliedern koennen.“ (A05/F02, ID10160SO, p. x).

Most LTAs mentioned physical rehabilitation or treatment at a health resort as well as different courses (e.g. computer course) as an answer to this question once again. Only seven LTAs were able to state other services that contributed to their rehabilitation. These were mainly psychotherapy, psychological counselling or self-help groups. One person also said that he/she started working at a child care centre, which was his/her personal initiative. Again, no differences between the illness types or the return to work types could be found.

3.5 Perceptions and Experiences of Returnees and Non-Returnees

The reasons why people returned to work variied across the sample of returnees but they felt healthier again or recovered from illness. Other statement were ‘the need to work again’ or just ‘financial aspects were the reasons to RTW’. Despite the decision to return to work, returnees faced issues and problems in this process and support from people in and outside the workplace were necessary. The changes since work resumption were meaningful, too. Non returnees were asked about the reasons for the return process to be prevented and what could have helped them for work resumption.

“*Ich verkrieche mich in meiner Wohnung, da fuehle ich mich am wohlsten.*”[37]
(A06/F01, ID10018LTA, p. x)

“*Ich muss hinauskommen – es hilft nichts wenn ich mich zuhause einsperre*.”[38]
(A06/F01, ID10056LTA, p. x)

In the quantitative study, most of the respondents reported not having returned to work. Approximately two third of the interviewed persons of this qualitative study stated this fact in the questionnaire and one third said that they had returned to work, completely or partially. The relative numbers differ between illness groups and therefore we only had nine returnees out of 24 which had been absent from work due to a physical health problem, five out of 15 persons returned but had been absent because of a co-morbid problem and only two out of 12 mental had returned to work. So the proportion of non-returnees was a little bit higher in the mental group than in the other groups.

In the family study we also asked for a change of the RTW status because we conducted the qualitative interviews after we had the information of return vs. non-return out of the quantitative study. About half of the interviewees said that there had been no change in status between the two studies. But there were also 17 interviewees who mentioned a change concerning the question of return or non-return to work.

As already mentioned, most of the interviewees had been in sickness absence from work due to a medical reason at the first quantitative study, only the minority had already returned to work. In the qualitative design the interviewed persons also stated “*no change in information at all*”. Also most of the interviewed people have not returned to work in the meantime. But five of our interview partners returned in between the time lag of the two studies. Two stated that they were working fulltime now in the family interviews and two worked part-time. One person recovered from his/her illness and went on holidays before he/she started to work again, some weeks after the interview had taken place.

Being a non-returnee does not mean that the persons are still long-term absent from work due to a medical reason. Other changes which occurred were that six people had then retired due to disability/invalidity or old age pension – or just applied for pension. Three interviewees also mentioned that they got the job dismissal from their former employer between the time of

[37] Translation: “I hid in my apartment. There I feel best.”
[38] Translation: “I have to get going – it doesn’t help locking myself up at home.”

taking sick leave and the interview date. Because of this, one interviewee was at that time unemployed because the financial support had run out, one interviewee had applied for retirement and one person was depending on unemployment assistance (*Notstandshilfe)*. Another LTA also achieved the status of unemployment and also depended on the same benefit since then. Two other persons were involved in an advanced training or further education programme.

3.5.1 People who have Returned to Work

3.5.1.1 Factors and People involved in the RTW decision

The answers to the question about which factors influenced the decision to return to work after the long period of sickness absence are rare, but we gained some knowledge what was important at that time.

First of all it is important to mention that the strongest factor for the decision to return to work was the feeling of the interviewees of being healthier or of having completely recovered from the illness (whatever it was). This was mentioned by people who had been absent due to a physical health problem, but also by people from the mental and co-morbid group. Another important thing mentioned by many who returned to work and who stated something concerning this question was that they had wanted to work again. Some explained that they liked to work and they had felt the inner need to return to work. A similar answering pattern exsists for answers by people who said that they could not stay at home any longer. They did not want to be at home any longer and they wanted to have something to do, something completely different to do compared to things one can do at home: "*(Hausfrau/-mann) sein, das ist ja auch nicht die Erfuellung des Lebens*." (F04/F02a, ID10086LTA, p. x) This factor was also mentioned throughout all illness types.

Not as many people as expected used arguments concerning financial pressure. One partner has to cover up financial shortages when the other one is absent from work because of a medical reason. Still, some argued that the financial aspect was the main reason to return to the workplace. One interviewee said that the salary of one person in the household was not enough for an additional month of absence[39]. Another person said also that the family had needed the money and that this financial part had been the reason to return. Persons who had planned to go retire after their recovery said that they had had to go to work again. The reason for this contrary decision was that they became aware of the fact that the pension would not be high enough to guarantee the current standard of living. Additional years of social security payments were necessary which was the basis for the decision to go back to work again. So in those cases the financial aspect was also given but it was combined with planning ahead.

Another factor for returning to work was stated only by returnees who had been absent due to a physical reason. They said that the company had needed him/her and therefore these three interviewees had decided to go back[40]. One of these persons simply said that he/she had been needed, another said the decision had been a cooperative step because he/she had not wanted to abandon his/her colleagues.

Some returnees had help from one or many different persons who helped them in the decision to return to work after the sickness absence period. But of all returnees only five stated that others were involved. The majority negated the questions of the involvement of other persons and said something like: "*No, nobody. That was my own decision.*"

[39] "(…) *es war notwendig. Sonst koennen wir unser Leben nicht bewaeltigen – nur mit einem Gehalt.*" (F04/F02a, ID10291LTA, p. x)
[40] "*Ich habe gespuert, dass ich dringend wieder gebraucht werde.*" (A04/F02a, ID10192LTA, p. x)

One mental LTA stated several of the mentioned factors together
This person felt better again and he/she felt the need to be active because after a long time period at home he had cabin fever. This was completely contrary to the beginning of the absence period. At that time he/she just wanted to stay at home by himself/herself only. After a while, it was an inner requirement to resume work. (A04/F02a, ID10017LTA, p. x)

Within the very small numbers of persons, the majority mentioned medical professionals like the GP, the orthopaedic, the doctor in the hospital or just unspecified "*the doctor said*". One interviewee also mentioned the psychotherapist he/she had consulted. This interviewee asked this professional about his decision and the latter said that it had been a good one. Another person involved in this step, which is reflected in a single statement only was the partner/the spouse. This person said that he/she had just talked to/discussed the decision with him/her. The human resource manager of his/her company was also involved in one case.

One statement of a returnee who had been absent from work due to a mental problem said that nobody had been involved in the return to work step and the decision. He/she answered this question vehemently with "*Nobody was involved!*" and also pointed out strongly that he/she was very happy to have made a decision all by himself/herself after a while: "*No! Finally I made the decisionon my own!*" (F04/F02a, ID10235LTA, p. x).

3.5.1.2 Issues and Problems faced – What could have been done?

Compared to the small numbers of returnees the number of answers was huge. We got several hints concerning the support they had liked to receive which would have helped the returnees with the aim to return to work in a better way. Only three of them said that they needed no support or that they had got enough. One was completely happy with the support and help having been offered to him/her.

Mainly returnees who had a physical problem wished to have more help and support which could have facilitated their physical restraints which had still been there at that time. One person had a crook and had no possibility to drive his/her own car. So this person needed other persons (family, friends) to reach the work place. Another interviewee wished to have more collegial support. When he/she was in hospital, visits from the colleagues would have helped him/her but he/she had notbeen visited, not even after more than 25 years of working for that company. An interviewee who had been a co-morbid also said that he/she had not received much support from the colleagues at work when he/she had returned to work. Also concerning the workplace another person stated that in his/her case there had not been any appreciation or readiness to talk about these things at the company (supervisor or colleagues). This person said that this would have helped in the RTW process, however.

In another case the returned interviewee said that he/she had problems with work because it had been difficult to cope with. In this case another job position within the company would have helped. Some statements concerning the employers were also that there had been no will to change something in the daily demand of work and how the work place should have been designed so that employees are satisfied there.

Concerning family support there was only one statement in the answers. This mental returnee stated that the family members had not given any verbal support so that he/she could tackle his work duties after "recovery" again. This had been a lack of supportive action that would have helped in the decision to return to work.

Problems and issues returnees faced in the beginning were very individual and were very specific to the physical or mental problems they had, but also depended on the work place as well on the people working there.

One returnee who still had physical problems had been confronted with mobility difficulties and also problems with the long sitting in the office. Others stated that it had also been difficult to work because of the physical interferences. They could not move parts of their body which would have been necessary to complete the daily work. Some of the work these people could not perform because of their movement problems, so other people at work had to help and to do these tasks instead. Three returnees also mentioned exhaustion after weeks of sickness absence because they had not been used to the intense work load at all.

Beside these practical problems and issues of work, some other returnees also mentioned some more abstract things but these are very useful to highlight the individual thoughts which were influencing the return to work threshold. Several people mentioned an inner threshold they had to go through. For instance one returnee mentioned that he/she worried about the own (regained) health which could worsen during the work process. Another person feared that the pain could come back at work again and this made the LTA nervous. Another fear was how the person would be able to find back into the work group again.

But basically, most of the interviewees had no idea or suggestions what could have been done to fasten the return to work process. Many returnees told us that they had gone back as soon as soon as possible due to their health situation. So most often they argued in the interview that an earlier return to work would not have been possible due to their bad health situation: "*Es ist mir nicht gut gegangen und dadurch war ich eben so lange daheim.*"[41] (A04a/F08, ID10013LTA, p. x) One explained that there had not been many possibilities which could have supported the sooner RTW because it depended on the healing process and nobody could have dobne anything to fasten this healing process. Also some interviewees, especially returnees who were absent due to a physical reason, rejected a positive answer. The argument for them was that they were medical laymen and that they could not judge if something could have been done to speed up the recovery. One person who had been absent due to a mental health problem also said that his/her doctor had advised a longer absence period due to the lengthiness of the health problem.

One interviewee also noted that he/she had nobody to look after his/her young child. That lengthened the absence period too. Answers given by the SOs were very interesting. For instance one SO stated that having a loyal supervisor would have maybe had the consequence of an earlier return to work. This was stated by a SO of a returnee who had been absent due to a mental reason. This was also the case when one SO mentioned that a better psychological treatment would have had the same consequence. Due to the fact that a psychologist is very expensive and the family did not have the financial resources to pay a psychologist, the SO responded that a psychological treatment paid by the social security agency might have led to an earlier return to work: "*Ich glaube, er/sie haette vielleicht eine bessere psychologische Betreuung gebraucht. Aber die sind teuer* (und) *wir hatten wenig Geld zur Verfuegung.* (...) *Es waere vielleicht anders gewesen, wenn das von der Krankenkasse mitfinanziert worden waere.*"[42] (A04a/F07, ID10160SO, p. x)

Concerning the RTW process, the majority of SOs said that there had not been any problems in the return to work process of his/her partner/spouse. Everything had been fine and his/her partner/spouse had done well or that his/her partner/spouse had felt very comfortable and he/she had fit in the work process very well. In the opinion of one SO the recovery process had fastened from the time point on he/she returned to work again. Another SO stated about her/his spouse/partner that he/she had wanted to work again and that had been the main reason why it had been a good decision to return. Also another SO said that he/she had prepared his/her return to work days or weeks before. So the return process had been

[41] Translation: "I didn't feel well and that's why I was at home for so long."

[42] Translation: "I think he/she would have needed a better mental attendance. But these are expensive (and) we didn't have enough money available. (…) Maybe it would have been different if it had been co-financed by the social security agency."

good and with the help of the colleagues it had gone well[43]. Also the return to work to another employer had meant motivation for the returnee. It had been another new and good challenge to meet new colleagues, a new work subject and to learn something new.

Two new experiences
- About the return to work experience one partner stated: "*The return helped him.* (…) *Due to this fact he recovered much faster*." (A04a/F05, ID10126SO, p. x)
- A new job was a breakthrough for one LTA: "*The new job was a motivation for him, new energy. It was a big difference compared to former times (...) new people, a new working area, learning.*" (A04a/F05, ID10291SO, p. x.)

On the contrary there were also cases in which the return to work process had not been the best option. One SO told us that his/her partner/spouse had wanted to retire after the sickness period because the situation at work had not been perfect at all. Another SO reported that the returnee had been motivated but in the same time it had been a risk because his/her spouse had not known his own health boundaries and when crossing the individual boundaries, health risks would have been the consequence.

Only two SOs stated that more could have been done to make the return to work process more straightforward for the LTA. In one case the psychiatrist of the LTA had wanted him/her to stay in sickness absence longer but the responsible social security agency had rejected the application. So in this case the RTW circumstances had not been perfect. The other SOs reported that it would have been better if the employer of his/her partner/spouse had had the desire to change something at the workplace. But this had not been the case and would never be the case, but this would have improved the return of his/her partner/spouse. In another part of the interview the LTA of this SO said that the employer should have stepped up to the returnee more and the employer should have respected that the returnee could not immediately work as hard as before. The LTA's own words were: "*Der Arbeitgeber (sollte) mehr eingehen auf einen und respektieren, wenn man nicht mehr alles machen kann*." (A04a/F10, ID10146LTA, p. x)

3.5.1.3 Support Provided in the RTW Progress

Persons from the workplace, family members and friends were the persons who had been available and who had provided support in the return to work process. Concerning the mentioned categories of contact persons, the persons of the returnees' company were stated more often than family members, in sum three times more often than family members. Only in one case friends were the answer to the question.

Within the persons at work, colleagues seemed to be more important than supervisors, mainly because they were closer to colleagues than to supervisors. Partner or spouse, parents and one´s own children were also mentioned and therefore available for supporting the return to work process.

Most of the statements concerning the way available persons had provided support were that these people had helped with things at work. They had helped to lift and carry heavy things at work mainly. All others were single statements such as picking somebody up to reach the workplace or the other way around picking somebody up to reach home because the person could not walk without a crook. One other person had easier work to do at the workplace or the colleagues said that he/she should work slowlier. Two other persons got emotional support from their work mates such as mental support.

[43] "*Es war wichtig, dass (er/sie) normal aufgenommen wurde*." (A04a/F05, ID10126SO, p. x)

The support provided mentioned above had a significant impact on the returnees. In one case it was essential because otherwise he/she could not have reached the work site. Other cases just stated that it had been helpful that somebody had supported them with everyday work and especially with work duties and secondly it had provided security. It had given a kind of secure feeling that somebody had been there who was ready to help if help was necessary.

- Concerning the support action one interviewee stated that "(...) *it somewhat gave me security because there was someone there helping me. I didn't have to do everything on my own. That's how I felt.*" (A04a/F05b, ID10040LTA, p. x)
- Another LTA also concluded that "(...) *it was a support for me knowing that they (the colleagues) are standing behind me.*" (A04a/F05b, ID10192LTA, p. x)
- One person highlighted the amazing fact that the support had been available over months: "*Das finde ich toll, weil das ueber Monate geht* (…) *das ist keine Selbstverstaendlichkeit.*" (A04a/F05b, ID10013LTA, p. x)

Only one returnee described the unhelpful output of the support provided. In that case the returnee could not do all the heavy work by him-/herself and therefore the colleagues had to do his/her work. That had been the beginning of a conflict situation within the company because there had been too little people who had to do the same work as before. "*Es war eben so, dass dann die anderen im Team die schwere Arbeit machen mussten*. (...) *weil zu wenig Personal da war. Es war ein bisschen eine Konfliktsituation.*"[44] (A04a/F05c, ID10192LTA, p. x).

3.5.1.4 Changes since Work Resumption

"*Die gesamte Familie kommt langsam wieder zur Ruhe.*" [45]
(A04a/F03, ID10291SO, p. x)

The returnees returned to the same job with the same working conditions. Twelve people stated this fact and four said that they returned to work with a different employer. Fourteen interviewees mentioned also that this was the most suitable option for them. But the descriptions and explanations for that differ.

Positive statements were for instance that the person had been very well integrated in the job and the job environment, even after long sickness absence. Another person stated that the return to the same job and the same job condition had been the best solution because he/she had liked his/her job and the activities at work. A third interviewee mentioned the reason that his/her job was a secure one.

Other returned interviewees also stated that it had been the most suitable option but it had sometimes been the best only because of several reasons in the background. Most often mentioned was a particular age of the interviewees. They said it had been the best option to return to the job because they had reached an age in which it is often a problem to get another job at the same or another employer. So, another job at his/her age was not imaginable and it was not possible to be employed at another job because of the interviewee's age. Other interviewees also stated that he/she had feared the high unemployment rate and he/she had not wanted to be one of them. So the decision had been easy and he/she had returned to the same job after sickness absence. Another interviewee also stated the fact that the possibilities to have a job in a certain regions did not exist and one had to be happy to have a job at all.

[44] Translation: "Well, as it were, the others had to do the heavy/difficult work. (…) because there were too little personnel resources. It was a bit of a conflict situation."
[45] Translation: "The entire family is slowly calming down again."

- "*Because of my age. I don´t have the opportunity to do something else.*" (A04a/F06, ID10040LTA, p. x)
- "*At my age, looking for another job wouldn't be imaginable for me any more*." (A04a/F06, ID10118LTA, p. x)
- "*One has to be glad to have a job. There are no alternatives*." (A04a/F06, ID10122LTA, p. x).

People who changed their job and working conditions mentioned significant other reasons why it had been a good decision. One stated that the decision had been made because in the "old" company too many unpleasant things had happened and that had been why the decision to look for another employer had been easy for this interviewee. Concerning the age, another interviewee also said that he/she was thankful that he/she had lost his/her old job and that the old job contract had been cancelled. In the new job with only 25 hours per week he/she had no stress at all and was happy that long term strains did not exist in this job.

Very interesting was also the statement of another interviewee who returned to a different employer. When a person works for the same employer within the same job one is likely to become more and more routine-blind. In this situation he/she had felt that the situation was normal and he/she had stopped thinking about the situation. He/she had stopped to scrutinise working conditions and he/she thought that everything would have to be like this because it had always been like this and therefore there was no possibility to change one´s thoughts. That was the argument for this person why the change to another employer had been the best for his/her.

- "*Actually I am thankful that my work contract had to be dissolved. Now I have a 25 hours job and it gives me the feeling of not being overloaded all the time. There I do not have the feeling to be over-worked*." (A04a/F06, ID10291LTA, p. x).
- "*If a person works in the same company for a long time then you are likely to get routine-blind. Then you're likely to think that everything in the company must be like it is. (…) whether it is reasonable or not, nobody scrutinizes it after a while.*" (A04a/F06, ID10086LTA, p. x)

Whereas, the receptions returnees got from people at the workplace were frequently positive. Especially the colleagues were very happy and therefore the returnees got a very warm welcome back to work. Most of the supervisors also reacted in a positive way. The answers were like "was good", "it was very positive", "supervisor was pleased". Two others said that the supervisor had been satisfied that he/she had returned to office so quickly. One interviewee, he/she had been absent from work due to a mental reason, also denoted that the new supervisor had focussed very much on the mental wellbeing of his/her employees. So, managers also had their positive responses on the return to work of interviewed persons. Some were also happy and satisfied that he/she returned to work. One interview person said that this had been extremely positive because the manager had also provided information and said that he/she could get practical help if there were any problems at work concerning the recent illness.

Not that positive or negative receptions were also mentioned on inquiry. Three returnees mentioned that the colleagues' reactions had been partly negative and the colleagues had problems dealing with the situation. One interviewee explained that they had not been openminded at all and another interviewee mentioned that the colleagues had no idea how to deal with the type of illness (i.e. cancer). In one case the supervisor had been very astonished and surprised that he/she had returned to work again. The supervisor had not expected this. Another returnee mentioned that he/she had severe problems because the supervisor had not accepted the medical certificate.

The impacts of returning to work for the person who had been in sickness absence were asked from both, the former LTA and his/her SO. The LTA question was only asked a general question addressing the impacts on the family and the Sos were asked several questions to break down the information of the impacts on the SOs partner/spouse, the SO him- or herself and the children or dependents if available. To mention it straight away, no impacts on dependents (other persons living in the household) were mentioned by the LTAs or SOs due to the fact that only four families had dependents in their household. So no information about the impact on dependents could be observed. But the impacts on the other family members were stated, additionally in both directions, positive and negative.

Due to the fact that the former LTA returned to work, some mentioned that the main impact was a relief of financial strain which could mainly be characterised as a financial reduction of the household income. Since he/she had returned to work, the family unit had more financial resources available. This was positively affirmed because it became clear that this financial reduction during the sickness period had sometimes been a problem for all, for the LTA and the SO but also for the children in the household. Only one returnee said that the financial benefit of returning to work had not brought a relief of financial burdens. Some other returnees stated that life had to be restructured and reorganised because of the return to work process. Facts mentioned in this respect were that the structure of the day needed a change, the change-over had been important because a single parent did not have the time since return to work for cooking for the own child. She/he had to pre-prepare the meals from that point on. Overall, the return to work meant the return to "everyday life" like some of the interviewees characterised the impact on all people involved in the process. "*Es war momentan wieder eine Umstellung, weil ich nicht mehr da war.*"[46] (A04a/F09, ID10040LTA, p. x)

Another very often stated positive effect was that the former LTA regained his/her self-esteem and self-respect which he/she had lost during the long time sickness period. One SO mentioned that her/his partner/spouse had got back his/her self-confidence and regained the feeling of internal control. So, the return process had in some statements been really essential for the involved persons also because work ment structuring of the day and the former LTA had ambitions to work which had been very essential. In this respect, a SO stated that his/her partner/spouse had lost all purpose during the sickness absence period and therefore had just been sitting in the household without doing anything and only thinking about the own disease. Another SO told us that the partner/spouse had learned many things about stress during the absence period. After that he/she was cooler and looked at things more relaxed. One SO also stated the positive effect on all people involved: on the returnee but also on the family life. The SO stated that his/her partner had recovered from illness and had restarted to work again and therefore life quality had improved also because the partner/spouse liked to work.

- "*It was important for (her/him) to hold down a job, to have an activity. (…) working and having aims is completely different compared to sitting at home thinking about being ill.*" (A04a/F01, ID10030SO, p. x)
- "*He/she didn't stress him-/herself out as he had before. He/she cut down his/her 13 hours day to eight hours. He/she takes things easier than before.*" (A04a/F01, ID10126SO, p. x)
- "*(His/her) life quality has improved. Additionally, he/she enjoyes going to work again … and he/she likes coming back home too.*" (A04a/F01, ID10194SO, p. x)

The interview partners also mentioned negative effects on the whole family life. For instance, one returnee and his/her SO mentioned, that the returnee had to work during the night (night shifts) and this had changed the living together dramatically. Before the return to work he/she

[46] Translation: "In that particular moment it was a change-over again because I wasn't there any more."

had “always” been available and after that he/she slept during the day because he/she was on night shift. “*Manchmal arbeitet er/sie am Tag und manchmal in der Nacht. Das ist natuerlich auch nicht so einfach.*”[47] (A04a/F01, ID10073SO, p. x) Another returnee told us about sorrows and problems in the beginning after return to work. These interviewees called this a stress situation and the return process therefore had a severe impact on him-/herself. Worries were mentioned, worries that it would be the same as it had been before the long sick leave or sorrows how it would work at the workplace because he/she had been far away from everything for very long. Additionally, one SO said that his/her partner/spouse had also thought about the problems with the supervisor he/she had gone through before. This had been a stress situation for this case in the beginning of the return phase. Last but not least one SO stated the concrete sorrow that nothing had changed at work during the absence and that he/she feared that the partner/spouse had learned nothing from the mistakes he/she made.Similarily, one SO had the severe fear that the partner/spouse would return to the same habits he had before the absence. “*Ich war eher besorgt, dass er/sie es wieder so angeht wie vor der Krankheit. Aber das war eh nicht.*“[48] (A04a/F02, ID10126SO, p. x)

These fears and sorrows of the SO of the returnee are only one mentioned negative effect in the interviews. Some complained about the impacts that occurred after the return of his/her partner/spouse. Statements for instance were that the SO now had more to do – especially the harder work at home. Another person also complained that the structure of the day had then changed dramatically.

But despite these negative effects, also many positive effects were specified by the SOs. Some of the statements also provide insight how the persons and especially the SO must have been strained during the critical time period. Because of the change of daily routine, many SOs mentioned that they now had time for themselves which they had not had during the time the partner/spouse had been at home. Two SOs said that they were now more independent than before not only concerning the household duties but also concerning financial aspects and personal matters. “*Mein Alltag halt … Ich war wieder freier.”* (A04a/F02, ID10194SO, p. x), “*Fuer mich ist es leichter. Ich kann den Haushalt wieder so arrangieren wie ich es frueher gemacht habe und mit dem Geld sieht man schon, dass es mit zwei Gehaeltern leichter geht*.”[49] (A04a/F02, ID10146SO, p. x). Some SOs very concretely specified the freedom from “pressure”, worries and fears. One SO said that he/she was now more quiet after the return to work of his/her partner/spouse and one SO also said that he/she had suffered from the situation mentally and the SO had had severe sleeping problems. After the return of his/her partner/spouse, the SO had recovered from these mental problems.

Concerning the impacts on the children due to the return of the LTA, also positive and negative effects were stated in the interviews. In one case the children recognised that the illness and the absence of one of the parents had been a crucial situation and not funny at all. But some families also stated that it had been positive that he/she had been at home because they could spend more time with each other as already mentioned before. On the contrary, one SO also stated that the return had changed something in the life of the children and that they were missing that particular part of the family now. On the other hand SOs also mentioned that the children were happy that the LTA had returned to work because they had recognised that something had been wrong, that one family member had had physical problems and perhaps mental problems too. When he/she was working they thought that everything was ok and when he/she was at home they paniced because they feared that their father/mother was ill (again).

[47] Translation: “Sometimes he/she works during the day and sometimes during the night. That’s not easy of course either.”
[48] Translation: “I was worried that he/she would behave like he had before the sickness. But it wasn’t that way.”
[49] Translation: “My everyday life … I was freed.”; “It is easier for me. I can arrange the household just like I had done before and concerning the money it is easier with two salaries.”

3.5.2 People who have not Returned to Work (so far)

3.5.2.1 Preventing the RTW Process and What could Support Work Resumption

Among all three groups of illness, the reason mentioned most often for preventing the LTAs from going back to work was that the LTAs were not healthy (yet). This reason was stated in 15 out of 24 cases within the physical group, in 6 out of 8 cases within the mental group and in 12 out of 18 cases within the group of the co-morbids. In most of these cases the LTAs and/or their SOs said that the LTAs were not healthy yet but would be able to go back to work when being well again; in four cases, however, the LTAs will not go back to work but received invalidity pension. These four people were all physicals.

The other main reason for not going back to work is that the LTAs cannot find a suitable position, because of various difficulties. In three cases, one of each health-group, the LTA looked for a part time job, because he/she was either physically not able to work full time or he /she was a single parent and could not afford a full time job due to his/her children. In three other cases, again one of each health-group, the LTA could not find the right job according to his/her qualification and according to his/her physical ability (e.g. not being able to lift heavy things). In three other cases, two physicals and one co-morbid, the LTAs stated that they did not get a job due to the fact that they had been on sick leave. According to them, as soon as a potential employer knows that they were ill, they are not willing to employ them. A similar situation can be found for two LTAs who consider themselves as too old. Due to their age, they think, noone wants to employ them. Two others, two physicals, said that they feared stress at work and that's why they did not want to go back, one person said that he/she lacked self-confidence and that he/she did not know what would suit him/her, and finally two people said that actually nothing kept them from going back to work.

Most interviewees (16 out of 23) felt they could do something in order to resume work and number one of their answers (stated 7 times within each group of illness type) was that they should get fit again[50]. This is not surprising, since the main reason for the LTAs preventing them from getting back to work was their bad health condition. On the other hand it shows that getting better is actually something a person has to work for, and the LTAs seem to know that.

Another idea of what to do to get back to work was to look for jobs (online, in newspapers etc.) and to send out applications. This was mentioned six times, three times from LTAs of the physical group, three times from LTAs of the co-morbids. Interestingly, not a single LTA from the mental group mentioned applying. (At the same time it has to be said that only five co-morbids actually answered this question.)

The other things people felt they could do were waiting (for being contacted by somebody who at that time were not available), organising transportation to the company which at that moment prevented one LTA to get back to work due to physical impairment, and to do a re-training in order to find a different job.

Interestingly, 7 LTAs who answered the question said they felt there was nothing they could do in order to get back to work. Five of them were co-morbids, and within the other two groups there was one LTA each. None of them specified why they felt there was nothing they could do. Instead, most LTAs did not feel that there was anything their family could do (17 out of 21 answered the question with no). Only four people, two physicals and two mentals (and no co-morbid) said that there might be something their family could do: one physical

[50] "*Ja, wieder fit werden, nicht.*" (A04B/F2, ID10338LTA, p. x.)

LTA said that a relative had connections to various companies and therefore might be able to help getting a job, one other physical LTA said that his/her family could help him/her by creating space and time for regeneration. In the eyes of the mentals who felt that there was something their family could do, this was to give time to recover and to ease the financial pressure by working more hours. No differences between family types (children vs. no children) could be found.

But what could help them to return to work again? Most of the LTAs and SOs who answered this question said that there was something that could have been done to help them getting back to work; only eight said that there was nothing that could have been done for them. Number one of the positive answers may be summarised as "new ways of working" which means that it would be helpful to be able to be part-time employable from the interviewee's point of view, which was not possible at that moment: one was both healthy and employable or on sick leave and not allowed to work at all. One SO called his/her idea "Sozialpool" (pool of people who are only able to work a few hours a week and/or who can only do special jobs). In his/her eyes something similar to workshops for handicapped people was necessary, where people get to do tasks they are able to handle, according to their physical and mental health. Another idea was to enhance working at home. This way one would be able to work more flexibly.

Another need stated was the one for a suitable job position, with only that amount of (physical and mental) stress the LTA could handle. This desire was mentioned both from people with physical and/or mental problems and included features such as more routine work (for a person with concentration problems) or less moving (for a person who needs to sit a lot), for example.

While physical therapy as a way of support was not mentioned at all, psychotherapy as a way to be able to get back to work was mentioned by three mentals and two co-morbids (and no physical) or their SOs.

Due to the modified abilities in some cases, four LTAs or their SOs said that they needed re-training such as a computer course. Unfortunately not all of the LTAs who wanted to actually participated in a course, due to the small number of places. Some, however, participated and thought that the course would help them.

Three people said that it would help them having a supportive structure (including the labour union) organising things for them such as bureaucracy or the transportation to and from work.

Finally, a few interviewees said that they would need connections (including former colleagues) in order to find and get a job: *"Ohne Beziehungen hat man heute keine Chance mehr."*[51] (A04B/F4, ID10305LTA, p.x)

3.5.2.2 Advantages and Disadvantages of having a Partner/Spouse who is Absent

The main advantage in the SOs eyes was that the LTA had more time, time for the family, which means for helping in the household and for spending more time with the children, as well as for themselves. The LTAs needed this time, according to their SOs, for convalescence as well as for working on their personality and focusing on the essential part in life. Some, however, could not see any advantages in their partner's absence.

Number one of the disadvantages stated was the financial aspect. Six SOs called this the major negative effect. Another effect often mentioned was that the LTAs were missing their work or any kind of work and that they were worried about the future in this context: "*Das*

[51] Translation: „Without connections you don't stand a chance nowadays."

war ein super Arbeitsklima fuer (ihn/sie). *Das* geht (ihm/ihr) *sicher im Kopf umher.* Dass (er/sie) *so eine Arbeit sicher nicht mehr bekommen wird, das ist mal logisch.*“[52] (A04B/F04, ID10083SO, p. x) Also, some missed the daily routine and having something to do as well as some missed being around people other than the family: *“(...) dass* (er/sie) *halt nicht mehr so unter den Leuten ist.”*[53] (A04B/F04, ID10115SO, p. x) In one case the SO reported a negative effect on the partner’s self-esteem as a major disadvantage, and one SO stated that the partner was in the way, that now the partner was around him/her more often, demanding a lot, sometimes even interfering: *“Naja, es war sicher eine Umstellung, dass wer da ist, der Ansprueche stellt, der einem dazwischen redet und funkt.”*[54] (A04B/F04, ID10338SO, p. x)

Nine SOs out of 14 additionally said that they would prefer their partner going back to work, under the condition that they are well again: *“Im Moment schon, bis* (er/sie) *vollstaendig gesund ist. Aber grundsaetzlich soll (er/sie) schon arbeiten gehen.”*[55] (A04B/F05, ID10077SO, p. x) Only two SOs would prefer the situation in which the LTA stays at home. This way the LTA would be less stressed and more relaxed and his medical condition would not improve being back at work.

Two SOs saw advantages and disadvantages in both solutions. In one case, the SO would prefer the partner to stay at home and to spend more time with the children from the family’s point of view, but from the financial point of view, he/she would like the partner to work again. The second case is similar: On the one hand the SO wanted the partner to stay at home, since he/she was ill, on the other hand he/she wanted him/her to work again to ease the grief about the financial situation.

One SO found a compromise between the two aspects. He/she wanted the partner to work at home, which he/she is going to do. Probably this solution would be the best in the eyes of many SOs, but it was only stated by one person.

3.5.2.3 Company Contacts and How they could Facilitate RTW

Approximately half of the LTAs who were still absent had contact with representatives of the company. The other half had no contact at all. Within the group who had contact, the differences in terms of the nature of the contact were huge.

Some LTAs reported that they had only one contact, some said that they had contact over a certain period of time and another group still has contact with people from the company. The types of contacts varied from telephone contacts mainly to personal get-togethers, letters and emails.

A small group of non-returnees reported about very intense contact with both, colleagues and in single cases also with the supervisor. The contacts were mainly described as telephone calls and personal contacts in or outside workplace. One person said that some colleagues became good friends of him/her. “*Einige Kollegen sind zu Freunden geworden.*”[56] (A04b/F06b, ID10037LTA, p. x). If so, they mentioned very warm and friendly relationships and they talked about both, private and non-private issues. The LTAs got information about what was going on at their workplace and were informed about the “latest news”. Based on this, some interviewees mentioned the helpfulness of this contact. It was amicable and they got a good feeling. It was also helpful because they regained hope that they would one day

[52] Translation: “It was a great working climate for him/her. It surely bothers him/her that he/she won’t be able to get another job like that. That’s for sure.”
[53] Translation: “(…) that he/she is not among a lot of other people any more.”
[54] Translation: “Well, it surely was a change-over that there is someone demanding, who interrupts and interferes.”
[55] Translation: “Yes at the moment, until he/she has recovered completely. But basically, he/she should be working.”
[56] Translation: “Some colleagues became (good) friends.”

return to the company. Because of the positive contact content, one interviewee lost his/her negative feelings about job insecurity. Job insecurity was described as stresswhich was reduced then. "*Das gibt einem ein gutes Gefuehl. Also ich mach mir entsprechend keine Sorgen um meinen Job und auch nicht um die Wiedereingliederung. Und da faellt eine grosse Belastung weg, weil das ist nicht selbstverstaendlich, das weiss ich.*" (A04b/F06c, ID10338LTA, p. x) One LTA had contact with his/her supervisor and realized that he/she was valuable for the company because the supervisor showed understanding and humanity.

But in some cases it became obvious that keeping in touch with colleagues was not that easy after a longer period of time of absence from the workplace. Some interviewees explained that they had contact which decreased over time. Also other interviewees reported from contacts in the beginning after reporting sick but there was no contact at all now. "*Zu einer Kollegin hatte ich noch eine Zeit lang Kontakt, aber das hat sich alles aufgehoert.*"[57] (A04b/F06b, ID10016LTA, p. x)

Also several non-returnees reported the fact that they had contact but only because of the job dismissal or they had contact in which they had informed the employer about their health problems and then the dismissal had followed. And these were no single cases. Many interviewees mentioned this. Two very significant statements about this were: "*Ich habe* (zum Arbeitgeber) *gesagt, dass es zur Zeit keine* (gesundheitliche) *Besserung gibt* (...) *und zwei Tage spaeter habe ich die Kuendigung bekommen.*"[58] (A04b/F06b, ID10018LTA, p. x), "*Einmaliger Kontakt und dann erfolgte die Kuendigung.*"[59] (A04b/F06b, ID10148LTA, p. x), "*Kuendigung, Abfertigung und aus!*"[60] (A04b, ID10072LTA, p. x) There were also cases where LTAs agreed to cancel their work contract.

The type of contact they desired was more personal contact with colleagues. One interviewee stated that the colleagues should pay more attention and offer more help and another LTA also wished to have contact but did not get any from persons from the workplace. Another LTA narrated how good the contact had been before his/her absence but after the leave nobody had taken care of him/her. A different interviewee also wished to have more contact with the supervisor but this was not possible due to personal problems and misunderstandings, and in another case the LTA suffered from having no contact because nobody from the company ever asked him/her about his/her wellbeing. "*Das sie* (die Firma) *mich fragen, wie es mir geht. Ich bin nichts mehr fuer sie. Da kommt man sich vor wie der letzte Dreck.*"[61] (A04b/F07, ID10056LTA, p. x). Another LTA was also very disappointed about what had happened or what had not happened. In this case he/she desired to have an open and honest discussion about 'all issues' but this did not take place. This person just wanted to talk about the reasons for losing his/her job after having taken the absence leave but had no success: "*Ich haette ein persoenliches Gespraech erwartet. Ich haette die Wahrheit vertragen. Dann waere die Kuendigung O.K., wenn wir offen darueber geredet haetten.*"[62] (A04b/F07, ID10214LTA, p. x) Additionally, one interviewee mentioned that contact would have helped him/her to finalize and to cope with the situation. He/she longed for the contact "(...) *um besser mit der ganzen Sache abschliessen zu koennen.*"[63] (A04b/F07a, ID10085LTA, p. x)

The LTAs longed for being given a chance at work. That means that the interviewees experienced the employers focusing on the illness and/or on age rather than knowledge, experience and competences one had. In this context, LTAs also wished for better

[57] Translation: "I still had contact with one colleague but after some time that all stopped."
[58] Translation: "I told my employer one time that there was no hope for recovery and two days later I got fired."
[59] Translation: "One time contact and then the dismissal followed."
[60] Translation: "Dismissal, settlement and that's it!"
[61] Translation: "That they (the company) ask me how I am. I am nothing to them any more. One feels like shit."
[62] Translation: "I would have expected a personal talk. I could have taken the truth. Then the dismissal would have been o.k. for me, if we had taked about it openly."
[63] Translation: "(…) to be able to get over it, done with the whole thing easier."

communication with their (potential) employers, having somebody to talk to at work and also clarifying what one was able to do and what one was not able to do.

Another way of helping the LTAs, according to themselves, would have been a slow or gentle introduction back to work. One example mentioned was to start as a co-worker and gradually gain more responsibility and autonomy. This way the LTAs could gain confidence in their tasks as well as get used to the process of working.

Also mentioned was the strategy of working fewer hours, such as 20 or 30 hours a week, according to their abilities, or to change tasks but to stay within the same company, again according to one's abilities. Finally, one person stated that it would have been helpful to have somebody working at his/her position temporarily during the LTAs absence, and not being fired immediately. This way the position would still be occupied, but after regeneration the (former) LTA could go back to work.

3.6 Comments on the General Section

In this general section we describe the answers of the interviewees about how work and living conditions effecs life quality, an incident of stress. The majority of interviewees, LTAs and their partners, think, that there are changes in society which differentely effect life quality as well as the levels of stress. Asked for the workplace, about 90% of all LTAs stated the main factors for absence and about 3 out of 4 interviewees of the opinion that changes in society are influencing absenteeism due to a medical reason.

3.6.1 Work and Living Conditions and Life Quality, Incident of Stress

The vast majority of the interviewees (LTAs and SOs) explicitly argued that the changes in the way how people work and live these days effect the quality of life and the levels of stress. In sum 59 people of 64 interviews who answered this question said this, whereas only 15 said that there are no effects on life quality and stress. Comparing the answers of LTAs and SOs it becomes obvious that more SOs said this than LTAs did. Concerning other variables no big differences emerged. There were for example no huge differences between the answers of physicals, mentals and co-morbids. (*See table 3.12*)

Most often technological change, new media and new technologies were the argument for the changes in work life and living. The interviewees said that circumstances like modernisation and mechanisation had a great impact on individuals' life and work. This also included new technologies like computer, internet, e-mails, mobile phones, etc. This has led to a total change of work and life and had, in the opinion of the majority, negative consequences. For instance these new technologies we have to use also effect occupational demands. These altered performance requirements were described by the interviewees with key words like more responsibility, overtime and changed working conditions (e.g. working on Saturday and Sunday and during the night).

Mainly because of the globalisation these economic tendencies lead to an occupational pressure and this is passed on to the individual. Nowadays, the individual has more responsibilities and the individual has to bring up a better performance. Only the output counts these days. Because of mechanisation, the whole society life is faster and human beings have to keep up with this pace.

But these higher responsibilities have the unpleasant effect of being associated with less salary and fewer people who have to work for the same tasks. "*Alles soll hunderprozentig sein.*" (A06/F01, ID10192SO, p. x)

Table 3.12 Number of LTAs and partners to the question how changes in the way we work and live affect quality of live and levels of stress by main reason for current absence

Changes in way we work and live affect life quality / levels of stress:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
LTA:				
- No/d.k.	9	4	8	21
- Yes	15	8	9	32
Partner:				
- No/d.k.	2	1	2	5
- Yes	13	7	7	27

So financial stress and lower payments mean stress for each employee and more people are dissatisfied with this situation. The interviewees also very often stated that this new pressure line in the work life situation also led to higher insecurity of losing one´s job. The pressure on the individuals have risen but the employers extort the employees but not changing these negative trends. "*Als Mensch gilt man nur etwas, wenn man gut funktioniert. (…) Der Druck kommt von ganz oben und wird von oben nach unten weiter gegeben und 'den Letzten fressen die Hunde'.*" (A06/F01, ID10235LTA, p. x)

On the one hand they cannot change it because they have to 'survive' because they are subject to market pressure and they also have to have a good performance, but on the other hand employers have access to an army of unemployed people which they can activate if the employed do not want to go with theses changes. People are afraid of losing their job or being dismissed if they do not comply and that's the reason why people go to work despite ill health. In this respect one LTA significantly stated: "*Man muss immer funktionieren, immer gut drauf sein. Und wenn man mal nicht gut drauf ist, dann fragen sich alle: Was ist los, ist die schon zu alt, schafft es die nicht mehr? Und mit der Technik: Man hat einen PC, ein Schnurlostelefon, etc. Jeder sollte jederzeit erreichbar sein. Die Qualitaet geht da ganz verloren, der Mensch selbst zaehlt nicht mehr*." (A06/F01, ID10005LTA, p. x)

The pressure on the individual is enormous and makes the transition from work to family life more difficult, because nowadaysprivate life comes after work. An interviewee said: "*Zuerst kommt die Firma, dann das Privatleben.*" (A06/F01, ID10189LTA, p. x) The recent trend has also led to a social and psychological change in these statements of the interviewees.

About how these changes effect the individual, a lot of things were mentioned. Most often stated were higher pace and hectic life. Pressure is higher and stress for all occurs more often for each individual: '*It is more stressful nowadays*' we could translate the most often the mentioned opinions. The pressure has changed dramatically when comparing work life from now to work life from earlier decades. Life as a whole is more stressful now and many people are completely overstrained. The pressure is a result of the economic demands and the working pressure at an occupational and individual level. The individual has to deal with harder conditions nowadays, because only the output counts and therefore everything must be faster and working output must be generated faster in less time.

In the opinion of many interviewees this is an inhuman and impersonal situation, the 'together' is less valued and the cooperativeness between people has declined. Everybody, especially the employees, are very often inundated with the situation which leads to lowered life quality in general. This again leads for instance to exhaustion, aggression and to a lack of concentration in the end. Accidents and health deterioration are the consequences.

Most interviewees stated the existence of economic trends with psychosocial impacts on the individual. The interviewed persons draw their consequences based on their experiences due to their own biography, employment situation and also because of their ill health.

For example one interviewee concluded concerning the new technologies, that each individual has the possibility to control the effects on there own: "*Ja, wir leben in einer sehr stressigen Zeit und das haben wir der Technologie zu verdanken. Nur ich denk, das liegt in der Hand jedes einzelnen, das zu kontrollieren fuer sich. Und das werde ich in Zukunft tun fuer mich. Ich mein, Mobiltelefone haben auch eine rote Taste, um nur ein Beispiel zu nennen. Man muss da nicht mitspielen*." (A06/F01, ID10338LTA, p. x)

Also this statement was striking: "*Ich hab mich sicher um 180 Grad geaendert. Das Finanzielle ist nicht das Wichtigste. In erster Linie ist es die Gesundheit und das Familiaere. Die Arbeit ist auch wichtig, hat nach wie vor einen hohen Stellenwert. Es ist gut, dass ich wieder arbeiten kann, ich muss aufpassen, dass ich nicht ueber meine Kraefte gehe, ich muss halt mit der Krankheit umgehen koennen. Es ist positiv, die ganze Natur erleb' ich anders. Es ist alles so schnelllebig. Heute geniesse ich die Ruhe, wenn ich nach Hause komme, es ist keine Hektik oder sonstwas*." (A06/F01, ID10160, p. x)

Or the consequence of an individual foreseeing the next job after the sick leave: "*Ich habe mir vorgenommen, wenn ich wieder arbeite: Die Suppe wird nicht so heiss gegessen, wie gekocht. Ich werde mir immer vor Augen halten, durch welche Hoelle ich gegangen bin*." (A06/F01, ID1005LTA, p. x)

But the picture is not complete if we do not mention other statements which do not represent the majority of answers. These statements are totally contrary to the other arguments mentioned above but represent the different views very well. For instance, one interviewee evaluated the effect of the development of new technologies and their consequences as facilitation and help for the individual who uses them: "(…) *ich glaub' eigentlich schon, dass diese Technologien eine Erleichterung sind*." (A06/F01, ID10016LTA, p. x) And with respect to stressful and hectic life, another LTA also emphasised the positive side of stress. This person argued that each individual needed a certain amount of stress and he/she expressed it like this: "*Ein bisschen Stress braucht man immer, weil sonst ist es fad*." (A06/F01, ID10261LTA, p. x)

3.6.2 Interviewees Impressions about main Factors for Absence from the Workplace

Interviewees were asked to verbalise their impressions about the main factors which had effected absence in their workplace. The interviewed LTAs had to analyse their own workplace, whereas the SOs were asked about the experiences of factors producing absence in the workplace of their partner or spouse.

First we have to say that this question was very difficult to answer for both, the LTAs and especially the SOs, because they did not have a very good insight in the situation of the partners' or spouses' workplace. So, in sum not as many factors for absenteeism were mentioned as we expected.

Among all answers – mainly from the interviewed LTAs –it is noteworthy, despite the main factors for absenteeism in the workplace, that many interviewees mentioned the employees´ fear to report sick because they were afraid of losing their job or being dismissed. One SO pointed out that sickness absence rates were declining because everyone would be in fear. People would be going out absent only if sickness absence was really necessary, and absentees then would try to be absent as short as possible, e.g. because of the fear of job loss.

In fear of job loss
- One LTA stated for instance: "*Wenn sie in der Produktion zum Beispiel zwei oder drei mal einen einzelnen Tag daheim sind oder zwei, drei mal an Fenstertagen zuhaus' sind, sind sie gleich ganz weg.*" (A06/F02, ID10073LTA, p. x)
- "*Man kann sich heute gar nicht mehr leisten, laenger in den Krankenstand zu gehen. Wenn man da laenger weg ist, dann wird man sofort gekuendigt.*" (A06/F02, ID10118LTA, p. x)
- "*Die Krankenstaende gehen zurueck, weil jeder Angst hat, seinen Arbeitsplatz zu verlieren. Wenn jemand in den Krankenstand geht, dann gibt es auch einen wirklichen Grund dafuer und die Leute halten die Krankenstaende auch so kurz wie moeglich.*" (A06/F02, ID10085SO, p. x)

Another LTA also explained the lower absence rates because the absence period would have the effect of not being able to complete one´s work when absent from work. When an individual returns to work after the sickness absence, he/she has more work then he/she would have had if he/she had not been absent, according to the interviewees. That's also a reason why people delay their sickness absence decision: "*Da ueberlegst du es dir ob du in den Krankenstand gehst. Weil du denkst dir, wenn ich jetzt geh', muss ich dann das Doppelte machen.*" (A06/F02, ID10083LTA, p. x)

Table 3.13 Number of LTAs and partners to the question how changes in the way we work and live affect quality of live and levels of stress by main reason for current absence

Main reasons for absence in the work place:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
LTA:				
- No/d.k.	2	2	2	6
- Yes	22	10	15	47
Partner:				
- No/d.k.	7	3	6	16
- Yes	9	5	3	17

Apart from these facts we got an insight in the absence behaviour and the main factors of reporting sick. The interviewees mentioned many physical complaints which produce absent rates in their company. First of all some interviewed people mentioned accidents at work which were factors for reporting sick and going out absent. Also several physical problems are considered factors. Some mentioned unspecified or chronic physical problems and diseases mainly caused by work like back problems, problems with their arms, legs, hips and shoulders. Some interviewees also mentioned that employees would be going out absent because of the need of a surgery.

The flu was also very often mentioned which seems to be a main cause of absenteeism due to a medical reason. The flu itself was also mentioned in relationship with the work related changes of temperature (warm-cold temperature change) and also in relation with the stress, hectic and pressure at work. Other interviewees also mentioned the relationship of stress with physical complaints (e.g. migraine, muscle tension, cardiovascular diseases) and employees sometimes need sickness absence for recreation: "(…) *weil der psychische Druck so starkt ist brauche den Leute quasi den Krankenstand um Abstand von der Arbeit zu kriegen und nachher wieder voll einsatzfaehig zu sein.*" (A06/F02, ID10194LTA, p. x) Despite these explanations, mental problems and psychosomatic problems were also a big issue. Working conditions, work environment and job climate mean stress and strain at work which is also mainly responsible for health problems, so the LTAs who perceive that many people have to

work too much because not enough personnel resources are available, which is sometimes the consequence of unrealistic expectations of the supervisor. Also cases of mobbing and burn-out were recognised as factors for reporting absent from work. One interviewee mentioned an example for the relationship of negative work climate, physical and mental complaints: "(Das) *negative Arbeitsklima fuehrt zu koerperlichen Beschwerden, Mobbing und Unpersoenlichkeit des Arbeitsverhaeltnisses*." (A06/F02, ID10198LTA, p. x)

It's also noteworthy that interviewees which were absent from work due to a mental or co-morbid reason mentioned mental factors for sickness absence at their workplace more often than people who were absent due to a physical reason.

3.6.3 Impact of Changes in Society on Absenteeism from the Workplace in General

Many interviewees discover and see similar impacts of changes in society on absenteeism from the workplace in general in comparison to the ones already mentioned in their own workplace.

In the opinion of the interviewees, the most dominant impact on absence from work is that employees do not stay at home as long when they are ill. In the last consequence it is the financial pressure they fear (e.g. female single parents), because when they are absent from work, people are more and more afraid of losing their job. Because the unemployment rate is high, employees do not want to give the employer a reason to discharge them. In the interviews, these kinds of statement were the ones most often mentioned, concerning societal changes and their impact on work absenteeism.

Table 3.14 Number of LTAs and partners to the question how changes in the way we work and live effect quality of live and levels of stress by main reason for current absence

Changes in society influence absence:	Main reason for current absence: Physical (N)	Mental (N)	Co-morbid (N)	Total
LTA:				
- No/d.k.	4	3	5	12
- Yes	20	9	12	41
Partner:				
- No/d.k.	5	1	1	7
- Yes	11	7	8	26

Many interviewed people also detected that other circumstances at work or on the part of the employer has changed. Many of these things are strongly related to the employer but have several impacts on individual behaviour. Work is nowadays very hectic and many people work under working conditions described as high pace[64], pressure and strain. People are evaluated only by their output and everything is about maximization of output. The only thing that counts is quantity, not quality. The companies' strategy is to reduce the number of employees, but the amount of work is the same and must be done in the same time or even faster than with more people employed[65]. Stress and strain is the consequence and people become more and more unhealthy. Also the broad usage of new technologies has an effect on these developments (e.g. new technologies are responsible for the work force reduction).

[64] "*Es wird immer mehr in immer kuerzerer Zeit gefordert.*" (A06/F03, ID10235LTA, p. x)
[65] "*Es wird permanent Personal eingespart. Die Arbeit bleibt aber gleich und wird mehr.*" (A06/F03, ID10040LTA, p. x)

Job fears in case of sickness
- About ill health one LTA stated: "*People have to stay at home more often but they don't do that because they are in fear*." (A06/F03, ID10013LTA, p. x)
- Or: „*Nobody has the courage to take an absence leave in case of illness any more because after two or three days a job dismissal is the consequence*." (A06/F03, ID10192LTA, p. x)
- „*If you have a job you are afraid to lose it.* (If so) *there thousands of other people are waiting for your job*." (A06/F03, ID10148LTA, p. x)
- "(…) *everybody is replaceable nowadays*." (A06/F03, ID10017LTA, p. x)

This also effects the solidarity and the feeling of 'together' in society. Everybody is afraid and tends to think individually and the relationship between employees and employers is now more aggressive nowadays: "*Die Ellbogentechnik nimmt zu*." (A06/F03, ID10305LTA, p. x) In this respect, the interviewees also mentioned a rise of mobbing, and unfair behaviour among employees is getting more and more common. Tolerance, understanding and humanity are the exception nowadays, some interviewees stated. Because of these changes, people are more frustrated.

Work and family life and society in general is nowadays characterised by higher pace, faster technology, enormous pressure and individuality. Many people are unable to cope with these general conditions and effects on the health situation: "*Ich glaube, dass viele Leute nicht mit den Problemen fertig werden und krank werden*." (A06/F03, ID10013LTA, p. x) The interviewees interpreted as follows: employees fear to go out absent from work because they fear a job loss with the consequence that workers go absent for only a short time or do not dare to take a sick leave. Both have a dangerous health risk with delay: "*Man muss heute damit rechnen, dass Leute, die laenger weg sind, gekuendigt werden. Heute geht man mit einer leichten Grippe trotzdem arbeiten. Dann geht man irgendwann laenger in den Krankenstand*." (A06/F03, ID10214SO, p. x)

Absenteeism due to health related problems holds a negative image at the moment, because the societal norms are constructed around high individual performance and this is put into practice through pressure. That is also the reason why older employees are not valuable nowadays and longer work experience has no importance anymore, at least some think so. A statement supporting this was: "*Es wird nicht geschaetzt, wenn man laenger gearbeitet hat.*" (A06/F03, ID10144LTA, p. x)

Other opinions are that the attitude towards work and working morale have changed. Not all people want to work hard throughout their whole life and therefore some employees try to exploit the social welfare system. But these statements do not correspond to the majority of opinions.

4 Conclusions

The conceptional model of this project is the threshold model of sickness absence. In this model, the sickness absence but also work resumption can be conceived as the result of an individual process where a decision is made individually. This decision making process can be conceived as passing a threshold (cf. ALLEGRO & VEERMAN, 1998). A variety of factors are influencing this decision, e.g. the health situation but also other individual factors or environmental contexts (family, work, legal system). The same (or other) is true for the decision (i.e. pass a threshold) in order to return to work again.

Following the threshold model for people who are long-term absent from work we can distinguish between several phases people are in or going through. From the familiy study perspective we can draw several conclusions in each stage and we can highlight some factors responsible for the individual decision to go through theses thresholds, namely the factors responsible for the situation before the sickness absence and the meaningful problems, considerations and decisions taken (Before Sickenss Absence), the different impacts, positive or negative, on the individual, on the family, the partner/spouse, children and other dependents due to the fact that one person in this setting was long-term absent due to a medical reason (During Sickness Absence), and what were the responsible factors mainly for the individual decision to return to work or if they did not return to work, what were the reasons not to resume work.[66]

Considering the results of the underlying Family Study, we come up with these conclusions:

4.1 Before taking the Absence Leave

1. The first result based on the family study is that the problems faced before going absent from work are different among people who were absent due to a physical and due to a mental/co-morbid reason. People who were absent due to a mental problem spoke more about work related problems such as work load, problems with the supervisior, stress at the workplace or mobbing, whereas people who were absent due to a physical problem only reported the related physical problems they faced before the absent leave (e.g. muscular-skeletal, etc.). But noteworthy is also the mental impacts in all groups of being (long-term) absent from work, whatever the main reason for the sick leave was. Different from this are cases where an unexpected event (e.g. accident, diagnosis) was the main reason for taking an absence leave. Most of those people had not faced any problem before.

2. Additionally, the considerations for taking an absence leave strongly depend on the specific health problem. Unexpected circumstances due to a diagnosis or an accident are responsible for a fast decision whereas in other cases the decision for the sickness absence took a long time (somethime several years) due to the fact that the health problem was not severe or there was an economic pressure on the individual. Many of such people, especially people who were absent due to a mental problem, tried to work as long as they could. But the individual decision for the absence leave was often taken because of financial, family, individual and work aspects.

[66] All these factors responsible for going through a threshold can be distinguished between factors on the individual (micro) and non-individual levels (meso or macro). If this structure occures it is going to be stated below and useful recommendations will be adapted here or in the last chapter of this report.

3. For crossing the absence threshold, social contacts are very important. People around the individual played a very important role in deciding whether to take sick leave or not. Approximately two of three interviewed absentees reported the involvement of other people in this process. Very often general practitioners and other medical professions were mentioned but more involved were family members, partner/spouse or children. On the other hand friends were mentioned less often but instead work colleagues were also involved in this step. But these results are only true for people with a partner/spouse because in the course of the analysis it became clear that singles do not have the same personnel background as the others have. In this respect, singles have unequal ressources.

4. For crossing the absence threshold, problems were discussed and advice was taken into account. Before asking the decision, people mainly discussed their problems with the above mentioned groups and got advice from them. In most cases talking about it helped and it was good to be taken seriously. The help received, whether it was verbal or practical, was sometimes the reason why they visited the doctor or the hospital. But sometimes people said that they did not want to discuss it with work people because they feared consequences such as job dismissal.

5. By asking for factors that could prevent the individual absence leave were rare but meaningful answers. Persons with mental health problems (also co-morbids) mentioned more things which could have been done to prevent the sickness leave. Very often the change in the individual or in his/her own behaviour were mentioned ("say no!", "listen to your inner voice", "different job", "earlier to the doctor"). But prevention strategies were also stated very often: job rotation, change of workplace, reduction of work load, etc. Similar responses came from their significant other and these statements were mainly based on the mental and co-morbid group.

4.2 During the Absence

1. To be absent from work due to a medical reason has an impact on many people – the individual but also the whole social context (the family and children). The most important individual consequences were financial drawbacks but also other personal problems the absentees had to cope with: feeling of usefulness, having too much time – time structure, future fears concerning their own health, job and financial situation or depressive feelings. Moreover, the consequences for the partner/spouse were mainly negative because of the financial loss, the job future and the health of the partner. Also for the children in the household similar issues were mentioned. Significantly, children had more problems with a mental health problem because it was not obvious why their father/mother was sick and at home. The results of this were problems in the relationship and quarrels. About one half of the interviewees mentioned negative consequences for the household and the family in this respect.

2. Despite the negative effects also positive changes due to sickenss absence could be found. Sometimes it is mentioned that the absent person helped with the household duties and had more time for himself/herself or for the family. The positive result was a better relationship to partner/spouse and children. Mainly this was true when there were children because their father/mother had more time for them compared to the time before where they were working the whole day.

3. Unfortunately, we have a low participation in rehabilitation and return to work programmes and therefore a lack of information from the interviews. The participation was often rated as partly helpful by the interviewees. For people with physical health problems physiotherapy and the acceleration of the healing process was considered positively. Absentees with mental problems often stated that it was useful to have somebody to talk to about the problems. But most of the people and among all types of illnesses they stated that it was not intense enough and that they would have needed further help and basically more information about what and which programmes were available. Concerning work rehabilitation there should be more possibilities, more support from the workplace and more counselling as well as reintegration at the right pace.

4. Due to long-term absence from work individuals reported that there was a recovery from illness or they better handled their health problems. Conversely people also stated that stress and pressure increased over time of absence because the health situation had not improved. So, mainly two kinds of changes during time of absence were recorded: on the one hand there was a health improvement or full recovery and all the people concerned learned to better handle the situation. On the other hand the people mentioned emotional stress and pressure because the health situation had not improved during the time period of absence.

4.3 Absentees who Returned to Work

1. The reasons why they (were able to) return were first of all the recovery from illness. But there were also statements such as the need to work or the fact that they did not want to stay at home any longer. Financial pressure was also an aspect and once again people around the individual were important for them making the deciscion to return to work.

2. Professionals, work place representatives and co-workers, family and friends: All were relevant in the process to return to work. This is true for the decision to RTW and also for the work itself. The most important groups, however, who provided support in the RTW process were the partner/spouse, parents and children and within the workplace co-workers were more important than supervisors. All this provides a feeling of security because there is ready to help if necessary, sometimes even over a period of months.

3. Most people returned to the same work as before the absence but it is interesting to find out the reasons why. Some returned to the same workplace because they were still well integrated or it was the best option because they liked the job and the work aspects. Another important reason mentioned for returning to the same job as before the sickness absence was that the job offered secuity. Additionally many interviewees/returnees also mentioned other reasons why they returned to the same job with the same work conditions. These reasons were mainly: no other option due to their age, problems to get another job (due to education, qualification, region, etc.), and fears of unemployment. Instead, people who changed the workplace said that they did not want to return to the former company due to the “unpleasant things” that had happened there. But reasons varied: One interviewee mentioned that the sickness absence offered the chance to change the job after recovery from illness (now working for only 25 hours in a different company).

4. Moreover the decision to return to work is also a relief and not only for the individual. The fact that the individual returned to work was not only a financial relief. Life itsself had to be restructured and reorganised and more structuring of the daytime was needed. But the

return to work was a relief to the whole household/family unit too. The individual, partner/spouse and also the children in the household had to return to "normal life". This was a significant change for many people. It was a positiv aspect that returnees got back their self-esteem, self-respect, their self-confidence and regained the feeling of internal control. Others said that the individuals started to be ambitious again since the return to work. They lost that during the sickness absence period. However the absence did not only have impacts on the individual. Also the whole family unit was affected because the partners/spouses suffered also in that situation, e.g. because they had no time for themselves, different time/day structuring, financial loss and worries. After the return to work of their partner/spouse they felt free from (mental) pressure, worries and strain. These aspects highlight what really happens when one is absent from work due to a medical reason for such a long time.

4.4 Absentees who did not Return to Work

1. First of all returning to work was not possible due to various factors. Basically most of the non-returnees wanted to resume work but were kept from taking this step. Some interviewees mentioned that they could not find a suitable job allowing their specific situation. Some searched for a part-time job due to the fact that they were not fully recovered from illness, due to their education and qualification, due to the fact that he/she was a single parent (no possibilities for child care). Some others mentioned that they were then branded after that long time of sickness absence and that was the reason why they could not get a job or they were simply too old. Others have lost their self-confidence and others fear the stress of returning to work again which might worsen their health again.

2. Does it mean that these people have no work future? Concerning this point, most of the non-returnees want to return to work and have also given useful hints what could be helpful for their return. A lot of ideas and suggestions were collected. Generally one can distinguish between active and passive strategies (e.g. waiting for recovery or waiting for a contact call from somebody concerning a job). On the one hand absentees think that they could contribute more to their own return to work if their own health was better. The stategies they suggested were: look for job positions in relevant media and send out applications, adequate and useful re-training/courses. Interestingly most of the interviewees (LTAs and SOs) had more or less no idea what the family could contribute to improving the RTW process. But on the other hand many suggestions were made by the people, suggestions about a present lack of job opportunities and what could help in this situation. To summarize: with "new ways of working" like a part-time employment for people who are on sick leave, enhance working at home during that time or more flexible work. These working possibilities during sickness absence should be coordinated with the possibilities of the handicapped/disabled people. So the work should consist of more routine or less physical moving. Other practical suggestions of non-returnees were the usefulness of having somebody who organises things or helps them with the bureaucracy during the sickness absence period.

3. Additionally, half of the interviewees who were still absent from work had either contact or no contact with people from the company. But the nature of contact had different quantity and quality as well. The nature of contacts varied from one to more contacts, from face-to-face and telephone to mail contacts. Some mentioned very intense contact with the co-workers resulting in their becoming good friends and in some cases the LTAs were disappointed because the contact broke off very fast. If contacts were intact people stressed

their helpfulness, e.g. the information they received and because of the amicable contact they felt good, had fresh hope for the future and new self-esteem. On the other hand it became obvious that keeping in touch with the colleagues over such a long time is sometimes very difficult. Due to this fact the quantity and quality of the contacts decreased in many cases over time. Sometimes the contact broke off completely. In sum many LTAs wished to have more personal contact with people from work, especially with colleagues.

4. However, being abensent from work does not only mean having disadvantages. Interviewees mentioned the advantages of being absent from work and being at home most of the time. For instance SOs mentioned the advantage that the family members have more time for each other and they mentioned the advantage of the possibility to help a little bit in the household. Other stated advantages were that the LTAs needed the time away from work and the convalescence for their own health and recovery and for refocusing on the substantial things in life. But most of the SOs prefer their partner/spouse to going back to work. Many disadvantages resulted from being absent from work due to a medical reason. Despite the fact that somebody was not healthy at all the interviewees first of all mentioned the financial loss as the major negative effect. People also mentioned that they were missing their job, that they worried about the future and about reduced self-esteem. Missing other social contacts outside the family, e.g. co-workers, was also considered a major disadvantage by the absentees.

5 Recommendations

This section aims at describing the types of recommendations which are – in our view, based on the results gained from the conducted interviews of the underlying family study – appropriate for tackling absence, especially long-term absence, and return to work. All suggested recommendations will be made available to agencies and organisations where these should/ could be targeted at.

The questions are: What should be done before absent from work? What is helpful and useful for absentees who are long-term abensent from work due to a medical reason and what measures could long-term absentees help to return to work again?

1. *(More) activities in the field of prevention*
   This is not only an issue concering long-term absenteeism but should be especially applied for this target group. We have seen that it is very important to tackle occupational stress, overload and worksite related load, mobbing and other related issues, because there is a need for everybody, employees and employers, to learn how to deal and cope with these issues, with the aim to strengthen the awareness regarding occupational ill health, mainly based on the health system but also through companies.

2. *Taking sick leave only due to medical reasons*
   The study has also shown that the decision to go out absent due to a medical reason is not only a decision based on the person´s own health situation. Other circumstances influence the step to report sick such as income, family, and work. But people should take a sick leave only due to medical reasons because the effect is that people delay their absence – the often very important/essential time off from work – because other things seem to be more important to them. If this is true, people cannot recover from their illness with the consequence of worsening their health status. So information campaigns seem to be appropriate, including information about what it means to delay the necessary sick leave

and also taking into account the legal aspects (individual rights, sick leave aspects, financial benefits, possibilities of the employer and the employee) and also information about child care for example provided by the company but also about the health system and the community.

3. *Information and awareness for all*
   Information and raised awareness for employees improve the whole social environment too, which is an important factor for crossing the absence threshold as well as RTW. Since particularly medical professionals, family, work colleagues and friends are very effective in the individual decision making process, these groups should be strengthened to improve the counselling and advice system of each other. So we suggest the strengthening of health based information and confidence-building actions to improve counselling and informal advice. Because singles have unequal social ressources, counselling should be amplified in companies through independent representatives (e.g. occupational physicians, psychologists, etc.) and medical professionals (e.g. GPs, MHPs, etc.) as well.

4. *Promote (more) occupational health promotion programmes*
   In our point of view it is also very important to develop and provide more occupational health promotion programmes. These should consider both, the personality of the individuals (i.e. workers) in connection to their work related characteristics, and seem therefore very useful to "transport" health related issues and adequate programmes which help to inform and to reduce potential health risks of employees with a look at individual behaviour in relation to issues such as work characteristics and work environment.

5. *Supportive actions for the whole family unit*
   The analysis has also shown that the individuals who were long-term absent from work have to cope with different aspects of life and with the personality as well. These problems extend from financial issues/problems to all kinds of mental problems like usefulness, problems with time structuring, worries and fears about their own health, depressive feelings, and future fears. Moreover, other individuals living together with the absentee (partner/spouse, children, parents, other dependents) are also affected by this development. Therefore the whole household unit and not only the individual need supportive action in order to cope with the new situation adequately. So it is necessary to offer supportive actions (e.g. mental therapy) for the individual which take into accout the setting as well as the involvement of other family members in this treatment (e.g. family therapy). This measure is best dealt with at health system level.

6. *(Better) allocation of rehabilitation and RTW programs*
   The main conclusions drawn from the family study with respect to rehabilitation and return to work programme was that the involvement of long-term absentees was not very high. This could be a sampling effect, but we have evidence that the information structure about programmes available is not the best. Especially the offers for people with mental problems stated the usefulness of psychotherapy for instance. Whereas people also said that the programmes were not intense enough and that they would need more and further help. So, the suggestions are to provide better allocation of the system requirements about health issues in general and concerning rehabilitation and return to work programmes specifically, to provide more adequate rehabilitation and RTW programmes, to take into account the specific needs of the absentees and to create more possibilities especially concerning work rehabilitation. These suggestions are not addressed at the health system

only but also at the workplace support/programmes, the community and counselling in general.

7. *Attendance of absentees during the whole absence period*
   In many cases, problems get worse in the absence biography especially when there is no/low recovery from illness which produces emotional stress and (additional) mental problems. Due to this fact, all supportive actions should not only take place in the beginning of the absence; instead they must be guaranteed and should take place regularly over the whole sickness period in order to have the possibility of identification and treatment of arising problems. Again, health providers should take an important role hereby.

8. *Information and awareness concerning the concequences of RTW*
   For many LTAs the reason to go back to work was the financial pressure, more or less independent of the health situation. Since this is a risky behaviour from the medical point of view, people should be able to stay in sick leave as long as necessary. However, most of the LTAs made their decision to return to work with the help of somebody else, mostly with a significant other. However, some LTAs went back to work, because "*the doctor said so*". In order to make the LTA a mature und responsible patient or person, the decision to return to work should be a decision of both, the doctor and the LTA. Concerning this it is evidently that the financial support should be granted as long as necessary but there is also a need for raising awareness and information about what it means to go back to work too early.

9. *Strengthening of the individual social network*
   Most LTAs have somebody supporting them during the return to work process. Within the family, this was mainly the partner/spouse, at work most LTAs mentioned co-workers. Since not everybody has a partner or spouse, it has to be made sure that also these people have somebody to turn to, such as psychologists, social service professionals or a support-group. Since at work the co-workers seemed to be most important, structured support from this group would be helpful. Returning to work was an aim of most LTAs, provided that ones health allowed it. Different LTAs had different opinions on whether or not to return to the same working place as before the leave. Some wanted to go back, others preferred a new position. Hence, it is necessary to enable both: help people stay involved with the company in order to ease the return, but also help people find alternatives, considering the health situation of the LTA. Company representatives and employment service agencies should provide more help and support.

10. *Help and counselling for the family - during and also after absence*
    Being absent from work due to a medical reason as well as the return to work after a long-time sickness absence period: these are life changing events with an effect on the whole family. To make this change as smooth as possible, preparations are needed for the LTA, the SO and the children/dependents. In many cases the help of a counsellor or other psychologists might be necessary. Therefore for some LTAs returning to work is quite difficult because they have been suffering from low self-esteem, low self-respect and low self-confidence. To counter this it is necessary to support the LTAs not only at the beginning and the end, but during the whole absence. Psychological help/counselling for the individual during absence and psychological help/counselling for the whole family before the actual return to work seem to be adequate.

11. *Long-term absentees have different needs concerning RTW again*
    Again, LTAs want to work but sometimes the circumstances do not allow that. Problems faced by the LTAs when trying to go back to work were too few part-time jobs, not having anybody to look after the child(ren), too few jobs suiting the LTAs qualification or being branded. The expressed needs of the interviewed were more part-time jobs for people who cannot work full time due to their health condition, more child care centres, re-trainings if necessary, an open communication with employer about what one can do and what one cannot do after being ill. Different stakeholders should be involved in the development of the specific needs of long-term absentees who return to work again.

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