

An explorative interview study of men and women on sick leave with a musculoskeletal diagnosis seeking an acceptable life role

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Abstract

Introduction: A dramatic increase in sickness absence in Sweden has led to a shift in the public debate. Departing from the view of sickness absence as a result of a poor work environment and stress, the debate in the early 2000s became more concerned with the breakdown of norms and the abuse of sickness insurance. Sickness absence became the responsibility of the individual rather than of society.

Aim: This study has sought to explore the consequences of being on sick leave with a musculoskeletal diagnosis, the experiences of encounters with rehabilitation professionals, and the attitudes towards sick-listing from the perspective of the sick-listed persons.

Methods: Individual in-depth interviews were conducted in 2010 with eight women and nine men aged 33-60 who were on long-term sick leave (at least 60 days) with a musculoskeletal diagnosis. We analysed the data using a grounded-theory approach.

Results: There was an obvious tension between work strategy as a societal norm and finding an acceptable life role when sick-listed. Four groups with partially differing experiences and perceptions crystallized out of the total population. These experiences and perceptions formed their choice of different acceptable life roles and strategies for gaining self-respect and the respect of others.

Discussion: The fact that the four groups that emerged from our study experienced their sickness absence in different ways and their pathways back to work were different demonstrates the value of not considering those on sick leave with a musculoskeletal diagnosis as a homogeneous group. The results imply that rehabilitators should adopt a sensitive approach based on the sickness absentees' wishes and views since the latter spend much of their time and thought during their period of sickness on counteracting distrust in search of an acceptable life role to regain respect.

Keywords: sickness absence, musculoskeletal diagnosis, societal norm, acceptable life role, respect

Introduction

Sickness absence in Sweden has been marked by considerable fluctuations (Lidwall, 2011). There was a dramatic change between the end of the 1990s and 2003 when the number on sick leave more than doubled in just a few years. Attitudes in the public debate on sickness absence also changed during the same period. From having seen sickness absence as the result of a poor working environment and stress in working life and the absentee as a victim of circumstances, the debate in the early 2000s, when sickness absence peaked, concentrated more on a breakdown in values, a misuse of the health insurance system, and even cheating (Johnson, 2004). Sickness absence became a political problem in the Swedish debate on welfare and came to be seen as the responsibility of the individual rather than of society (Junestav, 2010). The focus was on the state costs and the situation was seen as a threat to the stability of the health-insurance system (Frykman & Hansen, 2009). There was also considerable emphasis on what is referred to as 'work strategy', which implies investing in active measures to enable people to earn their own living (The Social Insurance Agency, 2008). Hofman has described work strategy as 'work as a social duty' (Hofman, 2011:53). Significant changes were successively introduced in the health-insurance system such as time limits, standardized national guidelines for length of sickness spells for most diagnoses, and legislation was made more restrictive (The Social Insurance Agency, 2008). Since 2003, the level of sickness absence has continued to decline and during the most recent years has been close to the average level for Western Europe (The Social Insurance Agency, 2009).

Another discussion that arose in the wake of the increase in sickness absence focused on the increase in diagnoses that some maintained did not represent real medical conditions and were not in accordance with objective conditions. This description resulted in a discrediting of these diagnoses (Michailakis, 2008). The 'new' diagnoses were termed 'symptom diagnoses' (*symptomdiagnoser*) because they were medically accessible through the patient's own experiences and conveyed to the doctor by means of the patient's description. This meant that it was also more difficult for the doctor to verify the symptoms through medical tests (Olin, 1999). Symptom-based diagnoses include psychiatric diagnoses but also many complex musculoskeletal diagnoses (Olin, 1999). These diagnoses account for a large number of the long-term (i.e., more than 60 days) sickness absences, representing together more than half of the total number (27 and 26 per cent, respectively). Psychiatric diagnoses are the most common among Swedish women on long-term sick leave whilst among men musculoskeletal diagnoses predominate (The Social Insurance Agency, 2010). Common psychiatric diagnoses are depression, anxiety, and stress reaction. Frequent musculoskeletal illnesses that cause long-term sickness absence are pain in the lumbar region and problems emanating from the neck and shoulder region (Brage, Ihlebaeck, Natvig & Bruusgaard, 2010).

There are several studies indicating that patients have negative experiences from their health-care encounters. Werner and Malterud (2003) have found that women with chronic pain were met with scepticism and a lack of understanding, although they made great efforts to be believed in. Further, they worked hard to maintain their self-esteem and dignity as patients and women. In a recent Swedish study it was found that approximately one-third of the studied population of long-term sickness absentees had experienced negative health-care encounters described as negligent behaviour, disrespectful treatment, and distrust (Wessel et al., 2012). In Eriksson, Starrin, and Janson's (2008) study of individuals on long-term sick leave with a psychiatric diagnosis, several of those interviewed experienced that sickness absence resulted in a reduction in status, which in its turn led them to withdraw from social contacts with friends and workmates. Withdrawal is one means of protecting one's social self and a signal of shame (Scheff, 2001). Schei (2006) suggests that being a patient in itself contains a threat to dignity when transformed into an object of study, a phenomenon caught by the doctor's eye. The potential shame of the patient is a barrier that has to be overcome by all in health-care encounters. Persons with musculoskeletal illnesses associated with pain often report feelings of shame when physicians doubt their wish to recover (Gustafsson et al., 2004). On the basis of interviews with persons on long-term sick leave Vidman (2009) has found that her respondents, in addition to the limitations resulting from their symptoms, had to deal with distrust due to the invisibility of their impairments, which made it hard for others to understand. These difficulties lowered their self-esteem.

Most studies on sickness absence have focused on the causes underlying sickness absence and not on its consequences (Bryngelson, 2009). Knowledge about sickness absence as a social phenomenon is limited and the number of studies which systematically investigate how individuals perceive and experience their sickness absence are few. According to Anthony (1993), an individual's own perceptions of the factors that are of importance for a return to work are of considerable prognostic value. Recovery also includes more subjective outcomes such as self-esteem, empowerment, and self-determination (Anthony, 1993).

The present study forms part of a more extensive Swedish-Norwegian research project on the social factors of significance for sickness absence. Sick-listing due to psychiatric and musculoskeletal diagnoses was selected as the main focus of the studies since they are the two most common diagnostic groups behind sickness absence. A number of studies have been conducted on the causes of sickness absence and on the perceptions and experiences of those on sick leave (Solheim, 2011; Batt-Rawden & Tellnes, 2012a; 2012b). The aim was to study the consequences of being on sick leave with a musculoskeletal diagnosis, the experiences of encounters with health-care and rehabilitation professionals, and the attitudes towards sickness absence from the perspective of the sick-listed persons.

Methods

Design and procedure

We collected the data, in the form of individual interviews, during 2010 and analysed it qualitatively. A qualitative research design was selected as it is

suitable for the study of a phenomenon that has previously not been sufficiently well understood (Starrin et al., 1997).

In designing the study, we paid particular attention to ethical issues and we obtained written consent before the interviews commenced (The Swedish Research Council for Humanities and Social Sciences, 1999). The research team was aware that the interview might deal with sensitive matters because the respondents might have suffered some traumatic experiences. There might be a risk that the interview would reopen 'old wounds'. However, our previous experience of interviewing people in difficult situations is that respondents can react positively when somebody listens to their story and they have an opportunity to verbalize their feelings. The interview might also increase their understanding of themselves in that they have an opportunity to talk about and reflect on these issues, and thus it might even contribute to the healing process. Still, if difficulties were to have arisen from the interview, arrangements were made to refer the interviewee to professional staff. However, the situation did not arise.

There were no previous relations between interviewer and interviewee. The respondents were recruited with the aid of staff at the regional branch of the National Social Insurance Agency, which registers and administrates sickness allowances for all inhabitants in Sweden. Two officials contacted by telephone individuals on sick leave who fulfilled the criteria for inclusion. All those contacted agreed to participate. The criteria for inclusion were as follows. The interviewees were to be long-term sick-listed (at least 60 days but no more than one year) or recently returned to work (after long-term sickness absence); Swedish-speaking man or woman aged between 20 and 60, with at least half-time employment prior to sickness absence; living in the province of Värmland, and diagnosed with some form of musculoskeletal illness of the following types according to ICD-10 (The National Board of Health and Welfare, 1999): M54.5 (acute lumbago), M53.9 (unspecified back illness), M54.9 (unspecified back pain), M79, R52 (established long-term non-malignant musculoskeletal pain), M62.6 (muscle strain), M62.9 (unspecified muscle disease), M75 (shoulder and shoulder-blade problems). The diagnoses were selected in consultation with medical staff. A strategic selection (i.e., purposive sample) was made to provide a spread in age, gender, and place of residence in order to achieve as rich and varied a picture as possible.

We conducted the interviews as semi-structured individual interviews. We asked open questions in order to capture the respondents' stories expressed in their own words. The interviews lasted between one and two hours, were recorded, and then transcribed. Apart from background questions the interview guide covered issues regarding sickness history, the respondent's own work and work environment, the balance between work and private life, and critical incidents in private and everyday life, the diagnosis, the rehabilitation, and finally the hopes and fears for the future.

Description of the study population

The study is based on interviews with 17 individuals (eight women and nine men) who were on long-term sickness absence with some form of musculoskeletal diagnosis. Almost all of them had pains in their shoulders and back and reduced mobility in their shoulders, arms or legs. In most cases, it was a question of gradually worsening repetitive strain injuries but there were

a number of cases where the injuries were acute or sub-acute, having occurred as the result of a heavy lift or an accident. Two of the respondents (a woman and a man) also had a psychiatric diagnosis.

The respondents were between the ages of 33 and 60. Ten respondents (five women and five men) were under 50, two men and one woman under 40. Seven women were married or cohabiting. Five of these families had one or two children at home. Five men had partners, two of them with schoolchildren. Of the four single men, two were divorced fathers with joint child custody. The level of education was relatively low. Six men had completed the nine-year compulsory schooling and the other three had completed upper secondary school or vocational training. Five women had completed upper secondary school or vocational training. All nine men were employed in the private sector and worked in the building, forestry, manufacturing or service and transport industries. Three women worked in the municipal home-help service or school. Four were privately employed in the service sector. One woman was self-employed.

Analysis

The interview data has been analysed using the grounded-theory approach proposed by Glaser (2011). This analysis method involves a process of continual coding, categorization, and constant comparison of conceptual indicators in the data.

The two researchers read each interview transcript repeatedly and made memos describing the relations between concepts and categories. The codes emerged from the data and the coding proceeded from the descriptive to the conceptual level in order to allow a core category to emerge. Theoretical coding enables the conceptual integration of the core and related categories to produce hypotheses about the relationships, thereby making it possible to explain the latent pattern of the social behaviour of the sick-listed individuals that forms the basis of the emergent theory. The data coded under each category was re-examined to ensure that it was represented in the transcripts, thereby minimizing the risk of bias. Excerpts from the interview transcripts are presented below to support and illustrate our categorization. False names are used in the quotations to prevent identification. We have also changed the place names and the names of workplaces, relatives or other identifiable attributes but without affecting the content.

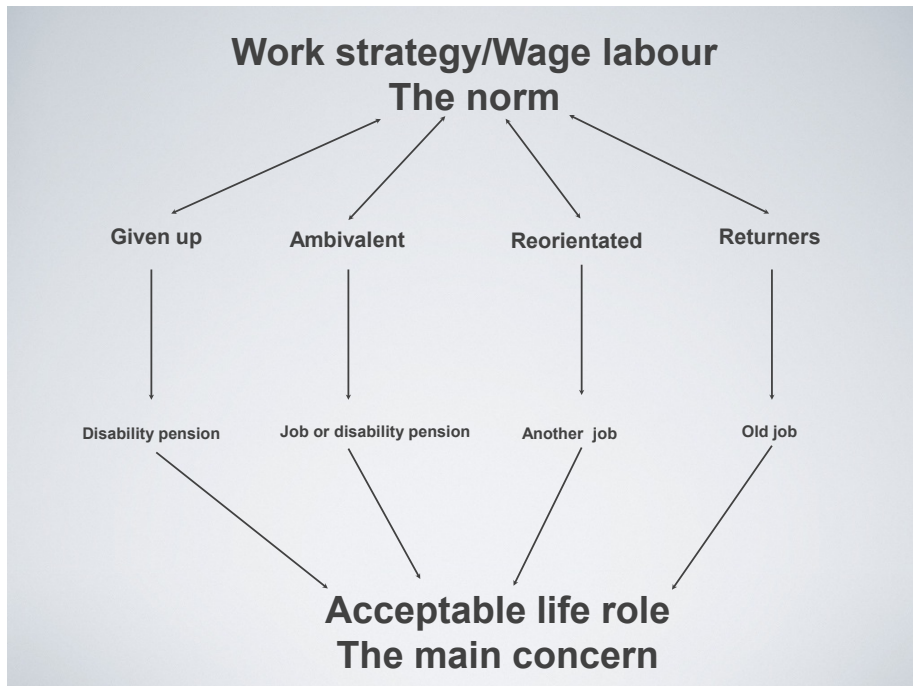
The regional ethical review board, Uppsala, has approved this study (dnr 2010/014).

Results

Finding an acceptable life role

The respondents experienced the social and health consequences of long-term sickness absence with a musculoskeletal diagnosis differently depending on illness, previous experiences, treatment, and total life situation. A pattern emerged from the interviews, which has been summarized in figure 1.

Figure 1. The sickness absentees' relation to the work strategy as the norm and their main concern during the absence of finding alternative life roles to regain respect and acceptance



The figure shows the field of tension between work strategy/wage labour, which is the social norm, and the ability to find an acceptable life role as a sick person. Since they were sick-listed, that is, not able to work and live up to the work strategy, they needed to find another life role to feel respected and accepted. Even if all expressed a wish to work and irrespective of prospects of a return, the search for an acceptable life role became their main concern. Four subgroups crystallized out with different acceptable life roles and with specific strategies for gaining respect in their own eyes and in those others. The following is an account of the significance of this thematic model.

Four different groups of sickness absentees

We categorized the groups in accordance with how the respondents experienced and coped with their situation during their sickness absence in the search for an acceptable life role.

Those who had given up sought disability pension

Disability pension was the acceptable life role that this group strove for during their sickness absence. They did not see any pathway back to work. At the same time as disability pension could entail a sense of defeat, of no longer being capable of working, the idea produced a feeling of relief. There would no

longer be any need to get a doctor's certificate for continued sickness absence and absence from work would gain a legitimacy, which meant that they would no longer need to be on their guard against those around them. Two individuals (a man aged 58 and a woman aged 60) were included in this group.

Those who were ambivalent vacillated between a return to work and disability pension

Characteristic of this group was that they vacillated emotionally between returning to work and trying to obtain a sickness pension. They felt a pressure to return to work too early despite the fact that they were unsure of a permanent return because they still suffered from obvious health problems. The group consisted of two women and two men between the ages of 34 and 48. The individuals in this group had as yet not found a final acceptable life role.

Those who had reorientated turned their sights on a new job

Three women and three men between the ages of 32 and 58 had injured themselves in their previous work and had been advised to look for a job that was better adapted to their disability. Sickness absence was for them a signal to change jobs. At the time of the interviews, they were in the process of finding new solutions and accepting some retraining. An alternative job was their acceptable life role.

The returners went back to their old job

This fourth group consisted of three men and two women aged 46-59 without previous experience of long-term sickness absence. They experienced their sickness absence as emotionally unproblematic and more as a stage in their rehabilitation, pending a possible operation. They really saw themselves as 'healthy' and reckoned that they would eventually be completely fit for work and could return to their old job. Their acceptable life role was thus a return to their previous job.

Even though there were certain experiences common to all the sickness absentees, their experiences and the way they coped with their life situation was clearly marked by the category to which they belonged. In the following presentation, therefore, the emphasis is on the features that distinguish the groups from each other as regards sick role, attitudes to work, and social relations, including relations with the rehabilitation institutions (i.e., health care and the social insurance office).

Experiences and perceptions during sickness absence

Varying attitudes to the sickness role

For the group who had *given up*, their illness formed and controlled their daily lives. Their illness placed a limitation on their everyday existence and, because of severe pain, they suffered sleep problems. Viktor, 58, who had injured his back in connection with loading, was up walking all night and could only sleep or rest in short periods. Rita, 60, who was physically worn down after two decades as a cleaner, could not manage cooking, cleaning or dressing without help. An adult daughter often helped her with everyday matters. Rita described a typical day in the following terms:

It's very tedious. I just lie on the sofa watching television all the time, sit at home, don't go out, can't cope, don't see anybody, but workmates phone sometimes.

Viktor and Rita had extensive health problems and did not believe their health would improve sufficiently for them to start working again. '*I reckon I'm through with work*', was Viktor's comment. As concerns rehabilitation, Viktor felt that it was pointless for him and not at all adapted to his individual situation, and though Rita had been on sick leave for almost a year, she had not been offered any form of rehabilitation during this period.

Those who were *ambivalent* had also previously suffered from extensive health problems. They expressed feelings of being under pressure to return to work before their injuries had healed or their pain abated. Ingvar, 48, who had been in the same workshop all his working life and on sick leave for six months when interviewed, was very concerned that returning to work too early would aggravate his problems, which would result in an even longer sickness absence.

Those who had *reorientated* gradually came to realize that their sick leave was clearly related to their work and that it would be impossible to return to the same workplace. After some time they began to look for alternative solutions. Despite his injury, Patrik, a 39-year-old carpenter, attempted to return to his work after six months on sick leave but was in such pain that he had to give up. As he expressed it:

It was a big defeat ... and then I realized it was over. ... [I] have never had any other job. [I] hope to retrain. I'm waiting to start. It's tough, but that's how it is. I'm not so old, have 26 years left to work, so I'll have to do something else.

The returners did not see themselves as sick but maintained that their body had been damaged as a result of an accident or hard work. It was not so bad that they could not live with it. None of those in this group had suffered from long-term sickness absence earlier and they described themselves as '*alert*', '*active*', and '*healthy*'.

Prospects of returning to work influenced attitudes to work

All the respondents stated that they really wanted to work. They had internalized the social norm of the work strategy but their attitudes both to work and to the role of work were influenced by the prospects of returning to work.

Those who had *given up* had had a long and hard working life. Both individuals had left school early and worked from that point on. Work was important to them but they were unable to work because of their extensive health problems. They also did not see any other jobs compatible with their current capacity.

Those who were *ambivalent* described work as important for social contact but, above all, they expressed a strong work ethic. Ulrika, 46, who had worked in the home-help service and suffered repeated injury from heavy lifts, maintained that she had a sense of value when she worked; she also said that it was her duty to work. Those who were ambivalent all voiced a tension between two worries. On the one hand, they expressed the fear that their being on sick leave would cause them to be labelled as work-shy; on the other, they were concerned at the same time about being forced to return to work before they had completed rehabilitation.

Those who had *reorientated* had heavy jobs but the fact that they liked their work meant that they had remained at their workplace even though, long before the last sickness absence, they had understood that it was the job that was causing their problems. During their sickness absence, they gradually began to have second thoughts and to look forward to a new job. Eva, 43, who worked in a shop, had previously undergone an arthrodesis operation for a back injury and then suffered an increasing lack of feeling in one hand and arm. Just prior to the interview, she had begun training to run a home for taking care of other children, '*Since I think that my body could cope with that – receiving children and young people at home*'.

Common to *the returners* was their professional pride, job satisfaction, and fellowship. They had status in their workplaces in that they were knowledgeable, experienced, and well liked. During her sickness absence, colleagues had sent flowers and letters to Nina, a 46-year-old animal keeper, who was waiting for an operation on an injured shoulder. She had also visited her workplace several times and felt that she was still a member of the team.

Secure or insecure social relations

Social relations contributed to no little extent to shaping the sickness and work roles. Those who had *given up* had tense relations with their families, friends, fellow workers, superiors, and health-care staff. They felt they had no real support from anybody apart from the odd relative or acquaintance. Both had been involved in conflicts at the workplace before their sickness absence. Viktor became depressed when he reflected on the mistrust directed towards him from both senior management and fellow workers who '*whispered*' behind his back. Even his neighbours treated him with mistrust.

He came here, half drunk, started on me saying I wasn't that sick.
Then I went and fetched the medical certificate and showed him. 'OK, but I'm sure there's something you could do without living off the taxpayer.'
... Then I got angry. After that, I haven't had much to do with him.

Rita did not feel she had been offered any form of rehabilitation. She was shunted between different doctors and did not get answers to her questions such as: '*What's the matter with me?*' '*What's going to happen now?*' She also found it very trying to have to describe her symptoms to new people repeatedly.

Respondents in the other groups did not describe any open mistrust. However, those who were *ambivalent* experienced general mistrust towards people who were on sick leave. Therefore, they only told a few people who they felt they could trust about their sickness absence. Ingvar's strategy was to lie

sometimes and to say he had time off to avoid having to answer the same questions all the time. He considered it was *'difficult to make people understand how I felt'*.

Those who had *reorientated* generally indicated that they had secure social relations with their families and their social networks. Sometimes it was the case that the relations had improved during the period of sickness absence as they had more time to spend with their children and friends. For instance, Erik's children appreciated the fact that father was home in the mornings and made breakfast for them. Their secure network was also seen as providing an environment where they did not need to pretend but were accepted for what they were. Even relations with their case officer at the insurance office were described as good and supportive. However, relations with the health-care service were seen from the start as problematic and a major source of irritation, perhaps because they were not given a thorough examination, had a feeling that the doctor thought they were simulating their sickness, or felt that waiting times were long. Nina put this in the following terms:

All that waiting. It's a scandal that Swedish health care should take such an awfully long time. It causes a lot more suffering and costs a lot more.

Several in this group had changed doctors or had to wait a long time for an appointment with a specialist. Some telephoned and persisted until they received quicker treatment. Getting a new doctor raised their spirits and they were generally satisfied with the measures taken but not with all the waiting they had experienced. Moreover, several in this group claimed that it was a doctor, physiotherapist or welfare officer who opened their eyes to the possibility of doing something different. The basic reason seems to be that they listened to and treated their patients seriously, which restored their hope for a better future. It had taken several years for Pia, a 41-year-old assistant nurse with repeated sickness absences, to obtain a medical analysis of the causes of her problems. She felt that the doctors on previous visits had adopted a nonchalant and uninterested attitude, and they found it much easier to prescribe more analgesics rather than to listen to her questions about the underlying causes of her problems. Her questions were not taken seriously and she often felt *'diminished in the encounter'*

The returners provided innumerable descriptions of the support they had received from their families, neighbours, and fellow workers during their sickness absence. Anders, for instance, a 57-year-old worker in the timber industry who was in a great deal of pain, reported that his neighbours went shopping for food for him, and Nina, the 46-year-old animal-keeper, expressed it in the following terms:

If I hadn't had the social safety net but had sat in an apartment and had a job where I wasn't welcome back, then I would've given up a long time ago.

During their rehabilitation, some of the returners had also formed new social relations and networks with others in the same situation during the time they participated in various group activities for those on sick leave. This made it easier for them to gain access to a social environment that treated them with respect and openness. Conversations with others in different groups also led to a certain understanding for and solidarity with others on sick leave – *'There*

are those worse off than me'. The returners also believed that the good contacts they had with their case officers at the insurance office were in part due to the fact that they agreed to the proposed rehabilitation and that they also showed initiative in making efforts to be able to return to work more quickly. They were 'good patients'.

Experiences of being on sickness absence affected status and self-image

It is clear that an individual's self-image is formed by their perception of how others see them. Being treated with open mistrust and burdened with guilt could create a powerful sense of shame and result in withdrawal from social relations to avoid the risk of further shaming.

Those who had *given up* believed that their only means of improving their self-image was to obtain a disability pension: '*Then I'd get a dignified end to my working life*', said Viktor.

In the *ambivalent* group Anna, a 36-year-old children's nurse, felt she had changed during her time on sick leave so that she no longer recognized herself but thought of herself as being surly and dull. She asked her son to answer the telephone, to lie, and to say she was taking a shower in order to avoid talking.

Several of those on sick leave thought it problematic that they were expected to behave in a certain way and that their illness should be visible. '*Pain is not visible*', was a comment from a number of them. In most cases, they felt that a clear and distinct diagnosis or a visible disability was necessary if they were to justify their sickness absence.

Among those who had *reorientated*, there were several examples where the expectations of their environment were seen as problematic and in contradiction to how they wished to present themselves. Pia did not want to show her crooked back and Christer did not want to appear as a cripple. However, a safe environment meant that it was possible to let go of these expectations. '*Now everybody knows I'm in pain*', said Tomas, 33, who had gone on working with severe pain until it became impossible – '*it's obvious I'm in pain*'.

The financial situation for all of them had deteriorated but not all of them experienced financial stress. One used their savings; another borrowed from a close relative. In one case, the partner resolved the situation by working longer hours. Several had reduced their outlay, switched to a cheaper car and so on. However, Rita, whom we have met earlier, was worried that they would have to sell their house and Nina did not like being financially dependent on her partner. Financial stress could create a sense of shame. This is partly a question of being perceived as poor or, as in Viktor's case, the negative feeling of being dependent on his wife for the family's income.

The *returners* felt so secure in their sickness role that they remained unaffected by their environment. Furthermore, they perceived themselves as healthy and as legitimately sick-listed and did not see these issues as a problem. On the other hand, those who had *reorientated* experienced certain mistrust at the beginning of their period of sickness absence. When they had

successfully managed to get better care and to orientate themselves towards a new job, their self-image strengthened. The pride of returning to work was the predominant feeling in both of these groups and they were treated with respect.

Discussion

The main result of this hypothesis-generating study is the exemplification of the tension between the work strategy as the social norm and finding an acceptable life role from the perspective of both the individual and the people around. The respondents' life situation during the sickness-absence period largely concerned the issue of convincing those around that their pain was real and that their sickness absence was justified despite the mistrust and disrespect.

However, those sick-listed with a musculoskeletal diagnosis proved not to be a homogeneous group. We identified at least four groups who coped with their sickness absence in substantially different ways. The respondents in the different groups experienced markedly different treatment from both the health-care system and other actors concerned with their rehabilitation. Their differing experiences had an effect on which strategy they used to find an acceptable life role and to gain respect. The value of being treated with respect for facilitating the process of rehabilitation emerges in other studies as well (Kugelmann, 1999; Werner & Malterud, 2003, Wessel et al., 2012). Treating people with respect may also affect the experience of health and pain. In the current study, the four groups on sick leave needed to apply different strategies. The group with dimmer prospects of returning to work was also the group that had most experience of being mistrusted and treated with disrespect. The disrespect described was both direct and indirect. This was the group that apart from struggling to gain respect and credibility also spent much time, energy, and effort in preserving their self-esteem and dignity, both as patients and as clients.

Semmer and his colleagues (2007) have shown that being treated in a disrespectful and disparaging manner represents a threat to an individual's self-esteem. It arouses negative feelings of failure and shame and has consequences for well-being. As illness is related to an individual's personal identity, general societal campaigns against sickness absence may have a counterproductive effect in that exposed groups feel even more exposed (Hofmann, 2011). This also concerns the status of different diagnoses. At the bottom of the status ladder are musculoskeletal and psychiatric diagnoses (Album & Westin, 2008). The respondents in at least three of the four groups in the present study had difficulty in coping with the fact that their illness was not visible and thus they risked being treated as malingerers by both the health-care system and those around them. To a large extent, they also took the blame for their illness upon themselves and this demonstrated that they had accepted the view of sickness absence as an individual problem. At the same time, they had also shown responsibility and willingness to work by carrying on and fulfilling the moral decree that one should work. They were aware of the distrust that existed towards those on sick leave and, on occasion, even shared this doubt themselves. When they did fall ill, they strove therefore by means of various strategies to regain respect in order to avoid feeling disparaged, failed, and ashamed. Nevertheless, several of the

respondents pointed out that a psychiatric diagnosis had an even lower status both for them and for the people around them. Vidman (2009) also shows that the experience of being ill differs between those with mental ill health and those with musculoskeletal disorders.

No clear gender differences emerged in the present study. The group to which the individual belonged seemed to be of greater importance for their perception of the situation. This may possibly be explained in part by the fact that several of the informants were older, did not have children at home, and were single or separated and thus had shared responsibility for the children.

The four groups of sickness absentees that emerged in the study experienced their sickness absence in different ways. Their pathways back to work also differed. It was evident that the period of sickness absence was lengthened for many of them through the long waiting times in the health-care system, which resulted in frustration and further suffering for the individual. Waiting may also aggravate the illness (Charmaz, 1983). The results demonstrate the value of not treating those on sick leave with a musculoskeletal diagnosis as a uniform group and indicate how important it is that those providing rehabilitation adopt a sensitive attitude and listen to the wishes and views of the individual in question. The need, for instance, for the alleviation of pain, an operation, a medical analysis or psychosocial support may differ from patient to patient. The group which in Larsson Lund's study (2001) had the shortest period of rehabilitation included those who felt they had actively participated in their own recovery. It is also evident that efforts and support on the part of close relatives was also of great importance for how they experienced their sickness absence. Furthermore, on many occasions the respondents themselves took the initiative in their process of recovery by, for instance, training, walking, and reorganizing work at home. The results show that even though they have worked hard some persons were experiencing disrespect and the treatment they received unnecessarily increased their suffering and hindered their recovery.

The focus of the current study has been on the life situation for the men and women on sick leave with musculoskeletal diagnoses. These, together with the psychiatric diagnoses, constitute the two major diagnostic groups for long-term sickness absence in Sweden. Despite this, these diagnostic groups receive less research funding, which has consequences for the level of knowledge. There is an urgent need for more research on these diagnostic groups; we also believe that continued research should, to a great extent, take the total life situation of the sickness absentee into account and place it in the social context. An approach of this nature would also be in agreement with a transition to a biopsychosocial concept of illness. This concept enables the medical system to reflect on the relationship between the organization of society and ill health and involves the experiences of the individual, as this study has done, adding biological signs and statistical links (Michailakis, 2008).

Although the current study is based on the experiences and perceptions of a limited number of individuals in a special context, the idea is that, in accordance with grounded-theory analysis, what has emerged from this study can be transferred to sickness absentees in other contexts. However, the results cannot be generalized directly to all long-term sickness absentees with musculoskeletal diagnoses. Several studies are needed to test the hypothesis

that sickness absence concerns striving for an acceptable life role in order to regain respect in one's own and other's eyes.

Acknowledgements

There is no conflict of interest to be declared in this study. The study was funded by the Norwegian Research Council (NFR).

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