

Supporting mental health

Effects, communicative processes and
experiences of a person-centred eHealth
intervention

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ABSTRACT

Corresponding to the appeal to develop supportive strategies for people on sick leave with common mental disorders (CMDs), focusing beyond illness and towards mental health, this thesis evaluates an eHealth intervention based on person-centred care (PCC). The overall aim was to evaluate and explore the effects and processes of a person-centred eHealth intervention for patients on sick leave with CMDs by illuminating experiences and communicative practices constituting and taking part in a PCC intervention in an eHealth setting.

Different methods were used in the individual studies, corresponding to the overarching and individual aims. One paper comprised a study protocol of the design and methodological choices of the project. Effects were evaluated in a randomised controlled trial, interactive processes related to narrative elicitation were explored in a conversation analysis, and participants' experiences were explored in a mixed methods analysis.

Overall, the evaluation of effects demonstrated an increase in general self-efficacy among intervention participants but no effect on level of sick leave. The elicitation of narratives was a central communicative task in the patient-professional interaction which provided opportunities for meaning-making processes but could also give rise to interactive challenges. Patients in the intervention group overall found the intervention to have offered meaningful support, particularly the phone communication with intervention professionals. The support participants perceived was due to the recognition they felt from the intervention professionals and the continuous availability that was enabled by the eHealth format.

In conclusion, the thesis contributes to understanding how health care can support persons on sick leave with CMDs. Drawing from findings in the individual studies, communicative processes inherent to the PCC agenda of eliciting narratives and forming partnerships were central to how support was enacted in the intervention and to the participants' experience of the intervention's meaningfulness. The essential elements of the intervention were the provision of a meaningful professional support within reach, through the continuous access to professionals provided by the eHealth format.

Keywords: Mental health, common mental disorders, Person-centred care, health care interactions, eHealth, intervention, randomised controlled trial, conversation analysis, process evaluation

SAMMANFATTNING PÅ SVENSKA

Under de senaste tre årtiondena har andelen sjukskrivningar som kan härledas till depression, ångest eller stressrelaterade psykiska sjukdomstillstånd ökat i Sverige och de står nu för en majoritet av alla sjukskrivningar bland kvinnor, och bland män i åldrarna 25–44. Depression, ångeststillstånd och stressrelaterade psykiska sjukdomstillstånd tillhör de vanligaste psykiska sjukdomarna, de är dessutom är närbesläktade och kan vara svåra att skilja åt i ett tidigt stadium. Stressrelaterade psykiska sjukdomstillstånd, som är den grupp där sjukskrivningarna ökat mest, har ofta en identifierbar utlösande faktor, såsom en temporär belastning eller kris, och förväntas gå över när livssituationen ändras eller med tidens verkan på krisen. De kan dock övergå i allvarligare sjukdomstillstånd, såsom utmattningssyndrom eller depression, vilket eventuellt förklarar att de vanligaste psykiska sjukdomarna har längre genomsnittlig sjukskrivningstid än genomsnittet för övriga sjukdomar. Långa sjukskrivningar utgör en riskfaktor för försämrad psykisk hälsa och permanent exklusion från arbetsmarknaden. För personer som drabbas av psykiska sjukdomar innebär det ofta en tid av ovisshet, med behov av såväl professionellt som privat stöd. Om en sjukskrivning blir aktuell är det ofta gynnsamt för en eventuell arbetsåtergång att arbetsgivaren är involverad i någon form.

I denna avhandling utvärderas en intervention som riktade sig till personer sjukskrivna för de vanligaste psykiska sjukdomarna. Interventionen bygger på ett ramverk för personcentrerad vård vilket förespråkar att vårdgivare och patient kommer överens om vårdens innehåll och upplägg, utifrån patientens egen situation och mål, och utifrån evidensbaserad kunskap. Interventionen utformades som ett eHälsastöd uppbyggt av telefonsamtal med dedikerad vårdpersonal och tillgång till en web-baserad portal, och var tänkt att fungera som ett komplement till sedvanlig vård. Syftet var att genom att involvera patienten och dess nätverk i vården stärka patientens tilltro till att kunna hantera sin situation och de utmaningar man själv såg att man stod inför, arbetsrelaterade såväl som sjukdomsrelaterade.

Det övergripande syftet med avhandlingen var att utvärdera och utforska effekter av och processer inom den personcentrerade eHälsaintervention för patienter sjukskrivna för de vanligaste psykiska sjukdomar.

Avhandlingen består av fyra delarbeten, **delarbete ett** var ett studieprotokoll där interventionen samt metodologiska ansatser för att utvärdera dess effekter och utförande presenterades.

Delarbete två var en randomiserad kontrollerad studie i vilken interventionens effekt på huvudutfallsmåttet, ett kombinerat mått av självskattad tilltro till egen förmåga (general self-efficacy) och sjukskrivningsnivå vid tidpunkten för uppföljning utvärderades. Efter bortfall deltog 209 patienter i studien, 107 i kontrollgruppen och 102 i interventionsgruppen. Vid uppföljning efter tre månader hade interventionsgruppen förbättrats signifikant i huvudutfallsmåttet jämfört med kontrollgruppen, men efter sex månader var skillnaderna inte längre signifikanta. Sjukskrivningsnivåerna var väldigt lika mellan grupperna vid båda uppföljningstillfällena, och skillnaden mellan grupperna drevs av att interventionsgruppen förbättrades snabbare i general self-efficacy.

Delarbete tre var en kvalitativ samtalsanalys av telefonsamtal som ägde rum inom ramen för interventionen, med fokus på hur patienters berättande genomfördes. Elva inspelade telefonsamtal mellan deltagare i interventionsgruppen och vårdpersonal inkluderades i analysen, samtalen transkriberades och analyserades utifrån hur patientberättelser introducerades, genomfördes och påverkade samtalet i samtalets olika delar. I analysen återfanns tre interaktiva mönster för patientberättelser; frågedrivna berättandesekvenser, patientdrivna berättandesekvenser och samskapade berättandesekvenser. Utifrån studiens resultat diskuterades hur uppmaningen att berätta kan orsaka kommunikativa problem mellan patienter och vårdpersonal, men också hur berättandet kan vara en meningsfull aktivitet som ger utrymme för att hantera omständigheter i livet som påverkats av sjukdomen eller sjukskrivningen.

Delarbete fyra var en mixad metodstudie av intervjuer och enkätuppföljningar med deltagare i interventionsgruppen, med fokus på deras upplevelser av interventionen och vilka aktiviteter och processer de upplevde som meningsfulla. Enkäten skickades ut till alla deltagare i interventionsgruppen (n=102) vid två tillfällen. Dessutom genomfördes semi-strukturerade intervjuer med 15 deltagare ur interventionsgruppen, som valdes för att få ett heterogent urval utifrån ålder, kön, diagnos och upplevelser av interventionen. Resultatet visade att en stor majoritet av deltagarna upplevde interventionen som ett meningsfullt stöd. Utifrån en syntes av både de kvantitativa och kvalitativa resultaten gjordes en övergripande tolkning av meningsfullhet som konstituerad av tillit till att professionellt stöd fanns enkelt och kontinuerligt tillgängligt.

Sammanfattningsvis hade interventionen effekt på deltagarnas tilltro till sin egen förmåga, som starkast tre månader in i interventionen, men ingen effekt på sjukskrivning. Det personcentrerade innehållet i stödet upplevdes som meningsfullt av en majoritet av deltagarna, och eHälsaformatet snarare som en möjliggörare för ett personcenterat stöd än ett hinder. Genom fokus på patienternas berättelser möjliggjordes förståelseprocesser av vikt både för den personcentrerade hälsoprocessen, och för patienternas egen förståelse och bearbetning av sin situation.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

- I. Cederberg, M., Ali, L., Ekman, I., Glise, K., Jonsdottir, I.H., Gyllensten, H., Swedberg, K. & Fors, A. A person-centred eHealth intervention for patients on sick leave due to common mental disorders: Protocol of a randomised controlled trial and process evaluation (PROMISE). *BMJ Open*. 2020;10:e037515. doi:10.1136/bmjopen-2020-037515
- II. Cederberg, M., Alsén, S., Ali, L., Ekman, I., Glise, K., Jonsdottir, I.H., Gyllensten, H., Swedberg, K. & Fors, A. Effects of a person-centered eHealth intervention for patients on sick leave due to common mental disorders (PROMISE study): Open randomized controlled trial. *JMIR Ment Health*. 2022 Mar 15;9(3):e30966. doi: 10.2196/30966
- III. Cederberg, M., Fors, A., Ali, L., Goulding, A. & Mäkitalo, Å. The interactive work of narrative elicitation in person-centred care: Analysis of phone conversations between health care professionals and patients with common mental disorders. *Health Expectations*. 2022 Feb 11. doi: 10.1111/hex.13440
- IV. Cederberg, M., Barenfeld, E., Ali, L., Ekman, I., Goulding, A. & Fors, A. Trusting professional support to be within reach: A mixed methods process evaluation of participants' experiences of a person-centred eHealth intervention. *In manuscript*

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ABBREVIATIONS

CMD	Common Mental Disorder
GSE	General Self-Efficacy
GSES	General Self-Efficacy Scale
GPCC	Gothenburg Centre for Person-Centred Care
gPCC	Gothenburg Centre for Person-Centred Care framework
HCP	Health Care Professional
ICD-10	International Statistical Classification of Diseases and Related Health Problems
MRC	Medical Research Council
PCC	Person-Centred Care
RCT	Randomised Controlled Trial
RTW	Return To Work
WHO	World Health Organization

1 INTRODUCTION

During the past decades, there has been an increase in the length and frequency of sick leave attributed to stress-related mental illness, depressive episodes and anxiety syndromes, to the extent that these conditions now constitute a majority of the ongoing sick leave spells in Sweden exceeding 60 days (Försäkringskassan, 2020). Stress-related mental illness, depressive episodes and anxiety syndromes are often referred to as ‘common mental disorders’ (CMDs). The concepts of mental disorder and illness are debated, as the origins of mental conditions are still essentially unknown. Critics are concerned that the increase in mental disorders represents a medicalisation of problems of living, while to others, it represents the achievements of research and greater awareness (Vingård, 2015; Doblyté, 2020). All the while, people are experiencing psychological distress and suffering to the extent that it influences their capacity to manage life and work. High CMD-related sick leave is not only a phenomenon in Sweden, it also exists in many other high-income countries (Henderson et al., 2005; Henderson et al., 2011; OECD, 2013). An international study found a 12-month prevalence of 18% and a lifetime prevalence of 29% of any CMD among the working-age population (Steel et al., 2014). Not all cases of CMDs require, or result in, sick leave, but sick leave spells related to CMDs are generally long, and there is a high risk of recurrence (Koopmans et al., 2011; Lidwall, 2015; Shiels et al., 2016).

Primary mental health care represents first-level care of CMDs, and the stated ambition is for it to be oriented towards the patient rather than the disease (OECD, 2020; SOU, 2018). Most evidence-based treatments for CMDs are rooted in the illness and entail pharmacological or psychological treatments (Socialstyrelsen, 2017b). Treatments targeting CMDs seem to have only a small effect, if any, when it comes to sick leave (Arends et al., 2012; Ejeby et al., 2014; Salomonsson et al., 2018). The sick leave process is complex and influenced by many factors beyond the illness, both environmental and personal, justifying a holistic approach in supporting persons to return to work (RTW). Respectively, support for RTW needs to be solidly rooted in a wider, long-term perspective of mental health, given the detrimental effects on health associated with poor working environments (SBU, 2014). Mental health is defined by the World Health Organization as *‘a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a*

contribution to his or her community' (Herrman et al., 2005, p.12). The promotion of mental health does not exclude or neglect the importance of reducing mental illness, but the pathways are likely to differ. While treatments are directed at the symptoms of illness, promotion of individual mental health requires a strong focus on individual goals and circumstances (Slade, 2010). In the national guidelines for treatment of depression and anxiety, these perspectives are intertwined through the emphasis on providing care based in a salutogenic approach of supporting the patient's own resources towards improving health, sense of self-efficacy and control (Socialstyrelsen, 2017b).

By suggesting a change in focus from the disease to the person with the disease, person-centred care (PCC) challenges reductionistic, biomedical traditions and perspectives on how care is and should be conducted (Naldemirci et al., 2018). PCC emphasises the importance of knowing the patient as a person, looking beyond the disease alone, and accordingly, it reformulates the traditional roles, status and tasks of patients and carers (Ekman et al, 2011). In a micro-perspective, PCC consists of communicative processes of trying to understand the situation of another human being, signified by the particular roles prescribed by the health care context of patients and carers. It is through the negotiated, continuous interaction between health care professionals (HCPs) and patients (and relatives) that an agreement on actions can arise. As such, PCC is not equivalent to certain actions, but an ethics of actions, which has implications for its implementation in routine care. Different suggestions on how to advance PCC in health care have gained ground, one of which is the framework for conducting PCC developed at the Gothenburg Centre for Person-Centred Care (GPCC) (Ekman et al, 2011).

The intervention evaluated in this thesis builds on this particular framework and corresponds to the call for novel approaches to supporting mental health and RTW among persons with CMDs, through the operationalisation of a PCC intervention that brings to the forefront the co-construction of care, rooted in the patient's experience of their situation, needs, resources and goals. The approach to mental health underpinning the thesis is influenced by the capability approach and the theory of human agency, which intersects with PCC in recognising the agency of persons, and by the emphasis on what the patient values in life (Bandura, 2001; Entwistle et al., 2018; Nussbaum, 2013). These perspectives are also foundational for the conceptualisation of support operationalised in the intervention and the thesis as a potential inherent in the relationships between patients and HCPs, in which the HCPs guide their actions towards recognising what matters to the patient and strengthening important aspects of the patient's agency (Entwistle et al., 2018).

1.1 Disposition of the thesis

This thesis concerns the evaluation of an eHealth intervention building on the principles of PCC for patients in primary health care on sick leave with CMDs. In the following section, I will outline the general background on support and treatment of CMDs and related sick leave. Thereafter, I will place the concept of PCC in a historical context and describe its relevance in primary mental health care, and then I will describe the approach to PCC in the GPCC framework and how it's been conceptualised in different interventions. Thereafter, the intervention and my role in the overall research project is introduced in the chapter 'Contextualising the thesis'. In this thesis, Paper I is a study protocol, a kind of publication in which no data are presented or analysed but which communicates the research agenda of a planned or ongoing trial. As Paper I guided the design of the subsequent papers of the thesis, it will also be described in this chapter, which bridges over into the rationale and presentation of overall and specific aims. In the following chapter, 'Methods and research design', an overview of research designs and the procedures of each study is described along with ethical considerations. Thereafter, findings from Papers II-IV are presented individually. In the chapter 'Integration and discussion of findings', the findings from the studies are integrated and discussed in relation to the philosophical and theoretical perspectives outlined in the background, and in relation to their clinical relevance. Finally, a summary of the most important findings of the thesis is presented under 'Conclusion'.

2 COMMON MENTAL DISORDERS AND MENTAL HEALTH

2.1 Common mental disorders

Since 2014, psychiatric diagnoses have been the most frequent cause of sick leave in Sweden and account for the largest proportion of new sick leave spells among women, and among men between the ages 25-44 (Försäkringskassan, 2017a, 2020). One particular category in the International Statistical Classification of Diseases and Related Health Problems (ICD-10), ‘adjustment disorders and reaction to severe stress’ (World Health Organization, 1992), represents about half of all new and ongoing sick leave spells among the psychiatric diagnoses (Försäkringskassan, 2017a). Adjustment disorders and reaction to severe stress comprise, in turn, different diagnoses, among which acute stress reaction (F43.0), exhaustion disorder (F43.8A) and reaction to severe stress, unspecified (F43.9) are the most frequently reported causes for new sick leave spells within the category (Försäkringskassan, 2020). After adjustment disorders and reaction to severe stress, depressive episodes and anxiety syndromes account for the largest proportions of ongoing sick leave spells among the psychiatric diagnoses. During 2018-2019, 15.6% of new sick leave spells attributed to psychiatric diagnoses among women were due to depressive episodes, and 14.9% were due to anxiety syndromes. For men, the respective figures were 20.8% due to depressive episodes and 16.4% due to anxiety syndromes (Försäkringskassan, 2020). All in all, of the total sick leave for psychiatric disorders, around 90% of sick leave among women and more than 80% among men is due to adjustment disorders and reaction to severe stress, depressive episodes or anxiety syndromes (Försäkringskassan, 2014, 2020).

Depression, anxiety and stress-related mental illnesses, such as adjustment disorders and reaction to severe stress, are often referred to as common mental disorders (CMDs) due to their prevalence rates, but the conditions that are included in the term vary some. For example, the WHO (2017) includes depressive and anxiety disorders, Axén et al. (2020) include depression, anxiety disorders and stress-related mental illness, while Steel et al. (2014) also include substance abuse disorders. In order to focus on the prevalent and closely related conditions corresponding to the high number of sick leave spells, CMDs will in this thesis refer to depression, anxiety disorders and stress-related mental illnesses unless otherwise stated.

Clustering CMDs into a group has the advantage of mirroring a clinical reality where these conditions are both distinct and separate in terms of different criteria, prognosis and treatments but also share parts of their symptomatology, and often the borders between the different conditions can be blurred (Bachem & Casey, 2018). CMDs are, like most psychiatric disorders, classifications based primarily on reported subjective experiences and patterns of behaviour (Jablensky, 2016). For the stress-related mental illnesses, there also needs to be an identifiable stressor causing the condition. Depression is characterised by a subjective experience of lacking positive affect, as well as associated cognitive, physical and behavioural symptoms, occurring on a continuum of severity. It is commonly associated with loss of interest in everyday life as well as feelings of worthlessness, lowered self-esteem and negative thoughts about oneself and one's past and future. Anxiety disorders consist of different conditions with generalised or specific anxiety, panic attacks and phobias. These conditions often result in difficulties carrying out everyday activities related to the anxiety and can be very inhibitive (National Institute for Health & Clinical Excellence, 2011). Stress-related mental illnesses, such as adjustment disorder, acute stress reaction or exhaustion disorder, are related to one or more identifiable life stressors, often but far from always work-related (Hasselberg et al., 2014), causing or significantly contributing to the condition. They are typically characterised by emotional distress, functional impairment (O'Donnell et al., 2019) and cognitive disturbance in exhaustion disorder (Grossi et al., 2015). In the case of an adjustment disorder, this is considered a more transient condition which may very well resolve organically with time or changes in life resolving the stressful situation (Bachem & Casey, 2018). However, adjustment disorder can also evolve into a chronic condition or a more severe condition, such as depression or exhaustion disorder. It can be difficult, in an early state, to differentiate between the cases which will resolve over time and the cases which will develop into chronic or more severe conditions (Bachem & Casey, 2018).

2.1.1 Prevalence and treatment

CMDs affect people of all ages and socio-economic categories, although they are more common among women than men (Kessler et al., 2005; Steel et al., 2014) and among people with low income (Lejtzen et al., 2014; Baumeister & Härter, 2007). It has been estimated that around 4.4% of the global population have a depressive disorder, while 3.6% have an anxiety disorder (World Health Organization, 2017). Adjustment disorder has been estimated to a prevalence of around 1-2% of the general population (Bachem & Casey, 2018; Glaesmer et al., 2015). In Sweden, Johansson et al. (2013) conducted a study suggesting that, at any given time, around 17.2% of the Swedish working population

experienced either clinically significant depression or anxiety. In a study conducted on primary health care registers, there was a 12.4% prevalence of depression and around a 9% prevalence of anxiety disorders and adjustment disorder respectively (Sundquist et al., 2017). Overall, the comorbidity between CMDs is high, and having a comorbid disorder is associated with higher symptom severity and lower health-related quality of life (Johansson et al., 2013). CMDs can be acute, singular events in a person's life as well as recurrent or chronic conditions (National Institute for Health & Clinical Excellence, 2011). Symptoms vary from mild to severe. Even for those with milder symptoms, the conditions may have a significantly negative impact on health-related quality of life and cause difficulties in handling personal and working life (Johansson et al., 2013; Socialstyrelsen, 2019).

In Sweden, CMDs are most commonly diagnosed, cared for and treated in the primary care setting (Sundquist et al., 2017). According to the Swedish national guidelines, treatment for depression and anxiety should primarily involve medication or cognitive behavioural therapy (CBT) or a combination of both (Socialstyrelsen, 2017b). There is no similar consensus on treatment for stress-related mental illnesses (Ahola et al., 2017; Bachem & Casey, 2018). The variation in severity, along with the high prevalence, have led to propositions of stepped-care strategies for CMDs, in which patients are guided to different treatments based on their illness and symptom severity (Clark, 2011; Salomonsson et al., 2018; Seekles et al., 2011; van Straten et al., 2015). For less severe conditions, that may entail self-guided programmes that the patient can perform more or less on their own, whereas more severe conditions receive additional professional guidance.

eHealth is often mentioned as one of the pathways through which modern-day mental health care can become more efficient, for example, by limiting the number of health care visits or strengthening patients' self-management (Karasouli & Adams, 2014). Most eHealth initiatives for CMDs are web-based and build on CBT techniques (Burger et al., 2020; Andersson, 2016; Sin et al., 2020). Comparisons between traditional and computerised CBT show either equivalence in terms of treatment results (Andrews et al., 2010; Carlbring et al., 2018) or that they may function as a complement to existing services (Arnberg et al., 2014).

2.2 Sick leave and common mental disorders

Sick leave describes a person's absence from work due to being ill. In Sweden, anyone over the age of 16 who is unable to work due to illness or injury can apply for sickness benefit granted by the Social Insurance Agency. Depending on how extensive the reduction in work capacity is, sickness benefit can be granted at 25%, 50%, 75% or full time. After 7 days of sick leave, a medical certificate verifying the reduction in work capacity needs to be issued by a physician (Försäkringskassan, 2021). The National Board of Health and Welfare has published guidelines on sick leave based on different diagnoses, aiming to assist and facilitate individual assessments. In the guidelines, the basic principle is that sick leave recommendations should be based on an assessment of how the illness affects the individual's work capacity and that the mere presence of a diagnosis does not in itself justify sick leave. Sick leave should be regarded as an activity which, combined with appropriate support and advice, should help the individual function to the best of their ability, despite potential limitations. In the sick leave recommendations for CMDs, the general approach to depressive episodes, acute stress reactions, adjustment disorders and anxiety disorders is to avoid sick leave, if possible, if the condition is mild or moderate, and to consider less than full-time sick leave. For a mild depressive episode or a moderate to severe adjustment disorder, sick leave is recommended to last up to 3 months. For a moderate to severe acute stress reaction, panic syndrome or generalised anxiety syndrome, sick leave duration is recommended up to 4 weeks. For exhaustion disorder, the recommendation is full or partial sick leave up to 6 months and a gradual RTW. In case of remaining cognitive impairment, sick leave can be prolonged up to 1 year. For mild recurrent depression, partial or full-time sick leave is recommended up to 6 months; for moderate recurrent depression, sick leave spells can expand to 1 year or more (Socialstyrelsen, 2017a).

Long-term sick leave is defined as spells lasting more than 60 days (Försäkringskassan, 2021). During the past three decades, the proportion of psychiatric diagnoses among all sick leave longer than 60 days in Sweden has increased from 16% to 33% among men, and from 13% to 45% among women. The median length of a sick leave episode related to a psychiatric condition is 90 days, however, sick leave spells are generally longer for severe mental illnesses than for CMDs (Försäkringskassan, 2020). Still, the median sick leave spell for adjustment disorders and reaction to severe stress is 57 days compared to 44 days for causes other than a psychiatric condition (Försäkringskassan, 2017a). Besides generally being longer, sick leave spells related to CMDs are at a substantial risk of recurrence (Dewa et al., 2014; Knudsen et al., 2013; Koopmans et al., 2011; Lidwall et al., 2015; Plaiser et al., 2010). The longer a

sick leave spell runs, the greater the risks of permanent exclusion from working life (Roelen et al., 2012).

The risk of sick leave due to a CMD is higher for women than for men, and the risk of sick leave due to stress-related mental illness peaks during the ages 30-44 for both women and men (Försäkringskassan, 2020). People with post-secondary education and above median income have lower risk of sick leave due to CMDs than people with primary education and income below the median, an association which is more substantial for men than for women (Försäkringskassan, 2014; Lidwall et al., 2018). Lower income has also been associated with a higher risk of recurrent sick leave episodes due to CMDs (Koopmans et al., 2011). Employees within health care, where a large majority are women, also have a higher risk of sick leave due to CMDs, and professions within health care as well as teachers are, more frequently than other professions, reporting inadequate psychosocial work environments (Försäkringskassan, 2014, 2017b), which also increases the risk of sick leave due to a CMD (Duchaine et al., 2020).

2.3 Associations between mental health and work

For people of working age, factors related to employment have a great influence, both positive and negative, on mental health. For example, unemployment or insecure employment has a negative effect on mental health, while job security and a sense of control at work are protective factors (Allen et al., 2014). Work environments where employees experience high demands and low possibilities to control, low support from leadership or co-workers and low rewards at work have also been associated with increased symptoms of depression and exhaustion disorder (SBU, 2014). However, work can also contribute other factors that are important to health in general and mental health in particular, such as the ability to influence one's economic and material situation, develop one's identity and interests and have an active role in societies where employment constitutes the norm (Waddell & Burton, 2006).

2.4 Mental health, agency and self-efficacy

In the 2018 Swedish national population survey, 17% of the respondents aged 16-84 described their mental well-being as reduced, and the numbers have increased during the past decade (Folkhälsomyndigheten, 2019). Mental health has been described by the WHO as '*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*' (Herrman et al., 2005, p.12). The emphasis on supporting persons' agency 'to be able to do and to be' is a key notion in the capability approach, which is concerned with how the quality of humans' lives can improve. The capability approach originates from the works of Amartya Sen and Martha Nussbaum in economics and development, and has been applied in theoretical work on quality of life and human flourishing (Law & Widdows, 2008). In the capability approach, human beings are seen as having functionalities and capabilities, and leading a life in which the basic functionalities to flourish and develop one's capabilities, is considered morally good. What makes for a good life, according to the capability approach, is having the capabilities to be and achieve that which is of value to each individual person (Law & Widdows, 2008; Nussbaum, 2013). Capabilities are determined by environmental, social and personal factors, and can be fostered or hindered through interactions with other persons (Entwistle & Watt, 2013).

In social cognitive theory, the capacity to exercise control over aspects of one's life is integral to the concept of human agency. People are not merely agents of action but self-examiners of their own functioning and behaviour, reflecting upon themselves, their motives, values and meaning of their life pursuits (Bandura, 2001). Mechanisms influencing personal agency have both external and internal determinants, but according to Bandura (1997), nothing is more pervasive than a person's belief in their capability to exert some measure of control over themselves and their environment. This personal belief in one's capability to produce desired results by their actions is called self-efficacy belief, and it has a direct impact on motivation and likelihood to engage in and endure challenging activities. Having a strong sense of self-efficacy is linked to perceiving oneself as capable of handling difficult and unforeseen situations, which has been associated with reduced vulnerability to stress and depression and a heightened resilience when facing obstacles (Bandura, 1997; 2001).

2.5 Care and support for people on sick leave with common mental disorders

Health care systems have an important part to play in enhancing participation in working life and preventing the decline or loss of work ability among people with CMDs, but this requires timely and adequate care (OECD, 2015). The psychological and pharmacological evidence-based treatments for CMDs do not typically focus on sick leave or RTW, and neither do they assert any greater effect on such outcomes (Arends et al., 2012; Ejeby et al., 2014; Salomonsson et al., 2018). Research on what is required in order to influence sick leave is slightly inconclusive, partly due to the difficulty of getting a clear overview of a heterogeneous field that includes various conditions and uses various outcome measures (Soegaard, 2012). Many studies have attested to the importance of somehow including the workplace in the intervention if the intention is to influence RTW, for example through modification of work, incorporating a workplace focus into a treatment programme or enabling workplace dialogues (Lagerveld et al., 2012; Mikkelsen & Rosholm, 2018; Nieuwenhuijsen et al., 2014; Nigatu et al., 2017). In order to achieve sustainable RTW, defined as RTW without relapses in sick leave exceeding 14 days during a period of 3 months, Etuknwa et al. (2019) suggested that RTW interventions should encourage supportive interactions between the employee, employer and co-workers. In Sweden, strategies to facilitate collaboration with the workplace have included, for example, the promotion of rehabilitation coordinators dedicated to facilitating communication between the patient and other parties involved in the sick leave process (Norén, 2017).

Sick leave can be experienced as a necessary break to rebuild capacity and engage in a process of re-evaluation. It can also be experienced as detrimental to recovery, linked to a sense of isolation and self-questioning (Simpson et al., 2015; Ståhl & Edvardsson Stiwne, 2013). This distinction can be understood as relating to the complex psychosocial aspects involved in work. Positive and negative work characteristics, interactions at work, as well as non-work-related factors influencing individuals' capacity to cope with stressors all occur simultaneously and have an impact on the individuals' health and experience of their work situation (Waddell & Burton, 2006). Supporting people on sick leave thus requires an understanding of this complex situation where multiple factors, both environmental and personal, and the interplay between them, have an impact on the possibility and motivation to RTW (Haugli et al., 2011; Holmgren & Ivanoff, 2004). From interviews with patients off work due to depression, the authors emphasised the importance of professionals' support in challenging an internalisation of the illness, 're-framing' illness and

reinforcing other aspects of one's identity and social roles, and setting realistic recovery goals (Millward et al., 2005).

Several studies have attested to an association between higher self-efficacy beliefs in an individual and likelihood of RTW (Etuknwa et al., 2019; Nigatu et al., 2017; Volker et al., 2015). Lagerveld et al. (2017) have also demonstrated in an intervention targeting RTW in patients with CMDs that increasing self-efficacy beliefs through the intervention had positive effects on RTW. As self-efficacy is a personal assessment of one's capability to manage specific or general situations, it has been suggested that self-efficacy might be an important psychological mechanism to consider in RTW interventions, in parallel with the effects of the illness and the presence of social support and co-ordination of support between systems (Andersen et al., 2012).

3 PERSON-CENTRED CARE

3.1 The concept of person-centred care

The concept of person-centred care has its origins in the medical field and in the field of psychotherapy (Leplege et al., 2007). Its first appearance dates back to the 1950s, in the works of psychologist Carl Rogers. According to Rogers, a signifying feature of human beings is every individual's innate capacity for and inclination to growth and self-actualisation (Rogers, 1974). In psychiatric counselling, the core mission of the professional is thus to provide a relationship with such qualities that the patient feels accepted, supported and free to express themselves, through which their capacities will be released and they will find ways to cope with their problems (Rogers, 2012). In the medical field, in the 1960s, the works of Michael Balint contributed greatly to appraising the importance of the doctor-patient relationship in general practice as a means to attend to the patient as a unique person (Balint, 1972). Throughout the second half of the 20th century, there was a shift from seeing patients as primarily passive recipients of medical interventions towards the current norm, in which patients take an active part in their own care and in decision-making, and their subjective experiences are valued sources of information (Leplege et al., 2007) .

Today, although the term is widespread, concept analyses of PCC have concluded that there is no general consensus on a definition of PCC. However, there are recurrent attributes which reflect the essence of the concept, such as holistic care, recognition of personhood and the importance of developing meaningful partnerships between HCPs and patients (Håkansson Eklund et al., 2019; Morgan & Yoder, 2012; Sharma et al., 2015; Slater, 2006; Waters & Buchanan, 2017). Entwistle and Watt (2013) suggest that the core of the concept of PCC is the overarching ethical idea that patients should be treated as persons. Treating someone as a person entails not reducing them to their illness or disability alone, but taking due consideration of their subjectivity, their integration within a given environment, as well as their strengths, rights and future plans (Leplege et al., 2007).

A closely related term is patient-centred care, occasionally used synonymously with PCC. According to Håkansson Eklund et al. (2019), there are similarities but also important differences between the concepts. Both person- and patient-centred care involve empathy, respect, engagement, relationship, communication, shared decision-making, holistic focus, individualised focus

and coordinated care, but they differ when it comes to their goals. In patient-centred care, the goal is a functional life for the patient, whereas in PCC, the goal is a meaningful life. They detect a further difference in the stance towards communication, where person-centred care goes beyond effective and accurate sharing of information towards using dialogue and narrative to clarify what really matters to the person (Håkansson Eklund et al., 2019). Thus, the emphasis on person-centred rather than patient-centred care indicates a shift from primarily focusing on patients in the medical context to a holistic approach which goes beyond in acknowledging the emotions, wishes, resources and social connections of persons, and the ethical aspects of interactions within the context of care (Britten et al., 2017; Entwistle & Watt, 2013).

3.2 Person-centred care in the context of primary mental health care

The concept of PCC raises different issues depending on the contexts within which it is used, and understanding the requirements of achieving PCC is dependent on understanding the context (Moore et al., 2017). Primary mental health care represents first-level care of mental illness, striving to be oriented towards the patient rather than the disease (OECD, 2020; SOU, 2018). Consultation with a physician is a prominent feature of primary mental health care, but it is also common for patients to be treated by other professionals such as psychologists, registered nurses or physiotherapists. A common barrier to PCC in the primary health care context is lack of time but may also include a too-narrow focus on the doctor-patient interaction at the cost of other issues impacting on the person-centredness of care, for example, the accessibility of care and the importance of professional teams (Gask & Coventry, 2012). In regard to mental health nursing, Barker (2001) has developed a model for PCC targeting persons with psychiatric and mental health issues in which the focus of psychiatric and mental health nursing differs depending on the patient's status and associated needs. Although it is emphasised that patients' needs may very well flow between the artificial boundaries of general or specialist care, what is often required in the context of primary mental health care is an egalitarian relationship involving an *'even more collaborative approach to education, personal growth and discovery'* (Barker, 2001, p. 5). In order to support recovery, it is important to recognise the patient's situation in a holistic perspective and to acknowledge both the barriers that may arise and the resources required to retrieve a balance in life (Arvidsdotter et al., 2016).

3.3 The GPCC framework

An approach to PCC which has been widely recognised was described by Ekman and colleagues in 2011 and was later referred to as the gPCC framework (Ekman et al., 2011; Gyllensten et al., 2020). In the framework, the ethical underpinnings of PCC are emphasised and three routines are suggested to facilitate adoption of PCC in clinical settings: initiating partnerships through eliciting patients' narratives, strengthening partnerships by making agreements and co-creating plans, and safeguarding partnerships in documentation (Britten et al., 2020). These have been central in subsequent studies evaluating PCC in different approaches (Gyllensten et al., 2020). The routines suggest that HCPs should invite patients to give a personal account of their illness through narrative elicitation. Through narrative elicitation, the patient's understanding of illness and health in relation to their daily life is explored and serves as the point of departure from which HCPs begin to learn about the person. It is also a means to discover obstacles and possibilities to achieve health (Wallström & Ekman, 2018). This knowledge, as well as the process, is instrumental for the formation of a partnership, which is the suggested form of relationship between HCPs and the patient and possibly also family members or significant others. The partnership is characterised by respect and sharing of knowledge. It is also emphasised that, along with evidence-based decisions and procedures, the agreement based in the narrative communication is properly documented and given a prominent position in the continuous care process.

In the framework, PCC is conceptualised as an ethics of practice, whose ontological assumptions on personhood build on the influence of the French philosopher Paul Ricoeur (Ekman, 2022; Ekman et al., 2011; Ricoeur, 1994). According to Ricoeur, a person is someone capable of acting as a responsible, moral agent whose sense of self is mediated through and changed by the continuous interactions with oneself and others. The human constitution is interdependent, as the notion of I is developed in relation to the presence of others (Ricoeur, 1994). As persons, we are not only capable and free but also suffering and dependent (Kristensson Uggla, 2020), and our interdependency is central to how we should live an ethical life, according to Ricoeur: '*aiming at the good life, with and for others, in just institutions*' (Ricoeur, 1994). Acting ethically requires each person to be committed in the relationships and situations which concern them and to cultivate their judgment of how the present circumstances influence what decisions and actions to pursue. It requires a dialectical movement between proximity, which is a deep understanding of the situation at hand, and distance, to critically reflect upon the situation from the general acquired knowledge. This can be translated to what is expressed in the framework as an emphasis on patient-professional

partnerships built on both the situated knowledge rooted in the patient's experiences and the professional competence and evidence-based procedures (Ekman, 2020). Partnerships differ from both paternalistic and consumerist relationships. In partnerships, the agenda of the visit is negotiated between the patient and the HCP instead of being decided by either party. Furthermore, the patient's values, experiences and goals are explored and taken into account in the planning of the care process (Heritage & Maynard, 2006). According to the gPCC framework, a PCC process can be achieved when patients are *understood* as persons, through communicative processes including but not limited to their narrated experiences (Ekman, 2022). From the perspective of Ricoeur, the activity of narrating, as an interlacing of past and present events, creates cohesion in life and identity. The narrative identity is coherent but not fixed, and the sense of self-continuity results from narratives of self-consistency throughout the changes in life, constructed in interaction and dialogue with others (Ricoeur, 1988).

3.4 PCC interventions

Lauver et al. (2002) claimed that patient-centredness of interventions can be attributed to a level of individualising the intervention's content according to the patient's characteristics or goals, with only little of the intervention content predefined but rather shaped through the interaction between the patient and the professionals involved (Lauver et al., 2002). Following the definition of PCC laid out earlier, and the distinction between person- and patient-centred care (Håkansson Eklund et al., 2019), the claim could be assumed valid also for person-centred interventions. As follows from the variability in conceptualisations of PCC, there is also variability in how PCC interventions are operationalised. For example, in a systematic review of PCC interventions evaluated in randomised controlled trials (RCTs), McMillan et al. (2013) guided their classification of interventions in terms of PCC on Morgan and Yoder's (2012) conceptualisation of PCC as care that encompasses the following attributes: holistic, individualised, respectful and empowering. Another systematic review of PCC interventions only included interventions which focused on partnerships between HCPs and patients and explicitly involved the patient as a partner in care (Olsson et al., 2013). This meant, for example, an emphasis on narratives, often in the form of an interview, to capture the patient's perspective instead of having patients follow predefined goals. A systematic review by Coulter et al. (2015) included and examined patient-centred interventions which explicitly engaged patients in both goal

setting and action planning, corresponding to the shared decision-making phase of their model of personalised care planning.

Partnership, in the form of qualities in the patient-provider interaction, has been identified as the core component in several PCC interventions building on the gPCC framework (Britten et al., 2020; Ekman et al., 2012; Fors et al., 2018; Fors et al., 2015; Olsson et al., 2013; Wolf et al., 2016). The gPCC framework has been used in health care interventions in different clinical contexts, both addressing a specific health-related problem through a specific intervention and employing a wider, generic approach to the patient's situation and health-related problems. Respectively, PCC interventions can be based on the gPCC framework alone or in combination with a specific theory or model (Gyllensten et al 2020). Evaluations of the gPCC framework have shown non-significant as well as significant effects (Britten et al., 2020). Positive effects have been demonstrated on, for example, health-related quality of life (Brännström & Boman, 2014), shortened length of hospital stay (Ekman et al., 2012; Olsson et al., 2006), patients' care experiences (Wolf et al., 2019), uncertainty in illness (Dudas et al., 2013), fatigue in patients with rheumatoid arthritis (Feldthusen et al., 2016), depression severity in patients with major depression (Danielsson et al., 2014) and self-efficacy (Fors et al., 2015; Fors et al., 2016a; Fors et al., 2016b). Most evaluations have been conducted in traditional face-to-face settings, but integrating PCC principles into telehealth or eHealth settings can enhance the potential to create partnerships that enable patients to manage their lives more independently (Heckemann et al., 2016). For example, in a blended approach to PCC that included traditional face-to-face care combined with an eHealth tool, the ability to positively impact patients' self-efficacy was enhanced among patients who also used the eHealth tool (Wolf et al., 2016). Positive effects on self-efficacy were also shown when PCC was conducted by telephone with no physical encounters at all (Fors et al., 2018; Ali et al., 2021).

3.5 PCC for supporting self-management

A common denominator in declarations on personhood in PCC is the standpoint that persons with illness or disability are not only vulnerable but are also in possession of strengths and capabilities (Ekman et al., 2011; Entwistle & Watt, 2013; Leplege et al., 2007). Embedded in the notion of 'treating patients as persons' is the imperative that HCPs recognise patients as moral agents with capacities and resources and make decisions or plans with them rather than for them. The notion of capabilities is influenced by the capability

approach, and to really appreciate a person's capabilities '*one must understand how their position in the social structure shapes their incentives and opportunities, as well as how these opportunities and incentives are interpreted*' (Smith & Seward, 2009, p.228). Personal capabilities are thus only one factor to consider, and in supporting self-management, it is important to take the patient's circumstances into consideration (Entwistle et al., 2018). Self-management involves patients taking responsibility for day-to-day management of their condition, assisted by HCPs as experts in their field but also as teachers, supporting the patient to develop their self-management skills (Holman & Lorig, 2004). Self-management initiatives can be too disease-focused, for example by taking a one-sided focus on professionals educating patients about disease-control or using motivational techniques to foster behavioural changes in a healthier direction. Support for self-management in a broader sense can also include an explicit focus on the patient's well-being and autonomy through interactions where the HCPs exert a form of moral support, acknowledging the troubles the patient is going through while still recognising their resourcefulness, reassuring them that they are not alone, and communicating in the '*kinds of respectful, caring and affirmative ways that help people to retain/develop a valued self-identity, personal narrative and sense of meaning in their life in face of a new diagnosis or the ongoing challenges and/or deterioration of lifelong conditions*' (Entwistle et al., 2018, p.54).

The concept of self-efficacy has connections to both self-management and PCC. A person's perceived self-efficacy is a judgment of one's capabilities to exercise control over situations one may find oneself in. For PCC interventions supporting self-management, theory on how to enhance self-efficacy could be incorporated into the purpose of supporting patients' agency. Through self-reflection, humans are capable of evaluating and learning from their own actions and those of others (Bandura, 1977). Self-efficacy beliefs are susceptible to change via different procedures, the most reliable being successful experiences of mastery in the present or the past, but it is also possible to influence someone's self-efficacy beliefs via vicarious experiences, verbal persuasion and physiological states (Bandura, 1977). For someone with low self-efficacy beliefs, there is little incentive to act or to persevere when facing difficulties, and it is partly on the basis of self-efficacy beliefs that a person decides what challenges to undertake, how much effort to expend, how persistent they will be in performing the intended behaviour and how to evaluate the outcomes of their actions.

4 CONTEXTUALISING THE THESIS

Corresponding to the need to develop accessible care making use of the patient's own resources for health, a person-centred eHealth intervention was developed and launched in an RCT starting in early 2018. The project was called Person-centred eHealth for treatment and rehabilitation of common mental disorders (PROMISE), and at the core was a remote support based on the gPCC framework. When I came onboard the project as a PhD student, the content and infrastructure of the intervention had already been developed. Besides investigating the effects of the intervention, I wanted to understand more about what actually happened in the process of carrying out the intervention programme. One of my first assignments as a PhD student was to write a study protocol of the project. In this thesis, the study protocol is an integral part of the research process, as it contributed to decisions on methodology of the following studies. Therefore, the study protocol will be presented here as a chronological phase leading up to the rest of the studies, which will be presented further on. Through that writing process I read up on interventions to support RTW for persons with CMDs and realised that this intervention took a different approach than most other studies I could find. First, I found it difficult to situate what kind of intervention it was; it did not fully resemble any of the health promotive, behaviour-change, or self-management interventions I came upon in my literature searches, but there were similarities. As in the health promotion programmes, the focus of the PROMISE intervention was more on strengthening health processes than treating disease. However, where many health promotion interventions focused on increasing particular healthy behaviours, no such behaviours were identified in the descriptions of the intervention that I had access to, and so I could not categorise it as a behaviour-change intervention either. Although similar to self-management programmes in its aim to increase patients' sense of capability to take care of their illness, the essence of the intervention was really the partnership, and the intervention elements corresponding to illness management or activities patients could engage in on their own comprised a rather small part. Within time I came to the realisation that the intervention was essentially a *person-centred* intervention, employing an ethical approach to co-construct the content and processes according to the agreements met with the individual patients. Realising this meant that I had to start by understanding what a person-centred intervention was in order to understand the intervention's logic and how the designated effects were intended to occur. Rather than a theoretically justified intervention, although there were

theoretically sound choices, it was justified by a normative notion that if patients were understood as persons, involved as partners in their care and supported in a way that was meaningful to them, they would be better equipped to live in a healthier way, whatever that meant for each one of them. For some, it could mean RTW as soon as possible, for others, it could be to ensure that the Social Insurance Agency approved a prolongation of sick leave.

4.1 Development of the PROMISE intervention

The PROMISE project was an externally funded research project tied to the Gothenburg Centre for Person-Centred Care (GPCC). GPCC is a research centre at the University of Gothenburg, founded in 2010 and committed to the agenda of conducting research contributing to the theoretical development, implementation and evaluation of PCC. The guiding idea in the PROMISE project was to evaluate PCC in the context of primary mental health care in the form of an intervention taking place through the use of eHealth. A challenge in care for people with CMDs is the imbalance between demand and supply, where primary mental health care in its present form relies heavily on access to pharmacological or psychological treatments delivered by specialists (Socialstyrelsen, 2017b). One strategy has been to improve access to psychological treatments by digitalising treatment programmes. Most of these are in the form of CBT modules targeting the condition, building on a principle of guiding the patient through a treatment process with minimal therapist support (Burger et al., 2020). In the development of the intervention in the PROMISE project, another direction was chosen. The idea was to offer patients on sick leave with CMDs access to support tailored to their situation as soon as possible in their care process and as a complement to usual care. This support would be delivered in a remote format and would build on the principles of PCC.

The general structure of such a remote support was developed in a participatory process involving patients with chronic conditions, HCPs, researchers and IT developers. The process resulted in a blueprint for a generic digital platform where each patient got access to a personal account containing functions designed to facilitate communication and to enable self-management and the co-creation of care. The generic prototype was adapted for the intended target group by designing the questions used for daily monitoring to capture common aspects of CMDs and by providing links to general information on CMDs. An intended benefit of the design of an eHealth intervention was the possibility for patients to receive care while at home.

4.2 The intervention: operationalising PCC in a remote care context

The intervention in the PROMISE project was an operationalisation of PCC building on the gPCC framework. The aim of the intervention was to support persons on sick leave with CMDs by identifying personal strengths and resources and making use of them in a process of regaining ability to work. The intervention programme corresponded to the routines suggested in the framework to develop and work in partnerships initiated by a patient-professional dialogue held by phone, in which the HCP elicited the patient's experiences of their situation, their needs, resources and goals. The first scheduled phone conversation was allowed to take time in order not to rush the patient's narrative, and the conversational guidance for HCPs was to encourage the patients to narrate their experiences and to listen carefully and attentively to their communication. Ideally, this dialogue formed the basis of a shared understanding of how to proceed, formalised into a health plan, which was documented on the patient's platform. In the framework, narratives relate both to the patient's narrative as a personal account of their experiences of illness, and to the form of communication that is established and carried on throughout the partnership. The 'patient narrative' and the 'narrative communication' could be considered two closely related but not identical aspects of a narrative approach underpinning communication in the intervention. The 'patient narrative' concerns *what* the patient communicates about themselves and their illness, continuously throughout the care process, and the 'narrative communication' describes the interactive approach, as '*sharing experiences and learning from each other*' through telling and listening (Ekman et al., 2011, p.250). Taken together, the framework suggests an explicit focus on the patient's experiences, expressed in dialogues with the HCPs and, possibly, significant others, and documented in a personal health plan. The patient's experiences, communicated in a narrative form, recur throughout each suggested routine and serve as a backbone in conducting PCC.

The eHealth character of the PROMISE intervention refers to the overall remote infrastructure in the form of phone communication and platform activities. In the study protocol, the communication between patients and HCPs was identified as the anticipated core component of the intervention. However, other intervention activities pertaining to the platform were also anticipated to contribute to the overall process of identifying personal strengths and resources and making use of them in the recovery process. eHealth has, for example, been applied to increase possibilities for patients' self-monitoring and to improve interaction between patients, HCPs and potential third parties

such as relatives or other professional contacts (Reynolds et al., 2015; Karasouli & Adams, 2014). Consequently, eHealth can affect the behaviour of both patients and health carers, and it can influence the patient's autonomy, roles and responsibility toward their health process, for example, in the form of self-management (Boers et al., 2020). These activities also relied upon communicative practices, with and through the platform, and included self-monitoring of symptoms, follow-up on documented health plans, information seeking and gathering of a supportive network by inviting the participation of significant others, such as family members or workplace representatives.

An attempt to illustrate the intervention logic is depicted in Figure 1, a logic model of the intervention (W.K. Kellogg Foundation, 2004). The model should be read as a visualisation of how the intervention was intended to work and the underpinning assumptions on a process of change. However, that does not mean that other associations and processes than the one depicted in the figure could occur, and that other factors could have a greater influence on the intervention outcome than those assumed when the intervention was planned (Morgan-Trimmer, 2015).

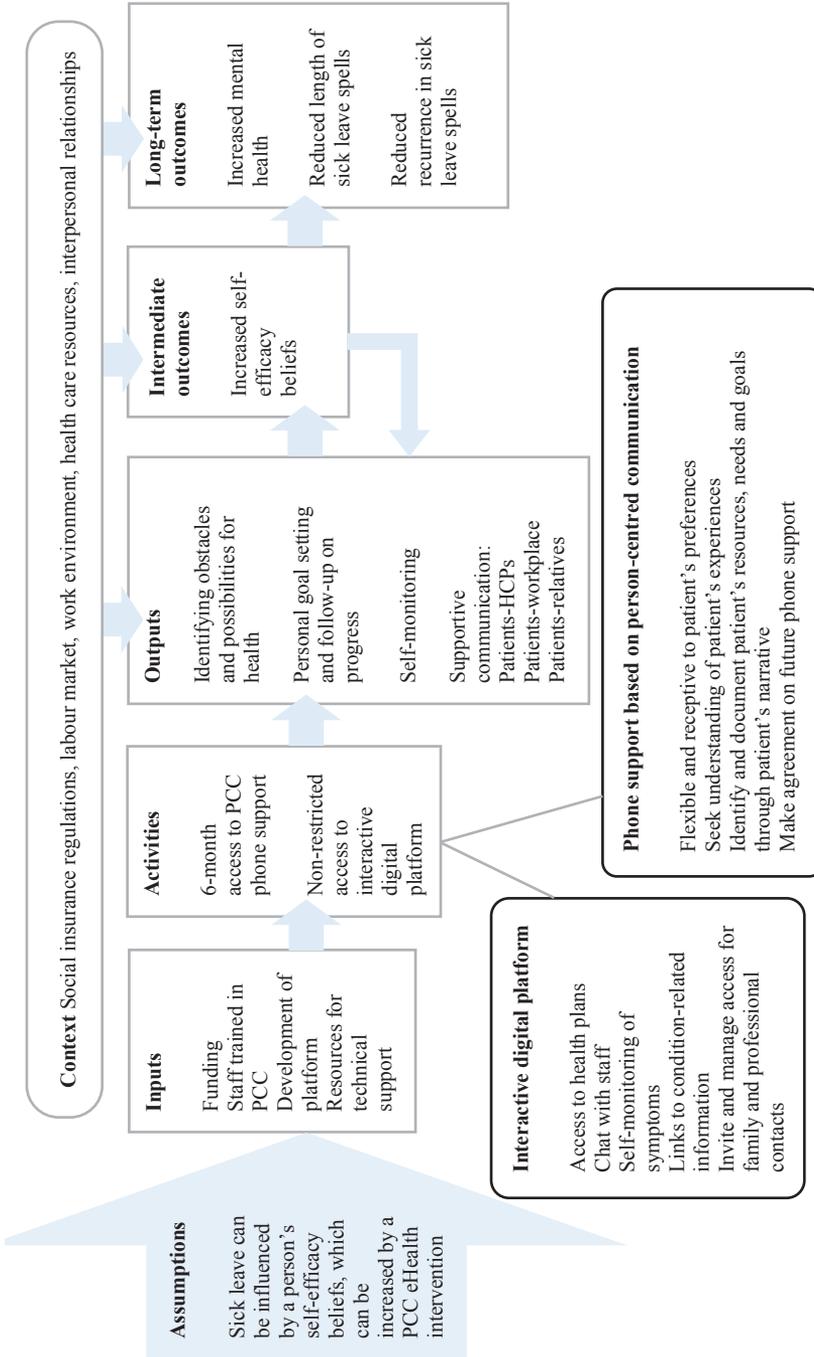


Figure 1. Logic model of the intervention

4.3 Evaluating complex interventions

Complex interventions are often described as interventions that contain multiple interacting components, but the complexity of an intervention can also concern the nature of the behaviours required by those involved in the intervention, the number and variability of outcomes, or the degree of flexibility or tailoring permitted within the intervention (Craig et al., 2008). Although this definition is still valid, recent definitions of complex interventions have to a higher extent emphasised the complexity of emergent, unpredictable and non-linear associations between actions and outcomes in complex social systems (Moore et al., 2019). The PROMISE intervention allowed for, and encouraged, a large degree of tailoring and flexibility and was considered an individualised intervention (Lauver et al., 2002). As depicted in the logic model (Figure 1), the intended process of change presupposed participants to be engaged in the intervention activities, but there was no standardised script for how or how often the patients should have phone conversations or use the platform. Those elements that were more fixed, such as making a health plan after the first conversation and including the patient's goal, resources and plan going forward, were fixed in the sense of form but not content, as the content was composed of material from the conversations (Hawe et al., 2004). With self-efficacy as an intermediate outcome, it was anticipated that the outputs of the intervention would strengthen participants' beliefs in their abilities to, for example, manage their health and RTW (e.g., self-efficacy beliefs), and that this would positively influence their recovery process, chances to reduce length of sick leave and ability to engage in otherwise meaningful activities. Target activities and situations were not specified in order to adapt the care process to the patient's identified goals.

Considering the extent to which the intervention was individually tailored, the complexity of behaviours undertaken by both HCPs and participants and the many contextual factors impacting on the outcome measures, the PROMISE intervention was conceptualised as a complex intervention where multiple processes could explain achieved or default effects. In the study protocol, I consulted the Medical Research Council's (MRC) guidance on evaluating complex interventions, which stresses the importance of identifying key intervention processes and focusing evaluations on these (Moore et al., 2015). Thus, the focus of the following studies included in the thesis was on effects, communicative processes and participants' experiences of the intervention.

5 RATIONALE

As CMDs are highly prevalent, they cause challenges for the health care systems, in particular primary care, where most CMDs are identified, treated and cared for. CMDs also impact the general society and societal expenses, in that they are frequent among cases of long-term and recurrent sick leave. For the patient affected by a CMD, the burden of illness can be related both to the condition itself and to the insecurities and effects of being on sick leave. Care for people with CMDs should take a holistic approach to their life situation and support resources that can improve health and self-efficacy (Socialstyrelsen, 2017b), in which strategies oriented towards enabling participation in working life and preventing the worsening or loss of work ability are central (OECD, 2015).

The person-centred eHealth intervention evaluated in this thesis corresponds to the call for novel approaches towards persons on sick leave with CMDs, looking beyond treatment of illness and focusing on providing support for mental health. In this thesis, the PCC intervention is conceptualised not as a range of components which, if delivered, result in the desired outcomes, but rather as an infrastructure to facilitate a PCC process signified by the co-creation of care, rooted in an understanding of the patient as a person. The quality and manner of interaction between the participants will influence the quality and characteristics of the relationship they form, i.e., the partnership. The thesis sets out to shine light on those processes, exploring how the eHealth intervention was applied and experienced, what effects were achieved and how PCC was operationalised in a digital context.

6 AIM

The overall aim of the thesis was to evaluate and explore the effects and processes of a person-centred eHealth intervention for patients on sick leave with CMDs. The specific aims of the included studies were:

- I To develop and present the design of a research project evaluating a person-centred eHealth intervention for patients on sick leave due to CMDs.
- II To evaluate the effects of a person-centred eHealth intervention for patients on sick leave due to CMDs.
- III To explore what activities are performed and what challenges participants face in the interactive process of narrative elicitation, carried through in patient-professional communication in a person-centred eHealth intervention.
- IV To explore participants' experiences of a person-centred eHealth intervention and illuminate meaningful activities and processes.

7 METHODS AND RESEARCH DESIGN

7.1 Overview of the studies

In accordance with the overall and the specific aims, different methods have been employed to study effects, processes within and experiences of the PROMISE intervention. The thesis has an overall exploratory approach represented in the one qualitative and one mixed methods study, and an explanatory approach through the deductive, hypothesis-testing and experimental design of the quantitative study. Using quantitative, qualitative and mixed methods allows for an exploration of the intervention and the actions taking place within it from different perspectives, which enables triangulation of findings. An overview of the study design is presented in Table 1.

Table 1. Overview of research design

Paper	Design	Data collection	Participants	Data analysis
II	Experimental Randomised controlled trial	Composite of changes in self- reported level of sick leave and general self- efficacy (GSES)	Primary care patients on sick leave with CMDs (n=209)	Descriptive statistics, non- parametric statistics, logistic regression
III	Exploratory Descriptive	Transcribed audio-recordings of HCP-patient conversations	HCPs (n=3) and patients (n=11) in the intervention group of Paper II	Conversation Analysis
IV	Exploratory Descriptive Interpretive	Questionnaire items on intervention experiences at 3- and 6- months follow-up Semi-structured interviews	Participants in the intervention group (n=102) Interviews with patients from the intervention arm of Paper II (n=15)	Descriptive statistics Qualitative content analysis

CMDs= Common mental disorders

HCP= Health care professional

7.2 Methodological choices

Experimental study designs, such as RCTs, are founded in positivistic epistemological assumptions, i.e., that objective knowledge can be obtained through scientific investigations of the object of interest (Corry et al., 2019). RCTs are considered the gold standard for evaluating an intervention's effects, as they minimise the risks of bias and comparisons of unequal groups (Odgaard-Jensen et al., 2011). RCT studies say rather little about what happens during the intervention in relation to the effects, or lack thereof, especially in interventions classified as complex (Craig et al., 2008). Therefore, when evaluating the effects of a complex intervention through an RCT, additional evaluations exploring the process of the intervention are recommended in order to understand the achieved or defaulted effects (Moore et al., 2015). The MRC framework was used as the starting point for balancing the RCT design and its positivistic assumptions (Paper II) with process evaluations using qualitative and mixed methods approaches. The study protocol (Paper I) leaned on the MRC framework when sketching out what to address in the process-oriented exploration in the conversation analysis (Paper III) and the process evaluation in the mixed methods study (Paper IV). In the MRC guidance it is suggested that process evaluations examine essential aspects of the intervention using methodology appropriate to capture these aspects (Moore et al., 2015).

In Paper III, interactive processes in the intervention were explored through conversation analysis which has been extensively used for examining patterns of interaction in various health care contexts (Drew et al., 2001). Conversation analysis is used to study the interactive procedures of reasoning and action through which people shape and recreate the social worlds they are part of (Goodwin & Heritage, 1990). The object of interest is what goes on in the interactions and how this is accomplished (Halkowski & Teas Gill, 2010). In conversations, participants display their understanding of the context and meaning of the activity they are engaged in through their respective conversational contributions, and the focus of analysis is the procedures through which conversational activities are realised. By unpicking the details of interactions, patterns of behaviour which may work against, or ease, a desired result might be identified and serve as the basis for the formulation of communicative strategies (Drew et al., 2001). In the thesis, the method of conversation analysis was used to explore interactive patterns of narrative elicitation, corresponding to the prominence of patients' narratives and narrative communication in conducting PCC according to the gPCC framework (Ekman et al., 2011). The choice to study these particular instances of interaction through conversation analysis reflects the assumption that it is through interactive work that the actions corresponding to PCC are,

potentially, accomplished, and that certain interactive practices are therefore constitutive of PCC (Halkowski & Teas Gill, 2010).

While Paper III explored communicative practices in the intervention from recorded material, in Paper IV I wanted first-hand accounts of how the participants experienced the intervention. According to the MRC framework, exploring participants' experiences is also an important part of evaluating complex interventions (Moore et al., 2015). As the object of interest was the participants' experiences, I chose a qualitative dominant mixed methods approach to capture experiences at a group level with the possibility to deepen the understanding of experiences through individual interviews (Johnson et al., 2007). Mixed methods build on pragmatist assumptions, which prioritises the research objective rather than a specific methodology and whose epistemology claims recognise both objective and subjective forms of knowledge (Borglin, 2015; Johnson et al., 2007). The approach chosen in Paper IV was a convergent parallel design, which aims to obtain complementary data about the phenomenon of interest through triangulation of quantitative and qualitative strands to achieve a more comprehensive understanding (Borglin, 2015; Fetters et al., 2013). The interview data were analysed using qualitative content analysis, which offers a structured method for analysing qualitative data without a presupposed set of ontological and epistemological assumptions. It can therefore be employed both in more positivistic or constructivist approaches and can entail both descriptions of the manifest content and interpretations of latent content (Graneheim et al., 2017; Graneheim & Lundman, 2004).

7.3 Participants and setting

All participants in the studies composing the thesis were part of the sample in Paper II, (hereafter the RCT), but for clarity on the specific requirements of participants in each study, they will be presented separately below. Participants were allocated at random to either a control group receiving usual care only or an intervention group receiving usual care in conjunction with a person-centred eHealth intervention comprising phone support and access to a web-based platform. They were all on sick leave due to a CMD. Further inclusion and exclusion criteria will be presented below. In Sweden, sick leave can be granted at 25%, 50%, 75% or full time. Usually, except for an initial qualifying day, the first 14 days of absence are paid by the employer, and thereafter by the Social Insurance Agency. From day 8 in a sick leave spell, a medical

certificate needs to be issued, which verifies the reduction in work capacity, in order for sickness benefit to be granted.

7.3.1 Paper II

In Paper II, the aim was to evaluate the intervention's effect on a composite score including level of sick leave and general self-efficacy (GSE) for patients on sick leave due to CMDs. Patients aged 18-65 were recruited from nine different primary care centres in an urban area of Western Sweden. Designated HCPs consecutively screened medical records for eligible patients, who received a letter with information about the study, including contact details. In the next step, either HCPs contacted patients via telephone, or the other way around. Patients who were interested in learning more, after having received oral information about the study and the rights of research participants, were sent additional information via letter and a consent form. When the signed consent forms were returned, patients were randomised to either the control or the intervention group based on a computer-generated random list created by a third party. Randomisation was stratified by age (<50 or ≥50 years) and diagnostic group (1: Depression, 2: Anxiety, 3: Stress-related mental illness).

Patients were eligible to participate if they met the following criteria: they had a minimum of part-time occupation during the past 9 months; their sick leave period had lasted no longer than 30 days at the time of inclusion; a sick leave certificate had been issued by a physician and attributed to one of the following conditions in the ICD-10: mild to moderate depression (F32 and F33), mild to moderate anxiety disorder (F41) or reaction to severe stress and adjustment disorders (F43, except post-traumatic stress disorder). Further, patients could be included only if they had a registered address in Sweden and were able to communicate in Swedish. Previous sick leave periods exceeding 14 days during the past 3 months which were attributable to these conditions were considered an exclusion criterion. Further exclusion criteria were severe impairments hindering the use of the intervention, ongoing alcohol or drug abuse, severe disease with an expected survival of less than 12 months or that could interfere with follow-up, the intervention being assessed as a burden, or the patient participating in a conflicting study.

7.3.2 Paper III

In Paper III, the aim was to explore the work of narrative elicitation in HCP-patient communication taking place within the intervention. Data consisted of audio-recorded interactions between HCPs and patients in the intervention arm of the RCT. The included HCPs were two registered nurses (RN_a and RN_b) and one physiotherapist (PT), all three of them women. The two RNs had several years of experience of person-centred communication and interventions whereas the PT had no formal experience in either and was undergoing training. They participated regularly in a forum for reflection and practice of PCC communication, with peers and specialists in the area. All three were employed in positions dedicated to managing the intervention. The included patients (n=11) were between 26 and 62 years old; five were men and six were women. Two of them had anxiety syndrome, three had a diagnosis of depression, and six had a stress-related mental illness (Table 2). The conversations were held during the first 10 months of the RCT, from February 2018 to November 2018. All patients in the intervention arm were offered a phone conversation shortly after inclusion, which corresponded to one of the core components of the intervention. Follow-up conversations were voluntary, and if wanted, they were scheduled upon agreement between the HCP and the patient. Only first-time phone conversations were included in the study. The recorded conversations lasted between 23 and 62 minutes (median 43.5).

Table 2. Characteristics of audio-recorded conversations between patients and professionals

Audio-recording	Length of recording (minutes)	Patient's gender	Patient's age	Patient's diagnosis (anxiety, depression or stress)	HCP's gender and profession
1	23	Man	28	anxiety	Woman, RN(a)
2	27	Woman	26	stress	Woman, RN(b)
3	26	Woman	29	depression	Woman, RN(a)
4	33	Woman	29	stress	Woman, RN(a)
5	51	Man	62	anxiety	Woman, RN(b)
6	48	Woman	31	depression	Woman, PT
7	50	Man	37	stress	Woman, PT
8	54	Man	36	depression	Woman, RN(b)
9	39	Woman	60	stress	Woman, RN(a)
10	49	Man	52	stress	Woman, RN(a)
11	62	Woman	33	stress	Woman, PT

HCP= Health Care Professional

RN= Registered Nurse

PT= Physiotherapist

7.3.3 Paper IV

In Paper IV, the aim was to explore patients' experiences of a person-centred eHealth intervention and illuminate meaningful activities and processes. Participants consisted of patients included in the intervention arm of the RCT. All intervention participants (n=102) were included in the quantitative part of the study. For the qualitative part, intervention participants were recruited consecutively after having completed the 6-month intervention period. A purposeful sampling to ensure heterogeneity in terms of age, gender, category of diagnosis and positive and negative experiences of the intervention's overall meaningfulness was conducted. In questionnaires sent 3 and 6 months after inclusion, participants in the intervention group could rate the meaningfulness of the intervention by choosing between the following answer options: Do not know (1/5), Fully disagree (2/5), Partly disagree (3/5), Partly agree (4/5), Fully agree (5/5). Throughout the recruitment period, 14 participants were unreachable, 2 declined to participate, 17 accepted to participate and at the time for interview, 2 were unreachable. The final sample thus composed 15 informants, 4 men and 11 women between 29 and 59 years of age.

7.4 Data collection

7.4.1 Paper II

Data on demographic information were self-reported at baseline and collected from medical records. Self-rated GSE and level of sick leave were collected through questionnaires sent by letter at baseline and after 3 and 6 months.

- *Demographic information* on gender, age, civil status, country of birth, level of education, occupation and years of work experience were self-reported at baseline. Data on diagnosis, illness history and medication were collected from medical records.
- *Self-efficacy* was measured with the General Self-Efficacy Scale (GSES) (Schwarzer & Jerusalem, 1995), for which there is a validated Swedish version (Love et al., 2012). The GSES is a self-assessment questionnaire measuring a person's belief in their general competence to handle unforeseen situations and demands in life. It consists of 10 question items which can be responded to on a four-point Likert scale (1 = Not at all true, 2 = Hardly true, 3 = Moderately true, 4 = Exactly true) generating summary scores between 10 and 40 points. Higher scores indicate a stronger GSE.
- *Self-reported level of sick leave* was assessed in the 3- and 6-month questionnaires with specification of percentage.

In calculating the composite score, patients were dichotomised into either improved or unchanged/deteriorated, based on both their GSE scores and their level of sick leave. Participants were classified as improved if they had a minimum 5-point increase in the GSES between baseline and measurement *and* reduced level of sick leave. They were classified as deteriorated if they had a minimum 5-point decrease in the GSES between baseline and measurement *or* an increased level of sick leave. If they were neither improved nor deteriorated, they were classified as unchanged. A 5-point difference in the GSES has been identified as an indication of clinically relevant change in prior studies (Fors et al., 2018; Fors et al., 2015) and corresponded approximately to reported standard deviations (Luszczynska et al., 2005; Schwarzer et al., 1997).

7.4.2 Control group

Participants allocated to the control group received usual care. According to the national guidelines for treatment of mild to moderate depression and anxiety, treatments should be based on an individual assessment and usually consist of pharmacological treatment or CBT (Socialstyrelsen, 2017b). Recommendations on sick leave depend on the patient's diagnosis, the severity of the condition and the individual assessment (Socialstyrelsen, 2017a). Depending on the services available at the primary care centre, usual care can also include contact with a physiotherapist, rehabilitation coordinator or occupational therapist, or group sessions targeting specific symptoms or problems. Care coordinators with a mission to enhance accessibility and coordination for patients with CMDs are also available at many primary care centres in the region.

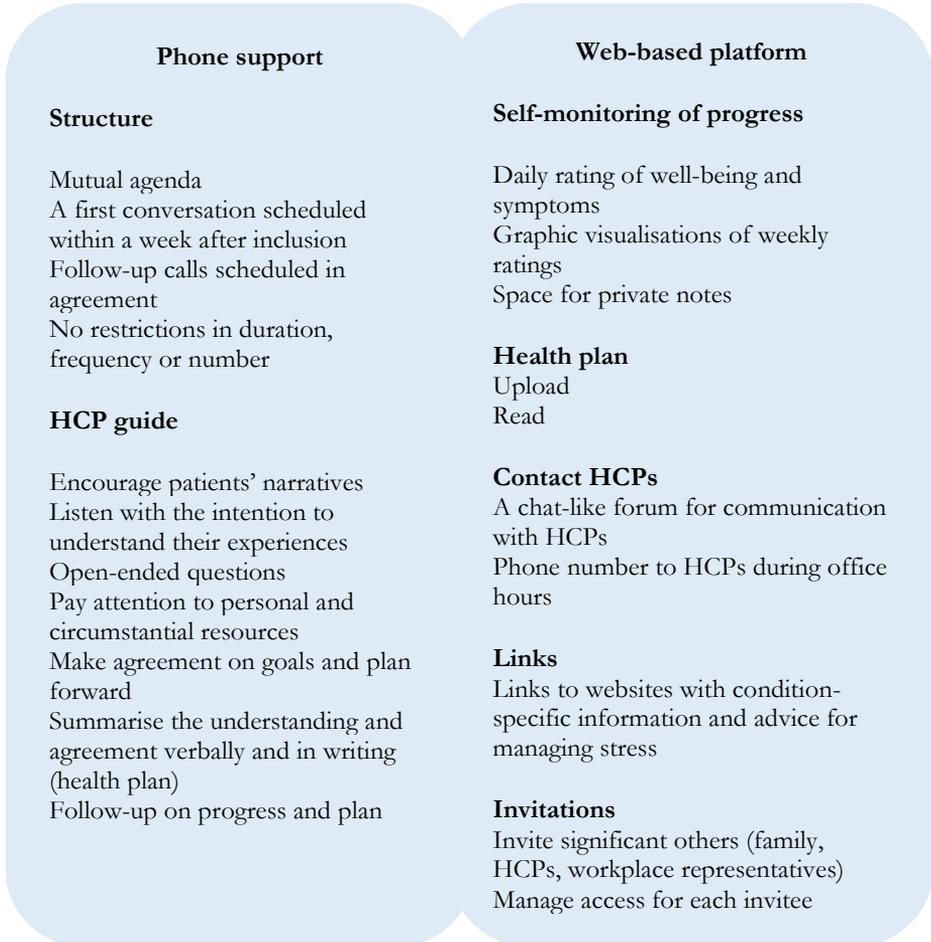
7.4.3 Intervention group

Because the PCC intervention was not intended as a stand-alone treatment, the intervention group also received usual care. In addition, they received access to a PCC intervention consisting of phone support and a web-based platform during the 6-month intervention period. The intervention was an operationalisation of PCC rooted in the framework by Ekman et al. and the relational ontology of Ricoeur (Ekman et al, 2011; Ricoeur, 1994). The main components, the phone support and the platform, corresponded to the routines suggested in the framework, through encouraging narrative communication (either by phone or on the platform), in which an understanding of the patient's current situation, needs and wants for the future were identified and constituted the foundation of the personal health plan. The phone support and the web-based platform were also intended to support patients' capabilities and agency.

The intervention had a flexible design intended to be tailored to the participants' situation, but all participants in the intervention group were advised to schedule a first phone conversation with the HCPs within a short time after inclusion. Thereafter, the following contact was scheduled according to individual plans. Designated HCPs conducted the intervention in a research area detached from the primary care centres. Throughout the study period, six HCPs with professional backgrounds as registered nurses, a physiotherapist and an occupational therapist worked full or part time conducting the intervention. All were women. They had various degrees of experience in PCC; some had considerable experience in conducting PCC in clinical and research settings while others were inexperienced and received training and education. All HCPs working with the intervention had access to a regular forum where

they could practise person-centred communication with each other and with specialists in the area.

Figure 2. Intervention content



7.4.4 Phone support

Support in the form of phone conversations with dedicated HCPs was offered to all patients in the intervention group. The guiding idea of the phone conversations was to provide personalised support according to each participant's situation and needs. The support was personalised in terms of content: the agenda was not pre-set but flexible towards the patient's needs, and in terms of structure: there was no pre-set decision on duration, frequency or number of conversations.

The conversations were guided by the gPCC framework and a narrative approach. This means that the superior idea guiding the conduct of the conversations was to root the understanding of the patient's situation in their own experiences and expressions thereof, and to use this understanding as a basis for planning future goals and next steps towards meeting them (formalised in a health plan). The health plan was a summary of the conversation, containing a formulation of the patient's issues and resources (in the form of personal and circumstantial attributes), health-related goals and steps towards meeting those goals.

7.4.5 Web-based platform

The web-based platform was constructed to be non-directive and to enable patients to participate in their care and recovery process. For an overview of the included features, see Figure 2. The platform was developed in a participatory process involving workshops with HCPs, representatives from patient communities and system developers (Sanders & Stappers, 2008). The features of the platform were intended to create prerequisites for self-monitoring and co-creation of care, for example, through a daily rating of well-being in order to get an overview of the recovery process or be alerted to a risk of relapse or worsening of symptoms, and through inviting the participation of family members, other health care contacts or workplace representatives. There were no automatic reminders to use the platform nor was there any obligation to do so.

On the platform, patients could make daily ratings of their well-being and common symptoms on a scale from 1 to 5, where 1 is poor and 5 is excellent (e.g., quality of sleep, ability to concentrate). Their answers were visualised in graphs to allow users to see trends and changes over time. Patients and HCPs could communicate via the platform in a chat-like forum. The platform also included links to different websites containing information on CMDs and advice for managing stress. The platform could be accessed from any device with an internet connection and web browser.

7.4.6 Paper III

In the intervention, a phone conversation between patients and the HCPs conducting the study was scheduled shortly after inclusion. This conversation corresponded to one of the core components of the intervention: eliciting patients' narratives and the subsequent creation of a health plan, and unless patients declined, the conversations were audio-recorded. These audio-recorded phone conversations constituted data for Paper III. Data were collected between February 2018 and November 2018, during this time the PT and the two RNs conducted 22 audio-recorded first-time phone conversations. More than half of them were conducted by one of the RNs (RN_a). To avoid a skewed sample overly represented by one HCP's communicative style, not all 22 audio-recordings were included in the analysis. The final sample included 11 audio-recordings purposively chosen to represent all HCPs at that time participating in the study.

7.4.7 Paper IV

During- and post-intervention follow-ups (at 3 and 6 months) were conducted using questionnaires. In these questionnaires, items on the intervention's overall meaningfulness, the meaningfulness of specific intervention activities and a semi-open-ended question on which intervention activity was considered most meaningful (Table 3) were included for participants in the intervention group (n=102).

Table 3. Items included in the quantitative analysis

<p>'How well does the following statement correspond to your experience of the eHealth support (i.e., phone support and web-based platform): "In my experience, the eHealth support has been meaningful for me to use"</p>
<p>Fully agree, Partly agree, Partly disagree, Fully disagree, Do not know</p>
<p>'Which activities in the eHealth support (i.e., phone support and web-based platform) have been meaningful for you? Mark one/several options:'</p>
<p>1. Scheduled phone communication; 2. Rating symptoms; 3. Monitoring symptoms over time; 4. Inviting important persons; 5. Contacting intervention staff through the platform; 6. Contacting intervention staff by phone; 7. Reading health plan; 8. Writing health plan; 9. Links to condition-specific information; 10. Other; 11. Nothing.</p>
<p>'If you marked several options on the previous question: is there any activity you experienced as most meaningful? If so, which?'</p>
<p>Semi-open, free-text answer</p>

Semi-structured interviews were conducted with 15 participants post-intervention during 2020 and 2021. Prior to the interviews an interview guide was developed (Table 4). The interview guide consisted of four question areas corresponding to the content of the intervention, and open-ended questions were used to encourage informants to describe their experiences. Before the first interview, a patient representative was consulted to discuss the interview guide, and further questions targeting the process of recovery were added. After the first interview, the opening question was slightly adjusted in order to better encourage patients to talk about their experiences. Patients were contacted via telephone or text message with information about the study. If they were willing to participate, they were sent additional information and the interview guide via mail a few days before the scheduled interview. All participants were invited to choose between conducting the interview in person or via telephone. 14 interviews were conducted via telephone and one at the participant's workplace.

Table 4. Interview guide for the semi-structured interviews

Experiences of the overall support offered in the intervention
<ul style="list-style-type: none"> • How were you doing at the time when you received access to the support offered in the study, and how did you feel about the support that was offered in the study? • <i>What expectations did you have?</i> • <i>What did it mean for you to have access to the support offered in the study?</i>
Experiences of the phone support
<ul style="list-style-type: none"> • How did you experience and how did you use the phone communication? • <i>Could you describe, on a general level, what you talked about?</i> • <i>How would you compare the communication to other health care interactions you've had in relation to your condition?</i>
Experiences of the platform
<ul style="list-style-type: none"> • How did you experience and how did you use the platform? • <i>How did you experience the different functions available on the platform?</i>
Experiences of recovery in general
<ul style="list-style-type: none"> • How are you doing now compared to when you began your participation in the study? • <i>What do you think has been most important for your process?</i> • <i>Is there anything you would like to add?</i>

Suggestions on follow-up questions in italics

7.5 Data analysis

7.5.1 Paper II

According to power calculations on 80% based on an alpha error of 0.05, a minimum of 91 participants was required in each study arm in order to detect an improvement in the composite score of 40% in the intervention group and 20% in the control group. 215 patients gave written consent to participate during the recruitment period from February 2018 to June 2020. After one withdrawal in the control group and five withdrawals in the intervention group, the final sample consisted of 209 patients, n=107 in the control group and n=102 in the intervention group. The significance level was set at $P < 0.05$ (two-sided).

7.5.2 Statistical methods

The study groups were characterised and compared using descriptive statistics. Pearson's chi-squared test for categorical variables, Fisher's exact test for dichotomous variables and Student's t-test (independent) for continuous variables were used to analyse between-group differences in baseline characteristics.

The composite score corresponding to the primary outcome measure was based on a dichotomisation of the groups (improved versus deteriorated or unchanged). To test for differences between the control and the intervention groups on the dichotomised composite score, binary logistic regression was used to calculate odds ratios with 95% confidence intervals and differences in improvement of ≥ 5 units on the GSES. The participants were also clustered into ordered groups (improved or deteriorated or unchanged) based on their trajectories. For calculations of the ordered, categorical composite score, the Mantel-Haenszel chi-square test was used. In analyses on the composite score, missing outcome data on GSES in the 3- and 6-month follow-ups were imputed using the last observation value carried forward.

In order to analyse between-group differences in changes in GSES scores, the Mann-Whitney U test was used.

All analyses were performed on both intention-to-treat (ITT) and per protocol (PP). In the PP analysis, intervention participants who had had at least one phone conversation leading to a health plan and who had used the platform at least once throughout the intervention period were included.

7.5.3 Paper III

Paper III was a conversation analysis on phone interactions carried out in the intervention arm of the RCT. Because the aim of the study was to explore interaction, the unit of analysis was neither the HCP nor the patient, but their verbal communication captured by the audio-recording and later transcribed verbatim and with attention to communicative features such as overlapping speech, emphasis and pauses (Table 5). In conversation analysis, there are various levels of transcription, depending on the interest of analysis. In a linguistic, structurally oriented conversation analysis, transcripts can be broken down to a level of detail which was considered unsuitable for the present analysis, which was less concerned with the minutiae of phrasing, for example, and more interested in the general patterns of sequencing, turn-taking and positioning of participants in carrying out the communicative agenda. The transcription was a first occasion to get familiarised with the data and the 11 conversations were listened to repeatedly to get a sense of the interaction. During analysis, the transcripts and the audio-recordings were used in parallel.

Table 5. Transcript legend

]	Beginning of overlapping utterance
[End of overlapping utterance
(.)	micro pause
(3.2)	Pause lasting 3.2 seconds
(xx)	Inaudible
-	Cut off sound
--	Cut off utterance
--?	Cut of utterance with intonation of a question
<u>Underlining</u>	Emphasis or stress
,	Continuing intonation
?	Intonation of a question
.	Falling intonation
(())	Transcriber's description

In conversation analysis, sequences of talk are analysed and utterances are attended to as specific contributions to the interaction rather than as isolated units of analysis. In conversations, speakers are generally entitled to utterances representing a single-turn constructional unit. When that unit reaches a recognisable point of completion, participants may alter speech initiative, or negotiate the continuation of their turn. Narratives and stories often extend

over longer sequences consisting of multiple-turn constructional units, requiring specific negotiations of speech initiative that may vary depending on whether the narrative is initiated by the speaker or requested by the recipient (Goodwin & Heritage, 1990). The analysis was guided by questions on how narratives were told and how they were embedded in the interaction and managed turn-by-turn (Goodwin & Heritage, 1990; Stokoe & Edwards, 2006). In the first step, the overall structure of the conversations and narrative sequences was identified. Thereafter, each phase across the conversations was analysed separately in order to search for interactive patterns in how narratives were commenced and maintained, and what type of activity they produced. Excerpts illustrating the patterns were then chosen to scrutinise the preliminary analysis in a data session with interaction scholars from other fields of research. In the final step, the findings were discussed among all co-authors.

7.5.4 Paper IV

The questionnaire items were analysed with descriptive statistics using SPSS. Item 2 was a multiple response question, and item 3 a semi open-ended question. After having read through all answers to the questionnaires, answers to item 3 were sorted in to one of the following categories: *phone communication, rating & monitoring symptoms, reading and writing health plan, using links, or two or more activities*. *Two or more activities* was composed of answers where the participant explicitly stated that two or more activities were equally, and most, meaningful, or if they described that a combination of two or more activities were most meaningful. If a participant did not respond to item 3 and only reported one activity as meaningful on item 2, this was also sorted into a category in item 3.

15 interviews were conducted with patients in the intervention group. They were audio-recorded and, after each interview, notations on the interview were made in order to reflect upon the researcher's preunderstanding and role during the interview. Each interview was then transcribed verbatim. The transcripts were scrutinised and listened to repeatedly in order to ensure consistency in transcription and to ensure the same level of familiarity with all interviews. The semi-structured interviews were analysed using qualitative content analysis taking an inductive approach (Graneheim et al., 2017; Graneheim & Lundman, 2004). After transcripts were read through repeatedly, meaning units were identified in each interview, which were then condensed and coded. Thereafter, codes were compared, abstracted and sorted according to similarities and differences into categories and sub-categories.

In a last step of the analytic procedure, the quantitative and qualitative findings were synthesised through an interpretation of the whole in the form of an overarching theme on meaningful activities and processes in the intervention, and how meaningfulness was enabled or blocked.

7.6 Ethical considerations

The RCT has ethical approval from the Regional Ethical Review Board in Gothenburg, Sweden (DNr 497-17, T 023-18, T 526-18) which also covers the data collection for Paper III and Paper IV. In accordance with the Declaration of Helsinki (2013), patients were informed on relevant aspects of the study and on their rights as participants, including their right to withdraw at any time without giving reasons and without it affecting usual care. Participants received oral and written information about the study prior to consenting to participate, and all participants gave written consent for their participation in the RCT. In the written information, it was stated that participants could receive a request to participate in interviews, and that their participation was voluntary. It was further stated that the phone calls could be recorded and possibly subject to analysis, however, oral consent was asked of the patient before each recording. The recordings and transcripts were treated with full confidentiality. In the sampling for Paper IV, participants were contacted by phone and informed of the study. If they were interested, further information regarding the specific sub-study and the interview guide was sent to them via email.

One important aspect to consider when conducting research involving human beings is the protection of their integrity and anonymity, which involves both how data is protected from hazards, such as being destructed in accidents or accessed by unauthorised persons, and how personal information is treated in scientific communications. All personal data in the project has been kept in a password-secured safe only accessed by authorised personnel, and personal information was replaced with a code. In Paper III and Paper IV, I replaced or omitted information in the transcripts which could potentially identify a participant, such as name or place of work. In conversation analysis the publication of conversation extracts is an important measure of transparency of the analytic procedure and findings, such as quotations in many other qualitative approaches. In order to protect the participants from recognising themselves in an extract containing personal communication, I also replaced or omitted some of the circumstances in their narratives, which did not have a value for the analysis but further protected their integrity.

An important consideration in the design of the RCT was the decision to evaluate the intervention not as a replacement for but as a complement to usual care. It was further important that participating in the RCT did not disrupt or affect whatever ongoing or planned treatments the patients had at their primary care centre or elsewhere. Some discomfort may be unavoidable in participating in an RCT. Participants were, for example, expected to answer questionnaires at regular intervals up to 2 years following inclusion. Prior to giving consent, they received information about how often they were expected to answer questionnaires and approximately how time-consuming answering the questionnaires would be. There were no physical procedures involved in the intervention and no risk of injury or physical pain. However, the design of an intervention building on partnership requires the patient not only to actively participate in their care process but also to share their experiences as this is important information in a personalised care path. Participants may have found the sharing of responsibilities burdensome, as reaching beyond their competence or going beyond their comfort zone. The patients were informed about the principles of PCC beforehand, as a measure to prepare them for what the intervention would encompass and require of them.

8 FINDINGS

8.1 Effects of the intervention

Between February 2018 and June 2020, 1317 persons were screened for participation in the study. 199 did not respond, 588 declined participation and 315 did not meet inclusion criteria. 215 participants gave informed consent and were randomised to either the control or intervention group. Six withdrawals, one in the control group and five in the intervention group, resulted in a final sample of 209 participants (n=107 in the control group and n=102 in the intervention group). Among the participants, 84.1% (n=175) were women. The mean age was 42.23 years (SD 11.45). Mean GSE at baseline was 25.9 (SD=6.1) in the control group and 25.8 (SD=6.4) in the intervention group. Participant demographic characteristics, level of sick leave and current diagnosis are shown in Table 6. There were no significant differences between the groups at baseline.

Table 6. Baseline characteristics

	Control group n=107	Intervention group n=102	PP analysis n=85
Age, mean (SD)	42.2(11.7)	42.3(11.2)	42.7(11.1)
Women n, (%)	93(87.7) ^a	82(80.4)	70(82.4)
General self-efficacy score, mean (SD)	25.9(6.1)	25.8(6.4)	25.9(6.0)
Civil status n, (%)			
Living alone	30(28.0)	40(39.2)	32(37.6)
Married/living with a partner	77(72.0)	62(60.8)	53(62.4)
Country of birth n, (%)			
Sweden	91(85.0)	89(87.3)	73(85.9)
Other	16(15.0)	13(12.7)	12(14.1)
Level of education n, (%) ^b			
Compulsory	7(6.6)	6(5.9)	4(4.7)
Secondary school	16(15.1)	21(20.8)	17(20.0)
Vocational college	20(18.9)	15(14.9)	11(12.9)
University	63(59.4)	59(58.4)	53(62.4)
Level of sick leave n, (%)			
0	4(3.7)	2(2.0)	2(2.4)
25	3(2.8)	5(4.9)	4(4.7)
50	21(19.6)	30(29.4)	25(29.4)
75	3(2.8)	5(4.9)	4(4.7)
100	76(71.0)	60(58.8)	50(58.8)
Diagnosis, ICD codes n, (%)			
Stress (F43)	69(64.5)	65(63.7)	55(64.7)
Depression (F32 and F33)	23(21.5)	21(20.6)	18(21.2)
Anxiety (F41)	15(14.0)	16(15.7)	12(14.1)
Medication n, (%)			
Antidepressant	54(50.5)	43(42.2)	37(43.5)
Sedative	49(46.2) ^a	37(36.3)	29(34.1)
Sleep medication	26(24.5) ^a	25(24.5)	19(22.4)
Illness history n, (%)			
Stress	29(27.4) ^a	34(33.3)	28(32.9)
Depression	28(26.4) ^a	30(29.4)	24(28.2)
Anxiety	33(31.1) ^a	29(28.4)	25(29.4)
Sleep disorder	15(14.0)	17(16.7)	15(17.6)

^a One missing^b Two missing

PP= Per-protocol analysis

SD= Standard deviation

ICD= International Statistical Classification of Diseases and Related Health Problems

Usage data from Paper II show that, in the intervention group, 97.1% (n=99) had at least one phone conversation resulting in a health plan. The mean and median number of phone conversations during the intervention period was four (SD 1.84, ranging from 0-9), with a mean length of 33 minutes (SD 10.3). The function of self-ratings was used at least once by 72.5% (n=74) of the participants. The mean number of ratings per user was n=19 (SD=27.2) and the median was n=7 (ranging from 1-170). Half of the participants used the function of writing chat messages to the intervention staff at least once during the intervention period (49%, n=50) with a mean of 3.6 (SD=4.1) and a median of 2 (ranging from 1-22) messages per user. Twelve participants (11.8%) invited someone to their platform, and in total, n=15 persons were invited.

Analyses were conducted on both ITT and PP. The PP analysis included patients in the intervention group who had a minimum of one phone conversation resulting in a health plan, and at least one interaction with the platform. Based on these premises, 17 patients in the intervention group were excluded in the PP analysis, 14 on account of not having used the platform at any time during the intervention period and 3 on account of not having had a phone conversation resulting in a health plan.

At the 3-month follow-up, a higher percentage of participants in the intervention group had improved on the composite score, compared to the control group, in both the ITT analysis (19.6%, n=20 vs. 9.3%, n=10, OR 2.37, 95% CI: 1.05; 5.34, P=0.038) and the PP analysis (21.2 %, n=18 versus 9.3%, n=10, OR 2.6, 95% CI: 1.13; 6.00, P=0.024). The significant difference did not persist at the 6-month follow-up, neither in the ITT analysis (31%, n=31 vs. 23.4%, n=25, OR 1.47, 95% CI: 0.80; 2.73, P=0.218) nor in the PP analysis (35.7%, n=30 vs. 23.4%, n=25, OR 1.8, 95% CI: 0.97; 3.43, P=0.063) (Table 7).

Table 7. Composite score effects, dichotomised groups

	Control n=107	Intervention n=102	P-value	PP analysis n=85	P-value
3 months					
Improved n(%)	10(9.3)	20(19.6)	.038	18(21.2)	.024
Deteriorated/ unchanged n(%)	97(90.7)	82(80.4)		67(78.8)	
6 months^a					
Improved n(%)	25(23.4)	31(31.0)	.218	30(35.7)	.063
Deteriorated/ unchanged n(%)	82(76.6)	69(69.0)		54(64.3)	

^a 2 missing values in the intervention group in the ITT analysis, 1 missing value in the intervention group in the PP analysis

When the same calculations were made on the ordered composite score (three-level), there was a significant difference between the intervention group and the control group in the ITT analysis at the 3-month follow-up and in the PP analysis at the 3- and 6-month follow-ups. The difference was not significant in the 6-month follow-up in the ITT analysis (Table 8).

Table 8. Composite score effects, ordered groups

	Control n=107	Intervention n=102	P- value	PP analysis n=85	P- value
3 months^a					
Improved n(%)	10 (10)	20 (20.8)	.038	18 (22.0)	.009
Unchanged n(%)	76 (76.0)	67 (79.8)		59 (72.0)	
Deteriorated n(%)	14 (14.0)	9 (9.4)		5 (6.1)	
6 months^b					
Improved n(%)	25 (24.0)	31 (33.0)	.150	30 (37.0)	.028
Unchanged n(%)	64 (61.5)	53 (56.4)		45 (55.6)	
Deteriorated n(%)	15 (14.4)	10 (10.6)		6 (7.4)	

^a 7 missing values in the control group, 6 missing values in the intervention group in the ITT analysis, 3 missing values in the intervention group in the PP analysis

^b 3 missing values in the control group, 8 missing values in the intervention group in the ITT analysis, 4 missing values in the intervention group in the PP analysis

Analyses on each component of the composite score (GSE and level of sick leave) showed a significant improvement in GSE in the intervention group compared to the control group at the 3-month follow up in both the ITT (P=0.034) analysis and the PP analysis (P=0.012). At 6 months, there was no significant difference between groups in the ITT analysis of GSE (P=0.068), but the difference remained in the PP analysis (P=0.040) (Table 9). The number of participants improving 5 points or more, corresponding to approximately a standard deviation and minimally important change, was significantly higher in the intervention group after 3 months (n=23, 22.5% vs. n=11, 10.3%, CI 1.167-5.530, OR 2.54, P=0.019) but not at the 6-month follow-up (n=36, 35.3% vs. n=28, 26.2%, CI 0.851-2.782, OR 1.54, P=0.154) in the ITT analysis. In the PP analysis, the improvement in the intervention group was significant both after 3 months (n=21, 24.7% vs. n=11, 10.3%, CI 1.293-6.342, OR 2.86, P=0.010) and 6 months (n=34, 40% vs. n=28, 26.2%, CI 1.020-3.468, OR 1.88, P=0.43) (Table 9).

Table 9. Change in GSES score from baseline to 3- and 6-month follow-ups

	Control n=107	Intervention n=102	P- value	PP analysis n=85	P- value
3 months					
Mean change GSE score (SD)	-.038(5.2) ^a	2.069(5.9) ^b	.034	2.557(5.4) ^c	.012
Increase ≥5 points (%)	11(10.3)	23(22.5)	.024	21 (24.7)	.011
6 months					
Mean change GSE score (SD)	1.380(5.9) ^a	3.204(6.6) ^b	.068	3.463(6.6) ^c	.040
Increase ≥5 points (%)	28(26.2)	36(35.3)	.154	34(40)	.043

^a n=84 at the 3-month follow-up, n=94 at the 6-month follow-up

^b n=84 at the 3-month follow-up, n=82 at the 6-month follow-up

^c n=75 at the 3- and 6-month follow-ups

Level of sick leave did not significantly differ between the groups at the 3- or 6-month follow-ups, nor in the ITT or in the PP analysis (Table 10). Around 75% of all participants had decreased sick leave at the 3-month follow-up and around 84% at the 6-month follow-up. Furthermore, 49.4% (n=41) in the control group, 53.6% (n=45) in the full intervention group and 54.7% (n=41) in the intervention group in the PP analysis reported 0% sick leave at the 3-month follow-up. At the 6-month follow-up, the corresponding numbers were

69.8% (n=67) in the control group, 69.9% (n=58) in the intervention group and 72.4% (n=55) in the intervention group in the PP analysis.

Table 10. Overview of sick leave reported at 3- and 6-month follow-ups

Level of sick leave	Control (n=107) ^a	Intervention (n=102) ^b	P-value	PP analysis (n=85) ^c	P-value
3 months					
Decreased (%)	62(74.7)	65(77.4)	.847	58(77.3)	.764
Unchanged (%)	19(22.9)	16(19.0)		15(20.0)	
Increased (%)	2(2.4)	3(3.6)		2(2.7)	
6 months					
Decreased (%)	82(85.4)	70(84.3)	.957	64(84.2)	.929
Unchanged (%)	11(11.5)	11(13.3)		11(14.5)	
Increased (%)	3(3.1)	2(2.4)		1(1.3)	

^a n=83 at the 3-month follow-up, n=96 at the 6-month follow-up

^b n=84 at the 3-month follow-up, n=83 at the 6-month follow-up

^c n=75 at the 3-month follow-up, n=76 at the 6-month follow-up

8.2 Communicative processes in the intervention

The findings in Paper III demonstrated communicative practices corresponding to the ethics of attending to the patient as a person and co-creating care based on the patient's narrative. Through the conversation analysis, three interactive patterns to narrative elicitation were found: *patient-driven narrative sequences*, *co-constructed narrative sequences* and *question-driven narrative sequences* (Table 11).

Table 11. Interactive patterns in narrative elicitation

Patient-driven narratives	Co-constructed narratives	Question-driven narratives
The patients deliver narratives with story-like qualities and without gaps or unclarities. The HCPs give interactive support through listener tokens but do not ask questions or comment on the content.	Narratives attended to as collaborative projects by HCPs and patients. The patients begin narrating but do not deliver a completed story. The HCPs participate in developing the story by asking questions and sharing reflections.	The patients do not deliver narratives or any extended turns at talk upon the HCP's requests. Speech initiative returns to HCP's and the sequence is driven forward by repeated questions, responded to with limited information.

While narrative sequences could be self-initiated in any phase of the conversation, eliciting them constituted the very essence of the main project. A narrative sequence typically evolved over several utterances, often in response to an open-ended question directed retrospectively, at the onset of illness or sick leave, or to the patient's present circumstances or well-being. In the patient-driven narrative sequences, the patients were the ones with the extended turns, and the HCPs used their turns for listener support in the form of 'mm-hm' or similar brief utterances signalling that the patient had their attention and could continue narrating. Although all kinds of activities occurring within the interaction are co-produced, in the sense that each turn is linked to the preceding turn, these narratives were not jointly elaborated on a level of content, and the story told by the patient was treated as complete.

In the co-constructed narrative sequences, both patients and HCPs were engaged in the content of the narrative. Patients initiated a narrating activity much like in the patient-driven narrative sequences, and likewise, the HCPs demonstrated their position as active listeners. However, the narratives

presented gaps, questions or troubles, motivating joint efforts to elaborate on aspects of the story. Either this occurred as joint elaborations of the content, on a narrative presenting gaps or that was difficult to tell, or the narrative was attended to by both participants in a joint reflective process.

The least frequent pattern in the material was the question-driven narrative sequences. In this pattern, the project of narrative elicitation was not carried through smoothly. The interaction featured many details indicating troubles, such as hesitations, dispreferred responses, long pauses and repetitions. They also failed to achieve narratives. Instead of elaborated answers extending over several turns, the patients' responses were short and stayed close to the elicited information, and speech initiative was rapidly returned to the HCPs. Despite coaxing, the interaction took on more of a traditional question-response pattern, more alike information eliciting than narrating.

8.3 Participants' experiences of the intervention

Through a mixed methods approach, Paper IV explored participants' experiences of the eHealth intervention. Of the 102 participants in the intervention group, n=84 and n=81 responded to the questionnaires at the 3- and 6-month follow-ups. Table 12 shows the number and percentage of participants' responses to the three questionnaire items on meaningfulness included in the analysis. The overall intervention was considered partly or fully meaningful by a large majority of intervention participants at both follow-ups. In Table 12, the activities are presented ranging from the activity marked as meaningful by the greatest number of participants to the activity marked as meaningful by the least number of participants at both follow-ups. The scheduled phone communication was the activity found meaningful by the largest number of participants, by far, followed by reading the health plan. The other activities in the intervention were considered meaningful by around 20-30% of the participants, except writing the health plan and inviting significant others, which were considered meaningful by less than 20% of the participants. Only 6% found it meaningful to invite significant others at the 3-month follow-up and 2.5% at the 6-month follow-up. When asked to describe which activity the participants found most meaningful (item 3), again, phone communication with intervention staff dominated the participants' answers.

Table 12. Meaningfulness of intervention evaluated at 3- and 6-month follow-ups.

	3 months (n=84)	6 months (n=81)
1. OVERALL MEANINGFULNESS (%)^a		
Fully agree	34 (41.0)	27 (33.3)
Partly agree	36 (43.4)	36 (44.4)
Partly disagree	7 (8.4)	7 (8.6)
Fully disagree	3 (3.6)	5 (6.2)
Do not know	3 (3.6)	6 (7.4)
2. MEANINGFUL ACTIVITY (%)^b		
Scheduled phone communication	73 (86.9)	65 (80.2)
Reading health plan	42 (50.0)	31 (38.3)
Contacting intervention staff through the platform	27 (32.1)	29 (35.8)
Rating symptoms	29 (34.5)	21 (25.9)
Links to condition-specific information	17 (20.2)	22 (27.2)
Contacting intervention staff by phone	18 (21.4)	19 (23.5)
Monitoring symptoms over time	19 (22.6)	17 (21.0)
Writing health plan	15 (17.9)	9 (11.1)
Nothing	5 (6.0)	8 (9.9)
Inviting significant others	5 (6.0)	2 (2.5)
Other	2 (2.4)	1 (1.2)
3. MOST MEANINGFUL ACTIVITY (%)^c		
Phone communication	46 (70.8)	39 (67.2)
Rating & monitoring symptoms	10 (15.4)	7 (12.1)
Two or more activities	5 (7.7)	9 (15.5)
Reading & writing health plan	3 (4.6)	1 (1.7)
Links to condition-specific information	1 (1.5)	2 (3.4)

^a One missing answer at the 3-month follow-up

^b Possible to choose more than one activity

^c n=65 responses at the 3-month follow-up and n=58 responses at the 6-month follow-up

The analysis of the interviews, using qualitative content analysis and an inductive approach, resulted in three categories and respective sub-categories describing the participants' experiences of the intervention (Table 13). Categories 1 and 2 present participants' positive experiences of the intervention, and category 3 presents experiences of disappointment about unmet expectations and needs.

Table 13. Categories and sub-categories of experiencing support or lack of support.

Category	1. Acknowledgment in a disconcerting situation	2. Finding ways forward	3. Unmet expectations
Sub-categories	1.1 Feeling heard and respected 1.2 Remote support as prerequisite and relief	2.1 Accessing oneself 2.2 Recognising ways forward 2.3 Making and maintaining changes	3.1 Expecting disease-specific guidance 3.2 Unexpected content and barriers in the design 3.3 Efforts outweighing the rewards

In ‘Acknowledgment in a disconcerting situation’, participants described how they experienced the intervention as a valuable acknowledgment of the situation they were in, the challenges they faced, the burdens they carried, and their need to feel like someone listened to and cared for them in a manner that didn’t add to their stress or burden. The sub-categories ‘Feeling heard and respected’ and ‘Remote support as prerequisite and relief’ covers different but related aspects of the experience of acknowledgment and the prerequisites for it. The participants felt that they were given time to talk and that their experiences were listened to and requested; they felt like they could speak their mind without feeling judged, and like there were no other motives to the conversations than their well-being. They also experienced the remote manner of the intervention to be of significant supportive value, relieving them of the burdens and stressors of physical appointments. First of all, it relieved them of having to take time off work, transportation, making oneself presentable and taking the time and energy such appointments consumed, and not seeing the person they were talking to could also be experienced as a relief.

The second category covers experiences of the intervention as a support in finding ways forward, through a process described in the three sub-categories ‘Accessing oneself’, ‘Recognising ways forward’ and ‘Making and maintaining changes’. The participants described how the intervention enabled them to reflect upon their situation and both gain perspective on it (i.e., getting an overview of the situation they were in) and get closer to it (i.e.,

understanding more what they wanted or needed from life). This process was important in recognising how they wanted to proceed, what changes they wanted or needed to make, and what their current priorities were. They also described how it was easy to fall back into old habits and how having someone follow up served as a reminder and an encouragement to carry on.

The third category contained three sub-categories: ‘Expecting disease-specific guidance’, ‘Unexpected content and barriers in the design’ and ‘Efforts outweighing the rewards’. They cover participants’ experiences of not having their expectations met by the intervention process, in either content or form, which contributed to the intervention not fulfilling its purpose as support. The participants described how they had expected the intervention to be more directed towards how they could manage their symptoms and their illness, and they felt like they did not receive enough information, advice or tools to help them better manage their condition. They experienced cumbersome log-in procedures, technical malfunctioning, lack of feedback and design issues connected to the platform, which impeded them from using it as they had envisioned and made the intervention burdensome. Overall, they experienced a lack of clarity regarding the purpose of the intervention as a whole, as well as specific parts, which was a barrier to engagement.

In a synthesis of the findings, meaningfulness of the intervention was interpreted as constituted by the overarching theme *Trusting professional support to be within reach*. Important to the experience of meaningfulness was the easy and continuous access to supportive and professional HCPs. However, experiencing that the intervention did not accommodate a clear purpose and content corresponding to one’s expectations and needs was understood as a barrier to meaningfulness.

9 INTEGRATION OF FINDINGS AND DISCUSSION

9.1 Principal findings

The analysis of Paper II demonstrated that in the intervention group, significantly more patients improved their GSE by 5 or more points than in the control group after 3 months into the intervention in the ITT analysis, and after 6 months in the PP analysis. This resulted in an alignment with the mean GSE scores of the intervention group with population means (Luszczynska et al., 2005; Schwarzer et al., 1997), whereas the control group were lagging behind at both points in time. No effects were found on level of sick leave.

In Paper III, the processes of interaction of the intervention were analysed in order to detect patterns and activities that occurred in the elicitation of patients' narratives. Three interactive patterns were identified in the material: patient-driven narrative sequences, question-driven narrative sequences and co-constructed narrative sequences. Their respective features were discussed in the context of the overall person-centred agenda of the conversations and the interactive norms such an agenda implies, such as patients being active in sharing their experiences, HCPs being active as recipients and elicitors of narratives, and both being active in creating a personal plan from the content of the conversation. Patient-driven narrative sequences largely corresponded to such a distribution of roles in which the patient was a driven narrator and the HCP a devoted listener and facilitator of patients' narrating activity. The narrative produced was mainly treated as a complete story without gaps or unclarities. In the co-constructed narrative sequences, the narrative was attended to as a collaborative project by both participants. HCPs were more involved in the plot, exploring circumstances through their questions and sharing their point of view on what they heard in the patients' stories. The content and trajectory of the narrative was more of a collaborative project than in the previous pattern. The third pattern found in the conversations was that of question-driven narrative sequences. In these sequences, the narrative activity failed, and patients did not deliver narratives in response to the HCPs' solicitation.

In Paper IV, participants' experiences of the intervention were explored through a mixed methods analysis. The analysis found that the intervention was experienced as a meaningful support by a majority of intervention participants, and that meaningfulness was constituted by trusting professional support to be within reach. If the content and structure of the intervention did not make sense to the participants, or failed to meet their needs or expectations, this was considered a barrier to experiencing meaningfulness. The most meaningful activities and processes in the intervention took place in the phone conversations, and the platform did not fulfil any greater supportive meaning on its own, especially the intention of gathering social and professional support. Findings pinpointed the importance of clearly communicating the logic behind particular functions and the intervention as a whole, as well as addressing issues in the design that made it difficult to use the platform as desired.

9.2 Outcomes illuminated by intervention processes and participants' experiences

According to the intervention logic model, outlined from previous evidence on the influence of self-efficacy on sick leave, and the influence of PCC interventions on self-efficacy, the estimated intervention process went through intervention activities resulting in the outputs of a personal health plan building on the patient's narrative and situated in the patient's context, identifying the patient's strengths, resources and goals, and engaging a supportive network (see logic model of the intervention on p. 36). Thereby, the intervention was estimated to influence GSE beliefs and, in turn, level of sick leave. First, we'll consider the increase in GSE among intervention participants, significantly higher than in the control group, and thereafter turn to the lack of effects on level of sick leave.

Self-efficacy is a concept within social cognitive theory, which postulates that an individual's beliefs in their capability to manage in challenging situations emanate from direct or mediated experience as sources of information, such as personal mastery experiences (i.e., attributing prior experiences of succeeding to one's own efforts and actions), vicarious experiences (i.e., judgment of ability influenced by seeing others succeed or fail), verbal persuasion (i.e., social encouragement on one's ability) and physiological states (i.e., physiological experiences, such as dizziness or high pulse rate, influencing one's judgment of ability). These different sources of information regarding

one's capabilities all weigh together in shaping the individual's efficacy beliefs and associated behaviour and effort in challenging situations (Bandura, 1977).

The demonstrated increase in GSE in the intervention group after 3 months, and at the 6-month follow-up in the PP-analysis, suggests that processes in the intervention have influenced intervention participants' GSE beliefs. By linking the findings from Paper IV to the theoretical descriptions on change in self-efficacy, a potential pathway of change, through enabling mastery experiences, could be suggested to have occurred in the identification of individually meaningful goals and plans on how to reach them, as postulated in the intervention programme. An indication thereof is how participants described intervention processes in the category 'Finding ways forward' as enabling a reflective process linked to identifying areas of change in one's attitude, behaviour or environment, and support in taking action and maintaining change (Paper IV). Furthermore, the explicit focus on identifying personal capabilities and resources in the patients' narratives and the personal health plan could be understood as a verbal persuasion of ability and also as a potential mechanism to influence participants' GSE (Bandura, 2012). However, the health plan, which represented the agreement on goals, resources and actions, was considered a meaningful activity by only 50% of the participants after 3 months, and even fewer (38%) at the 6-month follow-up. It is possible that the most important part of the health plan was not, from the participants' point of view, to have it in writing but the associated activity occurring in the phone conversations with the intervention staff (Paper IV).

Participants' experiences of how the intervention staff made them feel respected, understood and taken seriously were described in the category 'Acknowledgment in a disconcerting situation'. Positive experiences of health care interactions can have an influence on how patients' deem their ability to perform certain activities, such as RTW, and impact on self-efficacy beliefs. A study by Lynøe et al. (2011) suggested associations between experiencing positive health care encounters and having higher estimations of one's ability to RTW, among patients on long-term sick leave. They also found the reverse association, that experiencing negative encounters in health care reduced patients self-estimated ability to RTW. The importance of positive encounters in RTW processes was also suggested by Haugli et al. (2011) in an interview study with patients who had participated in an occupational therapy program when they were on sick leave with a CMD, however, they did not focus on patient's estimated abilities but their actual RTW. They concluded that positive encounters with HCPs were particularly valuable for patients who had not returned to work, while former patients who had managed to RTW emphasized the value of having opportunities for increased self-understanding in the

encounters with HCPs, through having the opportunity to question and reflect upon their identity, values, resources and alternative forms of action (Haugli et al., 2011).

Although there were significant differences in GSE in the intervention group, most clearly at the 3-month follow-up, we did not detect any difference in level of sick leave. Self-efficacy in RTW could be linked to a successful, gradual RTW process (Franché & Krause, 2005), which would suggest that it could also be the mastery experiences of RTW which improves self-efficacy, rather than the increase in self-efficacy leading to RTW. It is also possible that it is the achievement of personal goals, related or unrelated to sick leave, which strengthens self-efficacy, and whose increase might have effects also on other situations (Luszczynska et al., 2004). Previous studies on RTW interventions have suggested that the self-efficacy beliefs of the employee on sick leave are influential to the success of the RTW process (Black et al., 2018; Etuknwa et al., 2019; Lagerveld et al., 2017; Nigatu et al., 2017; Volker et al., 2015). However, most such studies have either used specific self-efficacy measures, such as RTW self-efficacy or job self-efficacy, and the associations between GSE and RTW are weaker than more specified measurements (Black et al., 2018). On the other hand, GSE is more in tune with the focus of a person-centred intervention which prioritises supporting patients' agency and goals relevant to them rather than illness- or situation specific goals decided by researchers or HCPs (Fors et al., 2016b; Håkansson Eklund et al., 2019).

Other intervention outputs aiming to enhance self-efficacy and influence sick leave were the engagement of a supportive network of the patient's choice. Usage data (Paper II) showed that the activity corresponding to engaging a supportive network, i.e., inviting significant others to one's platform, was only used by a fragment of intervention participants. It was also considered meaningful by only a fragment of participants (Paper IV). The participants described how they either felt reluctant to expose their situation by inviting others to their platform, which they regarded as a safe space to express their thoughts and feelings, or they felt no need to engage others by inviting them to the platform because they already had well-functioning communication. Accordingly, the intended function of the platform to gather social and professional support did not occur as anticipated. Such support has been found important for a successful and sustainable RTW in both experimental and qualitative studies (Andersen et al., 2012; Etuknwa et al., 2019; Holmgren & Ivanoff, 2004; Ståhl & Edvardsson Stiwne, 2013). The very small extent to which this part of the intervention was implemented could account for part of the explanation to why there were no effects on sick leave. Whilst it could be tempting to suggest the use of reminders or prompts to encourage participants

to invite their network, the precautions of inviting others to a valued private forum voiced by participants in Paper IV indicates the necessity of further exploring how social support and workplace representatives could be integrated into eHealth services in ways acceptable to patients.

In ‘Finding ways forward’ (Paper IV), participants’ described how workplace matters could be discussed in the phone conversations, but to what extent and how remains unknown, and since workplace representatives were not invited to the platform as anticipated, the extent of workplace involvement implemented in the intervention was scarcer than intended. Considering the evidence of workplace involvement as important to influence the RTW process and the likelihood of successful RTW (Holmgren & Ivanoff, 2004; Mikkelsen & Rosholm, 2018; Nieuwenhuijsen et al., 2014), it is also likely that this impeded the intervention’s possibility to assert effects on sick leave. Throughout the thesis, sick leave and RTW has been fused into a wider approach to mental health aligning with the ontological and ethical assumptions in PCC (Ekman, 2022). The main objective was not RTW, nor GSE per se but their potential influence on agency and capabilities towards health and ‘the good life’, in which work, or otherwise meaningful activities, has the potential to increase physical and mental health, but also to be detrimental if workplace conditions are unsatisfactory or destructive (Waddell & Burton, 2006; Allen et al., 2014; SBU, 2014).

Another perspective to consider regarding the lack of effect on sick leave is the limited information on participants’ trajectories before, between and after follow-ups. Approximately 50% of the participants in both study arms reported 0% sick leave already at the 3-month follow-up indicating a possible floor effect. Given that recommended sick leave episodes for several of the included conditions are between 2 weeks and 1 month (Socialstyrelsen, 2017a), it is likely that if there were any differences between the groups regarding sick leave, they were aligned by the time follow-ups were made, or undetected at these specific points in time.

9.3 PCC communication in the eHealth realm: challenges and opportunities for support

Paper III and Paper IV both explored communicative practices employed in the intervention. Paper III focused on the interactions through which patient narratives emerged (or failed), and Paper IV focused on participants’ experiences of the intervention, including the different communicative

activities taking place with and through the platform and in the phone conversations.

In Paper III, we found that tensions could occur in narrative elicitation when either the narrative agenda was unclear, or patients were unwilling or unaccustomed to such a narrativisation of their experiences. Arguably, the communicative projects realising PCC in a micro-perspective require something *more* from the interaction than merely providing and exchanging information. Although patient narratives are not unusual in clinical communication, they often serve the agenda of presenting a problem or justifying claims (Chatwin, 2006). When elicited in a context of PCC, narratives beg for openings into the patient's experiences in order to understand illness as it presents itself in the context of the patient's life. This understanding does not have to stem from patients' narratives, as actions, body language or words of a significant other are also valuable sources of information about the patient's situation (Ekman, 2022), but in the intervention, such information was unavailable. In addition, there was no manual or delivery of information, and the patient was encouraged not only to tell how they experienced their illness, but to set the agenda of the conversation according to their needs. Considering this 'minimalistic' set-up of the conversation, we suggested that the occurrence of tensions related to narrative elicitation could also pertain to patients not knowing what was expected of them in this particular situation, taking place in a remote research setting, between people who did not see each other and did not know each other before.

That the intervention and the phone calls could be experienced as enigmatic was described in Paper IV. As a comparison, Heritage and Maynard (2006) have discussed how visits to a physician generally follow a certain order of events, familiar to both patients and doctors through being socialised into such situations since childhood, which guides the expectations of how such a visit should play out. When attempting to recreate the agenda and order of communication and relationships between HCPs and patients, which is what PCC prescribes, evidently this may entail a novel interactive terrain, not only for HCPs but also for patients. A clearer framing of the communicative task could therefore help prepare patients and make explicit expectations which would otherwise be implicit, and could also help level the playing field for discussions on expectations on both (all) ends.

Furthermore, the communicative hardships displayed in these sequences also raised questions about patients' integrity and preferences, and how to professionally respond to such communication, which may potentially obstruct the process of care. Cribb and Entwistle (2011) have discussed similar

phenomena but in relation to shared decision-making. First, they describe how narrow conceptions of shared decision-making result in simplistic notions about preferences, autonomy, mutual discussions and joint deliberations tending towards either paternalistic or consumerist poles. For example, they describe how such a simplistic notion of immediately accepting patients' preferences can restrain the development of patient-professional interactions in which the professional's role includes exploring, checking, encouraging reflection on and co-creating patients' preferences. In the case of respecting autonomy, they further argue that supporting the capacity for autonomy might sometimes entail questioning or even challenging expressed preferences. Such balancing acts are descriptive also of the challenges facing HCPs in narrative elicitation, but on the other hand, they also point out what there is to gain if navigation is successful: *'some of the most important health-care resources available, namely those that arise from the personhood of professionals and the broad potential of supportive human relationships'* (Cribb & Entwistle, 2011, p. 217).

In Paper III we found an interactive pattern of co-constructed narrative sequences in which patients and HCPs attended to the narrative as a shared project. It could take the form of renegotiating the plot of a restrained narrative, or as joint elaborations of meaning tied to the experience of falling ill. In the literature on illness narratives, the *therapeutic* effect of arranging potentially chaotic experiences into a coherent plot containing all possible implications that the occurrence of illness has on life is well established (e.g., Frank, 1995; Hyden, 1997; Mattingly, 1998). In the occurrence of chronic illnesses, narratives can also represent reformulations of identity and meaning tied to the changes the illness forces upon life; they can serve as a vehicle to discuss the explanations for illness and force us to scrutinise how we live our life and how that might be connected with the illness. Narratives can also address the practical issues illness gives rise to and different ways of relating to the illness (Hyden, 1997).

The co-constructed narrative sequences in Paper III and the qualitative findings in Paper IV suggest that the conversations between patients and HCPs that took place within the intervention accommodated an extended agenda which could serve as an occasion for meaning-making processes. The experience of illness, in the form of a diagnosis, symptoms or the sudden or creeping suspicion of changes in one's disposition, was interwoven with sick leave and the circumstances in life, work-related or not, in exploration to understand why one's situation had become unbearable and required an action, such as taking sick leave. The exploration could cover reflections on what personal attributes might be understood in the light of a diagnosis, which symptoms could be

attributed to illness and which to circumstances and whether such divisions were even possible. This exploratory process of meaning-making pointed forward towards finding opportunities for change, understanding what required taking action and how to take action, and towards dealing with and approaching experiences of selfhood throughout the process of falling ill, such as not recognising one's thoughts, body or reactions. This resonates with Ricoeur's (1988) concept of narrative identity, in which a narrative does not merely imitate an inner experience but recreates and constructs identity by telling a story in response to the question *who?*. The narrative identity can include change and variability within the cohesion of a lifetime, woven together and refigured by the fictional and truthful stories told about oneself. The constancy of the self and the self-knowledge of a person is the fruit of an examined life, '*clarified by the cathartic effects of the narratives, be they historical or fictional, conveyed by our culture*' (Ricoeur, 1988, p. 247).

An important aspect of illness is the legitimacy it gives to not being able to perform what society or oneself expects, a temporary or permanent reduction in capacity caused by illness, not personal fault (Bolton, 2013). The sick leave certificate and the diagnosis issued by a physician serve to legitimise a sick role to society, the employer, one's social surroundings and also oneself (Millward et al., 2005; Parsons, 1991). The importance of someone else's, a professional's, recognition of one's *illness* and *needs* was attested to by participants in Paper IV. It is possible that the importance of acknowledging their illness and needs was of particular relevance for these patients, considering that the debilitating status of mental illnesses is not always recognised and whose mere identification and oftentimes also treatment require that the individual be able to communicate their suffering to HCPs (Weiste et al., 2018). In Paper IV, the experiences of patients not feeling like their needs of illness management and strategies were properly met attest to the delicacy of understanding the needs of a person, tailoring support accordingly, while using one's professional judgment and ethical reasoning (Entwistle et al., 2018).

9.3.1 Communicative processes with and through the platform

In the interviews in Paper IV, participants described how the summarising that HCPs did towards the end of the conversations helped them get perspective on their experiences, and so did the communication they engaged in with themselves through the platform. Although the number of participants finding platform activities meaningful was a clear minority, interviews gave perspective on how functions of the platform contributed to communicative processes which could have a supportive value. Participants appreciated the

ability to communicate in the chat-like forum with HCPs as it allowed spontaneous reflections or questions which participants did not expect or need to have immediate answers to. Just being able to spontaneously write or, during office hours, call, gave the participants a sense that support was within reach. Participants also described how the self-monitoring activity of daily rating of symptoms, and the adjoining possibility to write private notes, enabled a kind of communication with themselves as they had to reflect on how they were doing in order to know how to rate. However, the lack of response from intervention staff on their ratings was experienced as a missed opportunity to provide support. Stronger integration of the participants' activities on the platform into the phone conversations could prove to be a valuable use of their personal information in joint discussions aiming for recovery from illness and towards mental health.

9.4 Supporting sustainable RTW and mental health in routine care: Implications for practice

Slade (2010) argues that the distinction between mental illness and mental health requires a refocus and development of other skills in the mental health care services, and that HCPs in mental health care need to be able to work on both reducing illness and promoting mental health. In an individual perspective, promoting mental health can include focusing on what persons value in life, and what activities they can undertake to improve their situation (McCormack & McCance, 2006). This was the guiding principle to the PCC intervention evaluated in this thesis.

Regarding the implications of findings in routine care, a few remarks on context are warranted. The HCPs conducting the intervention were not employed by the primary care centres and did not carry out other clinical tasks related to the targeted group of patients, besides the research and the intervention. The context was not an integrated part of routine care, but an appending service resembling a call centre in its ties to routine care. If the intervention programme would be integrated into routine care, for example as a part of a stepped-care or blended approach, adaptations to the local context are necessary. With that in mind, the following is suggested:

- eHealth support in the form of phone calls based on PCC is acceptable and meaningful to patients on sick leave with CMDs.
- eHealth support in the form of a platform has potential to be meaningful and acceptable to patients but an app-format is preferred, and it should be integrated into the overall care.
- Providing the possibility of professional support that does not require physical appointments enhances the perception of support as present and available if needed, without necessarily being activated.
- When appropriate, face-to-face appointments can be redirected to phone calls without losing value to patients.
- Encouraging patients to narrate their experiences and contributing to the development of their narrative can enhance the patients' self-understanding and have meaning-making importance.
- Partnerships and the co-creation of care could be facilitated by clarifying expectations and presuppositions in PCC communication.

9.5 Methodological considerations

In the thesis, I used an approach of mixing quantitative and qualitative studies in order for different methodologies to complement and enrich the overall understanding of how the intervention worked. This approach was chosen early on and is described in Paper I. The choice to write and publish a study protocol was made to increase transparency of the RCT design and intervention set-up (Paper II). The logic of the intervention also guided the focus of Papers III and IV.

When wanting to understand the link between an intervention and certain effects, RCTs are the strongest methodological approach, if circumstances allow such procedures (Odgaard-Jensen et al., 2011; Richards & Rahm Hallberg, 2015). The control over background variables through stratification in the randomisation procedure and the clearly defined inclusion and exclusion criteria vouch for high internal validity but can be challenging to design and pursue. Traditionally, RCTs should be conducted in as ‘laboratory-like’ and controlled environments as possible to ensure internal validity and eliminate the risks that other, unknown factors explain differences (or lack of differences) between study groups, in line with the definition of efficacy trials. In health research settings, effectiveness is often preferred over efficacy trials, as those studies take the clinical complexity into account, whereas efficacy trials try to control as much of the setting as possible (Schmaling et al., 2021). Although the trial in Paper II was conducted in a research setting, allowing for a greater measure of control of intervention procedures than had it been conducted by HCPs in the primary care setting (‘real-world’), it did not completely adhere to either efficacy or effectiveness definitions. For example, the inclusion of not only one but several diagnoses corresponded to a clinical reality where these conditions can be difficult to separate at an early stage, the initial diagnosis often changes over time, and patients may have more than one diagnosis (Gask et al., 2008; Lynch et al., 2012). Another ‘real-world’ characteristic is that the control group was not a wait-list control, but participants in both study arms received care and treatment according to their individual agreements with the HCPs at their respective primary care centres, and the PCC eHealth intervention offered to participants was evaluated as an additional support (Frueh et al., 2004). However, the intervention was not integrated into the routine care at the primary care centres as could be expected had it been an effectiveness trial, and thus, future challenges remain if the intervention is to be implemented in clinical settings.

Other methodological aspects to consider concern the generalisability of the findings. Recruiting participants from nine different primary care centres in a

demographically diverse area limits the risk of a skewed sample compared to including only one or two primary care centres. However, it is also possible that the participants included in our sample were generally more positive towards eHealth interventions than those who declined, and in that sense were non-representative of the larger population. Analysing the reasons for declining to participate would have enabled such understandings, but this was not included in the ethical approval of the study. Further additional information that would have been valuable in interpreting the effects of Paper II is information on what care participants in both study groups received as part of usual care. Considering that the sample was large and that both study groups received usual care, we deem it unlikely that there is a potential confounding factor pertaining to usual care activities, explaining or contributing to the results (Schulz & Grimes, 2002; Sedgwick, 2015). However, considering that such information was not accessible, it cannot be ruled out. Another issue regarding participant selection was the requirement that patients were able to communicate in Swedish. Although it could have been possible to include translators in the phone communication, all text on the platform was in Swedish. For a democratic and equal health care system, it is important to make sure that research is conducted on samples representing the demographics of the population, and wider measures to include people who do not speak Swedish should be taken in future studies.

In regard to the demonstrated and lack of effects, analyses were conducted on both intention-to-treat (ITT) and per-protocol (PP). As ITT analyses include every participant in the trial, regardless of whether they are exposed to the intervention or not, such estimates of efficacy avoid the risk of overly optimistic results when non-compliers are removed. As the ITT analyses do not remove participants, a further advantage is that they keep statistical power. However, they have been criticised for being too cautious and thus enhancing the risk of making type II errors (Gupta, 2011). Therefore, it can be considered a strength in the analyses that they were conducted on both ITT and PP levels, and that the primary outcome measure was calculated on the more conservative ITT analysis, while the PP analysis contributed information on how outcomes differed among those participants who actually used the intervention.

While the experimental design of the RCT enabled a level of control of confounding factors unmatched in other study designs, entirely quantitative methods of evaluation are rarely sufficient in research on complex interventions with a scope that goes beyond that of assessing effectiveness (Richards & Rahm Hallberg, 2015; Skivington et al., 2021). Therefore, the qualitative and mixed method approaches in Paper III and Paper IV provide

important, complementary perspectives to understand how the intervention worked.

The conversation analysis chosen in Paper III represented an epistemological and ontological choice based on the assumption of the intervention as constituted by the communicative processes between HCPs and patients, under the banner of PCC. In conversation analysis, the researcher deals with ‘first-hand’ data and avoids interpretation of internal states of participants in unpicking what happens in the interaction. Rather, analysis is oriented towards what is observable in the interaction and within the context of the previous turn. From a conversation analytic perspective, interaction is structurally and contextually dependent. That is not, however, to be understood as predestined, as every conversation is shaped by the structure and the context of that particular moment and the contributions of each interaction participant (Halkowski & Teas Gill, 2010). A methodological challenge in conducting a conversation analysis is that to detect patterns of interaction with acceptable certainty, a large data corpus is necessary, and the analytical procedure is time consuming. Ideally, the analysis in Paper III would have included more than 11 conversations, however, that was not possible to combine with a sample including an evenly distributed number of conversations by the different HCPs, as one particular HCP was much more active in the intervention than the others. If the data collection period for Paper III would have continued beyond November 2018, it would have been possible to, within time, achieve a larger but balanced sample. Another benefit thereof would have been a sample reaching beyond the first months of the intervention, when it is possible that ‘teething problems’ were most present (Moore et al., 2015). However, extending the data collection period was not feasible in the overall time plan of the PhD project.

The mixed methods approach in Paper IV corresponded to the aim of gaining both a wider and deeper perspective on how study participants experienced the intervention, and it can be the most practical approach when investigating complex research questions (Borglin, 2015). Complementary approaches of both quantitative and qualitative methods have the advantage that integrating different analyses enhances the strengths of each analysis while restraining their respective limitations, which ideally enhances credibility and trustworthiness (Borglin, 2015). However, the quantitative strand of the paper primarily intended to provide the perspective of the entire intervention group in order to triangulate and validate the qualitative findings from a sub-sample of participants. Qualitative content analysis was chosen to analyse the interview data in order to provide categories remaining close to the participants’ descriptions of their experiences (manifest) and to allow for

interpretation of the material (latent). While triangulation of findings occurred in the integration of the different data strand, procedures of trustworthiness were also taken in the qualitative analysis of in the study. First of all, the selection of interview participants was made with the objective of having a heterogenic sample with various experiences of the intervention to provide a rich variation in the material (Graneheim & Lundman, 2004). It was assumed that approximately 15 interviews would be appropriate to achieve rich, broad and manageable material, and it was not considered necessary to change this decision throughout the period when I recruited participants and conducted the interviews consecutively. Other measures of trustworthiness taken in the analytic procedures of both Paper III and Paper IV included conducting the analysis in close collaboration with the co-authors, and as transparently as possible, describing everything from sample selection to each step in the analysis.

Another methodological challenge is the use of subjective assessments through questionnaires (Papers II and IV). First of all, data on level of sick leave was self-reported at 3- and 6-months follow-ups, which impeded more detailed analysis on participants' sick leave trajectories between these specific points in time. Had we instead used register data, it would have been possible to, for example, analyse if there were differences between the study groups in the length of sick leave spells. However, that was not feasible in the time frame of the thesis. Furthermore, whereas the GSES is a validated, well-known and much used instrument (Love et al., 2012; Luszczynska et al., 2005), the questionnaire data in Paper IV targeted experiences of this particular intervention. The questions were designed by me and research colleague, discussed in the research group, and piloted on a number of participants before being put to use. However, not using a validated instrument increases the risk of measuring other concepts than intended, and limits the possibility to make comparisons between interventions.

10 CONCLUSION

This thesis contributes to the understanding of how health care can support persons on sick leave with CMDs, from lessons learned in a PCC intervention taking place in an eHealth setting. Through the exploration of intervention effects, processes and participants' experiences, explanations to intervention effects intertwined with the constituents of support, have been formed, which can guide future adaptations of this particular intervention, and used to inform other kinds of support.

Drawing from the findings of the individual studies, communicative processes inherent to the PCC agenda of eliciting narratives and forming partnerships were central to how support was enacted in the intervention and to the participants' experiences of the intervention's meaningfulness. An essential element of the intervention was the provision of a meaningful professional support within reach, through the continuous access to professionals provided by the eHealth format. As self-efficacy beliefs are personal judgments on one's ability, positive and constructive dialogues enabling reflective processes, increased self-understanding and a personal plan may have contributed to changes in the intervention participants' perceptions of their abilities and self-efficacy.

With modifications, the intervention could potentially have better success in reducing sick leave. Such modifications include the design and content of the intervention platform, the coherence of the intervention components and the activities aiming to engage the surrounding system of support, private as well as workplace related.

11 FUTURE PERSPECTIVES

In order to assess the societal value and importance of this particular intervention, further research is warranted on the intervention's overall effects on other outcome measures. In regard to sick leave, it should be evaluated whether the intervention had any effect on sick leave in a long-term perspective and through analyses of register data, which would provide a fuller picture of the participants' sick leave trajectories. It will also be important to assess whether the intervention had any effect on overall use of health care, through health-economic evaluations, and if there were effects on other clinically relevant outcome measures. It is further important to conduct efficacy evaluations of the PROMISE intervention, taking place in clinical contexts, to assess the clinical value of the intervention. It would also be valuable to take an organisational perspective on such evaluations.

Furthermore, future qualitative research should be conducted to understand how workplace involvement and support can be included into clinical interventions in a feasible and acceptable way, preferably through a participatory research process involving patients' experiences and needs as well as HCPs and also workplace representatives. To enhance the understanding of if and how PCC communication enables changes in self-understanding over time, analyses and comparisons of initial patient narratives with later narratives would be a valuable contribution.

For a democratic and equal health care system, it is important to make sure that research is conducted on samples representing the demographics of the population, and wider measures to include people who do not speak Swedish should be taken in future studies of this or similar interventions. It would also be valuable to conduct analyses on people who decline to participate in similar interventions, in order to improve robustness of generalisability of findings in the general population.

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