Working while ill, going on sick leave and return to work again: The individual's perspective in primary health care

Kristin Lork

Department of Health and Rehabilitation, Institute of Neuroscience and Physiology at Sahlgrenska Academy University of Gothenburg

UNIVERSITY OF GOTHENBURG

Gothenburg 2023

Cover illustration: Christoph Comstedt

Working while ill, going on sick leave and return to work again: The individual's perspective in primary health care

kristin.lork@gu.se

ISBN 978-91-8069-159-8 (PRINT)
ISBN 978-91-8069-160-4 (PDF)

Printed in Borås, Sweden 2023
Printed by Stema Specialtryck AB

”Det har jag aldrig provat tidigare så det klarar jag helt säkert!”
Pippi Långstrump

Working while ill, going on sick leave and return to work again:
The individual's perspective in primary health care

Working while ill, going on sick leave and return to work again: The individual's perspective in primary health care

Kristin Lork
Department of Health and Rehabilitation, Institute of Neuroscience and Physiology at Sahlgrenska Academy
University of Gothenburg

Abstract

The overall purpose of the present thesis was to increase understanding of the dynamic process between working while feeling ill, going on sick leave, and returning to work among people seeking care at primary healthcare (PHC). The present thesis aimed to emphasise the individual's perspective on this process.

Methods and aims: Study I used a quantitative design, and studies II, III, and IV used a qualitative design. Following the dynamic process between work and sick leave, each of the four studies had specific aims. The process started with study I, investigating whether reasons for seeking care and self-rated health (SRH) could predict registered sick leave at a 12-month follow-up in non-sick-listed employed women and men seeking care at PHC centres for physical and/or mental symptoms. Study II explored a work-directed intervention, and what factors were important for sustainable work, from the perspective of workers with common mental disorders (CMD). Study III focused on how people on sick leave for various reasons experienced return to work self-efficacy (RTWSE). The final step in the process, study IV, explored how people on sick leave with CMD experienced rehabilitation coordination (RC).

Results: Study I showed that a high number of reasons for seeking care and a lower SRH were determinants for sick leave in 12 months. The main reasons for seeking care were mental symptoms and musculoskeletal pain, and significant differences in proportions concerning symptoms between the groups with and without sick leave in 12 months were found. The work-directed intervention in study II increased the participants' belief in their capacity through supported reflection and practice. In study III, RTWSE emerged as a global phenomenon

influenced by work capacity, a will to be independent and able to participate in society, and support from others. In study IV, RC was experienced as a bridge with many bricks between the person and society with the goal of improving health and returning to work. The bricks reflected the complex context of RC.
Conclusions: For people with comorbidity, a lower SRH, or CMD, it may be important to offer preventive rehabilitation interventions as these groups have an increased risk of sick leave. People with CMD experience that preventive rehabilitation interventions by means of occupational therapy and physiotherapy increase their self-efficacy and could strengthen work ability. For a sustainable return to work (RTW) it seems important that interventions not only involve the person but also include the workplace. RTWSE is perceived as a global phenomenon by people on sick leave, influenced by their own driving forces as well as the surrounding environment, and it is an influential phenomenon to consider in rehabilitation. RC is experienced as an important link between healthcare and work by people with CMD. However, information about RC needs to be more available to increase its accessibility.

Keywords: Common mental disorders, occupational science, person-centred approach, primary healthcare, rehabilitation coordination, return-to-work, self-efficacy, sick leave, vocational rehabilitation

ISBN 978-91-8069-159-8 (PRINT)
ISBN 978-91-8069-160-4 (PDF)

Sammanfattning på svenska

Det övergripande syftet med avhandlingen var att öka förståelsen för den dynamiska processen mellan att arbeta med en nedsatt hälsa, bli sjukskriven och att återgå i arbete igen bland personer som söker vård inom primärvården. Avhandlingen har som utgångspunkt att förstå personernas egna perspektiv och erfarenheter i den här processen.
Metoder och syften: Den första studien hade en kvantitativ design och studie II, III och IV hade en kvalitativ design. Varje studie hade sitt specifika syfte i processen mellan arbete och sjukskrivning. I studie I startade processen genom att undersöka om antalet orsaker till att söka vård och självskattad hälsa kunde förutsäga registrerad sjukskrivning under de följande 12 månaderna för personer som arbetade men som sökte vård på vårdcentraler för fysiska och/eller mentala symptom. I studie II utforskades en arbetsinriktad rehabilitering och vilka faktorer som var betydelsefulla för ett hållbart arbete för personer med psykisk ohälsa som arbetade eller var delvis sjukskrivna. Studie III utforskade hur personer som var heltids sjukskrivna uppfattade sin tilltro till att återgå i arbete. Det sista steget i processen mellan arbete och sjukskrivning, studie IV, utforskade erfarenheterna av rehabkoordinering hos personer med psykisk ohälsa som var sjukskrivna eller hade börjat arbeta igen.
Resultat: Studie I visade att fler orsaker till att söka vård och en lägre självskattad hälsa ökade risken för sjukskrivning inom 12 månader. Mentala symptom var huvudanledningen för att söka vård, följt av muskuloskeletal smärta och det fanns signifikanta skillnader i proportioner vad gäller symptom mellan de som blev sjukskrivna eller inte inom 12 månader. Den arbetsinriktade rehabiliteringen i studie II ökade deltagarnas tro på sin förmåga genom stöd till att både reflektera över och att praktisera sina förmågor. I studie III uppfattades tilltron till att återgå i arbete som ett helhetsfenomen som påverkades av arbetsförmågan, en strävan att bli självständig och delaktig i samhället samt av stödet från andra. Rehabiliteringskoordinering uppfattades av deltagarna i studie IV som en bro med många stenar mellan personen och samhället med målet att återfå hälsan och arbetsförmågan. De många stenarna reflekterade det komplexa sammanhang som rehabkoordineringen verkade i.
Slutsats: För personer med samsjuklighet, en lägre självskattad hälsa och för personer med psykisk ohälsa kan det vara viktigt att erbjuda preventiva rehabiliteringsinsatser eftersom dessa grupper har en ökad risk för sjukskrivning. Personer med psykisk ohälsa upplevde att

förebyggande rehabiliteringsinsatser med arbetsterapi och fysioterapi ökade deras tilltro till sin förmåga och kunde öka arbetsförmågan. För en hållbar återgång i arbete tycks det vara viktigt att interventionerna inte bara fokuserar på personen utan också inkluderar arbetsplatsen. Tilltron till sin förmåga att återgå i arbete uppfattades av de sjukskrivna som ett helhetsfenomen som påverkades av såväl deras egna drivkrafter som den omgivande miljön och det tyder på att det är ett inflytelserikt fenomen att ta hänsyn till i rehabilitering. Rehabiliteringskoordinering uppfattades som en viktig länk mellan vården och arbetet av personer med psykisk ohälsa. Dock behöver informationen om rehabiliteringskoordinering öka på vårdcentralerna för att öka tillgängligheten.

List of papers

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

I. Lork K, Holmgren K, Hultqvist J.

Does the Number of Reasons for Seeking Care and Self-Rated Health Predict Sick Leave during the Following 12 Months?
A Prospective, Longitudinal Study in Swedish Primary Healthcare

Int J Environ Res Public Health 2022;19:354-366.

II. Lork K, Holmgren K, Danielsson L.

A short work-directed rehabilitation to promote work capacity while depressed and anxious: a qualitative study of workers' experiences

Disabil Rehabil 2021;43(17):2487-2496.

III. Lork K, Holmgren K.

The experience of return to work self-efficacy among people on sick leave

Work 2018;59:479–490.

IV. Lork K, Holmgren K, Maria EH Larsson, Danielsson L.

"The most important thing is that the rehabilitation coordinator stands behind me." Experiences of rehabilitation coordination among people on sick leave with common mental disorders: a qualitative study in Swedish Primary Healthcare
In manuscript.

Working while ill, going on sick leave and return to work again:
The individual's perspective in primary health care

Content

Abbreviations

CMD	Common Mental Disorders
MSD	Musculoskeletal Disorders
OHS	Occupational Health Services
OR	Odds Ratio
OT	Occupational Therapist
PCA	Person-Centred care Approach
PHC	Primary Healthcare
PT	Physiotherapist
QCA	Qualitative Content Analysis
RC	Rehabilitation Coordination
RTW	Return To Work
RTWSE	Return To Work Self-Efficacy
SSIA	Swedish Social Insurance Agency
SRH	Self-Rated Health

Preface

I have long clinical experience as an occupational therapist and rehabilitation coordinator and have been working in different types of teams to support people in getting back to work. The people we encountered had often been on sick leave for a long time and experienced different obstacles and challenges on their way to better health and an increased ability to work. It was obvious that being on sick leave was an exposed and vulnerable situation, not only because people suffered from an illness but because a longer period of sick leave affected the whole life situation. Although sick leave could be necessary to recover and regain health, it became apparent that it could have negative consequences, such as an increased feeling of alienation, a loss of daily routines which could lead to passivity, and not least, a reduced belief in oneself and one's ability to work again.

Being on sick leave also involved being assessed at different phases of the sick leave process by different stakeholders. When could the person on sick leave start working again and to what extent? What efforts might be needed to get there? Various stakeholders, such as healthcare providers, employers, and the Swedish Social Insurance Agency, had different perspectives, and the person on sick leave was in a vulnerable situation in this regard as well. Understanding the perspective of the person on sick leave and making use of the person's own resources and abilities should be a matter of course for all stakeholders involved in the sick leave process; however, this is not always the case. Different interests of the stakeholders could clash and create conflicts, and the shared overarching purpose of supporting the person in getting back to work in the best possible way could get lost.

In the present thesis, I want to highlight the experiences people have when in the process between work and sick leave. They are in a vulnerable situation, and yet they demonstrate that they have strengths, capabilities, and dreams. Their experiences are valuable in increasing understanding of what it is to be on sick leave. My hope is that their experiences may also contribute to the growing knowledge about the kind of support people on sick leave perceive as meaningful to regain health and the ability to work.

Introduction

Human occupation is a foundation for survival and health. The occupation of work belongs to a vital area of life for most people (1). Working is important, not just for making a living but also because it gives structure to everyday life and, ideally, a sense of meaning and context (2). Work is usually beneficial for our health, but the physical and psychosocial work environment and the organisation of the workplace may cause injury or illness (2). Injuries and illnesses occur for several reasons besides those related to work; however, they may cause shorter or longer periods of sick leave (3). Both employees and society at large are strongly affected socially and economically by sickness absence (4-6).

People live in a complex reality, and the process of working, going on sick leave, and then returning to work is influenced by several factors (7). Although there is extensive research on various aspects of sick leave and return to work (RTW), more research is needed that shows the individual's experience of the sick leave process. It is the person on sick leave who has the main role in the sick leave process, and therefore this perspective is important. Thus, the overall purpose of the present thesis is to highlight the individual's perspective in the process between work and sick leave. The research area in the present thesis is formed by an occupational science perspective on work and revolves around person-centredness within the sick leave process and in rehabilitation efforts. The main concepts used in the present thesis and the setting of the thesis, which is primary healthcare (PHC), will be presented in the following introduction.

Occupational science in relation to health and work

Occupational science includes the study of human beings in activity and their ability to use time and environment (8). Environment is understood from a broad perspective as the physical as well as the social and societal environment (1, 9). Occupational science understands occupation from a holistic perspective, where a person, the occupation, and the environment are in constant interaction and where all parts affect each other (10).

Well-being by occupation

A basic assumption in occupational science, which takes a holistic approach to health (1), is that human occupation is the foundation for good health.

According to Wilcock (11), there is a strong relationship between occupation and health. As she describes it, "occupation is the natural biological mechanism for health" (11, p.2). To describe occupation in relation to health in a simple way, Wilcock (11) created four interacting concepts: doing, being, becoming, and (later) belonging. The concept doing is used synonymously with occupation and is usually the focus within occupational therapy. Being relates to being true to oneself, one's nature or essence, which requires time to simply reflect and exist. Becoming is about potential, development and self-realisation and is formed by doing and being. Belonging was added later to include the social context, dealing with relationships and interactions with others. From an occupational perspective, health is linked to these concepts by doing well, enjoying well-being, and becoming healthy. However, the concepts also relate to negative health effects described as occupational imbalance in doing, occupational alienation in being, and occupational deprivation in becoming (11). A critical analysis shows that, since the four concepts were introduced, doing and being have been used and developed more than becoming and belonging (12). As the concepts are general, they have contributed to a shared language for occupational therapists and have facilitated communication with patients and different stakeholders in society. However, there is a gap between theory and practice that needs to be bridged (12).

Healthcare represents a biomedical frame of reference when meeting the population's needs for medical care in case of illness or injury and in the sick leave process (13). It is therefore important to understand the concept of illness in relation to the concept of health. Boorse's (14) health theory describes health as an objective state of total absence of disease; however, the theory has been criticised for oversimplifying (15). Illness can be expressed in several ways, such as sickness, disease, or disorder. The terms illness and sickness have similar meanings, referring to an unhealthy condition of body or mind or to a more specific type of disease or illness (16). In the present thesis, illness and sickness will be used with these similar meanings. However, the terms are normally used differently; illness is a more formal way of referring to short- and long-term diseases, and sickness is a less formal word usually describing short-term diseases (16). Disease is another term for illness, which is used to refer to specific conditions in body or mind, and disorder, as a medical term, means an abnormal physical or mental condition (16). In the present thesis disease and disorder are used according to these definitions.

The World Health Organization (WHO) has a well-established definition of health from 1948, describing it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (17). At that time, it was a ground-breaking formulation, beyond the perspective of biomedicine, as the definition takes a holistic view of health that includes not only the physical body but also mental and social well-being. The definition also shifts the perspective of health as merely the absence of

disease. Defining health as well-being also increases the focus on the individual and on health instead of disease. Nevertheless, WHO's definition has been criticised for being too broad and difficult to fulfil (15, 18). The description of health as a complete state of well-being basically medicalises the whole society and excludes most people from having good health. The definition is therefore not considered to be useful in practice (18).

Mental health has been defined by WHO as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (19). This definition also highlights the individual experience of health, in this case mental health. Mental health is an ability to manage internal and external demands and resources and includes the opportunity to contribute to society by working (19). Criticism has been addressed against this definition of mental health as being too partial in focusing on well-being and on being well-functioning (20). Mental health involves the ability to handle challenging emotions as well, and people with good mental health also experience sadness, fear, and anger. Being unable to work is not necessarily due to mental illness as it can be interpreted but may depend on various contextual reasons. Based on this criticism, another definition of mental health has been developed (20, p.231-232):

> *Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.*

This definition emphasises the importance of an inner balance to be able to use one's abilities in interaction with the values of society. Mental health is perceived as a dynamic interaction between the person and the environment (20).

Self-rated health (SRH) is a way of capturing people's own perception of their health. A well-established method is to use the question "How would you say your health is in general?" from the Short Form Health Survey (SF-36) (21). This simple question provides a global answer as it captures physical, mental, and social well-being (22). Although SRH is one of the most widely used health concepts for measuring self-perceived health in many disciplines and in large national and international population studies, there is a debate about what is actually measured (23, 24). Jylhä (24) has created a cognitive model describing how people assess their health to increase understanding of SRH. The health assessment is seen as an interplay between

an evaluation of one's own health and the context in the form of culture, history, previous experiences, and norms regarding health. Self-perceived health is understood as the person's subjective assessment based on their health and context as well as an indicator of objective somatic and mental conditions at the same time (24).

In summary, there are many ways to describe health, depending on perspective. The biomedical perspective describes health as the absence of disease. The holistic perspective emphasises in various ways the subjective experience of health and ability to cope with life's challenges with reasonable inner balance. Health is also described as affected by the values and structures of society and is seen as an interaction between the person and society. The present thesis has a holistic perspective of health, however, knowledge of the biomedical perspective of health is vital as it influences the sick leave process.

Occupational performance in a transactional perspective

Meaningful occupations are another core concept in occupational science, and they are important building blocks for a meaningful life. Still, what is perceived as meaningful occupations varies over time depending on the different phases in life (25). The concept of occupation concerns the whole spectrum of activities that people do in their daily lives in an environment with its temporal, physical, and socio-cultural contexts (8). Occupations are understood as complex, having unique meanings for each individual, and they also form a sense of self (9). In occupational science, work falls within the broader concept of occupation, as work is only one of multiple meanings of the word occupation, which may create confusion. In the present thesis, work is therefore used in the sense of paid work or vocational rehabilitation in a workplace and will be understood from an occupational science perspective, which means that work is seen in a holistic perspective, interplaying with the person and the environment, and that work also shapes roles and identity (8).

The Person-Environment-Occupation (PEO) model developed by Law et al. (26) is an occupational therapy theory focusing on person-centredness and occupation. It was developed out of a need for a practice model linking transactional theory regarding the interaction between person and environment and clinical interventions (26). The model is based on a transactional perspective that gained increased interest in occupational science during the 1990s. Occupational performance is seen as the result of a dynamic relationship between the person, the environment, and the occupation. All parts are inextricably linked and interdependent in a transactional whole. Previous theories in occupational science considered the person and the environment to be separate and they could therefore be studied independently even if they interacted. The traditional, interacting perspective on person

and environment provides explanatory models based on a clear cause and effect. By influencing the person and/or the environment, the performance of occupations can be affected. In the transactional perspective, occupational performance cannot be separated from the environmental influence and the person's characteristics. The transactional perspective also emphasises the constant shifting of the environment, which affects the person's view of themselves and the occupational performance that takes place in different roles in a constant flow (26) (Figure 1).

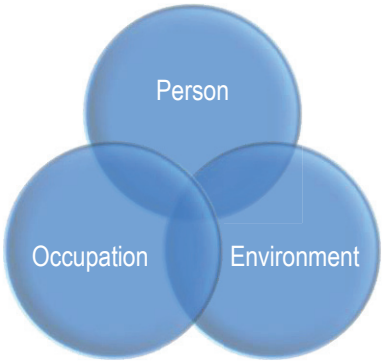

Figure 1. The Person-Environment-Occupation model adapted from Law et al. (26).

The interrelated circles describe the influence of the person, the environment, and the occupation on occupational performance at the centre, in a constant transaction. The person is described from a holistic perspective with body, soul, and spiritual qualities and with different roles which are constantly developing. The environment is broadly defined as the cultural, socio-economic, institutional, physical, and social environment. Occupation is described as the overall activities to take care of one's inner needs, such as taking care of oneself, expressing oneself, and seeking fulfilment. The activities are carried out throughout life in a temporal context of changing roles and habits and in shifting environments. Occupational performance, finally, is seen as a dynamic and complex phenomenon resulting from the transaction between person, environment, and occupation. Occupational performance occurs when a person is engaged in a specific activity in a certain environment. In occupational performance, a constant balance is needed between the view of oneself, one´s occupation, and the environment as they can conflict with each other. Over a lifetime, people's view of themselves and their roles in the transactional interplay changes, according to the PEO model (26).

In a clinical context, the PEO model can be used for interventions targeting the person, environment, and occupation in different ways, and the

model has been used in different settings as a process model for practice and research (27, 28). A greater overlap between the circles is estimated to give a more optimal occupational performance, and by affecting one part, the whole is affected according to the transactional perspective (26). Law (26), however, was later criticised by Dickie et al. (29) as not fully grasping the transactional perspective originating from Dewey's (30) holistic view of person and world as a continuum expressed as "organism-in-environment-as-a-whole" (p. 109). Dickie et al. (29), based on their perspective on transaction theory, have criticised occupational science's dualistic view of person and environment as separate, which is considered to create obstacles to understanding occupation. The traditional individual focus found in occupational science is questioned and substituted by occupation, which is placed in the centre. The transaction theory is based on a *functional* view of the relationship between person and environment, where the purpose of the transactions is to functionally coordinate the whole of the relationship. To understand the practical implications, an example is given in which a person may have a functional relationship with society in sharing the same need for survival, adaptation, and development through processes of education, work, and leisure. Occupation is explained as a transaction that unites person and environment, where both are important but transactional parts of each other. Occupation becomes a way to functionally coordinate the person within his or her environment, and habits are seen as occupational transactions to coordinate stable relationships for the person within the environment (29).

Occupational science is valuable as it may provide a holistic perspective to comprehend the dynamic process between the person, work, and sick leave, which is the purpose of the present thesis. The PEO model (26) will be used in the present thesis to facilitate the understanding of this process from a person-centred perspective. Therefore, the person's prerequisites and needs in transaction with requirements and opportunities in the occupation of work, which are part of a larger societal environment, are an important point of departure for the present thesis.

Person-centred care approach

The present thesis has person-centredness (31) as a fundamental concept as it emphasises the individual's perspective on the sick leave process and return to work. A person-centred care approach (PCA) is in line with core occupational science values regarding the understanding of individuals from their own perspective and conditions (32). Occupational therapists are expected to give respectful treatment, adapt their communication to the individual's ability, promote the individual's abilities, and emphasise empowerment. The encounter with the individual is a collaboration where both

parties share their experiences and knowledge and are actively involved in the rehabilitation process (8, 32).

Person-centredness is the term predominantly used in continental European literature while the term patient-centredness is more common in Anglo-American literature (33). This is a reflection of the underlying descriptions and definitions of the concept that vary due to different perspectives, disciplines, and historical traditions. In the present thesis, the terms person-centredness and PCA are used as they are commonly used in continental European literature. There has been growing interest in person-centredness and PCA since the early 2000s as the concepts have been increasingly recognised in both research and policy contexts. Person-centredness may be seen as a concept that can be used to develop healthcare delivery more broadly or to develop a more specific but complex intervention to enhance the quality of care (33). A review suggests that the term person-centredness may facilitate a shift from focusing on a patient with illness to seeing a person who is experiencing illness (34). The review further reports that the core element of recognising the ability to make autonomous decisions is more developed in studies using the term person-centredness than those using the term patient-centredness (34). Still, despite variations in terminology in different disciplines, there seems to be a quite unifying fundamental ethical principle: that patients should be acknowledged as persons and treated with respect and dignity, and their needs, wants, and preferences should be recognised when they are seeking care (33).

Most research on person-centredness has focused on the micro level concerning the interplay between the person/patient and the healthcare professionals. The meso level representing the organisational context and the macro level of health systems are rare in the scientific literature despite their fundamental impact on the provision of person-centred care (33). Swedish legislation underlines that respect for patients' self-determination and integrity is a foundation for PCA within healthcare (13, 35). The National Board of Health and Welfare describes person-centredness as an approach rather than a way of working. Interventions should be based on the individuals' needs, preferences, and resources and involve the experiences of individuals and their relatives (36). Healthcare professionals therefore need to be able to listen actively and show understanding of people's self-esteem and will.

There are several benefits of PCA, including improved health outcomes and increased satisfaction among the patients (37). In addition, a PCA may strengthen patients' hope and ability to handle symptoms (38). Co-creation of health plans is beneficial, especially for persons with low socio-economic background (39). Traditional health plans are frequently created only by the health professionals and guided by behavioural changes. In contrast, when individuals formulate goals with support from professionals, they include other important areas of life such as physical activity, social and leisure activities, and returning to work (39).

However, there is a lack of routines for a systematic approach in the healthcare system for PCA (37). According to a national follow-up of healthcare in Sweden, PHC can become more person-centred than it is currently (40). Sweden has lower results in terms of person-centredness and internal collaboration than comparable countries in Europe and compared to the average for the entire European Union (EU). Patients in Sweden feel that they are less involved in decisions about care and treatment than patients in other countries and that they receive less easy-to-understand information from the professionals (40). Hence, there are challenges with PCA in PHC settings that need to be addressed at all three levels: micro, meso, and macro.

Self-efficacy and return to work

Self-efficacy is another concept within occupational science alongside well-being and person-centredness as it relates to occupation. Self-efficacy is an important frame of reference in the present thesis and concerns individuals' belief in their ability to perform an activity, and it provides a fundamental experience of competence (41). The experience of ability may, in turn, bring improved occupational performance and well-being (42). The concept was originally developed by the psychologist Bandura (43) based on his social cognitive theory. The theory describes human activity as an interaction between the person (including biological, emotional, and cognitive abilities), the social environment, and behaviour and emphasises the social influence on behaviour (44). Self-efficacy varies in level and strength and develops through people's experiences of various activities. People's motivation and behaviour in managing life's challenges ultimately depend on their self-efficacy (44). According to Bandura (43), self-efficacy is changeable; there are primarily four influencing factors:

Enactive attainment is the most influential factor and concerns the experience of accomplishing activities. It is based on previous experience of success or failure. Experiences of success in an activity increase self-efficacy and setbacks lower it. However, those with higher self-efficacy deal with adversity more successfully and do not give up as easily as those with lower self-efficacy. In the evaluation, other factors are also considered, such as the effort required and support from the environment.

Vicarious experiences refer to one's abilities compared with the abilities of others, who are seen as role models. Based on that comparison, a person evaluates their ability to handle an activity.

Verbal persuasion means being persuaded or convinced by others to do an activity. It may increase a person's self-efficacy, although there is an obvious risk of decreasing self-efficacy if the activity turns out to be impossible to perform.

Physiological state includes the evaluation of one's physical ability to cope with an activity in a stressful situation. The experience of one's health, and of, for example, fatigue, pain, or stress, consequently affect self-efficacy (43).

Initially, Bandura (43) linked the concept of self-efficacy to specific activities, but over time the concept has evolved and is also used in a general sense. General self-efficacy concerns the subjective assessment of the ability to handle activities and challenging situations in general (45). Self-efficacy has been shown to be a considerable influencing factor in the sick leave process and in returning to work (46, 47). In the present thesis, the more specific concept of return to work self-efficacy (RTWSE) is used to refer to the belief in one's ability to handle the demands necessary for RTW.

The concept of work ability

Some perspectives on work ability will be described in the following text with relevance to the subject of the present thesis regarding the process of working, being on sick leave, and returning to work. Work ability is a complex concept that can be described in several ways, such as occupational performance, occupational functioning, or work functioning (48-50). In the studies included in this thesis, the concept of work capacity is used, but as the concept of work ability is more common in the literature, it is used in this introduction and discussion with the same meaning. Work ability is defined differently depending on perspective, such as the theoretical frame of reference and the purpose for which work ability is used (51). Theoretical frames of reference may include medical, psychosocial, or biopsychosocial theories, or they may be based on employability. The purpose may be to classify, quantify, compensate, or understand work ability. The purpose for which the concept of work ability is used largely depends, in turn, on the context, which may be, for example, legal, clinical, or research-based (49, 51).

Lederer et al. (49) investigated how the concept of work ability has been described and developed in a scoping review. The concept of work ability was initially defined based on a biomedical frame of reference that emphasises the impairment of physical health, and later also mental health, as the cause of reduced ability to work. The focus shifted over time from individual impairment to include the consequences in relation to the work demands and the work environment. Since the 1980s, the perspective on work ability was further broadened as research showed that work-related and psychosocial factors had a greater impact on long-term impairment of work ability than physical factors. Theories that include a broader social and societal perspective become more common, such as biopsychosocial or ecological models that emphasise the multidimensional nature of work ability (49).

The scientific literature shows that there is no uniform overarching definition of work ability, even though the term is frequently used in many different contexts within research and in society. However, there is consensus regarding work ability as *a relational concept* depending on the dynamic interaction between various dimensions at different levels that influence each other. There is also general agreement that the concept has *become more dynamic* over time (49). Three different dimensions describing work ability recur in many definitions: the individual dimensions (usually physical and psychosocial factors), the organisational dimensions (usually work demands and work environment), and the societal dimensions, which provide the framework based on laws and political decisions. Work ability is primarily related to the individual and organisational dimensions and less often to the societal dimension. The overview shows how the concept of work ability has evolved from its earlier reductionistic view that included only physical ability. Work ability is today perceived as a multifaceted and multidimensional phenomenon that is affected at the individual, organisational, and societal levels (49).

At the end of the 1990s there was a theoretical shift in work ability research from how work inability can be prevented to how work ability can be promoted based on a holistic perspective (49). A salutogenic perspective is emerging that emphasises strengths and abilities more than weaknesses and impairments connected to work ability. The ability to work is situated in a larger life perspective, and variations in the ability to work are seen as a natural part of life (52). To describe work ability built on this research, Ilmarinen's (53) model of the work ability house is illustrative. It aims to provide an overarching model for promoting work ability based on the challenges many European countries are facing with aging populations. The ability to work forms the roof, which sits atop a four-storey house. The house is influenced by the environment, including family, social network, and society at large. The foundation of the work ability is health and functional ability on the first floor. Floor two consists of skills and knowledge, and floor three consists of values and motivations. The fourth floor involves the work and its demands, the work environment, and management. In the model, the individual-based factors are called human resources, and a sustainable balance between them and the work-related factors is considered to create a good work ability (53).

Perspectives on work ability in different systems

One way to illustrate the various perspectives involved in the sick leave process and rehabilitation efforts is by using the Sherbrook model (54), originally focused on prevention of work disability. The model has a system-theoretic origin that assumes that society has several different social systems, such as medical, rehabilitation, legal or labour market systems.

Different systems have differing perspectives on reality and develop diverse norms leading to various interpretations of the same concept (55). In the Sherbrook model (54), four different systems are considered to influence work disability. The different systems are useful in understanding the complex interactions in the sick leave process and the concept of work ability. The four systems are: the person on sick leave, the workplace, the healthcare system, and the social insurance system. They will be explained in the following section (54).

The person on sick leave represents the person's subjective experience of resources and coping skills and the view of their own work ability in the system. Concerning work ability, the person on sick leave often wants to recover, be able to perform meaningful work, and regain financial stability. The workplace system represents a production and profitability perspective where work ability is assessed based on competence and the ability to be productive. Concerning work ability, the employer wants a functioning business where the person returning from sick leave can work efficiently. The healthcare system represents a biomedical and rehabilitative perspective and, concerning work ability, the main focus is regaining health. The social insurance system represents a legal perspective concerned with assessing the right to receive various benefits in relation to work ability (54). In Sweden, the Swedish Social Insurance Agency (SSIA) is responsible for sickness insurance, and the assessment of work ability based on sick leave certificates. The assessment of the SSIA is also built on a biomedical perspective (56). Other parts of the social insurance system, such as the Swedish public employment service, can also be activated if the person needs to find new work, or the social services within the municipalities if the person lacks other means of support. Since the different systems have different perspectives and norms affecting the concept of work ability, communication and cooperation between the systems may be hindered.

The dynamic process between work and sick leave

Research related to RTW is closely connected to work ability. Research about RTW has developed in a similar way, from a medical determinism with a linear progression from sick to healthy and thus able to work, to recognising the non-medical elements of a multifaceted and dynamic process (57). It is therefore important to have a process by which to understand the different phases of working, going on sick leave, and RTW. Young et al. (57) have criticised earlier research on RTW for not taking advantage of the process thinking when investigating sick leave outcomes. The fact that different aspects can have various effects at different stages and that RTW is a developmental process is overlooked in many studies where the outcome is limited to being on sick leave or working. To conceptualise RTW as a dynamic, multistage process, Young et al. (57) developed a model with four phases.

The model is also intended to present a more nuanced description of possible measures and outcomes of interest to the various stakeholders involved in RTW. The four phases are: off work, re-entry, maintenance, and advancement. By understanding RTW in this way, it becomes evident that outcomes often shift during the process. The first phase, off work, is about defining abilities and intentions and planning for RTW. In the second phase, re-entry, the person's ability to work is assessed as is the suitability of the work they plan to return to. If necessary, the work may be modified to suit the person´s abilities; if that is not possible, alternatives have to be identified. In the third phase, maintenance, the ability to maintain work ability is assessed, and in the fourth phase, advancement, further education and career development become relevant (57).

Another way of illustrating the complexity of the process is the *Dynamic work disability model for sickness absence and return to work* developed by Labriola (7) in Figure 2. The model shows the different but overlapping factors in the context that influence sickness absence and RTW. These factors are individual characteristics and socio-economic position, work and work environment, and societal aspects. An individual can move in both directions in the model, between work, sick leave, and permanent expulsion, or they can stay in any phase, depending on the individual and the context. Short-term or long-term absence or sick leave may be defined in different ways depending on the context, and the scientific literature offers no clear definitions. In Sweden, no definition of short- or long-term sick leave is suggested by the SSIA (E-mail SSIA, Wallentin D, 2022-12-02) and, as an example, studies in Sweden have defined short-term sick leave in various ways, ranging from 14 days (58) to 30 days (59). In the present thesis, the definition of short-term sick leave is <15 days.

Sickness presenteeism is another phenomenon of interest in the dynamic process between work and sick leave. According to a systematic review there are mainly two definitions of presenteeism, one focusing on the economic consequences and the other on the health consequences (60). The review investigated the health consequences and found that sickness presenteeism was a risk factor for decreasing SRH and future sick leave (60). Higher presenteeism has been found in healthcare and education sectors in Sweden, and the most frequent combination was high sickness presenteeism, high sickness absenteeism, and low income (61).

There is still little knowledge from the individual's perspective on the complex process between work and sick leave, and there is a need to gain a deeper understanding of the individual's experiences and perspective (62). To explore the different phases in the sick leave process, Young et al.'s (57) RTW model and Labriola's (7) dynamic work disability model have been guiding the understanding in the present thesis.

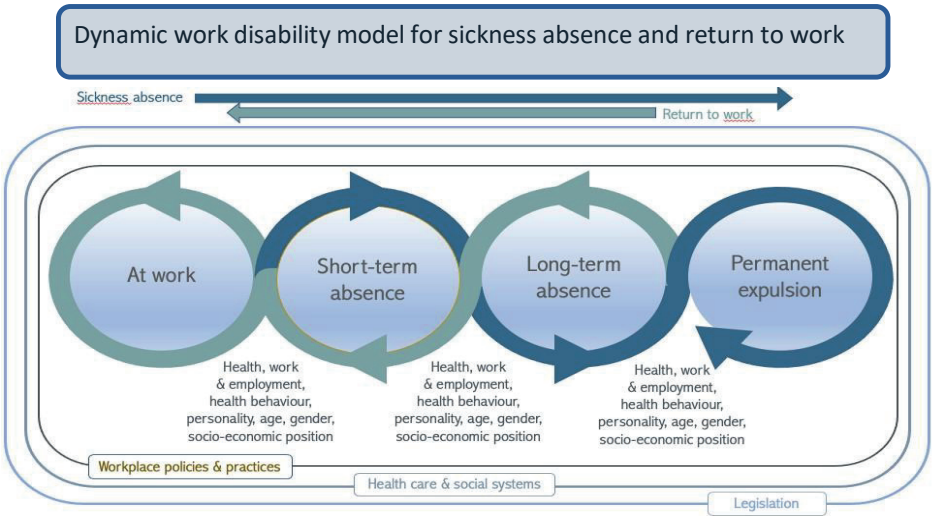

Figure 2. Dynamic work disability model showing the process between work, sick leave, and permanent expulsion. By permission from Labriola (7).

The primary healthcare setting

The PHC setting forms the basis of the present thesis as the participants had their healthcare treatment, rehabilitation, and sick leave certifications within PHC when they were recruited to the various studies. Most sick leave certificates are issued within PHC and comorbidity is common (63), which implies that work-related health is a vital concern for PHC (64). PHC is responsible for providing basic medical treatment and rehabilitation for the population (65). Every year, almost two thirds of the Swedish population visit PHC centres with a variety of diagnoses, including both physical and mental disorders (66). Fundamental principles for PHC in delivering care include a PCA, high accessibility and continuity, and collaboration with other stakeholders and society (65).

From a patient and population perspective, there are three areas of importance for healthcare delivery: the health outcome, person-centredness, and accessibility, all of which are supported by law (40). The goal for all healthcare is to support good health with good quality care, based on equal conditions. Healthcare providers have to prioritise those with the greatest need, according to the Health and Medical Care Act (13). The law also emphasises that healthcare must be accessible (13), and from a patient and population perspective it involves the possibility to easily get in touch with healthcare providers and reasonable waiting times (40). Public trust in PHC

is good, as two-thirds of the population have a very high or fairly high level of trust, and 70% of the population believe that waiting times are reasonable (67). Although PHC is the basis of healthcare, it does not always function as there are groups with complex needs who do not always receive the care they need, such as people with comorbidity and people with mental illness (66). Moreover, Swedish healthcare, especially PHC, has longer patient-perceived waiting times compared with similar countries within the EU, which is a challenge (40), and PHC has to develop organisational and methodological approaches to meet people with complex needs and manage waiting times.

Common disorders and sick leave

The leading causes of sick leave in Sweden are common mental disorders (CMD), such as depression, anxiety disorders, and stress-related disorders, and musculoskeletal disorders (MSD), such as disorders or injuries affecting nerves, discs, tendons, muscles, and ligaments. Both CMD and MSD are often related to work and affect work capacity (68-70). Symptoms of anxiety are emotions of dread, apprehension, and impending disaster, and symptoms of depression are expressed by a dysphoric state of mind and loss of interest in daily activities (71). Perceived stress may cause several physical and mental symptoms such as muscle pain, headaches, cardiovascular diseases, weakened immune system, insomnia, and emotional and cognitive symptoms. Eventually it may lead to burnout, a concept used internationally for work-related stress (72), or exhaustion disorder, a clinical diagnosis with similar criteria in Sweden (73). A cross-sectional study reports a significant association between work-related stress and sick leave among working women in Sweden (74). In line with this, a longitudinal study shows that work-related stress due to indistinct organisation and conflicts, high personal demands and commitment, or low influence at work approximately doubles the odds of taking sick leave (64). The odds for sick leave increase four times if the work-related stress is due to both indistinct organisation and conflicts and high personal demands and commitment (64). The association between long-term sick leave for mental disorders and other psychosocial work environment exposures such as effort-reward imbalance and overcommitment has been confirmed in a Swedish working population (75).

According to WHO, the global prevalence of all mental disorders is estimated to 970 million, which is equivalent to 13% of the entire population at any one time (76). Anxiety disorders and depression disorders are the most prevalent among all mental disorders worldwide, accounting for 60% of all mental illness (76). In Sweden, as in many developed countries, CMD is the main cause of sick leave today, accounting for approximately half of all ongoing sick leave (77). With CMD, the sick leave is often longer, and the risk of relapse is greater than for other disorders (77), which is a challenge not

only for the person affected but also for the healthcare system, working life, and society in general.

The sickness insurance system and rehabilitation coordination

The sickness insurance system applies to almost all residents in Sweden. It is an income insurance intended to cover loss of income in the event of disease or injury affecting the ability to work (56). A person can be on sick leave for 25%, 50%, 75%, or 100% of their working time. In the initial seven days, a person can be on sick leave without a certificate, but on day eight a sickness certificate from a physician is required. The employer pays a sick wage for the initial 14 days, and thereafter the SSIA pays for the sick leave. The extent of the benefit is determined by SSIA officials, who base their decisions on the sickness certificate issued by the physician. According to the law (56), the assessment must be based only on the medical conditions affecting the ability to work. Other conditions, such as the labour market and financial or social circumstances, are not to be considered (56). The ability to work is consequently assessed by the SSIA based on strictly biomedical criteria.

As the basis for assessing the ability to work in relation to the length of sick leave, the SSIA uses a so-called rehabilitation chain, and the assessment becomes stricter the longer a person is on sick leave (78). The rehabilitation chain has the following points of reference: on days 1-90, the ability to work is assessed as it relates to the person's regular work. On days 91-180, the ability to work is assessed with a view to the person doing other possible work at their current place of employment. On days 181-365, their ability to work is assessed in relation to the requirements of a specified profession (78). Previously, the assessment after day 180 was made towards the entire labour market, but a legal adjustment made in September 2022 has made the assessment of work ability less strict (79). In case of refusal of sickness benefits after day 180, the SSIA also must indicate one or more suitable professions for the person to facilitate understanding of the agency's assessment and decision. After one year, sick leave may still be granted with an existing employer if it is reasonable to believe that RTW is possible within 550 days (78). The reason for the legal adjustment was to increase the legitimacy of the sickness insurance system and the flexibility of the rehabilitation chain. Previously, when the request to change work was made earlier in the sick leave process, it sometimes prevented return to an existing work position despite ongoing rehabilitation or a graded increase of work hours (80).

Rehabilitation coordination

To facilitate the sick leave process, rehabilitation coordination (RC) was gradually introduced in the Swedish healthcare system in the 2000s (81). In 2020, a law was enacted to enable collaboration between employees, employers, healthcare providers, the SSIA, and other stakeholders in the sick leave process, and today RC is offered at all PHC centres (82). The law states that RC has to include personal support and internal and external collaboration, and it is voluntary for the patient (82). By mapping the current situation of individuals on sick leave and with guidance to empower the individual, the rehabilitation coordinator facilitates improved health and RTW (83, 84). Interventions such as rehabilitation plans should build on person-centredness in collaboration with the person on sick leave. Internal and external collaboration with other stakeholders is also essential (83, 84). A national survey from 2021 by the Swedish Association of Local Authorities and Regions evaluated the development of RC since 2018 (81). The rehabilitation coordinators report that 90% of the patient support consists of information, counselling, and mapping. More than 70% of the work also entails motivational interviews and establishing rehabilitation plans. Collaboration with external stakeholders has increased, especially with employers and social services. According to the national survey, the rehabilitation coordinators need continuous support from colleagues and management, and the role needs to be more distinct to create an internal as well as an external mandate for the assignment (81).

Since RC is a relatively new resource, research in the area is sparse. Reports from Swedish PHC settings indicate positive effects in terms of return to work and improved internal and external collaboration (85, 86). Having more contact with a rehabilitation coordinator and their help in designing a rehabilitation plan was important for the patients' experience of support within PHC and psychiatric care in a recent cross-sectional study in Sweden (87).

However, systematic reviews of RTW coordination programmes show differing results (88, 89). RTW coordination programmes resulted in a small but likely important increase in RTW in one systematic review (88). In contrast, another systematic review did not find any effects on RTW outcomes for RTW coordination programmes (89). It concluded that more studies with long-term follow-up of interventions are needed and that workplace integration in the RTW process is vital (89).

Rationale

The person on sick leave has the main role in the sick leave process, and it is important to recognise their experiences and needs. Despite having the main role, the person on sick leave is often in a vulnerable position, not only dealing with illness or injury but also being the subject of various assessments from different stakeholders with different perspectives (51, 90). A transactional occupational science approach in the sick leave process is rare, and therefore more research is needed to understand how people who are at risk for sick leave or who are on sick leave experience their situation as a transactional whole. The present thesis highlights the experience of the person in this process between work and sick leave. For the stakeholders involved in the sick leave process, the knowledge may strengthen the ability to meet each person as a unique individual and facilitate the co-creation of rehabilitation plans during the sick leave process.

There are several aspects in the dynamic process between work and sick leave that the present thesis emphasises. It is essential to learn more about the large group of workers seeking care for common symptoms to be able to identify the risk of sick leave early in the process (study I). Although it is important to offer preventive interventions to promote work ability, such interventions are rare within occupational therapy and physiotherapy (91). The next step in the process aims to deepen knowledge about workers' experiences of a brief work-directed rehabilitation intervention while still working or on part-time sick leave (study II). Self-efficacy has importance for sick leave and return to work (46, 47). To better comprehend RTWSE, it is important to understand the perspective of the person on sick leave. This is the third step, when people are on full-time sick leave (study III). Rehabilitation coordination supports people in getting back to work in collaboration with different stakeholders (82). There is a need to explore individuals' experiences of RC, which is the last step of the process, where people are on sick leave full or part time or are working again (study IV).

This thesis addresses the above-mentioned knowledge gaps. With a transactional occupational science approach and based on the individual's perspective, the thesis aims to developing in-depth knowledge and understanding of the dynamic process between work and sick leave in PHC settings.

Aim

The overall purpose of the present thesis was to increase understanding of the dynamic process between working while ill, going on sick leave, and returning to work from the individual's perspective in primary healthcare. Following the dynamic process between work and sick leave, the specific aims of the present thesis's four studies were as follows:

Study I

To investigate whether self-rated health and the reason for seeking care predicted sick leave during the following 12 months.

Study II

To explore how people with common mental disorders experienced a work-directed rehabilitation intervention, provided by occupational therapists and physiotherapists, intended to promote work ability.

Study III

To explore how people on sick leave for various reasons experienced their return-to-work self-efficacy.

Study IV

To explore how people at risk for sick leave or on sick leave with common mental disorders experienced rehabilitation coordination.

Participants and Methods

The present thesis is based on studies regarding the process between work and sick leave and how it is experienced by those who are at risk for sick leave or who are on sick leave. Four studies are included: one study has a quantitative design, and three studies have a qualitative design (Table 1).

Table 1. Overview of the four studies, including study design, collected data, and study population.

	Study design/Methods	**Data sources**	**Study population**
Study I	Quantitative, a prospective, longitudinal design. Non-parametric statistics. Logistic regression.	Baseline data and register data on sick leave.	Non-sick-listed workers seeking care at PHC for various reasons. *n*=271
Study II	Qualitative. A qualitative content analysis.	Semi-structured interviews.	Non-sick-listed or part-time sick-listed workers with CMD. *n*=16
Study III	Qualitative. A modified phenomenology method.	Semi-structured interviews.	Workers sick-listed full time for various reasons. *n*=9
Study IV	Qualitative. A qualitative content analysis.	Semi-structured interviews.	Non-sick-listed or part-time sick-listed workers with CMD. *n*=11

Study I

Study I had a quantitative design with a prospective longitudinal design and non-parametric statistics based on data from the project Tidig identifiering av risk för sjukfrånvaro, prevention och återgång i arbete (TIDAS), an RCT study (92) in a PHC context. The overall aim of the TIDAS project was to evaluate whether sickness absence could be prevented by early

identification of work-related stress, and the results are presented in several studies (64, 93-97).

The present study aimed to investigate the association between self-perceived health and sick leave within one year for employed men and women seeking care at PHC centres for various symptoms without being on sick leave. Three specific hypotheses were formulated:

1. A baseline difference in reasons for seeking care exists between those with and those without registered sick leave (>14 days) at 12-month follow-up.
2. Registered sick leave at 12-month follow-up is predicted by the number of reasons for seeking care.
3. Registered sick leave at 12-month follow-up is predicted by lower SRH at baseline.

Study design and procedure

An analysis of RCT data collected at baseline and of 12-month follow-up sick leave data from the SSIA register was performed. Recruitment of patients took place from May 2015 to January 2016 in seven PHC centres in Region Västra Götaland, Sweden. Patients who were employed, non-sick-listed, between 18 and 64 years old, and seeking care for mental and/or physical symptoms were included. Patients who had had seven days of sick leave or more during the last month were excluded, as were patients with full- or part-time disability pension. The total study population of 271 employed, non-sick-listed men and women from the RCT study was included.

Study population

The baseline data included socio-demographic information, self-rated health, and the reason for seeking care at the PHC centre. Baseline characteristics were obtained from a questionnaire designed for the RCT study. Most of the participants were married, cohabitant, or in a relationship (78%); a majority were female (68%); and 50% were between 31 and 50 years old. A majority of the study population (89%) had a secondary school or university education. Almost half the population had a private employer, and the other half had a public employer. The baseline characteristics for the total study population (n=271) and at 12-month follow-up between workers without sick leave (W) and workers with >14 days of sick leave (W-SL) are presented in the study. The only significant difference between the groups identified by the chi-square test was education level ($p<0.038$). For more characteristics of the participants, please see the attached study.

Analysis

The sick leave data was largely skewed, thus non-parametric statistics were used. Associations between sick leave and the number of reasons for seeking care, SRH, and socio-demographic data were investigated by means of the chi-square test, the Mann-Whitney U test, and Spearman's rank correlation. Logistic regression models were used to study the influence of these determinants on registered sick leave.

The outcome measure was sick leave >14 days granted by the SSIA at 12 months. An estimation of the odds ratio (OR) for belonging to the group W-SL was made in a logistic regression.

The first exposure variable, number of reasons for seeking care at baseline, had 15 response alternatives including mental and physical symptoms such as depression, anxiety, musculoskeletal disorders, gastrointestinal symptoms, cardiovascular symptoms, and other health-related symptoms, and it was possible to choose several. The second exposure variable was SRH and a question from the SF-36 was asked: "How would you say your health is in general?" Answers were rated on a five-point ordinal scale from excellent health=1 to poor health=5. Socio-demographic data comprised factors such as sex, age groups, civil status, educational level, occupational class, and employer.

To test the difference between W and W-SL regarding the first exposure variable, the number of reasons for seeking care, the Mann-Whitney U test was used. The difference in proportions between the groups was further investigated by calculating the 95% confidence interval (CI) on each reason for seeking care. The five-point ordinal scale for the second exposure variable, SRH, was used in the logistic regression analysis. The chi-square test and the Mann-Whitney U test were used to explore socio-demographic variables as covariates and confounders.

The outcome of registered sick leave days at 12 months was dichotomised into workers without sick leave (W) (0) and workers with sick leave (W-SL) (1). The influence of the exposure variables, adjusted for covariates, on registered sick leave was then investigated by logistic regression models. Model 1 was unadjusted, model 2 was adjusted for intervention/control, and model 3 was adjusted for intervention/control plus educational level in the logistic regression with both exposure variables.

Study II

The aim of this qualitative study was to explore how people with CMD experienced a work-directed rehabilitation intervention, provided by occupational therapists and physiotherapists, intended to promote work ability.

Study design and procedure

The study was designed as a semi-structured interview study and the participants were recruited from the intervention group in a pilot RCT study (98). The work-directed rehabilitation intervention aimed to promote the ability to work while depressed and/or anxious. The intervention period lasted 8 weeks with a flexible frame of 4 to 16 visits at a rehabilitation centre in PHC, Region Västra Götaland, Sweden. A fundamental approach was to proactively guide the participants to manage work and support recovery before full sick leave was inevitable. The present study was a qualitative exploration of the work-directed intervention by means of semi-structured interviews.

A PCA was a theoretical cornerstone and therefore it was important that the participants were able to make their own decisions and that they were acknowledged as active partners in the rehabilitation process. They were able to decide whether they wanted a physiotherapy module or an occupational therapy module or both. The physiotherapy module included basic body awareness therapy and individualised tailored exercise. The occupational therapy module was inspired by Redesigning Daily Occupations (ReDO) (99, 100) and focused on changing activity patterns to increase balance in everyday life. Another theoretical cornerstone in the study was the PEO model, which assumes that occupational performance is developed in a close interaction between the person, the environment, and the occupation. In this study context, work ability was seen as developed in the intersection of the person, work environment, and work tasks.

Participants

All participants were working full- or part-time even though they were experiencing problems at work related to their symptoms. In total, eleven women and five men who met the diagnostic criteria for depression and/or anxiety disorder participated, and diagnoses were established by a physician. The participants were 25 to 66 years old and had participated a minimum of four occasions in the intervention. For more characteristics of the participants, please see the attached study.

Method in study II and study IV

Studies II and IV both had a qualitative design using a qualitative content analysis, as described by Graneheim and Lundman (101, 102). This method has a hermeneutic approach based on the ontological assumption that phenomena can be interpreted in multiple ways, and subjective interpretation

within a context shapes the understanding. The qualitative content analysis takes into consideration that experiences are expressed both in a direct, manifest content, and in an indirect, latent content. This approach therefore recognises both the explicit and implicit descriptions embedded in people's narratives, in line with an interpretive, hermeneutic position. The method is useful in analysing data of varied character and richness and permits flexibility regarding abstraction and interpretation level (101, 102). The method was chosen mainly to account for the fact that the participants' descriptions would likely vary in depth and expressiveness.

Analysis

The basis for the analysis was the transcribed interviews and notes taken by the interviewer during the interviews. In the first step, all data was read to get an overview and an overall sense of the material. In the next step, a detailed analysis was done as meaning units were extracted and coded. Subcategories and categories were then formed by the codes, and in the final step, a theme was formed. Six interviews were coded independently by two authors to compare coding. The analysis process was continuously discussed among all authors, and the preliminary results were also discussed in a research group of OTs and PTs to increase the credibility and transferability of the study.

Study III

The aim of this qualitative study was to explore how people on sick leave for various reasons experienced RTWSE.

Study design and procedure

The study was devised as a semi-structured interview study. The inclusion criteria for the participants were an ability to understand and speak Swedish and being on full-time sick leave, as the aim was to explore RTWSE. The participants were recruited from PHC rehabilitation centres in Gothenburg, Sweden, by OTs and PTs who were informed of the study's design and purpose. They in turn informed eligible patients about the study both verbally and in writing. If interested, the patients were contacted by the research team. Consent forms were signed before each interview, and the first author conducted all the interviews. The interviews were conducted at Sahlgrenska Academy, University of Gothenburg (n=5), at a PHC rehabilitation centre (n=2) or in the participant's home (n=2). The interviews were recorded and transcribed verbatim.

Participants

The nine individuals who participated ranged in age from 30 to 60 years with a median age of 45 years. Six were women and three were men. Seven participants were cohabiting or married, and five had children of different ages. They represented different professions, and two of the participants were unemployed. The reasons for sick leave were both physical and mental illness for five participants, only physical illness for three participants, and only mental illness for one participant. The full-time sick leave varied from 3 months to 2 years, and two participants had been on part-time sick leave previously, one for 1 year, the other for 9 years. For more characteristics of the participants, please see the attached study.

Method

The study had a qualitative design inspired by a modified phenomenology as the theoretical framework, and the method described by Malterud (103) was used for processing and analysis. In qualitative research, the phenomenological perspective is valuable for understanding subjective experiences and people's lived experiences of complex phenomena (104). The perspective can be useful in contributing to a deeper understanding of RTWSE, which is such a complex phenomenon.

Analysis

The basis of the analysis was the transcribed interviews. The analysis followed the four steps recommended by Malterud (103): get an overall impression, identify meaningful units, abstract the content, and summarise the content. The first step included multiple readings of the interviews to get an overall picture. The second step included separate analyses of each interview, and meaningful units were sorted into sub-themes and themes. Parts of the text were then extracted and combined with text describing the same phenomenon from other interviews, and themes and sub-themes were adjusted. The third step included abstracting the content of each theme and sub-theme and adjusting them further. The fourth step included summarising the condensed text and developing credible descriptions of the experiences of RTWSE.

Study IV

The aim of the study was to explore how people at risk for sick leave or on sick leave with CMD experienced RC.

Study design and procedure

The study was structured as a semi-structured interview study. Several PHC centres in Region Västra Götaland were involved in the recruitment process. Eligible participants were people with CMD and with experience of RC. They were on sick leave full-time or part-time or were at risk for sick leave. They had attended at least three meetings with a rehabilitation coordinator, or with the rehabilitation coordinator and other stakeholders in collaboration. Rehabilitation coordinators at selected PHC centres informed eligible participants about the study's design and purpose and, if interested, participants were contacted by the responsible researcher. All interviews were recorded and transcribed verbatim.

Participants

In total, fourteen participants were contacted; however, three declined participation, and eleven participants were interviewed. The majority of the participants were working full-time or part-time with self-reported symptoms of exhaustion disorder or depression. The sick leave period was varied from <4 months to 11 years. The participants had various amounts of contact with a rehabilitation coordinator, ranging from three meetings to multi-year contacts. For more on the characteristics of the participants, please see the attached manuscript.

Method

Studies II and IV both had a qualitative design with a qualitative content analysis, as described by Graneheim and Lundman (101, 102). Please see the method section under study II.

Analysis

The transcribed interviews were the basis for the analysis. The analysis began with multiple readings of the interviews to get a sense of the data and to get an overview. The next step included a detailed analysis of some interviews when meaning units were extracted and coded by the authors. The authors then compared and discussed the coding. All data was examined when meaning units were extracted and coded in the following analysis by the responsible researcher. Finally, a theme was formed after several re-groupings of sub-categories and categories. Discussions among all authors

regarding the analysis were continuously held, and preliminary results were also discussed in a research group consisting of OTs and PTs.

Ethical Considerations

Research that affects people always involves certain risks. The Swedish National Council on Medical Ethics (105) has presented some key ethical principles that need to be considered in research involving human subjects. These principles include human dignity, autonomy, informed consent, and integrity. The studies complied with these ethical principles as presented in the World Medical Association's Declaration of Helsinki (106). In the following text, the key principles (105) are considered in relation to the studies included in the present thesis.

In a humanistic perspective, all people are considered to have equal value, which is a fundamental ethical principle. Equal value includes certain fundamental rights that must be respected. A human being has inherent value, regardless of ability, and should never be regarded as merely a means to an end; rather all humans are ends in themselves (105). In the studies, respectful treatment based on human dignity has been an obvious starting point.

Autonomy refers to the right to self-determination. Every person has the right to make decisions about their life and actions as long as it does not violate others' right of self-determination (105). In the studies, there was a risk that people who sought care at PHC centres were anxious to get help and therefore believed they needed to please the staff by participating in the studies. Therefore, both the oral and written information stressed that participation was voluntary and could be terminated without any consequences.

Informed consent is linked to autonomy. To be able to exercise self-determination, the person needs access to information and to be able to understand what the different options may entail. The person must not be exposed to pressure or coercion (105). Both oral and written information about the studies was given, and informed written consent was obtained from those who chose to participate.

Integrity is close to the concept of human dignity and emphasises the inviolable value of the human being. There is physical integrity, which means that no one can examine someone's body without their consent. Psychological integrity means that a person's values and opinions must not be influenced (105). A risk within the studies that could affect the integrity of the participants was that sensitive information about health conditions was being used. To counteract the risks related to that, all data was managed carefully in accordance with the ethical approvals. Analyses were only performed with coded data, and results were presented so that individuals

could not be recognised. The integrity of the participants was also ensured by the oral and written information emphasising that participation was voluntary and could be terminated at any time without affecting treatment or other interventions.

Furthermore, the target group in the studies included people with mental illness; as it was possible that their symptoms might fluctuate, there was a risk of deteriorating mental health. The researchers have extensive experience working with the target group, and a plan was devised to contact the relevant PHC centre in the event of participants' deteriorating mental health.

The risks of the research needed to be weighed against the benefits. A benefit of these studies was that increased understanding of what persons on sick leave consider to be effective and meaningful interventions may improve the sick leave process. Knowledge from the studies may strengthen the role of the person on sick leave and create better interventions and therefore bring health improvements for the person. The studies may also provide new insights into aspects that facilitate or hinder the process of getting back to work and improve the sick leave process on a societal level.

Study I was reviewed and approved by the Regional Ethical Review Board at the University of Gothenburg in 2015, with the reference number 125–15. An additional application was approved in 2021 by the Swedish Ethical Review Authority, with the reference number 2021-00627.

Study II was reviewed and approved by the Regional Ethical Review Board at the University of Gothenburg in 2016, with the reference number 782–16.

Study III was reviewed and approved by the Regional Ethical Review Board at the University of Gothenburg in 2011, with the reference number 542–11.

Study IV was reviewed and approved by the Swedish Ethical Review Authority in 2021, with the reference number 2021-02343. An additional application was approved in 2021 by the Swedish Ethical Review Authority, with the reference number 2021-06285-02.

Results

Summary of the results

In study I, the findings showed that lower self-perceived health in terms of a higher number of reasons for seeking care and a lower SRH were determinants for sick leave in 12 months. Significant differences in proportions were found regarding symptoms between the groups with and without sick leave in 12 months, and the main reason for seeking care was mental symptoms followed by musculoskeletal pain. Through supported reflection and practice, the participants' belief in their capacity increased in the work-directed intervention in study II. The participants in study III experienced their RTWSE as a global phenomenon influenced by the work capacity, a will to be active and autonomous, and support from others. Rehabilitation coordination, in study IV, was experienced as a bridge with many bricks between the participants and society. The bricks symbolised the complex context of RC, where several stakeholders were involved.

Study I

During the 12 months after baseline, 35% of the total study population (n=271) had more than 14 days of sick leave.
In total, 15 reasons were given for seeking care, and it was possible to seek care for several reasons simultaneously. The main reasons for seeking care were mental symptoms such as fatigue, stress, sleeping problems, anxiety, and depression; mental symptoms comprised 55% of the reasons given. Musculoskeletal pain, including neck/shoulder pain, back pain, and other pain, was the second main reason for seeking care, comprising 22% of the reasons. The difference in proportion between W and W-SL was calculated with a 95% CI on each reason for seeking care. Significant differences in proportions between the groups were found for all mental symptoms but stress, and for all musculoskeletal and other symptoms.

The participants sought care for 638 reasons in total, and the median was one reason in the group of W and two reasons in the group of W-SL. There was a significant difference (p<0.001) between the groups regarding the number of reasons for seeking care according to the Mann-Whitney U analysis.

A high number of reasons for seeking care was a determinant for sick leave in 12 months (p=0.001) when adjusted for intervention/control and

educational level in a logistic regression analysis. The adjusted OR was 1.33 with the 95% CI 1.14-1.56.
A lower SRH was a determinant for sick leave in 12 months (p=0.008) when adjusted for intervention/control and educational level in a logistic regression analysis. The adjusted OR was 1.45 with the 95% CI 1.10-1.91.

Study II

The participants experienced the work-directed rehabilitation intervention as a process interpreted by the overarching theme *Increasing belief in one's ability through supported reflection and practice.* This theme reflected the shifting between "reflecting" and "doing" through rehabilitation and a growing hope for change. The increasing belief in one's ability was developed through three stages, comprising three categories and ten subcategories (Figure 3 and Table 2).

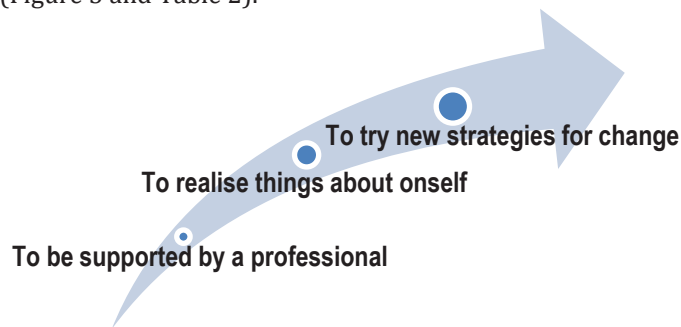

Figure 3. Illustration of the theme "Increasing belief in one's capacity by supported reflection and practice" and its categories.

Table 2. The categories and their sub-categories forming the theme.

To be supported by a professional	To realise things about oneself	To try new strategies for change
Seen and acknowledged	Increased body awareness	Practising recovery
Individualised approach	Grasping the consequences	Physical activity to increase energy
Being motivated	Practising acceptance	Setting boundaries
		Doing one thing at a time
		Changing the work situation

The participants valued the support of the professionals, and overall, they felt seen and mirrored. Based on their narratives and life situations it was vital for the participants to be heard. An individualised approach was also essential when tailoring rehabilitation plans to their needs. The flexible programme was important as they needed to integrate their rehabilitation with work and family commitments.

Realising things about themselves by reflecting brought new insights about the participants' work, health, and personal lives. New realisations often concerned valuing oneself; however, they could also give rise to feelings of guilt about having neglected important things in life or doubts about being capable of change. The participants also experienced a new awareness of their bodies and the fundamental needs for movement, rest, and food. Practising self-care and self-compassion increased acceptance and helped the participants make conscious choices.

Trying new strategies for change began by prioritising among activities. The participants reported lack of energy and tried strategies for recovery and increased sleep quality. Setting limits, such as by taking short breaks at work or by lowering inner demands by defining what was good enough, was important. The participants also expressed a need for change at the workplace. They wanted a different structure and work pace to prevent future sick leave. Even if it was challenging, the participants felt more courageous about standing up for themselves.

Study III

RTWSE emerged through the analysis comprising four main themes with a total of 10 sub-themes. RTWSE is understood as a global phenomenon reflecting the individuals' experience of a larger context. The findings were illustrated by a tree, where the roots consisted of the main themes that together affected the tree symbolising RTWSE (Figure 4). An overview of the themes and the sub-themes is presented in Table 3.

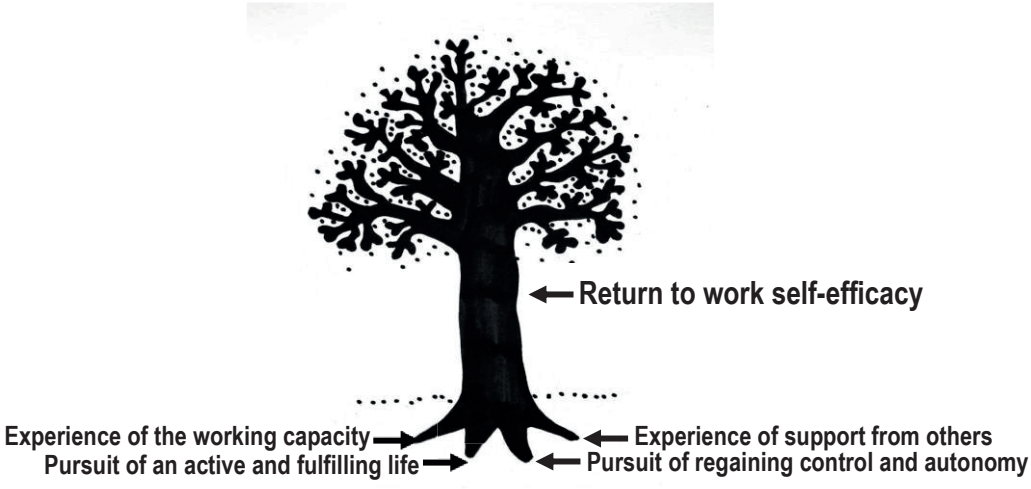

Figure 4. Illustration of RTWSE, symbolised by a tree, and the main themes, symbolised by the roots, affecting self-efficacy.

Table 3. Overview of themes and sub-themes affecting the experience of return to work self-efficacy.

The experience of the working capacity	Pursuit of an active and fulfilling life	Pursuit of regaining control and autonomy	The experience of support from others
The experience of health and the impact of sick leave	Wanting to participate	Gaining structure in everyday life	The experience of support from the individual's own network
The experience of general self-efficacy	To feel meaningfulness	Having strategies to return to work	The experience of support from the workplace
		To be financially independent	The experience of support from the societal organisations

The participants' experience of their working ability affected RTWSE. The working ability was in turn affected by the experience of health and the influence of the sick leave. The experience of general self-efficacy also affected working ability. It was important to keep believing in oneself and take active decisions concerning one's life. Being able to work again was expressed as an obvious goal and revealed a higher RTWSE. A lower RTWSE was shown in the uncertainty about one's work ability or even one's ability to find a work.

The pursuit of an active and fulfilling life was expressed as a will to be part of a workplace and of society in general, which strengthened RTWSE. Meaningful work suited to one's qualifications was important and gave a sense of being valuable. Working together, having responsibilities, and being in control over one's working hours were experienced as fulfilling and empowering.

The pursuit of regaining control and autonomy was formulated as a need to gain structure in everyday life for the participants. Work provided routines and security, and it was important to keep up routines during the sick leave period. It was also important to have strategies for returning to work. However, having experienced strategies that did not work or having a lack of strategies could decrease RTWSE. Another important driving force for returning to work was the desire to be financially independent and to support oneself.

The experience of support from the individual's own network of family and friends or business networks affected RTWSE. A supportive workplace with social support from both colleagues and managers was also important. Support from societal organisations such as healthcare providers, the SSIA, or insurance companies had a major impact on self-efficacy. Overall, it was important to have professional guidance and support to feel safe when returning to work. The organisations should also include all aspects of life in their assessments. However, conflicting information created a strong distrust for the organisations involved, and feelings of not being understood decreased RTWSE.

Study IV

Rehabilitation coordination was experienced in an overarching theme as *Building a bridge with many bricks between the person and society*, with the aim of regaining work capacity and health. The theme was formed by four categories reflecting the complex context of RC, as many bricks were needed to build the bridge between the person and society (Table 4).

Table 4. Overview of the theme and the categories showing the experience of RC

Building a bridge with many bricks between the person and society			
Collaboration in a new setting	**Unburdened within certain limits**	**The way back to work is a joint project**	**Recognising challenges beyond the person**

Rehabilitation coordination was experienced as a collaboration in a new setting. The participants had no previous knowledge of RC regardless of the length of their sick leave. They expressed that they needed accessible information about RC in order to make their own decisions, and they wanted early support. The rehabilitation coordinator was experienced in the sick leave network and was able to transfer information among the stakeholders, both within PHC and externally. The support was empowering and provided new perspectives. A good interplay between the rehabilitation coordinator and the person was experienced as a basic condition.

The participants were unburdened within certain limits by RC. Being on sick leave was demanding as the participants took great personal responsibility in the process, and sharing some of the responsibilities with the rehabilitation coordinator relieved their burden. However, if they perceived that the professionals were stressed, the participants were reluctant to ask for information.

Getting back to work was perceived as a joint project, and collaboration among all stakeholders, especially the workplace, was a foundation for a sustainable RTW. Early interventions supported by rehabilitation plans prevented decreasing motivation and were perceived as important. Without work adjustment, rehabilitation interventions were useless, and the risk of going back on sick leave was higher, according to the participants. Support from colleagues and managers, and three-party meetings with the participant, the manager, and the rehabilitation coordinator were perceived as important.

The participants recognised challenges beyond themselves, and that RC was important but not sufficient in helping them to regain health and be able to work again. Comprehensive measures at a societal level to promote health and to understand mental illness were needed, according to the participants. The participants also experienced that being on sick leave could affect self-esteem and generate feelings of guilt. A lower understanding and tolerance at work was understood as a lack of knowledge in society about mental illness.

Discussion

Summary of the process between work and sick leave

In the dynamic process between work and sick leave, the studies included in the present thesis are located in different but overlapping phases in the dynamic work disability model from Labriola (7). In the first phase, at work, people worked while having symptoms and experiencing lower self-perceived health. During the following year they had an increased risk of sick leave (study I). In the same phase, where people were working while ill, and in the two following phases, short-term and long-term absence, where people were on sick leave part-time, a work-oriented intervention could increase the people's belief in their capacity (study II). In the long-term absence phase, some people were on full-time sick leave. They experienced RTWSE as a global phenomenon shaped by their driving forces and by the support from the environment (Study III). People experienced RC as a bridge between them and society. They were in the long-term absence phase or had started working again, and by doing so they had returned to the first phase, at work (study IV).

According to the dynamic RTW model with four phases by Young et al. (57), some of the participants in study I entered the first phase, off work, while the participants in studies III and IV were located in this phase from the beginning or were in the second phase, re-entry (study IV). Some of the participants in study II were also in the re-entry phase or the third phase of maintenance.

The PEO model in the sick leave process

In the following discussion, the results will be reviewed with the help of the transactional PEO model (26) and with the person's perspective as a point of departure within all parts of the model. An adaptation of the PEO model (26) to suit the context of the present thesis has been designed as follows: the person is the one who is at risk for, or is on, sick leave; occupation is the specific occupation of paid work or vocational rehabilitation in a workplace, in contrast to the PEO model (26), which includes all daily activities; the work environment is in focus in the model, but the larger social and societal environment is included according to the original model; occupational performance is the work performance affected by the risk for sick leave at the

point of intersection that is influenced by all parts of the transactional whole (Figure 5).

Figure 5. The Person-Environment-Occupation model adapted from Law et al. (26).

The person at risk for sick leave, or on sick leave

In all four studies, different perspectives were found reflecting the person's perception of health and the influence of sick leave. The qualitative studies involved reflections about the life situation and strategies for going back to work.

The complex assessment of SRH and RTWSE

The assessments of SRH and RTWSE are complex processes. In study I, where the study population worked at baseline, the participants estimated their health by indicating symptoms and by estimating SRH. It was shown that comorbidity and lower SRH at baseline increased the risk of sick leave within a year. The results revealed that this, apparently healthy, group may need preventive measures to avoid future sick leave. Substantial research has shown, in a similar way, the connections between SRH and sick leave, where a lower SRH increased the risk of sick leave (107) and also of permanent work disability (108). The ability of SRH to predict the risk of sick leave may have to do with the overall assessment that people make of their own health. People may include physical health, ability to function, and general well-being (109). Health perceptions are also influenced by norms and

values of the surrounding society (24), and therefore the assessment of SRH transacts with the environment in the PEO model.

Study III explored how people on sick leave experienced their RTWSE. This was an overall assessment of important parts of a person's life. In study III, the assessment of RTWSE also transacted with the environment in the PEO model. Both SRH and RTWSE could, in different ways, reflect the complex assessments people made of their health and their work and life situation. Research has shown that RTWSE is a strong predictor for RTW (110, 111). The combination of self-understanding present in the self-rating combined with an assessment of environmental factors might explain why self-rating often predicts sick leave or RTW in a reliable way.

Studies II and III both highlighted different aspects of self-efficacy. Self-efficacy refers to what we *believe* about our performance rather than to how we truly perform (43). An overly negative self-efficacy may affect work ability as an employee with low self-efficacy risks performing work tasks below their actual ability, and they may not even be aware of their belief. On the other hand, self-efficacy that is too high may give a person an unrealistic picture of their work ability.

In study II, the overarching theme described an increasing belief in one's ability, which may be implicitly understood as increased self-efficacy. The study showed that the participants' self-efficacy increased through the unique combination of reflection and practice characterising rehabilitation interventions with occupational therapy and physiotherapy. Usually, self-efficacy beliefs promote the expected outcome, and confident persons expect positive outcomes (44). In this process, self-efficacy may have increased partly through what Bandura (43) calls enactive attainment, the experience of being able to do something oneself, and partly through vicarious experiences, having others as role models. In study II, the therapists were seen as inspiring role models, which made it easier for the participants to try new strategies. Here the therapists were part of the social environment in transaction with the person.

In study III, the explicit aim was to explore self-efficacy for going back to work after sick leave, and a person's general self-efficacy was the basis for the specific RTWSE. There were also driving forces directed towards the work concerning a meaningful life and regaining control and autonomy. Similar findings regarding the advantages of RTW among women during/after long-term sick leave for CMD have been reported (90). Having meaningful work, getting a salary, and having daily routines were perceived as advantages of RTW (90). In study III, there was a transactional interplay between the person's driving forces and work, and self-efficacy influenced these driving forces.

Empowerment as a transaction

Empowerment was found as a transaction between the environment and the person in studies III and IV. In study IV, it was found that people's perception of themselves and their own roles were affected by the treatment they received from other stakeholders. People in study IV were empowered and gained new insights when the interplay worked well.

Empowerment is a concept reminiscent of self-efficacy, and in healthcare it is described by WHO (112) as a process where people should be given greater control over decisions and actions affecting their health. However, this definition of patient empowerment can still be interpreted as the patient being a passive recipient, at least initially, to be trained in the role of an active patient. The WHO (112) definition reflects the hierarchical medical system that is dominant in healthcare, while empowerment per se can be seen as an ambition to distance healthcare from this system.

Another way of defining empowerment is as a process of gaining control over one's affairs at multiple levels: the individual level, the organisational level, and the societal level (113). People in study III, who were on sick leave, wanted to regain autonomy and control over their lives at an individual level of empowerment. In study IV, the participants found themselves in an inferior position vis-à-vis the healthcare system at an organisational level. Although they experienced support, they also needed to adapt to the professionals in a way that made them feel less empowered.

For a patient in the healthcare system, inferiority can be described on three levels: as institutional, existential, and cognitive inferiority (114). Institutional inferiority concerns the hierarchical organisation of the healthcare system, where the person often experiences being at the bottom of the hierarchy. Existential inferiority consists of the suffering and vulnerability that ill health creates, and cognitive inferiority concerns the person's lack of important skills and knowledge, even if the person has some knowledge and has searched for information in advance (114). For people on sick leave, this subordination can be experienced in multiple ways, as several stakeholders are involved, which accentuates the vulnerability. Empowerment, based on the perspective of those on sick leave in studies III and IV, could therefore be described as a transactional relationship between the person and the environment represented by the various stakeholders.

The experience of empowerment was dependent on the approach of the stakeholders in this transactional interplay as the stakeholders could empower or disempower the person.

Internalised stigma as a transaction

Indications of stigmatisation were found in study IV, where the participants had feelings of guilt for being on sick leave. Stigma is defined as negative characteristics devaluating and segregating people from participating in society (115) and is often divided into public and internalised stigma. Public stigma expressed in prejudices and discrimination often affects people with mental illness. Internalised stigma is a process explained by the modified labelling theory (116). In the socialisation process during childhood, the norms and values of society are learned, and stereotypes and prejudices are often accepted by people labelled with mental illness disorders (116).

A recent systematic review has investigated how health-related stigma affects sustainable employment and well-being at work (117). The attitudes and behaviour of employers as well as the internalised stigma in people with health problems created barriers to employment and well-being at work (117). The internalised stigma undermined the motivation to find or maintain work, and people with disabilities accepted being subjected to discrimination. The stigma could also deter people from seeking care, resulting in deteriorating health, which in turn could decrease work ability (117). In line with these findings, the experience of internalised stigma in study IV was understood as a transactional interplay between the person and the environment, both the workplace and society at large.

Strategies in relation to work

New insights in relation to work and applying new strategies at work were found in studies II and IV through the support of preventive rehabilitation interventions (study II) or through RC (study IV). According to the participants, knowledge of the requirements and conditions of work and a PCA were essential for rehabilitation interventions. Making rehabilitation plans and working in a team were considered important by the participants. However, the participants experienced rehabilitation plans without connections to the work as meaningless, and they increased the risk of new periods of sick leave. Going back to work therefore involved planning and preparation, where several stakeholders, not least the employer, needed to be involved and able to collaborate. Comparable findings on the importance of including the employer in the return-to-work process have been shown in interdisciplinary pain rehabilitation (118) and in ReDO, an occupation-based intervention (119).

Implementing rehabilitation plans at the workplace might be challenging, and Ilmarien (53) describes a knowing-doing gap between the extensive knowledge available about the challenges in workplaces and how this knowledge should be turned into action. It seems easier to increase

knowledge than to implement successful interventions to improve work ability. According to Ilmarinen (53), less successful interventions are due to a lack of prioritisation of actions, difficulties in involving the employees and management, and outcomes that are not sufficiently sensitive to changes. In the PEO model, work-directed plans were integrated in a transactional interplay between the person, the paid work or vocational rehabilitation, and various stakeholders in the environment, mainly the workplace, but also healthcare professionals, the SSIA, and occupational health services (OHS).

Paid work or vocational rehabilitation

Paid work or vocational rehabilitation involved a transactional interplay with the person and the work environment according to the PEO model, and the interplay was present in all the studies. In studies II, III, and IV, the participants reflected on their work tasks and possible work adaptations. The actual performance of real work tasks was not in focus in the studies; however, the participants demonstrated an awareness of the requirements of the work in relation to their own abilities.

There are well-established instruments for assessing both the requirements of a work task and how a person performs a specific work task. Assessment of work characteristics (AWC) assesses the general demands of a work task and is based on the assessment of work performance (AWP) assessing a person's observable performance in a work task (120). These work assessments can be used with all kinds of work disability and in both real-life workplaces and in constructed work settings (121). The AWC gives a requirement profile and AWP gives a skill profile (120); however, as they do not provide answers on how the environment may affect work ability nor on how the person experiences the work ability or the demands that are made complementary assessments may be necessary.

Work assessments of any kind need to be valid and reliable as they often form the basis for future interventions and decisions about eligibility for sickness benefits (121). A recent study has shown that an extensive insurance medical assessment of general work ability had limited value as a predictor for future sick leave (122). In this study, only the self-rated work ability had a predictive value for future sick leave and a possible explanation was that self-rated work ability reflected a more holistic understanding of the situation (122). These findings are in line with the results of studies II, III, and IV, where the participants expressed a holistic view of work as one part in their occupational life and the need to understand the ability to work in a larger life context.

The work, social, and societal environment

The environment played a fundamental part in the transactional interplay with the person in all the studies. The environment in this context is defined as various aspects of the work environment (colleagues, managers, and workplace), the social environment (family, friends, and healthcare professionals), and the surrounding societal environment (stakeholders, laws, and norms).

Supportive work and social environment

The importance of the psychosocial work environment for enabling RTW was described by the participants in studies II, III and IV. The support of managers and colleagues was vital, and lack of support was perceived as a major obstacle. In studies II and IV, the contacts with healthcare professionals such as OTs, PTs, or rehabilitation coordinators were a source of support and inspiration, and in study III, the person's own network, including family and friends, was vital. In summary, the psychosocial work environment and the professional and personal social environments were of great importance for the way the persons handled the situation, and a perceived lack of support from any party could prolong the sick leave process.

There is considerable research showing the importance of social support for returning to work (123, 124). Workers who had partially returned to work and were partially on long-term sick leave stated the need for support from supervisors, colleagues, healthcare professionals, family, and friends (123), in line with the studies included in the present thesis. Supportive guidance provided by a rehabilitation coordinator was central for persons on sick leave with exhaustion disorder participating in a dialogue-based work-directed intervention (124). A workplace dialogue with support from a PT for persons with pain was experienced in a similar way (125), and the findings are comparable to the results in study IV, where the participants valued structured workplace dialogues.

The importance of communication and trust

The importance of good communication and trust in the assessment of work ability was found in studies III and IV. The assessment of work ability in the sick leave process can often be demanding for the GP, who needs to understand the complex relations between work, health, and social security (126, 127). Lack of time and methods to evaluate the workplace has been reported by GPs, and they rely largely on information from the person seeking care (126).

Good communication between the participants, the GP, and the SSIA was of great importance for the participants in studies III and IV, and the decisions made by the SSIA had to be understood by the participants to be perceived as legitimate. These studies revealed that contacts with the SSIA could be problematic, and when the decisions were not understood, it created frustration and lowered trust in the SSIA. This in turn affected RTWSE and the coordination process and was perceived to prolong the sick leave.

Trust in the various stakeholders in the sick leave process and being able to understand the decisions being made were therefore important for the participants, and similar conclusions were made in a qualitative study concerning people's confidence in the SSIA (128). In line with this, a longitudinal qualitative study has shown that a common form of distrust between stakeholders was the frustration of the person on sick leave and the treating physician when the sickness certificates were diminished by the SSIA (129). In studies III and IV, the assessment of work ability showed a transactional interplay particularly affecting the person in transaction with the societal environment.

The importance of respectful encounters and good communication in the sick leave process is a recurring theme in scientific literature (128, 130, 131). A vast majority of women on long-term sick leave experienced positive encounters with healthcare professionals, and about half expressed that these encounters facilitated RTW (130). That healthcare and social insurance professionals believed in the work ability of persons on long-term sick leave was significantly associated with promoting the ability to RTW. Other positive encounters with significance for the ability to RTW were being encouraged and being supported in taking responsibility (131).

Collaboration and preventive measures

A need for collaboration between the different stakeholders in the sick leave process was emphasised by the participants in studies III and IV. Collaboration between different stakeholders is often challenged for organisational and structural reasons (132). From a system theory perspective, the various stakeholders have different values and objectives with their actions, and they can therefore come into conflict with each other (54). Good collaboration depends on all stakeholders understanding each other, and open and transparent communication is a fundamental condition (133). Ineffective communication with delayed information between the stakeholders is a barrier to RTW. In contrast, RTW is supported by effective communication, teamwork, and a trustful and credible relationship among the stakeholders. Interdependence seems to exist between human interactions and organisational structures (133) in line with the transactional model of PEO.

In study IV, the participants described challenges at a societal level, and comprehensive measures to promote health at work were suggested. There

is a need for preventive measures for people who are at risk of sick leave and for rehabilitative measures for people on sick leave. There is limited research focusing on interventions that include both symptom relief and increased work ability. Most studies investigating rehabilitative interventions in CMD for people on sick leave have focused on psychotherapy and, despite symptom relief, these interventions have not necessarily resulted in return to work (91). Regarding MSD, different approaches in European countries for prevention, rehabilitation, and RTW have been compared (134). Preventive measures were expressed in a theoretical manner, and no country had a national approach for rehabilitation of this group. Moreover, rehabilitation interventions in the workplace seemed to be used incidentally (134). For both CMD and MSD there are still few studies on how preventive rehabilitation efforts with occupational therapy and physiotherapy may improve work ability and reduce the risk of sick leave.

Enhance knowledge and tolerance

A need for increased knowledge in society about mental illness to enhance tolerance at workplaces was expressed by the participants in study IV. Stigmatising attitudes and behaviours of the employers are known to create barriers to employment and well-being at work (117). Employers have been showing discriminatory behaviours based on health-related stigma, which has hindered people with disabilities as they try to find and maintain work. Employers have been questioning the work ability and competence of people with disabilities or have believed that they could even be dangerous or violent. Employers have also been denying work accommodations. Coworkers have held the same stigmatising beliefs as the employers, and coworkers have been focusing on the disability rather than the work ability. Health-related stigma also affected stakeholders outside the workplace. Health professionals, who have a medical perspective, have been focusing on the disability. Therefore, they could have a discouraging role if they express a lack of belief in the person's ability to work (117). Employment and well-being at work are consequently threatened by both public and internalised stigma, and in the PEO model there is a transactional interplay between the work environment, the social and societal environment, and the person.

Summary with the PEO model

An overall summary of the findings regarding the dynamic process from working, being on sick leave, and going back to work based on a person-centred perspective using an adaptation of the PEO model is shown in Figure 6. Person-centredness was formed by the environment as the person was

depending on the transactional interplay with the environment, and the interplay was not always person-centred. In the dynamic process between work and sick leave, the person's self-perception was vital and expressed through self-perceived health, RTWSE, empowerment, and internalised stigma. Strategies related to RTW were also important for the person. Rehabilitation plans had to be based on knowledge about the working conditions, and they had to be created in collaboration. The support of the environment, good communication, trust, and collaboration between all stakeholders were essential for the person. In a larger perspective, the person expressed a need for preventive measures and increased tolerance for mental illness in society for developing sustainable working conditions. At the point of intersection between the circles, the person's work performance was shaped. The adapted PEO model is a way of illustrating the results in the present thesis and does not claim to give a comprehensive picture that can be generalised.

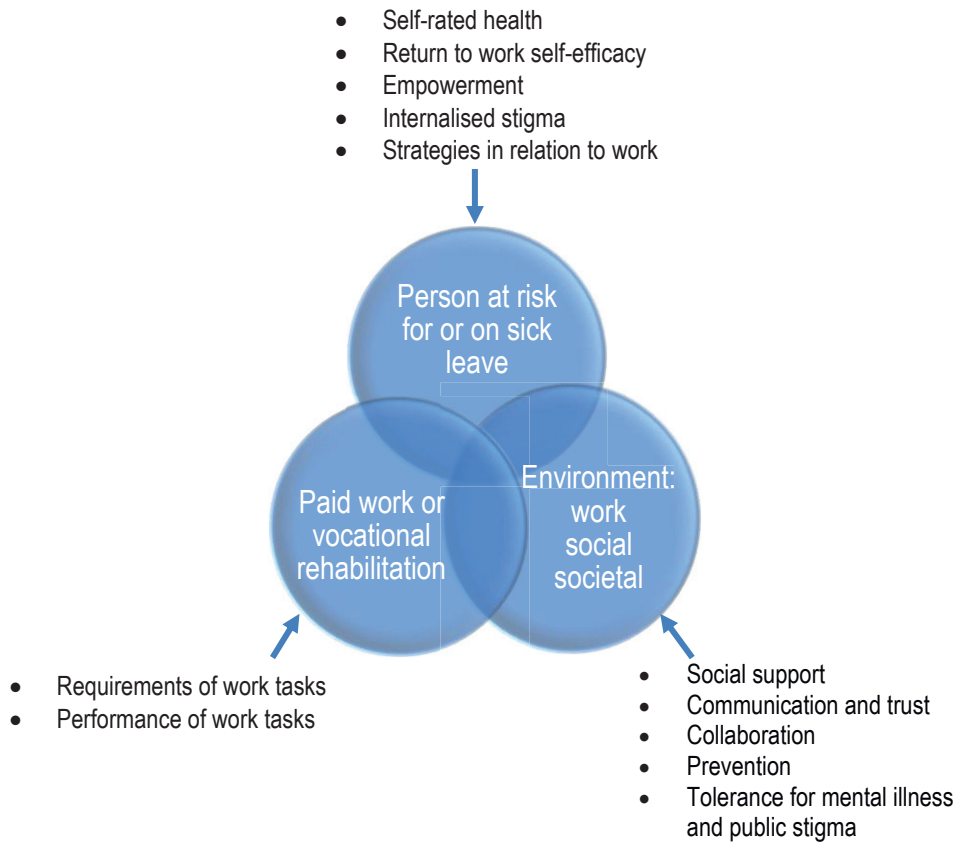

Figure 6. The Person-Environment-Occupation model adapted from Law et al. (26).

The tables below (Tables 5-7) show the concepts, categories, and themes that have been included in the adapted PEO model based on person, occupation, and environment.

Table 5. Person

Study	Person at risk for or on sick leave
I	Self-perceived health
II	Increasing belief in one's ability, to realise things about oneself, to try new strategies for change
III	RTWSE, the experience of the working ability, pursuit of an active and fulfilling life, pursuit of regaining control and autonomy
IV	Collaboration in a new setting, unburdened within certain limitations

Table 6. Occupation

Study	Paid work or vocational rehabilitation
II	To realise things about oneself, to try new strategies for change
III	Pursuit of an active and fulfilling life, pursuit of regaining control and autonomy
IV	The way back to work is a joint project

Table 7. Environment

Study	Work, social, and societal environment[1]
I	Societal: Self-perceived health, sick leave
II	Work: To be supported by a professional, to try new strategies for change
III	Social and societal: Experience of support from others
IV	Work and societal: Collaboration in a new setting, the way back to work is a joint project Societal: Recognising challenges beyond the person

Note: [1] The environment is divided into work environment (colleagues and managers, workplace), social environment (family and friends, healthcare professionals), and societal environment (stakeholders such as SSIA, OHS, healthcare, laws and norms).

The capable person in the sick leave process

In the following section, person-centred ethics in relation to people who live in the dynamic process between work and sick leave will be discussed. Based on the philosophy of Ricoeur (135), together with explanatory comments from the philosopher Kristensson Uggla (114, 135), an exploration of the capable person in the sick leave process will be made.
Ricoeur (135) formulates a philosophy of action based on a view of the human being as fundamentally capable, *a homo capax*. He sees capable persons taking responsibility for their actions and recognizing themselves and others as capable. Capable persons are continuously relating to others, and may appreciate others as they do themselves. It is therefore not a self-absorbed or omnipotent person that Ricoeur (135) is referring to, but one who knows their limitations. The capable person is both acting and suffering and realises the fragility of existence and their own and others' ultimate limit as mortals (135). Such a view of humanity may call for humility in the face of life's adversities and in understanding people's vulnerability. In the qualitative studies of the present thesis, the participants showed that a person on sick leave is fundamentally capable as a human being: in study II there was an increased belief in one's capacity; in study III there was a pursuit of an active and autonomous life; and in study IV the participants expressed their responsibility in the sick leave process. At the same time, the existence of illness made the suffering more acute for the participants and increased their vulnerability. The importance of support from the environment may be understood based on the vulnerability experienced by the participants.

According to Ricoeur (135), the self is perceived as both reflexive and relational and is formed in encounters with others: it is not about myself, but about *oneself on the same level as another*. Ricoeur's emphasis on reciprocity and the equality of people is perceived as central in his action philosophy (135) and counterbalances society's emphasis on the individual as autonomous. Self-reliance and autonomy also have a downside, which appeared when people on sick leave in the qualitative studies lost part of their autonomy and were in a situation of dependence on healthcare, the SSIA, employers, and other stakeholders. The participants in study IV experienced a stigma about being on sick leave and no longer being the capable, self-sufficient people they once were, and the participants on sick leave rarely experienced themselves as on the same level as others.

To comprehend who someone is, it is essential to listen to the narrative of what someone is (114). Ricoeur (135) considers the narrative identity of the capable person as significant but at the same time fragile and deceptive. He underlines that to narrate oneself is also to be able to narrate oneself in new ways, and a critically reflective attitude is necessary (135). The narrative of the patient has great importance in person-centred care, both to understand who someone is behind the descriptions of what they are and to

establish a partnership between patient and caregiver (37). In studies II and IV, a respectful encounter with the healthcare professionals built that kind of partnership. The influence of person-centred encounters was described by the participants in study IV as they stressed the difference between being seen as a patient with a diagnosis and as a person with experience and knowledge who also suffers from an illness. The participants underlined the importance of being seen as a person beyond the limiting framework of the diagnosis, and they emphasised that people with the same diagnosis nevertheless were different and unique. The uniqueness of the person needed to be recognised as well as the patient role and the diagnosis (114). Diagnosis and treatment are the main missions of healthcare delivery; however, these must not come at the expense of recognising the human nature of the patient, who always remains a person. Still, it is important to have a critical approach to what is narrated and to understand that it reveals one of several perspectives (114). The narrative of the person on sick leave needs to be weighed together with information from other stakeholders to create an overall picture, which the participants with experience of RC were aware of and supported in study IV.

For Ricoeur (135), ethics relates to what makes life worth living, and the ultimate goal of our actions is a good life. He states that it is not an egoistic pursuit but *a pursuit of the good life with and for others within fair institutions.* The ethical pursuit of living a good life includes the self in first person (the pursuit of the good life), second person (with and for others), and third person (within fair institutions). The self is reflected at all levels, from first to third person, and all parts are interdependent and presuppose each other in a complex interplay (135). The ethical pursuit of the good life relating to fair institutions concerns the larger societal perspective that includes justice for all. Institutions, according to Ricoeur (135), are the collective structures of coexistence of a people or state that are characterised by shared customs rather than enforced rules of authority. A good life therefore involves a further determination of the self as everyone, and a quest for justice and equality is the foundation of all institutions (135).

For the people on sick leave in the present thesis, the interplay with institutions such as healthcare, the SSIA, and various stakeholders in working life was extremely important. The threefold inferiority in the form of institutional, existential, and cognitive inferiority (114) is further reinforced by the multitude of stakeholders. The qualitative studies in the present thesis showed the vulnerability of people on sick leave. It became evident that the institutions were responsible for expressing and conveying their pursuit of justice and equality to those on sick leave. When different stakeholders assessed a person's ability to work in different ways, or had various opinions about appropriate interventions, conflicts often emerged. In this situation, according to Ricoeur (135), the practical wisdom that considers the specific situation guided by ethics might solve the conflict. There are no universal

norms that are appropriate everywhere and, in the end, capable persons rely on their own practical wisdom (114).

To conclude this section, the qualitative studies in the present thesis have shown that the person on sick leave is both capable and suffering. An asymmetric reciprocity will always exist in the encounters between the person on sick leave and the institutions (114). An important lesson is that the responsibility for reducing the asymmetry always lies within the institutions. When the participants in the qualitative studies of the present thesis were met as capable persons with both abilities and limitations, this asymmetry decreased. They described an increased belief in their capacity and trust in the institutions that were able to act in coexistence.

In contrast to Ricoeur's (135) concept of person-centred ethics, including institutions at a societal level, traditional occupational therapy has been almost exclusively focused on person-centred individual interventions within healthcare institutions (26). However, the PEO model may also be used at a group level, and the model can facilitate a shift for occupational therapists by expanding their field of work to the rest of society (26). The person-centred approach is similar whether it concerns a person, a group, an organisation, or a larger population (26, 27), and the group level is what Ricoeur (135) names institution. The PEO model therefore enables occupational therapists to improve health and participation at an institutional level. In working life, occupational therapists, with their expertise in the transactive approach to occupational performance, may contribute valuable knowledge that can facilitate the transition between sick leave and work and create conditions for a sustainable working life.

Methodological considerations

The methodological choices and challenges in the studies and how they may have influenced the results will be discussed in the following section. Quantitative and qualitative methods have different epistemological points of departure and complement each other. Quantitative research is part of a naturalistic tradition of knowledge which assumes the existence of a shared objective reality where phenomena are measurable, and quantities of phenomena can be compared (136). Qualitative research is part of a humanistic tradition of knowledge which assumes that people perceive reality in different ways, and the research strives to describe subjective experiences and perceptions of various phenomena (136). The present thesis had a multimethod design that included both a quantitative and a qualitative approach, which was a strength that enabled a broader understanding of the process between work and sick leave. The choice of suitable methods was based on the research questions for each study and an interest in various methods, and they were also chosen with the existing limitations in time and funding in mind.

The quantitative study (study I) will be discussed based on the quantitative concepts of internal validity and external validity. External validity is also referred to as generalisability (137). The qualitative studies (studies II-IV) will be discussed in relation to the qualitative concept of trustworthiness, including credibility, dependability, and transferability (101).

In study I, the internal validity, which means that the study measures what it is intended to measure, may have been affected by the small study population. The results therefore need to be interpreted with caution. At the same time, it is well known that poorer SRH increases the risk of sick leave (107, 138), which confirms the results of the study. The SF 36 (21), which measures SRH, is considered a valid measurement of health and is a well-established research instrument (139). Validity was further strengthened by using register data for sick leave, which reduced the risk of recall bias and dropouts. The groups that were compared were equivalent socio-demographically, which also strengthened the validity.

Study I showed an association between self-perceived health and sick leave at a group level. However, sick leave is a complex phenomenon involving multiple interacting factors in a transactional whole. The sick leave process is influenced by factors in the environment such as psychosocial factors, work environment, and the laws and norms of the society. Since reality is complex and changing, other aspects might have an effect over time, affecting the external validity or generalisability.

Various aspects of trustworthiness are important to highlight in the qualitative studies. Credibility concerns how well the data and analysis respond to the aim of a study (101). The choice of method for data collection and selection of participants lays the foundation for credibility. Conducting individual semi-structured interviews was considered a credible data collection method in all the qualitative studies. The interview format gave the opportunity to adapt and deepen the questions for each participant while at the same time maintaining the focus on the aim of each study. The study participants were selected because they had knowledge in the field, so-called purposive sampling. This provided deep and rich information about the phenomena being studied. The participants were also heterogeneous in terms of age, occupation, and background, which contributed to greater variation in information. However, a clear majority of the participants were women in all the studies, which may be due to the fact that more women are on sick leave (70) and that they have a greater burden of disease (140).

The credibility may have been affected due to dropouts in the studies. In study II, those who had participated in the work-directed rehabilitation intervention were interviewed, with a dropout of three participants. It is possible that those participants declined due to negative experiences, in which case valuable information was lost. In studies III and IV, potential participants received information about the studies via OTs, PTs, or rehabilitation coordinators, and it is possible that those with negative experiences were not asked or declined to participate. To counteract this, the information to

the professionals emphasised that everyone who met the inclusion criteria would receive information about the studies, and the results showed both positive and negative experiences. A further aspect regarding dropouts is the professionals' intentions to protect vulnerable patients and therefore not even provide them with the information. Such comments appeared in contacts with rehabilitation coordinators in study IV and were also made by GPs in PHC settings (141).

Difficulties in recruiting participants for studies is a well-known hindrance in research (142). According to Lasagna's law, the number of potential participants drops by 90% as soon as a study starts and increases to 100% again as soon as it ends. The "law" is a way of describing how it is easy to overestimate the number of potential participants (142). Within PHC there are organisational barriers for research. PHC has high demands on accessibility, and the professionals often work under time pressure and need to prioritise their efforts (143). The professionals may also be challenged by a lack of resources and collaboration (127), resulting in little or no time for participation in research. One strategy for recruitment was therefore to engage several rehabilitation clinics (study III) and PHC centres (study IV) in order not to place too much pressure on any one unit, and to plan carefully in advance for a flexible recruitment. In study IV, the recruitment of participants took 6 months, and the Covid pandemic at the time may have influenced the process. To facilitate participation, the possibility to conduct interviews digitally was offered, however, only one participant accepted. Most participants wanted to meet for an interview. In both forms of meetings, body language and facial expressions were visible, but the possibility of creating a safe environment for the interview might have been greater in the physical meetings (144).

The credibility is also affected by the quantity and the quality of the data (101). Presenting examples of the analysis process in studies II and IV might enable the reader to evaluate the credibility of the analyses. Representative quotes were also selected in all studies to show the connection between the data and categories or themes. The optimal amount of data depends on the aim of a study and the quality of the data, not on the number of participants (102). The relatively small number of participants in studies III and IV could have affected both the credibility and the transferability. However, the data was perceived as sufficient as the analyses provided rich and nuanced descriptions of RTWSE and RC respectively. Malterud et al. (145) suggest that the concept of information power should replace saturation in qualitative research. Saturation, originating from grounded theory, is used within other qualitative approaches without further explanation (145). In a model, Malterud et al. (145) introduce five dimensions that influence information power: study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy. The model is intended as a pragmatic tool for assessing sample size in an ongoing process during the analysis. The model is proposed to facilitate a shift from the number of participants to

recognising the new knowledge provided by the analysis (145). In the qualitative studies of the present thesis, the five dimensions for achieving information power according to Malterud (145) have been evaluated. The aims were relatively broad, no established theory was used in the analysis process, and the analysis strategy with a cross-case analysis required a larger number of participants. However, a purposive sample generated higher sample specificity, and the quality of the dialogue was considered predominantly strong which implied fewer participants, and the overall evaluation was that the information power was sufficient.

To strengthen the credibility in the analysis phase, the various phases were described as clearly as possible in the studies. Through triangulation, the authors had ongoing discussions about the analysis. Parts of the analysis in all the studies were performed in parallel by the authors, and thereafter, comparisons were made together in the group. On some occasions, the analyses were discussed in a larger group of researchers as well. Absolute consensus was not the goal and may not always be desirable (101). However, it was essential to listen to the different perspectives that came up in the discussions and to be open to various interpretations while the participants' voices, as conveyed by the interviews, remained in focus.

Dependability concerns how data may change over time and how the decisions of the researcher may evolve during the research process (101). Triangulation was a way to increase the dependability, but it was also important to take a self-reflective stance and be aware of one's pre-understanding as a researcher (101). Long clinical experience as an occupational therapist in the field of rehabilitation and return to work has given the author a deeper understanding of the research area, which has been experienced as a strength and a prerequisite for carrying out the studies. At the same time, it has been essential to have an open mind and a critical reflective approach to gain new perspectives.

Transferability concerns the extent to which the results can be transferred to other groups or contexts and has its counterpart in generalisability in quantitative research (101). By describing the method, recruitment process, and participants as well as the analysis process as clearly as possible, the evaluation of the transferability in the studies was facilitated. Still, it is ultimately the reader who decides about the transferability (101). There are some similarities with other research findings and the results of the studies, suggesting that there may be a certain transferability. Ideally, future research may strengthen the elements of the studies that are transferable to other contexts.

In summary, the various aspects of trustworthiness are overlapping and interdependent. During the course of the studies, efforts were made to highlight the participants' experiences and perspectives in a trustworthy way, as it is a group that has valuable experiences worth listening to.

Conclusion

People situated in the dynamic process between work and illness have valuable knowledge regarding what they experience as respectful encounters and what interventions they find meaningful and effective. The findings from the present thesis suggest that their experiences may facilitate planning and interventions for all stakeholders involved. To achieve this, a PCA is a prerequisite, and the responsibility for person-centredness remains with the various stakeholders involved.

The findings of the present thesis indicate an increased risk of sick leave for groups that are common within PHC. These groups are people with comorbidity, a lower SRH, and CMD. They might need early preventive measures to reduce the risk of future sick leave, which often requires collaboration between different stakeholders. However, both internal and external collaboration at PHC centres is challenged for organisational reasons. When the collaboration between the person on sick leave and other stakeholders functions well, people on sick leave experience the sick leave process as more efficient. A functioning collaboration and person-centred rehabilitation interventions with FTs and OTs may also generate increased self-efficacy for the person on sick leave. Self-efficacy, like self-perceived health, influences the length of sick leave and return to work. It seems that it is the person's overall assessment of the situation that makes self-efficacy and self-perceived health so powerful. Therefore, it might be important to focus on these perceptions in treatment and in rehabilitation. Interventions might not only address improved health but actively strengthen both self-efficacy and self-perceived health.

One way to enhance collaboration between healthcare providers and other stakeholders in the sick leave process is RC. For people with CMD, RC is experienced as a bridge between them and the rest of society, not least the workplace. For the person on sick leave, it appears to be important to involve the workplace at an early stage in the sick leave process in order to experience the interventions as meaningful. However, RC needs to become better known within PHC to really reach out to those who need support.

Future Perspective

As Swedish primary healthcare has lower levels of PCA than comparable European countries, person-centred care and rehabilitation need to be further developed. Even though research has shown several advantages of a PCA, it seems to be challenging to turn knowledge into action. The hierarchical structure of healthcare is probably a contributing factor, and a persistent effort would be necessary to strengthen person-centredness, not least in the sick leave process. In the present thesis, the micro-level of person-centredness has been in focus. However, there is a lack of research at an institutional level, at the meso and macro levels, and more research is needed at these levels to create better conditions for person-centred care through changed institutional structures.

Collaboration between the stakeholders in the sick leave process is important for those on sick leave, and RC was experienced as a hub in this collaboration. At the same time, RC was initially unknown to the participants, which may partly be due to the fact that it is a relatively new function. At PHC centres, information about RC needs to be made more visible and accessible to people on sick leave. With better information, people on sick leave might apply for RC without having to be referred by a GP or other healthcare professional as they do currently. Another challenge for the collaboration between various stakeholders is to jointly maintain a PCA that focuses on the person's needs and wishes while at the same time taking into account the stakeholders' varying interests and perspectives.

Within occupational science, the relationship between self-efficacy and occupational performance is of vital importance. It is a research area that would need to be further developed in connection with the sick leave process. In rehabilitating people on sick leave, interventions would need to be developed by PTs and OTs that consciously include self-efficacy, as it has a powerful impact on occupational performance. Working with aspects that are meaningful for a person's RTWSE might facilitate the rehabilitation process. Future research would therefore need to develop and evaluate clinical rehabilitation interventions with a focus on RTWSE for people on sick leave in PHC.

Another aspect that would need to be developed in PHC is rehabilitation interventions to promote the work ability of people who are partially on sick leave. The findings from the present thesis suggest that larger RCT studies may be needed to evaluate such interventions and that interventions would need to include the workplace in a deliberate way. An expansion of RC so that it becomes a stronger link between work and

rehabilitation clinics might facilitate this development. Closer collaboration between rehabilitation coordinators and PTs and OTs at rehabilitation clinics might facilitate preventive work-oriented rehabilitation interventions.

Finally, there are major challenges in society with respect to increasing knowledge about and tolerance for mental illness. Stigmatising beliefs create additional barriers to participation in working life for people who are already ill. Psychosocial and organisational factors such as an open conversational climate, adaptations at work, and support from colleagues and managers might contribute to reducing stigma and increasing well-being for everyone in working life.

Acknowledgements

Jag vill börja med att rikta ett stort och varmt tack till alla de deltagare som varit med i studierna i denna avhandling för att ni så generöst ha delat med er av era erfarenheter, tankar och förhoppningar. Utan ert engagemang och intresse hade denna avhandling inte blivit till.

Stort tack till alla arbetsterapeuter, fysioterapeuter och rehabkoordinatorer inom Närhälsan i Göteborg med omnejd för er hjälp att informera om studierna i er verksamhet. Utan ert goda arbete hade jag inte kunnat nå ut till deltagarna lika snabbt.

Alla mina handledare har varit betydelsefulla på olika sätt och i olika skeden på den långa resan med att skriva avhandlingen. Kristina Holmgren, min huvudhandledare i många år, redan innan jag fick förmånen att formellt börja mina doktorandstudier, är den som varit med allra längst. Din stora kunskap om hur saker går till i denna forskarvärld, ditt orubbliga stöd, din klokhet och tro på min förmåga när jag själv tappade bort den emellanåt har inte bara gjort resan möjlig utan också gjort den intressant, utmanande och spännande. Stort tack för ditt uthålliga stöd i en ofta krävande terräng!

Mina övriga handledare Louise Danielsson, Jenny Hultqvist och Maria EH Larsson har alla bidragit med sina kunskaper och erfarenheter under olika delar av avhandlingen. Tack för alla kloka råd och kommentarer! Ni har hjälpt mig att hålla fokus och riktning när jag ibland tappat riktningen på resan och era förklaringar om hur kartan kan läsas har alltid varit tydliga och hjälpsamma.

Stort tack till mina tidigare kollegor inom Närhälsan, på Olskrokens rehabmottagning och Olskrokens vårdcentral för allt jag lärt mig genom att arbeta med er! Det har gett många värdefulla erfarenheter som jag har tagit med mig på den här resan.

Stort tack till mina tidigare kollegor inom det som kallas Finsam idag. Vårt goda samarbete över myndighetsgränserna har varit oerhört lärorikt och givande. Den anda av vilja förstå varandra och att arbeta tillsammans trots alla utmaningar som fanns har lärt mig så mycket. Jag är så glad att jag fick arbeta med er!

Stort tack till mina nuvarande kollegor på arbetsterapiprogrammet för ert intresse och engagemang under resans gång. Ni har alltid tagit er tid att lyssna eller svara på en fråga och det känns fantastiskt att få arbeta tillsammans med så många kloka personer!

Stort tack till mina doktorandkollegor som jag fått förmånen att träffa. Tack för alla roliga och givande diskussioner både på våra möten och på fika-raster. Det har varit fint att kunna dela mina erfarenheter med er som färdkamrater!

Sist men inte minst vill jag tacka mina vänner och min familj som hejat på under resans gång, erbjudit mat och vätske-pauser och till och med underhållning för att jag ska komma i mål. Ert stöd har varit jätteviktigt och jag är så glad att ni finns i mitt liv!

Finansiellt stöd har jag fått från FoU primär och nära vård Göteborg och södra Bohuslän.

References

1. Wilcock AA. An occupational perspective of health. 3. ed. ed. Hocking C, editor: Thorofare, N.J. Slack; 2015.
2. Waddell G. Is work good for your health and well-being? Burton AK, editor. London: London : TSO; 2006.
3. McLellan RK. Work, health, and worker well-being: Roles and opportunities for employers. Health Aff. 2017;36(2):206-13.
4. Labriola M, Lund T, Christensen KB, Albertsen K, Bültmann U, Jensen JN, et al. Does self-efficacy predict return-to-work after sickness absence? A prospective study among 930 employees with sickness absence for three weeks or more. Work. 2007;29(3):233-8.
5. Krause N, Frank JW, Dasinger LK, Sullivan TJ, Sinclair SJ. Determinants of duration of disability and return-to-work after work-related injury and illness: Challenges for future research. Am J Ind Med. 2001;40(4):464-84.
6. Franche R-L, Krause N. Readiness for return to work following injury or illness: Conceptualizing the interpersonal impact of health care, workplace, and insurance factors. J Occup Rehabil. 2002;12(4):233-56.
7. Labriola M. Conceptual framework of sickness absence and return to work, focusing on both the individual and the contextual level. Work. 2008;30(4):377-87.
8. Kielhofner G, Taylor RR. Kielhofner's model of human occupation: Theory and application. 5 ed: Philadelphia: Wolters Kluwer; 2017.
9. Christiansen CH, Townsend EA. Introduction to occupation: The art and science of living. 2 ed. Upper Saddle River, New Jersey: Pearson Education; 2010.
10. McColl MA. Theoretical basis of occupational therapy. Law MC, Stewart D, editors: Thorofare, N.J. SLACK; 2015.
11. Wilcock AA. Reflections on doing, being and becoming. Aust Occup Ther J. 1999;46(1):1-11.
12. Hitch D, Pépin G, Stagnitti K. In the footsteps of wilcock, part one: The evolution of doing, being, becoming, and belonging. Occup Ther Health Care. 2014;28(3):231-46.
13. Socialdepartementet [Ministry of Social Affairs]. Hälso- och sjukvårdslag (2017:30) [Health and medical care act (2017:30)] [Internet]. Stockholm: Socialdepartementet [Ministry of Social Affairs]; 2017 [cited 2022 June 27]. Available from:

https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-201730_sfs-2017-30.
14. Boorse C. Health as a theoretical concept. Philos Sci. 1977;44(4):542-73.
15. Hamilton RP. The concept of health: Beyond normativism and naturalism. J Eval Clin Pract. 2010;16(2):323-9.
16. The Britannica Group. The britannica dictionary [Internet]. Chicago: The Britannica Group; 2022 [cited 2022 November 27]. Available from: https://www.britannica.com/dictionary.
17. World Health Organization [WHO]. Constitution [Internet]. Geneva: World Health Organization [WHO]; 1948 [cited 2022 Sep 15]. Available from: https://www.who.int/about/governance/constitution.
18. Huber M, Van Vliet M, Giezenberg M, Winkens B, Heerkens Y, Dagnelie PC, et al. Towards a 'patient-centred' operationalisation of the new dynamic concept of health: A mixed methods study. BMJ open. 2016;6(1):e010091-e.
19. World Health Organization [WHO]. Mental health: Strengthening our response [Internet]. Geneva: World Health Organization [WHO]; 2022 [cited 2022 Sep 15]. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.
20. Galderisi S, Heinz A, Kastrup M, Beezhold J, Sartorius N. Toward a new definition of mental health. World psychiatry. 2015;14(2):231-3.
21. Shahid A, Wilkinson K, Marcu S, Shapiro CM. Sf-36 health survey. New York: Springer New York; 2012. 317-8 p.
22. Perruccio AV, Katz JN, Losina E. Health burden in chronic disease: Multimorbidity is associated with self-rated health more than medical comorbidity alone. J Clin Epidemiol. 2012;65(1):100-6.
23. Layes A, Asada Y, Kephart G. Whiners and deniers – what does self-rated health measure? Soc Sci Med. 2012;75(1):1-9.
24. Jylha M. What is self-rated health and why does it predict mortality? Towards a unified conceptual model. Soc Sci Med. 2009;69(3):307-16.
25. Erlandsson L-K. Valmo-modellen: Arbetsterapi för hälsa genom görande. 2 ed. Persson D, editor. Lund: Studentlitteratur; 2020.
26. Law M, Cooper B, Strong S, Stewart D, Rigby P, Letts L. The person-environment-occupation model: A transactive approach to occupational performance. Can J Occup Ther. 1996;63(1):9-23.
27. Strong S, Rigby P, Stewart D, Law M, Letts L, Cooper B. Application of the person-environment-occupation model: A practical tool. Can J Occup Ther. 1999;66(3):122-33.
28. Lindsay S, Cagliostro E, Albarico M, Mortaji N, Srikanthan D. Gender matters in the transition to employment for young adults with physical disabilities. Disabil Rehabil. 2019;41(3):319-32.
29. Dickie V, Cutchin MP, Humphry R. Occupation as transactional experience: A critique of individualism in occupational science. J Occup Sci. 2006;13(1):83-93.

30. Dewey J & Bentley A. Knowing and the known. Boston: Beacon press; 1949.
31. Leplege A, Gzil F, Cammelli M, Lefeve C, Pachoud B, Ville I. Person-centredness: Conceptual and historical perspectives. Disabil Rehabil. 2007;29(20-21):1555-65.
32. Townsend EA, Polatajko HJ. Enabling occupation 2: Advancing an occupational therapy vision for health, well-being and justice through occupation. Ottawa: CAOT Publications ACE; 2007.
33. Nolte E, Merkur S, Anell A. Achieving person-centred health systems : Evidence, strategies and challenges: Cambridge, United Kingdom, New York, NY: Cambridge University Press; 2020.
34. Hobbs JL. A dimensional analysis of patient-centered care. Nurs Res. 2009;58(1):52-62.
35. Socialdepartementet [Ministry of Social Affairs]. Patientlag (2014:821) [Patient act 2014:821] [Internet]. Stockholm: Socialdepartementet [Ministry of Social Affairs]; 2014 [cited 2022 Sep 1]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/patientlag-2014821_sfs-2014-821.
36. Socialstyrelsen [National Board of Health and Welfare]. Patientcentrering i svensk hälso- och sjukvård [Patient-centredness in swedish healthcare] [Internet]. Stockholm: Socialstyrelsen [National Board of Health and Welfare]; 2012 [2021 April 25]. Available from: https://www.vardanalys.se/rapporter/patientcentrering-i-svensk-halso-och-sjukvard/.
37. Ekman I, Swedberg K, Taft C, lindseth A, Norberg A, Brink E, et al. Person-centered care - ready for prime time. Eur J Cardiovasc Nurs. 2011;10(4):248-51.
38. Olsson K, Näslund U, Nilsson J, Hörnsten Å. Hope and despair: Patients' experiences of being ineligible for transcatheter aortic valve implantation. Eur J Cardiovasc Nurs. 2019;18(7):593-600.
39. Ekman I, Ebrahimi Z, Contreras PO. Person-centred care: Looking back, looking forward. Eur J Cardiovasc Nurs. 2021;20(2):93-5.
40. Myndigheten för vård- och omsorgsanalys [Swedish Agency for Health and Care Services Analysis]. Nationell uppföljning av hälso- och sjukvården 2022 [National follow-up of health care in 2022] [Internet]. Stockholm: Myndigheten för vård- och omsorgsanalys [Swedish Agency for Health and Care Services Analysis]; 2022 [cited 2022 Sep 1]. Available from: https://www.vardanalys.se/rapporter/nationell-uppfoljning-av-halso-och-sjukvarden-2022/.
41. Gage M, Polatajko H. Enhancing occupational performance through an understanding of perceived self-efficacy. Am J Occup Ther. 1994;48(5):452-62.
42. Baum CM, Bass JD, Christiansen C. Interventions and outcomes. The person-environment-occupation-performance (peop) occupational therapy process. In: Baum CM, Bass JD, Christiansen C, editors.

Occupational therapy : Performance, participation and well-being. 4. ed: Thorofare, N.J. Slack; 2015. p. 57-79.
43. Bandura A. Social foundations of thought and action : A social cognitive theory. Englewood Cliffs, N.J.: Englewood Cliffs, N.J. : Prentice-Hall; 1986.
44. Bandura A. Health promotion by social cognitive means. Health Educ Behav. 2004;31(2):143-64.
45. Scholz U, Doña BG, Sud S, Schwarzer R. Is general self-efficacy a universal construct? Psychometric findings from 25 countries. Eur J Psychol Assess. 2002;18(3):242-51.
46. Volker D, Zijlstra-Vlasveld MC, Brouwers EPM, van Lomwel AGC, van der Feltz-Cornelis CM. Return to work self efficacy and actual return to work among long-term sick-listed employees. J Occup Rehabil. 2015;25(2):423-31.
47. Black O, Sim MR, Collie A, Smith P. Differences over time in the prognostic effect of return to work self-efficacy on a sustained return to work. J Occup Rehabil. 2019;29(3):660-7.
48. Ekberg K, Eklund M, Hensing G. Återgång i arbete : Processer, bedömningar, åtgärder. Lund: Studentlitteratur; 2015.
49. Lederer V, Loisel P, Rivard M, Champagne F. Exploring the diversity of conceptualizations of work (dis)ability: A scoping review of published definitions. J Occup Rehabil. 2013;24(2):242-67.
50. Townsend EA. Enabling occupation 2: Advancing an occupational therapy vision for health, well-being & justice through occupation : 9th canadian occupational therapy guidelines. 2 ed. Polatajko HJ, editor. Ottawa, Ontario: Canadian Association of Occupational Therapists; 2013.
51. Martimo K-P, Takala E-P. Concepts of work ability in rehabilitation. Cham: Springer International Publishing; 2020. p. 551-70.
52. Ilmarinen J, Tuomi K, Seitsamo J. New dimensions of work ability. Int Congr Ser. 2005;1280:3-7.
53. Ilmarinen J. From work ability research to implementation. Int J Environ Res Public Health. 2019;16(16):2882.
54. Loisel P, Buchbinder R, Hazard R, Keller R, Scheel I, van Tulder M, et al. Prevention of work disability due to musculoskeletal disorders : The challenge of implementing evidence. J Occup Rehabil. 2005;15(4):507-24.
55. Luhmann N. Social systems: Stanford, Calif. Stanford University Press; 1995.
56. Sveriges riksdag [Swedish Parliament]. Socialförsäkringsbalk (2010:110) [Social insurance act (2010:110)] [Internet]. Stockholm: Sveriges riksdag [Swedish Parliament]; 2010 [cited 2022 Sep 12]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/socialforsakringsbalk-2010110_sfs-2010-110.

57. Young AE, Roessler RT, Wasiak R, McPherson KM, van Poppel-Bruinvels MNM, Anema JR. A developmental conceptualization of return to work. J Occup Rehabil. 2005;15(4):557-68.
58. Bodin Danielsson C, Chungkham HS, Wulff C, Westerlund H. Office design's impact on sick leave rates. Ergon. 2014;57(2):139-47.
59. Hultin H, Lindholm C, Malfert M, Möller J. Short-term sick leave and future risk of sickness absence and unemployment - the impact of health status. BMC Public Health. 2012;12(1):861.
60. Skagen K, Collins AM. The consequences of sickness presenteeism on health and wellbeing over time: A systematic review. Soc Sci Med. 2016;161:169-77.
61. Aronsson G, Gustafsson K, Dallner M. Sick but yet at work. An empirical study of sickness presenteeism. J Epidemiol Community Health. 2000;54(7):502-9.
62. Hjarsbech PU, Nielsen MBD, Andersen MF, Rugulies R, Christensen U. Struggling at work - a qualitative study of working danes with depressive symptoms. Disabil Rehabil. 2015;37(18):1674-82.
63. Toft T, Fink PER, Oernboel EVA, Christensen KAJ, Frostholm L, Olesen F. Mental disorders in primary care: Prevalence and co-morbidity among disorders. Results from the functional illness in primary care (fip) study. Psychol Med. 2005;35(8):1175-84.
64. Hulten A-M, Bjerkeli P, Holmgren K. Work-related stress and future sick leave in a working population seeking care at primary health care centres: A prospective longitudinal study using the wsq. BMC Public Health. 2022;22(1):851-.
65. Sveriges Riksdag [The Swedish Parliament]. God och nära vård—en reform för ett hållbart hälso- och sjukvårdssystem. [Good and close health care—a reform for a sustainable health care system] [Internet]. Stockholm: Sveriges Riksdag [The Swedish Parliament]; 2020 [cited 2022 Sep 1]. Available from: https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2020/04/sou-202019/.
66. Sveriges kommuner och regioner [Swedish Association of Local Authorities and Regions]. Hälso- och sjukvårdsbarometern 2021[The health care barometer 2021] [Internet]. Stockholm: Sveriges kommuner och regioner [Swedish Association of Local Authorities and Regions]; 2021 [cited 2022 Sep 2]. Available from: https://vardenisiffror.se/rapport/befolkningens-syn-pa-halso-och-sjukvarden-2021.
67. Myndigheten för vård- och omsorgsanalys [Swedish Agency for Health and Care Services Analysis]. En primär angelägenhet. Kunskapsunderlag för en stärkt primärvård med patienten i centrum [a primary concern. [Knowledge base for strengthened primary care with the patient at the center] [Internet]. Stockholm: Myndigheten för vård- och omsorgsanalys [Swedish Agency for Health and Care Services Analysis]; 2017 [cited 2022 Sep 1]. Available from: https://www.vardanalys.se/rapporter/en-primar-angelagenhet/.

68. Publishing O. Mental health and work fit mind, fit job: From evidence to practice in mental health and work: Paris: Organization for Economic Cooperation & Development; 2015.
69. Vos T, Barber RM, Bell B, Bertozzi-Villa A, Biryukov S, Bolliger I, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: A systematic analysis for the global burden of disease study 2013. The Lancet. 2015;386(9995):743-800.
70. Försäkringskassan [Swedish Social Insurance Agency]. Socialförsäkringen i siffror 2022 [Social insurance in numbers 2022] [Internet]. Stockholm: Försäkringskassan [Swedish Social Insurance Agency]; 2022 [cited 2022 August 4]. Available from: https://www.forsakringskassan.se/download/18.7fc616c01814e179a9f192/1656398049738/socialforsakringen-i-siffror-2022.pdf.
71. World Health Organization [WHO]. The icd-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization [WHO]; 1992.
72. Maslach CH, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52(1):397-422.
73. Socialstyrelsen [National Board of Health and Welfare]. Klassifikationen icd-10 [Classification icd-10] [Internet]. Stockholm: Socialstyrelsen [National Board of Health and Welfare]; 2011 [cited 2022 Sep 05]. Available from: https://www.socialstyrelsen.se/statistik-och-data/klassifikationer-och-koder/icd-10/.
74. Holmgren K, Dahlin-Ivanoff S, Björkelund C, Hensing G. The prevalence of work-related stress, and its association with self-perceived health and sick-leave, in a population of employed swedish women. BMC Public Health. 2009;9:73.
75. Lidwall U. Effort-reward imbalance, overcommitment and their associations with all-cause and mental disorder long-term sick leave - a case-control study of the swedish working population. Int J Occup Med Environ Health. 2016;29(6):973-89.
76. World Health Organization. World mental health report [Internet]. Geneva 2022 [cited 2022 August 9]. Available from: https://www.who.int/publications/i/item/9789240049338.
77. Försäkringskassan [Swedish Social Insurance Agency]. Sjukfrånvaro i psykiatriska diagnoser. Socialförsäkringsrapport 2020:8 [Sickness abscence in psychiatric diagnoses. Social insurance report 2020:8] [Internet]. Stockholm: Försäkringskassan [Swedish Social Insurance Agency]; 2020 [cited 2022 June 13]. Available from: https://www.forsakringskassan.se/download/18.7fc616c01814e179a9f329/1656660446139/sjukfranvaro-i-psykiatriska-diagnoser-socialforsakringsrapport-2020-8.pdf
78. Försäkringskassan [Swedish Social Insurance Agency]. Rehabiliteringskedjan [The reabilitation chain] [Internet]. Stockholm: Försäkringskassan [Swedish Social Insurance Agency]; 2022 [cited

2022 Sep 13]. Available from: https://www.forsakringskassan.se/om-forsakringskassan/vart-uppdrag/om-socialforsakringen/rehabiliteringskedjan.
79. Försäkringskassan [Swedish Social Insurance Agency]. Förändringar i lag-stiftningen för sjuk-försäkringen från den 1 september 2022 [Modifications in sickness insurance legislation from 1 september 2022] [Internet]. Stockholm: Försäkringskassan [Swedish Social Insurance Agency]; 2022 [cited 2022 Sep 13]. Available from: https://www.forsakringskassan.se/nyhetsarkiv/nyheter-press/2022-08-18-forandringar-i-lagstiftningen-for-sjukforsakringen-fran-den-1-september-2022.
80. Regeringen [The government]. Kommitédirektiv, utvärdering av förändringarna i sjukförsäkringens regelverk [Committee directive, evaluation of modifications in sickness insurance legislation] [Internet]. Stockholm: Regeringen [The government]; 2022 [cited 2022 Sep 13]. Available from: https://www.regeringen.se/49e6ee/contentassets/a01e4613a7eb41ef81bffedc3d5394bd/dir-2022-64.pdf.
81. Sveriges kommuner och regioner [Swedish Association of Local Authorities and Regions]. Koordineringsinsatser inom hälso- och sjukvården [Coordination interventions within health care]. Stockholm; 2021.
82. Sveriges riksdag [Swedish Parliament]. Lag (2019:1297) om koordineringsinsatser för sjukskrivna patienter. [Act (2019: 1297) on coordination efforts for patients on sick leave] [Internet]. Stockholm: Socialdepartementet [Ministry of Social Affairs]; 2019 [cited 2022 June 27]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-20191297-om-koordineringsinsatser-for_sfs-2019-1297.
83. Västra Götalandsregionen. Vårdriktlinjer, försärkingsmedicin, rehabiliteringskoordinator [Healthcare guidelines, insurance medicine, rehabilitation coordinator][Internet]. Västra Götalandsregionen; 2021 [cited 2021 April 25]. Available from: https://www.vgregion.se/halsa-och-vard/vardgivarwebben/vardriktlinjer/forsakringsmedicin/rehabiliteringskoordinera/.
84. Sveriges kommuner och regioner [Swedish Association of Local Authorities and Regions]. Koordineringsinsatser försäkringsmedicin [Coordination efforts insurance medicine] [Internet]. Stockholm: Sveriges kommuner och regioner [Swedish Association of Local Authorities and Regions]; 2021 [updated 2021 March 12; cited 2022 Sep 25]. Available from: https://skr.se/halsasjukvard/sjukskrivningochrehabilitering/funktionforkoordinering.1033.html.
85. Hälso- och sjukvårdsförvaltningen Stockholms läns landsting [The Health and Medical Administration Stockholm County Council]. Lägre

sjukskrivning med rehabkoordinator [Lower sick leave with rehab coordinator] [Internet]. Stockholm: Hälso- och sjukvårdsförvaltningen, Stockholms läns landsting; 2018 [cited 2021 April 25]. Available from: https://skr.se/download/18.1f376ad3177c89481f74fd7d/1615550054215/utvardering-rehabkoordinatorsfunktion-i-sll.pdf.

86. Landstrom S, Norén A-M, Bengtner J, Werr J. Rehabilitation coordination for return to work, as extended role for health professionals– results from a randomized controlled trial. Int J Integr Care. 2017;17(5):464.

87. Berglund E, Friberg E, Engblom M, Andersén Å, Svärd V. Coordination and perceived support for return to work: A cross-sectional study among patients in swedish healthcare. Int J Environ Res Public Health. 2022;19(7):4040.

88. Schandelmaier S, Ebrahim S, Burkhardt SCA, de Boer WEL, Zumbrunn T, Guyatt GH, et al. Return to work coordination programmes for work disability: A meta-analysis of randomised controlled trials. PLoS One. 2012;7(11):e49760-e.

89. Vogel N, Schandelmaier S, Zumbrunn T, Ebrahim S, de Boer WEL, Busse JW, et al. Return-to-work coordination programmes for improving return to work in workers on sick leave. Cochrane Database Syst Rev. 2017;2017(3):CD011618-CD.

90. Hedlund Å, Boman E, Kristofferzon M-L, Nilsson A. Beliefs about return to work among women during/after long-term sick leave for common mental disorders: A qualitative study based on the theory of planned behaviour. J Occup Rehabil. 2021;31(3):604-12.

91. Joyce S, Modini M, Christensen H, Mykletun A, Bryant R, Mitchell PB, et al. Workplace interventions for common mental disorders: A systematic meta-review. Psychol Med. 2016;46(4):683-97.

92. Holmgren K, Sandheimer C, Mårdby AC, Larsson ME, Bültmann U, Hange D, et al. Early identification in primary health care of people at risk for sick leave due to work-related stress - study protocol of a randomized controlled trial (rct). BMC Public Health. 2016;16(1):1193.

93. Holmgren K, Hensing G, Bültmann U, Hadzibajramovic E, Larsson MEH. Does early identification of work-related stress, combined with feedback at gp-consultation, prevent sick leave in the following 12 months? A randomized controlled trial in primary health care. BMC Public Health. 2019;19(1):1110.

94. Bjerkeli PJ, Skoglund I, Holmgren K. Does early identification of high work related stress affect pharmacological treatment of primary care patients? - analysis of swedish pharmacy dispensing data in a randomised control study. BMC Fam Pract. 2020;21(1):70.

95. Hultqvist J, Bjerkeli P, Hensing G, Holmgren K. Does a brief work-stress intervention prevent sick-leave during the following 24 months? A randomized controlled trial in swedish primary care. Work. 2021;70(4):1141-50.

96. Sandheimer C, Hedenrud T, Hensing G, Holmgren K. Effects of a work stress intervention on healthcare use and treatment compared to treatment as usual: A randomised controlled trial in swedish primary healthcare. BMC Fam Pract. 2020;21(1):133.
97. Hultén A-M, Bjerkeli P, Holmgren K. Self-reported sick leave following a brief preventive intervention on work-related stress: A randomised controlled trial in primary health care. BMJ Open. 2021;11(3).
98. Danielsson L, Waern M, Hensing G, Holmgren K. Work-directed rehabilitation or physical activity to support work ability and mental health in common mental disorders: A pilot randomized controlled trial. Clin Rehabil. 2020;34(2):170-81.
99. Erlandsson L-K, Eklund M. Return to work outcomes of the redesigning daily occupations (redo) program for women with stress-related disorders: A comparative study: A comparative study focusing on return to work. Women Health. 2011;51(7):676.
100. Olsson A, Erlandsson L-K, Håkansson C. The occupation-based intervention redo™-10: Long-term impact on work ability for women at risk for or on sick leave. Scand J Occup Ther. 2020;27(1):47-55.
101. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.
102. Graneheim U, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. Nurse Educ Today. 2017;56:29.
103. Malterud K. Kvalitativa metoder i medicinsk forskning. Översättning: Inger Almqvist ed. Lund: Studentlitteratur; 2007.
104. Svenaeus F. The hermeneutics of medicine and the phenomenology of health: Steps towards a philosophy of medical practice. Linköping: Diss. Linköpings universitet; 1999.
105. Statens medicinsk-etiska råd [Swedish National Council on Medical Ethics] [Internet]. Ethics Stockholm: Socialdepartementet [Ministry of Social Affairs]; [cited 2023 Jan 4]. Available from: https://smer.se/etik/.
106. Anonymous. World medical association declaration of helsinki. Ethical principles for medical research involving human subjects. Bull World Health Organ. 2001;79(4):373.
107. Voss M, Stark S, Alfredsson L, Vingård E, Josephson M. Comparisons of self-reported and register data on sickness absence among public employees in sweden. Occup Environ Med. 2008;65(1):61-7.
108. Pietiläinen O, Laaksonen M, Rahkonen O, Lahelma E. Self-rated health as a predictor of disability retirement--the contribution of ill-health and working conditions. PLoS One. 2011;6(9):e25004-e.
109. Simon JG, De Boer JB, Joung IMA, Bosma H, Mackenbach JP. How is your health in general? A qualitative study on self-assessed health. Eur J Public Health. 2005;15(2):200-8.

110. Horn L, Spronken M, Brouwers EPM, de Reuver RSM, Joosen MCW. Identifying return to work self-efficacy trajectories in employees with mental health problems. J Occup Rehabil. 2022;32(1):64-76.
111. Skagseth M, Fimland MS, Rise MB, Nilsen TIL, Aasdahl L. Return-to-work self-efficacy after occupational rehabilitation for musculoskeletal and common mental health disorders: Secondary outcomes of a randomized clinical trial. J Rehabil Med. 2021;53(1):jrm00146.
112. World Health Organization [WHO]. Patient empowerment and health care [Internet]. Geneva: World Health Organization [WHO]; 2009 [cited 2022 Nov 7]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK144022/.
113. Rappaport J. Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. Am J Community Psychol. 1987;15(2):121-48.
114. Kristensson Uggla B. Personfilosofi- filosofiska utgångspunkter för personcentrering inom hälso- och sjukvård. In: Ekman I, editor. Personcentrering inom hälso- och sjukvård : Från filosofi till praktik. 2 ed: Stockholm : Liber; 2020. p. 58-105.
115. Goffman E. Stigma: Notes on the management of spoiled identity. [New 1990] ed. Harmondsworth: Penguin Books; 1963.
116. Link BG, Struening E, Cullen FT, Shrout PE, Dohrenwend BP. A modified labeling theory approach to mental disorders: An empirical assessment. Am Sociol Rev. 1989;54(3):400-23.
117. Van Beukering IE, Smits SJC, Janssens KME, Bogaers RI, Joosen MCW, Bakker M, et al. In what ways does health related stigma affect sustainable employment and well-being at work?: A systematic review. J Occup Rehabil. 2022;32(3):365-79.
118. Johansson E, Svartengren M, Danielsson K, Hellman T. How to strengthen the rtw process and collaboration between patients with chronic pain and their employers in interdisciplinary pain rehabilitation programs? Patients' experiences of the demand and ability protocol. Disabil Rehabil. 2022;ahead-of-print(ahead-of-print):1-8.
119. Olsson A, Erlandsson LK, Håkansson C. The occupation-based intervention redo™-10: Long-term impact on work ability for women at risk for or on sick leave. Scand J Occup Ther. 2020;27(1):47-55.
120. Sandqvist J. Development and evaluation of validity and utility of the instrument assessment of work performance (awp). Linköping: Diss. (sammanfattning) Linköpings universitet; 2007.
121. Sandqvist JL, Gullberg MT, Henriksson CM, Gerdle BUC. Content validity and utility of the assessment of work performance (awp). Work. 2008;30(4):441-50.
122. Ståhl C, Karlsson N, Gerdle B, Sandqvist J. Predictive validity of general work ability assessments in the context of sickness insurance. J Rehabil Med. 2021;53(4):1-8.
123. Noordik E, Nieuwenhuijsen K, Varekamp I, van der Klink JJ, J. van Dijk F. Exploring the return-to-work process for workers partially

returned to work and partially on long-term sick leave due to common mental disorders: A qualitative study. Disabil Rehabil. 2011;33(17-18):1625-35.
124. Strömbäck M, Fjellman-Wiklund A, Keisu S, Sturesson M, Eskilsson T. Restoring confidence in return to work: A qualitative study of the experiences of persons with exhaustion disorder after a dialogue-based workplace intervention. PLoS Med. 2020;15(7):e0234897-e.
125. Östlind EK, Grahn BE, Stigmar KE. Patients' experience of a workplace dialogue in physiotherapy practice in primary care: An interview study. Eur J Physiother. 2021;23(1):27-33.
126. Nordling P. Work capacity assessments – reviewing the what and how of physicians' clinical practice. Eur J Public Health. 2019;29(Supplement_4).
127. Hultén A-M, Dahlin-Ivanoff S, Holmgren K. Positioning work related stress - gps' reasoning about using the wsq combined with feedback at consultation. BMC Fam Pract. 2020;21(1):1-187.
128. Holmgren K, Rosstorp F, Rohdén H. Confidence in public institutions: A focus group study on views on the swedish social insurance agency. Work. 2016;55(1):77-91.
129. Karlsson EA, Sandqvist JL, Seing I, Ståhl C. Exploring interactions in the sickness insurance system in terms of power and trust. J Occup Rehabil. 2022;32(3):483-93.
130. Söderman M, Wennman-Larsen A, Alexanderson K, Friberg E. Experiences of positive encounters with healthcare professionals among women on long-term sickness absence due to breast cancer or due to other diagnoses: A nationwide survey. BMC Public Health. 2019;19(1):349-.
131. Olsson D, Alexanderson K, Bottai M. What positive encounters with healthcare and social insurance staff promotes ability to return to work of long-term sickness absentees? Scand J Public Health. 2016;44(1):91-7.
132. Russell E, Kosny A. Communication and collaboration among return-to-work stakeholders. Disabil Rehabil. 2019;41(22):2630-9.
133. Friesen MN, Yassi A, Cooper J. Return-to-work: The importance of human interactions and organizational structures. Work. 2001;17(1):11-22.
134. Zana J-P, Sandner S, Beck BB, Bloch M, Kuhn S, Kunz-Vondracek I. Msd s: Recommendations for prevention, rehabilitation and occupational reinsertion – results from a survey by the ergonomics working group of the issa health services section. In: Bagnara S, Tartaglia R, Albolino S, Alexander T, Fujita Y, editors. Proceedings of the 20th congress of the international ergonomics association. 820: Cham, Springer International Publishing; 2018. p. 404-9.
135. Ricoeur P. Homo capax. Göteborg: Daidalos AB; 2011.
136. Kristensson Uggla B. En strävan efter sanning: Vetenskapens teori och praktik. Lund: Studentlitteratur; 2019.

137. Björk J. Praktisk statistik för medicin och hälsa. Stockholm: Liber; 2020.
138. Halford C, Wallman T, Welin L, Rosengren A, Bardel A, Johansson S, et al. Effects of self-rated health on sick leave, disability pension, hospital admissions and mortality. A population-based longitudinal study of nearly 15,000 observations among swedish women and men. BMC Public Health. 2012;12:1103.
139. Robine J, Jagger C. Creating a coherent set of indicators to monitor health across europe - the euro-reves 2 project. Eur J Public Health. 2003;13:6-14.
140. Centrum för epidemiologi och samhällsmedicin Region Stockholm [Center for Epidemiology and Community Medicine Region Stockholm]. Förklaras könsskillnaderna i vårdkonsumtion av sjukdomsbörda? En studie i stockholms län [Are gender differences in healthcare consumption explained by the burden of disease? A study in Stockholm county] [Internet]. Stockholm: Centrum för epidemiologi och samhällsmedicin, Region Stockholm [Center for Epidemiology and Community Medicine, Region Stockholm]; 2019 [cited 2022 Sep 6]. Available from: https://www.folkhalsoguiden.se/globalassets/verksamheter/forskning-och-utveckling/centrum-for-epidemiologi-och-samhallsmedicin/folkhalsoguiden/rapporter-och-faktablad/rapport-2019.5-forklaras-konsskillnader-i-vardkomsumtion-av-sjukdomsborda.pdf.
141. Mason VL, Shaw A, Wiles NJ, Mulligan J, Peters TJ, Sharp D, et al. Gps' experiences of primary care mental health research: A qualitative study of the barriers to recruitment. Fam Pract. 2007;24(5):518-25.
142. Bogin V. Lasagna's law: A dish best served early. Contemp Clin Trials Commun. 2022;26:100900-.
143. Degen L, Linden K, Seifried-Duebon T, Werners B, Grot M, Rind E, et al. Job satisfaction and chronic stress of general practitioners and their teams: Baseline data of a cluster-randomised trial (improvejob). Int J Environ Res Public Health. 2021;18(18):9458.
144. Saarijarvi M, Bratt E-L. When face-to-face interviews are not possible: Tips and tricks for video, telephone, online chat, and email interviews in qualitative research. Eur J Cardiovasc Nurs. 2021;20(4):392-6.
145. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: Guided by information power. Qual Health Res. 2016;26(13):1753-60.