Scandinavian Journal of Occupational Therapy

ISSN: 1103-8128 (Print) 1651-2014 (Online) Journal homepage: https://www.tandfonline.com/loi/iocc20

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To cite this article: Christina Andersson & Lena Mårtensson (2020): Women's experiences of being in the sick leave process, Scandinavian Journal of Occupational Therapy, DOI: 10.1080/11038128.2020.1750692

To link to this article: https://doi.org/10.1080/11038128.2020.1750692

Published online: 16 Apr 2020.

SCANDINAVIAN JOURNAL OF OCCUPATIONAL THERAPY
https://doi.org/10.1080/11038128.2020.1750692

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ORIGINAL ARTICLE

Women's experiences of being in the sick leave process

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ABSTRACT

Background: Being on sick leave is a risky situation, with loss of meaningful activities, exclusion from the labour market and losing the worker role. Although the benefits of the person's active involvement in the sick leave process have been emphasized, an increase in sickness absence and longer sick leave periods is still seen, especially among women. Further studies are needed to more deeply understand the person's own view of the situation.
Aims/Objectives: To explore the experiences of being on sick leave among a group of women.
Methods: An explorative, qualitative design was used. The analysis was based on individual, semi-structured interviews with 13 women, using qualitative content analysis.
Results: Three categories emerged that describe the women's experiences of the situation of being on sick leave: being regarded as an object, being supported and being engaged. The categories appeared as either barriers or enablers during the sick leave process.
Conclusions: The sick leave process could be better understood through multiple dimensions, working at the individual, organizational and societal levels. Using occupation based models underlining the importance of the interaction between person, occupation (work activity) and the environment may contribute to elucidating the complexity in supporting options for the return to work.

ARTICLE HISTORY
Received 19 November 2018
Revised 13 March 2020
Accepted 30 March 2020

KEYWORDS
Occupational therapy; qualitative research; return to work; sickness absence

Introduction

From an occupational perspective, all human activities include a dynamic relation and fit between persons, their occupations and the environments in which the occupations are enacted [1]. This is also the case for activities in the occupational area of work. The ability to perform work activities can be understood through three concepts; occupational identity, occupational competence and occupational adaptation, all three constructing the worker role [2]. The worker role, i.e. a person's sense of self as a worker, is based on an interaction between motivation, lifestyle and environment. In combination, the occupational roles of a person construct his/her occupational identity. Thus the worker role is one important piece in the puzzle of constructing the identity of a person [3]. Engagement in daily occupations and having scheduled occupations have shown themselves to be beneficial for taking a worker role [4]. Further, work participation pertains to society's demand for a worker role, work performance, including individual working skills, as well as other life experiences and life goals [5]. Losing an important daily activity such as work, due to impairment or illness, may in this sense mean a loss of identity [6–8].

Being on sick leave may thus be understood as a risky situation, with a loss of both scheduled activities and identity. Being on sick leave also means a risk for exclusion from the labour market and insecure economic stability. In a European, societal perspective, the main purpose of allowing sick leave and sick benefits is to promote recovery and return to work (RTW) [9]. However, for society, the consequences of prolonged sick leave absence are higher costs and a decrease in labour force participation [10], which have been addressed in different ways with reforms and sickness benefit schemes [9]. Different measures have been proposed to reduce sickness absence rates and promote sick listed persons' RTW, such as early interventions, a greater focus on workplace interventions, activities in the health care system, and

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cooperation between stakeholders (in the case of Sweden, e.g. professionals from health care, the Swedish Insurance Agency, the Swedish Public Employment Service and the employer), or tightening the rules for claiming sickness benefits [11,12]. In Sweden the claim for sickness benefit is assessed according to the fixed time points in the so called 'rehabilitation chain'. One important breakpoint here is the 90th day on sickness benefit, where the work capacity is assessed against modified work tasks as opposed to the existing job. After 180 days, the assessment is made against all jobs in the market [10]. When such regulations are perceived as non-transparent, it has been shown leading to a feeling of vulnerability, affecting both the experience of health and the rehabilitation process [13].

In addition to structural measures, the person may play an important part in the sick leave and rehabilitation process because of his/her appraisal of work as a meaningful occupation with a connection to the construction of social identity [14,15]. Other aspects that make the person's engagement a crucial part in the rehabilitation process are motivation, self-knowledge, and a wish for life balance and being a valued citizen [16]. As the person's individual capacity is related to physical and psychological functioning [5], it is important that the person experiences that his/her interests are looked after. Thus, the persońs interests, preferences and skills, as well as the persońs opinions about suggested job options, should be considered in the rehabilitation process [16].

It has been proposed that the benefits of sick listed personś involvement in the sick leave process and further on, in actions for the RTW process, may be explained by the social interaction between the individual and the professional in the rehabilitation process. Interaction that induces positive self-evaluation is thought to induce pride, leading to empowerment and enhanced work ability [17,18]. Another suggestion is that a good ability to make decisions during the process is supportive of the individual's own participation during the period of sick leave. Preconditions for good decision-making were studied with a focus group methodology, where the result conveyed five contributing categories: self-reliance, own responsibility, significant others, a personal relationship and coaching [19].

In several studies [20–23], the individual's own perceptions during the rehabilitation process have been highlighted as an important factor influencing both the sick leave process itself and the probability of returning to work. Although the meaning of the construct 'expectation' has been challenged [23], expectations and motivation for work seem to have a close connection to a positive experience of onés own possibilities through the sick leave process [20,23]. Furthermore, positive encounters with e.g. healthcare professionals and social insurance officers have been reported to have a supportive effect during this process by means of facilitating the self-estimated ability to RTW [24,25]. Important aspects of such encounters have been described as attitudes on the part of the professional, the content of the information given, and discussions of relevant adjustments [26]. Another study showed that having an influence over the work situation, work motivation, financial consequences for sick leave, and receiving support from the work place were seen as promoting factors for RTW [27].

Compared to other countries in Europe, Sweden has medium high sickness absence rates, although the rate for women is higher than for men. In addition, compared to other countries in Europe, women in Sweden are to a larger extent taking part in the labour market [28]. A larger proportion of women is also reported among new cases as well as among those with mental disorders and/or longer sick leave periods [29]. While the proportion of new cases has decreased, there is still an increasing number of longer sick spells, especially two years or longer [30].

Although measures have been taken to reduce sickness absence rates, and in some ways also given results, there is still only limited support for how successful interventions works [31]. Despite the existing knowledge about benefits of the person's involvement in the sick-leave and RTW processes [26,32], there is also a need to explore factors that sustain long-term sick leave [33].

To achieve deeper knowledge about the persons' own views of their involvement in the rehabilitation process, it is necessary to turn to those who have experience of being on sick leave. As women are overrepresented in the statistics on sickness absence [29], a focus on this group is warranted. The purpose of this study was thus to explore the experiences of being on long term sick leave among a group of women.

Methods

Study design and setting

An explorative qualitative design with in-depth interviews [34] was used, as the purpose was to gain and describe new knowledge. The study was carried out in a region in the south of Sweden. Both authors have experiences of research in different fields within the

areas of occupational therapy, public health and the sick-leave process. One of the authors (LM) has extensive experience of qualitative research. Both are females and registered occupational therapists, employed as senior lecturers at an occupational therapy programme in Sweden. A public health scientist collected the data as a part of her Master studies. Neither of the authors, nor the interviewer, had any relations with the participants prior to the study. The study was approved by the Regional Ethics Board in Gothenburg, Sweden (Dnr 369-08).

Procedure

On the basis of purposive selection, participants were recruited from ten healthcare centres or occupational health service centres in the region. Professionals distributed written information about the study to women whom they considered appropriate according to the aim and the inclusion criteria. The information described in detail the aim of the study, the implications of participating in the study, how the data would be treated, and the voluntariness of participation. Women who showed interest in participating were contacted by telephone by the interviewer. In this call, more detailed verbal information about the study was given and, after this, forms for informed consent were sent by regular mail to those who agreed to be interviewed and fulfilled the inclusion criteria.

Criteria for participation were:

- Women of working age
- Having experience of being on sick leave for at least three months during the previous 12 months. This criterion was based on the judgement that three months was a necessary period to give expressions of experiences of the situation.

The exclusion criterion was:

- Such difficulty in speaking or understanding the Swedish language that an interpreter was needed to allow a conversation.

The recruitment process continued alongside with the interviews until data saturation was achieved [35]. After 12 interviews, no new experiences were provided in the sessions, although a final interview was carried out to secure this observation. Thus, the recruitment process was completed after 13 interviews.

Data collection

The data were collected in individual, semi structured interviews. The intention in using individual interviews in this study was to gain a deeper understanding of the subjective experiences of being in the situation of sick leave. To achieve this, it was attempted to maintain a balance of power in the interviews concerning the preferential right of interpretation and the meaning of concepts and words among both parties. This form of reflexivity was promoted by performing the interviews in a relaxed way so that it resembled more a conversation than a formal interview. The interview guide was based on the findings of a previous focus group study [19] that explored factors that contributed to the ability to make informed decisions about the process of rehabilitation among women on sick leave. The interview guide focussed on:

- Experience of support
- Experience of division between responsibility in the process
- Experience of relations and cooperation in the process
- Self-management and own activity in the process
- Foundations for decision making
- Information acquisition
- Goal planning

The areas in the guide were used as a general tool to develop more specific and deeper questions based on the answers of the participant. Thus, the questions were open-ended, which means that there were no given answers to them. The idea in this kind of question is that the participant can use her own words to describe experiences and reasoning from her own subjective perspective.

In all, 13 interviews were carried out that lasted from 60 to 80 min. The first interview was seen as a pilot test of the validity of the interview guide. However, as this interview gave rise to descriptions corresponding to the aim of the study, it was included in the analysis. Accordingly, the interview guide was not changed. The location of the interview was chosen by the participant, to assure a safe and relaxed environment that stimulated a free conversation. Thus, the interviews came to be carried out either in the participant's home or at a health care centre. Only the interviewer and the participant were present at the interview session, and only one interview was carried out with each woman. Questions about socio demography were asked in connection with each interview. Field notes were taken by the interviewer.

Table 1. Sociodemographic characteristics of the participants ($n = 13$).

Characteristics	$n = 13$
Age	
Mean years (range)	48 (31–63)
Health condition	
Musculoskeletal disorder	4
Burnout depression	4
Depression and musculoskeletal disorder	3
Cancer	2
Sick leave	
Full-time sick leave	4
Part-time sick leave	5
Returned to work	4
Duration of sick leave, mean years (range)	3.3 (0.5–11)
Unemployed	5
Occupation category*	
Managers	2
Professionals	4
Technicians and associate prof.	3
Clerical support workers	1
Skilled agricultural, forestry and fishery workers	2
Craft and related trades workers	1
Urbanity	
Regional city	2
Suburban municipality	4
Small rural town	2
Rural	5
Marital status	
Married/cohabit.	9
Single	4
Children <18 years	
Yes	4
No	9
History of language	
Native Swedish	9
Other	4

*Classification according to International Standards Classification of Occupations 2008, ISCO-08 (2012).

Participants

The 13 women were between 31 and 63 years old, with a variety of backgrounds concerning sociodemographic factors such as country of birth, history of language and education. Most of the participants were married/in a relationship, but singles were also represented. They had been on sick leave due to: musculoskeletal disorders such as osteoarthritis, fibromyalgia or low back pain; mental health problems in the form of depression, burn out depression or stress syndrome; or cancer. At the time of the interviews, eight had part-time or full-time work and five were unemployed, however with the experience of three months of being on sick leave during the most recent 12 months (see Table 1).

Analysis

All interviews were recorded and were transcribed verbatim (in Swedish) immediately after the completion of each interview. This step was taken in order to get a sense of the content and to develop and deepen the next interview.

The analysis was based on Graneheim and Lundman's method for qualitative content analysis [36,37]. The method provides an analytic framework with respect to the continuum from raw data to the interpretation of the latent meaning of the data. Both authors were involved in all parts of the analysis and held a continuous discussion about the codes and the interpretation of the emerging categories in order to establish credibility [36]. The interviewer's field notes were also considered in the process. In all parts of the process, reflexivity was considered in the form of acknowledging preconceptions as a factor that could potentially influence the process and the results during the analysis. Reflexivity was further considered by maintaining awareness of the professional preunderstanding and by looking for multiple interpretations of the experiences described.

The analysis process was started with a careful reading of the transcribed data to gain an overall understanding of the women's experiences. The second step was to find domains based on the manifest content; this was followed by distinguishing meaning units. The meaning units were then condensed. At this time, the content was still on a manifest level. In the following step, the content was abstracted and coded based on the latent content of the empirical data [36]. The interpretational process involved a continuous exchange between raw data, meaning units and condensed manifest meaning to secure an appropriate interpretation of the latent content. The process resulted in several codes. The next step included a discussion of the content of the codes to find relations and patterns based on similarities and differences [36].

The patterns that were found prepared the way for the development of three different qualitative categories, and altogether eight subcategories. The major part of the analysis was conducted in Swedish but, when patterns based on similarities and differences between the factors emerged, according to Graneheim and Lundman [36], a change was made to English.

Results

The analysis revealed three categories that describe the women's experiences of the situation of being on sick leave: being regarded as an object, being supported and being engaged. Two of the categories comprise three subcategories and the third has two subcategories. Citations are given to illustrate the

subcategories and ensure an empirical foundation [38]. The citations are adapted in written language according to Kvale [39] to avoid stigmatization.

Being regarded as an object

The category comprises experiences of how regulations beyond the individual's control influence the situation, leading to a feeling of powerlessness and of being in a subordinate position, where someone else rules the game. The category contains three subcategories with different dimensions of the experience of being regarded as an object.

Governed by rules

This subcategory includes experiences of being treated like a ball in a pinball machine, where rules and regulations from the different stakeholders manoeuvre the situation, with a lack of flexibility from the individual's point of view. Being governed by rules means that the stakeholders act as counterparts instead of being partners in cooperation. It also means that unexpected changes and decisions emerge, which in turn leads to a feeling of unpreparedness and greater worry for the future.

> … a person, who often feels very unwell, is put in a situation with … three strong people who have their own identity and have opinions and the like, it's a little … it was a little difficult.

Being reduced as person

This subcategory describes feelings of being reduced and objectified by being assessed and valued from an outside point of view, with the only focus being on the sick leave. Being reduced means experiences of being lifted out of the life situation as a whole, with a lack of consideration to other aspects in the life situation. It also means that the subjective perspective of the situation is neglected and that subjective opinions with regard to the rehabilitation process are questioned or not considered important. Being reduced as a person is experienced as a loss of identity and a breakdown in personality, i.e. not recognising oneself.

> There's that question all the time, 'is she really sick?' (laugh) 'is it that way?' 'can she really not manage?' And then you get answers to assessments and tests and … well, not much more happens and anyway it's questioned the whole time …

Being under pressure

This subcategory includes the experiences of being objectified by being expected to take actions and steps, or to take responsibility for the rehabilitation process with no consideration to what is realistic according to difficulties, abilities, level of energy and life situation. Being under the pressure of unrealistic demands and not living up to them raises feelings of being a burden to society and of a struggle without support. It also leads to fulfilling the role of being an object, taking a passive role in the rehabilitation process and adjusting to rules in order to be cooperative.

> … and it's the same as when you get the question' yes, when can you, when do you think you can start to work?' ooh, you just break down and start to cry, because you don't have any idea, you can't answer the question and you don't even want to have that question because you can't think, about that just then and then you don't want to have anything to do with it, like the Social Insurance Agency then for example that is pressing you …

Being supported

This category describes the experiences of being supported in different ways. The feelings of being supported are based on both direct and indirect support, which means that support was also experienced in actions and situations that were not intended to be supportive. The category is divided into three subcategories based on different forms of support.

A shared responsibility

A shared responsibility comprises the experiences of being supported by striving towards mutual goals or being guided in decision-making when onés own capacity is lacking. This striving includes cooperation with and help from the closest to the extended environment. It means collaboration with social security administrators, health professionals, next of kin, friends, workmates, and work supervisors, over the issues that emerge in the situation of being sick listed. The experienced share of responsibility for the situation arouses feelings of being an active and important part of the rehabilitation process.

> I feel that they're working for me, they're on my side, in some way, there's no one who puts a bunch of unreasonable demands but they understand me and they encourage me and they like lift me instead so that I'll just go to someone who, yes … maybe it's a little like, it's on my conditions, it maybe has to do with that … that you're a part of it and that they talk with each other about me and I'm, like, with them

Being regarded as a person

This subcategory includes the feelings of being supported when one is regarded and treated as a person.

It contains the experiences of being treated and evaluated by administrators and/or health professionals from a comprehensive perspective. This means being understood as a person imbedded in a complexity including family, work, experience of life, capability, loss of function, sickness, losses, joy, etcetera. Being respected on a personal level means that administrators and professionals take into account this complexity in discussions, plans and decisions related to the rehabilitation process. It also means the feeling of being understood in accordance with one's self-image.

> … support, believing in, believing in me as a sick person! And creating conditions so that I will be able to come back, and not … break me down but say … place just the right amount of demands, place demands that will make me come to, get myself moving and it's easier said than done … (laugh) but … and I don't think that you can work in ONE but that you have to work in many, many different ways, because we are different and we need different things during different periods

Being among like-minded

Being among like-minded describes experiences of support in the form of togetherness with others in the same situation. Sharing the unique situation of being on sick leave with others who are also on sick leave in meetings and activity groups gives feelings of not being alone. Hearing stories about others struggling with issues related to sick leave and illness confirms the validity of one's own experiences.

> … but I've gone to these groups the whole time during my sick leave, and without THEM I DON'T know how it would have gone … there's where I've gotten the greatest strength …

Being engaged

This category comprises experiences of being engaged and taking actions that aim at making the best of the situation.

Active problem solving

The engagement is represented in the form of reflections and reasoning on how to actively meet challenges connected with the situation of being on sick leave. Making reflected and active decisions about how to meet the challenges involves either leaning back and accepting things as they are or taking an active part in the rehabilitation process. Being engaged in the process means an active search for solutions to problems that arise and finding out how to behave in different situations. The decision to be engaged in the process means gaining control by achieving reliable and good knowledge about what is happening.

> I tried to take control and my goal the whole time was to go back to work, there wasn't any other direction then, you know, but at the same time it did exist since I got it back (the job),

Meaningful activities

Being engaged also means keeping up everyday routines, performing activities that include some form of responsibility, and implementing new meaningful activities into daily life. In this way the activities in everyday life become a source of joy and satisfaction and help to distract from demands and stressful thoughts. Taking part in meaningful activities also leads to feelings of being needed and belonging to a larger context, also including the work place.

Engagement and active steps taken in both the rehabilitation process and in daily life as a whole is experienced to contribute to self-reliance and maintain a positive self-image.

> I could have chosen to just let her go (concerning her own choice to take regular walks with the dog), but I'm not doing that and I would never do it. It's what's saved me, because then I have a demand on me, and at the same time I become, I get a stronger identity for myself.

Discussion

Exploring the persońs own experiences while she is on sick leave revealed three categories that could be discussed as related to, or having an impact on, each other in different ways, depending on the perspective used to understand the complex situation during the sick leave process. Furthermore, depending on the perspective chosen, the categories can be seen as either barriers or enablers during the rehabilitation process.

The first category, being regarded as an object, may be seen as a hinder to the persońs capacity to take part in the process. Having limited control over decisions made, with no concern given to individual resources or the life situation as a whole, has been discussed as having a negative impact on self-image and a disempowering effect on the rehabilitation process [17]. It has been proposed that, when the sick leave process works in the direction of inducing either pride or shame in the individual, resulting in a positive or negative self-evaluation, this will contribute to effects on both work ability and health [18]. This

result is also in line with those in a study by Holmgren et al., in which persons on sick leave experience that objectification, in many cases due to a non-transparent decision-making process, leads to vulnerability and distrust [13]. The experiences of being regarded as an object, and thereby losing ones sense of identity, further counteract the possibilities of being an active part in the process and making informed decisions about the process [19]. Considering all the negative aspects of the experience of being regarded as an object, the question is whether the process can be regarded as rehabilitative. These results rather indicate that it is an aggravating process.

Experiences of being ruled and being under pressure can also be discussed from an occupational perspective, as in the Person-Environment-Occupational Performance (PEOP) model [40,41], where the match between intrinsic factors, including sense of identity, and environmental factors, such as laws and policies, supports or restricts the activities and roles of the individual. When the interaction gives a positive match, this leads to occupational performance and participation as well as well-being. The individual's perception of needs, goals and meaning is an important feature in obtaining this match. An all too objectified assessment of work capacity during a period of sick leave, and where no consideration is taken to personal goals and meanings, or the impact of environmental factors, can lead to a mismatch. This hinders the rehabilitation process [41] and may also be regarded as aggravating instead of rehabilitating.

The category termed being supported can be understood as the opposite, where the individual is treated as an equal counterpart. During this type of encounter, taking note of the life situation as a whole is an important feature, in planning for further steps and timing, in the rehabilitation process. This result is supported by other studies [17,24,25,42] that have focussed on how encounters with professionals have an important impact on the person's feelings of being listened to and invited into active participation, as well as on the sick leave process per se.

Support comes not only from professional actors but may be experienced when a person feels she is understood and able to share troubles with family, workmates and, not least, others in the same situation of being on sick leave. The effect of supportive networks has been described in other studies. These can contribute to the ability to make informed decisions [19], or strengthen the experience of the 'return to work self-efficacy', a phenomenon that has been proposed to be an important factor with an impact on the sick leave process [32].

In the PEOP model [40], social support is described as an important feature among the social determinants belonging to the environmental factors, influencing performance and participation. Social support is described as central to individuals when engaging in everyday life activities, such as work. Support can be divided into three aspects: informational, such as advice and guidance; tangible, such as assistance; and the support of belonging, which arises from being a part of something. Social factors, in this sense, may be seen as enablers or barriers in the transition from being on sick leave to regaining a worker role [40].

The third category, being engaged, comprises factors that deal with how the individuals take actions to be an active and self-reliant person during the ongoing sick leave process. This means both keeping up with valuable everyday activities as well as searching for new strategies directly related to the situation of being on sick leave. Being engaged is closely related to the occupational identity: who we are, and who we want to be. According to the Model of Human Occupation (MOHO) [3], occupational identity together with occupational competence constitutes our occupational adaptation. For the participants that had had a workplace at which they were expected and which provided meaningful work tasks, this particular occupational identity (worker role) could more easily be matched to the experienced competence, and thereby support a plan for RTW. In another situation, e.g. that of being unemployed, the self-image of a worker's occupational identity is negatively influenced and in more need of support from others to be regained [43]. The struggling with retaining a worker role identity is emphasized in a study of Cameron et al. [44], describing that recovery has been promoted by sustaining routines, activities and social contacts. That study proposed a new concept, occupational capital, highlighting the occupational dimension in public health areas such as the sick leave process. In this sense, occupational capital is defined as a combination of external opportunities and support for occupational performance and the internal capacities to access this [44]. This is in accordance with the results of our study, where keeping up meaningful, everyday occupations leads to feelings of competence and importance. Adding a focus on participation in everyday occupations could thereby be proposed to support recovery against a more resilient worker-role [44]. In addition, such a focus is also compatible with

findings from another study [45], where coping-developing interventions were found to have an impact on work ability as well as other everyday activities.

To summarize, the results of our study acknowledge the sick leave process as a complex phenomenon, better understood and supported by using multiple dimensions. In correspondence with a study on the concept of work (dis)ability [46], these dimensions work at both the individual, organizational and societal levels, underlining the dynamic nature of the phenomenon. Further, the results also correspond to the understanding of occupation and occupational performance through the complex interaction between the person, occupation being performed and the environment, as is proposed in several occupation centred models [1,5,16]. According to the Value and Meaning in Occupations model (ValMO) [47], the occupation of working is seen as an important part of the life course repertoire, and therefore also contributing to fulfilling meaning and supporting health. As discussed above, having an occupational perspective on the sick leave process could contribute with a larger focus on how the individual's whole life situation interplays with the struggle of regaining work capacity and keeping up a worker role, both related to assessments for sickness benefits, and communicating rehabilitation plans.

Methodological considerations

The methodological issues will be discussed based on the concepts of credibility, dependability and transferability [36].

Concerning the credibility of the results, the group of women interviewed was heterogenic with regard to age, professional background and reason for/endurance of sick leave. This heterogeneity is assumed to have contributed to a variation of experiences and richness of content. This appears in the results in the form of the broadness of the dimensions related to the three categories, an indication that the credibility could be judged as sufficient.

On the other hand, a major limitation with regard to credibility and to transferability of the results is that the only exclusion criterion in the study (such difficulty in speaking or understanding the Swedish language that an interpreter would have been needed) may mean that some aspects of the phenomenon studied are missing. Not seldom, groups of people are excluded from research due to language barriers [48]. However, the exclusion criterion was set on the basis of the assumption that interpretation or translation may mean a risk for a change of the inherent meaning of data.

In the analysis process, the empirical data (the interviews) were clearly manifested in different categories. This is judged to strengthen the credibility of the results. A way to further strengthen the credibility would have been to ask the participants to give feedback on the findings. This was not done, however.

The fact that the interviewer was a Master student in public health with limited experience of the sick-leave process, occupational science and qualitative research may be regarded as both a limitation and a strength for the dependability as well as the transferability of the results. Due to her lack of knowledge in these areas she may have missed some possibilities to deepen the questions. On the other hand, she was not governed by preconceptions or other forms of preunderstanding, which may have contributed to unbiased interviews that gave open-hearted conversations with the women as well as honest and rich information. Further, the two authors' knowledge in the focussed area and their experiences of the method chosen may compensate for the limited experience of the interviewer. In all, the different levels of experience in the research group, concerning both method and area, may be viewed as a possibility to stimulate discussions at the prospect of data collection and in the data analysing process. However, a possible limitation may lie in the fact that both the interviewer and authors all were females, which may have influenced the process as a whole. Thus, regarding dependability and accuracy, this aspect must be taken into account as concerns the quality of the findings.

The experiences presented in the three categories are based on data collected from a small, limited group of women, who are homogeneous concerning being on sick leave and having an interest in sharing their experiences. Because of this small group of participants, the transferability of the results must be regarded as limited. However, this exploratory study does not claim to give evidence of the experiences described in the results, nor do we wish to make generalizations. Rather, our interest in hearing the women's views of their sick leave experiences guided the choice of the qualitative method.

It could further be argued that the transferability is limited concerning the sick leave situation for men. In this study, we have deliberately chosen women as the target group, as women are more highly represented in the sick listed group, and also have longer sick leave periods [30]. Whether our results could also correspond to groups of men, is beyond the

scope of the study. More research is needed to elaborate on that issue.

Conclusions

The results of the present study on the experiences of the situation of being on sick leave support the notion of this process as being a dynamic phenomenon, influenced both by structural and individual factors, affecting both the sick listed person and her closest environment as well as the professionals involved (in this process). Understanding the sick leave process, with the aim of supporting options for return to work, by using occupation based models that underline the importance of the interaction between person, occupation (work activity) and the environment, may contribute to elucidating the complexity of the matter.

Acknowledgement

The authors would like to express their gratitude to MSc, Public Health scientist Maria Andersson for carrying out the interviews.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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