

Enhancing credibility: A qualitative study of being on sick leave with a stress-related psychiatric diagnosis

Lena Ede

Department of Social and Psychological studies
Karlstad University, Sweden
lena.ede@telia.com

Ulla Rantakeisu*

Department of Social and Psychological studies
Karlstad University, Sweden
ulla.rantakeisu@kau.se

*corresponding author

Abstract

In the Western world mental health problems are increasing and in Sweden these problems are the most common reason for sick leave. Diagnoses of adjustment disorders and reactions to severe stress are increasing the fastest out of all mental health problems. The aim of this study is to contribute new insights into employees' experiences and management of being on sick leave with a stress-related psychiatric diagnosis. The empirical material consisted of individual interviews with 26 employees who were on sick leave from at least part-time employment because of a stress-related diagnosis. The grounded theory method was used to analyse the results. In the generated model, we propose that sick-listed employees engage in enhancing credibility in relation to themselves and others, here attempting to come across as credible and, thus, avoiding disbelief and the negative attributions of being on sick leave with a psychiatric diagnosis. The interviewees shared the general concern that being perceived as either healthier or sicker than the case may be, as well as greater sensitivity to what others might think, which was manifested as being on guard and controlling their behaviour and emotional display. To return to work, the sick-listed employees tended to re-evaluate their previous performance at work and saw the illness as self-inflicted and as the result of not having been capable of drawing the line between work and leisure.

Keywords: sick leave, stress-related mental health problems, credibility, emotional labour, grounded theory

Introduction

Mental health problems are increasing in the Western world (OECD 2016) and are the most common reasons for sick leave in Sweden. Diagnoses of adjustment disorders and reactions to severe stress are increasing faster than any other psychiatric diagnosis (Försäkringskassan [Social Insurance Agency], 2017). Hence, the intention of the current study is not to explain the causes behind stress-related mental health problems, which other studies have done (Aronsson et al., 2017; Sverke et al., 2016; Bryngelsson, 2013), but to increase our understanding of what it is like to be on sick leave. Research surveys have shown that there is a lack of qualitative studies of the experience of being on sick leave with a stress-related psychiatric diagnosis from the perspective of the afflicted employee (Vingård, 2020; Aronsson & Lundberg, 2015). However, there are a number of studies indicating poorer personal finances, risk of social isolation, and difficulties in returning to work, which are all aggravated by the duration of sick leave (OSHA, 2019; Hees et al., 2012; Gellerstedt, 2011; Hesselius, 2007). Therefore, the aim of the current study is to contribute new insights into employees' experiences and management of being on sick leave with a stress-related psychiatric diagnosis.

In the Scandinavian welfare model (Esping Andersen, 1990), sick leave provides a formal right to be absent from work to recover from an injury or illness, but it also involves the obligation to rehabilitate and return to work and have self-sufficient income (Lindqvist, 2000). In recent decades in Sweden, this obligation has been tightened through the so-called rehabilitation chain, in which there are scheduled checkpoint review meetings and the Social Insurance Agency's medical evaluation model, which involves specific sick leave recommendations for various diagnoses (Försäkringskassan, 2014). The work capacity strategy is applied more clearly in healthcare insurance through this shift from a focus on illness to work capacity. A medical diagnosis is no longer sufficient for sick listing unless the illness also leads to an incapacity to work (Nord, 2018; Seing et al., 2011).

Concurrent with the amendments above, there have also been changes in the social conceptions of sick listing practice (Johnson, 2010). Concepts such as morality, taking undue advantage of the system and fraud have become

commonplace in the public debate (Junestav, 2009). Previously, sick listing was seen as the result of a poor work environment and the sick-listed person as a victim of circumstances, but now, the discussion has turned into defining sick leave as a way of making a living and the sick listed as abusers of the insurance system (Johnson, 2010). These two social policy developments have increased the emphasis on the obligation to work and actively taking responsibility for rehabilitation rather than passively receiving financial reimbursement (Nord, 2018).

In addition, sick-listed employees with psychiatric diagnoses are burdened in two ways: First, they risk being ascribed the denigrating attributes associated with mental disorders. Second, there is the historical notion of the mentally ill as unpredictable, unreliable, dangerous and violent (Angemeyer & Dietrich, 2006; Pescosolido et al., 1999), along with the notion that a mental health problem is not a 'real disease' (Johnson, 2010). Studies have noted that mental health issues and illnesses based on patients' self-reports without clear, visible symptoms are trivialised and considered less legitimate reasons for being sick listed (Knapstad et al., 2014; Newton et al., 2013). These are disorders on the bottom rungs of the medical ladder, and patients are not taken seriously by doctors (Werner & Malterud, 2003; Album & Westin, 2008) or by the Social Insurance Agency and public employment service officers (Svensson et al., 2003). Indeed, other studies have described sick-listed employees' struggles to gain legitimacy and recognition for their conditions (Aronsson et al., 2015; Eriksson et al., 2008; Wessel et al., 2012).

The fact that stress-related mental problems have been predominant among psychiatric diagnoses in Sweden since the beginning of the 2000s (Försäkringskassan, 2020) accentuates the issue of work capacity assessment in relation to sick-listed employees. Research has shown that the view of mental health problems as hypochondria (Johnson, 2010) combined with the Social Insurance Agency's stricter emphasis on work capacity has caused sick-listed employees to feel questioned by the authorities and others (Lännerström et al., 2013), partly in terms of the seriousness of their conditions and partly in their efforts to recover (Flinkfeldt, 2016). In other words, sick-listed people with mental health problems run the risk of being viewed as averse to working, cheaters (Johnson, 2010) or as being healthier (Flinkfeldt, 2016) or sicker (Angemeyer & Dietrich, 2016) than they are. Whatever the case may be, being on sick leave involves potentially being categorised by others as cheaters or malingerers, which may contribute to a

sense of being stigmatised (Goffman, 1963/2014), in turn resulting in stress, status loss and lower self-esteem (Aronsson et al., 2015; Knapstad et al., 2014; Eriksson et al., 2008). One way of dealing with this is to adjust one's behaviour to match the social norms and perceptions of the sick listed in the appropriate way (Flinkfeldt, 2016; Lännerström et al., 2013; Wessel et al., 2012; Werner & Malterud, 2003). This behaviour, which Goffman (1959/2009) terms impression management, involves being constantly alert to making the expected impression and presenting oneself in the best of light.

Methods

The empirical material was collected in the spring of 2010 as part of a larger research project funded by the Norwegian Research Council, here with the aim to study the social aspects of sick leave in Sweden and Norway. The current article is based on the interviews conducted in Sweden by the first author together with another researcher, both of whom were members of the Swedish research team. The interviews were transcribed by the interviewers and used in three articles, including the present one. In total, the interviews were conducted with 26 individuals (15 women and 11 men) who were on sick leave from at least part-time permanent employment because of a stress-related psychiatric diagnosis¹ and who had been on leave for at least 60 and no more than 365 days. Apart from the criterion of being on sick leave, the selection was made based on having an even gender and age distribution. The sample, which was based on the most common psychiatric sick leave diagnoses, was selected by the research group, including a physician, in consultation with two case managers from the Social Insurance Agency.

For confidentiality reasons, initial contact with the selected interviewees was made by two case managers from the Social Insurance Agency. By phone, they were informed about the study, told that participation was voluntary and were asked for participation. A total of 40 individuals were contacted, and of these, 14 declined for health reasons. When consent was given, the contact details were forwarded to the research group. Then, the two researchers

¹ The sick-listed individuals in the study belonged to the following diagnosis groups (according to ICD-10): F32 (depressive episode), F43.0 (acute stress reaction), F43 (adjustment disorder and reaction to severe stress), F43.9 (stress reaction/crisis reaction), F43.8 (fatigue syndrome) and Z73.0 (burn out). They were diagnosed on the basis of these symptoms by their general practitioner.

conducting the interviews contacted the interviewees to make an appointment for the interview. Occasionally, a third person in the research group was involved. The research group estimated that the 26 individuals interviewed were sufficient to answer the research question, which is why no further contacts were made. All interviews were individual and typically conducted in the homes of the interviewees—in a few cases, in the workplace and at the university—and lasted between 1.5 and 2.5 hours. In accordance with the guidelines for classic grounded theory (CGT) (Glaser, 1998), the interview guide was fairly open although thematised. We wanted the interviewees' own stories of what it was like being on sick leave with a stress-related psychiatric diagnosis, and great emphasis was placed on letting the interviewees talk freely about their sick leave experiences. The interviews were recorded and transcribed immediately after the interview by the interviewers/researchers, and the name of each interviewee was replaced with a fictive name.

A great number of professions and educational levels were represented and evenly distributed between the private and public sectors (e.g., teacher, social worker, auxiliary nurse, engineer, photographer, security guard, printmaker). All of them had different types of service jobs or jobs involving frequent contact with people other than colleagues, and they belonged to various age groups, from 29 to 58 years old.

Analysis

The CGT method was used in the analysis. CGT is characterised by adopting an explorative and inductive approach towards discovering what is perceived as a problem in the attempt to understand the respondents' actions (Glaser, 1998). Because our study aims to seek new knowledge through the self-lived experiences of being on sick leave, CGT offered a suitable approach for the analysis. The steps in the analysis were taken in accordance with the principles of CGT, involving careful reading of the interview transcripts, open coding, selective coding and continuous comparisons of different events, that is, indicators that can be interchangeable, and finally conceptualising and generating a model presenting the results (Glaser, 1998). When the interviewees' central problem emerged, that is, how to credibly avoid the risk of being attributed negative associations of long-term sick leave and a psychiatric diagnosis, the open coding was concluded, and we moved on to selective coding, which was delimited to finding data related to the core category. The core category (i.e., the main concern) emerging from the empirical material was termed *enhancing credibility*. The crystallisation of *enhancing credibility* can be

understood as a process consisting of three phases: *healing of self*, *situational adjustment of self* and *reconstructing self*. These phases were reported by all the respondents, even if there were variations *within* the healing of self, for example.

Ethical considerations

Ethical aspects were given great emphasis because the interviews might touch on delicate areas. In compliance with the law on ethical review (SFS 2003), an application was submitted to the Ethical Review Board in Uppsala, which was approved on 17 February 2010, reg.no. 2010/014. In connection with each interview, the interviewees were provided with contact details to members of the research group, one of whom was a physician. All the interviewees were informed in person that they could withdraw from the interview at any point; they also signed a consent form

Results

The results of the generated model and the central concepts are presented in Figure 1.

Figure 1: Enhancing credibility

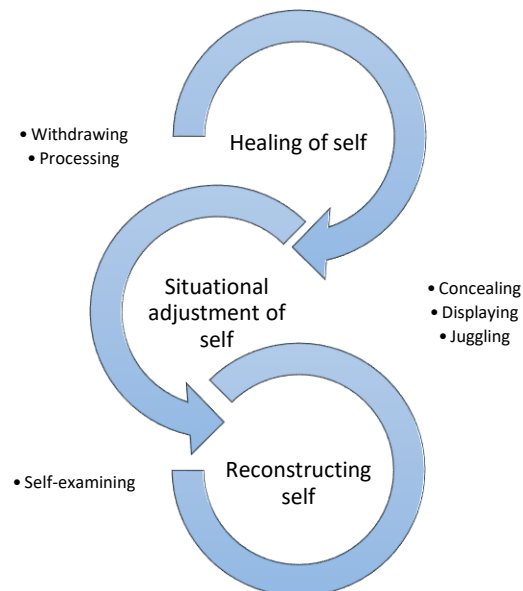


Figure 1: Model for reducing the risks of the negative attributions of sick leave and psychiatric diagnoses. A three-phase process of enhancing credibility.

Enhancing credibility

In the generated model, we propose that employees on sick leave engage in *enhancing credibility* in relation to themselves and others, here attempting to act in what others would believe is credible, thus avoiding disbelief and the negative attributions being on sick leave with a psychiatric diagnoses. This takes place in a process of three phases without strict borders. The first phase, *healing of the self*, involves withdrawing from others to recover at home. Somatic and cognitive disorders need attention and healing, and at the same time, the new experience of being on sick leave with a psychiatric diagnosis needs to be processed in relation to the previous experience of being gainfully employed. The second phase, *situational adjustment of self*, involves adjusting one's behaviour and the information provided about the situation when meeting others to avoid being discredited. This is done by concealing, displaying or juggling. In the third phase, *reconstructing self*, the causes for the sick leave and the previous approach to work are reconsidered during a self-examining process.

Healing of self

Healing of self refers to the acute and subsequent phase of being on sick leave when rest and acceptance of the new situation are needed, partly because of extreme tiredness—the body is exhausted and in need of rest—and partly because of social reasons that push one to escape from confronting others. This involves withdrawing to home to care for and heal one's somatic and cognitive ailments in the form of aches, attention deficiency and memory loss. At the same time, the reason for the sick leave is *processed*, along with how to handle the new situation.

Withdrawing

Healing the self involves an active choice, given the circumstances, to withdraw to one's home to save what is left of one's energy after a pressing situation at work that has been occurring for an extended time period. A characteristic feature of the interviewees' accounts is that they have experienced an increasing workload, which has led to work-related conflicts with superiors (Ede & Starrin, 2014). They have informed managers and superiors of their situation regarding getting on better terms and conditions at work but to no avail. To meet the employer's ideals and their own demands on performing well, several of them have shouldered their own duties, as well as

the duties of others, in an accelerating accumulation of tasks. Such behaviour may be understood as meaningful in the current work situation that is characterised by individualised responsibility for meeting and maintaining the requirements and quality of work through individual unicity, flexibility and social competence (see, e.g., Garsten et al., 2011). At the same time, it is a health hazard. Withdrawing to home means drawing a line for others to protect the self from further ordeals: 'I stay away from people, because if can't cope with myself, I can't cope with others either—so, sure, I isolate' (Ingvar).

Processing

Healing of the self is also about processing the new experience of being on sick leave, which is different from being at work. This means struggling with the social perceptions of sick listing and psychiatric diagnosis in relation to a changed view of themselves. This indicates a clear contradiction between their previous self-image as being a strong professional and being a weak professional. Ingrid described a bitter awakening when she saw this shift from strong to weak:

At first, I needed to take it in. What do I think, and what happened? Being on sick leave is a confirmation of not having the strength. I have heard this since childhood—such a person is someone who doesn't want to work and is on sick leave all the time. But I will not be on sick leave because I'm the strong kind.

David also did not want to acknowledge his new position as sick listed because this meant being a burden to others. The norm of making a livelihood is strong, and this norm is emphasised by the work capacity strategy in the social insurance system. Doris was very aware of her position as being sick listed and did not want to identify as such. Others refused to acknowledge the psychiatric diagnosis, which was experienced as a degradation of their own value: 'No way this is me. It was an absolutely shattering thought' (Maria). It was also common to grapple with the loss of status following the diagnosis and/or being on sick leave.

Conceptions are partly formed through the way work as a central institution structures life. At work, the interviewees were strong and loyal until their whole beings were drained of energy: 'I don't know if I ever will be who I was before. Don't know if I want to either—a person who always pitch whatever the cost' (Gunnel). Being on sick leave with a psychiatric diagnosis means being in a position in which a certain self-image cannot be maintained but runs the risk of

being replaced with an image of a vulnerable, insecure and weakened individual. Possibly, the gap between being healthy and at work and being sick and on sick leave is greater when individual responsibility and the power of initiative are increasingly emphasised in work organisations. If recognition of performance at work is ruled out, the issue of identity emerges, revealing one's experienced shortcomings. Also, the new social context differs radically from time period before the sick leave began. There is a clear difference between the previous self-perception as strong and the present sense of weakness.

Situational adjustment of the self

Situational adjustment on sick leave entails adjusting to what others are assumed to expect to avoid intrusive questions or a lack of understanding. The interviewees shared a great sensitivity to what others thought, which was manifested in their being on guard and controlling their behaviour and emotional display. The norms of behaviour that seemed important to follow varied depending on the situation. Three types of adjustments were identified: first, *concealing* the predicament to avoid detection; second, *displaying* the situation to gain recognition as a valuable person despite the sick leave; and, third, *juggling* appearances to the diverse needs of a situation when various and contradictory impressions should be displayed at the same checkpoint interview².

Concealing

The invisibility of the situation makes it possible to conceal both the sick leave and diagnosis to avoid being misunderstood. This was done by avoiding situations in which sick leave may be revealed and by resorting to white lies to escape talking about the predicament. Christer said that when placed in a situation of having to explain his sick leave, he resorted to a white lie to avoid revealing the diagnosis: 'It was very embarrassing, that's why I lied. I said it was stomach problems. At first, it felt awful to lie, but gradually it became easier'. Others blamed it on high blood pressure or backache or chose not to

² Checkpoint review meetings were introduced in the General Insurance Act (AFL 3) in 2003 as a demand placed on the Social Insurance Agency to evaluate medical conditions, work capacity and rehabilitation potential. The purpose was to assess the right to financial support and to draw up a rehabilitation plan (Seing et al., 2011).

say anything at all but instead ventured the risk of encountering prejudiced opinions about sick leave, which was also experienced in contexts where a diagnosis was unknown.

An invisible illness can also mean encountering disbelief in the illness and being treated as a fraud. 'I can't be laughing and talking on the phone in town', as Helena said, 'Somebody could see me and think I'm not ill'. Karin explained the difference between a visible illness or injury and the invisibility of her condition:

This is different from a broken leg, which takes six weeks to mend and you know that from the day on which the cast is removed, there may be two weeks until the leg is as it was before. (...) Everyone sees it and knows that it hurts and how uncomfortable and awkward it is with the leg. With my illness, no one knows anything. I would rather have broken both legs and arms, too, come to that, then enduring this because then I would know that I'll recover soon and that it would happen. The feeling of being disbelieved is the worst.

On the one hand, they hoped not to be perceived as healthier than they were because this would mean being regarded as lazy or a cheater. Conversely, they hoped not to be sicker than the case because the psychiatric diagnosis signalled a humiliating weakness. At the core of this was the problem of relating to two conceptions of sick leave and psychiatric diagnosis: as strong and, hence, *lazy* or as ill and, hence, *weak*. If the norm of strength as 'healthy but lazy' is placed at one end of the axis, the other end holds 'weak enough to be excluded' from any work. This problem is aggravated by the fact that the illness itself was devaluating and seen as self-inflicted. The absence of pronounced social circumstances causing the illness enabled linking the sick leave to the individual, who then became synonymous with *being* weak or having caused the illness.

Displaying

Situational adjustment involves the active pursuit of support by choosing to disclose the situation to gain recognition and be respected as a credible person with an illness, which, although invisible, seriously impacts one's health. The pursuit may target professional support—individual or in a group—or the support of family, friends and acquaintances. By carefully choosing to whom the truth can be revealed, independence is displayed, even if the choice is made in uncontrollable circumstances. Doris would carefully choose her

confidants: 'I have the true friends to thank for my road to recovery', she said, with emphasis on the word 'true'.

Physicians explained the bodily healing process to the interviewees, which meant that they had an understanding of their illness. As Gustav put it, 'I used to think that others should pull themselves together. I have really tried, but it doesn't work, and it's difficult to understand for anyone who hasn't been there'. Others participated in various forms of group therapy that were appreciated and useful, particularly hearing the stories of others and relating to them: 'I was not alone' (Eva). Support was also provided by fitness friends, hunting friends or friends in various associations. In a safe, social context, courage to share can be mustered, and the interviewees had also been treated with ego-boosting respect and warmth in these social contexts.

Most of interviewees were, at the time of the interview, back at work for a quarter of a normal workweek. For most of them, this was not a voluntary choice but a consequence of the Social Insurance Agency's scheduled checkpoint meetings. The interviewees struggled to regain the concentration required to solve tasks, and a supportive environment seemed to be a prerequisite for successful return. Stefan had returned to work part time and could testify that his superiors cared for him and showed that they wanted him back. Johan was also working half time and said that his colleagues were very supportive: 'If I have a really bloody awful day but still managed to go to work, then I say so and then they know. They back me up, if needed'.

Juggling

There are particular events related to situational adjustment of self when personal appearance is especially troubling in the rehabilitation process of the sick listed. These are the required checkpoint review meetings with the Social Insurance Agency case manager, the employer or a doctor. The interviewees were clearly aware of the various actors' different social positions in relation to themselves and the need to appear ill but in different ways. There were aspects they wanted to share with or keep from various actors, but the balance of power in which the sick-listed employee might feel insecure and powerless made it difficult to control the situation. Helena explained the balancing act of appearing as sufficiently ill and sufficiently healthy in the same meeting as follows:

If I appear to be too happy, the doctor might not see me as sick and might end my sick leave, and if I appear to be sad, my superior might not want me back. In the same meeting, I must show two different faces, but there is no difference in how I feel when I'm supposed to prove that I'm ill or in how I feel when I'm supposed to prove that I'm well. It's a struggle to show that I can manage but not too much. And that I'm ill but not too ill.

In the checkpoint review meetings that several of the interviewees referred to, they tried to demonstrate their capacity, but the nature of that capacity had varying characteristics in relation to the doctor, case manager and employer. If the appearance was not accepted, there might be repercussions in the form of sanctions, such as no extension of their sick leave or not being able to return to work. In such meetings, it is clearly important for the sick listed to be what they profess to be, but there is also the dilemma of having to present different versions of themselves in the same context. Johanna struggled with having to present herself as ill—and, in her own eyes, as weak—in relation to the doctor and the case manager, which was not the image she had previously presented to her superior and which she wanted him to retain:

It is very hard to show a side of me that my boss has not seen before. He got to see a weakness that I've never shown because I've tried to appear very capable of getting a higher salary. In his eyes, I wanted to be a high achiever, and now, that has been blown to bits.

Reconstructing self

Reconstructing self refers to the new experiences of illness and sick leave that contributed to the interviewees' re-evaluation of previous conceptions and approaches towards work. Through self-examining their activity, they sought answers to the causes of sick leave, and new insights emerged. Previous attitudes towards work and lifestyles were reconstructed, and their self-images were reshaped and modified.

Self-examining

The view that illness was self-inflicted was common among the interviewees. 'My sick leave was caused by my personality' (Birger). The previous approach to work was now seen as bordering on the pathological, as Maria explained:

This insight came at a cost for me, but it was necessary. I didn't know where the brake was. I only knew about accelerating. I have always been balanced on the brink of my limit of competence. I must learn to draw the line. I'll start

by taking care of myself and realising that everything might not be my responsibility. (...) Yes, I accept the blame, but I'm also responsible. Only I can do something about it. I became aware of what I was doing when this happened. What triggers me to get going.

Self-examining activity can also involve questioning one's previous career choice: 'If my work makes me ill, I'll try something else', as Doris said.

When our interviewees started rehabilitation, they learned that the cause of illness was primarily their inability to listen to bodily signals and draw the line between work and leisure. Their activities focused on stress-reducing techniques and new mindsets regarding settling for 'good enough'. In this way, people on sick leave can be burdened for failing to cope with work in an individualized way. Johanna explained the following:

What we talk about in the [therapy] group is, on the one hand, the need to shrug off capability and get a picture of how to be. That's slightly paradoxical: you should be good at not being good.

There were many accounts of changes made in their daily lives in an effort to recover. These included changed habits and health-promoting measures such as food, sleep, exercise and more social contact with people labelled 'energy-providing' people, that is, individual- and relationship-centred activities to change themselves and their attitudes towards their previous lifestyles. The common factor is that they were all expected to change their approach towards work because this was the main reason for their sick leave.

Discussion

The aim of the current study was to contribute new insights into employees' experiences and management of being on sick leave with a stress-related psychiatric diagnosis.

The results show that *enhancing credibility* is central to the sick listed in the process of creating and verifying their self-image to avoid the risk of being ascribed the negative attributions associated with sick leave and psychiatric diagnoses. This process has three phases. The first phase, *healing of self*, involves withdrawing from other people to recover at home and process the new experience of being on sick leave in relation to being gainfully employed. Having been a healthy and strong individual, the afflicted must confront a self-

image impaired by being weak because of a status-lowering diagnosis, as well as a position of dependency, that is, being incapable of coping. Being strong reflects an important quality in working life, indicating ambition, while being weak signals falling behind in an age when the duty to work is emphasised (Allvin et al., 2006; Garsten et al., 2011).

The second phase, *situational adjustment of self*, involves adjusting one's appearance to avoid being viewed as healthy, which might suggest laziness or sick leave cheating, or conversely, to avoid being perceived as mentally ill and, thus, of an unsound mind or being too weak. This adjustment is similar to what is found in a study by Werner and Malterud (2003), which shows that patients with medically inexplicable illnesses have to fight a battle for their credibility in claiming a medical condition, even though it does not show. The wish to make a good impression can be explained in terms of Goffman's dramaturgical perspective and the concept of impression management (1959/2009), which he defines as the way an individual constantly attends to their expected impression according to prevailing norms and to appearing at their very best to escape being miscredited. The interviewees in our study were invariably observant of their appearance and intent on displaying what they thought would be the expected appearance and feelings so that they could seem credible in each situation.

They shared great awareness of the importance of presenting themselves in the expected way. To understand the frustration demonstrated in their enhancing credibility, we turn to Hochschild (1983/2012) and her theory on 'emotional labour'. Sick-listed employees exert great self-control by disciplining and suppressing genuine and spontaneous feelings when meeting others to ensure that the 'appropriate' feelings are displayed. Happiness, for example, seems to be an emotion that needs suppressing to avoid suspicion of being healthy and a fraud. Conversely, excessive sadness or crying must also be avoided because such a display can be seen as weakness and a reason for being excluded from work. Long-term discrepancies between genuine feelings and surface acting creates emotional dissonance, which Hochschild (1983/2012) argues may have a negative impact on health and well-being if it continues. Efforts to conceal certain emotions while displaying others are frustrating and may result in an emotional dissonance, delaying recovery. There are studies showing that emotional dissonance leads to emotional exhaustion (Jeung et al., 2018; Rustad Indregard et al., 2017), but the issue of whether emotional dissonance may prolong sick leave needs

further study. There are also studies highlighting several causes of delayed recovery and prolonged sick leave, such as social isolation and concern about personal finances and unemployment (Hees et al., 2012; Gellerstedt, 2011; Hesselius, 2007).

The third phase of the process, *reconstructing the self*, involves self-examination regarding the causes of the sick leave. The individual's previous approach to work has to be redefined as a failure and in need of change, a self-judgement that coincides with and is strengthened by the individual-centred rehabilitation system with therapy sessions conveying the message that the cause of their sick leave lies in their inability to draw the line between work and leisure; this raises their awareness of the importance of 'relearning' to fit into a work organisation with the help of stress-reducing coping strategies and of new mindsets such as 'good enough'. The origin of the illness seems to be their previous approach to work. This kind of reconstruction of self does not allow for extended individual room for acting but rather more restrictions. The conditions set at work increase the demands for the ability to plan, organise and manage duties, which means that it rests on the individual to formulate and manage the drawing of lines. For some, this may mean a sense of freedom. For others, however, it may lead to insurmountable demands and sick leave because the conditions at work differ greatly.

Consequently, reconstructing the self involves attempts to meet the demands of modern boundaryless work (see Allvin et al., 2006; Garsten et al., 2011). We argue that there has been a shift in emphasis regarding both responsibility and level—from employer and organisation of work to the individual employee. To fit in at work again, sick-listed employees must reassess their previous work performance and reshape themselves to match the requirements of work. Combined with the stricter health insurance emphasis on work capacity (Nord, 2018), the changes made in work organisations are consolidated and can be maintained because it is up to the employees to change so that they can fit in and retain their employability.

Finally, in the current analysis, individual experiences emerge as analytically abstracted and linked to the underlying conceptions of normality and deviation in the context. The self-images presented in the efforts to enhance credibility must be understood in relation to the various negative conceptions of being on sick leave with a psychiatric diagnose and that recovery and readjustment of self take place against the background of such norms.

The current study has practical implications for social work because there are frail social relationships, on the one hand, and trusting social relationships, on the other hand, to which the individuals on sick leave can relate. Thus, it is not accessibility to different treatments or the joint efforts of various professional roles that may benefit one's return to work—the required checkpoint review meetings may seem problematic—but the highlighted aspect of significance emerging from the study is instead the quality of the social relationships, which ideally should be trusting and personalised.

Limitations

Although the results of this CGT analysis are only applicable to the respondents involved in the current article and though the empirical material dates back to 2010, we maintain that it still has great relevance and topicality because the urgent issues of stress-related mental problems remain today (Eurofond, 2018), probably even more so with the pandemic. Recent studies confirm that employees on sick leave with a psychiatric diagnosis still acts to legitimise their sick leave to avoid the stigma and shame of their situation (Strömbäck et al., 2020). Thus, the generalisability of our proposed credibility-enhancing process model will have to be explored in future studies. A well-conducted grounded theory analysis should have the level of abstraction required to ensure that the readers of the present article note the central concepts and the potential for modifiability by further research (Glaser, 1998).

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