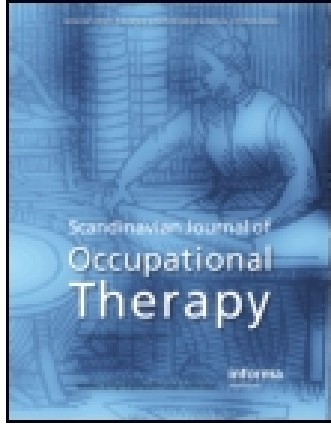


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### Health care professionals' experience-based understanding of individuals' capacity to work while depressed and anxious

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ORIGINAL ARTICLE

## Health care professionals' experience-based understanding of individuals' capacity to work while depressed and anxious

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### Abstract

*Aim:* The meaning of capacity to work while depressed and anxious is not well comprehended. The aim of this study was to explore and describe health care professionals' experience-based understanding of capacity to work in individuals with depression and/or anxiety disorders. *Method:* An exploratory qualitative design was used. Four focus groups were conducted with 21 professionals from psychiatric, occupational, and primary health care. Data were analysed using inductive content analysis. *Results:* Capacity to work while depressed and anxious was understood as a change from the familiar to a no longer recognizable performance at work. Managing time, daily work demands, and emotions was described as difficult for the patients, and capacity to work could be fragmented by anxiety attacks. Patients were perceived as continuing to work while life outside work crumbled. Capacity to work was described as part of a greater whole, the work community, and the patient's participation in the work community was considered problematic. *Conclusions:* The findings provide a deeper understanding of the reduced capacity to work compared with theoretical or medico-administrative descriptions. Applied to patient encounters it could promote fitness-for-work dialogues, rehabilitation, and tailor-made work interventions.

**Key words:** *work capacity, qualitative analysis, mental disorders, focus groups, fitness for work*

### Introduction

Common mental disorders (CMD) are a prevalent and increasing problem in the working population (1-3). CMD include mild to moderate depression, anxiety disorders, and mental exhaustion, but also sub-threshold symptoms of these disorders (3,4). Several studies point to a larger negative effect on work performance due to CMD compared with other conditions such as breathing disorders, back/neck disorders, arthritis, diabetes, and heart disease (5-7). Even in the large number of individuals with sub-threshold symptoms and in individuals in clinical remission reduction in work functioning has been observed (2,3,8). However, although CMDs have a

substantial negative effect on work capacity few studies have examined how capacity to work is experienced by the individual and how, more specifically, CMD influence this capacity. Recently there have been several calls for addressing the impact of CMD on people's functionality and work capacity (9,10) as well as a better conceptualization in order to understand the consequences and experiences of reduced work capacity due to CMD (11).

An important practical issue regarding work capacity is its relation to sickness benefits. In Sweden, there are two main criteria for an individual to attain sickness absence. First, the individual must have a clinical diagnosis. Second, this diagnosis has to result in reduced capacity to work. To be able to evaluate

this second criterion both physicians and the social security agency need sufficient knowledge of how a specific disease may result in reduction in work capacity. Today, this knowledge is insufficient. Furthermore, no scientific consensus exists regarding how to define work capacity and several concepts are used within the literature (11,12). One theoretical way to understand work capacity is to use the person–environment–occupation model (PEO model) (13). From this model work capacity can be described as the interplay between the person, the environmental support and barriers, and the inherent demands (including the work tasks) of the occupation.

Although studies are scarce in this field some previous results highlight the complexity of this matter. Lerner et al. (2004) found that individuals with depression perceived limitations in doing work carefully, in concentrating, and in meeting people (14). In line with some of these results Sanderson et al. (2007) found that the depressed and anxious have problems with getting started in the morning, sticking to routines, and thinking clearly while working (15). In a recent phenomenological focus-group study our research group identified how depressed and anxious individuals experienced a lost familiarity with their own work performance, and that this uncertainty was counteracted by new working habits, which was time-consuming and increased job stress further (16). Wang et al. (17) found that difficulties in managing work increased throughout the day. Health care professionals in both primary and psychiatric care meet people of working age with CMD. Consequently, they are a possible source of information in addition to self-report from affected individuals (18–21). Although previous studies among health care personnel have found that work capacity is interpreted as a vague and hard to define concept (18,21), health care professionals have much experience of patients' functionality and limitations and seem to be an underutilized source of information for studying capacity to work.

Despite being an increasing health problem in the workforce few studies have been directed towards identifying the specific limitations and characteristics of capacity to work in individuals with CMD. Moreover, since sickness absence due to CMD tends to be longer compared with other disorders (22,23), such knowledge would enhance the understanding of these individuals' situation at work and could be used to support them or to improve rehabilitation back to work for sick-listed individuals. Health care professionals can be expected to have an overall understanding of people's capacity to work from their professional encounters with patients with CMD and from patient narratives of how work capacity is affected and experienced. In Sweden it is common that health care also includes the patient's workplaces

in patient encounters such as with managers, especially when return to work is at hand. Such encounters will add to health care professionals' understanding of capacity to work. The aim of this qualitative study was to explore how the capacity to work was understood by health care professionals in relation to their clinical experiences and encounters with patients affected by depression and anxiety disorders.

## Material and methods

### *Design*

A qualitative exploratory design was chosen (24,25). We were interested to further develop the knowledge and understanding of the capacity to work while depressed and anxious. Focus groups were used for data collection as this is suggested as a sound method to grasp different perspectives of a subject not well explored (25,26). It was assumed that the joint discussion among participants would help them identify their understanding of the phenomenon as experienced in encounters with patients, which we considered an experience-based understanding. When the understanding of a specific phenomenon is poor, Morgan (1997) suggests that "less structured approaches to focus groups are especially useful" [ (25), p. 40]. He emphasises an atmosphere where the participants are allowed to discuss their point of view in relation to the phenomenon and recommends this to be best supported by the use of few questions (25). Due to the exploratory design these recommendations were employed in this study. The study was approved by the Regional Ethical Review Board in Gothenburg, University of Gothenburg, Sweden.

### *Selection of participants and procedure*

We invited health care professionals experienced in treating patients with CMD to discuss their understanding of patients' capacity to work. We strived for heterogeneity among the participants and therefore we purposefully included participants from different medical settings (occupational health care, primary health care, and psychiatry) and with different professional backgrounds (26). The heads of eight eligible clinics (one occupational health clinic, three primary health clinics, four psychiatric outpatient clinics) distributed study information (aim, procedure, and the right to withdraw from the study at any time) to employees. In this study CMD was operationalized as the following disorders in accordance with the International Classification of Diseases codes: F32 depressive episode, F34 persistent mood [affective] disorders, F38 other mood [affective] disorders, F39 mood [affective] disorders, F41 other

Table I. Characteristics of the participants.

Characteristic	n
Gender:	
Men	6
Women	15
Occupation:	
Counsellor	6
Nurse	4
Occupational therapist	2
Psychologist	2
Physician	5
Physiotherapist	2
Health care setting:	
Occupational	5
Primary health	11
Psychiatric outpatient clinic	5
Clinical experience within occupational, primary and/or psychiatric care:	
Range	5–40 years
Mean	18 years
Median	15 years

anxiety disorders, F43.8 other reactions to severe stress (27). These disorders were explicitly described in the invitation letter to potential participants. Interested participants (professionals within the clinics) contacted the first author. Of the contacted clinics, no contacts were taken by professionals from two of the psychiatric clinics. From the other clinics, 24 participants contacted us and all were invited; 21 participants took part in the study. The three professionals who did not participate were ill at the time of the focus group or otherwise inconvenienced. Primary health care and psychiatric outpatient clinics are part of the Swedish health care system and have territorial responsibility for citizens in their area. The occupational health care provides services mainly to public health care and dentistry, but also to cultural institutions, and some educational facilities. For the convenience of the participants, the focus groups were held at the clinic. Participants were asked to complete a questionnaire on demographics (Table I).

Participants received a letter of confirmation including the date, time, and place for the focus group, a reminder about the aim of the study and a call to refer to cases at the focus group. A pre-study meeting was conducted with health care professionals in a psychiatric outpatient clinic; the explicit proposal of referring to cases stemmed from this meeting. As preparation, the two main questions in the interview guide were included in the letter: (i) How is capacity

to work affected by depression and anxiety disorder? (ii) What does it mean for individuals when their capacity to work is affected by depression and anxiety disorders? Participants gave written informed consent at the focus-group session.

#### Data collection

Four focus groups were conducted: one in occupational health care, one in psychiatric outpatient care where the professionals came from two clinics (all knowing each other), and two within primary health care, where one group consisted of participants from two clinics, where all knew each other. In the literature it is emphasized that the groups should comprise enough diversity to allow for different views and stimulation of discussions (26). Therefore, we strove for a variety of professionals when forming the groups (Table II). The focus groups consisted of 5–6 participants per group and lasted for 80–98 minutes. They were conducted between September 2011 and January 2012.

All focus groups were facilitated by a moderator (the first author, an occupational therapist with extensive clinical experience in psychiatry) and a co-moderator (the second author, a behavioural scientist experienced in interview technique and qualitative methodology). The interview guide included a few questions to be discussed, recommended when the aim is exploratory (25). First the participants were asked to describe what kind of encounters they had with patients. Next, the participants were asked to describe what patients usually told them about issues concerning their work. Then the two questions sent in advance (see above) were thoroughly discussed by the participants. Finally, the participants were asked if anything seemed unclear to them, whether there was anything else they considered important to add and discuss in relation to the phenomenon and what they found most important of the topics discussed. The

Table II. Variety of professionals within the four conducted focus groups.

Occupation	Occupational health care	Primary health care	Primary health care	Psychiatric health care
Counsellor	–	3	1	2
Nurse	2	–	1	1
Occupational therapist	–	–	1	1
Psychologist	1	–	–	1
Physician	1	3	1	–
Physiotherapist	1	–	1	–

moderator ensured that the focus of the meeting was retained, that everyone participated in the discussion and used probes to get detailed descriptions of the professionals' experience-based understanding of capacity to work, such as "how is this topic related to capacity to work", or "how will this affect capacity to work". The co-moderator made notes during the session and at the end encouraged the participants to reflect further on expressed ambiguities in need of further explanation.

#### *Data analysis*

The study aimed for exploring a phenomenon and inductive content analysis was used (24,28). All focus groups were audio-recorded and professionally transcribed by a transcribing firm. The transcriptions were compared with the audio-records to ensure the accuracy of the transcriptions. The moderator made reflexive notes throughout the data collection, first immediately after each interview and then after listening to the audio-recorded interviews. The analysis began after all focus groups had taken place. Transcripts were read thoroughly and repeatedly to obtain a sense of the whole. Meaning units (ME) were derived from the data and identified. To accurately ensure that the excluded data did not reflect the study aim, the first and second author examined and discussed these together; some remained as an ME. The content of the MEs was condensed, while preserving the core meaning. In content analysis the MEs are labelled with codes (28), however, this labelling also means decontextualization of the data and might impede emerging interpretations, therefore this part was excluded in this study because of the exploratory aim of the study. In other words, throughout the analyses both the raw ME text from the transcript and the condensed ME were kept together, but no labels were made. All MEs were grouped and re-grouped into subcategories and categories by comparing similarities and differences. To ensure credibility, three authors read all transcripts (MB, JL, GA). Furthermore, all co-authors took part in the analysis by continuously reading and discussing drafts of the evolving results written with a wealth of descriptions and quotes, and by scrutinizing the categories and sub-categories. Preliminary results and more final results, but still in Swedish, were presented and discussed at seminars with experts, and comments were taken into consideration. Translation into English started when the categories and sub-categories were found to be coherent and stable, and the process of textual synthesis had begun. Reflexive notes were made by the first author throughout the analysis process (29).

## **Results**

The results presented here concern health care professionals' experience-based understanding of capacity to work in individuals with depression and anxiety disorders. Health care professionals are referred to as the professionals in the remainder of the article. The term patient narrative is used when the professionals explicitly refer to narratives drawn directly from patients' stories. Four categories emerged: reduced and altered capability at work; a "show must go on" experience; the crumbling life outside work; and difficulties to fulfil workplace expectations. Overall, the health care professionals stated that capacity to work was affected in similar ways for women and men.

### *Category 1: Reduced and altered capability at work*

In the professionals' experience, the patients' capabilities at work were reduced in many ways, hampering the patients in executing their work duties which seemed to contribute to an experience of a work performance changing from being familiar to unrecognizable. Five subcategories were identified.

#### *Experience of a change from the familiar to an unrecognizable performance at work*

Patient narratives included experiences of no longer recognizing their actions and behaviour in the workplace. Due to the experienced "change" the patients no longer trusted their own performance at work and this uncertainty made them double-check everything. Patients were also perceived to become tied to habits and routines. Capacity to work was described in patient-narratives as being affected by changed and more sensitive perceptions of sensory input such as vision and hearing. Coffee breaks or lunches were avoided because the acoustic environment was found to be exhausting. The professionals described how patients seemed to have lost access to psychological defence mechanisms (e.g. shrugging one's shoulders and not bothering) and the tolerance for poorer performance within themselves.

The patients seem to no longer care for things at work as they use to. The professionals perceived that the patients had "black glasses" through which they observed work and generating a resistance and barrier towards work that had to be overcome every day. The professionals described how the patients seemed to have lost the ability to appreciate themselves, their accomplishments, and to enjoy work. Yet, patients who were still able to receive appreciations from others described this as something helping them to endure and manage the work. All this contributed to the professionals' understanding of changes in

patients from being “themselves” to something new and unfamiliar, leading to an unrecognizable performance at work. The changed performance at work was described as affecting the capacity to work negatively.

...For she [the patient] couldn't manage being open and positive, so to speak. Instead, she became more and more trapped and rigid in how her work ought to appear and how she could be used, so to speak, at work. I think this is common in depression and anxiety... (Focus group 4).

#### *Difficulties managing time demands*

The professionals described how patients found it hard to cope with work hours. Morning tiredness was common. The professionals had the impression that the capacity to work was more impaired in the mornings due to morning anxiety and difficulties getting going. Difficulties with keeping appointments could hamper cooperation with colleagues. From patient-narratives the professionals described difficulties in coping with the pace of work due to slower work speed, and as a result work piled up. When new procedures or systems were to be implemented in the workplace, often under time pressure, patients were not able to learn things in the time available.

#### *Difficulties dealing with daily work tasks*

The professionals reported how patients found it difficult to get started with work duties, to drive their work, and to maintain a long-term plan. Multitasking situations were specifically difficult. The professionals expressed that capacity to work was fragmented by patients' inability to complete a thought before “a third and fourth intrudes”. They also pointed to patients' internal mental activity, for example ruminations, which hamper capacity to work, but this was considered a dysfunction that is hard for others to apprehend and understand the consequences of. Losing the thread or an interruption in the middle of duties made it hard to take action and affected the workflow.

In the professionals' experience, the patients were able to cope for a certain amount of hours at work before they were completely exhausted. In this mode, the professionals stressed that the patients were under increased strain because of the need to maximize their efforts to maintain concentration. The significance of verbal and written information was difficult to comprehend. Learning new tasks was described by patients as next to impossible and new knowledge was perceived to “not stick”.

...They [patients] work in a computer program [administrative software], and have different windows open that they have to switch between; when they switch from one window to another, they no longer remember what they are to do and what kind of information they are to fetch. It's like when you have to go between rooms because you have forgotten what it was you were supposed to get... (Focus group 1).

Most jobs include socializing with other people, but the professionals had the impression that patients seemed to be preoccupied with themselves, for instance by negative thoughts, making it difficult to focus outwards. The patient narratives described difficulties with occupations characterized by making others interested in something, requiring positivism and being able to engage with others, capacities which were no longer accessible. Taking part in important encounters between co-workers, where individuals need to take an interest in each other, was interpreted as difficult and patient narratives described withdrawal from colleagues.

#### *Reduced capacity to manage emotions*

The professionals perceived that the patients had difficulties in controlling their emotions in the workplace. Patient narratives told of difficulties maintaining patience, loss of temper, saying insulting things, and even telling people off. Crying and emotional breakdowns made patients withdraw to the toilet and could occur several times a day. The professionals believed that patients lost their calm and ease in social encounters. The professionals also highlighted the further burden of dealing with the consequences of inappropriate behaviour.

...I had a patient, she worked in health care ... suddenly she [the patient] had anger outbursts directed at colleagues and then she had to make apologies and amends for this, which required a lot of energy... (Focus group 1).

#### *Unpredictable anxiety attacks*

The professionals emphasized that the capacity to work was fragmented by anxiety attacks as well as preoccupying thoughts of the next attack. Patients could leave their work duties instantly and several times a day. Fluency in work disappeared and the patients might even become paralyzed and overpowered by fear. In patient narratives, workplaces were experienced as threatening and patients could vomit before going to work, or be sitting in the car park outside the workplace, unable to enter and instead going home. Capacity to work was further affected by

managing the anxiety and the coping strategies patients used to avoid anxiety, which the professionals believed drained patients of energy and reduced their capacity to work.

... the natural thing is to escape, to just disappear. You might leave the cash desk because you cannot cope with staying, instead you flee. It becomes quite obvious that all of a sudden the person is sitting in the store room. I've heard many, many descriptions of this, they just ran away from what they were doing. I mean when they were having anxiety attacks... (Focus group 3).

*Category 2: A "show must go on" - experience*

According to the professionals, many patients with depression and anxiety had difficulties letting go of work and tried to retain the capacity to work "to the last drop of blood". Work seemed to be very important and when the patients no longer performed well enough, self-perception changed in a negative direction.

The professionals mentioned patient narratives concerning the use of a façade to avoid losing face in front of others, and believed it to be energy consuming to maintain that façade. The professionals thought that the façade possibly hampered managers and co-workers realizing that the capacity to work was reduced. Some of the professionals had experiences of patients having piles of unfinished work that nobody in the workplace knew anything about. The professionals told of the shame associated with reduced capacity; patients did not want to lose face before the boss or others by speaking about this. Some patients reported a great fear of disclosure according to the professionals.

*Category 3: The crumbling life outside work*

The professionals found that patients primarily did not talk about their situation at the workplace; rather they talked about difficulties coping with life outside work. From patient narratives, all participating professionals described how patients could get home, completely exhausted, go to bed and sleep until the next morning, or for whole weekends in order to manage work. The professionals perceived that the patients stopped leisure activities, no longer bothered to meet friends, seldom left the home, and thereby lost the refuelling and relaxation that leisure activities could provide. The professionals also had experiences of many patients who were still working but were no longer able to manage the housework. For the professionals, this was problematic because they could not sick-list a person whose capacity to work deteriorated in an area not related to their work. Even though the professionals were very consistent in their

understanding of "outside work" incapacity as a part of capacity to work, they found this divided capacity puzzling.

I have a patient who works as a manager at some place, she [the patient] says, almost in a subordinate clause that: "Well, I don't recall as usual, and I'm not really myself, but it is later when I get home, I can't do any more. When I come home I lie and sleep the rest of the time. I can't even take the garbage out, I can't manage any housework at all." The professional continues: "She couldn't take care of the home any more, her husband had to take over the chores. In a way she has protected her capacity to work and upheld her work, she doesn't say much about how she could not function at work. So with this current status I have to tell her that I do not know if the Social Insurance Agency will approve her sickness absence, because I can't describe any work incapacity." (Focus group 2).

*Category 4: Difficulties to fulfil workplace expectations*

The professionals highlighted that broader and informal aspects of work, beyond more formal job descriptions, could impose on the patients' capacity to work. They understood capacity to work to be part of a greater whole at the workplace, comprehended as the work community. From encounters in health care where the patients' workplaces also took part, the professionals experienced that the patients were expected by their managers to contribute and take part in the work community, such as coffee breaks. However, this was next to impossible for individuals with depression and anxiety disorders according to the professionals. Workplace expectations, like not fully doing one's duties or not behaving as expected, affected relations at the workplace. The professionals found that patients who were no longer cheerful, positive, or flexible could sometimes be perceived as "a whining bitch" in the workplace. According to the professionals, patients' decreased capacity to work also led to colleagues hesitating to trust their performance and to uncertainty regarding how much the colleagues dared to burden their sick colleague. A patient's mood changes such as crying or anger were described as difficult to handle for the workplaces. The professionals referred to the "patient's prickly side" making co-workers uncertain whether the individual wants help in his/her work or not and how this uncertainty might cause co-workers to withdraw. They particularly highlighted anxiety attacks as something that deviated from expected behaviour and may seem daunting to colleagues. Not being able to fully participate in the work community, the professionals believed that some patients became outsiders at work. Furthermore, when the patients not were able to fulfil these expectations the professionals had

experienced that patients' work participation could be hampered by workplaces and employers.

...So to work is not only to perform your work tasks, it is rather to be at a place and form a sense of community that you feel comfortable in. And when a person is not able to do that or rather, I would say, is unable to participate in a satisfactory way, one wonders what that means? However, when you can't, the employer is not pleased... (Focus group 2).

## Discussion

This study aimed for a deeper understanding of the capacity to work while affected by depression and anxiety disorders. Capacity to work was understood by health care professionals to include a change from the familiar to an unrecognizable work performance. Time management, managing daily work demands and emotions were described as difficult, and work capacity was fragmented by anxiety attacks. The professionals also perceived "a show must go on" attitude whereby patients had difficulties letting go of work, and instead seemed to let their life outside work crumble. The workplace was revealed as a community in which individuals were expected to take part and act; according to the professionals this was next to impossible for individuals with depression and/or anxiety.

As far as we know, no other studies have used health care professionals as a source of information to explicitly explore capacity to work in individuals with CMD. However, health care professionals and other stakeholders have participated in qualitative studies of work ability assessments and return to work (RTW), research areas that are closely connected to work capacity (30,31). The professionals in the present study understood capacity to work as a change from a familiar to a no longer recognizable performance at work, including patients' distrust of their own capacity, loss of job satisfaction, and changed self-perception. To resume these factors was stated as important for a successful RTW in the study of De Vries et al. (30) which could be interpreted as support for our finding. The subcategory is also similar to the phenomenological essence described in our first study (16) and to the findings in a qualitative study describing the process leading to exhaustion disorder (32). It seems that the experience of a transition into unfamiliarity is an important feature in capacity to work. It might be an early sign of reduced work capacity since the participants in this study said that patients already in initial contact with the professionals expressed this experience. The finding comprised feelings of uncertainty and new habits of double-

checking. These habits have been identified in earlier qualitative studies (16,33) and in our earlier study (16) it was described as time-consuming and increasing job stress. Addressing the content of this subcategory and the individual's feeling of "unfamiliarity", with accompanied experiences and new habits, seems to be important in order to support individuals with decreased work capacity.

Other important factors for RTW found by De Vries et al. (30) were time management, simplified work tasks, and tackling performance issues (30), which corresponds to the described decreased capacity to work in the further subcategories of "reduced and altered capability at work" in the present study. The findings of the reduced and altered capability also correspond to a recent review of the impact of CMD on work functioning which showed that CMD affected an individual's interpersonal behaviour, for example isolation from co-workers and less capacity to collaborate, reduced work speed, and difficulties coping with emotions (34). A considerably narrower view of work capacity was found in the study by Slebus et al. (35), where all items identified by occupational physicians were similar to only one sub-category, "difficulties dealing with daily work demands", in the present study. This might be due to the study design. In our study we used the focus-group method and invited professionals with different health care occupations. This yielded a broad and comprehensive picture of work capacity in CMD, compared with the study by Slebus et al., which used only physicians. The finding of the strong negative impact that unpredictable anxiety attacks has on capacity to work has, as far as we know, not been described earlier. In rehabilitation back to work it seems important to acknowledge them, otherwise non-attendance in work tasks due to anxiety attacks might contribute to stigmatization at work.

The professionals highlighted the patients' use of a façade described in the "show must go on" category, which as far as we know has been described only in qualitative studies with affected people (16,32,36). The professionals in this study stressed that the use of a façade was energy consuming, which has also been found in earlier studies (32,36). However, in a study by Bertilsson et al. (16) the façade instead emerged as a kind of aid to be able to go on working. In the present study, the façade and the earlier discussed double-checking emerged as constituents of capacity to work, and, as such, are expressions beyond symptoms and functions. They could be interpreted as coping behaviour; however, the professionals did not define them as such.

The finding that areas outside paid work were incorporated as a vital part of work capacity is in conflict with the theoretical descriptions of work



capacity (37-39). In such descriptions of work capacity the individual's capacity outside paid work is seldom considered, and first and foremost it is not seen as part of the work capacity. In medico-legal contexts, for example in sickness absence legislation, only reduced capacity at paid work is regarded as valid. The different descriptions in our findings and in medico-legal contexts reflect different perspectives. The health care professionals in this study and the affected individuals interviewed in earlier studies apply a "holistic perspective" departing from the individual's life world. The medico-legal perspective on the other hand is based in societal needs to limit benefit grounds and therefore defines specific parts only of the individual's life as relevant in relation to work capacity. From a rehabilitation perspective it seems important to make visible and manage these different perspectives to avoid communication difficulties in describing areas of importance for a successful return to work. Our finding is in line with other qualitative studies that have explored what it is like to live and work with affective disorders (16,30,32,36). Entire weekends were used to regain energy; unpaid household work and social activities were let go of (32,36). In a recent phenomenological study, a constituent of capacity to work was identified as "trading leisure-time activity with inactivity to manage work". Leisure time was reduced and used to recover for the next day's work, and interpreted by the participants as a price to be paid to be able to continue to work (16). However, in earlier studies this kind of "divided" capacity has not been so clearly expressed, rather the inactivity during leisure time has been described as a necessity to regain energy, and not as incapacity outside work. Even if we do not fully understand how time at and outside work affect each other and the capacity to work, it seems as if affected individuals and health professionals find it important that this is taken into consideration.

Capacity to work was also understood by the professionals as the patients' ability to contribute to a greater whole at work and to the work community. According to the professionals, patients with difficulties with daily work demands, reduced emotional ability, and avoidance behaviour were not able to fulfil these expectations from the workplace. The expectations of sociability in the workplace and apprehensions concerning the capacity of depressed and anxious co-workers' capacity have been found in other studies (40,41), but the close connection to the capacity to work has not been described in these studies. Gates (42) argues that workplace accommodation is far more than technical changes in work duties or work hours, and that the social context of work has to be accounted for, a recommendation also supported by other studies (40,41). To express workplace expectations and the interplay with an individual's capacity to work seems

important because, if left unidentified, they might hamper RTW processes or hinder the right actions.

Tailor-made interventions are stressed for sustainable RTW (30,43). The present findings promote the understanding of decreased work capacity and problems faced at work for individuals with CMD. Transferred to patient encounters our findings could facilitate discussions on fitness for work and provide insight on what kind of tailoring is needed in RTW interventions for a patient with CMD. A sceptical attitude towards workers with CMD is reported in several studies (41,44,45); therefore it could be hypothesized that the more we know about the capacity to work, the better support could be offered to both employees and employers, perhaps also leading to reduction in stigmatization in workplaces. A further exploration of the phenomenon would benefit from the perspective of stakeholders in the work community, such as managers, workmates, and trade union representatives.

### Methodological considerations

The trustworthiness of the findings refers first to the interpretation of the data from the focus-groups interviews. It can be regarded as secondary data and retelling of others' stories. However, it can also be seen as a condensed knowledge bank gained from several and often recurring encounters with individuals with depression and/or anxiety disorders and decreased capacity to work. This was our intention when approaching the health care professionals. The interviews were mixed regarding direct retelling of specific patient stories as well as reflections or conclusions based, as it seemed, on combined experiences from several patient encounters. We chose not to separate these different ways of presenting experience-based understandings but considered both (and the sliding scale in between) as valid data for the analysis. Patient stories are part of the professionals' everyday practice, and in legal certificates health care professionals statements are considered valid, in line with that we consider the focus-group information to be of a high standard. Thus, these data can be seen as a form of primary data based on a number of patient encounters and thus based on broad experience rather than the single, individual experience that persons affected by the disease have of their own deeper experiences.

A second potential problem relates to our aim of exploring capacity to work. The professionals had some difficulties explicitly describing capacity to work; they often used symptoms and functions such as fatigue, sleep disturbance, or memory difficulties when discussing capacity to work and the moderators had to use probes frequently. Moreover, the capability to meet professional demands, e.g. showing

enthusiasm and politeness when needed, are most important in order to carry out some work tasks sufficiently (37). However, this seemed difficult to comprehend for the professionals. To some extent this vagueness in descriptions can be seen to invalidate the results, but we also interpret this as an illustration of the complexity and difficulty when it comes to describing something that currently lacks its own terminology. We do believe that using the focus-group method enabled the participants to recognize, identify, verbalize, and discuss capacity to work through each other's statements. We think the advantage of the focus-group method could be illustrated by a participant who through the discussions discovered the discrepancy between what was thought of as work capacity and what was discussed in the focus group with the aid of probes focusing on capacity to work. The participant said: "I realize that I don't have descriptions of capacity of work, this discussion has been an eye-opener." The participant's difficulties could be viewed as a secondary finding and this is in line with Swedish national evaluations of the quality of sickness certificates issued by physicians in which only 54% had an approved quality (46). The part in the certificates with least quality is the description of the individual's limited work capacity. This shows the importance of conducting studies like the current one because it is urgent that the understanding and interpretation of work capacity related to specific disorders improves, since lack of knowledge and terminology hamper communication and collaboration between stakeholders. The credibility was further strengthened by the use of cases in order to enhance discussions of capacity to work from a patient perspective as a way to modify the group discussion from remaining at merely a theoretical level. Note that the cases were presented in a way that full secrecy of patients was kept throughout the discussion.

Third, an important aspect was the heterogeneity of health care professions and the purposeful sampling of different medical settings (26). It can, however, be noted that no physician from psychiatric care was present and no occupational therapist from occupational health care. The patient narratives in this study stemmed from professionals' individual encounters with patients as well as encounters where other stakeholders were participating. This contributed to a broader understanding and depicted capacity to work. Furthermore, the individual encounters can be assumed to reveal stories not easily told elsewhere, an advantage in areas where stigmatization plays a part. Variation was further supplemented by the professionals' experiences of patients with different occupations enhancing a broader perspective of capacity to work.

Fourth, potential limitations of the focus-group method are that participants form a hierarchical structure that hampers expression of opposing views or strives for consensus opinions that would limit the exploration of capacity to work (26). To hinder consensus, the participants were encouraged to give as many diverse descriptions of capacity to work as possible. The invitation to discuss existing cases and having received two of the questions beforehand also contributed to lowering the risk of consensus. It is likely that patients disclose things differently to different health care professions, thereby further minimizing consensus opinions. Other potential limitations are that in all focus groups the participants knew each other and that contexts of the focus groups were different (two included participants from the same clinic, two focus groups included participants from different clinics). These limitations could have impacted on the participants' willingness to disclose statements or opposing views. However, none of the moderators or the third author who read the complete transcripts felt that the different contexts impacted on the discussions or the data in any way. Of importance was that the use of cases was also considered to reduce the risk of disclosing any personal experience, which could have brought potential harm to the participants.

A field diary was kept through preparation and analyses. Inductive content analyses allowed new findings to emerge and were suitable for secondhand data. The emerging results were written as summaries with a wealth of quotes and discussed continuously within the author-group, all documented by the first author. Trustworthiness was strengthened by the use of two moderators, and the second moderator also scrutinized the excluded data. All transcripts were read by three authors. Reflexivity was enhanced by all authors having different occupations. At two points in time, the emerging results were peer-debriefed by experts in the field.

## Conclusion

The elements of capacity to work while depressed and anxious identified in this study add to the scant knowledge of this phenomenon. Health care professionals' understanding of capacity to work comprised a perception of patients changing from a familiar to an unrecognizable performance at work and difficulties with time management, daily work duties, and emotional demands. The professionals also incorporated the patients' capacity to contribute to the workplace community and the patients' capacity outside paid work. The findings provide a deeper and extended understanding of the reduced capacity to work compared with theoretical or medico-administrative descriptions, which needs to be acknowledged in insurance

medicine, rehabilitation, and research. Findings such as double-checking, withdrawal, difficulties keeping pace or driving one's work, and other constituents of capacity to work from this study might help both patients and health care professionals to identify and establish clear descriptions of reduced work capacity. Transferred to patient encounters, it could promote fitness for work dialogues and enhance tailor-made interventions in RTW.

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