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ORIGINAL ARTICLE

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Strategies to keep working among workers with common mental disorders – a grounded theory study

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ABSTRACT

Purpose: Most people with common mental disorders (CMDs) are employed and working, but few studies have looked into how they manage their jobs while ill. This study explores workers' experiences of strategies to keep working while suffering from CMDs.
Methods: In this grounded theory study, we interviewed 19 women and eight men with depression or anxiety disorders. They were 19–65 years old and had different occupations. Constant comparison method was used in the analysis.
Results: We identified a core pattern in the depressed and anxious workers' attempts to sustain their capacities, defined as *Managing work space*. The core pattern comprised four categories describing different cognitive, behavioral, and social strategies. The categories relate to a process of sustainability. Two categories reflected more reactive and temporary strategies, occurring mainly in the onset phase of illness: *Forcing the work role* and *Warding off work strain*. The third category, *Recuperating from work*, reflected strategies during both onset and recovery phases. The fourth category, *Reflexive adaptation*, was present mainly in the recovery phase and involved reflective strategies interpreted as more sustainable over time.
Conclusions: The results can deepen understanding among rehabilitation professionals about different work-related strategies in depressed and anxious workers. Increased awareness of the meaning and characteristics of strategies can inform a person-oriented approach in rehabilitation. The knowledge can be used in clinical encounters to reflect together with the patient, exploring present options and introducing modifications to their particular work and life context.

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Depression; anxiety; work functioning; qualitative research

➤ IMPLICATIONS FOR REHABILITATION

- Self-managed work functioning in common mental disorders involves diverse strategies.
- Strategies interpreted as sustainable over time, seem to be reflective in the sense that the worker consciously applies and adapts the strategies. However, at the onset of illness, such reflection is difficult to develop as the worker might not want to realize their reduced functioning.
- Rehabilitation professionals' awareness of different strategies can facilitate a person-centered approach and understanding of the vocational rehabilitation process.

Introduction

Being depressed or anxious vastly affects the working life of the individual in terms of reduced work functioning and wellbeing, impaired productivity and increased risk of sickness absence [1]. Besides the consequences for the worker and their family, there is also a negative impact on the work organization. Given that mild to moderate depression and anxiety disorders (referred to as "common mental disorders (CMDs)") have a life-time prevalence of about 30% [1], and are leading causes of disability [2], they present a challenge to society, with both immediate and future concerns.

There is substantial knowledge about predictors of sickness absence and trajectories of return to work among workers with CMD [3–5]. Some interventions, such as cognitive behavioral therapy or workplace adjustments and support, have been suggested to improve work capacity [6–9]. However, the question of how workers try to self-manage their work while feeling depressed and anxious is yet underexplored. Since most people affected by CMDs are in fact employed and working, this focus demands increased attention.

Conceptual understanding of work functioning in common mental disorders

This study assumes that work functioning in CMDs is a multifactorial concept, which is dynamic over time and is, furthermore, affected by the interaction of several dimensions (e.g., personal attributes, as well as work, health care and community mesosystems, and macro-infrastructures) that influence each other through different structural levels (individual, organizational, and societal) [10]. Moreover, a person's general ability to work and their situational ability in the specific, real-life environment and context can be vastly divergent [11].

The dynamics between the individual and the environment have been examined in several models, such as the effort–reward imbalance model [12], the demand–control model [13], and the

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Person–Environmental–Occupation Model [14], all of which suggest an interplay between individual resources, occupational tasks, and the physical/psychosocial work environment. A novel angle is the concept of work instability [15–17], defined as a mismatch between job demands and the worker's present abilities. Furthermore, to understand work functioning in CMDs, it is important to consider factors in the worker's private life [18].

Efforts to sustain work can also be described in terms of coping. Coping is the cognitive and behavioral effort a person makes to manage demands that tax or exceed their personal resources [19]. It connects to a person's appraisal of a situation, their instant evaluation of what is at stake for them personally, and the possible ways to overcome difficulties [20]. In this way, coping means an action-based feature to the transactions we have with the outside world, related to personal significance of those transactions [21]. Coping strategies in turn seem to rely on factors such as locus of control, social support and self-efficacy [22,23]. In relation to the present study, coping means the depressed and workers' efforts to manage exceeding work demands, dependent on their personal meaning of work and their present options and confidence to act.

To summarize, the underpinnings of this study acknowledge that work functioning in CMDs is associated with, but is not merely a consequence of, the condition [24]. Here, we assume a dynamic interaction between personal resources and symptoms, situated job tasks and the social environment at and outside work, ultimately aiming at meaningful participation in the community. The perceived imbalance between abilities and demands, when the depressed or anxious worker feels that work cannot be managed as usual, will herein be referred to as "work instability" [15,25].

Experiences of working while affected by common mental disorders

Working while depressed and anxious has been described as feeling "remote" and "unfamiliar" at work [26], with the private life crumbling in the quest of keeping up at work [27]. The struggle depressed workers face at work has been described as conditioned by relationships with managers and coworkers, by the workload and by the workers' own self-image as a worker [28]. Adjustments of habits and routines can help in managing work and private life in CMDs [29]. Such adjustments can include reducing demands, prioritizing, and changing lifestyle habits [29]. Following a work-directed intervention, new strategies to handle the workload mainly focus on limitations: taking one thing at a time, delegating, and fostering an accepting or detached attitude to work [30]. The extent and consequences of limiting strategies point to an important issue to be further explored [30], and to be challenged: are there qualitatively different strategies for keeping up work in CMDs?

In a recent study [31], we found that workers with CMDs experienced a process of instability, understood as a work dissonance. The workers felt caught up inside the work stream, as if in a "bubble" that was both isolating and protective. This experience disturbed flow and collaboration, but paradoxically it also enabled work. The work dissonance had a particular impact on situations that demanded social interaction. Given the complexity of the work instability process, it is likely that the workers' attempts to keep working were intricate, which deserves further investigation.

Research rationales and purpose

Although our previous study gave insight into the process of work instability, it did not sufficiently answer the question of *how* workers attempt to manage their jobs. To develop the current body of knowledge on this aspect, we need to look further into what the affected individuals actually do and what works from their perspectives. It is likely that there are things that people do beyond clinical guidelines that are meaningful in their attempts to keep working successfully. To support workers with CMDs, learning from experience-based strategies may provide innovative ideas to advance the understanding of "what makes work work". Based on our previous interviews, we were interested to find out more about the interviewed workers' pragmatic modifications and the strategies they utilized to manage their jobs. The purpose of this study was to explore workers' strategies to keep working, while affected by CMDs.

Methods

This study was planned and conducted as an elaboration of our previous study [31]. The present research question arose during the early data collection. Originally our intention had been to collect data on aspects of work instability, but the detail-rich descriptions allowed us to expand the scope of our research. Therefore, our present aim developed from the findings and subsequent data collection, enabling a parallel exploration of two phenomena: work instability (presented elsewhere) [31] and strategies to keep working (the present study).

We used a grounded theory approach, theoretically based in social constructivism and pragmatism [32], mainly inspired by the methodology put forward by Charmaz [33,34]. In short, this involves acknowledging a relativist epistemology, co-creating data through an interaction between the researcher and the participants, adopting a reflexive stance toward how participants construct meaning and actions, and doing situated research in a social context [35,36]. The reason for using grounded theory was our assumption that work functioning in CMDs is a social, dynamic process. We anticipated that social constructivist grounded theory would enable a rich, yet practically oriented conceptualization of the participants' constructed meanings and situated strategies, firmly grounded in empirical data. Moreover, grounded theory focuses on how people respond and react to certain conditions or to change [34], which made the approach suitable for our research focus on strategies.

Reflexivity

The theoretical pre-understanding among the group was mainly derived from our previous studies on work and CMDs. To enable a reflexive, "bridling" [37] approach and restrain pre-conceptions, we used discussions and memos prior to and during the analysis to outline and question our different perspectives, which may be latent but may yet impact the research process [36]. Our perspectives were mainly related to embodiment theory, social gender theory and psychological theories of defense mechanisms, and to clinical experiences of work capacity assessment and rehabilitation.

Participants

The study included 27 participants, 19 women and eight men, recruited through clinical collaborators, a patient organization and public lectures (Table 1). Criteria for inclusion were: depression or anxiety syndrome (International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10),

Table 1. Participant characteristics.

		Number of participants $n = 27$
Age (years)	19–25	2
	25–35	9
	35–45	7
	45–55	5
	55–65	4
Civil status	Single	12
	Married/co-habiting	15
Family type	Children under the age of 18	6
	Children over the age of 18	5
	No children	16
Job/work[a]	Manufacturing	1
	Accommodation, food service activities	2
	Information and communication	3
	Financial and insurance activities	2
	Professional, scientific, technical activities	4
	Administrative and support service	4
	Education	4
	Human health and social work activities	4
	Arts, entertainment and recreation	2
	Other service activities	1
	Working full time	12
	Working part time	9
	Currently on sick leave	6
	Sick leave due to CMDs the past 12 months[b]	13
	No sick leave due to CMDs the past 12 months	14
Source of recruitment	Clinical collaborators in primary care	18
	Patient organization	6
	Public lectures	3
Main diagnosis[c]	Depression	9
	Anxiety disorder	13
	Elevated symptoms[d]	5

[a]According to the Swedish Standard Industrial Classification 2007, Swedish Statistics, www.scb.se/en/documentation/classifications-and-standards/swedish-standard-industrial-classification-sni/.
[b]Among these were also the $n = 6$ currently on sick leave. The remaining $n = 7$ were considered to be in a return-to-work phase.
[c]According to the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10).
[d]Scoring <50 on the World Health Organization Mental Well-being Index.

codes F32–33, F41, and F43 [38]), or self-reported mental distress corresponding to a cut-off <50 on the WHO-5 Mental Well-being Index [39]. Also, the participants had to be employed and currently working, or to be on sick leave for a maximum of 6 months. We wanted variation in this respect, but assumed that longer sick leave would make it difficult to recall strategies. The rationale for including both participants at work and participants on sick leave, was that we anticipated that the workers' strategies would vary at different stages of reduced functioning: from slight but manageable difficulties up until when work was no longer possible. We wanted to grasp this process of potentially diverse strategies. Workers in the return to work phase have experienced the whole process: from the onset of CMD to struggling with reduced functioning leading to sick-leave, and then to partial or full recovery. Hence, we also included participants who had been on sick leave the past 12 months but had returned to work ($n = 7$), assuming that they could share experiences of remodeled or newly developed strategies. Criteria for exclusion were psychotic symptoms or apparent suicide risk, as deemed by the recruiting health care staff, or, in the case of other recruitment sources, by the researcher during the initial telephone screening.

Among 30 volunteers, one person was not included because of an expired job contract, one declined participation because of increased stress and one did not respond to the researcher's attempts to contact him. Volunteers were contacted by phone by one of the researchers (L.D.), who checked the inclusion and exclusion criteria and provided study information. The telephone conversation was also meant to initiate a dialog and establish trust, preparing for the research interview.

Interviews

The interviews were conducted during December 2015 to June 2016. L.D. conducted 22 of the interviews and a female Master's student, working in psychiatric rehabilitation, conducted five interviews. To enhance validity, both interviewers started with the same initial probes and conducted a couple of interviews each, before they discussed together and compared questions and content. The probes had been used in a similar way, but one of the interviewers had followed up more on body experiences and the other interviewer more on social aspects. Awareness of this tendency, and the joint initial understanding of the data informed another subsample of interviews. After another round of reflection, L.D. completed the remaining interviews.

Depending on each participant's preference, the interviews took place at a primary care center, at the university, at a public library or in the participant's home. The interviews started with the question: "Can you tell me what an ordinary day at work is like for you?" Besides using thematic probes to capture experiences of work instability, such as the work environment, adjustments, interactions, lifestyle and bodily experiences [31], we asked about strategies to manage experiences of change at work. Typically, this theme was posed as a separate question: "How do you try to keep up at work?" The theme could also be brought up through follow-up questions to a specific situation that the participants talked about, for example, "How do you manage that task … ?" or "Can you give an example of how you make it work?"

Our grounded theory framework assumed a processual phenomenon, and we encouraged the participants to exemplify with early

and later adaptations during their illness progression. Participants who were in a return to work phase, were also asked about if they did things differently now compared to before sick leave.

Also, without there being a pre-defined probe concerning this topic in the interview guide, the participants reported about strategies outside work that helped them to keep working, for example, recreational activities. This finding was then incorporated as a probe in the subsequent interviews, in accordance with the iterative process of grounded theory. The interviews had a median duration of 48 min, range 23–96 min. They were audio-recorded and transcribed verbatim.

Analysis

The textual data used for the constant comparison analysis consisted of the transcribed interviews and handwritten memos from the interviews. The data analysis was a separate process with regard to the previous study. Whereas the previous study focused on the experience of work-related change, the present analysis extracted data related to behavioral and cognitive strategies to keep working. Thus, data extraction was guided by a focus on the participants' efforts to sustain work: what they did and why. Two analysts, L.D. and M.E., each independently coded the first 10 interviews, using open line-by-line coding and extracting all content that might be relevant to the study purpose. The two analysts then wrote memos, discussed together and reflected upon the content, which was summarized broadly in terms of themes, patterns and contradictions in the data for further analysis. Next, the two analysts coded five interviews each, discussing and forming tentative sub-categories to describe the empirical data. Informed by the initial data, the analysts independently arranged the codes according to onset or recovery phase to look for a potential processual pattern. Eleven tentative sub-categories were agreed on, which were discussed together with the third analyst, G.H., who had read a subsample of the interviews. From these discussions and after several more perusals of the raw data, a core category was loosely formed. The remaining interviews were analyzed (L.D., M.E.) using selective coding, bearing the tentative categorization in mind, looking for nuances, similarities and differences in the data. This step was meant to challenge and develop the understanding of the categorization. During this step, the 11 tentative sub-categories were rearranged into 10 sub-categories forming four categories, a process interpreted as higher in level of abstraction. A writing–rewriting process, including reflection among the three analysts, refined the descriptions of and relation between the categories. The data analysis is exemplified in Figure 1.

The results were then discussed in a seminar of researchers from diverse professional backgrounds in the social sciences, rehabilitation and public health. The discussion concerned the core category and our proposed use of the term "space". The researchers discussed different meanings of this term, such as the physical and the psychological sense of the word, and what it proposedly meant in connection with the explicated strategies and, further, how these featured in the interpretation based on sustainability. To validate our results in the working CMD population, we debriefed patients included in an intervention study to enhance work capacity in CMDs. As an example of validation, one patient responded: "Yeah, you know, what I really need right now to function well is to practise some ways to kind of *expand my space*."

Ethics

The ethical principles of the World Medical Association Declaration of Helsinki [40] guided the conduct of the study. The interviewers had vast clinical experience of talking to people with depression and anxiety. All participants were given verbal and written information about the study before deciding on participating and signing a written consent form. They were informed that participation was voluntary and that they could withdraw from the study at any time. They were encouraged to contact the interviewer afterwards, if questions or issues arose. Two participants contacted the interviewer to add information to the interview, which was recorded as written memos. The study has been approved by the Regional Ethical Review Board.

Results

The core category, *Managing work space*, captures the general pattern of the workers' strategies, which encompass four categories. These represent the different meanings of the strategies and consist of 10 sub-categories that describe how the strategies were carried out at a more concrete level. According to the participants, the different strategies rendered more or less sustainable possibilities to keep working, shown schematically in Figure 2.

Managing work space

The core category was interpreted as a process of *managing work space* in relation to job tasks, expectations and the environment. Here, "work space" meant not only the physical room where the workers performed their tasks, but the lived, embodied and social space that they inhabited in the context of their work, including a bridge to their private life. Acting on the experience of shrinking possibilities involved attempts to expand or keep the sense of space, situated within everyday tasks. The strategies were meant to release strain or force control as well as to find sustainable ways to manage work.

During the analytic step where the analysts looked at temporal aspects of the data, a processual pattern emerged suggesting that the first two categories, *Forcing the work role* and *Warding off work strain*, occurred more often in the earlier, onset phase of CMD. The third category, *Recuperating from work*, involved strategies that occurred both early and in the recovery from illness. The fourth category, *Reflexive adaptation*, occurred later in the process, and more often appeared in accounts of recurrent episodes and return to work. These categories involved a higher degree of reflective awareness with strategies that were deliberately carried out to improve function. Thus, they reflected not only rebalancing but also preventive strategies for workers with previous experience of CMD. Below, the four categories and their sub-categories are described.

Forcing the work role

This category reflects strategies where workers pushed themselves, extending present capacities and pushing limits. By using force, distraction and sometimes denial, the participants kept up their work. The work space was managed by pushing through, keeping up a front, and stretching boundaries.

To grin and bear it. In this sub-category, the strategies were characterized by the experience of "just doing it": sticking with it and pushing through the work day at all costs. The participants used variations of common idiomatic expressions when describing the action of pushing through, for example "putting a lid on" or "driving my head through the sand" (variations of "banging my head against the wall"/"burying my head in the sand"), which indicates some denial in the struggle. Participants described using this strategy periodically, and then needing to follow it up with a

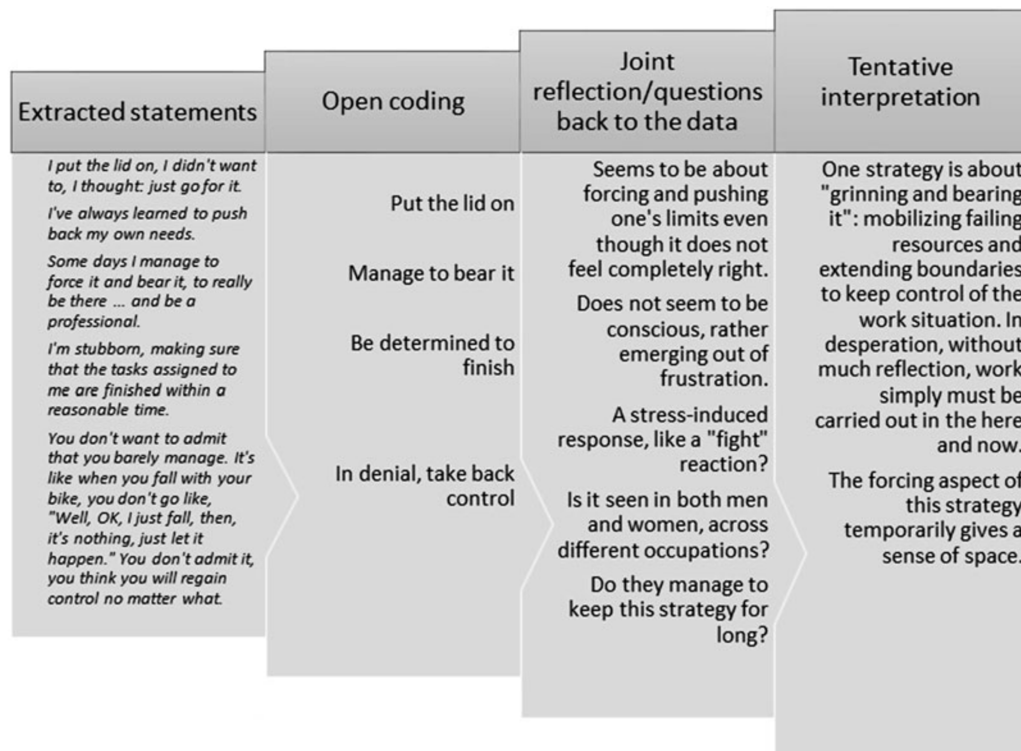

Figure 1. Example of the process of analysis, resulting in the sub-category *To grin and bear it*.

less pressured time, such as the weekend, a longer vacation or another project. One participant described repeatedly using this strategy, and "coming out at the other end".

> I could go for eight hours straight, without going to the bathroom, without eating anything, without doing anything else, but just keep going. *(Female community worker with major depressive disorder, on sick leave)*

> I would grin and bear it until it was time to go home; then all feelings and fatigue flooded over me. *(Female primary school teacher with major depression disorder and acute stress reaction, in return to work phase)*

To cover it up. The participants described that they kept working by hiding how they felt on the inside, feeling they had drifted from their genuine sense of self. It made them feel phoney, pretending to know what they were doing but not feeling it. This strategy was rarely consciously enacted, but was recalled in retrospect. The participants reported that their tasks could to a certain extent be managed while putting up this front. They also reported hiding the approaching instability *to themselves*, by distracting themselves with tasks. At work, they kept themselves constantly occupied. At home, they took on duties, keeping the feeling of inadequacy at arms' length:

> It's like I keep going just to avoid sitting down and thinking … even in my spare time. I've noticed that when I'm busy, for example building a veranda on our house, and I need to fetch some more material, I don't walk: I *run* to fetch it. I just rush on. *(Male social work associate with depressive symptoms, working full time)*

To compensate for shortcomings. The participants tried to compensate for negative changes related to energy, cognition, and interaction. This could involve starting later in the morning to make up for sleeping problems. It could mean taking on more simple tasks to compensate for a lack of concentration and creativity. To make up for delays, the participants skipped breaks, worked longer or continued working at home. They took extensive notes in order to remember: one participant wrote herself detailed instructions for navigating the computer system. Workers with interpersonal tasks kept these up by reducing other social elements at work, such as staff meetings or socializing with colleagues.

Warding off work strain

This category reflects strategies in which the workers "warded off" work strain to ensure enough room for manoeuver, and allow leeway. They talked about ways to withdraw and edge off the discomfort. They managed the work space by stepping back, removing themselves and thus taking the edge off emerging symptoms.

To escape and turn away. Participants used strategies to escape their experience of not functioning well at work. Strategies involved walking out of the workplace without telling anyone, calling in sick for a couple of days, or rationalizing with oneself that the problems were due to one's coworkers. Eating junk food, taking painkillers and overeating were among the actions used to take the edge of the increased strain. Alcohol was used in the same way, but this was sometimes done to enter another state of mind, and turn away from the mounting distress. Large amounts of coffee or energy drinks helped deal with tiredness. The strategies used in this sub-category indicate a high stress level.

> Sometimes I've just left and stayed away for a few days. It builds up; there were times when I was supposed to go in when I stopped on the way and thought like: should I go in or should I call in sick? And then I continued a bit. And hesitated. Then when I approached work, you have to turn, either you keep on straight toward (another village) or you turn (to the workplace). And then I just went straight ahead. *(Male mechanical assembler with major depressive disorder and panic disorder, on sick leave)*

To shield oneself at work. This sub-category reflects the strategy of shielding oneself from others at work. Sometimes, a very tangible shield was used, for example the person closed a door or

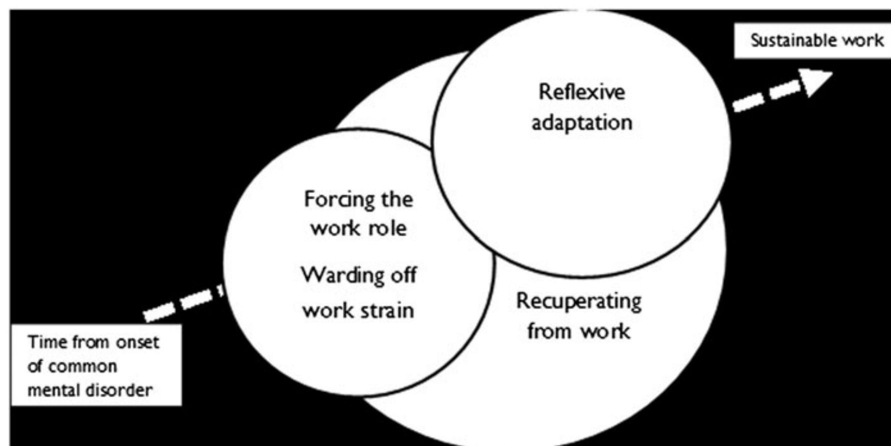

Figure 2. Model illustrating the categories of the core pattern "managing work space" in common mental disorders, positioned along a process of sustainability.

moved into a less crowded room, often to avoid stimuli. The participants detached themselves emotionally and socially, to keep up the focus and energy for the job tasks at hand. They needed distance from others' input; as described by one participant, "I'm going into my cave to dive into my work and be left alone." Another reported the experience of deliberately "putting blinkers on". The shielding strategy appeared in narratives at both illness onset and return to work, but in the latter phase it was a more deliberate choice of action.

Recuperating from work

This category includes strategies for recuperating and recharging to keep up at work. These strategies involved leisure activities but also included recuperative moments during the work day. A central experience in the recuperative strategies was to find a moment to be alone, and to be left at peace. Work space was managed by creating a private space and thus boosting resilience.

To commit to a presumably healthy lifestyle. Physical activity was mainly used to gain energy and resilience to keep up at work, and to have a breathing space. For some, however, the exercise became compulsive. The participants felt compelled to continue to exercise, either motivated by rational explanations of the good of exercise, or in a bid to control anxiety. Eastern movement practices were also described, such as yoga and mindfulness. Listening to or making music was another strategy, used to boost energy and feel connected, and as "balm for the soul". The participants related that social activities were essential, but they chose certain persons to socialize with as well as certain activities, often ones that were not stressful. They put an effort into maintaining healthy eating and sleeping habits:

> I really try it with my sleep and my food and my exercise. But it's hard, I think, I don't get the full hang of it. I need to turn my sleep pattern around and go to bed earlier. And I really want to eat properly, breakfast, a little snack, lunch … I was really good at this before./ … /And the exercise, it's so hard to go to the gym. I take walks in the forest, I love it, it's my religion you could say. It makes me feel in a good mood, like I'm clearing my veins from all the crap. *(Female community worker with major depressive disorder, on sick leave)*

To restore and reboot. The participants found ways to recharge a little during the workday. They created opportunities for a quick reboot, at different levels. This could be by resting in a peaceful room or sitting in a corner of the staff room pretending to read. Use of the bathroom as a solemn and private spot to recollect oneself was also mentioned in the workers' accounts. At home, the participants practiced "alone time", asking for space from, or simply avoiding, family and friends. They needed to think their thoughts through, and try to get an overview and a hold of their situation. One participant described the need for the whole weekend alone, just to catch up and prepare for the upcoming week. There were also descriptions of prophylactic boosting. For instance, one participant took a longer, relaxing route to work in the morning to get a good start to the work day. Another participant rebooted by taking her breaks outside:

> You wish for some free *space*, you know. You feel very cornered, in a way. You step outside [the workplace] so as not to feel pushed in. You want out to be able to breathe, for real. *(Female cook with reaction to severe stress, working part-time)*

Reflexive adaptation

Under this category, participants described developing conscious adaptive strategies to keep working: for instance, they might notice signs of instability and, in response, might modify their work in collaboration with others. These strategies were characterized by a long-term view of keeping up at work, despite resurfacing vulnerability. The work space was managed through continuous reflection and adaptation of time and responsibilities.

To reconsider one's attitude to work. The accounts of participants in the return to work phase contained descriptions of strategies for reconsidering their approach to work tasks, responsibilities and achievements. The participants described committing less to their tasks in order to save energy and emotional investment. They challenged themselves to practice to say "no" and decline assignments and events they would normally have accepted. They were strict on themselves about respecting work hours, neither skipping breaks nor working late:

> It's easy to think, "I have to do this first," but just go home! If you haven't finished, you haven't finished. It's not your problem: it's the company's problem if they don't employ enough people. *(Male engineer with panic disorder, working full time)*

They also consciously tried to prioritize differently: instead of giving their all at work, they tried to put their own wellbeing first. They emphasized the need to reflect with family and health care professionals: without challenging themselves through reflection, it was easy to fall back into old patterns. Reconsidering one's attitude to work also meant learning to act on personal cues of strain.

To modify the work frame. The participants described planning and modifying their work for sustainable change. This could mean reducing their work hours or not working full time. It could mean

switching workplaces, or changing jobs and careers. Mainly, the participants switched from jobs with interpersonal tasks in an intense environment, such as nurseries, schools or hospitals, to jobs with more administrative tasks. Some changed from a high-achievement, competitive job to a job with less career focus. For some, the modification entailed working as usual between CMD episodes, but quickly switching when a new episode was approaching. For example, one participant described taking a few weeks off work every winter, as soon as she felt that her depressive symptoms increased. On a lesser level, participants could adapt by rearranging their work tasks and prioritizing them, depending on their day-to-day wellbeing:

> I plan my days, how I structure the meetings. I don't always manage to take breaks together with my colleagues. And I sometimes cancel going out to restaurants for lunch, to save energy. If I had been working perhaps 70% I might have managed such things. So I need to weigh these things back and forth. *(Female social worker with generalized anxiety disorder, working full time)*

> When there are hiccups at work, my anxiety increases. Then I have to move that task to a different room. I get so affected, when I've been struggling with something for a couple of days that I can't stay in that room any more. It's like the room has been infected with the stress. Then I need to move my body someplace else to continue. *(Male artist with unspecified anxiety disorder, working full time)*

To reach for managerial and collegial support. The participants gave rich descriptions of turning to their managers for support: but not before they were at risk of falling short of their duties. Some felt understood by their manager who planned for immediate adjustments, while others felt neglected. The participants also described reaching out to a coworker by sharing the joint experience of a stressful work environment or by letting someone at work know how they really felt. One participant had a coworker appointed as her "support person" she could turn to on a bad day. To reduce but not shut down all social interaction was essential: the participants felt a need to be seen without being put under social pressure.

Discussion

Our main findings describe how workers with CMDs try to keep up at work by managing the work space: attempting to retain a sense of freedom and the possibility to manoeuver and perform in their working life. Diverse practical strategies were described under the different categories, and it is hoped that our findings will increase the knowledge of rehabilitation professionals working with the target population. The strategies presented in "Results" section could serve as items for future study among depressed and anxious workers, also in association with sick leave.

The core category bridges the gap between the individual and the environment as it draws focus to space as the interface between the subject, their work context and their private sphere. In this way, our understanding is in line with other models explaining work functioning as a number of complex, dynamic interactions [13,14,41]. Connected to our findings is the concept of margin of maneuver [42], which focuses on disabled workers' reintegration to work and the features determining "leeway" at work. Mainly, these features relate to the organizational level in terms of production demands and options to control and alternate work tasks, but the worker's self-efficacy and strategies are also included. Our core category corroborates this conceptualization, and potentially expands it: by addressing mental health and by analyzing experiences from different phases of illness.

Similar to coping models on work stress, our core category relates to processes and includes cognitive and behavioral efforts [19,43]. However, our findings in some ways seem to transcend the traditional distinction between problem and emotion-focused coping strategies. For example, *To reach for managerial and collegial support* and *To compensate for shortcomings* entail both pragmatic problem-solving and emotional aspects. Moreover, coping concerns the management of adaptational demands, related to the emotions instantly generated from a given situation [21]. Our categories *Warding off strain* and *Forcing the work role* relate to the worker's emotions of feeling threatened, fearful or ashamed, resulting in strategies based on affect-based impulses. The personal significance and meaning of sustaining work is essential here – there is a lot at stake for the workers – but paradoxically the high significance seem to block them in cramped or even desperate measures, unable to see the risk of trying too hard. This finding warrant further exploring, for example, connected to the recent emphasis in coping theory about appraising and the constructed relational meaning between the person and their environment [21].

In fiction literature, the symbols of space and room to reflect possibilities, agency and independence have been frequently used, such as in Virginia Woolf's *A Room of One's Own* and E.M. Forster's *A Room with a View*. The conceptualization of "creating space" has provided interpretative depth in health research from a feminist perspective, such as in a gender-sensitive intervention for adolescent girls with stress-related symptoms [44]. In our study, both women and men reported feeling challenged to "perform enough" with regard to occupational, social and family duties, craving "alone time" outside work. The recuperative strategies were not only health-promoting in the obvious sense (increasing fitness or calming a stressed mind), but also as ways for the participants to retrieve their own space.

Some strategies were used more often early in the process, i.e., at the onset of instability, while others were mainly used in return to work, for example, after a period of sick leave. It seems that the strategies *Forcing the work role* and *Warding off work strain* are associated with a fight/flight reaction [45] and as such a reaction to a stressful experience. The strategy *Reflexive adaption* is more conscious and thought through, and less reactive in character. It is adapted to the circumstances and suggests solutions based on the individuals' resources and the requirements of work. This strategy suggests that the stressful experience no longer occupies the participants. Consequently, the different strategies pull toward two positions, one characterized by high stress and physiological reactions ("reactive position") and the other characterized by reduced stress and the ability to use reflective strategies ("reflective position"). This interpretation suggests that rehabilitation in the early phase could focus on reducing stress to enable the worker's creation of reflective, sustainable strategies.

Similar to previous studies [28,30], we found that the workers practiced strategies to limit themselves at work, as described in the category *Reflexive adaptation*. However, this category involved other ways of handling vulnerability, for example working as usual (i.e., without limitations) until the first signs of a new episode, or changing jobs or careers.

Previous concerns have been raised that too much emphasis on limitations can reduce joy and commitment at work [30]. We share this concern and suggest that numerous strategies may be helpful in the rehabilitation process, in which modifications are reflected on and created with regard to keeping the individual's sense of meaning at work. We argue that interpersonal strategies, such as obtaining social support from the manager and coworkers [46,47], are particularly interesting as they have the potential to create a sense of belonging and coherence, but may

simultaneously hold a risk of draining energy. This knowledge should be of interest also for employers.

We were careful not to let our understanding from previous work and clinical guidelines pre-define the strategies into "good" versus "bad" strategies. Rather, we tried to view the workers' strategies as a palette of maneuvers: some were reflected upon and consciously practiced, others emerged out of frustration and need. Although it must be pointed out that the participants themselves claimed variation in sustainability, suggesting that the categories in the upper half of Figure 2 would facilitate a more sustainable working life, we cannot rule out the possibility that some individuals go through their working life using the strategies from the lower part of the figure. From an organizational perspective, these strategies may be valuable as they suggest high work ethics. A different study design investigating the long-term prevalence of strategies in relation to sick leave, but also to productivity and quality of life, would give more insight into how strategies in CMDs are to be valued from different perspectives.

Following this line of thought, we suggest that an individual's strategies are to be approached by rehabilitation professionals with openness and empathic creativity. People do what they can to keep up at work and their possibilities to manoeuver insufficiencies partly depend on factors beyond the scope of health care. We see a need for further investigation into the impact of socioeconomic factors, education levels and health literacy in relation to the "palette" of strategies presented here. For example, we noticed in the interviews that a manager and an engineer (i.e., workers with higher education and status) expressed knowledge about their rights and entitlement to work adjustments, while a cook did not. It is likely that the palette does not provide a full and equal range of strategies for all. According to Bourdieu's sociological theories [48,49], workers have habitual dispositions to respond to situations in everyday life. The social room provides a space where they are intertwined with, but not completely bound to, their economic and cultural capital. This suggests dialectics between social determinants and the freedom to act, between structure and agency, in the process of keeping working in CMDs.

Our results could increase employers' knowledge about more or less visible strategies that the workers apply. In particular, the category that highlights the benefit of managerial and collegial support, entails strategies that the employers can facilitate at the work place. Moreover, the strategy that some workers need to "shield off" would be of interest for the employer to learn about, so that they can try and facilitate less crowded rooms for those workers. Although the results reflect strategies in the CMD population, increased awareness of the strategies might facilitate prevention in healthy workers, for example, knowledge of recuperative strategies, social support at work and reflection on attitudes to work.

Strengths and limitations

The extensive in-depth exploration [36] using purposive sampling and the process-oriented analysis based on comparing and contrasting data [50] and the parallel discussions among the authors can be considered strengths. All three authors had previous experience of using grounded theory, but the authors provided different input to the analysis based on diverse clinical and theoretical backgrounds. Two of the authors had a prolonged commitment to the data [51] having been researchers in the previous study [31]. Transparency of the analysis was enhanced by outlining researchers' reflexivity and by exemplifying the stepwise condensation and discussion of data (Figure 1). Another aspect of reflexivity was the two interviewers' joint discussions during data collection, regarding their follow up questions. To show that the conceptualization had "earned its way" into the analysis [36], we have illustrated with direct quotes from the participants in the subcategories and in Figure 1. Validation was enhanced through debriefing with patients with CMDs.

This study used data from interviews that were primarily done to answer a different research question, which can be considered a limitation. However, the present research question about strategies caught our attention and was gradually explored in the co-constructive conversations between the interviewer and the participants. We believe that this manner of discovering content and meaning connected to a new research question, during the process of data collection, is in line with grounded theory principles and justifies our performance of a parallel analysis. Repeated interviews and using several data sources may have enabled deeper insight into the participants' working life [34,36].

Another limitation is that few of the participants were manual workers. Different sources of recruitment may have been better at reaching a diversity of workers. However, since sick leave is currently increasing mainly in the welfare sector, in jobs with interpersonal tasks [52,53], the present sample was suitable for providing important knowledge of immediate relevance.

Conclusions

This study conceptualizes depressed and anxious workers' attempts to keep up at work as *managing work space*, using strategies to manoeuver and to gain enough space for their work performance. In our interpretation, the notion of work space goes beyond the physical room, to involve the lived, social space of work, including the bridge to private life. It is hoped that our findings will deepen the understanding among rehabilitation professionals and increase their awareness of the meaning and characteristics of different work-related strategies in these patients. This knowledge can be used to reflect together with the patient, exploring present options and introducing modifications in their particular work and life context.

Disclosure statement

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