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RESEARCH PAPER

Capacity to work while depressed and anxious – a phenomenological study

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Abstract

Purpose: The aim was to explore experiences of capacity to work in persons working while depressed and anxious in order to identify the essence of the phenomenon capacity to work. **Method:** Four focus groups were conducted with 17 participants employed within the regular job market. Illness experiences ranged from symptoms to clinical diagnoses. A phenomenological approach was employed. **Results:** The phenomenon of capacity to work was distinguished by nine constituents related to task, time, context and social interactions. The phenomenon encompassed a lost familiarity with one's ordinary work performance, the use of a working facade and adoption of new time-consuming work practices. Feelings of exposure in interpersonal encounters, disruption of work place order, lost "refueling" and a trade-off of between work capacity and leisure-time activities was also identified. The reduced capacity was pointed out as invisible, this invisibility was considered troublesome. **Conclusions:** A complex and comprehensive concept emerged, not earlier described in work capacity studies. Rehabilitation processes would benefit from deeper knowledge of the individual's capacity to work in order to make efficient adjustments at work. Results can have particular relevance both in clinical and occupational health practice, as well as in the workplaces, in supporting re-entering workers after sickness absence.

Keywords

Fitness for work, focus groups, work capacity

History

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► Implications for Rehabilitation

- The reduced capacity to work due to depression and anxiety is not always understandable or observable for others, therefore, the rehabilitation process would benefit from increased knowledge and understanding of the difficulties afflicted individuals experience at work.
- Identifying tasks that contribute to "refueling" at work might enhance the success of the rehabilitation.
- Rehabilitation programs could be tailored to better address the inabilities that impact on the capacity to work when depressed and anxious.

Introduction

Common mental disorders (CMD) account for a substantial proportion of sick-leave days in most industrial countries [1]. Work capacity is reduced in persons with anxiety and depression [2–4] and this has greater influence on work performance than many other medical conditions including arthritis, back pain and breathing disorders [5–7]. Individuals with mental disorders report more frequent "extra effort days" than those with physical disorders [8]. Work capacity is affected also in individuals with subthreshold symptoms and in those who are in clinical remission [3,4].

Studies describing work functioning in individuals with CMD are sparse, despite the importance of the psychosocial and occupational functioning [9,10]. So-called presenteeism studies have shown that doing work carefully, concentrating on work and meeting people was difficult compared to controls without CMD [11]. Handling work load, getting started in the morning and thinking clearly while working have also been identified as problematic [12] and Wang et al. [13] found that difficulties increased over the day. Gärtner et al. [14] in a review found several areas of affected work functioning in health professionals due to CMD, including general errors, complex motor skills, work speed and interpersonal behavior. The capacity to work is also affected by medication [15,16].

In light of the above, it is somewhat surprising that the bulk of research on work capacity in mental illness focuses on persons with severe disability. Less is known regarding those who work while affected by CMD [1,17–19]. Exploration and

conceptualization of work capacity from the perspective of those working while ill might be a key issue to better understand work impairment, sickness absence and return-to-work (RTW) [20]. The aim of this study was to explore experiences of capacity to work in persons working while depressed and anxious and to use these lived experiences in order to identify the essence of the phenomenon capacity to work.

Methods

Design

A qualitative, phenomenological approach was chosen for this study. The content and meaning of a real-life phenomenon can be explicated and conceptualized with a phenomenological approach, and then understood in a theoretical and comprehensible manner [21,22]. Data were collected via focus groups. This approach is appropriate when the goal is to generate different perspectives on a subject that is less well explored [23]. It was assumed that recognition among peers would stimulate discussions, encouraging the sharing of lived experiences. The study was approved by the Regional Ethical Review Board in Gothenburg, University of Gothenburg, Sweden.

Participants

In order to obtain variation in participants' illness experiences, individuals with differing types and severity of symptoms were invited to take part in the study. For inclusion, participants were required to be of working age (18–65 years) and currently working at least part time within the regular job market. Persons working in the context of job training, rehabilitation, supported employment, or subsidized employment were excluded. Individuals who did not speak Swedish were excluded due to the focus group design.

Potential participants were recruited in two manners. Depressed/anxious persons with ongoing health care contacts (primary health care, psychiatric out-patient care and occupational health care) were identified by staff who distributed written information about the study to patients with one or more of the following clinical diagnoses, in accordance with the International Classification of Diagnosis: F32 depressive episode, F34 persistent mood (affective) disorders, F38 other mood (affective) disorders, F39 mood (affective) disorder, F41 other anxiety disorders, F43.8 other reactions to severe stress [24]. In order to reach also depressed/anxious persons without health care contact, oral and written information was provided during 12 public meetings held at public health information centres. In this non-clinical group there was no formal screening procedure and a clinical diagnosis was not a requirement for study participation. Instead recruitment was made on the basis of self-report of symptoms including worry, fatigue and feeling blue. Attendees at the public meetings were also advised that they could forward the written information to other persons who might be interested in participating in the study. All who wished to learn more about the study then submitted an application of interest ($n = 32$). The first author contacted these persons by telephone and explained further the objectives of the study. After potential participants gave informed consent, a brief telephone interview was carried out. The interview focused on sociodemographic and occupational data, and those who were recruited from health care were asked to report their clinical diagnosis. Eleven persons did not meet inclusion criteria, the most common reason being that they were not currently employed within the regular job market. One declined further participation. In all, 20 persons were invited to participate in the focus group study. Two of these cancelled and

Table 1. Characteristics of the study population.

Age	Years
Range	30–62
Mean	46
	<i>N</i>
Gender	
Men	5
Women	12
Recruitment places	
Public health information centre	5
Primary health care	8
Psychiatric out-patient care	4
Self reported diagnoses ^a	
Depression only	2
Depression and anxiety	5
Depression and exhaustion	1
Exhaustion only	4
Work hours	
Full time	12
Part time	5
Employer	
Public sector	11
Private sector	6
Type of work	
Manual work	8
Non-manual work	9

^aParticipants recruited from health care only.

one did not show up for the focus group session, resulting in a total of 17 participants (Table 1). At the initial stage of telephone contact and during the session, they were informed of their right to withdraw from the study at any time.

Focus group procedure

There were four focus groups with 3–6 participants per group. Participants received a confirmation letter (date, time and place) and the following list of questions to reflect upon prior to the focus group meeting.

- *What, in your opinion, characterizes a good capacity to work?*
- *What do you think is part of a good capacity to work?*
- *How is your capacity to work affected by problems such as worry, fatigue, sadness, depression or anxiety?*
- *What does it mean to you that your capacity to work is affected by problems such as worry, fatigue, sadness, depression or anxiety?*

Participants gave written informed consent at the focus group session. All sessions were held in a centrally located research facility. There were no incentives but travel expenses were compensated. Focus groups met for 83–113 min. The participants were informed that they were welcome to contact the first author if any issues arise in connection with the focus group discussion.

All focus groups were facilitated by a moderator (the first author, an occupational therapist with long clinical experience in psychiatry) and a co-moderator (the second author, an occupational therapist experienced in primary healthcare). The moderators ensured that focus was retained, and that all took part in the discussion. Probes were used (“*How does this affect your capacity to work?*”) and moderators asked for more details when participants described lived experiences. All focus groups were audio-recorded and recordings were professionally transcribed by a transcribing firm. Quality was controlled by reviewing the audio-tapes and controlling for accuracy, correcting any mistakes. To control and bridle researchers' pre-understanding reflective notes were made throughout the research process, and the

moderator's actions were analysed through transcript readings after the first two focus groups.

Data analysis

Data analyses were initialized once all four focus groups had been conducted. Data were analysed in accordance with the reflective lifeworld approach as described by Dahlberg and colleagues [21,22]. Preliminary data analysis was done by the first and third author. Transcripts were read and reread to get a sense of the whole. Initially, data from each focus group were treated separately. Each of the two authors identified text segments related to capacity to work and these preliminary analyses were compared. The text segments were treated as meaning units and clustered. At this point, data from the individual focus groups were merged. Clusters of meaning were configured and reconfigured through an iterative process and emerging themes were identified. First drafts of clusters of meaning, later drafts with themes, with a wealth of descriptions and quotes were worked and re-worked, moving from concreteness to a more abstract level. Finally, a structure was captured and constituents were distinguished. The essence, that is, a condensed description of the phenomenon was then derived and made explicit from the structure and the constituents. The constituents are to be viewed as parts of the essence, further elucidating the phenomenon. During the final stages of the analysis, themes, subthemes and constituents were critically reviewed by all co-authors, to enhance the credibility of the findings [25].

Results

The essence

The essence of the phenomenon capacity to work while depressed and anxious is experienced as a loss of familiarity with one's work performance, one's behaviors and emotional and physical reactions. It is like being a guest in one's own working life. Body and mind are experienced as disconnected and work performance is possible by means of a working facade and great effort. To work is a challenging act accompanied by feelings of not being "good enough". The decreased capacity to work is particularly exposed in human encounters. Capacity to work fluctuates and new work practices are developed to monitor personal achievements. All this consumes energy, necessitating withdrawal from leisure and social activities. Good work performance normally generate job satisfaction and elicits gratification from others, but these daily moments of "refueling" are absent, making work even more difficult. The reduced capacity to work is experienced as causing a sense of remoteness in the work community and feelings of loneliness at the workplace. The essence is constituted by nine constituents, described below.

The constituents

Surrounded by a continuous work flow with a hypersensitive mind

Participants described a continuous work flow in which it was very difficult to handle work tasks and the work environment. There was no room to withdraw for natural breaks to think and reflect. They described their minds as hypersensitive. Demands beyond the everyday routines and external stimuli, such as loud discussions or sounds of machinery could reduce capacity to work instantaneously. At night several participants were plagued by work-related ruminations.

You cannot work with several things at the same time, as I did before...I can stand and talk to a customer, the telephone

...I become very frustrated, I lose focus on everything and often it ends up in chaos, I just stand there and do not know what to do, I am probably like a fool for a while before I can sort out what I should do. (focus group 3)

Fatigue was pinpointed as a major problem. Participants described feeling as if their heads were full of cotton or dough, and this was experienced as a massive obstacle to managing work, and forced a slower pace. They experienced that fatigue decreased the ability to concentrate. Focusing on information, reading, writing and learning were difficult. Decreased concentration led to failures and increased risk of injuries. Participants experienced that it was difficult to make choices and to prioritize tasks. Forgetting things, not being able to complete tasks, or starting too many things at once all contributed to a trapped feeling where it was impossible to work successfully. This resulted in periods of improductivity. Taking initiatives, coming up with new ideas and finding solutions were other problematic areas.

I notice of course, that my memory has become really bad, I have become quite uncertain. Perhaps I should call someone and ask a question, but I might as well have already called and talked to that person, I have no idea; it could very well be so. In principle, I have to write down everything I do. Then, I can only concentrate for relatively short periods of time, before I kind of lose focus, so long meetings are next to impossible. (focus group 1)

The participants described difficulties of holding on to objects, fumbling, dizziness, nausea and pain. Some experienced a strange visual sensation while trying to focus on another person or a computer screen. This was sometimes accompanied by a swaying feeling. The physical sensations were scary and led them to a focus on the body, which made it difficult to focus outwards and to work.

It is a part of my work to be responsible, which requires me to be the most flexible and the one who knows the most, I lost this ability entirely because I was so preoccupied by my dizziness, and what it could be and how I could solve it. The shifts I work did not turn out particularly well because I was not [mentally] present, I was completely absorbed by myself. (focus group 1)

Unequipped to handle the demands of time and pace

Some participants described that adherence to times and keeping up the pace of work as more challenging than the task itself and this inability generated stress. Disturbed sleep or medication side effects were described as leading to delays and other difficulties in performing morning work tasks. Participants also described an uneven work speed. Periods of inactivity were followed by periods of intense activity and catching up. Some considered flexible hours a solution, although for others this freedom to choose led to increased workload and emotional strain as certain tasks were postponed or never performed.

Exposed in professional interpersonal encounters

Interpersonal encounters were described by the participants as the most demanding type of work task. Such encounters require mutual give-and-take, engagement, mental presence and alertness. The participants perceived that they were not able to interact fully. They were already on the move to the next task. Participants who worked with professional encounters described this as particularly

challenging due to the professional responsibility they felt during such meetings. Emotional detachment and loss of empathy were described.

There is a client that I know who is going through a very difficult transition in life right now, she broke down in a consultation with me, but I felt that I wasn't at all affected by this, I just sat there and kind of waited out this reaction, kind of watched the clock, I couldn't enter into her situation at all and what she was going through. (focus group 1)

Being able to co-operate and manage emotions were two important components of the capacity to work. However, the participants experienced an increased emotional sensitivity, and were unable to control anger or sadness. They felt thin-skinned in encounters with others and they were defenseless when it came to the emotional reactions of others. Participants also described misconceptions at work. They were oversensitive to criticism and often took things personally. This contributed to feelings of failure, shame and worthlessness.

Putting on a working facade

The participants described that they put on a facade, a shell or a costume on “bad days”. With this facade, they could continue working but felt closed off, less flexible and performed tasks mechanically. Work quality was influenced negatively compared to better days when they felt alive and spontaneous. Entering the working facade was connected with an experience of feeling unprotected, as their incapacity could be exposed to others at any time. This could lead to embarrassing situations, which further aggravated the feeling of vulnerability. They described feeling uncertain about their work performance. To counteract this feeling, they developed a habit of note-taking and checking repeatedly to make sure that things were done correctly. These new work practices were time consuming, and increased job stress. When it was no longer possible to enter the facade, work capacity vanished.

The demanding act of being “good enough”

To perform at work was described by some participants as an inner demand, as something they were compelled to do. Furthermore, the work performance had to be “good enough”. This inner demand was considered to be as demanding as the work itself; if the performance did not reach this personal standard it influenced self-confidence negatively. Performance was also boosted by personal notions including the positive value of work. Capacity to work was regarded as something healthy, important to maintain, whatever the cost. Performance was likewise triggered by a fear of losing work and by demands related to insurance terms regulated by sick-leave legislation. All these “triggers” further increased strain on the individual. Some stressed the risk of exceeding the limit of one’s coping ability, which aggravated symptoms.

Deficient work satisfaction and loss of “refueling”

Participants previously experienced feelings of work satisfaction, meaningfulness and appreciation from others. These feelings were described as energizing the work performance. These previously important sources of gratification and “refueling”, however, were cut-off due to their illness. This lack of “energy refueling”, which decreased work capacity, was likened by participants to wading through syrup and contributed to an inner resistance at work that had to be dealt with every moment, every day.

Retaining a sense of humour keeps you going, right? It's a big deal when you start to lose your [job] satisfaction, you cannot

do your work, you become angry and always moaning, in the end you can't manage physically. (focus group 2)

Trading leisure-time activity with inactivity to manage work

All participants described that they had cut down on leisure and social activities in order to have sufficient energy to manage work. This was experienced as a “trade-off”. For some, they had been doing this for several years. The trade-off was described as a vicious circle, negatively influencing the capacity to work in the long run. Another effect described was a lack of topics for conversation at work since they had limited activities to talk about. This exacerbated alienation. A few noted that they had learned to prioritize leisure activities, and found that this improved their work performance.

I can function at work or I mean that over time I achieve what I am supposed to . . . but then I go home, that's the price I pay to be able to keep up with work. I feel so bad at nights, avoiding friends periodically, I don't activate myself, it's a vicious circle, but I do continue working. (focus group 3)

Disrupting work place order

Participants experienced that their decreased work capacity disrupted the work place order and routines. The inability to manage work tasks or frequent requests for help was perceived as putting an extra burden on workmates. The need to rest during the day, to leave early or to be temporarily sick-listed interrupted the structure at work. Misunderstandings and overreactions were described as rendering collaboration more difficult.

Instead of me doing what I am supposed to do, create clarity, bring order, plan, I created chaos instead. It could be a training course [staff] are going to and I have no clue of who should go there and I forgot to arrange for temporary staff. I make a mess of things instead of me doing something well. (focus group 3)

Participants described that they could manage everyday work routines, but problems arose when they were expected to carry out other duties or to work in other settings. Involvement in work-related events after normal work hours was impossible for some due to fatigue. Job-related social activities were challenging for some, since this was experienced as crossing a border between occupational and private roles.

When we are to go out with work mates to a party or when we have gone away [and left work] for planning days, I get such anxiety, it's like the professional role disappears and I am a private person and I feel naked, real panic attacks, but in some way you force yourself and fix it anyway. (focus group 2)

The dynamics of alienation

Participants stressed that a sense of belonging to the group was important for the capacity to work. This feeling was influenced both by the individual’s own behavior and the behavior of workmates. Some lacked the energy to socialize and avoided coffee breaks and work activities outside work hours, which contributed to feelings of loneliness and lack of refueling. There were participants who could not tell their manager and/or colleagues about their decreased capacity to work and, thus, did their utmost to hide their difficulties. Some made excuses to hide

their inabilities, pretending, for example, to have prior engagement so that an invitation could be declined. Others claimed that disclosure of mental ill-health was natural and a prerequisite for working. Support and understanding at the workplace, or the lack of it, was described as central. Those who lacked support felt detached, which made it even harder to ask for help.

Symptoms of mental ill-health and decreased functioning were described as “invisible”. This made it difficult for others at work to understand how the participants’ capacity to work was affected. Even those who disclosed their symptoms and disabilities found that it was difficult for colleagues to comprehend the nature and the magnitude of the problems. They expressed that there was a need for increased understanding, both in the workplace and in society as a whole, of the impact that depression and anxiety could have on work capacity. Some participants, whose work situation had been modified due to decreased capacity, described that colleagues perceived these changes as “special treatment”, and that this was held against them. When colleagues did not understand their disability, workplace alienation was increased.

Person 1: Well for me it has been a prerequisite that my manager has known and supported me.

Person 2: God, what a relief. That's not what it looks like at my workplace. It was the opposite. There you got reduced wage in the end since you were no longer able to work [satisfactorily]. And that of course was a burden in itself, that you knew that you weren't one of the gang.

Person 1: You mean you felt that way when you were sick, that they turned their backs . . .

Person 2: Yeah. I was a spanner in the works. You can't have a good capacity to work when you are ill, so to speak, but things do not improve by the fact that others do not comprehend [the incapacity] either. They probably did as good as they could, but no one ever asked me about anything and then you don't get any feed-back. (focus group 4)

Discussion

Capacity to work while depressed and anxious is a phenomenon hitherto primarily described and conceptualized from a juridical and medico-administrative perspective. This study is the first to explore and describe its essence, which turned out to be both complex and comprehensive. Participants experienced a phenomenon separate from symptoms, spanning over tasks, time, physical and psychological reactions, behavior and social interactions. They stressed the difficulties and also the need to convey to other people such as managers, co-workers, physicians and social insurance officers what it means to lose the capacity to work. Gradually, a sense of loneliness seemed to develop. The perceived stigma of CMD might contribute to this process.

Our study provided a broader and more comprehensive perspective than identified in previous studies involving GPs and insurance physicians [26,27]. Insurance physicians were asked to identify the 10 most important disease-specific aspects of work ability in major depressive disorders, and from the point of the content of these aspects, all of them can be found within the constituent “Surrounded by a continuous work flow with a hypersensitive mind” [27]. In a study of GPs’ conceptualization of work functioning were social ability and demands only briefly mentioned [26]. This suggests difference of perspective between clinicians and of the afflicted individuals. Bridging this gap seems to be of central importance, as pointed out by de Vries et al. [20], in order to improve support for those who do work while depressed and anxious, and to facilitate a successful RTW of

persons who have been on sick leave. The latter is important to avoid longer sick-leave spells and marginalization from work life.

Overall, research on capacity to work while depressed and anxious, from the perspective of the individual, is scarce. To the best of our knowledge, there are to date no other phenomenological or other qualitative studies with an explicit focus on work capacity. However, a qualitative study by Michalak et al. [28] found that participants with bipolar disorder experienced decreased work functioning more often during the depressive episode than in the hypomanic state. As in our study, participants in the bipolar study experienced decreased confidence, fatigue, withdrawal from others in the workplace, less enthusiasm and decreased productivity during the depressive episode. Increased irritability and conflicts at work were also described and congruent with our findings, but more often perceived in the hypomanic state [28]. Similar to our study, a study exploring the RTW process in individuals with CMD found difficulties with pace, frequent checking of own actions, and fear of exceeding the limit of one’s coping ability [29].

The “working facade” has been described in qualitative studies of depressive disorders and in a study on work disability in arthritis [30–32]. However, the phenomenology of the facade differs between the studies. In our study the “facade” was described as a means of continuing work. In earlier studies the facade was described as a means of disguising the disorder or disabilities. Furthermore, the use of the facade was considered energy consuming, contributing to exhaustion [30–32]. Porr et al. [31] have also described the experience of engaging mechanically at work, but as a more severe state of fatigue compared to the use of a facade. Therefore, when individuals perceive that they use a facade or perform mechanically, this might be understood as a sign of increased risk of sickness absence. However, longitudinal observational studies are needed to confirm this.

Deficient job satisfaction and specifically the lack of “energy refueling” during the workday has not been described earlier, but it relates to the findings of de Vries et al. [20], who showed that a positive level of energy was important in RTW processes. The lack of daily refueling in an already vulnerable individual probably affects RTW negatively. Leisure time is another subject seldom highlighted as an element of work capacity in the large body of quantitative research [5,8,11–13]. In such studies, the work environment and the individual are seen as isolated units and considerations regarding the employee’s family life and leisure-time activities are exceptions. However, activities undertaken during leisure time and in the context of social engagement, like frequency of social activities, have been found to be related to depression; the more activities the less likely the symptoms of depression [33]. The finding that individuals who are depressed and anxious deliberately decrease leisure and social activities in order to preserve their remaining capacity for work makes the issue more complex.

The participants in this study experienced that their altered behavior and reduced work capacity impacted the workplace’s routines and order. This is an important finding that might, however, be perceived as contributing to stigmatization. Still, the burden on colleagues of a workmate with reduced work capacity, possible decreased social functioning and associated distractions at work are to a very small extent highlighted in research. Barriers at work have though been suggested as one of the major obstacles to RTW [34]. Independently of one another, employers, employees and the re-entering worker who took part in a recent Swedish study all reported apprehensions about the RTW process. The work mates were uneasy regarding the level of strain the re-entered worker could manage [35,36]. This part of the RTW process is often ignored, but important if a sustained RTW are to be achieved [37].

Methodological considerations

The phenomenological design was well suited for this study question. The focus groups enabled the participants to verbalize their lived experiences from their working lives, producing sound data that could be analysed and described. Most qualitative work-related studies concerning psychiatric disorders either have non-working or a mix of non-working and working participants. In the non-working group expectations or beliefs would be explored rather than experiences, so the inclusion of only currently working participants was an advantage. The inclusion of individuals with a range of illness experiences is another advantage, since variation is crucial in qualitative studies. Participants were self-selected and those who chose to participate might have experienced decreased capacity to work to a larger extent than those who did not. On the other hand, taking part in a study such as this requires mental energy and some might choose not to participate for this reason. Women are more likely to seek care for CMD and might also be more likely to attend public meetings, which might have affected the recruiting process and led to women being more addressed to participate than men.

It is not always easy to distinguish capacity to work from symptoms of disorder as these phenomena are closely linked and they may overlap. Another consideration is the distinction between decreased and preserved capacity to work. The participants probably experienced both, but the emphasis during the focus groups might have been on the decreased capacity to work. Experience of sickness absence was not part of the inclusion criteria but informants spontaneously brought this up during the focus groups. Sickness absence experiences were very heterogeneous. While some had never been on sick leave due to CMD others had been absent during shorter or longer periods. There was no analysis of separate experiences related to full- or part-time work in this study. Both sickness absence experiences and the influence of full- versus part-time work would be important to explore in future studies.

The choice of terminology is essential in qualitative studies. We have strived to keep the expressions as close as possible to the original content of the lived experiences, while at the same time condensing content to enhance the communication of results. The translation from Swedish into English is an important step and it is a strength that the authors included a native English speaker also fluent in Swedish. We accounted for trustworthiness through reflexivity in data collection and analysis, the use of two analyzers and the involvement of all authors in the process of identifying the essence of the phenomenon and its constituents [25]. The phenomenon described in this study might have some restrictions regarding transferability. Few participants were young and young people might have different experiences. There were also relatively few men. Most of the participants were working with people (clients, customers and children) in one way or another which might restrict the transferability of the results to other work settings.

Conclusion

Capacity to work is a highly relevant clinical topic. The conceptualization will be important in at least three ways. First, it moves beyond symptoms and bridges the gap between the medical perspective and the afflicted individuals' experiences of capacity to work. Second, the findings may enhance communication and collaboration between physicians and patients regarding fitness for work. Third, the findings can be used to support re-entering workers. The elucidation of the difficulties encountered working while depressed and anxious can help professionals to understand better the challenges facing the re-entering worker.

A more work-related supportive approach will increase the chances of a sustained RTW.

Other perspectives needed to elaborate further the phenomenon and to develop the concept is health care personnel's understanding and aggregated knowledge of patients' capacity to work. Another perspective of interest is employers' and employees' experiences of colleagues' capacity to work with depression and anxiety. Sustainable work participation can be feasible with better knowledge regarding the person, environment and occupation fit.

Declaration of interest

There is no conflict of interest for any of the authors.

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References

- Hensing G, Wahlstrom R. Swedish Council on Technology Assessment in Health Care (SBU). Chapter 7. Sickness absence and psychiatric disorders. *Scand J Public Health Suppl* 2004; 63:152–80.
- Adler DA, McLaughlin TJ, Rogers WH, et al. Job performance deficits due to depression. *Am J Psychiatry* 2006;163:1569–76.
- Plaisier I, Beekman ATF, de Graaf R, et al. Work functioning in persons with depressive and anxiety disorders: the role of specific psychopathological characteristics. *J Affect Disord* 2010;125:198–206.
- Rai D, Skapinakis P, Wiles N, et al. Common mental disorders, subthreshold symptoms and disability: longitudinal study. *Br J Psychiatry* 2010;197:411–12.
- Collins JJ, Baase CM, Sharda CE, et al. The assessment of chronic health conditions on work performance, absence, and total economic impact for employers. *J Occup Environ Med* 2005;47: 547–57.
- Burton WN, Pransky G, Conti DJ, et al. The association of medical conditions and presenteeism. *J Occup Environ Med* 2004;46:S38–45.
- Holden L, Scuffham PA, Hilton MF, et al. Which health conditions impact on productivity in working Australians? *J Occup Environ Med* 2011;53:253–7.
- Dewa CS, Lin E. Chronic physical illness, psychiatric disorder and disability in the workplace. *Soc Sci Med* 2000;51:41–50.
- Lam RW, Filteau MJ, Milev R. Clinical effectiveness: the importance of psychosocial functioning outcomes. *J Affect Disord* 2011;132:S9–13.
- Zimmerman M, McGlinchey JB, Posternak MA, et al. How should remission from depression be defined? The depressed patient's perspective. *Am J Psychiatry* 2006;163:148–50.
- Lerner D, Adler DA, Chang H, et al. The clinical and occupational correlates of work productivity loss among employed patients with depression. *J Occup Environ Med* 2004;46:S46–55.
- Sanderson K, Tilse E, Nicholson J, et al. Which presenteeism measures are more sensitive to depression and anxiety? *J Affect Disord* 2007;101:65–74.
- Wang PS, Beck AL, Berglund P, et al. Effects of major depression on moment-in-time work performance. *Am J Psychiatry* 2004; 161:1885–91.
- Gärtner FR, Nieuwenhuijsen K, van Dijk FJH, Sluiter JK. The impact of common mental disorders on the work functioning of nurses and allied health professionals: a systematic review. *Int J Nurs Stud* 2010;47:1047–61.
- Haslam C, Brown S, Atkinson S, Haslam R. Patients' experiences of medication for anxiety and depression: effects on working life. *Fam Pract* 2004;21:204–12.
- Price J, Cole V, Goodwin GM. Emotional side-effects of selective serotonin reuptake inhibitors: qualitative study. *Br J Psychiatry* 2009;195:211–17.
- Harvey SB, Henderson M, Lelliott P, Hotopf M. Mental health and employment: much work still to be done. *Br J Psychiatry* 2009;194:201–3.
- Henderson M, Harvey S, Øverland S, et al. Work and common psychiatric disorders. *J R Soc Med* 2011;104:198–207.

19. Myette TL. Research on depression in the workplace: where do we go from here? *J Occup Environ Med* 2008;50:492–500.
20. de Vries G, Koeter M, Nabitz U, et al. Return to work after sick leave due to depression; a conceptual analysis based on perspectives of patients, supervisors and occupational physicians. *J Affect Disord* 2012;136:1017–26.
21. Dahlberg K, Dahlberg H, Nyström M. *Reflective lifeworld research*. Lund: Studentlitteratur; 2008.
22. Dahlberg K. The essence of essences – the search for meaning structures in phenomenological analysis of lifeworld phenomena. *Int J Qual Stud Health Well-being* 2006;1:11–19.
23. Morgan DL. *Focus groups as qualitative research*. Thousand Oaks (CA): Sage; 1997.
24. World Health Organization. *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. World Health Organization; 1992.
25. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349–57.
26. Krohne K, Brage S. How GPs in Norway conceptualise functional ability: a focus group study. *Br J Gen Pract* 2008;58:850–5.
27. Slebus FG, Kuijer P, Willems J, et al. Work ability in sick-listed patients with major depressive disorder. *Occup Med* 2008;58:475–9.
28. Michalak EE, Yatham LN, Maxwell V, et al. The impact of bipolar disorder upon work functioning: a qualitative analysis. *Bipolar Disord* 2007;9:126–43.
29. Noordik E, Nieuwenhuijsen K, Varekamp I, et al. Exploring the return-to-work process for workers partially returned to work and partially on long-term sick leave due to common mental disorders: a qualitative study. *Disabil Rehabil* 2011;33:1625–35.
30. Lacaille D, White MA, Backman CL, Gignac MAM. Problems faced at work due to inflammatory arthritis: new insights gained from understanding patients' perspective. *Arthritis Care Res*. 2007; 57:1269–79.
31. Porr C, Olson K, Hegadoren K. Tiredness, fatigue, and exhaustion in the context of a major depressive disorder. *Qual Health Res* 2010; 20:1315–26.
32. Jingrot M, Rosberg S. Gradual loss of homelikeness in exhaustion disorder. *Qual Health Res* 2008;18:1511–23.
33. Harvey SB, Hotopf M, Overland S, Mykletun A. Physical activity and common mental disorders. *Br J Psychiatry* 2010;197:357–64.
34. Pransky G, Gatchel R, Linton SJ, Loisel P. Improving return to work research. *J Occup Rehabil* 2005;15:453–7.
35. Tjulin Å, MacEachen E, Ekberg K. Exploring workplace actors experiences of the social organization of return-to-work. *J Occup Rehabil* 2010;33:1–11.
36. Tjulin A, Maceachen E, Stiwne EE, Ekberg K. The social interaction of return to work explored from co-workers experiences. *Disabil Rehabil* 2011;33:1979–89.
37. Young AE, Roessler RT, Wasiak R, et al. A developmental conceptualization of return to work. *J Occup Rehabil* 2005; 15:557–68.