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ORIGINAL ARTICLE

Workplace inclusion of employees with back pain and mental health problems: A focus group study about employees' experiences

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Abstract

Aim: To explore how employees experience workplace inclusion of their colleagues or themselves when having back pain or mental health problems. *Methods*: Three focus group interviews with a sample of 16 kindergarten employees were conducted. Systematic Text Condensation was used for analysis. *Results*: The participants emphasized that it was easier to include colleagues whose health problems were specific, especially when they were open about having problems and expressed their needs for accommodation clearly. Discussions revealed difficulties of acceptance and accommodating colleagues with longstanding health problems, when the burden on the other staff members was heavy, and if it had negative consequences for the kindergarten children. Some of the participants had experienced health problems themselves, which was also described as challenging. Having health problems at work often induced feelings of guilt, being a burden to their colleagues, and experiencing a disparity between the ideals and the realities of inclusion practices. ***Conclusions*: Workplace inclusion of employees is difficult when their health problems are unspecific, longstanding, and lead to negative consequences for children or colleagues. System level efforts are necessary to reduce negative stereotypes about employees with health problems and facilitate inclusion practices.**

Keywords: *Workplace inclusion, accommodation, mental health problems, back pain, employees, stigma*

Introduction

Back pain and mental health problems are prevalent in Norway [1], and have a major influence on quality of life and work participation for those affected [2]. These health problems constitute the main causes of long-term sickness absence and disability in Western countries [3–5]. Working is generally beneficial for health, and exclusion from the workforce is a significant predictor for poor health [6,7].

In 2001, the Norwegian government launched the agreement of a "more inclusive working life" (Inkluderende arbeidsliv – "IA-agreement"), imposing cooperation among the government, workers' unions and employers' associations to prevent exclusion of employees with reduced working functionality. In line with this agreement, workplaces have become a priority setting for establishing an inclusive working life through activities such as accommodation and follow-up of employees with health problems.

Work adjustment, accommodation, and social support from managers and colleagues are vital to keep employees with health problems at work [8,9]. Participation for people with health problems requires support in the labor market and willingness

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among employers and staff to include them [10]. However, lack of awareness about disability and accommodation issues, fear of legal liability, cost concerns, and misconceptions about work performance are important barriers to the employment of workers with disabilities [11]. Nevertheless, employers report several advantages of accommodating employees with temporary or permanent disabilities, such as retaining competent employees, increasing company profitability, avoiding the costs of hiring and training a new employee, and an improved organizational climate [12]. To be socially accepted by colleagues and employers at work, individuals' work performance is more important than their health problems or disability [13].

Most of the literature on workplace inclusion explores the perspectives of managers. More knowledge about workplace inclusion from the perspectives of the actual employees and their colleagues is needed to understand the factors promoting or obstructing participation in working life for individuals with health problems. Attitudes and expectations among the coworkers of employees who need special accommodation due to health problems set the scene for interaction. Stigma remains a persistent barrier to the workplace inclusion of individuals with back pain and mental health problems [14,15]. Cultural and psychological stereotypes, attributing certain traits to people with health problems, have a strong impact on their prospects of inclusion. The Stereotype Content Model by Fiske et al. [16] postulates that stereotypes can be positive, negative, or mixed, reflecting emotions such as admiration, contempt, pity, and envy. Fiske et al. [16] emphasize the dimensions of warmth and competence, arguing that social groups are attributed different combinations and directions of these dimensions. How people behave toward specific social groups in a particular context depends on how these groups are judged according to such dimensions. Thus, this model can draw our attention to the influence of stereotypes for how employees with back- and mental health problems are perceived by their colleagues and support our understanding of behavior related to inclusion practices in the workplace.

We are four authors (one general practitioner and three researchers with a background in health psychology) with a special research interest in marginalized groups, especially how they are perceived by colleagues and included at work when they are partly disabled. In this study, we aimed to explore how employees experience workplace inclusion of their colleagues or themselves when having back pain or mental health problems, and how perceptions of employees with such health problems are expressed among their colleagues.

Method

A focus group design was chosen as it enables social interaction and communication among participants sharing similar experiences [17].

Recruitment and sample

We recruited a convenience sample of 16 kindergarten employees working with children aged 0–6 years. The participants were recruited from three kindergartens who had participated in atWork, a workplace intervention targeting musculoskeletal and mental health problems [18]. The intervention aimed at increasing work participation among individuals with musculoskeletal and mental health problems by providing research-based information and reassurance. The goal of atWork was to change employees' misconceptions about health problems and increase expectations of remaining at work despite health problems. All the included kindergartens were enrolled in the Norwegian government's plan for a "more inclusive working life."

The present study was not set up to evaluate atWork but rather to take advantage of a study context in which workplace inclusion had recently reached the management's agenda. To achieve a power balance in the discussions, managers were not included in this study. Participants were recruited by contacting the manager in each kindergarten, who forwarded the invitation to his or her employees. Our sample consisted of three men and 13 women, aged 29–62 years, working at three different kindergartens in eastern Norway in 2017. The kindergartens were located in different municipalities in Norway, representing urban and rural areas. The kindergartens differed in size (11, 14, and 21 employees). Two of the kindergartens had three departments taking care of approximately 50 children, while the largest unit had five departments taking care of 103 children.

Data collection

Data were drawn from three focus groups, each group consisting of employees working in the same kindergarten. The interviews took place at the kindergartens in which the participants worked. Each interview lasted for 90 minutes and followed established focus group principles [17]. The moderator (ER in two interviews, TLJ in one) invited the participants to share experiences and tell stories about how either their colleagues or themselves had been included at the workplace while having back pain or mental health problems. We did not demand a diagnosis of their health problems from a medical

professional, as long as the actual participants had reported subjective experiences of struggling with these problems. An observer took notes during the interviews. Sample size was guided by assessment of information power, assessing the specificity of the research question and sample, application of a theoretical framework, the quality of the dialogue, and the analysis strategy [19]. Although a cross-case analysis method was used (see below), our study had a specific research question, and the sample was highly relevant for the aim of the study. The dialogue quality was good in all interviews, the participants shared plenty of experiences relevant to the study aim, and the study was supported by established theory. After three interviews, we concluded that the information power of the sample was sufficient to conduct a responsible analysis. The interviews were audio recorded, encrypted, and transcribed. Participants were assigned pseudonyms prior to transcription.

Analysis

Systematic Text Condensation (STC), a thematic, cross-case strategy [20], was used for analysis. The method comprises four steps: (i) read the transcribed interviews to obtain a general impression of the material and to identify preliminary themes, (ii) develop code groups based on the preliminary themes and identify units of meaning related to the code groups, (iii) establish subgroups and condense the content in each of the coded groups to provide meaning, and (iv) synthesize the contents of each code group to present a reconceptualized description of each category concerning employees experiences on including colleagues with back pain and mental health problems at work. Analysis was supported by the Stereotype Content Model [16] to sharpen our focus on how cultural stereotypes are present in processes where participants describe their perceptions of employees with back pain and mental health problems at work. The analysis was inductive and iterative, not theory-driven with predetermined coding categories. We used theory to sharpen the focus for interpretation and discussions [21]. All authors cooperated on the analysis.

Ethics

The Regional Committee for Ethics in Medical Research regarded the study not to be within their mandate (2014/162-1). The study adhered to the Helsinki Declaration and was recommended by the Norwegian Social Science Data Services (NSD, ID 50766).

Results

The analysis established various relevant perspectives on how employees with back pain and mental health problems were included at work and how these employees were perceived by their colleagues. The participants stressed that it was easier to include and accommodate colleagues whose health problems were specific, when they were open about having problems, and when they expressed their needs clearly. They emphasized that it was more difficult to accept and accommodate colleagues with longstanding health problems, especially when it placed a heavy burden on the other staff members and led to negative consequences for the kindergarten children. Being the employee with health problems was also a challenging position to be in, accompanied by feelings of not pulling their weight and experiencing a gap between the ideal and the reality of inclusion practices. These findings will be elaborated below. Quotations are assigned pseudonyms.

Inclusion of colleagues with physical and specific health problems is simple when they present their needs clearly

Several participants expressed that it was easier to accept, understand, and tell others about back pain than mental health problems. They believed that colleagues with mental health problems needed more attention and more time to be comforted at a time that was basically reserved for children. Therefore, they sometimes found it difficult to include colleagues with mental health problems at work. Some participants said it was easier to deal with colleagues whose health problems appeared more "specific." However, some commented that back pain varied and could also be perceived as "diffuse." Several participants emphasized that it was difficult to accommodate colleagues when they did not know what kind of problems they struggled with and how they could contribute at work. If they saw someone do a specific task one day, they usually expected them to be able to do it the next. For this reason, it was important for employees to be candid about their health problems, as expressed by one of the female participants:

> "I think it is important that we talk together then, because if you do not tell me that you have a headache, then I will not know" (Emma).

The participants gave several everyday examples of offering help to their colleagues with back pain, such as assisting them in dressing the children, changing

diapers, or lifting heavy objects. Employees with back pain also had assistive devices at the workplace, such as stools that the children could step up on when washing their hands in the bathroom so that the employees would not have to lift them. The participants explained why it was harder to accommodate colleagues with mental problems. They mentioned giving a hug, talking to them, or just offering support, depending on how well they knew the person. Still, several participants admitted being afraid of saying something wrong, making their colleague feel worse. One participant mentioned the difficulties arising with a colleague who was depressed. At that time, he did not know what was wrong with his colleague, and sometimes he thought that the colleague was just lazy. Another participant said that he even stayed out of the break room to avoid a colleague who was struggling with mental health problems. At the same time, they thought that everybody at work had to do what they could to help include their colleagues. A female participant mentioned feeling helpless when her colleagues struggled with mental health problems: "If the pain is physical, it is easier to help. When it becomes mental, I do not know how I can help. I become a bit helpless and feel so useless" (Camille).

Inclusion is challenging when problems have lasted a long time, especially when accommodation has negative consequences for children or colleagues

The participants talked about the challenges of accommodation when the health problems of their colleagues affected their own working conditions. It was not helpful if a colleague was at work full time if he or she could do only half the work. The rest of the staff would then have to work harder to pick up the slack. It was overwhelming to feel that they had to do the work of two people. In such cases, the participants often preferred that the colleague stayed at home, so they could get a temporary worker to take his or her place, as that was customary practice when a colleague became full-time sick-listed. In addition, they said, the work environment became unfriendly when a colleague took out his or her bad mood on everyone else. Some of the participants claimed that their employers were very good at accommodating employees who had health problems, but not their co-workers.

Furthermore, the participants commented that it was harder to accommodate long-term physical or mental health problems. Someone who was having a bad week was easier to tolerate than someone who was having a bad month. In the latter cases, the colleagues of those with health problems became exhausted because they had to push themselves for too long. Sometimes the consequence of such a situation was that they got health problems themselves. This could also make them angry and grumpy, although they did their best to keep up the mood. A couple of stressful days were manageable, they said, but when it lasted for weeks, they became physically and emotionally exhausted. This point was reiterated in all interviews and became especially apparent in one of the kindergartens in which several of the participants were young assistants. An assistant in his thirties who had worked at the kindergarten for four years said:

> In the beginning, it is much easier to be nice and fair. However, as time goes by you get exhausted yourself. Yes, now I have to compensate for her in additionally three weeks… yeah, yeah… I'll just have to roll up my sleeves then. (David)

Several participants pointed out that their work was specialized, working with children who depended on them. A participant said that if he worked in an office he could just shut the door, but in a kindergarten, that was out of the question. Some thought that if colleagues showed that they were not safe to be left alone with the children, they should not be at work.

Being responsible for other people's children, there were important boundaries to what they could accept from their colleagues. The participants said that although they could empathize if a colleague was sick, the children could not. The participants were concerned about the safety of the children, especially the toddlers. At the same time, they wished to take care of their colleagues. In the end, the children came first, and several participants agreed that if a colleague could not stand being near the children, that colleague should not be at work. A 35 year old female participant had experienced several times how the behavior of her colleagues affected the children negatively:

> You have those who are completely put out and do nothing, but you also have those who can react in a noisy way that can harm others, right? Who cannot handle an angry child, who cannot handle an uncooperative child. We cannot have people at work who are so ill that they hurt a child. (Sophie)

Being the one with health problems, at the margins of ability, is likewise a challenging position

Several participants had also been in the opposite role, coming to work with their own health problems. They noted the difficulties of having their limitations

make extra work for their colleagues, for example if they worked slowly or could not perform some of their tasks. They spoke about not being able to follow the regular time schedule and thought they were disrupting their colleagues' routine. When they were on duty, they were expected to do certain tasks at designated times, and their colleagues became frustrated if they were not able to keep to the schedule. Some participants said it might be easier to be on sick leave than present at work when having health problems, because if they were off sick, their colleagues would have back-up plans like bringing in a substitute.

On the other hand, many participants reported that it was better for them personally to continue working fulltime despite health problems, because they felt it was unacceptable to take sick leave. Some also said that it could be hard to call in sick because some of their colleagues had made disparaging remarks about them when they had done so in the past. One participant had once been so depressed that she could not stay at work. When informing her colleagues that she was going home, she got no sympathy. Others had experienced the opposite, receiving support from the colleagues, especially at the beginning of their sick leave. However, after being sick-listed for a while, they often felt their colleagues pondering if they really were as ill as they said. Some explained why it could be difficult to return to work after an extended sick leave. They felt they had lost the overview and their sense of belonging, and things might have changed in their absence. One of the participants, who had been sick-listed for seven months with musculoskeletal pain, described her colleagues' acceptance of her absence:

> At first, I felt they understood why I was not there. But, when it lasted for a long time, I felt that it was no longer accepted. Then it was almost like I felt it uncomfortable showing up with the sickness certificate. Because if they only looked at me from the outside they could not see that I had a really bad time. So this understanding they showed me in the beginning was diminished. (Helen)

Many of the participants with health problems commented that intentions about an inclusive working life and accommodating employees with health problems often is better in theory than in practice. They described having been sick-listed, wishing to return to work. The participants had been promised that their workload would be modified to accommodate their limitation, but when they returned to work, they often were expected to function as usual. Many said that in small workplaces like kindergartens, every employee was expected to function at 100%. A participant who had been sick-listed for a long time said that the temporary employee who had replaced her when she was sick-listed left when she came back, and she was expected to do the same tasks as before. Even though she was exhausted halfway through the workday, she pushed herself through the rest of the day. Several of the participants confirmed pushing themselves despite feeling the need to go home early.

Participants expressed that their concern for colleagues made it challenging being the one who needed accommodation, because someone else had to do the tasks they were not able to do themselves. Daring to convey what they felt they could not contribute to was difficult. They thought and hoped they could manage it and wanted to contribute, but tensions emerged when they failed to do so. They commented that this could become a vicious cycle. If they pushed themselves to do tasks they were not ready for, they feared a negative influence on the recovery process. Thus, the period with need for work facilitations might be extended, and the situation may become even more frustrating for the colleagues. An experienced female participant in her mid-forties, who had struggled with muscle pain for several years, described how she forced herself to work because she thought it was what the situation demanded:

> Like I said when I was sitting outside and not really managed to walk: if someone falls then you run, no matter what happens, you run. You do lift the child up even though you… because things happen like this here [snaps her fingers]. (Lily)

Participants who were able-bodied expressed that their willingness to help others increased if the colleague who needed help had helped them in the past. If a colleague had previously never offered to help, these participants were more reluctant to help them, even if they knew it was needed. The culture of the workplace was important to them. If others had gone out of their way for them, it was much easier to reciprocate. Furthermore, they said that the trust in colleagues' willingness to help made it easier to come to work despite health problems. They also said that it would be easier to go to work with health problems if they knew that a temporary employee was also present. If so, they would feel like a resource instead of a burden. One participant said that when she was having bouts of anxiety and depression, she had trouble with setting boundaries and navigating stressful situations. When the temporary employee was there with her, she got assistance in situations she perceived as difficult because of her health problems. Being able to regulate her activities and tasks helped her get better. A 43-year old assistant in the kindergarten said:

> "We have situations where for example the person having health problems chose to come, and where we have hired a temporary employee so that the person may work on top" (Ella).

Discussion

Our analysis demonstrated that inclusion was easier when employees' health problems were specific and spoken openly about. Regardless of this, inclusion was considered more difficult when the health problems were unspecific, longstanding, and led to negative consequences for children or colleagues. Being an employee with health problems was also a challenging position that induced a sense of guilt and of being a burden to co-workers. Below, we discuss the impact of these findings and the strengths and limitations of our study design.

What was already known – what does this study add?

In line with the stereotype content model by Fiske et al. [16], employees' perceptions of warmth and competence in their colleagues with health problems seemed to come at a price. Sympathy and willingness to include colleagues with health problems at work appeared contingent on their willingness to be forthcoming about their problems, and to know their own limits. When employees were unaware of being a burden to their colleagues and unaware of providing inadequate care for the children, their competence were questioned by their colleagues.

Assuming that people with health problems lack the competence to perform their jobs and that they are hazardous or erratic are, according to Krupa et al. [14], examples of workplace stigmas. They argue that such prejudices are accepted without question. The employees with health problems in our study said they felt that their colleagues had made similar assumptions. The participants explained that they sensed negative vibes from colleagues if their health problems lasted for a while and if they were not capable of doing the usual amount of work or in the same way. Not sharing their needs and the difficulties associated with their health problems seemed to be related to healthy employees' lack of warmth to their affected colleagues, but also the other way around. According to Fiske et al. [16], warmth includes appearing trustworthy and friendly, which is in line with the findings in this study, where sympathy and warmth appeared to be conditioned by friendship and reciprocity. A good relationship between colleagues in a climate of reciprocity and openness seemed essential for an inclusive work environment.

Our findings support previous studies in which employees with back pain describe not feeling understood because their health problems were invisible [15,22]. Many studies have stressed the need for a supportive and inclusive work environment for employees staying at work despite their health problems [23–25]. Our study adds to previous knowledge by expanding on how social support and a flexible working environment for employees with health problems can be achieved [8,9]. The current study transcends previous research in providing the perspectives from employees with health problems in need of accommodation as well as from their colleagues. Our findings illustrate how employees' perceptions of colleagues with health problems influence their own behavior, and vice versa.

In line with our findings, Tveito et al. [21] found that employees with health problems struggled with working despite pain or maintained appearances to meet the expectations of their employer and colleagues. Some employees kept their problems to themselves because they felt stigmatized and ashamed. In a meta-ethnography, Brohan et al. [26] identify several reasons for employees to conceal their health problems, such as expectations and experiences of discrimination, fear of losing credibility in the eyes of others, and fear of being gossiped about. Similarly, in a qualitative synthesis, Toye et al. [27] found that the struggle to prove that they were good workers and the striving for legitimacy and to be believed by their colleagues were important barriers for staying at work for employees with health problems. The authors argue that there is a need for changes at a systems level to make it possible for employees with health problems to stay at work.

None of the participants in our study expressed spontaneously any experiences of change in their workplace's inclusion practices after the atWork intervention. In a previous trial, the atWork intervention did result in reduced sick leave, but did not affect the participants' health problems [28,29]. In line with the aim of the intervention, this indicates that the intervention is effective in increasing work participation among employees with health problems. However, our findings indicate that there are still challenges regarding conditions for how these employees are included. With more employees staying at work despite health problems, not being able to do the same amount or type of work as usual, their colleagues become overworked, and the employee with the health problem then feels shame and guilt. Increased efforts at the management level are probably needed to promote inclusion practices that reduce negative stereotypes towards employees with health problems.

Strengths and limitations

The focus groups consisted of employees who had experienced health problems and needed accommodation at work, and of their colleagues who had accommodated them. This study context could have resulted in withdrawal of negative experiences to avoid offending others. However, we highlighted that our purpose was not to evaluate their inclusion practices. We also stressed that difficult situations did not suggest a poor work environment or that someone was doing a bad job. The participants seemed reassured, and we received several examples of both positive and negative inclusion practices. The participants recalled and shared their experiences in a positive atmosphere. Being co-workers who already knew each other well seemed to encourage the discussions. The sample in our study was diverse in terms of age, gender, positions, and work experience, which brought a range of perspectives and nuances in the data.

The factors described by the participants as promoting or inhibiting inclusion of employees with back pain or mental health complaints are to some extent transferable to other workplaces. However, as emphasized by the participants, kindergartens are unique in that employees are working with children, which can be regarded as a vulnerable group. In this sense, our findings might be transferable to other workplaces taking care of vulnerable groups, such as those in the health care sector. Some examples might also be relevant for inclusion of employees with health problems aside from mental illness and back pain, but this was beyond the scope of this study.

All authors belong to research environments in which the focus is on individual rather than structural factors. Thus, the interest of the research team is more on the consequences for the people involved. However, despite our previous involvement in the atWork intervention and our concern with positive inclusion practices, we noticed more negative than positive stereotypes, and several organizational challenges related to inclusion of employees with health problems.

Implications

Our findings indicate that inclusion practices intended to reduce negative stereotypes about employees with health problems require system-level efforts to complement interventions such as atWork. The Norwegian Labor and Welfare Administration (NAV) offers several benefits for employers, such as wage subsidies for hiring people with reduced ability to work and for offering workplace accommodation, facilitation, and interventions for employees with permanent chronic or longstanding health problems [30].

However, at present, NAV does not seem to offer support for temporary employees working alongside employees with health problems, or similar interventions for employees with common health problems. For employees who are temporarily sick-listed with, for example, 60% sick leave, NAV pays 60% as sickness benefit, while the remaining 40% is paid by the employer as salary, for a total of 100% coverage. Being covered only for the 60% does not trigger an obligation to appoint a full-time temporary substitute – a solution called for by the participants in our study. Our findings indicate that interventions such as arranging for a temporary employee to work alongside employees with health problems would lighten the workload on colleagues and probably also the disabled employee's sense of being a burden.

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Declaration of conflicting interests

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