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Aligning stakeholders' understandings of the return-to-work process: a qualitative study on workplace meetings in inpatient multimodal occupational rehabilitation

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ABSTRACT

Purpose: Although it is believed that involving the workplace and stakeholders in return-to-work interventions is beneficial, Norwegian occupational rehabilitation programmes rarely do. During 2015–2016, Hysnes Rehabilitation Centre provided inpatient multimodal occupational rehabilitation, including workplace meetings with employees, supervisors, and rehabilitation therapists. This study aims to explore the meetings' content and stakeholders' experiences.

Methods: This was a multiple case study including non-participant observation of workplace meetings and interviews with participants

Results: Essential features of meetings included revealing and aligning the employee's and supervisor's understandings. Three components seemed instrumental in developing shared understandings leading to appropriate adjustments: 1) disclosing causes of absence, 2) validating difficulties, attitudes, and efforts, and 3) delimiting responsibility. Therapists played a vital role in addressing these components, supporting employees, and ensuring planning of appropriate solutions.

Conclusion: Developing shared understandings by addressing and aligning illness- and return-to-work representations appears important for return-to-work interventions. Although pivotal to developing appropriate adjustments, disclosure depends upon supervisors' display of understanding and should not be encouraged without knowledge of the employee's work situation. How supervisors relate to employees and implement adjustments may be as important as the types of adjustments. The therapist's support and validation of employees in vulnerable situations also seem valuable.

Trial registration: The trial is registered at clinicaltrials.gov (NCT02541890), 4 September 2015. <https://clinicaltrials.gov/ct2/show/NCT02541890>.

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Introduction

Because long-term sickness absence is a multicausal phenomenon, it has been proposed that return-to-work interventions should address factors of individual psychology, workplace environment, and the involvement of various stakeholders in addition to health impairments (Briand et al., 2007, 2008). Several studies have found that multimodal rehabilitation which includes workplace interventions are effective in facilitating return-to-work for workers with musculoskeletal and pain-related conditions (Carroll et al., 2010), and mental health conditions (Cullen et al., 2018). For both groups, such interventions seem to reduce time to return-to-work; however, there appears to be little reduction in lasting return-to-work for those with mental health problems (Van Vilsteren et al., 2015). Effective intervention components include graded activity, work modification, as

well as active, structured consultations between key stakeholders, namely employees, employers, and occupational health professionals (Carroll et al., 2010; Cullen et al., 2018; Franche, Cullen et al., 2005). Communication and problem-solving skills are thus possibly more important than knowledge of health problems in workplace interventions (Van Oostrom & Boot, 2013).

Although psychosocial adjustments in the workplace are important in the return-to-work process, interventions often aim exclusively to improve the individual employee's capacity (J Eakin et al., 2002; Van Oostrom, Driessen et al., 2009). In Norway, it is common to provide 3–4 weeks of inpatient multimodal occupational rehabilitation programmes including components such as physical exercise, psychological/behavioural therapy and work-related problem solving for individuals on long-term sick leave. However, these programmes have rarely included

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List of abbreviations

GP: General PractitionerHR: Human ResourcesNAV: Norwegian Labour and Welfare Administration

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workplace interventions (Rise et al., 2018), and many employees have no contact with their employers while attending (Rise et al., 2015). During 2015–2016, Hysnes Rehabilitation Centre provided inpatient multimodal occupational rehabilitation involving a workplace intervention to employees on sick leave due to musculoskeletal pain, common mental disorders, and/or other non-specific disorders (Fimland et al., 2014). The 3.5-week multidisciplinary programme included physical exercise, work-related problem-solving, and psychological treatment, all with Acceptance and Commitment Therapy as the comprehensive approach (Hayes et al., 2006; Rise et al., 2018). The workplace intervention was developed from van Oostrom et al.'s (2009) participatory process of workplace interventions (Van Oostrom, van Mechelen et al., 2009). It entailed a meeting at the workplace with the employee and his or her supervisor and primary rehabilitation therapist, as well as preparatory and evaluative work (Rise et al., 2018). The study presented here was conducted during a randomized controlled trial investigating the effect of adding such a meeting to the rehabilitation programme (Skagseth et al., 2019).

Workplace interventions within occupational rehabilitation programmes comparable to the one we studied have been found to facilitate return-to-work (Anema et al., 2007; Bultmann et al., 2009; Finnes et al., 2019; Lambeek et al., 2010; Loisel et al., 1997). However, the RCT of the present intervention, and another intervention combining Acceptance and Commitment Therapy-based occupational rehabilitation with a workplace intervention, showed no evidence that adding workplace interventions reduced days absent due to sickness or injury (Finnes et al., 2019; Skagseth et al., 2019), or time until sustainable return-to-work (Skagseth et al., 2019). While quantitative studies often include return to work as an outcome, qualitative studies inform the process or nature of various phases (Corbiere et al., 2019; Durand et al., 2014; Tjulin et al., 2010) in which experiences and expectations are dynamically interrelated and influence how employees relate to and act in the present regarding return-to-work (Andersen, Nielsen, Brinkmann et al., 2012a). Qualitative studies can also illuminate how intervention components, along with the sociocultural and legislative context, influence the execution and outcomes of workplace interventions. Although many qualitative studies have examined stakeholders' experiences with or perceptions of return-to-work rehabilitation and/or the return-to-work process (Andersen, Nielsen, Brinkmann et al., 2012b; Franche, Baril et al., 2005; Gensby et al., 2019; M Grant et al., 2019; MacEachen et al., 2006; Young et al., 2005), qualitative studies investigating workplace interventions as a part of rehabilitation programmes have remained limited. Therefore, we

aimed to explore the content of workplace meetings conducted as a part of an inpatient multimodal occupational rehabilitation programme and the experiences of the various stakeholders involved: employees, supervisors, and rehabilitation therapists.

Materials and methods

For this qualitative study, a multiple case study approach was chosen (Stake, 2005). This approach attempts to understand a phenomenon by investigating in how it manifests in multiple contexts (Stake, 2006) and draws upon naturalistic, holistic, ethnographic, phenomenological and biographic research methods (Stake, 1995). We observed workplace meetings and conducted individual semi-structured interviews with participants, and the findings are based upon the analysis of seven cases, complete with observation and interviews with the employee, supervisor and rehabilitation therapist.

Setting

Sociocultural context

Scandinavian workplace values include equality and consensus, and management styles and behaviours are "egalitarian, consultative, participative, informal, somewhat collectivistic and non-confrontationist" (Schramm-Nielsen et al., 2004), p. 184. In Norway, the large number of small companies and micro firms have also been linked to the display of high mutual trust between managers and employees (Grenness, 2013). Norwegian welfare legislation emphasizes the primacy of work. For instance, the Letter of Intent regarding a more inclusive working life ("IA-agreement") regulating the majority of workplaces describe activity through work as health-promoting and underscores the importance implementing active measures early to prevent withdrawal from employment (IA Agreement, 2017). Sick-listed workers receive full wage compensation from day one up to 52 weeks with the employer covering the first 16 days and the Norwegian Labour and Welfare Administration (NAV) the remaining period. Graded sick leave is encouraged. Sick leave entails both activity requirements and follow-up and the employer, employee, the health professional issuing the sick leave certificate (usually the employee's general practitioner (GP)) and NAV are the main stakeholders in the return-to-work process (Norwegian Labour and Welfare Administration, 2019a). The employee and employer should create a return-to-work follow-up plan within four weeks, have a "dialogue meeting" within seven weeks, and, with NAV's invitation, engage in a second dialogue meeting within 26 weeks to deliberate work-related actions, such as work adjustments. An appointed NAV caseworker

coordinates the second meeting in which the health professional issuing the sick leave certificate can also attend, and if considered necessary, a third meeting is conducted. If workability remains impaired after 52 weeks, the employee may apply for long-term medical benefits. However, these compensate for only two-thirds of the former income (Norwegian Labour and Welfare Administration, 2019a).

Rehabilitation programme and workplace meetings

Between 2015 and 2016, Hysnes Rehabilitation Centre provided inpatient, multidisciplinary occupational rehabilitation. The program involved physical exercise, work-related problem-solving, and psychological treatment, all guided by processes of acceptance, mindfulness, and commitment- and behaviour-change (Hayes et al., 2006; Rise et al., 2018). The rehabilitation was provided in individual and group sessions to employees diagnosed with musculoskeletal, psychological, or general and unspecified conditions listed in the International Classification of Primary Care, Second edition (ICPC-2). The programme prescribed 11 days at Hysnes Rehabilitation Centre, followed by a week at home with a workplace meeting and another five days at the Centre. The workplace meetings were prepared in the individual sessions during the first two weeks of the rehabilitation by mapping the employees' work situations and their challenges and possibilities in the return-to-work process. Beyond that, a work-specific group session addressed expectations for the meetings and the return-to-work process. The rehabilitation therapists, hereafter called "therapists", worked according to the principles in Acceptance and Commitment Therapy (Hayes et al., 2006; Rise et al., 2018) and received guidance from a NAV representative on how to conduct the meetings. The meetings were arranged with the employees' immediate supervisors, hereafter called "supervisors". To help participants prepare, the therapist provided the employee and supervisor with a booklet titled "A Conversation about Work Possibilities" (Norwegian Labour and Welfare Administration, 2019b), a NAV-designed tool for assessing function in return-to-work focused problem-solving. Because the rehabilitation addressed the employee's whole life situation, the therapist consulted them before the meeting to clarify topics permitted for discussion with the supervisor. Each meeting was allotted two hours, including a tour of the workplace. Although relevant others—human resources (HR) personnel, employee representatives, GPs, union representatives, and NAV caseworkers—could be invited, the meetings typically involved only the therapist, the employee, and the supervisor. Chairing each meeting, the therapist used "A Conversation about Work Possibilities" as a template.

Afterwards, the therapist contacted the supervisor to ensure that agreed-upon solutions had been enacted and sent a report to all attendees. In the last week of rehabilitation, the therapist and employee discussed how they had experienced the meeting. The return-to-work plan was finalized and, if deemed relevant, relayed to the employee's GP, supervisor, and social security office with the employee's consent. The intervention is more thoroughly described in a protocol article (Rise et al., 2018).

Participants and recruitment

Participants in this study were the employees, supervisors and therapists who took part in the workplace meeting. Employees were recruited between October 2015 and April 2016. The 38 employees referred to the rehabilitation program in this period received written information about the study and were invited to participate. A total of 29 employees consented to take part by returning a signed consent form, and on the first day of rehabilitation, they received additional oral information about the study and were interviewed by NEK. This was a short 15 minutes interview encompassing why they were referred to the rehabilitation programme, knowledge about the programme, expectations of the programme and their future work situation, and perceived barriers and possibilities for return to work. If the employee consented, their supervisor was asked to take part in the study. The employee provided the name and contact information of the supervisor, and once the therapist, employee and supervisor had scheduled the workplace meeting, NEK contacted the supervisor by telephone or email and asked for their consent to participate in observation of the workplace meeting and conduct an individual interview. Not all supervisors were contacted due to scheduling conflicts, and one supervisor declined to participate. When 16 supervisors had agreed to take part in the study, and 16 meetings had thus been observed, we chose to end further recruitment since we found that the meetings no longer raised novel issues and we also recorded a variation in the employees' gender, age, occupations, diagnosis and length of sick leave. However, not all employees and supervisors answered our request to participate in the subsequent interviews, and they were not asked why. Having conducted interviews with those who replied, we chose to focus on examining the cases that were complete with both observations of the meeting and interviews with the employee, supervisor and therapist. There were seven cases in total. The participants' characteristics from these cases are minimally described and not matched case-wise to ensure anonymity in a highly recognizable setting.

The employees were five women and two men aged between 32 and 56 years. The diagnosis established by their GP's included musculoskeletal pain and depression. The length of sickness absence at

inclusion to the rehabilitation ranged from 67 to 316 days with a mean of 202 days. Participant employee occupations were salesperson, factory worker, cashier, teachers and technicians. The supervisors were two women and five men between 41 and 64 years old with between 4 months and 30 years' experience as leaders in their workplace. All therapists were men, had worked at Hysnes Rehabilitation Centre for 2.5–6 years, and had backgrounds in nursing, psychology, physiotherapy, or exercise science.

Data collection

Between October 2015 and April 2016, the first author (NEK), who has experience with participant observation and interviewing, conducted the data collection. Non-participant observation of the meetings involved taking field notes of the dialogue, context, verbal and non-verbal reactions, and analytic comments (Agar, 2008; Hammersley & Atkinson, 2007; Liu & Maitlis, 2010). Once the observations of meetings yielded no new insights, i.e., data saturation was considered to have been reached, we ceased observations. Subsequently, individual interviews were conducted with employees and supervisors. Fifteen employees and eleven supervisors were interviewed, supervisors 2–4 weeks after the workplace meeting, and employees approximately four months after the meeting. Both employees and supervisors were encouraged to recollect what had happened and was said in the meetings, consider if this possibly could or had affected the return-to-work process and how the meetings compared with other return-to-work meetings. They were also asked how they perceived the therapist's presence, to describe the cooperation with their employee/supervisor prior to and after the meeting and consider the need for being open regarding cause of sick leave. The short 15-minute introductory interviews with the employees from the first day of the rehabilitation programme were used as a starting point for the second interview with the employees, which lasted about 1–1.5 hours. These interviews took place either at their workplace or in a meeting room at the university. All interviews with the supervisors were conducted at their workplace. The therapists were interviewed between October 2015 and April 2016 at the university. They were asked to share their perceptions of the meetings, describe their roles, and provide examples. All interviews were audio-recorded and transcribed verbatim.

Data analysis

We chose to focus on exploring the seven complete cases, all containing both observation of the workplace meeting and interviews with employee, supervisor and therapist since this provided an opportunity for contextualizing the different data sources within each case. Informed by Stake's multiple case study

analysis (Stake, 2005), we began data analysis by examining the seven cases individually to understand the complexity and uniqueness of each. MBR (who has conducted several qualitative studies) and NEK read all interviews and observational data, while MSF (who has participated in several qualitative studies) read a selection of the material. After that, we discussed first impressions. NEK then coded the transcripts according to descriptive and interpretational themes denoting, for example, the topic of conversation (e.g., "Sick leave not reflecting lack of motivation") and further interpretation or abstraction (e.g., "Validation of work ethic"). Based on regular discussions with MBR, NEK constructed a document including a synopsis of each case, its situational constraints, reflections on prominent themes, relevant excerpts, and any correspondence and discrepancies with other cases. After that, we made a shift to go "beyond the case" to explore the concepts or ideas composing them (Stake, 2005). All themes were then revised in light of one other while simultaneously attempting to retain their case-specific context and investigate any divergent themes. In this phase, the seven synopses were read by all authors, discussed, and the case findings were then merged into themes. At the end of the analysis, we reviewed the remaining observation and interview material from the incomplete cases. As a result, we prioritized some aspects of the theme concerning responsibility and included adverse experiences with disclosure. The summary of the main findings are presented in Figure 1. This paper contains excerpts of field notes from the meetings and quotations from the interviews to give an impression of the dialogue and the development of themes and to illustrate, nuance, or extend the analysed material. To improve readability of the quotations, we have omitted some word repetitions, frequent use of utterances such as "eeeh" and length of pauses if not considered meaningful to the interpretation.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics in Central Norway approved the study (no.: 2014/2279), and all participants (employees, supervisors and therapists) signed an informed consent form before observations and interviews commenced. Participants were informed that interviews would focus on the workplace meetings exclusively to ensure that interviews with supervisors did not address employees' private issues. Pseudonyms are used instead of real names.

Results

The results are based on the analysis of seven cases from the following workplaces (occupation of the employee

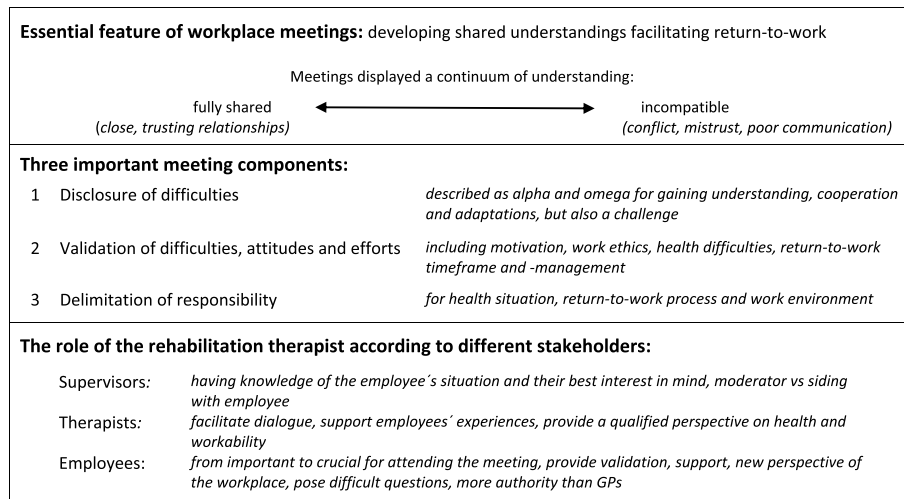


Figure 1. Summary of main findings.

in parenthesis): 1) high school (teacher); 2) hardware store (cashier); 3) laboratory (technician); 4) rental firm (salesperson); 5) factory (factory worker); 6) primary school (teacher); and 7) factory (factory worker). In the workplace meetings, a variety of subjects relevant to facilitate return-to-work were addressed, including the presumed timeframe for return-to-work, the appropriate increase of work hours, and the adjustments needed to resume work. However, the foundation for finding these practical solutions, and what surfaced as the prominent feature of the meetings, was the time spent on developing a shared and appropriate understanding of the employees' health- and work situation that could facilitate return-to-work. We identified disclosure of difficulties, validation of difficulties, attitudes and efforts, and delimitation of responsibility as important meeting components that the therapists played a vital role in addressing.

Developing a shared understanding appropriate for facilitating return-to-work

The most prominent feature of the workplace meetings was the development of a shared understanding. In this context, the concept *understanding* refers to perception or view, including the normative aspect of *having* understanding (as in showing acknowledgement). This entailed first to reveal and then align the employee and supervisors understanding of the employee's health- and work situation, including the causes of absence and actions to enable sustainable work participation. Although the meetings rarely mentioned the employee's diagnosis, factors perceived to uphold and alleviate health difficulties received frequent attention. Addressing those factors, even when unrelated to work, helped in finding common ground for understanding the employee's situation.

From fully shared to incompatible: a continuum of understanding

Because most employees had acquired new perspectives during rehabilitation, the meetings provided an opportunity to discover how the understandings of the employees and supervisors now compared. The observations revealed that these understandings ranged from fully shared to incompatible and in most cases were aligned to some extent during or after the meetings. The subsequent interviews revealed that the long-term results of the meetings sometimes differed from those achieved during the meetings.

In five cases, the supervisors and employees seemed to more or less share understandings, and these meetings were characterized by close, trusting relationships. For instance, in Case 3, both the supervisor and employee reported having a good relationship, and the employee underlined how her supervisor had shown great understanding of her situation and made all necessary adjustments in work tasks and hours. Although having a workplace meeting in this situation may seem redundant, it revealed that the return-to-work process had stagnated due to too many adjustments:

Employee *What I need to do is to stop reminiscing and address what's important. And work is important to me.*

Therapist [Addresses the supervisor.] *What do you think?*

Supervisor *Maria [the employee] has been sick leaved due to something from 2013.*

Employee *There's no hope!* [Laughs nervously.]

Supervisor *Maria's easy to talk to. She's open and wants to be here [at work]. I wonder whether it's something in your body. Well,*

I'm not a doctor. I've made a lot of changes and want to keep her here, but I could use a new employee who can perform more tasks. My supervisor won't approve any additional changes, and she's not aware of all the changes that have been made, either. [...] If anything, I've made too many.

(Workplace meeting, Case 3, laboratory)

Later in the meeting and the subsequent interview, the employee acknowledged the need to leave her comfort zone by expanding hours and work tasks to include those she found challenging.

Conversely, the two meetings defined by incompatibility (Cases 2 and 6) were marked by conflict, mistrust, and poor communication. Here, the meetings revealed stark differences between the supervisor's and employee's understandings, and the therapist actively sought to reconcile them. In Case 2, the employee was sick-listed due to a combination of pain and distress. In addition to the supervisor, an HR representative attended the meeting, and it soon became evident that the understandings of the stakeholders diverged significantly:

Therapist *To Ellen [the employee], the worst thing is being a bother, like now. Ellen wants to address something.*

Employee *I was hurt by something that you said. I felt threatened when you said that you could reject my medical certificate. It didn't make me feel better. I can't forget that.*

Supervisor *Well, I can do that, actually.*

Employee *No.*

Supervisor *Whatever. It concerned that episode, which was private [...].*

HR Rep. *When we see that people are active on social media when they're home from work, we question it. Why should we accept that?*

Therapist *Many participants at Hysnes [Rehabilitation Centre] tell us that they refrain from going outside because they fear what'll happen if they're seen.*

Supervisor *Here it's the opposite!*

Therapist *Research shows that if you're going to resume working, then you generally need to go outside, but [doing] that doesn't necessarily mean that you're ready to work.*

(Workplace meeting, Case 2, hardware store)

During the meeting, the stakeholders' understandings did not seem to approach one another, though they agreed upon some workplace modifications. Afterwards, the therapist contacted the supervisor and suggested attending a course on how to follow

up employees on sick leave, which he did. In the subsequent interview, the employee described significant changes in her work situation, which she ascribed mainly to a transformation in how her supervisor approached her:

It took a while, but I think that it opened my boss's eyes when what it was really about began to sink in because he's become totally different since. Then and there, I felt that it [the meeting] was wasted, but not today. He's gotten very good at asking how I am and whether I'm OK at work. And now he asks in a way that makes me think that he means it.

(Employee, Case 2, hardware store)

Although addressing differences in understanding during the meeting in Case 2 seemed productive as it prompted actions with positive outcomes, it seemed to have the opposite consequence in Case 6. Therein, the therapist asked the employee, a primary school teacher, and her supervisor several questions about their relationship:

Therapist *How's the relationship between the two of you?*

Employee *I can tell her what I think, but she doesn't always understand. We see things differently.*

Therapist *How does that feel?*

Employee *You don't get the support.*

Therapist *Who is "you"?*

Employee *I am. [Laughs.] I get sad and feel bad. [Starts to cry.]*

Therapist *At Hysnes [Rehabilitation Centre], we work on what's happening on the inside. How does that feel?*

Employee *I don't feel understood. I want to get by [at work].*

Therapist *What do you need from her [the supervisor] to feel that she understands?*

Employee *It's a bit strange to say, but I need acknowledgement, support.*

Therapist *[Addressing the supervisor.] What do you feel?*

Supervisor *I think it's sad that she doesn't feel that I'm supportive. But I must be honest; our assignment is the children, and we have different perceptions of them.*

(Workplace meeting, Case 6, primary school)

This meeting revealed that the employee and supervisor diverged in both their professional perspectives and viewpoints of what the employee needed to return-to-work. In the subsequent interviews, both described that it was more challenging to relate to each other after the meeting since their differences in understanding and views of one another were made explicit. In particular, the employee reported actively searching for another job.

Components of the meetings

Several meeting components concerning disclosure, validation and delimitation of responsibility seemed valuable in revealing and aligning the stakeholders' understandings. These components defined the meetings to different extents, and the therapists played a vital role in addressing them.

Disclosure of difficulties

All stakeholders expressed that being open about private and work-related difficulties was essential in developing shared understandings and, in turn, facilitating return-to-work. Several therapists described that employees often concealed health difficulties from their supervisors, fearing repercussions or being perceived as weak, or believing that personal concerns should be kept private. One therapist underscored that sharing such vulnerability can make explicit what supervisors nevertheless already infer, and many associated being open with gaining understanding. The therapists stressed that employees should feel comfortable with disclosing personal information. However, in the interviews they described encouraging employees to do so by asking if it would be helpful if the supervisor knew some aspects of their core problem.

Both supervisors and employees described openness as the alpha and omega for cooperation and, consequently, successful return-to-work. During the workplace meeting in Case 4, the importance of being open was mentioned repeatedly by all parties. The employee had been open not only about his diagnosis but also his spouse's health situation, which could suddenly worsen and require his absence from work. In the interview, he underlined the value of being open:

It might be a warning that one day you could be absent. [...] I believe that he [the supervisor] will be more forthcoming [if he knows my situation] than if he knows nothing. I believe it'll be easier to take a day off, instead of quarrelling over the phone about whether I can. At least I feel that it's like that. So, I'm honest and open to my supervisor and colleagues about the sickness that I've had and my wife's sickness [...]. It should be like that between a supervisor and an employee. You get furthest by being honest. [Laughs.]

(Employee, Case 4, rental firm)

In several meetings, the supervisors applauded the employees' openness, and many reported having close contact and regular communication during their absence. However, in the interviews, several spoke of feeling insecure about how to approach employees who were not as open, then having to rely upon the employees' willingness to share information.

Although we did not find that any of the employees in the seven complete cases feared repercussions

due to disclosure, the additional workplace meetings and interviews revealed that several employees had experienced that being open about specific topics affected their work situation. In one case, the employee associated disclosing her lack of motivation with losing her job during a subsequent wave of lay-offs. In two other cases, the employees described how revealing difficult working conditions as worker-/union representatives had caused their supervisors to target them, which had impaired their workplace environments.

Validation of difficulties, attitude and effort

The workplace meetings also provided an arena for validating several aspects relevant to the return-to-work process. The employees' desire to resume work, eagerness to contribute at work and difficulties with being unable to do so was made explicit in the meetings, usually by the therapists who simultaneously voiced their impressions of employees. As such, the therapists seemed to validate the work ethic of employees by communicating to supervisors that sick leave did not signify a lack of motivation. In addition, several employees expressed appreciation for the therapist's validation of the severity of their health conditions in their interviews.

Most meetings also addressed expectations about when employees could resume working full-time. The therapists commonly proposed quick and graded return in a small percentage of the employees' position followed by a gradual increase in work hours to ensure sustainable employment:

Therapist *So, you're playing around with the idea of [working] 20%. When do you think that you'll increase to 40–50%? In the summer? In the fall?*

Employee *It's hard. I feel that I could start [in a] 20% [position] but not increase any faster than my health allows. [...].*

Therapist *There's no blueprint, but at Hysnes [Rehabilitation Centre], many participants are too eager. It's better to take it slow, to achieve stability first [...]. Whenever there's a mismatch between demands and capacity, a gap emerges. We recommend starting slow. How old are you?*

Employee *Thirty-nine.*

Therapist *Then, it's wise to start slow. Athletes think four years ahead of the Olympics. At Hysnes, we have a goal of continuous work participation. That doesn't imply 100% or 80%; it doesn't indicate when, whether now or in a year. It concerns whether it works not for two months but in the long run.*

(Workplace visit, Case 7, factory)

In most cases, such information was directed at the supervisors, and the employees often stressed the value of a professional validating their need to let the body's recovery determine the return-to-work process in the interviews. In the meetings, the therapists could also address the private difficulties of the employees if perceived relevant to their workability. In that sense, the therapists seemed to validate the idea that supervisors should consider their employees' overall life situation in the return-to-work process.

Some employees and therapists described that the meetings also influenced the final week of rehabilitation. According to the therapists, visiting the workplace was especially important to verify or adjust the self-reported experiences of employees, who had sometimes exaggerated or extenuated their work situations:

[It is also important] to consider the supervisor, to see what sort of supervisor he or she is. Because you might get one story from the employee, and then you might encounter something completely different [at the workplace]. [...] Many employees are insecure about whether they've experienced things right, if that's how it's supposed to be [...]. So, in cases in which we have those [situations], and we see something that we believe is valid to address, I can absolutely provide support [by saying], "What you see is in fact real".

(Jon, therapist)

Most employees described that such validations ensured them that they could trust their perception. However, the therapists were sometimes more direct, and one employee explained that the therapist suggested she changed jobs after the meeting due to the conduct of the supervisor.

One therapist also underscored how knowledge about an employee's workplace and supervisor helped to construct a trusting relationship with the employee, who relied more on his input after the meeting. Apart from validating employees, therapists endorsed some supervisors' management of the return-to-work process and applauded those approaching their employees in caring ways, daring to ask about their lives.

Delimitation of responsibility

Another essential component of the workplace meetings was delimiting responsibility for the causes of absence and upcoming return-to-work adjustments. Often, employees were held responsible for maintaining their health difficulties by either the supervisor or therapist, albeit in different ways and to different extents. In Case 5, the supervisor showed understanding for the employee's care burden at home, even proposing changes to relieve her of some of the strain impairing her health:

Supervisor *I know what's the matter with Lise [the employee]. She's too kind.*

Therapist *She has a big heart.*

Supervisor *Changes should've been made a long time ago. We men are spoilt; it was no surprise that Lise got sick.*

Employee *I've done myself a great disservice.*

Supervisor *Yes, you have. [...] If you're too kind, then—.*

Employee *I'm overworked.*

Supervisor *The kids are big enough to have chores ...*

(Workplace meeting, Case 5, factory)

This meeting served to confirm that the supervisor had made all necessary adjustments and that the solution for return-to-work remained private. In this case, as well as in Case 1, the causes of the employees' difficulties were described as positive personality traits defining the employees as simultaneously caring and eager to work, and a close supervisor-employee relationship and shared understanding characterized both cases. By contrast, if supervisors attributed employees' absence to their non-compliance—for example, disregarding advice on how to approach work tasks, as in Case 6—employees felt (mis)judged. Also, in the two cases with different understandings between supervisors and employees, both supervisors expressed that the meetings shouldered them with too much responsibility. Whereas the supervisor in Case 6 worried that being held overly responsible in the meeting would have ramifications for later supervisor-employee cooperation, the supervisor in Case 2 felt that the meeting—and the meeting report—was oversimplified. Although agreeing about the misfortune of past incidents, he stressed that the employee's complex situation warranted a more fine-tuned delimitation of responsibility.

Although those supervisors felt the responsibility was distributed unfairly, the employees in those, as in all other cases, appreciated how the meetings established a shared commitment to their return-to-work process. The employee in Case 1, for instance, described feeling that the meeting finally put problems regarding her sick leave on the agenda:

My impression is that the supervisor treats it [my sick leave] more "seriously", to put it in quotations, afterwards. You had a meeting, you signed a paper, you're in contact, a third party was present, and I believe that it's been very fortunate. In the time since the meeting, we've had a continuous dialogue.

(Employee, Case 1, high school)

Some supervisors also described how the return-to-work process felt like a shared responsibility after the meeting. The supervisor in Case 4 valued the dialogue about the employee's situation and to feel assured that he was cared for and enrolled in a system.

However, many supervisors missed follow-up from the rehabilitation therapist, feeling unsure about how to implement and evaluate the workplace modifications afterwards. In contrast, the therapists regarded the meeting as a new starting point from which the supervisors and employees were responsible for continuing the return-to-work process based on the tangible information uncovered during the rehabilitation.

In several cases, employees used pronouns such as “one” or “you” instead of “I” when describing their difficulties or mentioned how co-workers also struggled with managing the pace or workload. If so, the therapist usually interrupted them, stating how the meeting concerned them as individuals. However, they occasionally resumed posing questions about the workplace environment later in the meetings if it seemed relevant:

Therapist *The workplace environment is straining. Have you noticed that?*

Supervisor *Well, considering sick leave, we have four [employees] on long-term leave and two working 50%. But the causes vary. It has nothing to do with the workplace environment. [...]*

Employee *Many [employees] have been talking, but it never goes anywhere. Many are in physical pain.*

Supervisor *But when you sit and talk like that, the next person hurts even more. [...]*

Therapist *The talk behind the scenes is discouraging; could that be an expression of something?*

HR Rep. *I have no answer to that [...]. Employees have responsibilities as well. Many employees seem to enjoy wallowing in their problems together, and those particular coffee breaks should be avoided.*

(Workplace meeting, Case 2, hardware store)

The therapists also underlined that the workplace meetings enabled them to approach the topic of work during the rehabilitation and to hold employees responsible for including work participation amongst their rehabilitation goals and consider work-related actions.

Role of rehabilitation therapists

The therapists played an active role in the meetings. However, when asked to describe that role, the supervisors, employees, and therapists differed in their responses. Whereas several supervisors appreciated the therapists' thorough knowledge of the employees' situations and dedication to keeping their best interests in mind, they also described that the therapists merely moderated the meetings. The exceptions were the meetings characterized by incompatible

understanding, in which both supervisors found the therapists to side actively with the employees. In contrast, the employees described the presence of the therapists as important or even vital. One described that she would not have attended the workplace meeting without the therapist, another told of addressing things she otherwise had not dared to do. In general, the employees appreciated the therapists' attendance since they provided support and validation of their situation. One employee also spoke of being open as a direct result of the therapist's presence:

As long as I had someone from Hysnes [Rehabilitation Centre] there, it was a kind of support to feel that someone has your back, who confirms that that's how my days are. Perhaps it's easier to talk to your supervisors when you have that support than being by yourself. Because they [supervisors] perceive things their own way. They want you to perform and produce as much as possible; your mental state and your private life come second. [...]. To bring someone along to that meeting is like having a union representative present when negotiating salary.
(Employee, Case 4, rental firm)

This employee explained that his relationship with his supervisor had suddenly worsened after the workplace meeting due to what he found to be unreasonable activity requirements. Having worked in the company for many years, the employee contacted his supervisor's manager who stepped in and resolved the situation.

Another employee described how the therapist provided a new perspective on the workplace. He had identified the “true problems” that she now realized contributed in impairing her health, and articulated topics that had gone unaddressed, despite her close relationship with her supervisor:

Employee *We [employees] know that others must do what we don't, and everybody takes that into account.*

Therapist *And then you contribute extra?*

Employee *I think we do. [...] You have a responsibility to the students, too.*

Supervisor *We don't have much sickness absence. The work ethic is good.*

Therapist *Yes, but you may reap what you sow. If you overexert, then your body will let you know [...].*

Employee *The medical doctor at Hysnes [rehabilitation centre] said, “Doesn't the Working Environment Act apply to your workplace?” [Employee and supervisor laughs.]*

Therapist [Gravely] *It may affect your health.*

(Workplace meeting, Case 1, high school)

Although the employee and supervisor refuted the therapist's critical questions regarding work

organization, these questions seemed to present the employee with an opportunity to address difficulties later during the meeting. In the interview, she said that she therefore valued the therapist's presence. The therapist also described how he was in a position to question aspects of the workplace that was otherwise difficult to address and emphasized that a seemingly good employee-supervisor communication does not mean that all possibilities for improvement are exhausted.

Whereas the employees often characterized the therapists as an essential or valued source of support, the therapists underlined that they strove not to take sides during meetings. Instead, they sought to be a corrective if noticing that the employee and supervisor misunderstood each other and provide a new way of conversing based on a shared understanding. One therapist also mentioned the possibility of adjusting inappropriate demands from supervisors and providing a qualified perspective of employees' health and workability alongside GPs. However, the therapist's role in workplace meetings was differentiated from the GP's role in the dialogue meetings arranged by NAV by an employee:

Interviewer *Having Jon [the therapist] present at the meeting: Did that make any difference?*

Employee *Yes, the meeting was a bit kinder in a way, because NAV is merciless. It's like, "You're going back to work, or you'll lose everything. You'll have to sell your house, your car" [Laughs.] It's a bit like that. But in the workplace visit, we didn't have to go that far. It was somewhat nicer: "We're here to help you. We're here to facilitate, to see that all's well" [...].*

Interviewer *So, the role of the rehabilitation therapist didn't equal that of your GP?*

Employee *No, she doesn't have the same power. No —power isn't the correct term. The GP is just ... I don't think NAV trust the GPs. They're like, "What? Did you put her on sick leave again? Why?" NAV is much more relentless, really. And the rehabilitation therapist had much more to say in the meeting than the GP.*

(Employee, Case 5, factory)

When asked to compare the workplace meetings with the dialogue meetings, supervisors and employees agreed that they differed substantially. Most described the dialogue meetings as being formal, standardized, and chiefly aimed at establishing when the employee could fully return to work. By contrast, the therapists in workplace meetings were described as more interested in addressing employees' well-being, putting their sickness and treatment on the

agenda, and thereby making the meetings more personal.

Discussion

This multiple case study aimed to explore the content of workplace meetings conducted as a part of an occupational rehabilitation program as well as the participants' experiences with attending them.

An essential feature of the workplace meetings was revealing the employee's and supervisor's understandings of the employee's situation to develop a shared understanding. Disclosure of difficulties, validation of difficulties, attitudes and efforts, and delimitation of responsibilities were prominent meeting components. In addressing those components, therapists played a vital role in aligning understandings and ensuring the planning of appropriate solutions.

Value of a shared understanding of representations of illness and return-to-work

The most prominent feature of the workplace meetings was the alignment of the stakeholders' understanding. For this purpose, much time was spent on elaborating their experience of the employee's health situation and perceived possibilities for return-to-work, and the meetings can thus be seen as an arena for revealing representations of illness and return-to-work. *Illness representations* are defined as the thoughts, beliefs, and attitudes associated with the perceived diagnosis, symptoms, causes, course, consequences, and controllability of illness (Leventhal & Leventhal, 2003). Likewise, representations concerning return-to-work could be said to include thoughts, beliefs and attitudes concerning the path towards sustainable work participation. Coutu et al. (2013) have emphasized the need to address illness representations to find consensual return-to-work strategies, or, at a minimum, ones that make sense to the employee (Coutu et al., 2013). A previous study on therapists' experiences with addressing the return-to-work process in the same rehabilitation programme as this study found that the therapists attempted to help participants develop more appropriate illness representations (Klevanger et al., 2018). Aligning supervisors' understandings of such representations may also increase adherence to the return-to-work plans made in workplace meetings. At the same time, it is crucial to view illness representations as products of interaction, not individual traits. From a symbolic interactionist perspective (Blumer, 1969), employees' perception of themselves is developed in interaction with others, which stresses the importance of how supervisors approach employees in the return-to-work process. On that topic, a recent meta-ethnographic synthesis

found that employers' attitudes and understandings are paramount to the return-to-work process (M Grant et al., 2019). Developing a shared understanding by addressing and aligning representations of illness and return-to-work in workplace meetings thus seems beneficial.

Our study also revealed that bringing incompatible understandings to light can have various consequences. In one case, the workplace meeting functioned as an arena where differences were solidified and worsened, in another it was a catalyst for actions committed to resolving such differences. Nevertheless, return-to-work ultimately resulted from both cases. Recently, Gouin et al. (2019) found that return-to-work is possible with imposed or negotiated decisions; however, most studies have highlighted how stakeholder consensus about return-to-work objectives benefits the process (Coutu et al., 2013; Gouin et al., 2019). Stakeholders can learn to tolerate paradigm dissonance while they share common goals (Franche, Baril et al., 2005) even if the optimal solution perhaps is to gain an understanding of the logic and reasoning of the other stakeholders (Maiwald et al., 2011). However, it is essential to also acknowledge the dynamic nature of return-to-work, including the potential for volatile understandings and relationships. In our study, one seemingly close employee-supervisor relationship suddenly became conflicted, whereas another marked by mistrust was improved, both due to revealing and addressing the core problem and providing relevant information. Therefore, it is necessary to recognize the employee-supervisor relationship as not merely a variable in the return-to-work trajectory but a continuous process that may change and, for that reason, requires sustained attention from all involved.

Influence on and nature of adjustments

Because the observed meetings tended to address the psychosocial aspects of return-to-work primarily, the content of proposed adjustments could differ from conventional ergonomical workplace adjustments. Instead of providing, for instance, an adjustable desk, the planned adjustments could entail supervisors to relate differently to their employees. The results also revealed that an essential aspect of adjustments was the reasoning behind them—that is, the stakeholders' understandings of why they would be appropriate. Therefore, the implementation sometimes seemed as important as the content, and the supervisors' display of understanding may thus have constituted the chief aspect of adjustments. Research has shown that what matters to participants/employees is not merely the content of rehabilitation or physical work accommodations but moreover the socioemotional qualities of rehabilitation agents, i.e.,

how they are encountered (Östlund et al., 2001) and the interpersonal aspects of supervision (Shaw et al., 2003). Thus, work adjustments not only matter from a practical standpoint but may also serve “as symbolic gestures of trust and value” (Wainwright et al., 2013). For that reason, how adjustments are implemented—ideally, with understanding—may serve as an important means to validate illness, their symbolic meaning sometimes exceeding, or at least adding to, the physical necessity that they present. Although the meetings addressed the psychosocial aspects of return-to-work and occasionally the larger work environment, the therapists regularly underlined that the meetings concerned the specific employee. As such, difficulties were mainly framed as individual issues, and adjustments seldom entailed changes in work structure. The lack of a platform to address work conditions that influence return-to-work can cause work environment issues to go on unnoticed (Gensby & Husted, 2013), and the workplace meeting seems to be an ideal arena for attending to such issues and their solutions to an even larger extent.

Dilemma of disclosure

All stakeholders emphasized that employees need to be open about their health-related difficulties to identify adjustments appropriate in content and scope. Both employees and managers have previously been found to value that return-to-work meetings improve knowledge of diagnosis or reasons for sickness absence (Andersen, Nielsen, Brinkmann et al., 2012b; Eskilsson et al., 2020; Strömbäck et al., 2020). In our study, being open sometimes required revealing highly personal information, in some instances also concerning family members. Although none of the participants described any dilemmas regarding disclosure, the additional cases revealing that openness can have repercussions underscore the importance of questioning disclosure as a norm in return-to-work. A previous study found that while employer representatives framed disclosure as a valued practise leading to greater understanding and improved psychosocial work environment, employees experienced it as an “uncertain balancing act” (Norstedt, 2019), pp. 21.

Norstedt (2019) also underlines the paradox that refraining from disclosure to pass as normal possibly only serve to reproduce norms suggesting that the able worker is the ideal one (Norstedt, 2019). In our study, one employee associated disclosure with being honest with his supervisor. However, Norstedt proposes that “(non)disclosure should not be reduced to personal traits such as honesty/dishonesty” (Norstedt, 2019), p. 22, it should rather be viewed as a struggle for normality and strategies to preserve control over one's identity. Although the participants in our study mostly celebrated disclosure, a few

employees described omitting details they deemed too personal or irrelevant to the return-to-work process. In that sense, disclosure should be seen as a nuanced act that reflects the stakes that an employee takes when sharing information they can legally withhold instead of telling either the whole truth or nothing at all. Since disclosure may have various repercussions, and a workplace meeting perhaps is a setting especially susceptible for peer pressure, rehabilitation therapists and other stakeholders should hesitate to uncritically encourage the act without being familiar with the employee's work situation. The emphasis on disclosure in our findings should also be seen in light of Norway's egalitarian workplace environments and strong legal protections for workers' rights, which necessarily influence the extent to which disclosure of health- or other personal difficulties is even conceivable. The supervisors' display of understanding and attitudes towards sick leave and return-to-work in general also seem essential for disclosure to occur.

Need to validate and delimit responsibility

Validation and responsibility touch upon the moral aspects of sick leave and work participation. Several studies have described how employees on sick leave are concerned with legitimating their illness (JM Eakin et al., 2003; S Grant et al., 2014; Roberts-Yates, 2003; Wynne-Jones et al., 2011) and troubled by being perceived as abusing the system (JM Eakin et al., 2003; Roberts-Yates, 2003). The need for validation expressed by all employees in our study indicates that workplace meetings could be useful even if the supervisor-employee relationship is characterized by openness and cooperation. It also suggests that employees find the formal validation of sickness from the GP insufficient when relating to their supervisors. This implies that a discourse questioning the legitimacy of long-term sick leave is present. Eakin et al. (2003) have described how a "discourse of abuse" of the compensation system compels workers "to 'perform' their moral integrity" and be careful to "present themselves in such ways as to dispel suspicions, allay concerns of misuse, and ensure that their actions and claims are seen as legitimate" (JM Eakin et al., 2003), p.32. Based on our findings, validation should thus be regarded as essential to return-to-work oriented meetings to facilitate communication that can relieve employees of those concerns. Once validation is accomplished, the stakeholders can advance from the need to establish legitimacy towards identifying solutions that enable return-to-work.

A vital component of all meetings was delimiting responsibility for the occurrence and sustenance of health problems, as well as the solutions believed to

alleviate them. The results stressed the importance of how the causes of employees' sick leave were framed and that supervisors differed in doing so. Experiences of frustration and disillusionment in the return-to-work process have been found to cause "social hardening" (JM Eakin et al., 2003), characterized by less accommodation and diminished trust of injury and the return-to-work system. Because supervisors' responses to return-to-work emerge from previous experiences with and attitudes towards sick leave, future studies should investigate their experiences with employees' sick leave and return-to-work, as well as how they perceive their role in facilitating return-to-work.

In our study, several supervisors were uncertain about how to manage their employees' return-to-work processes best and described that they had appreciated follow-up from the therapists. Such results corroborate Tjulin et al.'s (2009) findings concerning the implementation of a multi-stakeholder return-to-work programme, namely that employers often are held responsible for the process even though they lack training in managing it (Tjulin et al., 2009). This study describes that often as many as three meetings, or even more, were arranged over three months to monitor the employees' progression and adjust their return-to-work plans if necessary. Given the dynamic nature of the return-to-work decision-making process, as described by (Gouin et al., 2019), having only one meeting at the workplace is probably insufficient in some cases. For instance, in Case 2, the employee's return-to-work process benefitted from the follow-up that resulted in her supervisor taking a course, whereas additional precautions in other cases seemed redundant. Therefore, follow-up could be reserved for cases in which one or more stakeholders perceive a need for further assistance.

The supportive role of therapists

Rehabilitation providers are identified as key intermediary players in facilitating the return-to-work process because they can both obtain a close understanding of the employees' needs and mediate between them and their GPs and employers (MacEachen et al., 2006). In our study, the employees' collective experience of needing support from therapists highlights the vulnerability of being long term sick-listed. Eakin et al. (2003) have found that employees who resume work before having recovered experience considerable strain in having to cope with being sick under the gaze of others (JM Eakin et al., 2003). A previous study exploring experiences with convergence dialogue meetings found that employees valued both the neutrality of rehabilitation coordinators, and to have someone on their side who

gave voice to their needs, acknowledged their impairments and balanced power and responsibility (Strömbäck et al., 2020). In that study, the diagnosis of the employee was disclosed. Without having to do so, we propose that therapists can provide the necessary support and validation when employees discuss return-to-work with their supervisors. Since some supervisors may experience the therapist to be biased or interloping with their relationship with the employee, arranging an individual conversation before the workplace meeting, such as in convergence dialogue meetings (Eskilsson et al., 2020; Finnes et al., 2019; Strömbäck et al., 2020) could be advantageous. An impression of the supervisor and workplace might also help therapists in advising the employee on which information to share. However, conversations excluding the employee could jeopardize the therapists' therapeutic alliance with the employee, who have been found to worry about the information being exchanged in such conversations (Strömbäck et al., 2020).

Two studies have revealed that Acceptance and Commitment Therapy coupled with a workplace intervention does not reduce sickness absence (Finnes et al., 2019; Skagseth et al., 2019). Unlike our study, Finnes et al. (2017) stressed the importance of the neutrality of therapists in workplace meetings and thus required that the therapists providing Acceptance and Commitment Therapy differed from those administering the workplace intervention (Finnes et al., 2019). Considering the results of our study, we contend there are advantages with the therapist being familiar with the employees' overall life situation when they participate in workplace meetings to act as support if necessary. In another study, Ilvig et al. (2018) found that participants in Acceptance and Commitment Therapy-based rehabilitation experienced instructors as supportive and trusting, for they seemed to understand them, accepted their situations, but did not refrain from challenging them (Ilvig et al., 2018). That combination of support and challenge was also evident in our study, the therapists addressed the use of inappropriate or overabundant adjustments and urged employees to take responsibility for their health and return-to-work processes. The value of having therapists who address participants negative illness perceptions (Giri et al., 2009) and challenge them on self-reflection (Haugli et al., 2011) has also been reported elsewhere. Our results also showed that the therapists felt that the workplace meetings made it easier to broach the topic of return-to-work in rehabilitation with an Acceptance and Commitment Therapy framework since rehabilitation goals were set by the participants and not confined to return-to-work. In addition, they could align their therapeutic approach according to how they experienced the employees' work situations.

Such meetings might thus enable therapists to address work participation as a given rehabilitation component and provide employees with appropriate support relative to their work conditions.

It should be noted that the randomized controlled trial investigating the effect of the workplace meetings described in our study showed no evidence in favour of adding a limited workplace intervention (Skagseth et al., 2019). Since the rehabilitation programme alone was found to reduce sick leave (Gismervik et al., 2020), the room for improvement by adding a workplace meeting might be limited (Skagseth et al., 2019). Skagseth et al. (2019) also mention the similarities between the programmes, that the workplace intervention possibly interfered with the return-to-work process and the lack of coordination between stakeholders as potential explanations for the lack of effect (Skagseth et al., 2019). For instance, social insurance caseworkers are return-to-work stakeholders that were not present in the meetings. Since an occupational health physician commonly provides such interventions in European countries, it is also possible that the rehabilitation therapists working within an Acceptance and Commitment Therapy framework had a somewhat different role and approach. The workplace meetings may have contributed in other ways than return-to-work, e.g., resolving wishes to change workplace or increasing well-being at work by addressing the employee-supervisor relationship, and this may account for the predominantly positive experiences of the participants of this study. On a related note, the return-to-work for all but one employee by the interviews four months after the meeting also suggests that the selection of cases might not be representative to the RCT participants. Nevertheless, our results reveal that although Norwegian employees are well protected by legislation and may have good relationships with their supervisors, the vulnerability involved in being on long-term sick leave demands support in the return-to-work process. A study by Seing et al. (2012) found that multi-stakeholder meetings had an uneven power distribution in which employers' perspectives seemed decisive due to their ability to offer adjustments (Seing et al., 2012). Our study reveals the importance of therapists' presence in workplace meetings as they, with knowledge of the employee's overall life- and work situation, can provide needed support and ensure the planning of appropriate return-to-work solutions.

Strengths and limitations

The combination of methods in our study enabled us to investigate the content of workplace meetings as well as stakeholders' experiences. To date, few other studies have involved examining the experiences of such stakeholders in the same setting (JM Eakin et al.,

2003; Gouin et al., 2019) and provided examples of interaction. Because the ideal number of cases in multiple case studies is 4–10 (Stake, 2006), the seven cases comprising our study made it possible to conduct in-depth analysis of each case while also making cross-case comparisons. The results were seen in light of the material from nine additional workplace meetings and connected interviews, which largely confirmed the results and also provided important nuance to the theme describing experiences with disclosure. We, the authors of the article, have backgrounds in social science and public health research, and preliminary results and analysis were presented and discussed in two inter-professional research groups on several occasions. The researcher conducting the data collection did not work at the rehabilitation centre and had no prior affiliation with the study participants. The limited time frame of the meetings precluded any familiarity with either the setting or the other participants, and since all attendance in a field nevertheless affects the conduct of those present (Agar, 2008), the meetings were necessarily affected by the presence of the researcher. However, the novelty of the setting for all those present may also have reduced the effect of the researcher's presence. To make the researchers attendance as non-invasive as possible, she was seated apart from the other participants when possible. Field notes (Agar, 2008; Hammersley & Atkinson, 2007) were taken continuously throughout the meetings to avoid interruption if beginning to write at a particular time during the dialogue. The researcher strived to render the conversation as close to a verbatim report as possible, and the notes were filled in retrospectively to complete sentences and secure meaning. Nevertheless, field notes are inevitably not as reliable as video- or audio-recordings; because recall distorts quotations (Agar, 2008), excerpts from observations should not be treated as verbatim accounts.

The pragmatic timing of the interviews results in several limitations to the study. Since the supervisors were interviewed shortly after the workplace meetings, they generally recalled them in greater detail than the employees, who were interviewed four months later, creating a recall bias. Conversely, the employees could provide information on long-term changes in the workplace, which the supervisors could not. Interviewed during the period of the workplace meetings, the therapists did address specific meetings; however, because some had not yet been conducted, the interviews often concerned their overall experiences, e.g., with how they perceived their role. Conversations with the therapists after the meetings also informed subsequent interviews and the analysis. Optimally, all participants should have been interviewed shortly after the meeting, and the supervisors should have been interviewed after four months.

We are also unsure of why some employees and/or supervisors did not want to participate in individual

interviews after the meeting since we did not enquire into the reason for not answering our request. Since all but one employee who agreed to participate had returned to work by their interview four months after the rehabilitation, it is plausible that those who had not were less likely to partake. This also indicates that our results possibly describe constructive workplace meetings, which are not necessarily representative. However, participants from two conflicted meetings chose to participate, as did participants from one meeting where the relationship between the employer and supervisor had worsened since the meeting. As such, the material does cover contesting perspectives. Even though our results are contextually bound to characteristics of the individual cases, the role of the rehabilitation therapists and the cultural and legislative setting of Norway, they nevertheless reveal components and experiences of the workplace meetings that transcend the particular context from which they originate. Important questions regarding disclosure in the return-to-work process as well as the role of therapists and nature of adjustments may be transferable to other settings and provide valuable reflections for return-to-work practice.

Conclusion

The essential feature of the workplace meetings was to align understandings of illness and return-to-work and plan appropriate adjustments. Components of the meetings that seemed instrumental in developing understanding included disclosing difficulties, validating attitudes, and delimiting responsibilities. Such interrelated components should be viewed as complex processes that stakeholders should maintain throughout the return-to-work process. The results suggest that the symbolic meaning of adjustments may exceed their physical necessity and that the conditions under which they are implemented sometimes seem more important to the employee than their content. Because the supervisors expressed insecurity in managing the return-to-work process after the meetings, it is important that their responsibilities in the return-to-work process are clearly defined and that they are given appropriate support in workplace interventions. Although employees' openness about difficulties and challenges seem to be a prerequisite for supervisors' responses to return-to-work, it is nevertheless questionable whether openness and disclosure should be the norm in the return-to-work process. Ultimately, by validating important aspects of employees' situations, therapists can provide necessary support with identifying and ensuring appropriate workplace adjustments. Future research should address the workplace as the setting for return to work, in particular the interpersonal and

environmental aspects that influence the process beyond the condition of the individual employee on sick leave.

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Ethics approval and consent to participate

This study was approved by the Regional Committees for Medical and Health Research Ethics in Central Norway (Norwegian University of Science and Technology, Faculty of Medicine and Health Sciences) (No.:2014/2279). All

participants signed an informed consent form before taking part in the study.

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Authors' contributions

NEK (MA) designed the study, collected, analysed and interpreted data, drafted and completed the manuscript. MBR (PhD) designed and supervised the study, interpreted data, and was a major contributor to writing and completing the manuscript. MSF (PhD) contributed to interpreting the data and to writing and completing the manuscript. All authors read and approved the final manuscript.

Data availability

Due to ethical concerns, supporting data cannot be made openly available. Data could be made available from the authors upon reasonable request and with permission of participants.

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