Focus on health, motivation, and pride: A discussion of three theoretical perspectives on the rehabilitation of sick-listed people

Tommy Svensson^{a,b} and Anita Björklund^c

^a*Department of Behavioural Sciences and Learning, Linköping University, Linköping, Sweden*

^b*Nordic School of Public Health, Göteborg, Sweden*

^c*School of Health Sciences, Department of Rehabilitation, Jönköping, Sweden*

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Abstract. *Objective/Method:* During the last decades sickness absence from work has become a great societal problem. Questions of how rehabilitation processes should become successful and how peoples' ability to work can be improved have become of great public interest. In this paper we discuss three well-known theoretical perspectives regarding their usefulness when it comes to research on rehabilitation for return to work.

Results: The three perspectives are: Antonovsky's salutogenic model of health, Kielhofner's model of human occupation and Scheff's sociological theory of "shame and pride".

Conclusions: Each of these can be applied to increase understanding and knowledge concerning sickness absence and return to work. We discuss points of affinity among the three perspectives, as well as significant differences, and we propose that a very essential common denominator is the importance of self-experience.

Keywords: KASAM, Model of Human Occupation, self-experience, social emotions

1. Introduction

During recent decades sickness absence from work has emerged as a major societal problem in several countries, among them Sweden. The number of people sick-listed and the length of sick-leave spells have tended to increase. This constitutes a major problem on the national level of economics and allocation of resources, but it also involves difficulties from the points of view of the sick-listed themselves. In current political discussions of the problems of sickness absence two quite different ways to direct the attention and two

corresponding suggestions for where to look for explanations and solutions could be discerned. On the one hand there are intense discussions of work-place conditions and changes for the worse when it comes to peoples' well being at work and their options to influence their work environment. This goes especially for work in the public sector where down-sizing and decreased resources during the 1990's have resulted in stress, dissatisfaction and organisational insecurity. On the other hand there is a focus on the sickness absence, work moral, and options for return to work of individuals. This often includes issues of how to make rehabilitation efforts successful and how to enhance peoples' incentives and abilities to work. In this article we shall discuss some theoretical perspectives that may be useful when it comes to increase understanding of what are important factors in rehabilitation for return to work.

* Address for correspondence: Anita Björklund, School of Health Sciences, Department of Rehabilitation, Box 1026, SE-551 11 Jönköping, Sweden. Tel.: +46 36 101265, Mob: +46 708 261250; Fax: +46 33 269706; E-mail: Anita.Bjorklund@hhj.hj.se.

Our focus on rehabilitation aspects of sickness-absence problems does not imply a suggestion that the root causes of the problems or their solutions should be searched for in the person on sick leave, rather than in the work environment she/he is absent from. There are undoubtedly work environments that sickness absentees should refrain from returning to until they have been substantially improved. But even if there is a great need for research into causes of sickness absence related to the workplace, there is also a lack of knowledge concerning what circumstances are significant when it comes to successful rehabilitation for return to work of sickness absentees. In spite of numerous research efforts in this area we still do not know enough about the psychological and social conditions of long term sickness absence and about the psychological and social processes that are decisive for the outcome of rehabilitation efforts. We do know that psychological and social circumstances in a broad sense are important. There is research indicating that successful rehabilitation for return to work must take into account the views and perceptions of the sickness absentee her-/himself concerning her/his abilities and that she/he should be actively involved in all decision making during the rehabilitation process [5,7,13]. There is also research that demonstrates that long sick-leave spells involve a risk of lowered self-esteem that may negatively affect rehabilitation options [6,12]. Moreover, some studies have shown that the way interaction with rehabilitation professionals is perceived and experienced by sickness absentees can influence their self-esteem in a way that may be significant when it comes to return to work [11, 18].

The problem area of sickness absence, rehabilitation, and return to work has so far not been the subject of much theoretical contextualisation and theoretical development. There is a need of developing theories and conceptual tools that could stimulate empirical research in this area [1]. The aim of this paper is to contribute to a discussion of theoretical frameworks and perspectives that may be fruitful. We shall suggest three theoretical perspectives that focus on rather basic psychological or social processes: a theory of salutogenesis, a theory of activity, volition and motivation, and a theoretical view of social emotions. The three perspectives will be discussed from the point of view of their applicability and usefulness when it comes to the problem area of sickness absence and rehabilitation for return to work. Common to them is that they are rather well established but that they have not been much used in the specific context of sickness absence and return to work. Some

of the applications to this problem area we suggest are a matter of course and rather straightforward, whereas some others may be less obvious.

2. A salutogenic model

During the last decades, it has been an axiomatic element in health care discourse and rhetoric to direct one's attention towards factors maintaining and promoting people's health, and not only towards those causing and aggravating diseases. Probably, this is closely linked to the successful introduction of a holistic (as opposed to a reductionist and biomedical) health concept during the later decades of the 20th century. A well worked-out and well-articulated theoretical attempt to clarify what focusing on health instead of disease implies was presented by Aaron Antonovsky whose "salutogenic model" has attracted much attention [2,3].

A starting point for Antonovsky [2] is the quite pessimistic observation that the normal state of the human organism is disorder and conflict rather than order and harmony. He turns against the dichotomized outlook of traditional medicine, where people are looked upon as either healthy or ill. There is, he suggests, a continuum between health and disease. Most of us are at some distance from the end-points most of the time and we are also often moving in one or the other direction. It may often be fruitful to ask, "What factors contribute to maintaining a person's position at the continuum or promote a movement in the direction of the positive pole?" (rather than "What is the cause of a person's disease?"). He emphasizes that this question is always relevant to ask, irrespective of where a person is found to be at the continuum. Antonovsky also turns against the common pathogenic-model view of stressors as always destructive to health and therefore always to be combated. Stressors, he maintains, should be accepted as something always present in people's lives. Their influence could be pathological or health promoting depending on the type of stressor and how they are handled (for instance in the presence or absence of social support).

The most central concept in Antovsky's model is 'sense of coherence' (SOC). He defines the concept of sense of coherence (SOC) as:

... a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable,

and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement [3, p. 19].

Furthermore, Antonovsky [3] claims that it is the SOC that enables the individual to maintain her/his position on the healthy side of the health-disease continuum. SOC includes the three components *comprehensibility*, *manageability* and *meaningfulness*. Comprehensibility concerns the extent to which one experiences external and internal stimuli as rationally comprehensible, and impressed by order, coherence, structure (in contrast to chaos, disorder, inexplicability). He suggests that an individual with a strong sense of comprehensibility will expect that her/his future experiences will be predictable or at least possible to explain. It should be noted that the degree of comprehensibility says nothing about the desirability of different stimuli.

Manageability refers to the individual's ability to handle her/his experiences and challenges, and that she/he has a feeling of controlling enough resources to meet various demands. It may concern the resources under one's own control as well as resources, that are under the control of people one trusts.

Meaningfulness is regarded by Antonovsky as the motivation component of the SOC. It concerns the experience of life as having a meaning, in a cognitive and emotional sense. It also involves experiencing the demands you are facing as worth engaging in and regarding them as challenges rather than burdens. Antonovsky [3] sees each of the three components of SOC as more or less essential for the sense of coherence.

Antonovsky [3] also writes of "overarching psychosocial *generalized resistance resources* and *resistance deficits*" (GRR-GRD). The former contribute to a strong SOC, and the later to a weak SOC. Depending on the character of the stressors, they could be classified as "chronic stressors, important life events or acute everyday annoyances", all with different intrinsic qualities. He proposes that chronic stress, like general resistance resources, is similar to a life situation, a state or a quality which essentially characterizes an individual's life and is a conclusive factor for an individual's SOC-level. Regarding important life events, for example termination from work or a change of work place, it is not the event itself that is crucial for the SOC-level but the stress it causes and the consequences for the individual. It is the strength of the individual's SOC that determines if the consequences of the event are harmful, neutral or healthy. Acute every-day annoyances, such as a one-

time insult at the work place, have little or no influence on the individual's SOC, according to Antonovsky [3].

It is obvious that there are good reasons for applying a salutogenic model in a general sense to the problem area of work/sick leave/rehabilitation. Research regarding the connection between work and health/ill health has often been carried out from a pathogenic-model perspective focusing on the negative influence of work on health. The main interest has been directed towards potentially pathogenic factors at work, such as work tasks, work performance and work environment that are detrimental to health. It should be just as important to study factors that are important for the individual's health in a positive sense at the work place. An over-arching salutogenic perspective would also seem fruitful when it comes to the rehabilitation of sickness absentees for return to work. To focus on health, on positive options, and on factors that contribute to a movement towards the positive pole on the health-disease continuum, would presumably be important to strengthen the sickness absentee's view of return to work as a realistic and meaningful objective.

Also Antonovsky's [3] rejection of the notion of a sharp dichotomy between health and disease may be applied to the discussion of the complexity of problems of sickness absence and rehabilitation. People are sick-listed as a consequence of diminished work ability, in most cases caused by a disease or an injury. But a sharp distinction between those who have work ability and those who have not is doubtful. It would probably be more reasonable to speak of a continuum between total loss of work ability and full work ability, where each of us are at some point, often at a certain distance from the end poles and where we are often on the move in either direction. With reference to Antonovsky [3], the most important question to ask would be: "Which factors contribute to create a movement towards greater work ability?" or "How can present work ability be maintained?". Moreover, such a view could contribute to reducing the polarization between those who work and those who are sick-listed and to weaken the negative stereotyped characteristics that are often attributed to the latter in current public and political discussion.

The more specific features of Antonovsky's salutogenic model, the SOC-concept and its components, and his concept of general resistance resources and deficits (GRR and GRD), appear to be useful in analyses and discussions of work ability and health/illness. They could also be applied to identify important steps in the rehabilitation process. The SOC-components of comprehensibility, manageability and meaningfulness may

be important in the analysis of, and in the work to influence, the sick-listed individual's view on her/his illness and deteriorated work ability as well as her/his attitude to the rehabilitation process as such and to her/his returning to work as a meaningful objective. Important prerequisites for meaningful rehabilitation work may also be that the sick-listed individual has her/his ill-health problems analyzed and explained in such a way that they are comprehensible, put in an understandable context and where it is possible to take care of them rationally.

The manageability component can be regarded as very significant in the rehabilitation process in several ways. It could be suggested that rehabilitation professionals really contribute in helping the sick-listed person to activate the internal resources that she/he possesses. Furthermore, successful rehabilitation probably depends on how the sick-listed person comprehends and experiences the rehabilitation professional as being "on her/his side" and that the professionals' resources are available to the sick-listed individual.

It is important that a sick-listed individual experiences meaningfulness in various ways. Rehabilitation work, in order to be successful, should be experienced as something worth engaging in and as something one believes will lead to an objective worth by investing in it. This also concerns the individual's attitude to the impairment or illness that causes the sick leave. To be able to look at this as something that does not dislocate or destroy the experience of meaning in the life project as a whole, but something that could be handled as a challenge rather than a burden, seems essential for the rehabilitation outcome. In both cases the attitude and interventions from different rehabilitation professionals may be considered as important.

The GRR- and GRD-concepts are tools to be used in an analysis of what causes and triggers the sick listed individual's ill health problems as well as in reflections on what resources could be developed to counteract the problems.

With a salutogenic-model perspective on work rehabilitation it is important to investigate possible GRR-GRD in the individual in relation to stress load in the work environment and /or work situation. For an individual it could sometimes be devastating for her/his SOC and accordingly her/his health to return to the stressful work place from where she/he has been absent. A more suitable intervention in such a case might be a change of work place, which in turn represents an important life event for the individual. In the case of changing work places it is important for the rehabili-

tation professional to be aware of and to pay attention to the individual's experience of the work place change and its consequences and to understand how it will affect the individual's SOC-level and health condition.

3. A theory of volition, occupation and motivation

A well-established occupational therapy theory for describing and explaining human occupation in terms of *volition*, *habitation* and *performance capacities* in interaction with the *environment* is the *Model of Human Occupation* [10].

Kielhofner presents three fundamental aspects of importance for people finding motives for their *volition* to be active. Meaningful and engaging occupation provides a feeling of personal causation, values concerning what is important and meaningful to do, and experiences of pleasure or satisfaction with what one does (interests). Consequently, questions for motivation for occupation are: "Am I good at it?", "Is it worth doing?", or "Do I like it?".

Furthermore, our self-image depends on how the surrounding world responds to our actions and our world view indicates what we have done and experienced when we met it. Volition could, according to Kielhofner [10], be seen as a continuously ongoing process where volitional thoughts and feelings originate from people's experiences, interpretations, anticipations and choice of occupations. Activity choices arise when we must or have the possibility to determine what we shall do in a shorter time perspective. Decisions of occupational choices presuppose an engagement to begin an action chain or maintain a regular performance over time, for example, when someone chooses to begin a certain employment. All together, the action- and occupational choices affect the occupational performances, which constitute our daily lives. These choices could be seen as a function of volition, that is, they reflect our personal causation, our values and our interests.

Our *habitations*, that is, much of what we do, belong to a taken-for-granted circle of daily life. By engaging in certain routine behaviors we confirm our identities. These aspects of standard daily life arise automatically but are organized in relation to temporal, physical and social habits, (i.e., a taken-for-granted circle of daily life, to do things the way we use to do them and to meet other people as we usually meet them). When something is not as it used to be in our surrounding world, we have to start thinking about what we do and the routine habit is broken [10].

Our physical characteristics and abilities both enable and hinder us from establishing action patterns. This becomes obvious when we experience a limitation of our capacity or meet new social contexts, when our usual way of acting no longer works. When our surrounding world is stable we have a tendency to behave in established patterns. This is a function of habits and roles. According to Kielhofner, habituations may be defined as certain acquired ways to respond and perform in well known surroundings and situations. For habits to exist we have to repeat the action a sufficient number of times to establish the pattern and stable circumstances in the environment must be present.

Our patterns of actions also reflect the roles we have internalized. Our behavior is influenced by other people's expectations from us to act according to the role. Roles shape our self-image, supply us with an outlook or attitude and evoke certain behaviors. An internalized role may, according to Kielhofner [10], be defined as the incorporation of a certain social and personal status and clusters of attitudes and behaviors. People usually have many roles that they play. A complementary set of roles gives rhythm and variation among identities and expressions.

Performance capacity is, according to Kielhofner [10], dependent on functioning physical body systems and mental and cognitive abilities such as memory and planning, but he stresses the individual's subjective experience of her/his ability is crucial for the individual's performance capacity. Hence, in his model, performance capacity is defined as the ability to do things supported by one's actual status concerning objective physical and mental components *and* corresponding subjective experiences. The experience aspect of the performance capacity refers to the phenomenological philosophical concept of the 'lived body', that is the experience of being in and knowing the world through a specific body and consequently the performance is directed by how it "feels" to engage in occupation.

Furthermore, Kielhofner writes about occupational identity as a complex experience of who we are and who we want to be and this is shaped by our previous experiences of engaging in occupations. Our volition, our habits and our experiences as the 'lived body' are integrated in our occupational identity, which serves both as an objective for our self-identification and as a plan for ongoing occupations. Together with environmental factors they determine what we really do. Occupational competence concerns to what extent one maintains a pattern of occupational participation that mirrors one's occupational identity. Over time, our par-

ticipation in occupation produces and maintains our occupational identity and competence, which altogether constitute our occupational adaptation.

From a system-theoretical approach, Kielhofner's [10] model provides an understanding of the complex number of factors that influence people at work. The model illustrates how physical and psychosocial *environmental factors* interact with the person's motive for occupation, her/his occupational pattern, and physical and mental abilities, and how these factors together influence the person's health.

A role of vital importance is the worker role and the real motive for being active in the worker role is, in Kielhofner's view, to be found in the individual's experience of personal causation and her/his values concerning what is important and satisfying to do. To maintain a worker role involves an expression of personal identity. The behavior in the worker role is to a great extent shaped by other people's expectations of the worker's performance as part of the role and is shaped in interaction with the environment.

Unemployment and/or long term sick leave will break routine habits and behavior that are part of the worker role and will separate the individual from what previously constituted a certain identity. They therefore imply a new identity, new habits and new ways of meeting the surrounding world. Frequently the individual's self image is negatively influenced by unemployment and sick leave, since the individual's personal causation, according to Kielhofner, is a determining factor for performance capacity. Work ability will also be negatively influenced. Psychosocial support from rehabilitation professionals is necessary for the individual to be able to experience her/his value in relation to the worker role, despite unemployment and sick leave. Sometimes this may involve very concrete matters, such as helping her/him to put a resume together [9].

For new habits to be established and entrance into a new worker role to be facilitated, Kielhofner [10] proposes that besides the individual's personal motivation, a sustainable environment is required. For this reason it could be questioned if participation in unemployment projects that one has not chosen or wished for and that have a diffuse connection to work life really promote returning to work, or if it makes it more difficult for the individual to establish the required habits/behaviors for re-entrance into the worker role. In order to maintain a positive self image the individual may come to accentuate life roles other than the unattainable worker role. A consequence of this reasoning is that crucial factors for

successful re-entrance into the labor market are to be found in the individual's personal causation and values concerning what are important and satisfying to do.

Since a set of complementary roles and interchange between them contribute to a healthy life rhythm, it is not always the case that it is the work in itself that causes ill-health, but the individual's inability to combine the different roles. A conclusion from this is that one can not regard the worker role as separated from the individual's context of roles.

An additional aspect worth noticing in work ability assessments is putting together the different perspectives that, according to Kielhofner, are necessary for the understanding of the individual's performance capacity. This requires a combination of an external objective assessment by rehabilitation professionals and an internal subjective assessment by the individual. Assessment of work ability ought to be grounded in a dialogue between the rehabilitation professionals and the person to be rehabilitated. For some work places or work contexts it may sometimes be a matter of habilitation (to get hold of new habits), instead of rehabilitation (return to earlier habits). In line with Kielhofner's point of departure in a phenomenological view of the body-mind [10], new habits and work do not solely mean new movements and thinking operations that are needed for performance of the tasks. It is rather a matter of feeling and experiencing the performing of them.

4. Theories of social emotions

During recent decades theories have been developed concerning emotional dimensions of social interaction. With important contributions from the disciplines of clinical psychology, social psychology and the sociology of emotions, interest has been directed towards emotions that involve peoples' experiences of "social monitoring" and social evaluation of their own selves. It has been suggested that the emotions of pride and shame are particularly significant. These are closely related to positively or negatively experience outcomes of self-scrutiny and self-evaluation and they have very dissimilar behavioural consequences. Experiences of shame tend to make people withdrawn, silent, socially passive and so forth, whereas pride often make people extrovert, active, willing to partake in social interaction and eager to "stand up" for themselves.

In the literature one can notice some differences between writers who approach this problem area from psychological (often psycho dynamic) perspectives on

the one hand and sociologically oriented theorists on the other. We shall in this context direct our attention primarily towards some of the latter. Within a symbolic interactionist tradition, early writers such as Cooley [4] stressed the importance of the feelings that are involved when people interact. In the context of his famous "looking-glass self" metaphor he suggested that there are self-evaluative feelings accompanying the self image that the individual establishes by watching her-/himself through the eyes of "the other" and he stresses that those often are feelings of either pride or shame. Shott [17] suggested the term "role-taking emotions" for the type of feelings that can only evolve when you put yourself in another's position and view (and evaluate) yourself from that position. Shott also noticed that a major part of those emotions are reflexive and focused on one's own self (shame, guilt, pride, vanity, embarrassment).

One of the most well developed theories of pride and shame within an interactionist sociological tradition is the one presented by Thomas Scheff [14–16]. Several aspects of his theory appear to fit well into a discussion of potentially fruitful ways of theorising the problem area of sickness absence and return to work.

A starting point for Scheff is that humans are fundamentally social creatures. It is through social interaction, social co-existence with others that people develop and find their life meaningful. An important concept in Scheff's theory is "*the social bond*", which refers to the force that ties people together and integrates individuals, groups and societies. People have a need to experience that they are parts of a social context or a network of social relationships. However, it is also important, according to Scheff, that there should be a balance between closeness and distance in social relationships that allows individuals to feel that they are part of a social context without having to give up their individuality. When people interact the social bonds are put to the test. It is in social interaction that the bonds are constructed, reproduced, renegotiated, strengthened or weakened, broken, and so forth. Referring to Goffman, Scheff stresses how social interaction, apart from its communicative, verbal aspect, also includes an emotional and evaluative aspect. There is a "deference-emotion system" that is expressed through the form of the interaction rather than through its contents. This also involves displaying the interacting individuals' evaluation of each other as well as of the relationship between them. And this is where the emotions of *pride* and *shame* become significant. They are "master emotions", that is, they are fundamental and they are very

frequent in all social situations where an individual experiences being the object of judgement and evaluation. It is important to notice that these emotions are exclusively social in the sense that they are intimately tied to a person's notions of how "The Other" judges her/his self. But as most men and women have a great ability to imagine the evaluation of "The Other", pride and shame will tend to be almost permanently present even in solitude.

Feelings of pride or shame are thus very closely related to a person's experience of others' evaluation of her/him self. Shame is the outcome of others' judging you to be inadequate, unsuccessful, faulty, and unsuitable and so on. Pride derives from others' (real or imagined) view of you as successful, admirable, functional, and well integrated and so on. According to Scheff, a person's *self-esteem* is an expression of the balance between pride- and shame-states in her/his life.

Theories of social emotions, and especially Scheff's theory as sketched above, appear relevant to the problem area of sickness absence from work and rehabilitation for return to work. It is quite obvious that long term sickness absence involves a risk of the absentee becoming distanced from social groups and networks that are linked to her/his participation in work life. Being part of occupational activities and life at work strongly contributes to experiences of social participation and integration into your society and to lose them may result in a weakening of the social bond in Scheff's sense. To have a job and to function well in that job is also, in many cases, very important to the experience and sustaining of a person's sense of identity and self image. It is reasonable to assume that long term sickness absence from work as a consequence of loss of work capacity entails a risk of developing a negative self-image.

Furthermore, if attitudes to the long-term sick-listed as a group are characterised by suspicion and questioning, as expressed for instance by the way they are collectively depicted in mass media or as manifested in political suggestions of enhanced control and scrutiny of the functioning of the social insurance system, this would seem to weaken the possibilities of many sick-listed to maintain a positive self-image and self-evaluation.

The parts of Scheff's theory that seem most directly applicable to sickness absence and rehabilitation problems, however, are those that concern the social emotions that are evoked, reproduced and strengthened in concrete interaction situations. According to the theory a person's self-esteem is an expression of the balance between pride and shame in that person's life. If expe-

riences of pride are more frequent this will result in positive self-esteem, whereas a lot of shame experiences will lower self-esteem. Feelings of pride or shame accompany the evaluations and judgements made by others, according to the individual's interpretation. It is reasonable to suppose that those feelings are more readily evoked and more strongly perceived in interaction with others who are important to you or who have some measure of power over your future and your well being. When it comes to the long-term sick-listed, the various rehabilitation professionals that they encounter would seem to belong to that category. Social insurance officials, unemployment agency personnel, physicians, occupational therapists, physiotherapists, and other categories of health care personnel will in many cases be very important others in the life of the sick-listed person, mainly because they often have a very substantial influence over her/his future but also because they can be viewed as symbolising and manifesting the attitudes of society at large towards the sick-listed. It appears significant that the sick-listed's interaction and relations with rehabilitation professionals should result in experiences of evaluations and judgements that induce emotions of pride rather than of shame. It is likely that an amount of positive self-esteem, following from a positive pride-shame balance, in most cases can be seen as a resource that enhances motivation, will-power and options for finding a way to return to work.

5. Affinities and differences among the three perspectives

Finally we shall reflect on some similarities, differences, points of affiliation and possibilities of combination regarding the three theoretical perspectives and their usefulness in the context of the problem area of sickness absence and return to work. The three perspectives sketched above imply three different focuses on this problem area: 1) A focus on that which is "healthy" rather than on that which is "ill" and incapacitating in the sickness absentee; 2) a focus on activity and on the creation of will power and motivation to action in the sickness absentee; and 3) a focus on social dimensions of the rehabilitation process, especially emotional aspects of the interaction and relationships between the sickness absentee and various rehabilitation professionals and officials. Each of those foci opens up possibilities of research that could increase understanding and knowledge when it comes to reaching a successful rehabilitation.

However, it is obvious that there are points where the three perspectives touch and overlap each other. A lot of Antonovsky's reasoning about the three SOC-components can be seen to be in line with Kielhofner's model of how people choose to engage in meaningful activity. It is essential to comprehensibility in Antonovsky's sense that a person's experiences could be ordered and explained, even if they are not always predictable. According to Kielhofner, people's identities evolve through a combination of roles that presuppose an organisation of behaviour into patterns of habit. Encountering new social situations, as for instance in entering a new work place, often entails demands of modification of one's previous ways of acting. Otherwise an experience of limitations regarding one's capacities may follow. This modification requires that employers and work mates cooperate in making the new work conditions comprehensible to the newly employed.

When it comes to Antonovsky's concepts of manageability and meaningfulness there are also counterparts in Kielhofner's concepts of personal causation and values that, together with interests, supply motives for the will to be active. One could say that where Antonovsky speaks of manageability as a sense of having enough resources to be able to meet current demands, Kielhofner speaks of a sense of causation that has its basis in an expectation to succeed with what you do. Antonovsky describes meaningfulness as experiencing the demands as worthwhile to engage in, whereas Kielhofner talks of the person's evaluations of what is important and meaningful to do. As regards GRR in Antonovsky's sense, they could be related to performance capacity in Kielhofner's model, which does not just depend on a functioning body system but also has to do with the person's subjective notion of her/his capacities.

When comparing Kielhofner's model with Scheff's theory one can note that Kielhofner suggests that our self-image is built with the help of the responses to our actions that our social surrounding supplies and that our world view is influenced by our experiences in encountering it. This is to some extent compatible with Scheff's thesis that social emotions can be related to experiences of social "monitoring" and evaluation of one's own self. This experience of evaluation of the self results in emotions of shame or pride where pride is motivation enhancing whereas shame lowers motivation. Pride in Scheff's sense could be related to Kielhofner's notion of sense of personal causation as an important motivational component when it comes to the individual's will to act and to engage in activity. Kiel-

hofner's idea of the way the self-image is created has obvious affinities with an interactionist perspective that is present in Scheff's theory and implies, among other things, a socially grounded evaluation or judgement regarding personal causation.

Antonovsky's and Scheff's theories also have obvious affinities. Antonovsky's notions of health/disease as well as Scheff's notions of pride/shame involve the idea of a balance/continuum. The state of the individual is not static but changes continuously depending on internal and external influences. Health, according to Antonovsky, implies a sense of a high degree of coherence, but the experience of manageability could be rocked when rehabilitation resources are out of your own control and you have to depend on others' (for instance rehabilitation professionals) good will or judgements that could induce feelings of shame rather than pride. Experiencing a strong feeling of sense of coherence, that is, comprehensibility, manageability and meaningfulness presupposes that the individual is offered possibilities to be part of a context that is comprehensible, manageable and meaningful to her/him. This is in line with Scheff's reasoning that humans are basically social and that it is through interaction with others that development and meaning come into being. He speaks of "the social bond" as the force that binds together and integrates people, groups and society.

When these similarities and affinities have been pointed out, however, the different foci of the perspectives need to be highlighted as well as the relevance of these differences when it comes to a multidimensional elucidation of the problems of sickness absence and rehabilitation. In our view there are two important differences. The first concerns whether the focus is on cognitive or emotional aspects of sickness absence problematics. None of the theories has a one-sided or exclusive focus on cognitive or emotional aspects of human life, but there are significant differences. Even though Antonovsky and Kielhofner pay attention to emotional aspects of the individual's experiences, interpretations and understanding, this aspect is far more forcefully stressed in Scheff's theory. Feelings of pride or shame are singled out by Scheff as fundamental for the interpretation of people's attitudes and actions. Regarding the problem area of sickness absence and rehabilitation, one could argue that it is most important to take into account both cognitive and emotional dimensions of the personal circumstances of the sickness absentee. The theories provide partly similar and to a great extent complementary ways of comprehending the individual's thinking about her/his situation. When it comes to

Fig. 1. With focus on self-experience.

the often overlooked problem area of emotional aspects of being sickness absent, Scheff's theory of social emotions can be a very important contribution. This perspective in a fruitful way complements and balances an analysis of sickness absence that is primarily based on a salutogenic model or on an application of Kielhofner's model.

The second difference where the application of the three perspectives directs our attention in somewhat divergent ways, concerns whether intrapersonal or interpersonal factors are focussed on. Antonovsky's perspective can be seen as having a certain focus on the individual's internal resources and qualities. With Kielhofner to some extent and with Scheff to a high degree there is a clear focus on the importance of social interaction circumstances and processes. The partly diverging notions and basic suppositions concerning the extent to which people's "inner" conditions are shaped and influenced by social relations, interactions and processes will direct our attention towards particular intrapersonal or interpersonal aspects of the problem area of sickness absence and rehabilitation for return to work.

Let us finally point to a common characteristic of the three theoretical perspectives that could also be suggested to underline what could be argued to be the most significant in a rehabilitation process. This is the very strong stressing of the importance of the individual's own subjective interpretations and attitudes concerning who she/he is, what she/he can do and what she/he is worth and so forth. The significance of people's self-image and self-evaluation is in all three theories, although in partly different ways, pointed out as very great when it comes to understand their actions

and choice of strategies. With some simplification one could argue that, according to these theoretical perspectives, "self-experience" of the sickness absentee is the factor that should be regarded as the most important to a successful rehabilitation. This is a suggestion of a simple comprehensive graphic illustration of the partial compatibility of the perspectives:

It is an urgent research task to understand what circumstances in the context of sick-listing and rehabilitation that affect and shape the individual's self-experience. The three perspectives presented supply a basis for developing empirically testable hypotheses. Contributing to the positive self-image and self-evaluation of the sickness absentee will also be an important task for various rehabilitation professionals. This involves trying to strengthen the SOC in Antonovsky's sense of the sickness absentee, to contribute to a positive occupational identity in the spirit of Kielhofner and in line with Scheff's theory actively attempt to develop relations and interactions that induce feelings of pride rather than shame.

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