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ORIGINAL ARTICLE

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Occupational health care return-to-work practices for workers with job burnout

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ABSTRACT

Background: Occupational health care supports return to work in cases of burnout; however, there is little research on return-to-work practices.
Aim: To describe occupational health care return-to-work practices for workers with burnout and to identify potential for the development of the practices.
Methods: Open-ended interviews and essays were used to collect data from 25 occupational health care professionals. A qualitative content analysis method was used.
Results: Occupational health care was involved in the return-to-work support in the off-work, work re-entry and maintenance phases during the return-to-work process. However, occupational health care had no influence in the advancement phase. The key return-to-work actions were: (i) defining burnout, (ii) supporting disengagement from work, (iii) supporting recovery, (iv) determining the return-to-work goal, (v) supporting re-engagement with work, (vi) monitoring the job–person match, (vii) re-evaluating the return-to-work goal, (viii) supporting the maintenance of the achieved return-to-work goal, and, where appropriate, (ix) supporting an alternative return-to-work goal. There were varied return-to-work practices among the occupational health care centers evaluated.
Conclusions: The occupational health care return-to-work practices for workers with burnout are described with recommendations to further develop common practice guidelines.

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KEYWORDS
Guidelines; job burnout; occupational health care; qualitative study; sick leave

Introduction

This study is part of a larger research project aimed at developing a model for supporting return to work (RTW) in cases of burnout from the perspective of different parties involved in the RTW process. In this study, we examined occupational health care return-to-work (OHC RTW) practices for workers with burnout. Although a large body of research has examined RTW, there is little research on RTW practices for burnout in the OHC setting. The need for research on developing OHC RTW practices has been indicated in the literature [1–3].

Job burnout

Job burnout is a work-related, stress-induced syndrome [4]. The risk for developing burnout increases along with work overload, lack of control, lack of recognition and reward, lack of support and trust, unresolved conflicts, lack of equity and social justice, and a mismatch of values between the worker and the workplace [5]. However, the psycho-social factors of worker's private life may also predict burnout [6]. Burnout increases the risk of depression, cardiovascular and musculoskeletal disorders and diabetes [7], and it may lead to prolonged sick leave [8,9] and even disability pension [10]. Presenteeism is characteristic in burnout [11]. The recovery process for burnout is long, and symptoms may persist for years [12]. Although validated measures for assessing burnout exist [13,14], it is difficult to distinguish burnout from depression [15]. Burnout is not defined as a disease in the International Classification of Diseases (10th revision; ICD-10) [16] or the Diagnostic and Statistical Manual of Mental Disorders (4th revision; DSM-IV) [17]; therefore, the problem is often diagnosed as a co-occurring disorder for which the worker is eligible for sick leave compensation, such as depression [14], and is treated as such [18]. In Finland, OHC physicians may state burnout as an additional diagnosis using code Z73.0 [16].

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Return to work (RTW)

We used the conceptual RTW approach of Young et al. [19] as a framework to describe RTW practices for workers with burnout from an OHC perspective. In their approach, RTW is defined as a process rather than simply resuming work. Furthermore, they highlight the importance of the actions prior to and after RTW. RTW proceeds through off-work, work re-entry, maintenance and advancement phases. RTW does not necessarily progress linearly, and the worker might withdraw from the labor force at any phase.

The off-work phase begins at the start of sick leave. Work ability and performance are assessed, RTW goal is determined, preparations for RTW are made, and a suitable position is established. The main outcome of this phase is the ability to attempt work re-entry.

The work re-entry phase begins when the worker returns to work, either to the previous role or to some other work task. The worker's work ability and performance are reassessed, the RTW goal is re-evaluated, and the goal RTW status is initiated. The RTW actions are targeted to establish a good match between worker capabilities and work requirements, which is indicated by the term 'job–person match' in our study. The main outcome during this phase is the ability to perform satisfactorily.

The maintenance phase begins when the goal RTW status is achieved, and the actions are targeted to maintain that status. The RTW goal is re-evaluated, and the desire for career advancement is considered. The main outcome of this phase is the ability to maintain the goal RTW status and employment.

The advancement phase begins when the worker has demonstrated consistent performance. The worker moves on with his/her career by qualifying for higher-level work tasks with greater responsibility and, potentially, achieve a promotion. Alternatively, the worker might seek work opportunities outside of his/her current workplace. The worker may also return to the off-work phase while gaining qualifications for his/her desired work. The main outcome during this phase is the ability to advance in one's career. Workers and employers are the primary parties involved in career advancement [19].

Occupational health care (OHC) in Finland

In Finland, legislation regulates the principles of good OHC practices, including the management of RTW [20]. Employers are obliged to provide OHC services [21] through private OHC medical centers, municipal OHC centers or employer-operated OHC centers. The Social Insurance Institution reimburses part of the OHC costs to the employer [22]. Professionals working in OHC are qualified OHC physicians, nurses, psychologists and physiotherapists [20].

We aimed to describe OHC RTW practices for workers on sick leave with burnout based on an existing conceptual RTW approach, and to identify the potential for further development of the practices. Developing OHC RTW practices is important in order to better manage RTW of workers with burnout in an OHC setting. We define OHC RTW practices as the RTW actions performed by OHC professionals during different phases of the RTW process.

Our research questions were:

1. What are the OHC RTW actions for workers on sick leave with burnout during the off-work, work re-entry, maintenance and advancement phases?
2. Which, if any, OHC RTW practices for workers on sick leave with burnout have the potential to be developed?

Table 1. Participants by type of occupational health care (OHC) organization and the data collection method.

	OHC professionals ($n = 25$)			
	Physicians ($n = 7$)	Nurses ($n = 7$)	Psychologists ($n = 4$)	Physiotherapists ($n = 7$)
OHC organizations	n	n	n	n
Private OHC	0	2	1	2
Municipal OHC	1	1	1	3
Employer-operated OHC	6	4	2	2
Interviews				
Individual interview	1	4	4	7
Dyadic interview[a]	3	0	0	0
Focus group interview[b]	0	1	0	0
Essays	2	3	2	5

[a]Two participants in each interview.
[b]Three participants in each interview.

Materials and methods

Design and participants

This is a qualitative study with a descriptive design. Twenty-five OHC professionals, including seven physicians, seven nurses, four psychologists and seven physiotherapists across nine OHC centers participated in the study.

Five participants were employed at private OHC centers, six participants at municipal OHC centers and 14 participants at employer-operated OHC centers (Table 1). Of the 25 participants, 22 were female, and the participants' age ranged from 36 to 63 years.

All participants were qualified OHC professionals with 4–36 years of experience working in occupational health. The client companies with which the

participants operated were based in health care and social services, commercial and financial businesses, education, agriculture and forestry, the service sector, transportation, construction and manufacturing industries.

All participants had been involved in treating workers with burnout. Nineteen of the 25 participants had bolstered their vocational skills and reported the use of additional strategies (psychotherapy, mind–body methods, mental health and work counselling) to support workers with burnout.

Data collection

This study was approved by the Research Ethics Committee of the Northern Savo Hospital District, and it followed the ethical guidelines of the World Medical Association Declaration of Helsinki [23]. Private OHC medical centers, municipal OHC centers and employer-operated OHC centers in geographically different regions in Finland were purposively contacted to obtain an adequate and appropriate sample [24]. In addition, psychologists were recruited through the Association of Work and Organisational Psychologists, and physiotherapists through the Association of Finnish Physiotherapists in Occupational Health.

Prior to data collection, a letter was sent to all participants including information about the purpose of the study, confidentiality, voluntary participation and the potential to withdraw from the study. Detailed information about the study was provided by telephone. The managers of the OHC organizations gave written consents to recruit their personnel and the participants signed a written consent form. Individual pre-interviews ($n = 4$) were conducted with the service managers of the physicians, nurses, psychologists, and physiotherapists at one private OHC center to develop the interview guide and to provide comments on the requested essay assignments.

The first author, who has many years of experience as an OHC physiotherapist, conducted the data collection, transcription and analysis. Data from the 25 participants were collected between June 2014 and January 2015 through open-ended, semi-structured interviews [25]. Sixteen individual interviews, three dyadic interviews [26] with two physicians in each, and one focus group interview [26] with three nurses were conducted. Dyadic and focus group interviews were conducted if there was more than one participant with the same profession within the same OHC center who volunteered to be interviewed together. To avoid dominance of any one profession, interviews with each profession were conducted separately. Data were also collected through open-ended essays that were submitted via an encrypted e-form. Twelve participants responded to the essay assignment. The participants by type of OHC organization and data collection methods are presented in Table 1.

Prior to each interview, the purpose of the study was repeated and a demographic questionnaire was completed. The demographic questions considered the type of OHC organization, gender, age, qualification of the OHC professional, the length of the working experience as an OHC professional, the sector in which the client organizations operated, experience in treating workers with burnout, and any additional training of the OHC professional. The interviews began with the open-ended questions: (i) 'describe your experiences about the burnout of your clients', and (ii) 'describe your experiences with the return to work of your clients with burnout'. When appropriate, the researcher asked clarifying questions to gain more detailed descriptions. The participants received the following guidelines for the essay: 'describe your experiences, feelings and thoughts about the burnout of your clients, 'what kind of experiences do you have of burnout of your clients?', 'what kind of experiences do you have of return-to-work support for your clients with burnout?', 'as a researcher, I am interested in your subjective experiences, thoughts and feelings, not in general interpretations'. Participants decided on the length of the essay, which varied from half an A4 sheet to three sheets.

The researcher attempted to avoid presumptions and approached each interview with an open mind. The researcher encouraged the participants to talk about their work with workers with burnout and summarized the descriptions verbally during the interview to ensure that the focus was on workers with burnout. The interviews lasted 40–100 minutes, and all participants agreed to have their interviews recorded. The participants decided where the interview took place: two interviews were conducted in a local library, one at the home of the participant, one at the home of the researcher, and the remaining interviews were conducted at the participants' workplace. The participants demonstrated good motivation to participate. The researcher experienced the interview atmosphere as open and approving.

Data analysis

The data were analyzed through qualitative content analysis using both deductive and inductive approaches [27,28] to identify the OHC RTW

practices for workers with burnout, and to identify potential areas for the development of the practices. The data were prepared by transcribing the manifest content of the interviews verbatim. The interviews and essays generated approximately 460 pages of written text. The data obtained from the essays supplemented the interview data. Words and sentences were used as the units of analysis and the data were reviewed repeatedly to become familiar with their content.

Structure of the analysis was operationalized deductively based on the conceptual RTW approach of Young et al. [19]. The data was coded for correspondence with the main categories: off-work, work re-entry, maintenance, and advancement. The sub-categories were further derived from the text inductively through the researcher's interactions with the data. The sub-categories with similar actions such as 'recognizing burnout' and 'stating burnout in the additional diagnosis' were grouped together as a generic category 'defining burnout' and they established the key RTW actions.

Furthermore, an inductive analysis was conducted to find ways in which OHC RTW practices might be developed. Similarities and differences in the OHC RTW practices were identified and coded. Quotations have been included to support the trustworthiness of the results [29].

Results

The OHC RTW practices to support the workers with burnout corresponded to the conceptual RTW approach of Young et al. [19] with respect to the off-work, work re-entry and maintenance phases (Figures 1–3). The advancement phase, however, couldn't be identified.

Off-work phase

The off-work phase began when the worker stayed on sick leave. Five key RTW actions were identified: defining burnout, supporting disengagement from work, supporting recovery, determining the RTW goal, and supporting re-engagement with work (Figure 1).

Defining burnout

Every professional who was involved in the treatment of workers was also involved in defining burnout. Physiotherapists that suspected psychological problems sent the worker to other professionals in the multidisciplinary team. Nurses and/or psychologists used validated measures to recognize burnout. Physicians assessed the diagnosis after consulting with the other professionals and often a psychiatrist. Burnout was primarily recognized through open interviews concerned with both work-related stress and private life-related stress. The signs of burnout were also observed, with one nurse reporting that 'the worker might burst into tears'. The Bergen Burnout Inventory (BBI) was mentioned as a tool for measuring burnout. Depression was often measured using the Beck Depression Index (BDI).

According to the participants' experiences, physicians often stated depression as the primary diagnosis for the workers with burnout. The additional diagnosis code for burnout was used by some physicians.

Supporting disengagement from work

Workers with severe burnout did not always want to stay on sick leave. This was the time for the physician to step in and strongly recommend sick leave. The workers needed support to disengage from work whilst on sick leave because they might want to take their laptop home and continue to work from there. Participants noted that workers were especially vulnerable at the start of their sick leave and needed to be closely monitored at this stage, with one nurse stating that 'the first two weeks are extremely difficult … at this stage I think it is really important to monitor the worker'.

Supporting recovery

The workers were supported to manage both work-related and private life-related stress using strategies such as mind–body methods. The workers were provided psychological support to change their perceptions of work (the relationship they had with work and the meaning they gave to work), and they were referred for further psychotherapy treatment. Co-occurring disorders were also treated. A physician stated that 'medical treatment was provided if there was depression or sleep disorders or other disorders'.

Determining the RTW goal

The workers were involved in determining the goal for the RTW including timely return to a suitable work option. Evaluating timely RTW was sometimes difficult within the OHC setting. As described by one physician, 'the occupational physician assesses the

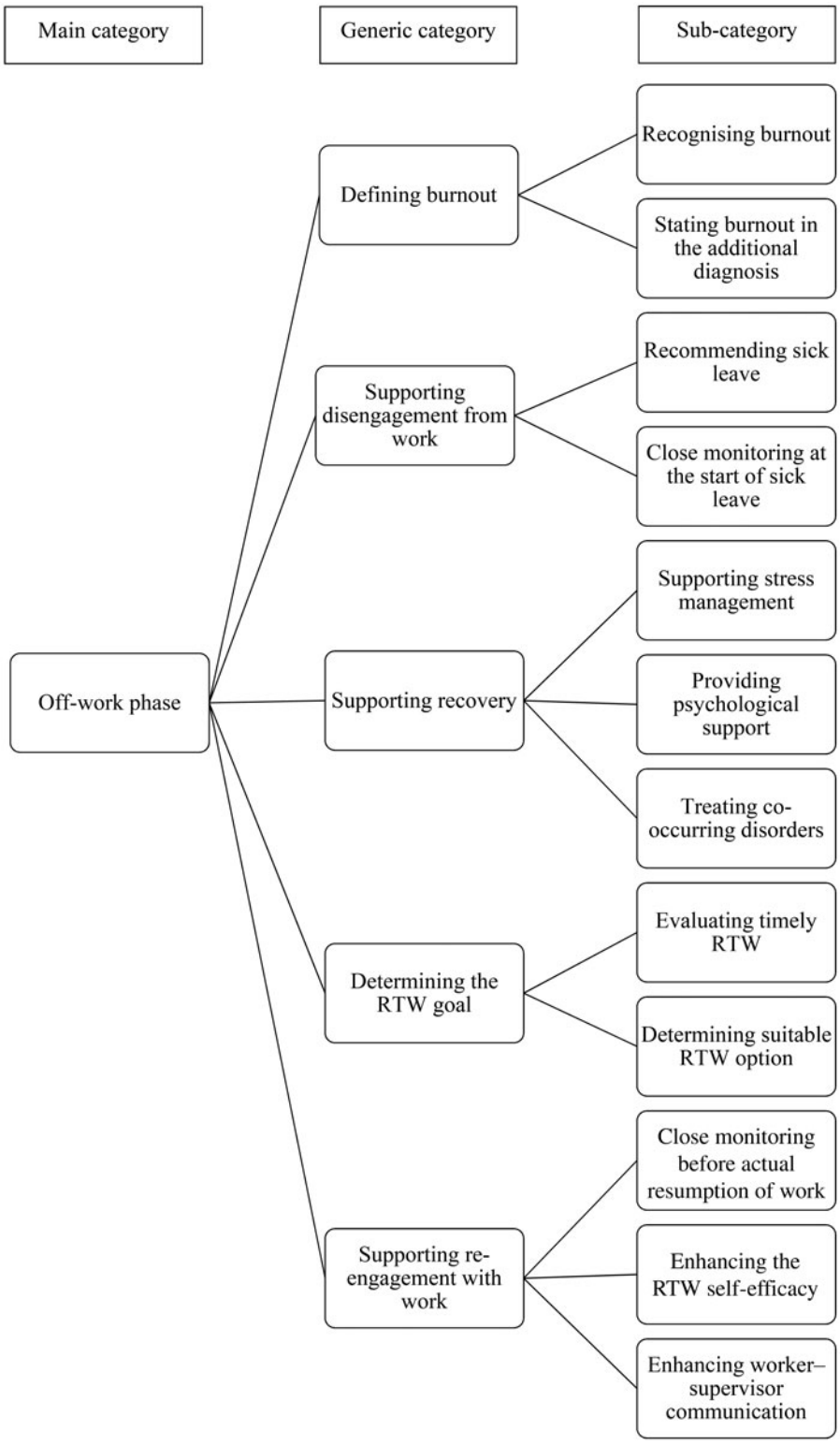

Figure 1. The main category obtained from deductive content analysis; the off-work phase by Young et al., [19] and the generic and sub-categories obtained from inductive content analysis; the key return-to-work (RTW) actions for workers with burnout according to the experiences of 25 occupational health care (OHC) professionals.

work ability and evaluates whether the worker is ready to return to work, and I think that it is sometimes difficult'. Part-time or full-time return to a previous work or modified work or new work were the RTW options that were discussed in joint meetings between the OHC representative, the supervisor and the worker. Joint meetings were arranged with the worker's permission.

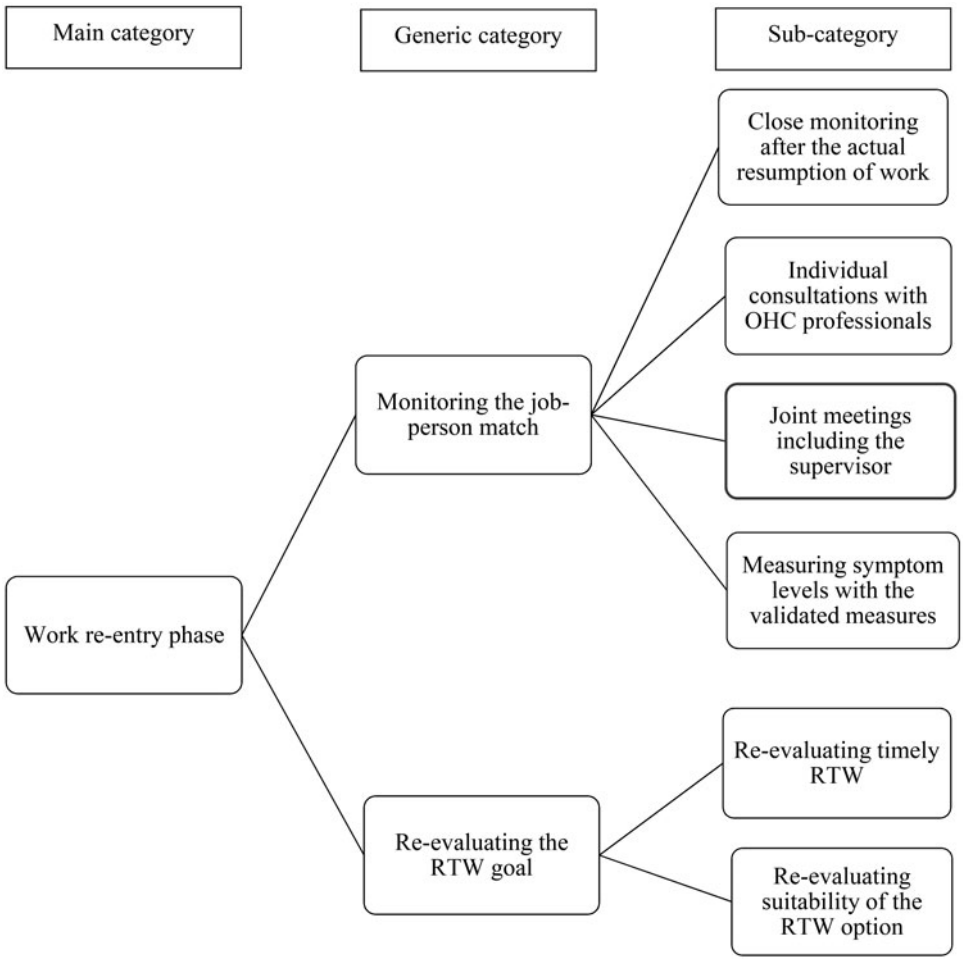

Figure 2. The main category obtained from deductive content analysis; the work re-entry phase by Young et al., [19] and the generic and sub-categories obtained from inductive content analysis; the key return-to-work (RTW) actions for workers with burnout according to the experiences of 25 occupational health care (OHC) professionals.

Supporting re-engagement with work

Close monitoring before actual resumption of work was considered important because symptoms such as sleep problems might reappear as the date of RTW approaches. Participants mentioned that they had enhanced the RTW self-efficacy of the workers through encouraging them to RTW while still experiencing burnout symptoms. Furthermore, enhancing worker–supervisor communication supported re-engagement with work. The worker was supported in bringing up the situation with his/her supervisor, and was encouraged to agree to a joint meeting with his/her supervisor. In turn, the supervisor was supported in practical terms with help regarding how to contact the worker during his/her sick leave and what to say. Support for the supervisor was emphasized because the supervisor was able to support the coworkers in welcoming the worker back to work. A psychologist stated that 'occupational health care has the role of helping the supervisor to act as a supporter'.

Work re-entry phase

The work re-entry phase began when the worker returned to work. Two key RTW actions during this phase were targeted toward monitoring the job–person match and re-evaluating the RTW goal (Figure 2).

Monitoring the job–person match

An important period for close monitoring of the worker's performance at work was after the actual resumption of work, because the worker can easily resume his/her old, undesirable working patterns. Monitoring was conducted through individual consultations with OHC professionals. A physician stated that 'we continue to monitor, whether the nurse or the physician, or both, or the psychologist monitors'. Joint meetings were arranged. In those meetings, the worker's coping at work could be discussed also based on the supervisor's observations. Furthermore, the validated measures (heart rate variability measures,

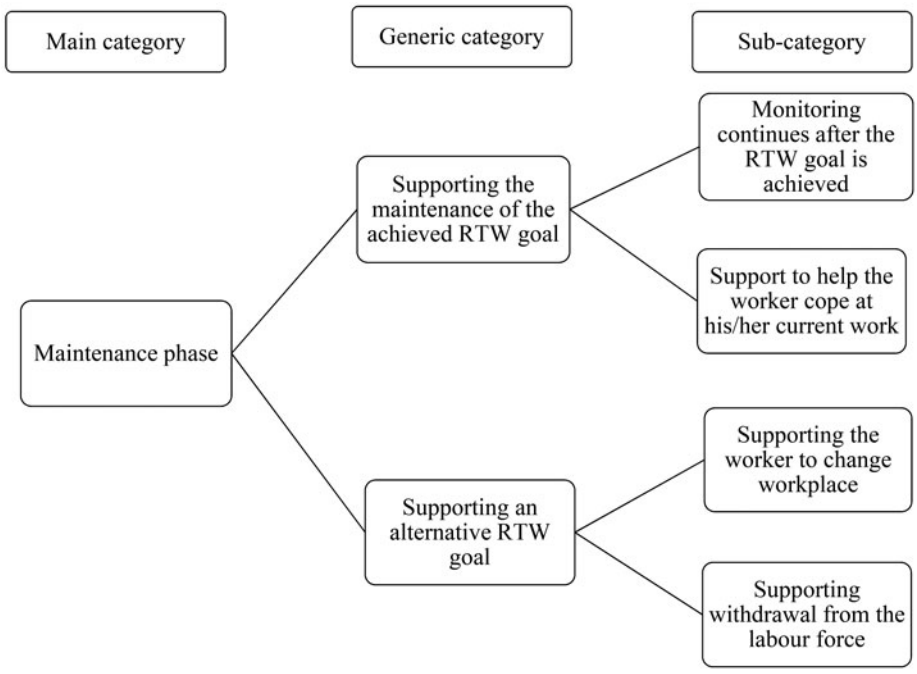

Figure 3. The main category obtained from deductive content analysis; the maintenance phase by Young et al., [19] and the generic and sub-categories obtained from inductive content analysis; the key return-to-work (RTW) actions for workers with burnout according to the experiences of 25 occupational health care (OHC) professionals.

burnout and depression measures) were used in some OHC centers to monitor symptoms after RTW.

Re-evaluating the RTW goal

The RTW goal, that was determined during the off-work phase, was re-evaluated after the worker returned to work. The OHC professionals (physicians, psychologists or nurses) met the workers with burnout in their OHC settings and evaluated whether the RTW had taken place at right time and whether the worker coped with his/her work. Suitability of the RTW options and implemented work modifications were discussed in the joint meetings with the supervisor and the worker. When interviewed, a nurse stated '… after returning to work, how then do the things go in practice, do the agreed things work? Of course, we arrange follow-up joint meetings'.

Maintenance phase

The maintenance phase began when the worker had achieved his/her RTW goal. Two key RTW actions were identified: supporting the maintenance of the achieved RTW goal or supporting an alternative RTW goal (Figure 3).

Supporting the maintenance of the achieved RTW goal

Monitoring of the worker's performance continued after the RTW goal had been achieved through individual consultations or a joint meeting after several months. The worker was supported to help him/her cope with the work if an adequate job–person match was achieved. In cases of a less optimal job–person match, the worker was supported to continue at his/her current work if he or she had only a few years of employment left before planned retirement, or if the worker had not recovered sufficiently to cope with a change in workplace. A physician stated that 'we try to find out ways to support the worker to continue at work until retirement'.

Supporting an alternative RTW goal

If the job–person match was not achieved in the current workplace, young workers at the beginning of their careers were supported to change workplaces. Based on the experience of the OHC professionals, the workers typically recovered from burnout and returned to work. Nevertheless, withdrawal from the labour force might also be an alternative as stated by a physiotherapist by 'in some cases, the worker might retire and not return to work'. It is noteworthy that the OHC professionals might support the worker to

find alternative RTW goals already during the off-work and work re-entry phases.

Potential to develop the OHC RTW practices

There was potential to develop the OHC RTW practices, as there were varied practices for defining burnout, recommending sick leave, supporting recovery, supporting the supervisor and monitoring the sustainability of the achieved RTW goal (Figure 4).

Burnout was not always measured with a validated burnout measure. It was not easy to distinguish burnout from depression or private life stress-induced exhaustion, or to recognize burnout that might be attributed to a physical comorbidity. Recognising burnout could take time. A nurse stated that 'many have used pretty much physician services … there were some symptoms but it was not recognized that the symptoms were related to burnout'. Thus, the RTW support could have commenced before burnout was confirmed. Furthermore, burnout was not always stated as an additional diagnosis.

The workers did not always stay on sick leave if they insisted on remaining at work. Some workers wanted to try to hang on at work and consulted the psychologist and limited the work. Timely RTW was not always achieved, as expressed by a psychologist by 'some physicians always recommend one or two weeks of sick leave at a time and the worker cannot recover properly because returning to work comes too quickly'. A physician explained that if the OHC professionals and the supervisor did not monitor the worker sufficiently, sick leave might be prolonged.

The participants reported that if burnout was not recognized and mentioned in the diagnosis, the treatment focus was the co-occurring disorders, and the work-related factors were not considered. Multidisciplinary cooperation within the OHC team was not always structured. In particular, physiotherapists' role in the RTW process was not clearly defined. Physiotherapists were not always integrated into the RTW support for the workers with burnout, even though they indicated wanting to be included, as stated by one physiotherapist by 'we have competence for more, but we are perceived to only have competence for the treatment of musculoskeletal problems'. The content of the RTW support was dependent on the interest and competence of each OHC professional, meaning that several participants had additional training (psychotherapy, mind–body methods, mental health and work counselling) which was not required by legislation. The support for the supervisors, and thus for the coworkers, was noted as being insufficient, and participants expressed the need for more support tools. When interviewed, a psychologist stated that 'it is important for occupational health care to develop new tools for supporting supervisors and work communities … mere recommendations are often not enough'. Sometimes joint meetings were not arranged and, in these cases, the supervisor was not included in the RTW support, with one psychologist reporting that 'usually, when the worker returns to full-time work the joint meeting is not arranged'. In addition, individual consultations might be lacking after the worker achieves his/her RTW goal. Lack of joint meetings and individual consultations during the maintenance phase indicate that the sustainability of the achieved RTW goal was not always monitored by the OHC professionals.

Discussion

We described OHC RTW practices for workers with burnout based on the conceptual RTW approach of Young et al. [19]. The OHC professionals provided support during three phases of the RTW process, namely the off-work, work re-entry and maintenance phases. The advancement phase was not relevant in the OHC setting. The off-work phase was more extensive than the other phases. Sick leave was part of the treatment in severe burnout cases, and thus, the RTW support had to be provided while the worker was off work.

The OHC professionals reported difficulties in distinguishing burnout from depression, which is not uncommon [15]. The sources of work stress [5] and private life stress [6] seemed to confuse decisions about the work-relatedness of burnout. The practice of measuring depression instead of burnout might stem from the fact that workers with burnout have an increased risk of depression [7], and this diagnosis makes the worker eligible for sick leave compensation. As noted in a previous study [14], burnout is often diagnosed as depression. As a consequence, the focus of the RTW actions might be on the treatment of depression [18] and not the work-related factors.

Previous studies indicate that workers with severe burnout need sick leave [8,9]. Objective tools might be required to assess the work ability of workers with burnout during the RTW process. Such tools could be useful for determining the need for sick leave, timely RTW and timely end of monitoring sustainability of the achieved RTW goal. The symptoms of burnout may persist for years [12]; therefore, it is important to consider this factor.

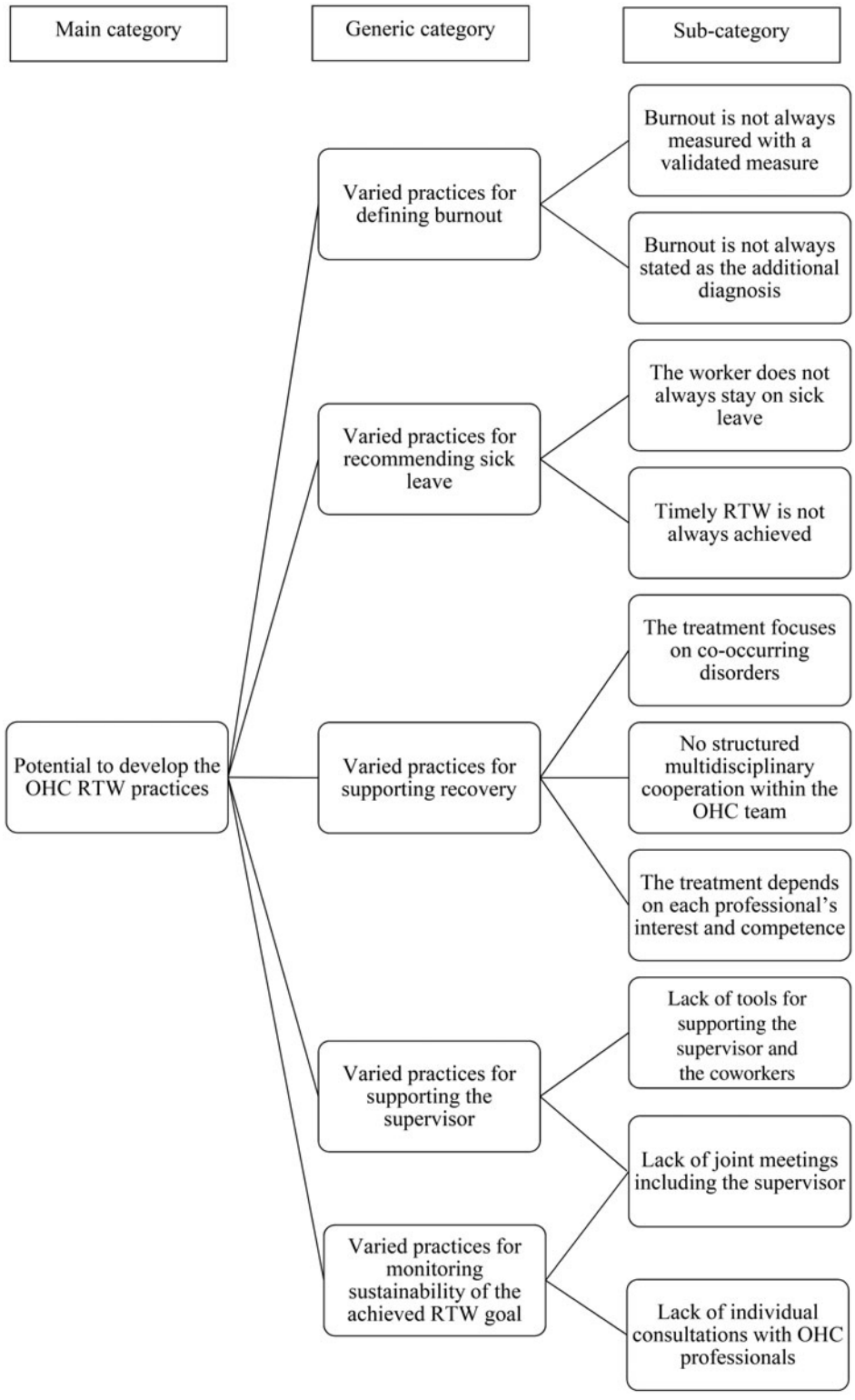

Figure 4. The main category, generic and sub-categories obtained from inductive content analysis; the potential to develop occupational health care return-to-work (OHC RTW) practices for workers with burnout according to the experiences of 25 OHC professionals.

Any evaluation of timely RTW should consider the readiness of the supervisor and the coworkers to provide support to the worker. Joint meetings were useful for providing the worker with the collaborative support of both the OHC professionals and the supervisor, and also for the OHC professionals to provide support to the supervisor. Thus, a lack of joint meetings had multi-dimensional consequences including

diminished support from the supervisor to the worker and diminished support from the OHC professionals to the supervisor. Because the coworkers were supported mainly via the supervisor, the support for the coworkers was also diminished in these cases. The varied practices used also to support recovery from burnout suggest that the RTW support for workers with burnout is unequal.

Methodological considerations

The conceptual RTW approach of Young et al. [19] was appropriate in our study as we found that RTW of workers with burnout in OHC proceeded similarly through off-work, work re-entry and maintenance phases. Future research findings might supplement these concepts in relation to the advancement phase.

To facilitate a broader understanding of OHC RTW practices, data were collected from various OHC organizations in different regions of Finland. We assumed that acceptable data saturation would be reached with 25 participants, as plenty of data was obtained through interviews and essays. Replication of data occurred, indicating an adequate sample size [24]. The sample was appropriate because participants were all qualified and experienced OHC professionals [24], and all discussed their work in relation to RTW for workers with burnout from their own professional viewpoint. Lack of measuring and diagnosing burnout may weaken the trustworthiness of this study; we cannot be sure if the descriptions were of workers with burnout or of workers with depression.

Individual and dyadic interviews might have produced more detailed, in-depth data from each participant when compared with the focus group interview due the longer time for each participant to contribute [26]. Individual interviews may have produced information that the participants were not willing to share with others [26]. The pairs of participants in the dyadic interviews, as well as the participants in the focus group interview, were close colleagues who volunteered to participate in the interview together. We cannot determine whether there was substantially less data produced through dyadic and focus group interviews compared with individual interviews. In addition, the participants were given the opportunity to describe their individual experiences through open-ended essays. On the other hand, the interaction in dyadic and focus group interviews might have produced a more complete picture of the OHC RTW practices when compared to the individual interviews [26].

Detailed reporting of the data preparation and organization and of the creation process of the results increases the trustworthiness of the study [29]. The majority of participants worked at employer-operated OHC centers, and therefore, the results may not be completely transferable to private OHC centers and municipal OHC centers.

Conclusions

Our study examined RTW practices for workers with burnout from the perspective of OHC professionals. We described the OHC RTW practices for workers with burnout and provided important insights into the potential for the development of common practice guidelines. Development of such guidelines appeared to be important for the OHC professionals managing RTW in order to provide equal RTW support for the workers on sick leave with burnout and to improve the possibility to RTW.

Disclosure statement

The authors report no conflicts of interest.

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