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Work Life and Mental Health, Employees' Perspective

Anita Krüger Leifson
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Anita Krüger Leifson

Supervisors:

Svein Bergvik

Eva Therese Næss

Hans-Christian Vangberg

PSY-3900

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Department of Psychology

The Arctic University of Norway

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Author: Anita Krüger Leifson

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Abstract

Minor mental disorders are widespread and may have significant consequences for the individual, their family and colleagues, as well as for the society (Mykletun & Knudsen, 2009). The purpose of this study was to examine the challenges and experiences employees with mental health problems have with maintaining employment. Hopefully, this will provide an increased understanding of how employees with mental health problems may be included and cared for at the workplace.

This was investigated by interviewing twelve employees from the age of 18 to 67 years, who had minor mental health problems to the extent that they received treatment from specialised health services. The informants were recruited by displaying posters in public places in Tromsø and by mail to patients at the Adult Psychiatric Outpatient Clinic in Tromsø, at the University Hospital of North Norway. Qualitative research interview as described by Kvale & Brinkmann (2009) was applied. Interpretative Phenomenological Analysis (Smith & Osborne, 2008) was used for analysing the results. The results were discussed in light of relevant literature, Norwegian laws and psychological theories. The identity as individual and employee is preferred to be sustained, the use of diagnoses and labels should be avoided in the workplace. It is important to consider the vulnerabilities that lie in the employees with mental health problems to be able to secure inclusiveness. Social support should be balanced to avoid disempowerment and to promote development and recovery. It is valuable to consider motivating and challenging aspects in the work environment to secure inclusiveness and care for employees with mental health problems. The employers are ascribed the responsibility to tend, respect and acknowledge their employees, the employees have a responsibility to notify sickness and lack of support. This is challenged by capacity and knowledge.

Forfatter: Anita Krüger Leifson

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Sammendrag

Lettere psykiske lidelser er utbredte, og kan ha betydelige konsekvenser for individ, familie, kollegaer, så vel som samfunnet (Mykletun & Knudsen, 2009). Formålet med denne studien var å undersøke utfordringer og erfaringer med å opprettholde arbeid hos personer som har lettere psykiske plager i den grad at de oppsøker og mottar behandling av spesialisthelsetjenesten. Dette ble gjort for å bidra til økt forståelse av hvordan psykisk syke ansatte bedre kan inkluderes og ivaretas på arbeidsplassen.

Dette ble undersøkt ved en intervjustudie av tolv arbeidstakere som har mottatt behandling for sine psykiske lidelser, og var i arbeidsalder 18 til 67 år. Deltakerne var rekruttert ved oppslag på offentlige steder i Tromsø og ved utsending av forespørsel til brukere ved Voksenpsykiatrisk Poliklinikk ved Universitetssykehuset i Nord-Norge. Det ble benyttet kvalitativt forskningsintervju, slik det er beskrevet av Kvale og brinkmann (2009). Fortolkende fenomenologisk analyse (Interpretative Phenomenological Analysis) (Smith & Osborne, 2008) ble brukt til analyse av resultatene. Resultatene ble diskutert i lys av relevant litteratur, Norges lover og psykologiske teorier. Det er ønskelig at identiteten som individ og arbeidstaker forsterkes, og at bruken av diagnoser og merkelapper unngås på arbeidsplassen. Det er viktig å ta hensyn til sårbarhetene og maktforholdet som arbeidstakere med psykiske helseproblem erfarer for å kunne sikre inkludering. Sosial støtte burde være balansert for å unngå umyndiggjørelse, og for å fremme utvikling og bedring. Det vil være verdifullt å ta hensyn til motiverende og utfordrende aspekt i arbeidsmiljøet for å bedre kunne sikre inkludering og ivaretakelse av arbeidstakere med mentale helseproblem. Arbeidsgiverne tillegges ansvaret for å tilrettelegge, vise respekt og erkjenne sine arbeidstakere, mens arbeidstakerne har et ansvar for å gi beskjed om sykdom og manglende støtte. Dette utfordres av kapasitet og kunnskap.

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I am very thankful for the opportunity to carry out this thesis about employees with mental health problems, as this is a personal interest of mine.

Anita Krüger Leifson. 04.05.2015

Preface

A few years ago, my mother brought to my attention the difficulties concerning employees with mental health problems at the workplace, and the necessity of inclusion. I am passionate about this subject and have always had a personal commitment to this thesis as I have relatives with mental health problems.

Attendance at the conference "Ung Identitet uten arbeid. Flere i arbeid, færre på trygd" organised by Jobb Aktiv in Oslo enriched and broadened my abilities to reflect on the informants' narratives in the present study. It was of great inspiration to attend the presentations of Arnstein Mykletun, Øystein Spjelkavik and other important contributors to the field of employees with mental health problems. I sincerely respect the employees who contribute to the work with training, placement and inclusion of applicants and employees with mental health problems. Employees from NAV and vocational rehabilitation enterprises from different counties of Norway who attended the conference were of immense inspiration, and I have sincere respect and gratitude for them as important resources for the work toward an inclusive work life.

The practical and empirical part of this study, such as design of research questions, conducting interviews, transcriptions, analysis, and writing was done by me. The supervisor Svein Bergvik at the Department of Psychology at the Arctic University of Norway supported selection of target group by deliberation of alternatives. He also accompanied me for the meeting at Adult Psychiatric Outpatient at the University Hospital of Northern Norway, and guided methodological aspects of the analytic process.

Svein Bergvik, Eva Therese Næss and Hans Christian Vangberg guided me in the consideration of relevant literature and questioned my findings and reflections in important ways.

Anita Krüger Leifson
Master Student

Svein Bergvik, PhD
Supervisor

Eva Therese Næss
Supervisor

Hans Christian Vangberg, PhD
Supervisor

TABLE OF CONTENTS

Work Life and Mental Health, Employee's Perspective
- **Prevalence**
- **Work and Mental Health**
- **Employment as a Challenge**
- **The Norwegian Health Care System**

Method
- **Recruitment**
- **Ethics**
- **Informants**
- **Interview Procedure**
- **Analysis Method**

Results
- **Identity**
  - **The individual identity**
  - **The patient identity**
  - **The employee identity**
  - **Identity summarised**
- **Social Vulnerability**
  - **Openness**
  - **Power relations**
  - **Others with mental health problems**
  - **Boundaries**
  - **Social Vulnerability summarised**
- **Social Support**
  - **Family, friends and others**
  - **Support from health care services**
  - **Social support in aspects of work**
  - **Lack of support**
  - **Social support summarised**
- **Work Environment**
  - **Care**
  - **Arenas for openness at the workplace**

Challenging Environments
Motivating aspects in the work environment
Work environment summarised
Discussion
Identity
Identities are affected by others
Identities change
Vulnerability
Concerns of openness and stigma
Concerns of stigma when applying for work
Others with mental health problems understand
Social Support
Psychologist treatment of mental health problems
The general practitioners treatment of mental health problem
Care at the university
Social grouping as a result of restricted openness
Work Environment
IA-agreement
The use of “dialogmøte”
Flexibility from the employer
Limitations of the Present Study
Conclusion
References
Appendix A
Appendix B
Appendix C
Appendix D
Appendix E
Appendix F
Appendix G
Appendix H
Appendix I

Work Life and Mental Health, Employee's Perspective

Prevalence

Disorders related to anxiety, depression and drug abuse are among the most common mental health problems in Norway, and occur in a third of adults each year. Mental health problems are regarded as mental illness and mental disorders, and vary from minor to major severity. Depression is in example highly prevalent and recurrent (Cuijpers, Boluijt & Van Straten, 2008; Thapar, Collishaw, Potter & Thapar, 2010), 30 per cent of the population are found to have clinical relevant depressive symptoms that are not meeting the criteria for major severity (Sund, Larsson, & Wichstrom, 2011). Minor mental health problems are defined as mild to moderate disorders and are highly prevalent in the general population, major mental health problems as bipolar disorder and schizophrenia have lower occurrence (Mykletun & Knudsen, 2009). Mental health problems are the second leading cause of sick leave in Norway (Sundell, 2012), and can result in increased levels of sick leave, disability, risk of developing other diseases and mortality. These therefore represents major personal and societal burden (Mykletun & Knudsen, 2009).

Mental health problems are often seen as a barrier to work, and many with mental health problems are therefore unemployed as a result of difficulties in retaining or obtaining employment. After a short absence, 76 per cent of employees with mental health problems return to their occupation, while 8 per cent enter long-term sick leave (Dewa et al., 2012). There are differences in length and number of absence periods. Employees with mental health problems are seven times more likely to experience subsequent sick leave compared to people without previous disability, whilst people with other diseases are twice as likely (Dewa, Chau & Dermer, 2009). Mental health problems are the cause of one third of disability pensions in Norway (Norwegian Institute of Public Health, 2014), and are mentioned as a cause for women's sick leave more often than that of men, although the distribution of gender varies by diagnosis. In 2000-2003, the average age for people on disability benefit with mental health problems was 46 years, and 20 years of work were estimated lost by these (Mykletun & Knudsen, 2009). Despite high numbers of sick leave and disability benefit, studies of people with mental health problems state that 60-70 per cent aspire to work (NAV, 2015).

Work and Mental Health

Work can provide health benefits through increased sense of coping and belonging by positive feedback, activity, and structure in everyday life, as well as economical income (Mykletun & Knudsen, 2009; Helsedirektoratet, 2011a). Work is healthy for the individual because it provides a social life with focus on the person as something more than a patient (Davidson et al., 2005). Work can be meaningful by contributing to development of identity and social legitimacy. To contribute to something meaningful and participate in the community is valuable for the motivation to work (Fryers, 2006). Participating in everyday life and work can contribute to recovery, well-being, self-confidence and social abilities (Anthony & Farkas, 2009; Borg & Topor, 2007). Work can therefore have preventive effects for mental disorders and is recommended as part of rehabilitation from mental health problems (Mykletun & Knudsen, 2009; Helsedirektoratet, 2011a).

Work environment that is characterized by clear organisational structures, little administrative implications of the work process, fair reward system, and trust and care for employees, are associated with better mental health (Gavin, 1975). Peters & Brown (2009) found that focus on mental health at work was important for perceived care, and individuals with mental health problems sought treatment even easier if they felt well treated at work. Moderate job requirements and increased social support from colleagues and superiors leads to higher perceived work related quality of life (Flores et al., 2011). Support from both colleagues and managers, perceived control over tasks and follow-up management are important factors for work to be perceived as positive, this is concluded by a literature study from The National Institute of Occupational Health (2011). Conversely, lack of social support at work can be a risk factor for mental health (Sanne et al., 2005). Some mental health problems can affect efficiency, reduce concentration levels, and make it difficult to complete tasks. This can lead to feelings of guilt and reduced self-esteem (Rådet for psykisk helse, 2004). Diversified ability to work when you are depressed and anxious is related to symptoms, work tasks, social life outside and at work, and other aspects in the work environment (Bertilsson, et al., 2013).

Rugli et al., (2013) found that three of the twelve symptoms indicating depression are predictors for long-term sickness absence among female employees within elderly care. These symptoms are; feeling sad, lack of energy and strength, and difficulties sleeping at night. Early identification and treatment of people with these symptoms may contribute to prevention of long-term absence. Hensing et al., (2013) found that persistent mental health

problems and low well-being increased the probability of late return to work after sick leave. They also found that the disease leading to sick leave might have been intensified by the absence period (Hensing et al., 2013). Preventing relapse can be targeted through initiatives (Dewa, Chau & Dermer, 2009). Absence from work can result in anxiety reactions related to work. Such reactions can disable adequate functions and is described as ergophobia by some (Dewa et al., 2013). General practitioners are more likely to consider work capacity as more impaired than the patient does in cases of mental health problems, although it is recommended that work should be considered as part of the rehabilitation process as a preventive measure (Helsedirektoratet, 2011a).

Unemployment can contribute to mental health problems caused by concerns related to economy and socioeconomic position (Mykletun & Knudsen, 2009). People with mental health problems might end up in a vicious circle, where unemployment can increase the risk of progressing the mental health problems and impair improvement (Dewa et al., 2013). Preventive measures by removing risk factors or implementing aid might decrease negative effects of the crisis that have already occurred (Espnes & Smedslund, 2009). As work is good for mental health there is reason to believe that employment can have a preventive function for mental health problems (Mykletun & Knudsen, 2009).

Positive and negative emotions in one aspect of life can affect other aspects, job satisfaction and general mental health are for example positively associated (Wiener, Vardi and Muczyk, 1981). People with psychological distress reported lower levels of job satisfaction (Lee, Lee, Liao & Chiang, 2009). Positive work-related attitudes have been found to contribute to mental health, more than individual and situational variables (Wiener, Vardi, & Muczyk, 1981). This is also supported by Lee, Lee, Liao & Chiang (2009) who found that mental health was strongly related to attitude variables such as work and career satisfaction, and to a lesser extent the individual variables like need for achievement. Other studies point out that positive perceptions about career achievements are important parts of the person's self-esteem, and there is a broad consensus that self-esteem is an indicator of mental health (Hall, 1976). Situational variables such as job characteristics, leadership style, and payroll related strongly to stance variables. They may have important practical effects on mental health through their influence on attitude variables (Wiener, Vardi, & Muczyk, 1981).

Employment as a Challenge

Various aspects of work may increase the risk of mental health, such as stress caused by high effort with low wages, overtime, changing working hours or the like. Employees in high or medium status work with low work security are at greater risk of poor mental health than employees in positions of lower status (Dewa et al., 2013). Changes in the organisation can affect the physical and mental health negatively, but such effects are preventable (Falkenberg et al., 2013). Occupations with greater risk where employees are exposed to psychosocial reactions and traumatic events, or conflicts with other employees at work, are elements of risks that are important to address in order to prevent adverse health effects such as mental health problems. These risk factors should encourage employers to take action and arrange team building (Dewa et al., 2013).

Work can be demanding for individuals with mental health problems and might result in deterioration or resignation. Mental health problems can lead to challenges maintaining work because of its negative impact on working capacity and longer periods of absence than people with other disorders (Mykletun & Knudsen, 2009). Mental health may affect work performance and interpersonal communication, and thus have negative impact on the security and quality of the service provided. A survey of medical laboratory personnel revealed that errors occur more frequently when the worker has poor attention (Lee, Lee, Liao & Chiang, 2009). Reduced mental health is associated with lower chance of being employed, whilst active coping and good work are more typical for those with good mental health (Vijfeijke et al., 2013). Psychological distress influences quality of life and psychosocial competence. It also affects productivity and quality of work (Lee, Lee, Liao & Chiang, 2009). Mental health problems, having a history of sick leave because of mental health problems, lack of support from colleagues and superiors, and perceived job insecurity are risk factors for dismissal while on sick leave (Flach, Groothoff & Bültmann, 2013).

Reduced ability to work due to mental health problems may sometimes be difficult to see. The rehabilitation process can be improved by utilizing knowledge of the difficulties employees with mental health problems may experience at work, and other consequences the health problems might convey (Bertilsson, et al., 2013). By better understanding the work-related risk factors, initiatives to prevent unwanted development and disorders can be implemented more easily (Dewa et al., 2013; Flach, Groothoff & Bültmann, 2013).

As previously pointed out, being employed has benefits for several aspects of the mental health, given proper workplace contributions in sense of empowerment, support,

perceived control and monitoring among others (The National Institute of Occupational Health, 2011). Lack of these factors may cause the work to have a negative effect (Mykletun & Knudsen, 2009). Employees' own perception of their situation seems to be a recurrent central factor in the relationship between mental health and work. Research and initiatives largely focus on practical and organisational matters, it is important to consider the employees' own experiences and perceptions in this field. Spjelkavik, Hagen & Härkäpää (2011) found that people with mental health problems hesitate to apply for work caused by fear that are related to deterioration of their mental health problems. Their informants had anticipations of feeling defeated, underachievement, being stigmatised in the employment process or at work, and loosing pensions. They also stated motivation and self-confidence as important for the ability to work, together with belief in their own work capacity. Most importantly, the ability to work relies on the quality of support because that is where the challenges lie. Quantitative research shows the consensus of this (Corrigan & MacCracken, 2005; Hand & Tryssenaar, 2006; Robinson et al., 2011). Anvik & Gustavsen (2012) found that poor working and supervision, stress, and high standards of knowledge are experienced as particularly challenging for the workday to be perceived as positive for young individuals with mental health problems. This is confirmed by Graneruds report (2004) in which participants with mental health problems specified that lack of social integration in everyday life could be improved through work. Participants experienced work positively because the employees felt resourceful, experienced participation in society, and felt less lonely. This study aim to obtain knowledge about the challenges and experiences of employees with mental health problems. Hopefully, this will contribute to improve our understanding of how to care for and include employees with mental health problems at the workplace.

The Norwegian Health Care System

The health care system in Norway is semi-decentralised. The municipalities are responsible for primary care, while the responsibility for specialist care lies with the national government. The waiting lists for elective care is a prolonged debated issue, even though Norway has a high number of health care personnel per inhabitant compared to other countries in the EU. Norway has a relatively high rate of physicians per inhabitant, but in spite of that there are still problems with giving immediate health care in all areas. Of the OECD countries, Norway has the highest rate of sick leave among full time employees (Ringard, Sagan, Saunes & Lindahl, 2013).

The Norwegian Labour and Welfare Administration (NAV) (previously New Labour and Welfare administration) deals with unemployment benefit, work assessment allowance, sickness benefit, pensions, cash-for-care benefit, child benefit and are responsible for activities within the labour market. One third of the state budget is administered by NAV to different services (Berg, 2014).

The Inclusive Workplace Agreement (IA-agreement) has been made through recursive collaboration between the government and central work related organisations in Norway since 2001. This is done to prevent drop-out from work life, has shown to reduce absence, prolong the employees' years of work life, and aim to both employ and keep disabled employed. The workplace is the most important arena for inclusive work life. The intention of the agreement is for the employee representative, employees and employers to set goals. It is also intended for the authorities to help them with initiatives to reach these goals, with the aim of improving inclusive work life. The IA-agreement shows that the responsibility to handle employees on sick leave not only lies with the health care services. Companies that have signed the IA-agreement are obliged to contribute in the areas described in the agreement (IA-avtalen, 2014).

“Raskere tilbake” (faster return) is organised by NAV and specialist health care services in each county. The purpose of the service is to get employees to return faster to work, and the service is offered to employees within the age group 18 to 62 years. It requires the employer to make a follow-up plan and to report the initiatives they have put into effect to alleviate the employees' afflictions. “Raskere tilbake” is a work-oriented initiative that was agreed upon by “Sykefraværsutvalget” (the Sick Leave Committee) in 2006 and is included in the IA-agreement. The state budget includes funds reserved to this service, and the continuation of “Raskere tilbake” is assessed annually (NAV, 2014a).

A “dialogmøte” (dialogue meeting) is a meeting where the employee with health problems meets the employers’ representatives, NAV, the employees’ representatives, and the general practitioner. The general practitioner is not necessarily obliged to meet. The possibility for care at the workplace in accordance to the employee’s health problems are discussed in these meetings. The “dialogmøte” aim to get the employee to return to work as fast as possible. The employers are obliged to arrange the first “dialogmøte” after seven weeks of sick leave. NAV is responsible for arranging the second and third meeting if long-term sick leave occurs (Arbeidstilsynet, 2015a; Helsedirektoratet, 2011c).

Method

Recruitment

The aim was to recruit twelve to fifteen employees to the study, preferably those who received the treatment in Adult Psychiatric Outpatients Clinic at the University Hospital of North Norway. The criteria for recruitment was limited to informants between the age of 18-67 years with minor mental health problems. There could be employees from both the public and private sectors (not reported), and from different professions.

After a meeting with the Adult Psychiatric Outpatient clinic in Tromsø at the University Hospital of North Norway it was agreed upon to recruit patients receiving the treatment program "Raskere tilbake". The informants were recruited by mail to patients at Adult Psychiatric Outpatient clinic in Tromsø at the University Hospital of North Norway (see appendix A). The inquiry was sent together with the notice letter for therapy treatment. Counsellors in "Raskere tilbake" received a letter with information about the content of the study (see appendix B).

Posters were placed in public areas in Tromsø to attain informants (see appendix C); all of the general practitioner offices at Tromsøya, Adult Psychiatric Outpatient Clinic waiting room, four company health services, in different institutes at The Arctic University of Norway, City Library, Fontenehuset, St. Elisabeth Health House (all sections), Senter for Jobbmestring, Stamina Fitness Centre, Aleris Hospital, Austadbygget Nord. E-mails were sent to employers at NAV and Tromsø municipality. The inquiry was posted in groups on Facebook; Mental Helse Tromsø, Outpatient clinic treating substance use in Tromsø, and different student groups. Several other public organisations were asked to take part, but they declined.

Those who wished to participate contacted us by telephone or email to arrange a time and a place for the interview. It was assumed that the interviews would be conducted at the University of Tromsø - Norway's Arctic University, but in special circumstances the interviews could be held at Adult Psychiatric Outpatients or at the informants home. An informed consent statement was reviewed and signed in the beginning of the interview (see appendix D and E).

It was desirable that the informants were employees of IA-companies, although this was not mentioned in the inquiry. The IA-agreement and the Norwegian law were of interest for the present study because these contain requirements for both the employer and the employee regarding mental health in the workplace (Arbeids- og velferdsdirektoratet, 2012).

Ethics

Applications for approval were sent to Regional Committees for Medical and Health Research Ethics, Region North (REK) and Data Protection Official for Research before the study was commenced. There was no need for notification according to the evaluation from REK. It was recommended that the Data Protection Official for Research was applied (see appendix F, under "Framleggingsplikt" and "Godkjenning fra andre instanser"). The Data Protection Official for Research requested an informed consent to be signed (see appendix G for request and H for consent).

The handling and storage of data were attended as follows. Interviewers own thoughts and impressions were noted immediately after the interview to maintain corporeal idiom, but not much rendered. All the interviews were audio taped to get more details of the informants' own words and descriptions, and to be more attentive in the conversations. The recordings were stored, properly locked and used for transcription and analysis. Only the researcher and the supervisor had access to the recordings and they were only used for the present study. When the thesis is submitted and evaluated, the recordings will be deleted. Transcribed text did not contain identifiable information, and all informants were described with fictitious names. Other identifiers such as corporate names or descriptions that may help to identification were amended and made anonymous.

Table 1

INFORMANT	AGE	POSITION	TYPE OF COMPANY	IA OR NOT	HEALTH AFFLICTIONS	RECOVERY STATUS
1 MARIA	40-50	Senior consultant	Transportation	IA	Symphysiolysis Depression	In therapy, first round
2 DAVID	40-50	Researcher	Public services	IA	Arthritis Burned-out	In therapy, first round
3 ANNA	20-30	Student and part-time worker	Grocery store	Do not know	Depression	In therapy, relapse
4 SARAH	20-30	Nurse	Health services	IA	Bipolar	In therapy, relapse
5 TOM	50-60	Economic advisor	Public services	IA	Next of kin with personal experience of anxiety	Not in therapy
6 EMMA	40-50	Secretary	Public services	IA	PTSD Chronic depression	In therapy, chronic
7 ELISABETH	40-50	Student Former: Industrial consultant	Service	Not (abroad)	Depression	Completed therapy, first round
8 CHRISTINE	30-40	Social worker	Health services	IA	Depression Self-harming Suicidal	Completed therapy, relapse
9 CAROLINE	20-30	Student and supply teacher Former: Assistant	Education Former: Health services	Do not know	Anorexia Anxiety Bipolar Self-harming	Completed therapy, relapse
10 JULIA	20-30	Student Former: 1. Administrative 2. Sale	1. Charity 2. Cafe	Do not know	PTSD Anxiety Depression Sexual abuse	Completed therapy, relapse
11 VERONICA	20-30	Student and part-time worker	Clothes shop	Do not know	Anxiety	In therapy, first round
12 MARTHA	20-30	Hairdresser	Cosmetics	Do not know	Depression	In therapy, relapse

The names in this study are fictitious.

Informants

Twelve informants were interviewed, ten of which took place in a private room at The Arctic University of Norway. Maria wanted to be interviewed at home due to physical pain, and Emma was interviewed at "Senter for Jobbmestring". Two of the informants were men (David and Tom).

The aim was to recruit employees with minor mental health problems because the informants had to convey their experiences and challenges without a distorted perception of reality. The informants took initiative to participate and therefore evaluated themselves within the inclusion criteria as having minor mental health problems. The informants were not asked directly about their diagnoses or stage of recovery, they mentioned their diagnoses and recovery process in subordinate clauses. Their health afflictions and recovery status should therefore be treated only as an indication of their mental health problems. Tom was next of kin but experienced mental health problems as a result of having a wife with mental health problems. All interviews were relevant to the study and were therefore included.

A few of the informants phoned prior to the interview to clarify contents of the study regarding confidentiality and anonymity. One informant withdrew her participation before the interview was conducted. The meeting never took place. The response on the inquiries and posters were low, all informants that volunteered were included in the study. The informants expressed that participation was important to them because they hoped it might enhance the situation for others with mental health problems. Social involvement was also mentioned as a reason.

Interview Procedure

The main objective of the present study was to learn about employees' experiences of having mental health problems and how this is handled in relation to the workplace. This was examined by qualitative in-depth interviews, with broad and open-formed questions. The purpose was to detect individual experiences in relation to the topic in detail and the approach in the interviews was based on the work of Kvale & Brinkmann (2009). The design of the questions was based on themes and findings described by Dyrstad, Mandal & Ose (2014), Anvik & Gustavsen (2012), and Bertilsson et al (2013). An interview guide was used, the interviews were semi-structured and slanted towards the employee's challenges and point of view on the themes. Questions and topics followed the conversation, with the emphasis on following up the informant's descriptions of topics and issues. The informants were

encouraged to freely express their views, influence the conversation and partly have impact on the focus of the interview.

The supervisor approved the questions and themes. The interview was angled towards the employee's experiences and thoughts on the theme, but also included themes that were believed to be important such as the feeling of inclusion and experiences as employees with mental health problems. The questions that were asked included the following (see appendix I):

- I would like to hear about what it is like for you to be at work when you have the mental afflictions that you have, could you tell me a little about that?
- How do you feel your employer have handled your situation?
- Can you tell me something about how you feel inclusion have been for you at work?
- What are your thoughts about openness regarding mental health?
- What are your experiences with health care services?
- What are your thoughts for the future?

Follow-up questions were asked frequently as the informants told their experiences. The researcher had previous experience with qualitative interviews and the first interview was used as a pilot study. The information from this interview was sustained and was therefore included in the present study. Each informant was interviewed once, the duration of the interviews were in average 1,5 hour. Each interview was given focus for full in-depth engagement.

Analysis Method

Interpretative phenomenological analysis (IPA) as described by Smith & Osborne (2008) was used. This approach seeks to understand the informants' perspective and understand how they perceive certain situations, in this case how it is to be an employee with mental health problems. The use of phenomenological analysis is widely used (Malterud, 2001 A; Malterud, 2001 B) in medical and health care research and IPA has especially become popular in health psychology (Brocki & Wearden, 2006). Selected parts that proved to be essential through the analysis were transcribed. Transcriptions were written in near verbal form and reproduced as accurately as possible. Emma did not approve of audiotaping, her interview was documented by taking notes near verbal form. Emma approved and supplied the transcripts from her interview by email. A meaningful interpretation was made,

analysing underlying attitudes and opinions of what was said openly in the interviews. The interpretation was obviously influenced by the researchers' background, experience and knowledge, in an attempt to convey what the informants tried to say. Informants were offered to review the final thesis after publication. All of them accepted the offer.

The analytical process was built on phenomenological analysis by Smith & Osborne (2008) in the following steps: recordings of the interviews were heard several times, topics that interviewees emphasised and which arose was listed in chronological occurrence. Similarities, conformity, differences and contradictions between the themes were compared. It was also sought for possible underlying explanations of the themes. The categories were strengthened by examples, and weak themes were excluded. The categories were developed on the basis of transcription analysis and the information that was prominently emphasised as important by the informants. This part was conducted for each interview separately. Once all interviews were completed, it was searched for similarities and new aspects between the themes and across the different interviews. Sections of information were marked during the analysis as a form of coding. After the most recursive categories were identified, the theme-categories were constructed and named. After all the information from the interviews was reviewed in detail, patterns, main categories, and an overall impression of the categories became present. All of the interviews were heard once more to search for new levels of categories. The categories were then supplied with explanations, illustrations and nuances. Fragments as sentences, and also single paragraphs with statements that illustrate examples were used (Smith & Osborne, 2008).

NVivo 8 (QSR, 2008) (a computer-assisted qualitative data analysis software program) was used to organise the unstructured data, and to execute deep analysis in the first rounds. NVivo 8 (QSR, 2008) liberated more time to do the analysis thoroughly by making orientation easier. In addition to the technical analysis, a manually analysis on paper was also performed. The use of different analysis tools has stimulated an inductive and dynamic interpretation process (Nilssen, 2012 and QSR, 2008). The supervisor also took part in the analysis by reading through the interview transcriptions. Selections, emphasis and interpretations of the themes were discussed in several rounds with the supervisor before final themes and categories were decided.

A theoretical generalisation was carried out by discussion of the results where previous research, the constraints from the Norwegian law, and psychological models were taken into consideration. The psychological models considered were identities and self, role conflicts, false consensus, and social grouping.

Results

Some of the participants had difficulties with placing memories in chronological order, or retrieving memories from certain periods at all. The informants were eager to tell their stories; it often took a while until the second question was asked.

The informants talked about others with similar problems using terms of diagnosis. They underlined the importance of having a diagnosis, not being their diagnosis. They spoke of it as psychic components, psychic problems, and psychic health. Preferably, they used terms like mental health problems or challenges mentally. They did not fancy the use of the term mentally ill because it made them feel vulnerable, although they sometimes used it themselves in their statements.

Categories were found by evaluation, scrutiny analysis of the ample transcriptions, and decided after deliberation with the supervisor. These categories embrace some themes that might overlap. The categories are created as an attempt to summarise the wide range of topics that were accentuated as important by the informants. The four categories were *identity, vulnerability, social support* and *work environment.* The different roles the employees with mental health problems experienced are described in the first category, identity. The second category, vulnerability, regards the thoughts and concerns they had before they dared to accept receiving help or support. In the category social support it is emphasised the informants need for and wish for social support to be improved, and suggestions for how this can be applied. In the category work environment, the challenges and motivating aspects the informants experienced in their work environments are described. These categories reflect the different aspects that the informants emphasised as important to improve inclusiveness and care for employees with mental health problems in the work life.

Identity

The informants had a prominent focus upon identity feeling. The identities were described to vary between their role as an individual, employee, and patient. The informants used words like work identity and patient identity. David, Martha and Tom did not have as strong focus on identity as the other informants. The identities were affected by others and were not always chosen. Their identities were challenged by changes. Both work identity and personal identity were expressed as wished for and needed. The patient identity was accentuated as forced upon them.

The individual identity. This sub-category is mostly based upon the informants' need to separate themselves from their mental health problems. The informants expressed a struggle to keep their identity through the themes of this sub-category; normality, changes in themselves, others perception of them, a fight to remain themselves, and acceptance of the mental health problems.

The informants used the word normal a lot. They saw themselves as normal, and wanted to be seen as normal. Being normal was highly accentuated by Sarah.

Sarah: You can have a bad mental health and still function as normal in work life, in community, as friends and as the different roles one have (...). I want everyone to see me as the one I am daily, not she who is ill. I want to be perceived as normal, because I dear to allege that I am normal.

They stressed the importance of being able to do the same things as others. Some also pointed out a change in their own behaviour caused by diagnoses that they did not see as part of themselves. Abnormal changes in behaviour from their normal self. Others did not see the change, or at least did not notice them to be warning signs. This might be due to the informants being at different stages in the recovery process (see table 1).

The informants experienced changes in how others saw them after they were open about their diagnoses. As if they became a different person than they were just a minute ago, before the other person knew about the diagnosis. How others saw them made them feel forced into a new role different from the role they used to have. The informants were aware of how other people affected their perception of themselves, their identity or role. Based on their own experiences of how they had been met before, but also by their own stigmas, they developed a fear of others changing their perception of them. This fear sometimes obstructed openness. Those who felt changes, that in retrospect could have been signs of becoming ill, kept on going and tried to defeat the symptoms. They tried to analyse the symptoms because it was hard to know if the signs of mental health problems was just for a period, if the symptoms they noticed were worse for them as an individual than for others, or if they just handled it in a worse way. They explained it as a feeling of loosing themselves to their mental health problems.

The informants expressed a longing for their old self. They had a wish to become the person they were before and to have the capacity they used to have. In that way they acknowledged that the changes were a fact. They described it as a struggle with accepting

their mental health problems, but also a fight to remain themselves. They expressed that it was hard to have mental health problems and well at the same time, and to find back to that resourceful person that they once were. Several of the informants accentuated a fight to take back their identity and their human worth, demanding to be treated well, and to maintain their spare time interests. They highlighted an existential crisis, a striving to find their own identity that was separated from their mental health problems. For some, this required a big change in life e.g. change of work or getting rid of bad friendships. To find themselves was expressed as hard and long lasting. Elisabeth spent two years until she found herself again after what she called her breakdown. Some fought to find themselves, others accepted that things would never be the same, and a few did not mention this struggle at all. Some of those who could speak of the mental health problems more in retrospective felt they knew themselves better after than before the mental health problems occurred.

Veronica: One get very very well acquainted with oneself when, both when trying to cope with that kind of problem on your own, but also when you actually go into treatment because then you have. You learn a lot about what you want from yourself and what you want with your life, and what is important and what is less important, and what is unhealthy for you. So I think absolutely that, I am much more aware now of what I want in my life and do not focus on which goals I want to work towards and such, yes.

Some of the informants mentioned to have gained a belief in themselves to be competent and to have a good work life. They also described limits they now see as a part of themselves, limits that had to be considered to prevent relapse (elaborated in the vulnerability category regarding boundaries). It was important that it was they who decided the limits of what could be done and not. Personality traits that were positive and negative were declared as part of their personal identity. The traits from the patient role were however not seen as part of them, those traits had become part of their vulnerability but not as a personality trait.

The patient identity. The patient identity was also described by changes, and will further on be elaborated in this sub-category by the informant's struggle against the mental health problems. They mentioned contributing factors to the patient identity, and spoke of the abnormal to be accepted as normal. This sub-category will also contain the informants' experiences with excessive acceptance, and confusions about what are themselves and what are symptoms. This sub-category will be completed by mentioning the contributors that were

described as important for enhancing their individual identity and for letting go of the patient identity.

The informants spoke of changes in their reaction patterns, manners and functions while having mental health problems. The changes varied in description and of diagnosis; Exhausted, slow functions, low energy, reduced attention, reduced concentration, poor memory, fatigue, sleep a lot or sleeplessness, overtiredness, extreme need for rest, stress, reduced self-efficacy, unhealthy personal life e.g. excessive sex and alcohol intake, deadlock, easily emotional or ambivalence. The informants expressed that the changes affected work and created insecurity about own reactions in public places. Several informants mentioned that they did not want to make a fool of themselves.

They accentuated that they did not see or accept the mental health problems when they became ill. Some felt that the diagnoses were thrown at them. Veronica said that when she received the depression diagnosis, it was harder to handle than the anxiety diagnosis, because the depression diagnosis was unforeseen. Even after they had been given their diagnosis they would not accept it. The diagnosis was not something they wanted to be identified with, but they could not resist when it became too much to handle. They did not have more energy or faith left to continue fighting against it.

Christine: At one point I had come to stage where I really identified myself with the diagnosis, the personality disorder and patient role. So I have done an enormous amount of resistance against actually wanting it, but it still came. A bit like self-fulfilling prophecy then, because there were situations I felt completely helpless and perplexed.

The mental health problems became too much to handle, the informants emphasised several factors that contributed to forcing the patient identity on them. Veronica reasoned the patient identity by her solitary coping with her mental health problems and by having a lot of thoughts and concerns about her health problems. Being alone with the mental health problems made the patient identity insistent. Several of the informants experienced that when they tried to sharpen up and fight their mental health problems, their condition worsened.

The relation to their family and sometimes friends also changed, they became what the informants mentioned as care assistants (elaborated in the social support category). This reinforced the patient role. It was hard for them to be themselves entirely when they were put in a new role. The role as a patient was expressed as increased when they were among friends and family. At work it was easier to only open up to a limited group of people so that they did

not risk being considered as anything else than themselves. It was a good arena to be kept away from the patient role and to be met on the same premises as others. The psychologists (in institutions as well as private psychologists) were mentioned as good support in the work of the informants finding themselves and what was important to them. Although they also strongly expressed a hope for this support to be more emphasised in the treatment to magnify their individual identity. Caroline mentioned that the nurses forced the patient identity on her by explaining her actions by symptoms.

Some of the informants expressed the changes to be easier later in the recovery progress, and spoke of the changes as expected to be persistent. Emma was the only informant who had been in therapy over decades and expressed that the abnormalities had become normal for her. The informants said that they finally saw themselves as healthy, but with many challenges to consider. They talked about acceptance of the changes:

Julia: I must still live with not having the energy level that I used to have. And it is something I try to adjust to almost every day. Because it is difficult, even if it is a long time since I was ill, there are many times I have burned myself by taking on too much. Things that I earlier knew that I could have managed, but today, I have a completely different energy level. I have a completely different threshold for noise, and for stress. I notice it right away if I get very stressed, but I have been very good at calming down and not to stress. If I get stressed, I have become much better at just lowering my shoulders and relax. So for the future, I think I just have to keep doing the same, and then I just have to accept that I am never going to get to where I was before I got ill.

Caroline specified that the patient identity had been taken too far in the community as an excessive acceptance. She referred to diagnoses that are more spoken of like ADHD (Attention Deficit Hyperactivity Disorder). In her view, a lot of people define themselves through their diagnosis and use the diagnosis as an excuse for inhibited behaviour. Blaming their behaviour on the diagnosis. The informants stressed that they might have accepted the mental health problems, but that they are not their diagnosis.

The diagnoses were seen as vulnerabilities in the individual as a person, but not something that defined them. They had experiences with personality traits being mistaken for symptoms. The informants themselves felt that it sometimes was difficult to know what aspects of them self were the mental health problems, and what was part of their personality. It was hard to know if they reacted by their symptoms or by their genuine attitudes and

feelings as a person. For example if they became angry, it was difficult to know if they became angry because of high symptom pressure or because they had attitudes towards that specific subject that enforced these feelings of anger.

According to the informants, the questions about feelings as a person and feelings caused by symptoms would be hard to find an answer to without therapy. The informants themselves also contributed to letting go of the patient identity. Caroline retrieved her identity when she stopped referring to her feelings as something sick. Instead of feeling anxious she referred to it as feeling worried or afraid. She said that she demanded her feelings back as a part of herself as a human being and not as a mental illness. Work was maybe the most important contributor to retaining their identity as something else than a patient.

Even though they mentioned to have accepted the mental health problems and accepted possible changes, they still had concerns of relapse and about the vulnerability they described to be within them. That they somewhere had certain features and sides that made them vulnerable for pressure or for that certain diagnose.

Elisabeth: But it's very scary, that is what I am thinking. It is a little scary when you first have been there (been ill). Although I do feel like myself again today, and think about these things as more of a resource rather than as something negative. Then, I am very anxious as well, to go back there again. And that is a little scary because I cannot run away from myself. So, I do have some features and sides somewhere that I should be aware of.

The employee identity. The sub-category employee as an identity was described through positive aspects of being employee, the use of diagnoses, incompatible values between identities, and loss or lack of employment.

The informants mostly spoke of work as desired and showed motivation to work in many various ways. The informants saw work identity as important because the mental health problems was more forgotten when they were at work. It was therefore important that the employer considered them as more than just their mental health problems or diagnoses, and encouraged their worth as an employee as well as an individual. According to the informants, the employer and the psychologist have a responsibility to secure this and to be active in uplifting their identity as something more than a patient.

Christine: For me at least, it have been more important to experience to be useful for others, more than others to be useful for me. Because after being a patient, one often become. Even though one is meant to have involvement and things like that, and you have to be the captain of your own ship and all of that. It becomes so much take-take-take-take-take. I was ill and tired of it at one point! I had to be allowed to give something back (...) I receive a lot by having a job I enjoy, a job where I can feel that I get to use my qualities and to be challenged in a way that makes it fun.

They emphasised that the use of diagnoses only were meant for the psychiatry and not for the employers. That way they expressed a wish to keep the patient identity out of the workplace. The informants justified this by diagnosis being an instrument, which needs six years of education to be rightfully used. It was mentioned that the diagnoses belong on the paper to the psychologist, psychiatrist or NAV employees who takes care of the patient and their mental health problems. The diagnoses were underlined to not be used at school, university or at work because it is a part of a toolkit.

Caroline: It is not a tool to be used. Just like a scalpel is a tool for a surgeon, but it is not, the patient does not take the scalpel out of the operating room to wave it around. Dangerous-dangerous, right. You don't. It is a specialised instrument for a surgeon (...). A psychiatric diagnosis is in the same way, in fact, an instrument that is made for the therapist and the health care system. It is not there to describe anything about me. It's not about me at all! It's about my illness.

The diagnoses have to be taken into consideration at the workplace as vulnerabilities and not as diagnoses. According to the informants, the vulnerabilities that were caused by the health problems should be taken into consideration without focusing on the patient role. The informants wanted a dialog between the employer and themselves as employees, to talk about symptoms, limits and care instead of label tags and diagnoses. That way they might avoid stigma and wrong assumptions. The informants expressed a strong wish for the employers, psychologists, psychiatry and other health services to encourage the employee to this conversation as a gesture of support. The informants thought people should continue bringing all the parts of themselves as human beings to work, and be honest about everyone being emotionally conditioned humans.

One mentioned downside of work was that when the values in their work were incompatible with their own, it felt like a threat to their identity. Elisabeth discovered a change in her behaviour by adapting to strategies to perform good at work. This made her scared of losing her own values and identity. Maria was bullied for her work role and responsibilities at work and not as a person, even though it was taken personally in the end. The informants expressed an existential crisis as a result of struggles with change of behaviour and incompatible values.

The problems occurred when the work identity was lost by unemployment. The feeling of not being able or allowed to go to work, university, or to do daily activities like others do, made their situation worse. Informants expressed that when they were not participating in the community, important aspects of them as a person tended to disappear. The informants explained this partly with their identity being built on the interaction with others and that the varieties in the workdays developed and stimulated their identity feeling. The informants were afraid to be economically dependent on their family (as some of them had been), to lose themselves by becoming dependant of others. To be employed was important for retaining their identity as a person and as an economically independent individual. They also pointed out that it was hard to retrieve a work identity when they had been out of work life, even though it was just for a couple of years. The patient identity had then taken over their life and it was hard to retrieve their personal identity or work identity. Together with the loss or lack of work, they also lost the possibility to participate in the community, social interaction and economic independency.

Martha: To go unemployed or not knowing what you want to be is the most boring thing there is. Because it has often been a problem previously, that I had no idea what I wanted to be. I had like absolutely no ideas, and now I feel that I want to be a hairdresser. I thrive very well in that occupation. And then a very big part of what I've struggled with has disappeared.

To be an employee was seen as a confirmation of the informant as an individual. Work was specified as strengthening to their identity as a person, and suppressing their identity as patient. That was an important value of being an employee.

Identity summarised. The informants stressed the importance of acknowledging their identity as an individual, and employer to secure a sense of inclusiveness. It was valued to focus on the employee as an individual, acknowledge them as the same person they were before they became ill, and to sustain their interests. Employers should not categorise or give their employees a new role based on their mental health problems, not treat them as anything other than normal, because others perception of them influenced their identity. They wished for others to consider their difficulties with change, feelings and symptoms, and to show understanding for the changes in reaction patterns, manners and functions that varied by diagnose. The diagnoses and labels should be avoided and replaced with symptoms, limits and care. It is important to encourage and focus on their identity as an employee. The individual identity and the identity as employee were stated as positive, and should therefore be sustained by the employer.

Social Vulnerability

Acknowledgement and social support were accentuated as opposites to rejection and vulnerability. By the informants' descriptions, the vulnerability was directly connected with having mental health problems. The informants used words such as defeat, loss, weakness, conscience, whining, stigma, taboo, shame and powerless to describe their feeling of vulnerability. The degree of vulnerability depended on situations. This category describes the vulnerabilities the informants had experienced in different situations due to their mental health problems. The category is divided into four sub-categories that describe the vulnerabilities the informants experienced as important for employers and others to consider. The sub-categories are openness, power relations, others with mental health problems, and boundaries.

Openness. In this sub-category it is argued that lack of visibility is a reason for openness, there will be given reasons for not being open. The informants' aspects on openness in new employment will complete this sub-category.

They felt that their problems were not as accepted as physical problems, and that it was difficult not having a visible health problem. Self-harming could be a way to make it more noticeable for others. Caroline expressed that you are not growing green skin just because you have mental health problems; therefore, it requires openness for others to be aware. They gathered strength and energy to perform their best in certain situations, especially at work. It was therefore hard for colleagues or others to see their lack of energy.

In retrospect, it was understandable if it was confusing and difficult for others that they put on a facade to avoid showing vulnerability. The informants also mentioned that hiding the problems obstructed support and sympathy.

Several of the informants emphasised that they did not have the energy it would take to be open with close ones. They had anticipations that being open would result in further questions or advices they did not want to hear. They feared that people would encourage them to resign from work, and not think about long-term consequences. It was easier to isolate themselves to avoid explanations than to have a conversation about their health problem. They needed someone to overcompensate extremely for the judgemental attitudes they had within themselves about mental health, but they did not trust anyone to be able to do that. How people would react was a serious concern because they could not be certain of the response.

Emma: I've been open, and it ended with misunderstandings and slander. You do not manage to function without talking about how things are. Just as healthy people who are going through a breakup. They too have a need to tell in order to function. But as we natives of northern Norway say, "It is too late to blow one's nose when the nose is gone." And slander affects a mentally ill differently than someone healthy. Openness is a dilemma that is especially intrusive for newly ill, you often say things you shouldn't.

The informants had concerns about themselves as weak. They described mental health problems as loosing or being defeated because they could not handle the work pressure, or because they had failed on something they had invested themselves in. They had also expressed feelings of defeat because their social life did not work as it used to. The word shame was used a lot and was described as awful and degrading.

Elisabeth: And that is also the reason I do this (interview) with certain ease because it is important for me to show both for myself and for others that this is, this isn't something that should be hidden, it is not something I should be ashamed of. But I am actually, even though I say all these things. There is plenty of shame in it, it actually is! There is nobody who wants to present themselves as a total loose cannon, out of control. It's hurts tremendous to lose control.

They felt dysfunctional and worthless. Destructive thoughts lying behind the feeling of shame made openness difficult for them and they avoided openness to protect themselves from stigma. Earlier experiences with bad outcome had left the informants in a vulnerable position. It felt better to be silent because they did not know how others would react. Others avoided openness to protect themselves from acknowledging their health problems, because to be open would be to accept the problems and admit that they had failed. It would be a confrontation of the fact that they were not able to handle their job or that they could not stand against the pressure. To be open would be like expressing that they had given up, and to show others that they were vulnerable.

Emma: I have a wish that it could be just as normal to say that I'm depressed as to say I have injured a knee. It is painful that people must keep their cards so close to their chest. There is something about the successful pressure today, there is a disparity between removing the taboo and success pressure. The success pressure today is worse than ever and it makes it difficult to be open.

The informants saw mental health problems as a taboo that was stigmatised in the community and had assumptions that the stigma would affect their working life. Some stressed the importance of employers not being afraid to hire applicants with mental health problems, meaning that employers had a responsibility to hire applicants with mental health problems to decompound the attached stigma.

The informants brought up vulnerable aspects with new employment. Some stating that it was important to be open about their health problems from the start. This was reasoned by possible consequences of not being open, such as confusions, bad care or lack of understanding. Julia was the only one who felt that her diagnosis (Post Traumatic Stress Disorder) was accepted and was therefore open about her health problem in all her employments. David did not tell his new employer about his health problem, because he did not want the evaluation of his work to be affected by that knowledge. He though about being open, but his general practitioner and his union advised him not to because they had experiences with similar cases where the applicants were not hired. Sarah got a new manager during her sick leave and did not have a relationship to her, so she did not feel like sharing her difficulties with her. Several of the informants regret not being open about their health problems. Those who felt they were healthy emphasised the fact that it was not important to

inform their employer about their health problems because it was something in the past that would not affect work, and would not need care for neither.

There were many concerns with the consequences of being open. The potential negative consequences made it easier to suffer in silence. The informants stressed the importance of employers who encouraged openness and reassured them of opposing negative consequences.

Power relations. The subjects in this sub-category is important for inclusiveness at work because it reflects the vulnerability that lies in different power relations. It will be important to secure inclusiveness and care in a way the employee understands so that they feel safe and less vulnerable. This sub-category starts with introducing power relations that arise with the threshold of openness, and the consequences this might have by breach of trust. Power relations were also noticed in the job market, at work as an employee in general and as an addiction to work. The informants said the power relation at work was a reason for not being open. The last paragraph will argue the difference between personal and private information.

The informants emphasised a power relation and mentioned a threshold that was passed by opening up. The moment they opened up, they felt they stepped over this threshold and that the relationship changed. It put them in a vulnerable position around the person they were opened up to. The reason they felt as the weaker part in this power relation was because of previous experiences with breach of confidence after being open. To be taken out of work was an example the informants used to describe such a breach, by not renewing their contracts (even though that is not legal), advising them to resign or change work tasks without their approval. A second example was that opening up to others and subsequently not being taken seriously felt like a rejection. The thoughts and emotions that arose in earlier situations were reactivated when they decided to be open in situations later. The choice between being open and making themselves feel vulnerable versus not being open and miss the chance to receive support was challenging. There was also an expectation that some things would backfire, meaning that care must be taken when speaking with others. It felt dangerous if others got too close because if they of their mental health problems, this would make them vulnerable.

As mentioned there were several informants who changed or had plans to change work, some also had experiences of being unemployed. The informants specified feeling vulnerable in the job market. They felt vulnerable when applying for work because they saw

themselves as weaker applicants. Informants also brought to attention difficulties promoting themselves in the job market with a hole in their Curriculum Vitae, or by being open about their health problem. Completion of high school education at the psychiatric institution was also underlined as embarrassing information to include in the Curriculum Vitae. Those who had completed therapy and accepted the health problem wished to use their vulnerability as a strength in their work life. They hoped the employers could see it as a strength too. Christine mentioned that applying for part time work often was more attractive because the reduced hours of work would be more bearable considering her health problems. The employers were seen to have different expectations of the employee in reduced positions. The informants expressed a wish for more reduced positions in the job market.

The informants emphasised a power relation at work. They felt vulnerable because of the power relation in the employment, but also because of their mental health problems. The power relation was stronger at work because the informants described the consequences to be disastrous. They emphasised that most people would like to stay in the position as employee as long as possible, and that would automatically make them the weaker part. Therefore, they were frightened to be open about their mental health at the workplace because they felt they were automatically put in a vulnerable position where work could be deprived.

Sarah: I am so afraid that it will get some consequences, the things that would come up on "dialogmøte", but it was okay. No diagnoses revealed and I was very pleased with that. (…Consequences such as) that they do not want me to work. That it is grounds for dismissal or. I do not know. I'm really afraid that they, because I have the diagnosis I have. If it is something that comes up on a "dialogmøte", then I'm afraid it will destroy my employment. If one has a broken leg, it is much easier (laughs).

The informants expressed worries about not being good enough as an employee. They spoke of feelings of guilt and shame for not fulfilling the capacity needed. They were vulnerable because they felt they could not work the anticipated amount, or with the capacity that was expected of them. It was pointed out that the employer needed the work to be done. They highlighted that it made everything easier when the employer knew why they could not come to work, although they felt guilty because it affected their employer and colleagues. For some, their conscience pushed the fear of not being good enough too far. So far that that it was partly what caused their health problems. These emotions made them especially vulnerable. The informants felt that everything they did as an employee was filled with

vulnerabilities. They felt that way because it was easy for the employer to say that the error was in them personally, without having respect for their mental health problems. Several of the employees have experiences with conflicts at work that they felt were affecting their mental health. Employers have more power in such situations, so the informants felt there was not much they could do as the weaker party in the conflicts.

Work was compared to the feeling of power-abusive relationship because they could not let go of work since it gave them so much, but at the same time they felt hurt by it when it became too much. They needed the employer to set limits for them, pay attention and be mindful because they felt they could not take care of themselves and see when they were over worked.

Several of the informants used the words “personal” and “private” to describe a difference between work life (personal) and family life (private). The private information that was shared with family would be talked less about in work life due to the power relation. They said there was not a definitive limit between personal and private information, but the limit had to be felt to secure oneself from misuse of the power relation. As people did not have confidentiality, they could easily tell others who were not meant to know, thus making it a breach of confidentiality even though it was not meant to be. The power relation was mentioned as a barrier to tell others about vulnerable information. Information that could put the informant in a bad light in front of others whom they would like to keep the information from.

Caroline: To let others into your personal life. There is a power relation in that. If you know a lot more about my vulnerabilities and weaknesses, and about my life and how things are going there. More than I know about you and your life. Then you have an advantage in our relationship. And we are never. We never signed any contract about, if I get to know a lot about your life then you should certainly know a lot about my life. But with close family, you are so close anyway, so they will find out. So, the private life is a lot more intruding in the nearest relations.

The employers' have confidentiality, but it was stated that they could abuse their power to change different aspects at work, like work tasks. It was easier to keep the health problem hidden at work than in front of friends and family. It was good to be around people who did not see them as vulnerable and who wanted to be around them for other things.

Therefore, it was often evaluated as beneficial to not be open about it. The workplace could be used more easily as an arena to be themselves entirely, free from their diagnoses.

Others with mental health problems. In this sub-category the informants' relation to others with mental health problems will be described. The vulnerability in relations including others with mental health problems was outbalanced, because they also showed vulnerability and knew how it felt.

The informants felt their problems were so overwhelming that they did not anticipate others to be able to understand them. They said that people could be empathic or that they could try to put themselves in their situation, but they believed that only people who had experienced it truly knew how it felt. They said it was hard for others to comprehend mental problems if they lacked knowledge of, or experience about it. Without knowledge, it was assumed that others could not help positively. Therefore, it was easier to trust someone who had experienced mental health problems and knew what it involved.

Four of the informants mentioned finding support in others with similar health problems. David had a colleague, Julia had her godmother, and Veronica and Martha had the nearest leader. Those who had experienced mental health problems themselves were specified as more understanding. This understanding was by the informants described to be different and better than others could convey. When asked what they did differently the informants mentioned that they understood that their absence should not be accepted, and although it was rejected, the support kept coming. They understood that they did not want to be in crowded gatherings, sent them messages, initiated contact and asked them to join them at a café. To stay in contact and invite them to social things or to talk alone was stated as important. This was Julia's answer when she was asked what her godmother did differently:

Julia: I do not know how to describe it, but there was no one else in my family who took me for a drive. Somehow, can you tell me if everything is all right or. But she realised somehow that my absence, it was maybe a cry for help, or something like that. See me, do something, just something. So. Just like bodily contact, like striking me and such. That actually means a lot to me that she actually did it. There is no one else who did it, of the ones in my family. It might be the reason why I felt that she understood me in a different way.

They were more patient and understanding in the descriptions the informants gave, compared to others. For Veronica and Martha to know that there was someone else at work that knew and understood, because of similar experiences, made them feel secure. The power relation and feeling of vulnerability was not present here because they felt equal. According to the informants, others can learn by these experiences and try to convey the same support.

Boundaries. This sub-category is built on the informants' statements on boundaries that were made to reduce vulnerability. Benefits occuring from boundaries, reasons for boundaries and factors reducing vulnerability will be described, and how boundaries were made in the knowledge of possible relapse will be mentioned.

The boundaries were made to maintain their health, prevent relapse and reduce their vulnerability. The boundaries also gave them a sense of control. To set boundaries required that they knew what to prevent, and which signs to look for. For those informants who experienced mental health problems for the first time (see table 1), it required that they were at the end of therapy (David), or that they had completed therapy (Elisabeth) and they accepted that they had mental health problems.

The boundaries they made for themselves were a confirmation of their vulnerabilities. Most of the informants seemed to be aware of their vulnerabilities and had learned to take them into consideration. Boundaries were made so that they were in control of how to respond to the feeling of not coping, not having energy or not being good enough in their own eyes. They had learned how their bodies gave hints and how to respond to these, e.g. breathe with the stomach, take a break, sleep. Boundaries were made so that they had structures and guidelines around them. Most work environments were mentioned to have something that affected their vulnerabilities; the boundaries balanced this by giving them a sense of control. The need for control was mentioned by most of the informants. Stability in everyday life and predictability in work tasks over time were expressed to reduce the feeling of vulnerability.

Social support was accentuated to be important for reducing vulnerability. The informants mentioned different factors as contributing to reduction. Veronica was ashamed until she learned her triggers and boundaries, then it was easier to be open with friends. Her openness resulted in others being open about their problems too. Julia felt less vulnerable when the health problems were talked through, and questions that earlier would provoke strong feelings were now peeling off. Meditation, self-help books and social support was

mentioned as something that reduced vulnerability as well. Martha also mentioned education as a safety against vulnerability as something to fall back upon.

The fact that they had made boundaries for themselves meant that they were aware of the possibility of relapse.

Elisabeth: I am overambitious, I am super idealistic and have no. I am limitless. I do not have any limits for myself. But I think a lot about being careful, I have to secure some structures and rules around me that prevent me from being burned out again. Even though I will not go back to that type of workplace (...) I think a lot about it, how I'm going to secure and prevent relapse, because I think that is a scary thought.

Several things was mentioned as preventive, e.g. Healthy food, enough rest, sleep, limits at work concerning amount and hours of work, pleasurable activities and exercise. The vulnerability was expected to be reduced if relapse occurred compared to the first time, because they knew the reactions of their social network, the routines of the health system and their own reactions. The boundaries could also help them to separate themselves from their mental health problems. These boundaries had to be respected by others, as an acknowledgement of the vulnerabilities within them and as a gesture of support.

Social Vulnerability summarised. To be able to secure inclusiveness and to covey support the consideration of the employees' vulnerabilities and challenges was stated as important. It might be difficult for individuals with mental health problems to understand that their problems are not visible. However, some felt it was too visible, and therefore put on a façade to hide their problems in some cases. This obstruct support, and it is therefore important for others to respond to signals and encourage openness. They felt like the weaker part because of their health problems, and implementing care in a way that the employee understands is valuable. Employers should hire applicants with mental health problems to oppose stigma. These vulnerabilities were outbalanced when they were among others with mental health problems, because they felt as equals. They had boundaries that should be respected because these had a preventive cause. In general, massive support should be conveyed to refute the vulnerabilities and to secure inclusiveness.

Social Support

The informants emphasised social support as affecting openness. Experiences of how their openness had been met affected how they evaluated the need of support. Sometimes the risk of being open has been valued as larger than the need for support. If the opportunity of support were given, it was important for the support to be sincerely conveyed. This category is about how support can be conveyed and how it reflects the importance of finding the balance between too much and too little support, so that disempowerment or exclusion does not occur. This category is divided into four sub-categories that reflect the informants' statements regarding support from family and friends, social health care, and employer and colleagues at work. Lack of support will be described in the last sub-category. They all reflect the value of social support as employee with mentally health problems.

Family, friends and others. This sub-category gives a description of the informants' focus on support in relation to friends, family and others. The types of support that were mentioned in this sub-category were by the informants propounded as adaptable for the work life. It was stated that when support from friends, family or others was lacking, the support at work became even more important. It might be valuable for the employers to understand aspects in the private life to be able to convey support at the workplace. This sub-category will focus on types of support that were stated as appreciated, the one special person who supported them more than others, change of relations when next of kin became care assistants, and economical support.

The informants brought up support as a topic and had no problems giving examples of support they appreciated. Tom expressed as next of kind that it was good to have "sick free days" every week, where the subject of conversations was everything else than mental health. Support could be given by just being present, being quiet and listening to the one with mental health problems. Positive thoughts and doing things that were perceived to be good that specific day should be in focus because the preferences might be changed the next day. It was comforting to receive such an amount of support that they had no doubt that the loyalty, presence and support from others was lasting. To be told that they were valuable as a person, that it was all right to reduce the work amount (not resign), and to express a genuine acceptance for and focus on the human worth instead of large achievements. Other suggestions of showing support were to buy flowers, participate with practical things like making dinner or go for a walk. For others to ask if they should come visit when the informants were hospitalised at a psychiatric institution were also perceived as positive. The

most important thing was to say I am here for you, I see you and to give the informants time. Christine said that it is allowed for everyone to step wrong in an effort to help. They understood that it was never easy to know how they would respond to the help given, and that there was never a guarantee that the help would be received. Support was also misinterpreted. It was therefore important that the next of kin kept trying in different ways, and did not give up hope. It was of importance that the support from the employer and colleagues was given in a way that the colleagues themselves felt best suited. The support was seen as acknowledgement. It was described as valuable for the self-esteem and to avoid feeling rejected.

Some of the informants had received more support than others in general, and some had a larger network than others. However, all of them were thankful for those who had stood by their side and never left, although the informants had not let them in or been open about everything. Even if others never understood everything, they knew they were loved. Most of the informants had at least one person who supported them more than others. That person was emphasised (by those who had completed therapy) as valuable for the recovery process and for the encouragement to work. The following example does not illustrate the lasting support from the one person that most of the informants mentioned, but it summarise the aspects that the informants emphasised.

Elisabeth: I was just lying at home, I had nothing to do, did not have the energy for it so I was just lying in bed. And I remember one time she came (laughs), so she came home to me and said that YOU, GET UP NOW! And pointed like (using her index finger to illustrate) towards the shower. And then we went down to, what is it called, Kristiansand. It was incredibly fun, that is why I remember it (...) But it is actually the only time I remember that some of my friends have said that hey, enough is enough! (...) First of all we had much fun, but it was a kind of reminder of, yeah, that it is no use, to lie down and isolate yourself. It is funny because it was a reminder of that, at the same time as it is a painful reminder if you know what I mean. Because it is also a reminder that I do not manage it alone.

Change of relations regarding next of kin becoming care assistants were stated by the informants. They supported them more than ever could be expected. Especially those who expressed to have had mental health problems for a longer period mentioned their mental health problems as debiting. Emma mentioned that some of those who have chronic mental health problems have enough with themselves, so that taking a significant other into

consideration or establishing a family is not an alternative. The significant other would become a care assistant. This is an insecurity she expressed. The informants mentioned it as important for the next of kin to set limits for themselves. When the mental health problems became too much for the next of kin, the best thing they could do was to spend some days apart. It was important for the informants that the next of kin took care of themselves too.

For the next of kin to help the one with mentally health problems too much was mentioned to be a disservice, because the support worked against its purpose and they would end up doing more work than necessary. It was emphasised that others should let go because they cannot be in control of the one with health problems all the time. The informants emphasised the need for space to develop, to be allowed to contribute both at work and at home and to have a sense of achievement. Next of kin were encouraged to be careful so that the informant did not get addicted to having support all the time, because then they could stop believing in themselves. The informants described an underestimation of people with mental health problems. Too much help could give them the feeling of being disempowered or excluded. It was a medicalization that removed their self-efficacy, which is reflected in the identity category.

It was also mentioned that it was not easy for the next of kin to know when they were helping too much or too little, especially when the informant had gone from bedridden to recovery. The informants stated it as particularly important to be challenged, feel achievement and not be held back when they were in the process of recovery. It was not that easy for the informants themselves to notice the change either, so the balance of help had to be tried out.

Some of the informants' families had been economically supportive. The informants were thankful for the development of the economic support from NAV that had been elaborated the last ten years. To be economically dependent on others was something that they were not fond of because it made them feel like a burden. However, they were thankful for those who supported them when needed.

Support from health care services. The support from health care services affected the employee's return to work. In this sub-category it is reflected how the informants were in need of the health care services to give them the support they needed to function at work. Some of the informants were very satisfied with the quick evaluations and help from psychiatry and general practitioners, others had different experiences. Some informants did not feel heard by their general practitioner. Others were heard but felt misevaluated. The

informants expressed it to be the employers' responsibility to inform them about different services provided. In this sub-category the following will be described; the informants' relationship with their general practitioner and the value of their evaluation to be heard and not misevaluated, therapy, the health care services in general and the spread of information.

A good relationship with one's general practitioner was valuable for openness, and the relationship also affected whether advices were accepted and respected. Those who were satisfied with the help received accentuated that their general practitioner took time to uncover all problems, and sometimes helped the informants seeing or describing the symptoms. They expressed having an open and stable relationship with their general practitioner where they could easily express their concerns. Most of these informants had the same general practitioner over a longer period, and had consulted them with other problems earlier. They had built a relationship with their general practitioner. Good communication was also stressed as important for being open and for whether the advices were accepted or not. At least six of the informants (Tom, Elisabeth, Christine, Caroline, Julia and Veronica) had experiences of being advised, opposed to their own wishes, to resign from work. This was strongly felt as a rejection, and in these situations the support seemed totally absent. It was also stated that some went to work even though the general practitioner recommended them to be on sick leave.

A few of the informants had both somatic and mental health problems. Some also described having a weaker immune system while having their mental health problems. Sometimes they had problems knowing if the struggles were partly mentally caused or all physically, and what was what. In these cases, both psychological and physical attention was needed. It was stated as presumably hard for the general practitioner to evaluate this, but it was expressed as important to estimate the mental symptoms.

Some had been at their general practitioners office without any progress regarding their mental health problems. When these health problems escalated, the help was given more immediately. To not be heard or believed before the health problems had escalated were described to make the informants feel unsecure and worried. Several informants had thoughts regarding their condition to have had a milder outcome if help had been put into effect earlier. The evaluation of the general practitioner was mentioned to affect the employee's return to work. It was also mentioned that it was probably hard to tend for the employee if the employee themselves had uncertainties about the reason for feeling ill. Not to be evaluated as having health problems might have meant that employees who should not be at work were at work.

Anna: *So dad took me to the doctor and I think both my parents and my teachers had expected that my doctor would give me a referral to, I do not know if it was BUP at that time, BUP (The Children's and Young People's Psychiatric Out-patient Clinic) or PPT (The Educational and Psychological Counselling Service) or what he called it. But he took some blood tests, and we were told that the blood samples were okay, so there was nothing more than that. So when I came back on my own a few years later, then, I think he realised that things were a bit worse.*

They emphasised the amount of time spent at their general practitioners office as important for having time to clarify the actual problem. Some of the informants argued little time as a reason for improving access and lowering the threshold for therapy in the community. They mentioned that the psychologist had better time to talk, and that it would have been easier to go directly to the psychologist than to the general practitioner to receive a referral. When they did get help from the general practitioner and received a reference to therapy, long waiting lists were experienced, which was not satisfactory. It should not be necessary to wait when feeling in need of therapy. They waited because it was cheaper to be referred than to localise a private psychologist. When therapy was put into effect, the informants felt relieved.

Veronica: Because when I first got the diagnosis and knew that I was going to treatment and was to start on medicine, then it was just as if I could finally relax properly and then I collapsed completely. I was so tired, so it was really just to sleep, I was a little, until I had a little more energy. And then it was really necessary that I was not at work either. I do not think, I do not know how I would have gotten myself through the day.

For those who were informed about the diagnosis as something to work their way out of, perceived it to be highly encouraging. It was also reassuring to be told that the psychologist would be available if something were to happen, e.g. relapse, even though the informants knew that the health system could not guarantee the same psychologist. The psychologist's help with new coping strategies that also could be used at work were mentioned as valuable support. The psychologist also helped with which warning signs to look for regarding relapse, and how to set boundaries for themselves. Sarah was the only one pointing out desires from her psychiatric institution that were not merely therapeutic. She

wanted an emergency plan in her journal and a user controlled bed (a bed in a ward available for her when needed).

There were some unfortunate examples given by the informants where they felt that their treatment process was not adjusted to their needs. Anna was sent to group therapy where she got panic attacks and got individual therapy after requesting it. David had to see several general practitioners, and Anna had evaluations by four different psychologists. They experienced it as hard to tell the whole story to several consultants compared to consulting just one and the support therefore felt lacking.

The informants highly praised information from various health care services in general, but the information from NAV was for some of the informants hard to retrieve. This information was regarding what rights and for how long they could claim support. They experienced that they were not heard, but if a professional said the same, it was easier to get approval. That felt discriminating, but at the same time it was good to have a psychologist in attendance to explain their case. The language to express needs was described as absent in several situations, to be allowed to bring a friend, relative or psychologist who could share the employees needs to cooperation meetings were emphasised as important. It was hard to know what to ask about, and what the possibilities to cover their needs were.

They appreciated support from NAV such as work assessment allowance, time limited disability benefit or graded disability benefit. Education through the psychiatric institution was also spoken of as positive. NAV had seminars during which employers were informed about how to include employees with mental health problems; they stressed such information to be helpful in the work life.

The psychologists' were great resources for recovery, and "Senter for jobbmestring" was also positively spoken positively of. Health care services' function for the prevention and recovery of mental health problems in the community were emphasised with enchantment. The informants wished for better knowledge of these in the community, and for these arenas to be used more frequently by people in general. The employer should encourage the use of company health service, psychologist, NAV, or other instances that could give the extended support that they did not expect from their employers. The informants brought up different arenas for openness where they could show vulnerability, and where social support was given; "Senter for jobbmestring", "Bikuben", "erfaringsformidling", and the work and activity centre. Not everyone knew of these arenas before they got mental health problems and had a hope for employers or others to encourage and inform them about the opportunity to seek support at arenas like these. Helpful recommendations given by employers were

absent. Attending the arenas mentioned above is stressed as a good advice to receive from their employer.

An issue the informants specified was that support could not be given if there was no knowledge of the presence of the mental health problems. A lot of them thought it to be better that way, the reasons for that are described in the category vulnerability. Therefore, it was very important for support to be offered if the employees were open about their problems. To see others receive support might encourage employees to show vulnerability and could make them willing to receive support too.

Social support in aspects of work. The informants wished for both understanding of being too ill to manage and understanding of being ill but coping. This depended on where in the process the informants were and reinforced the need for inclusion of the employee in the evaluation of capacity. In this sub-category the focus will be on support as the employers responsibility, how work capacity has been evaluated at work, change of work tasks, understanding colleagues, and the balance of how much support to convey (balance was also mentioned in the friends, family and others sub-category).

Support was mentioned as partly the employers' responsibility together with the social health system, the informants themselves, family, friends and others next of kin. The informants mentioned that they did not need any kind of support. However, it was commented that the employer should notice their employees' absence from work and should therefore take responsibility for including and safeguarding. As everyone in the community is expected to work unless they are on social welfare, it was argued that the employers are responsible for the employees to land safely and to implement routines for paying attention. If the employee made the choice to be open, it was particularly important that the employer clearly showed support and understanding.

Evaluations that diverged with their own self were felt as the opposite of support. The fear of being misjudged or rejected was so large that they sacrificed the chance of support. Tom's employer evaluated him as bad at cooperating because of being too quiet and not sharing his thoughts. For him there was a shortage of others asking him how he was. That judgement made him frustrated. It was highly emphasised that the employee should be included in the evaluation of their capacity. It was also pointed out that the care should secure acknowledgement and self-efficacy at a realistic level.

Several of the informants did not inform their employer about their health problems to avoid assessment of work capacity. They spoke of episodes where they lied about their

mental health problems and excused their absence with something else or by not giving any reason at all. Several of them stated that the employer have no rights to know why their employees are on sick leave.

Several mentioned change of work tasks, and Emma said that work tasks were easily lost when on sick leave. It was also stated as important to prevent risk of fault at work by taking into consideration the health problems and their consequences for work. The informants emphasised that it is all right to change work tasks, but that the changes should be decided in consultation with the specific employee it affects every time there is a need for change. This was accentuated to be done individually by the employer with the employee, and to be done again each time they have a relapse because the symptoms change and should therefore be treated differently at work each time. It was important for the informants to be allowed to participate and to do something they felt they could overcome.

Christine: For some it is awesome to work outside in an environment, if you work in health care services and think that human contact is what is best for me right now. But I do think that I would have recommended the employer to examine that together with the employee who struggles with mental health problems at the same time as being an employee. I think it could become a more inclusive workplace in a way.

As in the example, there were several of the informants that specified the importance of the tasks to be evaluated in deliberation with the individual with health problems because symptoms might vary from day to day, and because every situation is unique. They thought it should be mandatory for the one with health problems to participate in the discussions and determinations regarding their own working hours and tasks. It was stressed that a certain solution does not exist, because these parameters can vary.

The colleagues' understanding was stated as important. Different degrees of acceptance at the workplace was described. If the employee and general practitioner or psychologist evaluated them as too ill to work, then this should be accepted at the workplace. Sometimes, the management could be understanding and inclusive, but the colleagues did not have the insight or sympathy even though they knew about the mental health problems. They met employers and colleagues who did not understand why they were not able to work, when they were able to join social arrangements. As mentioned in the vulnerability category, some of the informants struggled to gather energy to be social. To be met with lack of understanding after trying to gather strength was a tough experience.

Christine: So I would try to come on Friday coffee and to stay at least a few hours. With a small amount of fixed time that I would be working, and thought yes, it must be very important to keep in touch with work and try a little bit to build it up again. I was greeted by some colleagues with "if you are able to come to Friday coffee, then you are be able to work". So that did not make it very easy to think that, yes this was a good idea. So there was the further problems regarding becoming quite helpless in my own psyche, while my identity as a worker and social worker was pretty much put to the test.

After being open, some noticed that it was hard for the colleagues to know how to behave around them. Their colleagues looked at them differently than they normally would, looked more worried, and communicated and behaved more carefully. Colleagues did not make contact because they did not want to bother them, so they stopped asking them to help with tasks they normally would. The informants expressed a wish for their colleagues to ask them carefully instead of not asking them at all, so that they could make the decision themselves to do the extra work or not. It was hard to not be given the chance even though it was meant as a good gesture to protect them. They described people taking too much consideration and David reasoned this with communication.

David: *So even though I was open, so, tried to say that this is the situation and I will continue to work on this so just take contact, they would still take more consideration. Or, so they took more consideration, a little too much consideration in a way, but I do not think it had the opposite effect, I think it was just more that there were misunderstandings and although I communicated it quite clearly and was very open, it never gets very easy that people are taking consideration.*

It was important for the informants to be met with understanding and demands, for the employer to acknowledge their absence by conveying support. They also wished for their management to give them academic support as well as care for their well-being. It was not good to be (as Christine stated) "understood to death". It was accentuated that it is good to challenge the employee with work tasks as long as there is a possibility to give a heads up if it becomes too much, and that it is accompanied by encouragement and support. It felt good to be included and it felt good to have the opportunity to be able to say no thank you. If there were changes of work tasks or work hours due to the health problems, it was emphasised by

the informants that the changes had to be presented in a way that they understood. The employer have to take time to explain, give reason and encourage questions, and to approach the employee at their level of mental capacity at that time. Such conversations were the sort of support that was strongly encouraged and wished for by the informants.

There was a great variation in how open, and how many they were open with at work. Several of the informants described social grouping at work, where the in-group was the colleagues they confided to and the out-group not. The informants mentioned it to be easier to be open with a group of colleagues because it was hard to ask them about things without them knowing. It also felt safer for the informants to be open only within a limited group, the more people who knew the more vulnerable they felt. Some did not experience any kind of top down attitude, and especially Emma mentioned experiencing many exciting social arrangements through work. However, many of the informants did not want anyone at work to know. Sarah gave her colleague the contingency plan because she experienced it as comforting to have one colleague seeing the warning signs if she started to get mental health problems again. As emphasised in the vulnerability category, those outside of the in-group did not need to know.

Anna: And then there are the ones outside that circle, who I don't work so often with and who aren't so close in age either. That probably doesn't know any thing about it. She is like representative, whatever it is called, she probably knows roughly about it. But it is mostly just the ones I am familiar with, and my manager who, like, who knows the most. It's sort of okay, I trust them to be keeping it to themselves and can, can cope with it. They have shown to be able to handle it.

Lack of support. The opposite of social support is loneliness and exclusion. This was described by all of the informants. Loneliness, isolation, feeling alone, rejected, excluded, or outcast were the word that were used. All of the informants mentioned situations where they felt rejected or left out. Most of the informants talked about their own need for isolation. In these situations, the isolation was not described as loneliness, but more as a choice to seek distance from their surroundings. In other situations, the isolation was described as inflicted by others. The isolation was explained as both physical and mental. Anna mentioned that the transition from high school to university was hard because the everyday social support was lost. It was easier to feel alone and isolated. At work there was a closer social relationship and known faces. The social support was easier found in work situations than at university. It

was mentioned that care at university was difficult to comprehend by the informants who were students, and it was hard to know where to go or who to speak to.

The informants described the lack of support in different arenas; Christine and Julia had experiences with being excluded from friends, Maria and Tom with exclusion at work (mentioned in work environment category), Emma described self-exclusion from normal life (described above), and Veronica felt alone with her health problems (mentioned in the vulnerability category).

Martha: They could surely have tried better to put themselves in my situation, I have gotten the impression that certain people want you to just bite the bullet. But it is not that easy, and it is important that people realise that it is not so easy, it is actually an illness to a certain degree and you need to treat it as an illness, not just as sharpen up! It is going to be fine, because that certainly does not work.

Each and all of the informants described some sense of lack of support, but Sarah was the only one who said directly that she felt lonely. The need for isolation was elaborated in the category vulnerability, with examples and reasons for not being open, which obstructs support. Informants had experiences where support was missing, which gave them knowledge about the importance of early and appropriate treatment. Lack of support made them struggle with their health problems more than probably necessary. When support in the private life was absent, the support from health care services and workplace was described as prominent.

Social support summarised. The success criteria the informants stated as important for continuing working were expressed as support through actions, one extremely supportive friend, next of kin as care assistants, to balance the amount of support, and economical support. From the health care services it was also emphasised as important to have a relationship history with their general practitioner, for the general practitioners to make thorough evaluations together with stability in the treatment and therapy. Economical care through the health care services were valued, as well as information. Aspects that were stressed were the importance of responsible employers at work, codetermination in both evaluation of capacity and change of work tasks, understanding colleagues, for the support to commensurate with capacity, and including of, not rejection of the employee.

Work Environment

Psychosocial and organisational aspects in the work environments were accentuated by the informants to affect health. This category might reflect how work environment can be both health destructive and health promoting. The informants emphasised the importance of care, to have an arena for openness, and to consider the challenging and motivating aspects in the work environment. This to ensure inclusiveness and care for employees with mental health problems.

Care. This sub-category reflects the informants' request for better care to ensure inclusiveness as part of the work environment. Their input on care included controls of IA-companies, deliberation of sick leave alternatives, better follow up by management, flexibility regarding work time and amount, in addition to notification and reason for absence. The sub-category will be completed with extensive care alternatives and the need for present leaders.

Some of the informants did not know if they were working in an IA-company, and some of them had no knowledge about the IA-agreement. Emma was the only one who expressed to be very satisfied with the care and inclusiveness regarding the IA-agreement. The IA-agreement was meant as a support for employees with mental health problems, but in some descriptions, this support was absent. The informants felt lonesome with their health problems at work. The IA-companies (except Emma's) did not live up to the agreement according to the informants because the agreement was not implemented in practice. Some of those who were in IA-companies said that the agreement was not fulfilled, and a wish for strict controls of the IA-companies was expressed. Suggestions were made by the informants for the companies to set annual goals and strategies to maintain good mental health amongst employees, and that the results should be reported. Strict control would improve care and therefore also the feeling of inclusiveness.

It was mentioned that an interpretation of the 50 per cent sick leave was legal and could mean two different things. The employer could request the employee to work the whole day on half engine or half a day with full productivity. The interpretation and decision of what was best for the employee was stated as important, the employee should be included in the deliberation. Problems occurred regarding hour accounting with how to distribute the amount of hours to which project when working full-length days was the choice. Since they then worked all day, it was pointed out that they overdrew some projects because they only worked with half capacity. It was also difficult to pay attention through the day if they

worked with 70, 50 or 90 per cent productivity because the capacity would vary. It affected the productivity negatively when they had to pay attention to their efficiency. It was no longer a case regarding the employee's health, or finding easy and uncomplicated solutions, but more about finances.

It was pointed out that care was easily infracted in stressful work environments. Maria waited thirteen weeks for her "dialogmøte" and there was several informants describing absence of appraisal. When the management did not follow up on the employee's sick leave or agreements made individually, it affected the work environment and the employee felt forgotten. The informants expressed bad experiences with long-term sick leave and violation of demands they expected from IA-companies.

It was mentioned that the companies did not get fines anymore when the time limits were not over-held, and that there were no consequences for breaking the IA guidelines other than the risk of employees becoming ill. Informants emphasised that the criteria to be an IA-company was too low and that it was up to the company what they made out of the IA-agreement. It was perceived as high status to be an IA-company by the informants. It was therefore argued that it should be expected from the companies to fulfil demands and criteria in order to be qualified as an IA-company. Wishes were expressed regarding establishing a practise to remove the IA-status from companies who do not meet the criteria.

Tom: It's a pity that one concludes at that level in today's society, because my company say they have measures that can help me, but I know that there are no employers who have time for mental challenges. So, then you become responsible for your own happiness, and you can only hope that if you keep silent, that you get to keep your job. If you nag about your mental challenges then it becomes like yes, maybe you should apply for disability benefit. So unfortunately it has come to the point that you would rather keep silent than to speak out.

One problem that several informants mentioned was that physical health problems was perceived as easier for employers to facilitate than mental. The typical example used was an adjustable table for physical health problems, and that mental health problems were more comprehensive. Something that might be of great help to one might worsen the health problems of someone else. Suggestions of care or adjustments at work that could be perceived as motivating or health promoting came easily to mind.

Flexibility in work time and amount of hours were mentioned as difficult to implement at some workplaces but were propounded to be considered. The flexibility could be regarding arrival and leaving as best suited during the day, but also to have a reduced position or graded sick leave. Flexibility was also mentioned as the possibility to work fewer hours and more often, or to work in shifts depending on e.g. the need to see colleagues or circadian rhythm. They stated that depending on symptoms and situations, there would be different needs regarding social environment or noise. The employee could e.g. prefer to sit in an open plan office, to have a private office alone or share an office with just a couple of colleagues, or to work out in the field. Flexibility from the employer in several areas was therefore stressed as important. Other suggestions for care were e.g. to attend to seminars where they could sit and listen without participating, for someone with social anxiety and need for predictability this was stressed as a possibly bad idea. The flexibility of the employer was also important regarding notification and reason. Several of the informants said it was challenging to give notification about their absence straight away when they woke up. It was also difficult to explain why they could not come to work that day because the reasons were not felt as obvious reasons to be absent from work.

Julia: To be in bad shape when I was ill, it could have been so much triggering it. I remember I could lie and scream if there was some who did the dishes and the sound of it was too loud. And it is quite difficult to explain to someone who is not ill, because it sounds totally stupid when I say it, right. I cannot call and say hey, there was someone doing the dishes. The noise was so loud, so loud that I cannot go to work today. And I never needed to elaborate on what it was that was wrong, I could just send a text message, send an e-mail saying that hey I'm ill. Said hey. It was never something I needed to elaborate and it felt very good, to not have to explain.

It was also given examples of experienced care that was extensive. David got grant leave from his job. During that period, he tried out a new workplace to see if he wanted to change work permanently. The informants requested help with care to secure well-being and to prevent the employees from becoming overworked. Mental health problems were mentioned as often connected with muscular health problems so it was preferable to be offered equipment.

Care could be demonstrated by asking the employee to come in to the office for a ten-minute talk when they came back from sick leave. Some kind of conveyed support was

requested and it was preferred if the employer made an effort to see the challenges that the employee experienced. To be told that the employers' doors were wide open and that if they wanted to work, there would always be work for them, and that they would find a way to work around the health problems were perceived as positive. They also had a wish for a conversation about their absence to be encouraged, and for the employer to check if there was something that could be done to make working more comfortable. A problem with sick leave that was brought up was that there were no possibilities for substitutes when the informants called in sick. They knew their absence affected their colleagues. Because of the conscience regarding this, it was important that the employer reassured them to take their time to get well as a routine for care.

Arenas for openness at the workplace. To have an arena to talk about well-being at team level, and about problems or positive things that occurs in different aspects of life was stated as important. This sub-category reflects the wish for conversations about how things are, arenas for these conversations, and encouragement and deliberation of openness. All of these aspects were emphasised as important for inclusiveness and care of employees with mental health problems.

The employees were not open to conversations about private life or how things were going, something that affected the work environment. The conversations were said to be superficial and the amount of openness was therefore restricted. Some informants assumed this to be especially present in work environments where the work tasks regarded others with various health problems (health care services of different kind). Some of the informants problematized lack of time or too much stress to take care of each other as colleagues, the informants would like that to be improved. Although Tom (next of kin) was requesting more personal conversations, he mentioned that it could sometimes become overwhelming to listen to other people's problems when he had enough with his own. The informants stressed lack of social interaction and support as reasons for difficulties knowing how much openness were socially accepted at work.

Work environment affected the likelihood for openness according to the informants. The informants stated a prominent wish for arenas to talk about how things were going. They requested establishment of work environments where it was allowed and encouraged to be open about different problems and to different degree. They missed invitations to openness where alternatives for care could be propounded. They had suggestions of how it could be improved. One example was to arrange team building and create social arenas for the

colleagues to get to know each other and the employer. Other suggestions were mostly focused upon social meetings or personnel meetings where the agenda was to hear what each employee individually had going in their private life as well as at work. Then it was easier for the employees to say that e.g. they had a bad day, were tired because of the kids, daily problems, or challenges regarding their mental health problems. Arena for openness about small things like noisy kids would give the possibility to talk about things that are more serious. It was stated as important to have an arena to talk about things that were challenging for those who were healthy as well. The informants wished for an environment where it was allowed and encouraged to show vulnerability, then it would not be so hard to bring up challenges or explain mental health problems when they occur.

Julia: And the fact that we were open with each other about how things were privately and not just at work, that was probably important for being able to get an understanding for each other. Not just for me, but it was also important for me to know how the others were doing so that I could adjust myself to them. So I think it's important, even though it may be difficult to get a personal relationship with everyone. It's a bit like that. You can't expect that from a job really.

Some of the informants were never open because they never received any questions about how they were, no invitation to talk or sign of support on that matter. Some had not thought of the possibility of being open. For others there was not an alternative

Caroline: There is nothing in my head that like, it does not ring a bell that says hey, you, it would be wise to be open with your employer about these things. More like totally opposite! Everything in me resist when I think of a scenario where I would go in to one of them I have as employer today to talk about bipolar suffering. Oh, hmm. No! My body resist.

They emphasised the value of someone helping them to see that it might be good to seek support and be open at the workplace, and for the employer to create that opportunity. They needed the employer to encourage and help them share their mental problems in an understandable way at the personnel meeting. It was stressed that the employer should not share the employee's health problems too early, not share too much and should make an agreement with the employee what is allowed to be shared with others. The management

should work for a high level of tolerance in the workplace regarding openness about health problems.

Challenging Environments. In this sub-category, aspects in the work environment that the informants experienced to be especially challenging will be described. Specific environments that were seen as challenging will be described, and how it might affect mental health and social integration. Aspects that were important for the work environment such as qualities of the leader and size of the companies will also be described.

Aspects at work that could be challenging while having mental health problems were drawn attention to by the informants. These environments were elite environments, highly competitive, encouraging winners and losers, rewarding the best, going through reorganisation, focused on finances and financial control or sales goals.

David: At the same time, the system becomes more and more focused on performance and individual measurements, and that does not contribute to (thinks). It's not a system that makes the employees work well together to achieve best possible results. It could contribute to poorer work environment and that you have to show, those who are good to show that they are performing and doing well in performance measures can save themselves, while others that are equally important and do it well they (thinks). It rewards pointy elbows and those who emphasise themselves.

Aspects in the work environment where a collective amount of money had to be negotiated personally were stated as destructive. This was reasoned with everyone having to argue to get more for themselves at the expense of the others. In practise, that meant arguing that they were better than their colleagues that they actually were meant to cooperate with. It was also mentioned that not all of the above necessarily were valuable for the social economy. According to the informants, these aspects influenced the work environment and felt especially stressful when having mental health problems. Other aspects in the work environment were also seen as challenging, such as environments valuing efficiency improvement, containing a lot of (academic) criticism, environments that were stressful, or not valuing preventive measures. Pressure on production that relied on professional integrity was seen as unhealthy because it appealed to their conscience and could result in free work.

To introduce more stress to someone with mental health problems was argued as destructive for that person's mental health. They gave examples of how work environment

affected the mental health. Maria and Tom gave specific episodes where they felt bullied or debased at work (as mentioned in the identity category). Maria was bullied for her role and not for things about her as a person, but was partly the reason why she got mental health problems. The informants also mentioned the importance of being prepared for work tasks, because a sudden change in work task or work hours could afflict their health problems. They described feeling like a failure, rejected, avoided or excluded because of aspects at work. Several of the informants described a resistance against their workplace because of too much challenges at work, even though they were expressing hanker to work.

Maria: It's a lot because of the appearance of the other members in my union and the managements absolute absence that disappoints me deeply, and is the reason for why I struggle with going down there again. I have a sick note in my handbag, I will not go down there do deliver it either. I'll send it in the mail, it would never occur to me in half sleep even to go beyond that door.

Several of the informants mentioned problems with socialising at work; Sarah preferred to eat lunch alone to avoid social difficulties with integration. Work environments where emotions were not accepted to be shown made the health problems more difficult to handle.

The informants highlighted aspects that could improve socialising and work environment. It was desired that the managements had greater emphasis on conflict prevention, communication and cooperation to secure preventive measures. The informants brought up the importance for the employer and employees to be able to say that they are sorry if contravention occurs, and to have a conversation about the contravention instead of ignoring it or act as if nothing has happened. Implementing rules that were valid and known were argued as important for improvement of work environment. Absence of these was experienced as possible sources for confusions and conflicts. There was also a wish for discussions about culture at the workplace, so that the company was working towards the same goal and that it was clear what social behaviour was wanted and expected. Good routines, predictability and that the colleagues took precautions were also mentioned as important for the well-being at work, especially while having mental health problems.

The qualities in the leader were stressed as important. The informants experienced leaders without leading competence, leaders with short-term thoughts and ad-hoc management as challenging. It was important that the closest leader was caring, present,

structured, and had competence in planning. It was emphasised as valuable if it was all right to be absent from work without feeling you let the employer down, the informants stated that it would require an understandable and accommodating management. Regarding management, the difference between being a boss and a leader was underlined. Some of the leaders were referred to as leaders only on paper as a title, however not in a practical sense. The informants pointed out the absence of leadership and support. It was expressed a request for the management to be more distinct.

The size of the companies was mentioned as a factor that affected openness and social inclusion. It was easier to be open and get a close relationship with colleagues in smaller companies, and they did not feel as vulnerable as in larger companies. Large companies were described as impersonal, and the support was more easily missing. The human resources or personnel responsible were taking care of the formalities, but the employees expressed lack of social support from the closest leader. They therefore felt it was easier for the sick leave to go unnoticed in large companies. The need for support and acknowledgement was strongly expressed. Acknowledgement of their absence and to show support could be done by saying "take your time to be ill, but know that you and your good skills are wanted at work, and that care could be implemented if needed". That response should be a routine and conveyed with care according to the informants. They felt that the employers need better knowledge about mental health problems and should not be afraid to approach employees with health problems. They knew that the employers were busy and had major responsibilities, but the company could have long-term economic benefits of prioritising time to approach the employees with precaution and care.

It was perceived as stressful that the decision-making often took place in a different city in the large companies, and that the commands came from someone they did not have a relationship to. They had experiences with guidelines being hard to bend for care purposes because the same rules had to be equal for everyone. It was therefore argued that large companies were not suitable for special needs. If these aspects that were experienced as challenging by the informants were taken into consideration, they argued the possibility for a good work environment for employees with mental health problems.

Motivating aspects in the work environment. The informants stressed work as valuable and motivating, also while having mental health problems. The descriptions they gave about their workplace and work tasks indicated their desire to be at work. This sub-category will bring attention to motivating aspects in the work environment that were

highlighted as important while having mental health problems. These are regarded as liberating from their mental health problems, generosity, specific motivating aspects, ambitions, and consideration of motivating aspects as challenging.

There were many positive experiences and statements about work. Some said that work meant everything, it was a place to relax and disconnect from the health problems and therapy. As reflected in the identity category, work was a place to create other thoughts than a constant focus on diagnosis, the pain and the awfulness. Work made them feel committed and was by some mentioned to relieve symptoms.

Caroline: The thing that kept me from tipping over the edge was to have a job to go to (…). I had full anorexia and the bipolar illness. So when I arrived at work, there was these sliding doors. And it's so strange because it have become so symbolic for how those sliding doors, when they opened up in front of me, there was something that let go of the anorexia and of the isolation of anxiety. It just let go. And when I went in those doors and they shut, then I was at work. Then I was Caroline, in my twenties, strong in my arms, strong in my upper body. I was Caroline who could lift a man on hundred and ten kilos.

Work was seen as a place to be liberated from their mental health problems where they could escape from their own challenges. Therefore it was good to have the difference between personal and private (as mentioned in the vulnerability category), so that work was about a lot more than the diagnosis aspect. To respect the workplace as a location to be free from problems, there had to be a difference between the work and private life. Julia were motivated for work and therefore worked voluntarily. She stated it as a win-win situation where the employer received free work and she gained work experience while adapting her body to work life again.

Specific aspects that were experienced as motivating work tasks were tasks that were exciting and fun with the possibility to be autonomous. Work gave them strength, confidence and energy, and was described as propulsive, meaningful and life giving. They experienced positive challenges, achievement, confirmation, exuberance, social affiliation, and compassion. The list of motivating and valuable aspects at work were long, among other things the informants emphasised that it was good to feel needed by meaning something to others and by participating in the community. Some experienced to be met at the same premises as others, and they felt secure and safe both because of economic aspects but also to have predictability in the everyday life. It was especially motivating to work in an

environment characterised by colleagues who were proud of their workplace and who brought good mood and humour. Work environments with spread in gender were expressed as beneficial. Most prominent for the motivation was to be noticed and talked to, to participate to the work environment, and to be allowed to be mistaken, blunder or make mistakes.

Anna: The most palpable thing that make me feel included is when my leader, or some of the others give me specific work tasks that they want me to do (...). That they trust me with work task, not necessary that they trust me more than anyone else, but just that they have noticed that. This thing here is something that I am good at. And that I should do more of it because I'm great at it. To be noticed and talked to. And when it's quiet in the shop, to talk about other things too. It's very good to be social and that people wants to talk to you. That's a good feeling. And if people are happy and take considerations.

They appreciated generosity from their colleagues. The generosity could be expressed by having a conversation over a cup of tea to talk about the problems, or about anything else or to make them feel better. They also emphasised being met with curiosity, accept and understanding, and to be able to take a break when needed. They appreciated caring and sympathy from their employer and colleagues. They wanted a focus on social inclusiveness.

Most informants were ambitious and saw the ambitions as signs of healthiness. They sought new challenges at work and were looking forward to be able to work full time again. The ones that were in the middle of therapy expressed that ambitious thoughts felt exhausting because they had enough with just existing. Each and all of the informants accentuated work as important for the recovery process.

There were several examples of motivating aspects and personal desire to work that had unhealthy consequences when not restricted. The informants experienced to go beyond the resources they actually had, due to work environments where they were easily engaged in work tasks because of hectic tempo and exciting work. The informants described an eagerness to do well at work. Health was easily forgotten because of high devotion and conscientiousness. Pressure on time accounting did not have any function while working reduced hours because they worked till the work was done, ignoring amount of hours. They therefore worked more than was reported without being paid. Several informants revealed working more than necessary. It was expressed that it was challenging to find a balance between performing good work and focusing on their needs. This was a source for several of them becoming burned out and reason for concern regarding relapse.

It was expressed that the informants themselves did not have the competence or experiences to handle these kinds of challenges in the work environment. They stressed the importance of the management's responsibility to; follow up, pay attention to their employees' mental well-being, secure preventive measures for their employees to work too hard or too much.

Work environment summarised. Aspects in the work environment that were experienced as challenging while having mental health problems as employee were; if the companies do not pursue the IA- agreement, lack of follow-up, competitive environments, explaining or notifying absence, absence of social interaction, large companies, excessive devotion and conscientiousness, and lack of competence to handle challenging environments.

They mentioned aspects that motivated them, as employees with mental health problems, to work. Work environments with positive qualities such as encouraging and caring colleagues, encouragement of openness, present leaders, generosity, qualities as a leader and not a boss, ambitions, and to be separated from the health problems for a while, were positive. Arenas for openness were stated as important for the feeling of inclusiveness at work and as a good opportunity to talk about types of care.

Discussion

A lot of information was obtained from the interviews; the findings that were considered most important will be discussed. The information was divided into four categories as shown in the foregoing. The examples showed variation, reasons and contrasts, and are based on information that was emphasised as important by the informants.

Identity

Identities are affected by others. Self, personality, roles and identity are used to describe aspects about the individual. The informants highly emphasised the importance of being seen as normal, to feel normal, and to be valued for their personal or work identity. According to Mead (1934), the self is constructed trough interaction with others and perceived on behalf of background and experiences. The informants mentioned their identity to be affected by others' perception of them. Most people with disabilities have a desire to work, their identity and work ability are (besides their disability) affected by the environment and which abilities others see in them (Fryers, 2006). How we perceive others are described by what we think they expect from our behaviour, and which expectations these are. The

expectations of our own and others' behaviour affect our role. Our role changes on behalf of the context and situation, and on behalf of the person who see us (Mead, 1934). This might be the reason why the informants felt the person identity as insistent.

The informants gave examples (in the work environment category) of motivation for work where it was described experiences of symptom relief, and that the health problems were left outside when they entered the workplace. This was also reflected in the descriptions given in the identity category where work identity supressed the patient identity. The informants seemed to feel their individual identity and employee identity as reinforced at work. According to Hull, Lam & Vigo (1994) the values and meanings in the identity are affected by physical surroundings. It describes a subjective sense of belonging, which the informants felt at work. The theory about place-identity has not much empirical support in the psychology and is criticised for problems with measurement (Lalli, 1992). However, the place-identity has to be seen in addition to the usual approaches that are used to define identity in the psychology (Hauge, 2007). It have been said that children find their adult identity when they enter the work life (Fryers, 2006). The feeling of reinforced identity at work may also be due to group identification with colleagues (Speller et al., 2002), work is healthy for the identity because one establishes relationships outside the formalities of being a patient (Davidson et al., 2005). The work identity is important for health. People with disabilities outside the work life might experience discrimination reasoned by the lack of work identity. The informants describe experiences by being labelled by their diagnose and having an identity as a patient, their health problems became their identity. This is the same as unemployed disabled may experience because the diagnoses are often used in the community as labels. The use of labels for identity such as 'diabetic' or 'depressed' is stigmatising (Fryers, 2006). According to the information given by the informants, it seems like it is immensely important to let the person be at work, for the surroundings to lessen the focus on the patient identity, and to focus on the individual.

Identities change. The informants described a feeling of change in their identity. Carey et al., (2007) found that change in mental health patients occurs through feelings, thoughts, and actions. The informants expressed difficulties with change regarding identity and acceptance of health problems. Higginson & Mansell (2008) confirm similar findings. By interviewing people who were in recovery from mental health problems, they found changes in the informants' self-perception, feeling of control and their perspective on problems. The informants in the present study mentioned to have gained more control, and to handle

different challenges. Support on this may lie in the findings of Svanborg, Bäärnheim, Wistedt & Lützen (2008), who found that patients acquired knowledge of how to approach life, problems, and thought management. Other studies have also provided findings of accepting change where the person were determined to recover, accepted themselves as normal transversely of their mental health problems, respected their rights, and restored social interaction through work (Davidson et al.,, 2005).

The informants felt the need for control. The therapists contribute to a positive outcome by helping the patients through the stages of perceiving an inner chaos that maintain a gap in their identity, to a stage where they feel in control. The patients should be brought calmness through challenging their inner discontinuity by having continuity in the surroundings. The sense of control is partly reasoned by the routine of going to treatment that brings predictability and stability to their lives. It is also reasoned by the help they receive trough therapy with thought management and change of habitual patterns. The informants in the present study focused on the importance of identity in therapy, this can be done by showing understanding and by giving the patients tools for coping with their problems (Binder, Holgersen & Nielsen, 2009).

Role conflicts appear when mental changes are experienced; the conflict depends on the person's reflections (Huseby, Gjøsund & Nordheim, 2010). The informants described values at work that did not coincide with their own; this may be seen as a role conflict. They also described some sort of role conflict by the struggle with finding themselves to be something different than the patient identity that they felt was forced upon them. They described being torn between different identities (Macionis & Gerber, 2011). The informants felt difficulties related to knowing what part of their reactions were their own and which were due to their symptoms. A study by The Mental Health Foundation (2000) found that 70 per cent of people with mental health problems experienced questions where they had to explain their feelings to others. It was clear that their surroundings had prominent influence on their perceptions of identity. It is therefore important to focus on identity in the health care services, but also for the employer to be conscious of these difficulties. To have focus on return to work after sick leave and to employ applicants with mental health problems is important to reinforce the individual identity. This will also improve inclusiveness.

Vulnerability

Concerns of openness and stigma. Some of the informants expressed concerns of possible consequences with being open about their health problems at work. 66 per cent of the informants in the study by The Mental Health Foundation (2000) had concerns of openness reasoned by discrimination and stigma, and is supported by Glazier (2002). Friends and family were found to be the most frequent source of discrimination, followed by their workplace. Many employees with mental health problems have experiences with lack of promotion, and are a reason for not being open at work (The Mental Health Foundation, 2000). The literature abounds of findings that confirm the existence of stigma and discrimination of people with mental health problems (Brohan & Thornicroft, 2010; Corrigan, 2000; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Kobau et al., 2009; Krupa, et al., 2009; Tsang et al., 2008). The informants esteemed the consequences of being open about mental health problems as larger than the motivation to challenge the negative anticipations of outcome, these findings are confirmed in a study by Krupa et al., (2009). The employer has confidentiality and is not allowed to misuse the information given by the employee (Lovdata, 2005).

Dismissal was the most extreme outcome that was feared by the informants. It was unclear if they knew that it is not legal to dismiss an employee based on mental health problems, or if they thought the employers would find a different reason to dismiss them as a lie. Some of the informants were diagnosed with mental health problems for the first time, others expressed to have relapse and recurrent sick leave (see table 1). The informants also expressed differences in the length and the number of periods of absence. It is found that employees with mental health problems are more likely to have recurrent sick leave than employees without similar experiences (Dewa, Chau & Dermer, 2009). The employee has to be on sick leave for over a year for the employer to legally dismiss their employee. The law secures the employee from being dismissed on non-factual reasons (Arbeidstilsynet, 2015b). Although it is illegal to dismiss or discriminate for reduced capacity due to mental health problems (Lovdata, 2013), the informants have concerns and experiences of this matter. Stigma and discriminations can cause social isolation (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). There should be focus on prevention and reduction of both stigma and discrimination by education initiatives at schools and workplaces, and by a more positive perspective of mental health problems in the media (The Mental Health Foundation, 2000). Protest, education and contact with people with mental health problems are also influential if

psychological research on minorities and stigma are taken into consideration (Corrigan & Penn, 1999).

Concerns of stigma when applying for work. The informants had worries of meeting stigma and discrimination if they were open about their mental health problems when applying for work. These concerns might be legitimate according to literature. Stigma and discrimination can cause difficulties with employment (Crisp, Gelder, Rix, Meltzer, Rowlands, 2000). Employers hesitate to employ applicants with mental health problems because of the extra work with statutory regulations, risk, and economic cost (Spjelkavik, Hagen & Härkäpää, 2011: Kaye et al., 2011). It is assumed that discriminating and stigmatising anticipations of applicants with mental health problems is a reason not to employ applicants with mental health problems (Kaye et al., 2011). Employees with mental health problems are anticipated to be stubborn, aggressive, hypersensitive, having unstable emotions and lacking the ability to receive criticism. They were argued as behaving weird or inappropriate, not being flexible, having low motivation, and unstable work capacity with subsequent sick leave (Spjelkavik, Hagen & Härkäpää, 2011; Crisp, Gelder, Meltzer, Rowlands, 2000).

The negative aspects at work that make employees change work have negative affect on health and increase the likelihood for sick leave (Bernstrøm, 2013). This is also due to the length of period between the initial thought about change of work and new employment (Swider et al., 2011). When employed at new workplace, the likelihood for sick leave is reduced. This is due to increased thrive and motivation, but also because one often strive to avoid sick leave in the preface of employment to please the employer. Change of work does not have negative effect on health. The likelihood of reduced sick leave will fade away after six months of employment because the employee have settled and reached a normalisation in the employment (Bernstrøm, 2013). Unemployed with mental health problems behave out of fear for consequences, and may reason why unemployed with mental health problems does not apply for work (Corrigan, 2000).

Others with mental health problems understand. The study from Mental Health Foundation (2000) found that people with mental health problems have concerns of not being understood. This was found to be a reason for not being open, and confirm the findings in the present study. The informants accentuated others with mental health problems as the only ones to be able to really understand. Like the phrase "once burned twice shy", the informants

seemed to think that only those who had been burned (or in this case had experienced mental health problems) had learned. This exclusion criteria will make it difficult for others to help. It also emphasise the importance of arenas for openness at work, as well as forums where they can meet and exchange experiences with others with similar experiences.

This might be explained by the psychological theory of false-consensus where we assume that others in similar situations think or are likely to respond in the same way as ourselves. This is done to increase our feeling of fitting in, normality and to be part of something. People surround themselves with people similar to themselves. Being with others with mental health problems seemed to give the informants a sense of safety and had the assumptions that they would understand. We assume others to be alike ourselves because we surround ourselves with people who are alike. If they spent a lot of time thinking of their problems, it happens that one easily assume others with mental health problems have the same thoughts as themselves. The informants mentioned the power relation to be absent because they felt as equals. It may be a sort of exaggeration of our own beliefs that we ascribe others to feel safe (Martin, Carlson, Buskits, 2007).

Social Support

Psychologist treatment of mental health problems. Several of the informants expressed to be evaluated with lower capacity than themselves did, the likelihood for this is confirmed by research (Helsedirektoratet, 2011a). It is fair to assume that the general practitioners do their best to do the right evaluations. Therefore it may be problems with communication as a reason for evaluations that does not coincide. However, if the general practitioner is insecure of how much work that is healthy for the patient, it is understandable if he or she reduces the amount of recommended work instead of risking their patient's health to be deteriorated by being overworked. Work situation, satisfaction with management and work tasks, and being overworked are associated with risk of health (Berge & Falkum, 2013). The evaluations made by the general practitioners might be correct, but hard to accept or realise for the patient. The patients might be overestimating their own capacity, and underestimating their need for rest. The informants expressed the need for care to not become overworked caused by inclination to work. There might seem like the general practitioners offer this type of care, as the informants initially requested from their employer.

The informants had comments of psychologist being able to understand their health problems better than a general practitioner, as well as having time to talk. The second leading cause of sick leave in Norway is mental health problems (Sundell, 2012). Psychologist are

specialised in the field of mental health and could be used as an argument for them to influence on sick leave. The proposal for the psychologist to be allowed to authorise sick leave have been declined by the government, although it have been found that the patients request it (Halvorsen & Høstmælingen, 2014). Positive outcome by implementing psychologists authorise to give sick notes have been argued. The psychologist has treatments that seek to increase the possibility for return to work after sick leave, time to evaluate and are specialised on mental health (Aanonsen, 2005). The psychologists right to authorise sick note is among other things argued by saving time, costs and resources (Høstmælingen, 2014). It would be important for the patients to go directly to the psychologist to receive early treatment by avoiding mediators such as general practitioners. The informants mentioned problems with having to explain the same problem to several psychologists or general practitioners. To go directly to the psychologist instead of through the general practitioner would relief these concerns to a certain extent (Aanonsen, 2005). It will also be time saving for the general practitioners who will be updated by reports and meetings on their patients status.

The psychologist right to authorise sick notes were also argued to improve better access to treatment in the municipalities (Aanonsen, 2005). To have municipality psychologists were also argued as an alternative for easier access for adult mental health specialists, without having to experience deterioration to receive treatment. They wanted the opportunity to receive treatment by lower thresholds. One has the possibility to receive treatment in short time by private psychologist, but as the informants argued, the costs exceed the motivation to seek private treatment (Wiker, 2015). This might create a class distinction. In average, a patient have to wait 55 days before treatment is put into effect (Helsedirektoratet, 2011b), this affect the probability for attendance to treatment or reduce the outcome of the treatment (Biringer et al., 2015). To be offered therapy at a psychologist in the municipality before one experience deterioration and the need for specialist treatment at an outpatient clinic is important (Wiker, 2015). It might prevent relapse or chronic health problems, and may relieve some of the burdens that mental health problems cause relatives, community or others. There are different organisations working for establishment of municipality psychologist by law, as an offer to receive therapy by lower threshold (Ekelund, 2015).

The psychologists have the right to refer their patients directly to other health care services (Halvorsen, 2015). This is argued for the general practitioners to save time by not having to familiarise and sign the referrals to health care services. It also reduces the

likelihood for misunderstandings when the psychologists refer the patients directly to specialists (Aanonsen, 2005). To relieve burdens, mediators and time pressure for the patients in the health care services would affect the well-being in other aspects such as the workplace. It is important to consider the different aspects that exist in the life of the employee with mental health problems.

The general practitioners treatment of mental health problem. The informants mentioned lack of respect for their general practitioners advice. They disregarded their general practitioners advice by attending work although they were given a sick note. It might be discussed as a wrong judgement where the eager of the one with mental health problems are being overlooked. On the contrary, if the judgement of the general practitioner is right and the health of the ill is in such a state that it is not healthy or secure to work, it might have tremendous consequences for them selves and others if they do. Attending work while on sick leave prevents a possible risk in several occupations.

The general practitioners are probably in the belief that the patient will deliver the sick note to their employer because the sick note have to be approved by the patient. The employees are obliged by law to notify the employer about illness (according to Arbeidsmiljøloven §2-3, e) (Lovdata, 2005). The general practitioner is not allowed to notify the employer because it would be a breach of confidentiality. It could be argued that the general practitioner should send out the sick notes after agreement with the patient, the employer would still not have the right to know the reason for sick leave as the rules are today (Altinn, 2014; Lovdata, 2005). However, it might have negative consequences for the relationship and trust between patient and general practitioner. The general practitioners confidentiality is solid and valued in Norway today, and even in court a general practitioner would not retell their patients information unless there was a probability for recurrence of a serious incident or if the patient was innocent (Lovdata, 2015; General practitioner, telephone meeting, April 29, 2015).

Some of the informants made it clear that if they evaluated their health as appropriate and if they wished to work, then they would omit the sick note. When the employers attend work while on sick leave, the employers insurance for the employee would not be valid in case of emergency or injuries at the workplace. It might have consequences for themselves as well as their surroundings. To avoid such consequences it would be important to have a clear dialog about the reasons for the advice given by the general practitioner (General practitioner, telephone meeting, April 29, 2015).

The general practitioners have the right to commit the patient to a psychiatric ward if needed according to §3-2, subparagraph 6 ("vedtak om tvungen observasjon"). To commit the patient is only done when it is the best alternative (Lovdata, 2014; Lovdata, 2015). There are different strategies that could be used if the employee is too ill to work, but not ill enough to be committed to psychiatric ward. To create an alliance where the patient have trust in the general practitioner, and for the general practitioners to give a clear advice is important. Openness, good relationship and good communication would likely improve such situations (General practitioner, telephone meeting, April 29, 2015). The evaluation the general practitioners do is important. The informants stressed the support from the health care services as wanted and needed. The need for health care services is invaluable for identification, treatment and recovery (Caldas de Almeida & Killaspy, 2011).

Care at the university. The knowledge of care at the university appeared to be little and not well examined. The informants had worries about care at the university. The rights for care regarding mental illness are as righteous as for physical illness according to the regulations at The Arctic University of Norway; §28 deadlines for applications for individual care and §29 persisting physical and mental impairment (Karlsen, 2013). It might seem like the informants had not been bothered to check their rights, not having the capacity or maybe they had problems with knowing where to look. The student consultants would probably be helpful with information about care for mental illness.

Social grouping as a result of restricted openness. Social grouping are important to our identities, and can contribute to support (Aronson, Wilson & Akert, 2010). The informants mentioned social grouping at work where the in-group were the ones they confide to and the others seemed to have qualities that made them distrust them. Secrecy might be forced upon the colleagues in the in-group, and might bring dilemmas to the colleagues. What is best for the individual might not be the best for everyone else in the group (Aronson, Wilson & Akert, 2010). The groups are distinctly separated and conditioned by the employee's confide. The grouping might harm the work environment or create dilemmas because the colleagues interact and are often dependent of each other in different situations (e.g. when work tasks become abandoned when on sick leave).

Problems between the groups can occur. Firstly, if the in-group colleagues have friends from the out-group, then the in-group might have to answer questions asked by the out-group. The in-group members are in a way pressured to make moral choices of keeping

secrecy if others confront them about the employee's absence. That is something that would depend on the colleagues values and moral, but also on the guidelines given by the employee regarding who are accepted to know and who are not.

Secondly, if the management are part of the out-group (like Sarah gave example of by informing one colleague and not the management) there might be problems regarding ethics or moral. The in-group might get a large dilemma between care the friendship by secrecy contra notifying the management by breach of trust. That is a large responsibility to be given. There can be situations where the colleagues then have to evaluate the safety or risks regarding work tasks by keeping secrecy.

Thirdly, if the in-group is larger than the out-group it might have problematic consequences for the work environment. The out-group does not make the choice themselves, and are not able to evaluate the information as interesting or not when they do not know the information (in this case, about the mental health problems). The problem is that in- and out-groups might have consequences of obvious exclusion that can be hurtful for the out-group. The in-group decides who are to be included. Thereby there is a power relation to the groupings. There are different scenarios and outcomes by social grouping. It is important for the employee to have support and confide to others at the workplace, but the management should also know about the health problems. To be at work is important for the individual because it is a social arena for development and interaction. Lack of social interaction (through work) might have consequences for the social skills, social support, and sense of belonging (Aronson, Wilson & Akert, 2010; Martin, Carlson & Buskits, 2010).

Work Environment

IA-agreement. None of the part-time employees knew if they were employed in an IA-company (see table 1). The IA-agreement includes all the employees of an IA-company, it includes part-time employees, reduced positions as well as full time employees. After twelve weeks of signing the agreement, there should be compiled aims and plan of action. The company's IA-advisor from NAV follows up on the company's work towards their aims. The informants requested stricter follow up and consequences when the agreement was not over-held. There is one sanction if the IA-companies do not fulfil the agreement and that is for NAV to dismiss the agreement (NAV Troms, Arbeidslivssenter, electronic communication, April 16, 2015). According to the information from the informants, it seems like there could be done more work in this field.

The employees mentioned interpretations of the reduced sick leave by being 50 per cent productive the whole day or hundred per cent productive half of the day. According to NAV (and "rundskriv" §8-6 graded sick leave) this interpretation is legal (NAV, 2014b). The employee is on sick leave from amount of work and not necessarily work hours. The informants mentioned difficulties with distributing work hours when working on projects. When working with half productivity, half of the hours should be distributed to the projects and the other half are covered by NAV (NAV Hordaland, Arbeidslivssenter, telephone meeting, April 30, 2015). The informants seemed to overcharge the projects because of lack of knowledge or information about the support from NAV. Better information would probably improve the employees understanding and reduce frustrations regarding the system. It is not certain if the informants sought advice from their employer on this matter, but it might indicate lack of communication.

The use of "dialogmøte". The employers are by law (Folketrygdloven §25-2) obliged to implement "dialogmøte" and therefore regards all companies (NAV, 2014c). If the obligations are not fulfilled, The Norwegian Labour Inspection Authority can give the companies orders to implement "dialogmøte" (NAV Hordaland, Arbeidslivssenter, telephone meeting, April 30, 2015). The "dialogmøte" should be completed within seven weeks (Arbeidstilsynet, 2015a), the informants had experiences of this to not be over held. This is one of several things that made them feel alone with their health problems and let down by their employer. The employer have the right to notify, and are sometimes obliged to (Arbeidstilsynet, 2015c). The employees are obliged to notify the employer about illness, contribute to follow-up plans and solutions for work tasks, follow the advices from NAV and meet at "dialogmøte" (according to Arbeidsmiljøloven §2-3, f, g, h) (Lovdata, 2005). It seemed like this was difficult for the informants. They seemed like they did not know who to contact in these situations when their employer did not contribute. The Norwegian Labour Inspection Authority can be contacted with questions, they have an advisory as well as an executive function. NAV or the company health service can also be contacted for advice. The employees have the right to bring or notify their employee representative, safety delegate, and working environment comitee (Arbeidstilsynet, 2015c). This requires that the employees have energy and that they trust the ones they contact.

Flexibility from the employer. The employers are also obliged by law to follow up and tend for employees with mental health problems. The employees should preferably keep their usual work. Work hours should also be adjusted to the employees needs (Lovdata, 2005). This means that the employers are obliged to as far as possible, to meet the informants wish for flexibility in amount of work and to what time. This obligation is independent of age, amount of work, and permanent or temporary employment. The possibilities depend on the work tasks, size of the company, economy, and employment. The employer is obliged to send a report of the follow-up to NAV and the general practitioner (Helsedirektoratet, 2011c). The informants did not seem to know what their rights were, those who did requested consequences for the company. When the employer did not follow-up on their obligations or there were delays in care it had consequences for the informants. The informants felt rejected, alone, and it may have serious consequences for employment and deterioration of health problems. The informants feeling of being alone with their problems seemed like a form for helplessness because the employee was left alone with their problems. They experienced to be let down by the system, but it did not seem like any of the informants had used their right to notify. The vulnerability and fear of misused power relation might be a reason for this, if not lack of knowledge.

Limitations of the Present Study

In the observations and analysis, the information is assigned a subjective meaning by the researcher. The subjective meaning is both academic and personal. In the present study, the researcher had e.g. academically interests within organisational psychology and personally interest caused by relatives with mental health problems. The researchers' expectations for the study might also influence the research process. It is possible to attempt to put the subjective interpretation aside and be focused on having an open view on the phenomenon of study, but it will never be entirely possible. Also known by Edmund Husserl as bracketing (Jennings, 1986).

The informants spoke about reduced motivation during the polar nights, a time when it is dark throughout the day. This phenomenon occurs from November 25th to January 17th in Tromsø. The recruitment improved in the spring semester, therefore it might be that the polar nights actually affected the willingness to become involved in the study. The delay of recruitment might have affected the study.

The fact that some people (employees with mental health problems) were unaware of this experiment must be taken into consideration when evaluating the outcome. Meaning there are still aspects of mental health problems that remain uncovered because of the limitations of recruitment area.

Only two out of the twelve informants were male, which might reduce the generalisation of the study. There were variation in both diagnoses and stages in the recovery process might have affected the results of this study. The informants were not asked directly which diagnoses they had, the obtained information about health afflictions is an indication of the informants health problems.

The study has been affected by the choice of qualitative research interview (as described by Kvale & Brinkmann, 2009) and Interpretative Phenomenological Analysis (by Smith & Osborne, 2008). The present study might have had a different outcome by the use of other methods. The decisions made throughout the process of this study affected the outcome, Further study should consider these limitations.

Conclusion

It is important to have focus on identity in all the arenas that the employee with mental health problems roams. The individual identity, and the identity as an employee are both stated as positive and wanted. It is important to sustain these for the person to develop and to stay grounded. The use of labels and diagnoses should be avoided, the patient identity should be handled with care and balanced support. To be let down by the employer or health care system may have consequences both for the individual, their family and colleagues. It is important to spread knowledge of the employees' rights to notify and how it is done. Social support has to include identity focus and take the vulnerabilities into consideration. Treatment needs to be accessible, and the support has to be balanced to not disempower, exclude or make the person feel helplessness. Although support is rejected, different approaches of concern should be tried. Challenges and motivating factors in the psychosocial and organisational work environment have to be considered. It is also important to consider the different aspects in the life of the employee with mental health problems, to understand their challenges and secure inclusiveness. It is valuable to treat each employee as an individual with individual health problems and needs. These considerations might contribute to improve the understanding of how to include and tend for employees with mental health problems in the workplace.

References

Aanonsen, A. (2005). Psykologers adgang til henvisning og sykemelding. *Tidsskrift for Norsk Psykologforening, 42*(4), 353-356. Retrieved from: http://www.psykologtidsskriftet.no/pdf/2005/353-356.pdf

Altinn. (2014). *Egenmelding.* Retrieved from: https://www.altinn.no/no/Starte-og-drive-bedrift/Drive/Arbeidsforhold/Sykdom-og-skader/Nar-er-egenmelding-tilstrekkelig/

Anthony, W. A., & Farkas, M. D. (2009). A Primer on the Psychiatric Rehabilitation Process. Boston: Boston University, Center for Psychiatric Rehabilitation. Retrieved from http://cpr.bu.edu/wp-content/uploads/2011/11/Primer-on-the-Psychiatric-Rehabilitation-Process.pdf

Anvik, C. H., & Gustavsen, A. (2012). *Ikke slipp meg! Unge, psykiske helseproblemer, utdanning og arbeid*. (NF rapport nr. 13/2012). Bodø: Nordlands Forsknings Institutt.

Arbeids- og velferdsdirektoratet. (2012). Ansatt i en IA-virksomhet, hva betyr det for meg? Oslo: 07 Gruppen.

Arbeidstilsynet. (2015a). *Tilrettelegging for og oppfølging av sykemeldte arbeidstakere.* Retrieved from: http://www.arbeidstilsynet.no/fakta.html?tid=78249/

Arbeidstilsynet. (2015b). *Oppsigelse.* Retreieved from: http://www.arbeidstilsynet.no/fakta.html?tid=78229

Arbeidstilsynet. (2015c). *Varsling om kritikkverdige forhold på arbeidsplassen.* Retrieved from: http://www.arbeidstilsynet.no/fakta.html?tid=92257

Aronson, E., Wilson, T. D., & Akert, R. M. (2010). *Social Psychology.* New jersey: Pearson Education Inc.

Berge, T., & Falkum, E. (2013). *Se mulighetene. Arbeidsliv og psykisk helse.* Oslo: Gyldendal Norsk Forlag AS.

Bernstrøm, V. H. (2013). En forfriskende endring. *Scandinavian Journal of Organizational Psychology. Norsk Organisasjonspsykologisk Selskap. 5*(2). Retrieved from: http://sjop.no/index.php/sjop/article/viewFile/304/315

Bertilsson, M., Peterson, E., Östlund, G., Waern, M., & Hensing, G. (2013). Capacity to Work While Depressed and Anxious – a phenomenological study. *Disability and Rehabilitation. An International, multidisciplinary journal. 35* (20), 1705-1711 doi: 10.3109/09638288.2012.751135.

Binder, P., Holgersen. H., & Nielsen, G, H. (2009). Why Did I Change When I Went to Theraphy? A Qualitative Analysis of Former Patients' Conceptions of Successful

Psychotherapy. *British Association for Counselling and Psychotheraphy. 9*(4), 250-256. Doi: 10.1080/1473314090289088

Biringer, E., Sundfør, B., Davidson, L., Hartveit, M., & Borg, M. (2015). Life on a Waiting List: How do People Experience and Cope With Delayed Access to a Community Mental Health Center? *Scandinavian Psychologist. (2).* doi:org/10.15714/scandpsychol.2.e6

Borg, M., & Topor, A. (2007). *Virksomme relasjoner: Bedringsprosesser ved alvorlige psykiske lidelser.* Oslo: Kommuneforlaget.

Brocki, J. M., & Wearden, A. J. (2006). A Critical Evaluation of the Use of Interpretative Phenomenological Analysis (IPA) in Health Psychology. *Psychology & Health. 21*(1), 87-108. doi: 10.1080/14768320500230185

Brohan, E., & Thornicroft, G. (2010). Stigma and Discriminations of Mental Health Problems: Workplace Implications. *Occupational Medicine. 60* (6), 414-420. doi: 10.1093/occmed/kqq048

Caldas de Almeida, J. M., & Killaspy, H. (2011). Long-Term Mental Health Care for People With Severe Mental Disorders. *European Union.* 1-20. Retrieved from: http://ec.europa.eu/health/mental_health/docs/healthcare_mental_disorders_en.pdf

Carey, T. A., Carey, M., Stalker, K., Mullan, R.J., Murray, L. K., & Spratt, M. B. (2007). Psychological Change From the Inside Looking Out: A qualitative investigation. *Counselling and Psychotherapy Research, 7,*(3), 178-187. doi:10.1080/14733140701514613

Corrigan, P, W. (2000). Mental Health Stigma as Social Attribution: Implications for Research Methods and Attitude Change. *Journal of Clinical Psychology, American Psychological Association. 7,* 48-67. Retrieved from: https://und.edu/health-wellness/healthy-und/mental-health-stigma-fawn.pdf

Corrigan, P. W., & MacCracken, S. G. (2005). Place First Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation. *Social Work. Oxford University Press. 59* (2). Retrieved from: http://www.jstor.org/discover/10.2307/23721297?uid=37855&uid=3738744&uid=2&uid=3&uid=5909240&uid=67&uid=62&uid=37854&sid=21106681847573

Corrigan, P. W., & Penn, D. L. (1999). Lessons From Social Psychology on Dedicating Psychiatric Stigma. *American psychologists. 54*(9), 765-776. doi: org/10.1037/0003-066X.54.9.765

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatation of People With Mental Illnesses. *The British Journal of Psychiatry. 177*(1), 4-7. doi:10.1192/bjp.177.1.4

Cuijpers, P., Boluijt, P., & van Straten, A. (2008). Screening of depression in adolescents through the Internet. *European Child & Adolescent Psychiatry, 17*, 32-38. doi: 10.1007/s00787-007-0631-2

Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., & Sells, D. (2005). Processes of Recovery in Serious Mental Illness: Findings from a Multinational Study. *American Journal of Psychiatric Rehabilitation, 8*, 177-201. doi:10.1080/15487760500339360

Dewa, C. S., Chau, N., & Dermer, S. (2009). Factors associated with short-term disability episodes. *Journal of Occupational and Environmental Medicine, 51*(12), 1394-1402. doi: 10.1097/JOM.0b013e3181bc3f7c

Dewa, C. S., Corbiére, M., Durand, M., & Hensel, J. (2012). Challenges Related to Mental Health in the Work Place. In Gatchel, R. J., & Schultz, I. Z. (Ed.) *Handbooks in Health, Work and Disability*. (105-129). New York: Springer. doi: 10.1007/978-1-4614-4839-6

Dewa, C. S., Corbière, M., Durand, M-J., & Hensel, J. (2013). Challanges Related to Mental Health in the Workplace. R. J. Gatchel, & I. Z. Schultz. *Handbook of Occupational Health and Wellness*. Springer.

Dyrstad, K., Mandal, R., & Ose, S. O. (2014). *Rapport, Evaluering av Jobbstrategien for personer med nedsatt funksjonsevne.* Trondheim: SINTEF.

Ekelund, S. M. (2015). Jakten på lavterskeltilbud. *Norsk Psykolog Forening.* Retrieved from: http://www.psykologforeningen.no/Foreningen/Politikk/Psykolog-i-kommunen/Jakten-paa-lavterskeltilbud

Espnes, G. A., & Smedslund, G. (2009). *Helsepsykologi*. Gyldendal Norsk Forlag AS.

Falkenberg, H., Fransson, E. I., Westerlund, H., & Head, J. A. (2013). Short- and long-term effects of major organisational change on minor psychiatric disorder and self-rated health: results from the Witehall II study. *Journal of Occupational and Environmental Medicine, 70,* 688-696. doi: 10.1136/oemed-2013-101385.

Flach, P. A., Groothoff, J. W., & Bültmann, U. (2013). Identifying employees at risk for job loss during sick leave. *Disability and rehabilitation, 35,* 1835-1841. doi: 10.3109/09638288.2012.760657.

Flores, N., Jenaro, C., Orgaz, M. B., & Martin, M. V. (2011). Understanding Quality

of Working Life of Workers with Intellectual Disabilities. *Journal of Applied Reasearch in Intellectual Disabilities, 24,* 133-141. doi: 10.1111/j.1468-3148.2010.00576.x

Fryers, T. (2006). Work, Identity, Health. *Clinical Practical Epidemological Mental Health. 2*(12). doi: 10.1186/1745-0179-2-12

Gavin, J. F. (1975). Employee Perceptions of the Work Environment and Menthal Health: A suggestive Study. *Journal of Vocational Behaviour,6,* 217-234. doi:10.1016/0001-8791(75)90048-2

Glazier, N. (2002). Mental ill Health and Fitness for Work. *Occupational & Environmental Medicine. 59*, 714-720. doi:10.1136/oem.59.10.714

Huseby, R., Gjøsund, P., & Nordheim, B. (2010). Mennesket i utvikling. Oslo: Cappelen Damm.

Granerud, A. (2004). *Sosial integrering for mennesker med psykiske problemer – erfaringer, utfordringer og ønsket støtte.* (Rapport nr. 19/2004). Elverum: Høyskolen i Hedmark.

Hall, D. T. (1976). *Careers in organizations.* California: Goodyear publications.

Halvorsen, P. (2015). Henvisningsretten, en seier for pasientene. *Norsk Psykolog Forening.* Retrieved from: http://www.psykologforeningen.no/Foreningen/Politikk/Henvisningsrett/Henvisningsretten-En-seier-for-pasientene

Halvorsen, P., & Høstmælingen, A. (2014). Får ikke sykemeldes av psykolog. *Norsk Psykolog Forening.* Retrieved from: http://www.psykologforeningen.no/Foreningen/Politikk/Sykmeldingsforsoeket/Faar-ikke-sykmeldes-av-psykolog/(language)/nor-NO

Hand, C., & Tryssenaar, J. (2006). Small business employers' Views on Hiring Individuals With Mental Illness. *Psychiatric Rehabilitation Journal. 29*(3), 166-173. doi: org/10.2975/29.2006.166.173

Hauge, Å, L. (2007). Identity and Place: a Critical Comparison of three identity Theories. *Arcitectual Science Review.* 1-15.

Helsedirektoratet. (2011a). Arbeid er viktig for den psykiske helsen. *Helsedirektoratet.* Retrieved from: http://helsedirektoratet.no/psykisk-helse-og-rus/psykisk-helsearbeid/arbeid-og-psykisk-helse/forebygging/Sider/arbeid-er-viktig-for-den-psykiske-helsen.aspx

Helsedirektoratet. (2011b). Ventetider og pasientrettigheter. *Helsedirektoratet.* Retrieved from: https://helsedirektoratet.no/statistikk-og-analyse/statistikk-fra-norsk-pasientregister/ventetider-og-pasientrettigheter

Helsedirektoratet. (2011c). Faglig veileder for sykemeldere. *Helsedirektoratet.* Retrieved from:http://sykmelderveileder.helsedirektoratet.no/samarbeid/dialogmote/Sider/default.aspx

Hensing, G., Bertilsson, M., Ahlborg, G. Jr., Waern, M., & Vaes, M. (2013). Self-assessed mental health problems and work capacity as determinants of return to work: a prospective general population-based study of individuals with all-cause sickness absence. *Biomed Central Psychiatry, 13,* 259. doi:10.1186/1471-244X-13-259

Higginson, S., & Mansell, W. (2008). What is the Mechanism of Psychological Change? A Qualitative Analasis of Six Individuals Who Experienced Personal Change and Recovery. *Psychology and Psychotherapy : Theory, Research and Practice, 81*, 209-328.

Hull, B. R., Lam, M., & Vigo, G. (1994). Place Identity: Symbols of Self in the Urban Fabric. *Landscape and Urban Planning. 28,* 109-120. doi: 10.1016/j.sbspro.2012.07.014

Høstmælingen, A. (2014). Sykemeldingsforsøket. *Norsk Psykolog Forening.* Retrieved from: http://www.psykol.no/Foreningen/Politikk/Sykmeldingsforsoeket/Sykmeldingsforsoeket

IA-avtalen. (2014). Intensjonsavtale om et mer inkluderende arbeidsliv. 4. Mars 2014- 31. Desember 2018. (IA-avtalen). *Regjeringen.* Retrieved from: https://www.regjeringen.no/globalassets/upload/asd/dokumenter/2014/ia_20142018/signert_ia_avtale.pdf

Jennings, J. L. (1986). Husserl Revisited: The Forgotten Destinction Between Psychology and Phenomenology. *American Psychologist. 41*(11),1231-1240. doi: org/10.1037/0003-066X.41.11.1231

Karlsen, G. (2013). Forskrift for eksamener ved Universitetet i Tromsø – Norges Arktiske Universitet. *Universitetet i Tromsø Norges Arktiske Universitet.* Retrieved from: http://uit.no/utdanning/art?p_document_id=347697&dim=179018

Kaye, H. S., Jans, L. H., & Jones, E. C. (2011). Why do not employers hire and retain Workers with disabilities? J Occup Rehabil, 21(4), 526-536. doi: 10.1007/s10926-011-9302-8

Kobau, R., DiIorio, C., Chapman., & Delvecchio, P. (2009). Attitudes About Mental Illness and its Treatment: Validation of a Generic Scale for Public Health Surveillance of Mental Illness Associated Stigma. *Community Mental Health Journal. 46,* 164-176. doi: 10.1007/s10597-009-9191-x

Krupa, T., Kirsh, B., Cockburn, L., & Gewurtz, R. (2009). Understanding the stigma of mental illness in employment. Work, 33(4), 413-425. doi: 10.3233/WOR-2009-0890

Kvale, S., Brinkmann, S. (2009). *Det kvalitative forskningsintervju*. Gyldendal Akademisk.

Lalli, M. (1992). Urban Related Identity: Theory, Measurement and Empirical Findings. *Journal of Environmental Psychology, 12*, 285-303. doi:10.1016/S0272-4944(05)80078-7

Lee, M. S-M., Lee, M-B., Liao, S-C., & Chiang, F-T. (2009). Relationship Between Mental Health and Job Satisfaction Among Employees in a Medical Center Department of Labaratory Medicine. *Journal of the Formosan Medical Association, 108,* 146-154.

Lovdata. (2005). Lov om arbeidsmiljø, arbeidstid og stillingsvern mv. (Arbeidsmiljøloven). *Lovdata.* Retrieved from: https://lovdata.no/dokument/NL/lov/2005-06-17-62

Lovdata. (2013). Lov om forbud mot diskriminering på grunn av nedsatt funksjonsevne (Diskriminerings- og tilgjengelighetsloven). *Lovdata.* Retrieved from: https://lovdata.no/dokument/NL/lov/2013-06-21-61

Lovdata. (2014). Etablering og opphør av tvungent psykisk helsevern. *Lovdata.* Retrieved from: https://lovdata.no/dokument/NL/lov/1999-07-02-62

Lovdata. (2015). Lov om etablering og gjennomføring av psykisk helsevern. *Lovdata.* Retrieved from: https://lovdata.no/dokument/NL/lov/1999-07-02-64/KAPITTEL_5

Macionis, J. J., & Gerber, L. M. (2011). *Sociology.* Ottawa: Pearson Education.

Malterud, K. (2001a). Qualitative Research: Standards, Challenges, and Guidelines. *The Lancet Publishing Group. 38,* 483-488.

Malterud, K. (2001b). The Art and Science of Clinical Knowledge: Evidence Beyond Measures and Numbers. *The Lancet Publishing Group. 358,* 397-400.

Martin, G, N., Carlson, N, R., & Buskits, W. (2007). *Psychology*. Edinburgh: Pearson Education Limited.

Mead, G. H., (1934). *Social Psychology. The Heritage of Sociology.* In *Selected Papers, Edited and With a Revised Introduction*. Strauss, A. (Ed.). Chicago: The University of Chicago Press.

Mykletun, A., & Knudsen, A. K. (2009). Rapport 2009:8. Psykiske lidelser i Norge: Et folkehelseperspektiv. Folkehelseinstituttet.

NAV. (2014a). *About NAV.* Retrieved from: https://www.nav.no/en/Home/About+NAV/What+is+NAV

NAV. (2014b). Rundskriv. *NAV.* Retrieved from: https://www.nav.no/rettskildene/Rundskriv/§+8-6+Gradert+sykmelding.147690.cms

NAV. (2014c). Rundskriv. *NAV.* Retrieved from: https://www.nav.no/rettskildene/Rundskriv/§+25-2+Arbeidsgiverens+plikt+til+å+føre+statistikk+over+sykefravær,+utarbeide+oppfølgingsplan+og+gjennomføre+dialogmøte.148015.cms

NAV. (2015). Arbeid og psykisk helse. *NAV.* Retrieved from https://www.nav.no/internett/no/Person/Arbeid/Oppfolging+og+tiltak+for+å+komme+i+jobb/Relatert+informasjon/Nasjonal+satsing+på+arbeid,+psykisk+helse+og+rus.346114.cms

Nilssen, V. (2012). *Analyse i kvalitative studier, den skrivende forskeren.* Oslo: Universitetsforlaget.

Norwegian Institute of Public Health. (2014). Folkehelserapporten 2014. *Folkehelseinsituttet.* Retrieved from: http://www.fhi.no/eway/default.aspx?pid=239&trg=Content_7242&Main_6157=7239:0:25,8904&MainContent_7239=7242:0:25,8906&Content_7242=7244:110542::0:7243:5:::0:0

Nieuwenhuijsen, K., Faber, B., Verbeek, Jos. H., Neumeyer-gromen, A., Hees, H. L., Verhoeven, A. C.,… Bütmann, U. (2014). Interventions to Improve Return to Work in Depressed People. doi: 10.1002/14651858.CD006237.pub3

Peters, H., & Brown, T. C. (2009). Mental illness at work: An assessment of co-worker reactions. *Canadian Journal of Administrative Sciences / Revue Canadienne des Sciences de l'Administration, 26*(1), 38-53. doi: 10.1002/cjas.87

Ringard, Å., Sagan, A., Saunes, I. S., & Lindahl, A. (2013). Health Systems in Transition. Norway Health System Review. *World Health Organisation. European Observatory on Health Systems and Policies. 15*(8), 1-162. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0018/237204/HiT-Norway.pdf

Robinson, L., Dickinson, C., Rousseau, N., Beyer, F., Clarck, A., …C, Exley. (2011). A Systematic Review of the Effectiveness of Advance Care Planning Interventions for People with Cognitive Impairment and Dementia. *Oxford Journals. 44(3).* doi: 10.1093/ageing/afr148

Ruglies, R., Hjarsbech, P. U., Aust, B., Christensen, K. B., Andersen, R. V., & Borg, V. (2013). To what extent do single symptoms from a depression rating scale predict risk of long-term sickness absence among employees who are free of clinical depression? *Archives of Occupational Environmental Health. 86*, 735-739. DOI 10.1007/s00420-012-0797-x.

Rådet for psykisk helse. (2004). Psykiske problemer og jobb, råd og fakta om oppfølging av medarbeidere. Merkur trykk. *Arbeidslivssatsningen ved Sosial- og helsedirektoratet.* Hentet fra http://www.psykiskhelse.no/novus/upload/file/temah/PsykProb&Job.pdf

Sanne, B., Mykletun. A., Dahl. A. A., Moen. B. E., & Tell. G. S. (2005). Testing the job demand-control-support model with anxiety and depression as outcomes: The Hordaland health study. *Occupational Medicine*(55), 463-473. doi: 10.10.93/occmed/kqi071

Smith, J. A., Osborn, M. (2008). Four: Interpretative Phenomenological Analysis. Qualitative Psychology, A practical guide to research methods. SAGE Publications Ltd.

Speller, G. (2002). A Community in Transition: A Longitudinal Study of Place and Attachment and Identity Process in the Context of an Enforced Relocation. Unpublished PhD Thesis. Guildford: University of Surrey.

Spjelkavik, Ø., Hagen, B., & Härkäpää, K. (2011). *Supported Employment i Norden.* Oslo/Akershus: Arbeidsforskningsinstituttet.

Sund, A. M., Larsson, B., & Wichstrom, L. (2011). Prevalence and characteristics of depressive disorders in early adolescents in central Norway. *Child and Adolescent Psychiatry and Mental Health, 5*, 28. doi:10.1186/1753-2000-5-28

Sundell, T. (2012). Utviklingen i sykefraværet, 3. Kvartal 2012. (Ed.): Arbeids- og velferdsdirektoratet, seksjon for statistikk. NAV.

Svanborg, S., Bäärnhielm, Wistedt, A. Å., & Lützen, K. (2008). Helpful and Hindering Factors for Remission in Dysthymia ans Panic Disorder at 9-year Follow-up: A Mixed Methods Study. *BMC Psychiatry, 8,* 52. doi:10.1186/1471-244X-8-52

Swider, B. W., Boswell, W. R., & Zimmer- man, R. D. (2011). Examining the Job Search-Turnover Relationship: The Role of Embeddedness, Job Satisfaction, and Available Alternatives. *Journal of Applied Psychology, 96*(2), 432−441. doi: 10.1037/A0021676

Thapar, A., Collishaw, S., Potter, R., & Thapar, A. K. (2010). Managing and preventing depression in adolescents. *British Medical Journal, 340,* 254-258. doi: 10.1136/bmj.c209

The Mental Health Foundation (2000). Pull Yourself Together! A Survey of the Stigma and Discrimination Faced by People Who Experience Distress. *The Mental Health Foundation.* 2(4).

The National Institute of Occupational Health. (2011). Mental helse og deltakelse i arbeidslivet. Hentet fra http://www.stami.no/mental-helse-og-deltakelse-i-arbeidslivet

Tsang, H. W. H., Angell, B., Corrigan, P. W., Lee, Y., Shi, K., … Fung, K. M. T. (2008). A Cross-cultural Study of Employers' Concerns About Hiring People With Psychotic Disorder: Implications for Recovery. *Social Psychiatry Epidemiology. 42,* 723-733. doi:10.1007/s00127-007-0208-x

Vijfeijke, H. Van de., Leijten, F. R. M., Ybema, J. F., Heuve, S. G. Van den., Robroek, S. J. W., Beek, A. J. Van der., …Taris, T. W. (2013). *Journal of Occupational and Environmental Medicine, 55*, 1238-1243.

Wiener, Y., Vardi, Y., & Muczyk, J. (1981). Antecedents of Employees' Mental Health-The role of career and Work Satisfaction. *Journal of Vocational Behaviour, 19,* 50-60.

Wiker, G. (2015). Psykologisk lavterskeltilbud til befolkningen i et livsløpsperspektiv. *Norsk Psykolog Forening.* Retrieved from: http://www.psykologforeningen.no/Foreningen/Politikk/Psykologisk-lavterskeltilbud-til-befolkningen-i-et-livsloepsperspektiv/(language)/nor-NO

QSR (2008). Nvivo 8. Dencaster, QSR: International Pty Ltd, Victoria, Australia.

Appendix A

Arbeid og psykisk helse - arbeidstakers perspektiv 25.08.14

Forespørsel om deltakelse i forskningsprosjektet

Arbeid og psykisk helse - arbeidstakers perspektiv

Bakgrunn og hensikt
Dette er et spørsmål til deg om å delta i en forskningsstudie om psykisk helse og arbeid. Studien gjennomføres av UiT – Norges arktiske universitet. Formålet med studien er å få økt kunnskap om erfaringer og utfordringer personer med psykiske plager opplever i forhold til å opprettholde eller gjenoppta arbeid. Studien vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke på arbeidsplassen, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser. Studien inngår i en masteroppgave i psykologi ved Institutt for Psykologi ved UiT – Norges arktiske universitet. Deltakere inviteres blant de som mottar hjelp ved Voksenpsykiatrisk poliklinikk og behandlingstilbudet "Raskere tilbake", er mellom 18 og 67 år og arbeidstaker.

Hva innebærer studien?
Deltakelse i studien vil for deg innebære et intervju om dette temaet. Intervjuet antas å ha en varighet på omtrent 1,5 time. For å få best mulig kvalitet på intervjuet og studien, og å få frem dine egne ord og beskrivelser, vil vi gjøre lydopptak av intervjuet. Tid og sted for intervjuet avtales direkte med deg når du kontakter oss på telefonnummeret under.

Mulige fordeler og ulemper
Deltakelse vil ikke medføre særlige fordeler eller ulemper for deg. En mulig fordel kan være at det kan bidra til økt forståelse for egen situasjon og en mulighet til å fremme dine erfaringer. Deltakelse kan også bidra til økt åpenhet og forståelse for utfordringene psykisk syke arbeidstakere opplever. En mulig ulempe er at det kan tenkes å føre til ubehagelig erindring og sette i gang tanker om problemer du opplever i forhold til dette temaet. Generelt er likevel erfaringer med slike intervju at de fleste opplever det som positivt og bekreftende å få samtale om slike tema. Du vil ha mulighet for å påvirke fokus og tema, og kan velge å ikke snakke om tema du ikke ønsker å komme inn på. Det vil være mulighet for å trekke seg når som helst underveis i studien.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Det er kun student og veileder (navngitt under) som vil ha tilgang til lydopptakene. Behandlere eller personalet ved Poliklinikken vil ikke få kjennskap til hvem som velger å delta i studien eller det som blir sagt i intervjuene. Resultatene fra studien vil bli rapportert i en masteroppgave i psykologi ved Universitetet i Tromsø og søkes publisert i et relevant fagtidsskrift. I oppgaven og i en eventuell publikasjon vil ikke identiteten til deltakerne fremkomme. Alle opplysningene vil bli behandlet uten navn og fødselsnummer, eller andre direkte gjenkjennende opplysninger. Opplysninger om deg vil bli anonymisert og lydopptaket vil slettes når oppgaven er levert, senest 31.12.15.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Studien er uavhengig av din behandling og om du velger å delta eller ikke vil uansett ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta kontakter du oss på telefonnummeret under. Om du nå sier ja til å delta kan du senere trekke tilbake ditt samtykke på deltakelse, uten at det påvirker din øvrige behandling.

For å delta i studien, ta kontakt

- på tlf: 930 514 77
- eller epost: anitakleifson@gmail.com

Ønsker du å vite mer om studien eller informasjon om utfallet av studien?
Som deltaker har du rett til å få informasjon om resultatet av studien. Ta gjerne kontakt med oss om du ønsker dette.

Gjennomføring av studien ved: Anita Krüger Leifson
Tlf: 930 514 77

Ansvarlig prosjektleder: Svein Bergvik
Førsteamanuensis ved Institutt for psykologi, Universitetet i Tromsø
Tlf: 971 84 448 / 776 46 323.

Appendix B

Arbeid og psykisk helse - arbeidstakers perspektiv 21.08.14

Informasjon om forskningsprosjektet

Arbeid og psykisk helse - arbeidstakers perspektiv

Bakgrunn og hensikt
Et mindre antall pasienter ved Voksenpsykiatrisk poliklinikk forespørres høsten 2014 om deltakelse i en forskningsstudie om psykisk helse og arbeid. Formålet med studien er å få økt kunnskap om hvilke erfaringer og utfordringer personer med psykiske plager opplever i forhold til å opprettholde eller gjenoppta arbeid. Studien vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke på arbeidsplassen, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser. Studien inngår i en masteroppgave i psykologi ved Institutt for Psykologi ved Universitetet i Tromsø. Deltakere inviteres blant de som mottar behandlingstilbudet "Raskere tilbake", er mellom 18 og 67år og arbeidstaker.

Hva innebærer studien?
Deltakelse i studien vil innebære et intervju om dette temaet. Intervjuet antas å ha en varighet på omtrent 1,5 time. For å få best mulig kvalitet på intervjuet og studien, og å få frem deltakernes egne ord og beskrivelser, vil vi gjøre lydopptak av intervjuene. Tid og sted for intervjuet avtales direkte ved at pasienten kontakter oss på telefonnummeret under.

Mulige fordeler og ulemper
Deltakelse vil ikke medføre særlige fordeler eller ulemper for deltakerne. En mulig fordel kan være at det kan bidra til økt forståelse for egen situasjon og en mulighet til å fremme egne erfaringer. Deltakelse kan også bidra til økt åpenhet og forståelse for utfordringene psykisk syke arbeidstakere opplever. En mulig ulempe er at det kan tenkes å føre til ubehagelig erindring og sette i gang tanker om problemer som deltakeren opplever i forhold til dette temaet. Generelt er likevel erfaringer med slike intervju at de fleste opplever det som positivt og bekreftende å få samtale om slike tema. Deltakerne vil ha mulighet for å påvirke fokus og tema, og kan velge å ikke snakke om tema de ikke ønsker å komme inn på. Det vil være mulighet for å trekke seg når som helst underveis i studien.

Hva skjer med informasjonen om deltakerne?
Informasjonen som registreres om deltakerne skal kun brukes slik som beskrevet i hensikten med studien. Det er kun student og veileder (navngitt under) som vil ha tilgang til lydopptakene. Behandlere eller personalet ved Poliklinikken vil ikke få kjennskap til hvem som velger å delta i studien eller det som blir sagt i intervjuene. Resultatene fra studien vil bli rapportert i en masteroppgave i psykologi ved Universitetet i Tromsø og søkes publisert i et relevant fagtidsskrift. I oppgaven og i en eventuell publikasjon vil ikke identiteten til deltakerne fremkomme. Alle opplysningene vil bli behandlet uten navn og fødselsnummer, eller andre direkte gjenkjennende opplysninger. Opplysninger om deltakerne vil bli anonymisert og lydopptaket vil slettes når oppgaven er levert, senest 31.12.15.

Frivillig deltakelse
Det er frivillig å delta i studien. De forespurte kan når som helst og uten å oppgi noen grunn trekke sitt samtykke til å delta i studien. Studien vil være uavhengig av behandlingen de får ved poliklinikken og om de velger å delta eller ikke vil uansett ikke få konsekvenser for deres videre behandling. Dersom de forspurte nå sier ja til å delta kan de senere trekke tilbake sitt samtykke på deltakelse, uten at det påvirker deres øvrige behandling. I forkant av intervjuet undertegnes det en samtykkeerklæring på deltakelse, denne kan også trekkes tilbake når som helst.

Arbeid og psykisk helse - arbeidstakers perspektiv 21.08.14

For å delta i studien, og dersom deltakerne senere ønsker å trekke seg eller dersom du som behandler eller dine pasienter har spørsmål til studien kan dere kontakte:

Prosjektleder: Svein Bergvik
Førsteamanuensis ved Institutt for psykologi, Universitetet i Tromsø
Tlf: 971 84 448 / 776 46 323
Epost: svein.bergvik@uit.no

Gjennomføring av studien ved: Anita Krüger Leifson
Tlf: 930 514 77

Informasjon om utfallet av studien
Deltakerne vil ha rett til å få informasjon om resultatet av studien, og oppfordres til å ta kontakt med oss dersom de ønsker dette.

Appendix C

UIT NORGES ARKTISKE UNIVERSITET

Mars 2015

UNIVERSITETSSYKEHUSET NORD-NORGE
Arbeids- og miljømedisinsk avdeling
Bargo- ja birasmedisiinna ossodat

Forespørsel om deltakelse i forskningsprosjektet

Arbeid og psykisk helse - arbeidstakers perspektiv

Bakgrunn og hensikt
Dette er et spørsmål til deg om å delta i en forskningsstudie om psykisk helse og arbeid. Studien gjennomføres av UiT – Norges arktiske universitet. Formålet med studien er å få økt kunnskap om erfaringer og utfordringer personer med psykiske plager opplever i forhold til å opprettholde eller gjenoppta arbeid. Studien vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke på arbeidsplassen, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser. Studien inngår i en masteroppgave i psykologi ved Institutt for Psykologi ved UiT – Norges arktiske universitet. Deltakere inviteres blant de som har lettere psykiske helseproblemer, er mellom 18 og 67år og arbeidstaker.

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Mulige fordeler og ulemper
Deltakelse vil ikke medføre særlige fordeler eller ulemper for deg. En mulig fordel kan være at det kan bidra til økt forståelse for egen situasjon og en mulighet til å fremme dine erfaringer. Deltakelse kan også bidra til økt åpenhet og forståelse for utfordringene psykisk syke arbeidstakere opplever. En mulig ulempe er at det kan tenkes å føre til ubehagelig erindring og sette i gang tanker om problemer du opplever i forhold til dette temaet. Generelt er likevel erfaringer med slike intervju at de fleste opplever det som positivt og bekreftende å få samtale om slike tema. Du vil ha mulighet for å påvirke fokus og tema, og kan velge å ikke snakke om tema du ikke ønsker å komme inn på. Det vil være mulighet for å trekke seg når som helst underveis i studien.

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Gjennomføring av studien ved, Anita Krüger Leifson. Forskningsansvarlig, Svein Bergvik – Førsteamenuensis.

Ta kontakt på mail: anitakleifson@gmail.com

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anitakleifson@gmail.com

Appendix D

Arbeid og psykisk helse - arbeidstakers perspektiv 29.10.2014

Forespørsel om deltakelse i forskningsprosjektet

Arbeid og psykisk helse - arbeidstakers perspektiv

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Deltakelse vil ikke medføre særlige fordeler eller ulemper for deg. En mulig fordel kan være at det kan bidra til økt forståelse for egen situasjon og en mulighet til å fremme dine erfaringer. Deltakelse kan også bidra til økt åpenhet og forståelse for utfordringene psykisk syke arbeidstakere opplever. En mulig ulempe er at det kan tenkes å føre til ubehagelig erindring og sette i gang tanker om problemer du opplever i forhold til dette temaet. Generelt er likevel erfaringer med slike intervju at de fleste opplever det som positivt og bekreftende å få samtale om slike tema. Du vil ha mulighet for å påvirke fokus og tema, og kan velge å ikke snakke om tema du ikke ønsker å komme inn på. Det vil være mulighet for å trekke seg når som helst underveis i studien.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Det er kun student og veileder (navngitt under) som vil ha tilgang til lydopptakene. Behandlere eller personalet ved Poliklinikken vil ikke få kjennskap til hvem som velger å delta i studien eller det som blir sagt i intervjuene. Resultatene fra studien vil bli rapportert i en masteroppgave i psykologi ved Universitetet i Tromsø og søkes publisert i et relevant fagtidsskrift. I oppgaven og i en eventuell publikasjon vil ikke identiteten til deltakerne fremkomme. Alle opplysningene vil bli behandlet uten navn og fødselsnummer, eller andre direkte gjenkjennende opplysninger. Opplysninger om deg vil bli anonymisert og lydopptaket vil slettes når oppgaven er levert, senest 31.12.15.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Studien er uavhengig av din behandling og om du velger å delta eller ikke vil uansett ikke få konsekvenser for din videre behandling. Om du nå sier ja til å delta kan du senere trekke tilbake ditt samtykke på deltakelse, uten at det påvirker din øvrige behandling.

Ønsker du å vite mer om studien eller informasjon om utfallet av studien?
Som deltaker har du rett til å få informasjon om resultatet av studien. Ta gjerne kontakt med oss om du ønsker dette.

Gjennomføring av studien ved: Anita Krüger Leifson
Tlf: 930 514 77
E-post: anitakleifson@gmail.com

Ansvarlig prosjektleder: Svein Bergvik
Førsteamanuensis ved Institutt for psykologi, Universitetet i Tromsø
Tlf: 971 84 448 / 776 46 323.

Samtykke til deltakelse i studien

Ved å signere på dette skjemaet samtykker du til deltakelse, bruk av lydopptak og til at du har lest og forstått informasjonen gitt i dette skrivet.

(Underskrift og dato)

Appendix E

Arbeid og psykisk helse - arbeidstakers perspektiv Våren 2015

Forespørsel om deltakelse i forskningsprosjektet

Arbeid og psykisk helse - arbeidstakers perspektiv

Bakgrunn og hensikt
Dette er et spørsmål til deg om å delta i en forskningsstudie om psykisk helse og arbeid. Studien gjennomføres av UiT – Norges arktiske universitet. Formålet med studien er å få økt kunnskap om erfaringer og utfordringer personer med psykiske plager opplever i forhold til å opprettholde eller gjenoppta arbeid. Studien vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke på arbeidsplassen, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser. Studien inngår i en masteroppgave i psykologi ved Institutt for Psykologi ved UiT – Norges arktiske universitet. Deltakere inviteres blant de som har lettere psykiske helseproblemer, er mellom 18 og 67år og arbeidstaker.

Hva innebærer studien?
Deltakelse i studien vil for deg innebære et intervju om dette temaet. Intervjuet antas å ha en varighet på omtrent 1,5 time. For å få best mulig kvalitet på intervjuet og studien, og å få frem dine egne ord og beskrivelser, vil vi gjøre lydopptak av intervjuet.

Mulige fordeler og ulemper
Deltakelse vil ikke medføre særlige fordeler eller ulemper for deg. En mulig fordel kan være at det kan bidra til økt forståelse for egen situasjon og en mulighet til å fremme dine erfaringer. Deltakelse kan også bidra til økt åpenhet og forståelse for utfordringene psykisk syke arbeidstakere opplever. En mulig ulempe er at det kan tenkes å føre til ubehagelig erindring og sette i gang tanker om problemer du opplever i forhold til dette temaet. Generelt er likevel erfaringer med slike intervju at de fleste opplever det som positivt og bekreftende å få samtale om slike tema. Du vil ha mulighet for å påvirke fokus og tema, og kan velge å ikke snakke om tema du ikke ønsker å komme inn på. Det vil være mulighet for å trekke seg når som helst underveis i studien.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Det er kun student og veileder (navngitt under) som vil ha tilgang til lydopptakene. Behandlere eller personalet ved ditt behandlingssted vil ikke få kjennskap til hvem som velger å delta i studien eller det som blir sagt i intervjuene. Resultatene fra studien vil bli rapportert i en masteroppgave i psykologi ved Universitetet i Tromsø og søkes publisert i et relevant fagtidsskrift. I oppgaven og i en eventuell publikasjon vil ikke identiteten til deltakerne fremkomme. Alle opplysningene vil bli behandlet uten navn og fødselsnummer, eller andre direkte gjenkjennende opplysninger. Opplysninger om deg vil bli anonymisert og lydopptaket vil slettes når oppgaven er levert, senest 31.12.15.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Studien er uavhengig av din behandling og om du velger å delta eller ikke vil uansett ikke få konsekvenser for din videre behandling. Om du nå sier ja til å delta kan du senere trekke tilbake ditt samtykke på deltakelse, uten at det påvirker din øvrige behandling.

Ønsker du å vite mer om studien eller informasjon om utfallet av studien?
Som deltaker har du rett til å få informasjon om resultatet av studien. Ta gjerne kontakt med oss om du ønsker dette.

Gjennomføring av studien ved: Anita Krüger Leifson
Tlf: 930 514 77
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Ansvarlig prosjektleder: Svein Bergvik
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Tlf: 971 84 448 / 776 46 323.

Samtykke til deltakelse i studien

Ved å signere på dette skjemaet samtykker du til deltakelse, bruk av lydopptak og til at du har lest og forstått informasjonen gitt i dette skrivet.

(Underskrift og dato)

Appendix F

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord			05.03.2014	2014/69/REK nord
			Deres dato:	Deres referanse:
			21.01.2014	

Vår referanse må oppgis ved alle henvendelser

Svein Bergvik

2014/69 Psykisk helse og arbeid - Arbeidstakers perspektiv

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 20.02.2014. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikklovens § 4.

Forskningsansvarlig: UiT - Norges Arktiske Universitet
Prosjektleder: Svein Bergvik

Prosjektleders prosjektomtale:
Tema for oppgaven er psykisk helse og arbeid, fra arbeidstakers perspektiv. Dette skal undersøkes ved en intervjustudie av femten arbeidstakere som går til konsultasjoner ved Voksenpsykiatrisk poliklinikk ved UNN i Tromsø. Kvalitativt forskningsintervju beskrevet av Kvale & Brinkmann (2009) skal brukes til metode for intervju. Utforming av spørsmål baseres på tidligere forskning på feltet. Det vil benyttes fortolkende fenomenologisk analyse (Smith & Osborne, 2008). Resultatene vil bli diskutert opp mot litteratur, IA-avtalen 2010-2013 og psykologiske teorier. Formålet med studien er å fremskaffe mer kunnskap om arbeidstakernes erfaringer og opplevde utfordringer som psykisk syk på arbeidsplassen. Dette vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke i arbeidslivet, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser.

Vurdering

Framleggingsplikt
De prosjektene som skal framlegges for REK er prosjekt som dreier seg om "medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger", jf. helseforskningsloven (h) § 2. "Medisinsk og helsefaglig forskning" er i h § 4 a) definert som "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Det er altså formålet med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

I dette prosjektet er formålet med studien å fremskaffe mer kunnskap om arbeidstakernes egne erfaringer og opplevde utfordringer som psykisk syk på arbeidsplassen, hvor målet er å bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke i arbeidslivet, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser. Å øke forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke i arbeidslivet, vil ikke fremskaffe mer kunnskap om helse og sykdom som sådant.

Prosjektet skal således ikke vurderes etter helseforskningsloven.

Godkjenning fra andre instanser
Det påhviler prosjektleder å undersøke hvilke eventuelle godkjenninger som er nødvendige fra eksempelvis personvernombudet ved den aktuelle institusjon eller Norsk samfunnsvitenskapelig datatjeneste (NSD).

Vedtak
Etter søknaden fremstår prosjektet ikke som et medisinsk og helsefaglig forskningsprosjekt som faller innenfor helseforskningsloven. Prosjektet er ikke fremleggingspliktig, jf. helseforskningslovens § 10, jf. forskningsetikkloven § 4, 2. ledd.

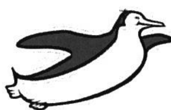
Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK nord, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Kopi til: postmottak@uit.no

Appendix G



UNIVERSITETSSYKEHUSET NORD-NORGE
DAVVI-NORGGA UNIVERSITEHTABUOHCCEVIESSU

PERSONVERNOMBUD

Svein Bergvik
PSTO
9038 Tromsø

Deres ref.:	Vår ref.:	Saksbehandler/dir.tlf.:	Dato:
	2014/2194	Per Norleif Bruvold, 77755855	07.04.2014

ANBEFALING AV BEHANDLING AV PERSONOPPLYSNINGER

Viser til melding om behandling av personopplysninger, mottatt 19.03.2014.
Meldingen gjelder prosjektet/registeret:

Prosjekt nr: 0409
Psykisk helse og arbeid – Arbeidstakers perspektiv.

Formål: Tema for oppgaven er psykisk helse og arbeid fra arbeidstakers perspektiv. Dette skal undersøkes ved en intervjustudie av femten arbeidstakere som går til konsultasjoner ved Voksenpsykiatrisk poliklinikk ved UNN i Tromsø. Formålet med studien er å fremskaffe mer kunnskap om arbeidstakernes erfaringer og opplevde utfordringer som psykisk syk på arbeidsplassen. Dette vil kunne bidra til økt forståelse for hvordan man kan styrke ivaretagelse og inkludering av psykisk syke i arbeidslivet, hindre frafall, og bedre tilrettelegging og bruk av virkemidler ved arbeidsplasser.

Prosjektet er en kvalitetsstudie hvor Universitetssykehuset Nord-Norge HF er behandlingsansvarlig og gjennomføres som en del av en studentoppgave av student Anita Krüger Leifson.

Prosjekter innenfor medisinsk og helsefaglig forskning igangsatt etter 01.07.2009 skal forhåndsgodkjennes av REK. REK godkjenner også fritak fra taushetsplikten samt opprettelse av biobank i henhold til den nye Helseforskningsloven. Personvernombudets (PVO) rolle er å ha oversikt over forskningsprosjekter samt se til at informasjonssikkerheten og personvernet blir ivaretatt. Helselovgivningen stiller krav til samtykke også for kvalitetsstudier, men dette kan fravikes etter gitte kriterier. PVO vil fremdeles godkjenne behandlings- og kvalitetsregistre.

PVO har vurdert prosjektet, og finner at behandlingen av personopplysningene vil være regulert av § 7-26 i Personopplysningsforskriften og hjemlet etter Helsepersonelloven § 26, j.fr Personopplysningsloven § 33, 4. avsnitt. Hjemmelsgrunnlaget krever at ansvarlig for studien er ansatt eller har et ansettelsesforhold i UNN. Prosjektet er derfor registrert under ditt arbeidsforhold i UNN og ikke i Universitetet i Tromsø – Norges arktiske universitet

(UIT). Studien skal gjennomføres i UNN. Kvalitetsstudier skal fortrinnsvis innhente samtykke fra den registrerte, men kan fravikes når tungtveiende grunner vanskeliggjør/ikke er tilrådelig for en slik innhenting. Det innhentes samtykke fra respondentene i denne studien, men godkjennelse fra REK er ikke nødvendig.
PVO registrerer at studenten ikke har en arbeidsavtale med UNN og vedlagte avtale må signeres. På bakgrunn av avtalen kan tidsbegrenset brukerkonto opprettes for tilgang til lagringsområdet. PVO ber om å få tilsendt signert avtale samt melding om hvilken brukerkonto studenten er tildelt.

PVOs anbefaling forutsetter at prosjektet gjennomføres i tråd med de opplysningene som er gitt i selve meldingen, i øvrig korrespondanse og samtaler samt i henhold til Personopplysningsloven og Helseregisterloven med forskrifter. Videre forutsettes det at data anonymiseres etter prosjektavslutning ved at kodelista slettes, jfr. Pkt. 8.6 i meldeskjemaet samt at tilgang til kodelista tillegges prosjektleder.
Det er opprettet et eget område (mappe) på \\asterix7\felles.avd\forskning (o:\) med navn **0409** hvor all data i forbindelse med prosjektet skal lagres. Tilgang til dette området er begrenset til kun prosjektleder og den som prosjektleder definerer.
I tillegg er det opprettet et område på \\asterix7\felles.avd\forskning\key med navn **0409N** hvor nøkkelfil skal oppbevares og som bare prosjektleder har tilgang til.
PVO vil også kunne få tilgang til området, jfr. pkt. 8.5 i meldeskjema.

Det gjøres oppmerksom på at det skal gis ny melding (remelding) dersom registeret ikke er slettet eller ikke ferdig innen 3 år og som ligger til grunn for PVOs anbefaling.

PVO gjør oppmerksom på at dersom registeret skal brukes til annet formål enn det som er nevnt i meldingen må det meldes særskilt i hvert enkelt tilfelle.

PVO ber om tilbakemelding når registret er slettet.

Med hjemmel etter Personopplysningslovens forskrift § 7-12 godkjenner PVO at behandlingen av personopplysningene kan settes i gang når krav om avtale er signert og med de endringer som er nevnt i dette skriv. Tilgang til lagringsområde vil bli gitt når dette er utført.

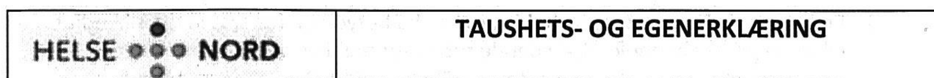
Med vennlig hilsen

UNIVERSITETSSYKEHUSET NORD-NORGE HF

Per Bruvold
Sikkerhetssjef IKT/Personvernombud

Kopi: Klinikksjef Magnus P Hald
Student Anita Krüger Leifson

Appendix H



1 OMRÅDE FOR DENNE INSTRUKSEN

Denne instruksen gjelder for bruk av foretakets IKT-system. Med "IKT-system" forstås maskiner, arbeidsstasjoner, skrivere, programmer, data, flyttbare lagringsmedia, utskrifter m.v. som benyttes av eller stilles til disposisjon av foretaket, inklusive alle former for nettverk og de systemene som man får tilgang til gjennom slike nettverk. Reglene gjelder for ansatte, studenter og andre som får tilgang til foretakenes IKT-system, heretter kalt bruker.
Brukeren plikter å holde seg informert om den til enhver tid gjeldende instruks. Instruksen skal være oppslått på egnede steder. Den finnes hos din leder og kan også fås ved henvendelse til Sikkerhetssjef IKT/Informasjonssikkerhetsansvarlig.
Alle data/registre som er fremkommet i forbindelse med foretakets virksomhet eies i henhold til lover og forskrifter av institusjonen. Programvare som er utviklet i arbeidsforholdet eller i prosjekter der foretaket deltar, er institusjonens eiendom dersom ikke annet er skriftlig avtalt.

2 GENERELLE KRAV

a) Foretakets IKT-systemer skal kun benyttes til virksomhet som har direkte tilknytning til faglig virksomhet, administrasjon, egen forskning, studier eller organisasjonsarbeid i forening ved foretaket, med unntak som nevnt i pkt. 8.
b) Ved all bruk av systemet skal brukeren identifisere seg ved å oppgi eget brukernavn og passord.
c) En bruker har plikt til å følge anvisninger om bruk av systemet og tjenester knyttet til systemet. En bruker skal sette seg inn i aktuelle bruksanvisninger og dokumentasjon, for på den måten å hindre feilbruk eller driftsforstyrrelser.
d) Når arbeidsplassen forlates, skal brukeren alltid logge seg av systemet eller låse arbeidsstasjonen. Dette bidrar til å hindre at ikke-autoriserte får innsyn i IKT-systemene.
e) Alle ansatte eller andre som skal ha tilgang til de elektroniske informasjonssystemene i foretaket må gjennomføre og bestå e-lærings kurset om informasjonssikkerhet.
f) Brukernavnet er strengt personlig. Bruk eller forsøk på bruk av andre brukeres brukernavn og/eller passord ved pålogging er ikke tillatt. Det er ikke tillatt å utgi seg for å være en annen person ved bruk av foretakets IKT-systemer.
g) Passordet skal være på 8 eller flere tegn, og skal inneholde både tall, bokstaver og tegn for å gjøre det vanskeligere å avsløre passordet for uvedkommende. Navn, brukernavn, fødselsdato eller lignende skal ikke benyttes. Husk at passordet er din nøkkel til de opplysningene som finnes på foretaket.
h) En bruker skal beskytte passord og liknende sikkerhetselementer slik at disse ikke blir kjent for andre. Dersom brukeren har mistanke om at slikt er blitt kjent, skal bruker sørge for at passord m.v. skiftes umiddelbart.
i) En bruker skal forhindre at ikke-autoriserte personer får tilgang til bruk av systemet eller tilgang til rom hvor utstyr er tilgjengelig.

j) En bruker skal rapportere forhold som kan ha betydning for systemets sikkerhet eller integritet i henhold til gjeldende rutine for melding av avvik. Alvorlige hendelser eller tilstander rapporteres i tillegg umiddelbart til Sikkerhetssjef IKT/Informasjonssikkerhetsansvarlig/Helse Nord IKT, *se prosedyre Melding om avvik informasjonssikkerhet – PR26149.*
k) En bruker skal ikke benytte seg av muligheten til innsyn i informasjon som brukeren i utgangspunktet vet han/hun ikke har tilgang til. Dette gjelder uavhengig av om dataene er beskyttet eller ikke (snoking).
l) Modem eller lignende kommunikasjonsutstyr er ikke tillatt brukt på foretakets IKT-systemer (hjemmekontorløsninger er omfattet av eget reglement).
m) Reparasjon av utstyr skal alltid organiseres av Helse Nord IKT.
n) Det er ikke tillatt å importere programmer fra eksterne nett uten at dette er godkjent.
Kun programvare som er lisensiert til foretaket og som Helse Nord IKT har godkjent, kan benyttes på foretakets IKT-system. Kopiering av foretakets programvare uten tillatelse er forbudt!
o) Datafiler skal virussjekkes før bruk i IKT-systemet. Normalt er dette en prosedyre som utføres automatisk på den enkelte maskin. Dersom en bruker har mistanke om at en slik kontroll ikke blir utført skal Sikkerhetssjef IKT/Helse Nord IKT varsles umiddelbart.
p) Private maskiner/utstyr er ikke tillatt å koble til foretakets system/nettverk (produksjon), men kan kobles til et eget nett som er tilrettelagt for dette formål. Alt utstyr som skal kobles til foretakets IKT-system skal være godkjent av Helse Nord IKT.
q) Ved opphør av ansettelsesforhold skal brukeren rydde sitt reserverte område. Skjer ikke dette vil Helse Nord IKT slette filer og deaktivere brukernavnet. For øvrig henvises det til personalrutinene vedrørende avvikling av arbeidsforhold.

3 ELEKTRONISK POST (E-MAIL/E-POST)

a) Alle brukere ved helseforetaket har egen postkasse som skal brukes til mottak og sending av e-post. Foretaket bruker e-post som en av de viktigste informasjonskanaler over for de ansatte. Den enkelte ansatte bør daglig sjekke sin innboks.
b) E-post skal ikke brukes til å sende pasientrelaterte eller andre sensitive opplysninger uten at dette er spesielt sikret (kryptert i h t Datatilsynets krypteringskrav) og godkjent av sikkerhetsledelsen. Enkelte skannere har innebygd funksjonalitet for å sende e-post til brukeren med de skannede dokumentene. Slik funksjonalitet skal ikke benyttes for å sende pasientsensitive opplysninger til en selv eller andre.
c) E-post skal kun sendes til personer som kan ha nytte av å motta den fra deg jfr. pkt. 3a i denne instruksen.
d) Innsyn i e-post, se § 9-3 i Personopplysningsforskriften samt pkt. 6 i denne instruksen.
e) Dersom e-post skal være tilgjengelig på mobiltelefon skal dette sikres særskilt og virksomheten skal ha oversikt over brukere med mobilt tilgang.
f) Privat bruk, se pkt. 8.

4 WEB (INTRANETT/INTERNETT)

Foretaket legger inn viktig informasjon på sine interne intranett-sider. De ansatte skal gjøre seg kjent med innholdet og bør daglig sjekke disse sidene.
Brukere kan få adgang til Internet og ekstern e-post etter autorisasjon fra sin avdelingsleder og etter at Egenerklæring om bruk av informasjonssystemer er akseptert og signert.
Privat bruk se pkt. 8

5 FORHOLD TIL GJELDENDE LOVER

a) Bruker skal gjøre seg særlig kjent med de regler som gjelder for behandling av personrelaterte opplysninger. Avdelingsleder skal ha disse reglene tilgjengelig ved behov.
b) Alle som utfører arbeid for foretaket – ansatte, midlertidige ansatte og oppdragstakere – er underlagt lovbestemt taushetsplikt. Plikten gjelder både i arbeidet og privat, og den varer også etter avsluttet arbeidsforhold, jfr. Taushetserklæring
c) Etablering av elektroniske registre (for eksempel overføring av pasientinformasjon til et regneark, Access og lignende) med opplysninger om fysiske eller juridiske personer er underlagt bestemte offentlige krav og regler og skal registreres. Skal du opprette slike registre eller overføre slike data, ta kontakt med Sikkerhetssjef IKT/Informsjonssikkerhetsansvarlig.
d) All bruk av klipp- og lim-funksjoner fra pasientrelaterte systemer er forbudt.
e) Det skal ikke forekomme videreformidling av konfidensielle opplysninger til ikke-autoriserte personer.
f) Pasientrelatert informasjon lagret på foretakets IKT-systemer skal oppbevares med Datatilsynets tillatelse og i henhold til offentlige lover og regler. Dette gjelder også informasjon som ikke er oppbevart i foretakets sentrale pasientregistre, eller på sentrale servere (frittstående maskiner/register).
g) Foretaket behandler og oppbevarer konsesjonsbelagt informasjon og informasjon underlagt taushetsplikt. Foretaket skal behandle og sikre data etter de vilkår som konsesjonen setter og etter lov og forskrifter gitt av offentlige myndigheter, vår taushetsplikt og foretakets egne krav til sikkerhet. Det er derfor ikke tillatt å koble internettforbindelser opp mot foretakets nettverk uten særskilt tillatelse.

6 UTVIDET ADGANG

Hver bruker har sitt personlige reserverte område, vanligvis P:\. Dette området har ingen andre brukere tilgang til. I spesielle tilfeller er det likevel nødvendig for Helse Nord IKT og/ eller Sikkerhetssjef IKT/Informasjonssikkerhetsansvarlig å benytte seg av sin særskilte autorisasjon til å skaffe seg tilgang til den enkelte brukers reserverte område:

a) for å administrere systemene og sikre anleggets funksjonalitet
b) for å bistå en bruker i problemløsning/opplæringssammenheng. Brukeren skal være informert om dette
c) for å avdekke og/eller oppklare brudd på sikkerheten
d) når det foreligger skjellig grunn til mistanke om at brukeren har brutt Sikkerhetsinstruksen og det kan være av stor betydning for foretakets ansvar og renommé.

Hvis tilgang søkes i henhold til a) skal brukeren som hovedregel varsles på forhånd.

Hvis tilgang søkes i henhold til c) eller d) skal dette dokumenteres og loggføres i en sikkerhetslogg.

Innsyn i personlig e-postkasse skal som utgangspunkt ikke finne sted.
I enkelte situasjoner er det likevel mulig å foreta innsyn for å hente ut virksomhetsrelatert e-post. I slike tilfeller skal prosedyren for Innsyn i e-post følges, jfr. kapittel 9 i Personopplysningsforskriften. For å redusere behovet for innsyn bør den enkelte ansatt:

- lagre personlig e-post i egen mappe
- benytte fraværsassistenten når planlagt fravær gjennomføres
- gi arbeidsgiver anledning til å benytte fraværsassistenten på vegne av ansatt ved uforutsett fravær
- sørge for at arkivverdig materiale blir registrert i arkiv-/saksbehandlingssystemet (ePhorte).

Helse Nord IKT har taushetsplikt med hensyn til opplysninger om brukeren eller brukerens virksomhet som Helse Nord IKT får på denne måte. Unntak fra dette er forhold som kan representere brudd på Sikkerhetsinstruksen. Slike forhold kan meddeles til overordnete instanser.

7 Hjemmekontor/Bærbare maskiner/Smartphone

Hjemmekontor og bærbare maskiner er omfattet av eget reglement som administreres av Helse Nord IKT.
Se Prosedyre Hjemmekontor og bærbare enheter.

8 Privat bruk

Foretakets IKT-systemer er beregnet og skal primært (jfr. pkt. 3) benyttes for jobbrelatert formål. Noe privat bruk tillates imidlertid som:

- Mindre mengder e-post, nyheter og nødvendige opplysningstjenester
- Mindre mengder private filer kan lagres i egen katalog (normalt P:\) på personlig område. Av plass og kapasitetshensyn skal ikke private bilder, video, musikk eller lignende som krever stor plass, lagres på foretakets sentrale servere.

Privat bruk må imidlertid ikke påvirke jobbrelaterte oppgaver eller være i strid med denne instruks, lover eller allmenne normer for oppførsel og sosial atferd.

TAUSHETS- OG EGENERKLÆRING OM BRUK AV INFORMASJONSSYSTEMER PÅ UNN

NAVN: ANITA KRÜGER LEIFSON **PNR.:** SENSURERT PERSONNUMMER

Denne erklæringen gjelder for all bruk av informasjonssystemer, maskiner, program og data ved UNN.
Av sikkerhetshensyn blir all bruk av informasjonssystemet lagret i sporingslogger for å avdekke eller oppklare sikkerhetsbrudd. Disse loggene inneholder oversikt over den enkeltes bruk av informasjonssystemet, f.eks. vil den avdekke hvilke steder som oppsøkes på Internett, av hvem og tidspunkt.
Hvis det avdekkes at bruken av informasjonssystemet er i strid med UNN's bestemmelser, herunder sniklesing i pasientjournaler, vil det kunne bli iverksatt sanksjoner.
9
JEG FORSTÅR:
- At jeg i mitt arbeid/praksis som STUDENT
ved UNN vil kunne få kjennskap til forhold som det av hensyn til pasienter, deres pårørende , barn og foreldrer/foresatte eller andre er nødvendig å bevare taushet om.
- at dette arbeidet krever ansvarsfølelse, lojalitet og pliktroskap.

Jeg har satt meg inn i den nedenfor siterte lovbestemmelse.
Jeg er klar over :
- at brudd på taushetsplikten kan medføre straffeansvar og eventuelt fjernelse fra tjenesten.
- at taushetsplikten også gjelder etter at jeg har sluttet i tjenesten

Jeg er innforstått med at den taushetserklæring som jeg har undertegnet også gjelder for bruk av Internett og e-post.
Jeg er og innforstått med at eiendomsretten til all IT-utstyr ved UNN, det være seg innhold, programvare, virksomhets relatert e-post og dokumenter som er lagret på UNN's maskiner, er å regne som UNN's eiendom. Med dette forstås at ingenting kan regnes som privat og ikke benyttes til andre formål enn det som denne erklæringen omfatter. Forskningsdata/arbeid reguleres i tillegg av egne retningslinjer.
Når jeg bruker Internett og e-post så opptrer jeg på vegne av UNN og må handle i tråd med dette.

Passord som man bruker for å logge på UNN's systemer er et personlig passord og skal ikke utleveres til andre.

Jeg bekrefter herved at jeg har mottatt et eksemplar av UNN's Sikkerhetspolicy og Reglement for bruk av UNN's IT-system, har gjennomgått, forstått og akseptert dette.

2014 Den 03.12

Anita Krüger Leifsen
underskrift

Fra "Lov om spesialisthelsetjenesten" kap. 6

§ 6-1. *Taushetsplikt*

Enhver som utfører tjeneste eller arbeid for helseinstitusjon som omfattes av denne loven, har
taushetsplikt etter forvaltningsloven §§ 13 til 13 e.
Taushetsplikten gjelder også pasientens fødested, fødselsdato, personnummer, statsborgerforhold, sivilstand, yrke, bopel og arbeidssted. Opplysning om en pasients oppholdssted kan likevel gis når det er klart at det ikke vil skade tilliten til helseinstitusjonen.
Opplysninger til andre forvaltningsorganer etter forvaltningsloven § 13 b nr. 5 og 6 kan bare gis når dette er nødvendig for å bidra til løsning av oppgaver etter denne loven, eller for å forebygge vesentlig fare for liv eller alvorlig skade for noens helse.
For ansatte i sykehusets barnehager gjelder også Lov om barnehager § 21.

Appendix I

Presentere meg selv og studien:

Jeg er går masterstudiet i psykologi ved UIT med fordypning i arbeid og organisasjonspsykologi. Vi vet at arbeidstakeres egne erfaringer er viktig kunnskap som bør komme frem, spesielt fordi det kan bidra til å bedre forholdene for andre i lignende situasjoner.

- Informer om lydopptak og samtykkeskjema, har deltakeren noen spørsmål?

Generelle spørsmål til tabell:
- yrke (Kan du fortelle litt om bedriften du er ansatt i?)
- Er bedriften en IA bedrift?
- I hvor stor grad er du i jobb nå?

Helseplager
Jeg vil gjerne høre litt om dette med hvordan det er for deg å være på jobb, når du har de plagene du har. Kan du si litt om det?

Arbeidsplassen
Kan du fortelle litt om hvordan du opplever at arbeidsplassen har håndtert din situasjon?

Inkludering
Kan du si litt om hvordan du føler at inkluderingen har vært eller er på jobb?

Åpenhet
Hva tenker du angående åpenhet om psykisk sykdom?

Tiltak/ hjelpeprogram
Hva er dine erfaringer med å ta i bruk hjelpeprogram?

Fremtiden
Kan du fortelle meg litt om dine tanker for fremtiden?

Utdypende: Bekymringer, forventninger, oppleves som positivt / utfordrende

Oppfølgingsspørsmål:
- Når det gjelder dette med_____
- Hvordan har du opplevd det?
- Kan du si litt mer om dette med___ som du nevnte?
- Du sier at______på hvilken måte da?
- Kan du gi noen eksempler på det?
-______hvordan har det vært for deg?
- Jeg ble litt nysgjerrig når du sier ___
- Du sa ____ har det vært vanskelig?

Typer av intervjuspørsmål (Kvale 1997: 80)
- Introduksjonsspørsmål: Kan du fortelle meg om ....
- Oppfølgingsspørsmål: Kan du utdype det?, et lite nikk, "mm", pause.
- Spesifiserende spørsmål: Hva tenkte du da, Hvordan reagerte du , Hva gjorde du når ..
- Indirekte spørsmål: "Hvordan tror du andre opplever --?"
- Fortolkende spørsmål: "Du mener altså at ...

Avslutning
- **Er det andre ting rundt dette med arbeid og psykiske plager som du mener er viktig å få frem?**
- **Takke**