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Supporting workers with lower back injuries to return to work: A meta-ethnography.

Introduction

Lower back injuries can prevent people from engaging in the occupation of work, which is considered to be beneficial to physical and mental wellbeing. Return to work programmes aim to support people to re-engage with work, however, the success of these can be varied. The aim of this review was to explore what factors facilitated a return to work for those in employment, and what the factors may be in preventing others from making a successful return to work.

Method

A systematic search of the literature identified ten qualitative research studies and a meta-ethnographic approach was then used to critique and synthesise the findings to provide a line of argument.

Findings

Interrogation of the selected studies brought about three third-order interpretations as follows: enabling injured workers to return to work safely, challenging negative assumptions, overcoming organisational barriers.

Conclusion

The study supports previous findings that emphasise consideration of wider organisational and psychosocial factors relating to supporting people to return to work, rather than focusing solely on the injured worker. Suggestions are made for modification of current work practices, the need for a strength-based approach to rehabilitation and for occupational therapists who might work with people living with back pain.

Keywords: Low back pain, return to work, psychosocial, psychological phenomena, musculoskeletal system

Introduction

The economic impact of musculoskeletal disorders in developed countries is significant. In 2016/17, an estimated 507,000 people in the UK with musculoskeletal disorders cost the economy in excess of £6 billion (Nestorova and Mircheva, 2018). Musculoskeletal disorders include injuries that may affect bones, muscles and joints (da Costa and Vieira, 2010) with the most common form involving the lower back (Soklaridis et al., 2010). Snodgrass (2011) reported that 20.4% of work injuries necessitating time away from work in the United States of America were related to the lower back.

The consequences of prolonged absenteeism from work has significant consequences to both physical and mental health (Waddell and Burton, 2006). There is a risk that prolonged absenteeism could lead to a state of occupational deprivation, whereby individuals are restricted from acquiring, using or enjoying the occupation of work (Wilcock, 1998). For the economy, significant costs are incurred due to absenteeism, loss of productivity and increased healthcare (Centers for Disease Control and Prevention, 2016).

Figures regarding successful return to work vary considerably across countries, with return to work rates ranging between 22% and 62% in German and Dutch populations for example (Anema et al., 2009). What is consistent however, is that the longer a person is absent, the less likely they will be successful in returning to work (Anema et al., 2009, Heijbel et al. 2006). Previous studies have identified factors that can influence the success of return to work interventions. For example, MacEachen et al. (2006) report mechanisms that can affect the success of return to work which include taking into account relationships between parties (such as workers, employers, and physicians), work modifications, and other organisational dynamics.

Park and Bhattacharya (2013) found that a person who has a history of compensation claims is more likely to be terminated from employment than their non-injured counterparts and concluded that this implied there were lingering ill-effects due to injury. Another factor that may influence the return to work process, is the individual's perception of their injury and expectation regarding prognosis. Heijbel et al. (2006) found that those with a negative self-prediction of their ability to return to work were less likely to make a success of this than those with a positive outlook. Heijbel et al. (2006) concluded that changing views from negative to positive is crucial to facilitate successful return to work. While programmes may

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3 differ in the range of interventions provided, it is generally accepted that they should address
4 a combination of psychological, environmental and external factors (Iles, Davidson and
5 Taylor, 2017).
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10 The above literature reflects the return to work process generally, rather than focusing on
11 individuals who experience lower back pain. Considering the prevalence of lower back
12 injuries and the consequences associated with long term absenteeism from work, it is vital to
13 understand how best to support people to return to work and develop interventions that reflect
14 the needs of individuals who experience lower back pain and are attempting to return to
15 work. No systematic review, to the researchers' knowledge, has attempted to draw together
16 current evidence on the factors that can support the return to work process for workers with
17 lower back pain. The PROSPERO International prospective register of systematic reviews
18 was searched on 20 December 2018 and yielded no results. Furthermore, quantitative
19 research has been prevalent in this field, with relatively limited focus on the experiences of
20 those involved in the return to work process (Ryan et al., 2014).
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30 The aim of this review was to explore what factors facilitated a return to work for those in
31 employment, and what the factors may be in preventing others from making a successful
32 return to work. A meta-ethnographic approach, as originally proposed by Noblit and Hare
33 (1988), was used to draw comparisons and highlight differences between studies in order to
34 generate new insights. This approach was considered suitable to address the above aim due
35 to its interpretive rather than integrative approach. By combining findings from separate
36 studies into a synthesis it is anticipated that practitioners might benefit from acquiring new
37 insights in this field.
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44 **Method**

45 ***Search Strategy***

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48 On 23 January 2019, the electronic databases PubMed, Health Research Premium Collection,
49 AMED, CINAHL, MEDLINE and PsycINFO were searched for articles related to lower back
50 injuries and the return to work process. Search terms used included "low* back pain",
51 "lumbar pain", "return* to work" and "vocational rehabilitation". Return to work and
52 absence from work were used as separate concepts in order to maximise the amount of
53 relevant material generated. Noblit and Hare (1988) recommend an exhaustive search to
54 identify all relevant accounts and articles published, a search was carried out therefore
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3 between 1 January 2009 and 23 January 2019 to ensure findings reflected current work
4 practices.
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8 Duplications were then discarded and the remaining papers were manually screened using
9 pre-determined inclusion and exclusion criteria. For an article to be included, it must have
10 been published in a peer-reviewed journal, report primary, qualitative data and relate to
11 rehabilitation and return to work. Papers were excluded where the focus was on
12 musculoskeletal injuries generally rather than the lower back and if the study referred to
13 prevention of injury rather than rehabilitation. Examples of articles excluded include: papers
14 relating to prevention or acute phases of injury rather than rehabilitation; papers which laid
15 out protocol for research or feasibility trials; papers related to specific populations;
16 quantitative papers; and papers related to developing research tools.
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24 A process of citation chaining was used to identify additional papers relevant to the review's
25 aim. Backward searching was used to screen the references of the included papers in order to
26 identify any further articles (Boland, Cherry and Dickson, 2017). Forward searching using
27 Google Scholar 'cited reference search' was used to identify which papers had subsequently
28 cited the key reference. See Figure 1 for details of articles retrieved at each stage of the
29 search using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses
30 (PRISMA) guidelines (Moher et al., 2009).
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36 37 **Study selection** 38 39

40 This review only included primary data from peer reviewed journals in order to facilitate
41 systematic and transparent searching of databases and for clarity of reporting results (Boland
42 et al., 2017). The findings presented do not include articles reporting secondary data due to
43 the risk of misinterpreting original findings. Grey literature was not used due to difficulties
44 ascertaining peer-reviewed status and because of the challenge this presents for systematic
45 reporting (Boland et al., 2017). Methodological quality of the included studies was judged
46 using the National Critical Appraisal Skills Programme (CASP, 2018). The appraisal tool
47 assisted the recording of key findings, as well as to identify strengths and limitations of the
48 studies (see Table 1).
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Data analysis

Analysis was influenced by the authors' interpretation of the findings and consideration of the original participant quotes presented in the identified studies. Noblit and Hare's (1988) meta-ethnographic process was followed, which allows immersion in the writing and findings of included studies in order to interpret the overall findings. The initial stages of this process outline that the researcher must select a topic and initial area of interest, undertake a systematic search of literature to identify relevant articles, and then repeatedly read the research noting common or recurring concepts (Britten, 2002). The concepts from each study are then translated into one another to identify reciprocal or refutational categories (see Table 2). The final stage of the process is to synthesise and express the translations into a line of argument (see Table 3).

Statement of researchers' interests

The researchers held a relativist ontological position, and approached this review from a constructivist epistemology. Constructivism proposes that there are multiple socially constructed meanings that may or may not be shared among individuals or across cultures (Guba and Lincoln, 1994). This epistemological position fitted well with meta-ethnography in order to interpret findings from the qualitative research sourced. An awareness was adopted that personal interpretation would be integral to the review of the literature (Noblit and Hare 1988). Nadin and Cassell (2006) suggest all researchers should be aware of their own epistemological assumptions and should make a commitment to reflexivity, in this regard a reflexive diary was maintained by the first author which was discussed with the second author to identify, explore and challenge assumptions.

Figure 1. Number of studies identified and screened. Based on PRISMA flow diagram (Moher et al., 2009).

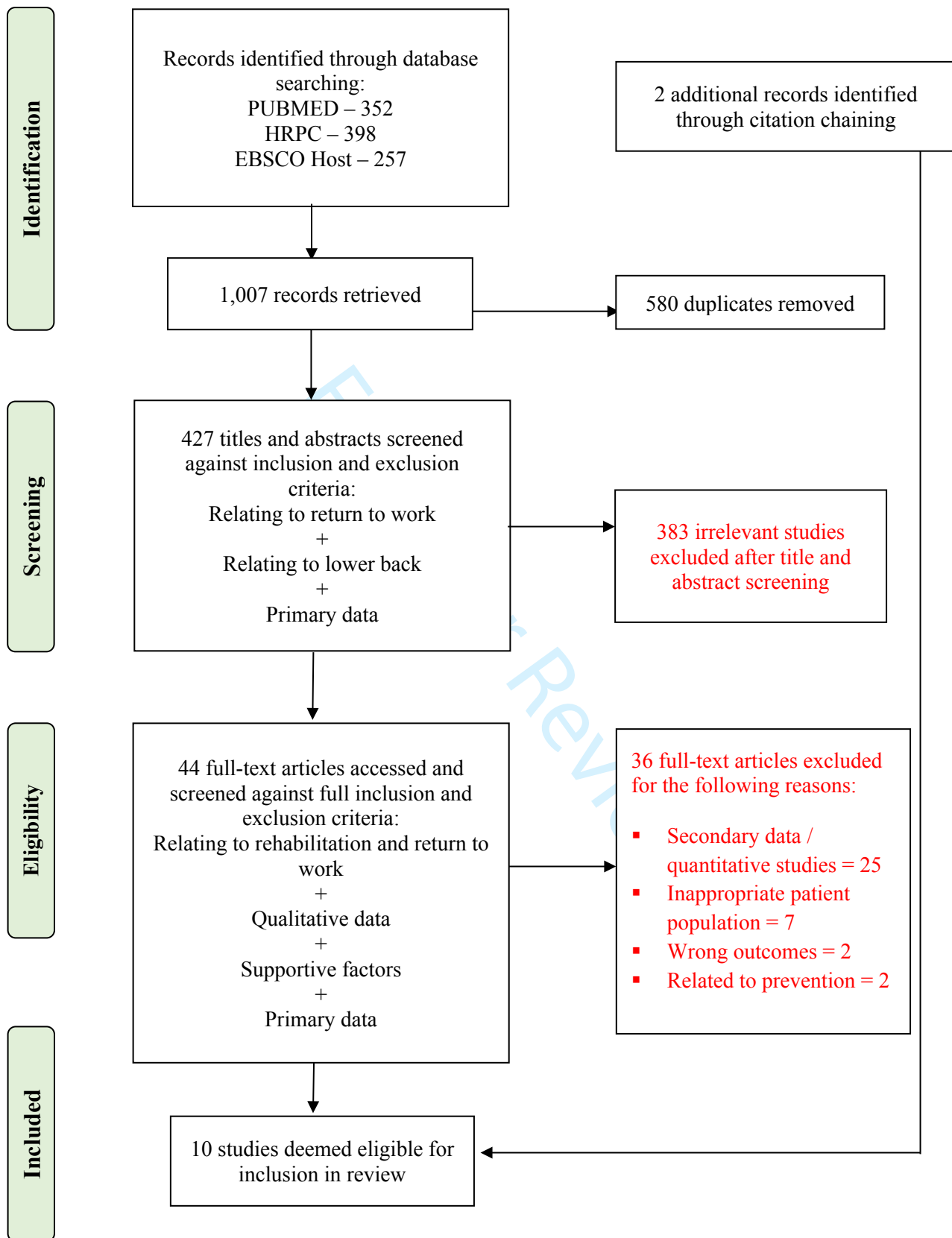


Table 1. Summary of selected studies

Authors / Country	Aim	Sample	Findings	Conclusions	Limitations
Coole et al. (2010) - UK	To better understand the experiences of workers with back pain who are struggling to stay at work.	Convenience sampling	Five main themes identified by thematic analysis – justifying back pain at work, concerns about future, coping with flare-ups, reluctance to use medications and concern about sickness record.	Patients had not been reassured as to benign nature of recurring back pain, concerns regarding analgesia and felt uncomfortable about disclosing their health conditions at work. Specific attention to these factors is required to enable people to work more confidently with low back pain.	Interviewer had recently been working as a clinician with the back-pain rehabilitation team.
Ryan et al. (2014) - UK	To explore the experiences of individuals returning to work after an episode of sickness absence due to lower back pain.	Purposive sampling	Interpretative phenomenological analysis (IPA) used. Two primary themes emerged – perceived pressure to return to work and strategies employed to relieve pressure to return to work.	Individuals who suffer lower back pain experience considerable pressure to return to work. Individuals implement psychological strategies to mediate negative feelings such as returning to work unfit in an attempt to reduce feelings of guilt.	Small sample size comprising of all females from the same place of work. Detailed inclusion criteria was not noted. Some questions could be seen as leading. No evidence of reflexive practice during data analysis stage.
Buijs et al. (2009) - Netherlands	To explore how patients and health care providers perceive the effectiveness and implementation of a multidisciplinary outpatient care programme.	Convenience sampling	The programme was successful in changing patient's goal setting from pain orientated towards function restore and return to work, even for patients with low expectations at the start of the programme. However, patients were also unable to overcome barriers in return to work procedures.	Generally, patients and professionals perceived the multidisciplinary outpatient care programme as applicable and effective. Alternative strategies should be explored for those unable to overcome barriers and persisting in their negative judgment of the programme.	Researchers were evaluating a return to work programme that they developed. Participation was voluntary therefore less motivated participants may not have participated.
Stewart et al. (2012) - Canada	Exploration of how expectations regarding return to work are formed.	Purposive sampling	Expectations of return to work are constructed based on the degree of perceived uncertainty about the future. Five further subcategories emerged from the data.	Perceived uncertainty plays a key role in injured workers' formation of expectation of return to work.	Researchers acknowledge that different interviewers may have elicited different responses. Larger more diverse sample required. Nearly all participants were self-selected.
Wrapson and Mewse (2011) - New Zealand	To understand how work supervisors respond to sickness certification for an episode of low back pain.	Purposive sampling	Two types of initial supervisor responses to sick certification identified and three types of subsequent responses identified.	Employers and their representatives often postpone return to work intervention which potentially delays rehabilitation.	Employees reporting on employer/supervisor responses may be biased. The study did not note whether consideration was given to reflexive practice when analysing data.

Soeker, Wegner and Pretorius (2009) – South Africa	To explore the perceptions and experiences of adaptation that individuals who received back rehabilitation face when resuming their worker roles.	Random sampling	One overarching theme of taking responsibility for oneself and several categories related to this were identified.	The study presents the development of a conceptual model of adaptation to the worker role following back injury.	Random sampling limited the diversity and variation of responses among participants.
Soklaridis, Ammendolia and Cassidy (2010) - Canada	To explore which psychosocial variables are most important to workplace stakeholders involved in the return to work process for individuals with low back pain.	Purposive sampling	The majority of participants described how psychosocial factors were the product of larger systemic and organisational issues that contribute directly or indirectly to the management of lower back pain and return to work.	The study concluded that we need to move beyond psychosocial conceptualisation of lower back pain and return to work towards a socio-political and economic conceptualisation.	The nature of this study was descriptive and exploratory and therefore caution is noted in drawing definitive conclusions.
McCluskey et al. (2014) - UK	To examine the treatment expectations of the ‘significant others’ of individuals who have become unable to work due to persistent low back pain.	Convenience sampling	Template analysis revealed significant others expected a substantial reduction or complete removal of pain in order for treatment to be considered successful.	Significant others have similar unrealistic/unhelpful expectations to the individuals with low back pain.	Of the nine significant others, seven were not working and two were claiming disability benefits. All bar one had worked in unskilled or manual occupations and none had continued their education past high school. This sample may not be representative of a wider population. It is impossible to determine whether significant others effect patients or vice versa. Authors conclude quantitative study is now required.
McCluskey et al. (2011) – UK	To initiate qualitative research into the influence of ‘significant others’ on persistent back pain and work participation.	Convenience sampling	Significant others share and <i>perhaps</i> reinforce claimant’s unhelpful illness beliefs. They act as a ‘witness to pain’ supporting individuals self-limiting behaviour and statements of incapacity.	Findings from this exploratory study reveal how others and wider social circumstances might contribute to the propensity of persistent back pain.	Lack of diversity within sample as above. All significant others also had long term conditions which may influence their views. It is not possible conclude that significant others reinforce claimant’s unhelpful beliefs in an exploratory study.
Brooks et al. (2013) - UK	To explore whether the illness beliefs of significant others differ depending on their relatives’ working status.	Convenience sampling	The beliefs of significant others differed depending on whether their relative had remained in work or ceased work.	The inclusion of significant others in vocational rehabilitation programmes may be a valuable way of supporting optimal functioning.	Researchers acknowledge that the small sample of participants recruited from one geographical area may limit generalisability of findings.

Table 2. Concepts from selected studies

Key concepts emanating from the studies' findings	Coole et al. (2010)	Ryan et al. (2014)	Buijs et al. (2009)	Stewart et al. (2012)	Wrapson & Mewse (2011)	Soeker et al. (2009)	Soklaridis et al. (2010)	McCluskey et al. (2014)	McCluskey et al. (2011)	Brooks et al. (2013)
The worker's personal characteristics, attitudes and perceptions	Workers perceptions of their injury and prognosis could result in them placing limits on themselves.	Perceived pressure to return to work. Feelings of guilt due to feeling other workers have to do more work. Workers ignoring their limits. Perceived lack of control.	Despair was identified as an internal barrier to return to work. People who experienced feelings of despair were more likely to view the rehabilitative programme as ineffective. Motivation to reach personal goals.	Perceived lack of control with regards to return to work. Perceived lack of ability to perform pre-injury job. Fear of re-injury. Testing ability to get back to the job. Coping with impact of injury varies according to individual.	Fear job is in jeopardy when receiving negative response from employer	Taking responsibility for oneself helped injured individual develop a positive self-image and motivated them to engage in rehabilitation. Being competent /assertive in role helped participants adapt.	Psychosocial factors can have an impact on return to work. Where you come from and the cultures within that community influences psychosocial factors which influence return to work.	Workers who were reliant on long-term heavy pain medication may see this as a testament to the severity of pain and incapacity to work.	People became self-limiting and fearful of work activity. Claimants felt the need to stress their desire to work to perhaps not appear fraudulent. Psychological risk factors such as distress, fear-avoidance, catastrophizing and unhelpful pain beliefs contribute to work incapacity.	Out of work claimants were self-limiting and fearful of activity. Lack of control over circumstances linked to inability to continue in employment. Self-identity and distraction from pain were seen as positive consequences of work.
Workplace relations	Perceived pressure to return to work by others.	Support from employers. Pressure from colleagues to exceed their reduced ability to function.	Lack of supervisory support was an external barrier to effectiveness of a rehabilitation programme.	Not having a voice in the rehabilitation or decision-making process. Perceived lack of recognition	Employer responses to sick certification varies and can change. Some employers put blame on employee.	Change in political system to eliminate discrimination at work helped back injured individuals adapt to their roles.	Small employers wary of pushing injured workers too hard. Workplace factors play a role in perpetuating and (mis) managing early and safe return to work.	Research has indicated that important significant others in the return to work process are managers, co-workers and healthcare providers.	The need to find an understanding employer. Job dissatisfaction and perceived lack of social support in the workplace impacts on work capacity.	Good relationships with managers facilitates negotiation of necessary concessions. Flexibility from employers is vital.
Significant		Significant		Development of			Attitudes towards	Significant others	Act as 'witnesses	Significant

others		<p>others objecting to return to work.</p> <p>Pressure from families to remain off work longer.</p>		<p>educational programs tailored to family members and friends is required.</p>			<p>injuries, recovery times and compensation can be inherited from family.</p>	<p>hold similar treatment expectations to injured individual.</p> <p>Significant others portrayed themselves and others as powerless in their relative's recovery and return to work.</p>	<p>to pain' from claimant.</p> <p>Reinforce unhelpful beliefs including fear of pain and re-injury, and pessimism regarding returning to work.</p>	<p>others shared similar views to injured person.</p>
Credibility	<p>Participants cautious about disclosing back pain due to fear of being labelled a fraud or appearing unreliable.</p> <p>People wanted to prove they were genuine.</p>	<p>Experiences of not being believed by colleagues.</p> <p>Invisibility of lower back pain.</p> <p>Manager's calling to see how you are.</p> <p>Re-appraising perceptions.</p>		<p>Invisible nature of back injuries plays a role in perceived lack of recognition and interacts with the fear of re-injury.</p> <p>Perceived lack of recognition by others.</p> <p>Wanting proof / validation of condition.</p>	<p>People feared not being believed if they were seen carrying out personal/household tasks when away from work.</p> <p>Some workers visited worksite for the purpose of validating their incapacity.</p>		<p>Validation of injuries that are "invisible" created by organisational structures.</p>		<p>Need to fulfil 'disabled role' to not appear fraudulent.</p> <p>Pursuit of 'authenticity'.</p>	<p>Injured workers and significant others feel need to emphasise disability in face of stigmatising socio-cultural beliefs about 'benefit cheats' and 'malingering'.</p>
Uncertainty	<p>Uncertainty about future working capacity or needing to retire early.</p> <p>Uncertainty related to pain.</p>	<p>Feeling lost, anxious and insecure about the future.</p> <p>Ambiguity / lack of clarity about future work options.</p>	<p>Patients with long medical histories were unsure what they could expect from the programme.</p>	<p>Workers struggle with varying degrees of uncertainty.</p> <p>Apprehension regarding expectations from employers.</p>	<p>Fear that jobs may be in jeopardy.</p>	<p>Fear from new immigrant workers about losing their jobs.</p>	<p>Language barriers can exacerbate the process of understanding the injury trajectory.</p>	<p>Doubt from significant others over relative's future work potential.</p> <p>Uncertainty over whether the condition will improve.</p>		

Communication	Participants did not feel reassured or fully informed about their condition by clinicians.	Sense that colleagues or managers had an ulterior motive for having contact.	<p>Protocolled communication designed to overcome problems can actually be a barrier to return to work.</p> <p>Information exchange among health care providers positively influences patient compliance.</p>	<p>Mutual communication between insurer, external providers, employer and injured worker are all essential parts of the return to work process.</p>	<p>Varying levels of communication from employers in response to sick certification.</p> <p>Proactive employer response included keeping in touch with employee.</p>		<p>Language barriers hinder process.</p> <p>Lack of communication resulted in feelings of frustration, stress and anger.</p> <p>If injured workers asked too many questions it portrayed them in a negative light.</p>			
Modification of work duties, activity and environment		<p>Lack of appropriate work environment.</p> <p>Limits placed on phased return.</p> <p>Patient initiating own phased return.</p> <p>Respecting people's perceived limits of their ability.</p> <p>Using annual leave instead of sick leave.</p>	<p>Multidisciplinary outpatient care programme was perceived positively and applicable.</p>	<p>Perceived lack of workplace accommodation/ appropriate duties.</p> <p>Inadequate rehabilitation.</p> <p>Concern that employers would not recognise their rights for accommodation</p>	<p>Light duties not initially proposed.</p> <p>Providing modified work duties / making ergonomic changes perceived positively.</p> <p>Failure of employers to offer work accommodation has the potential to contribute to poor outcomes.</p>	<p>Multiple work skills enabled workers to alternate work tasks to minimise strain.</p> <p>Utilising good ergonomics, energy conservation and adapting tasks.</p>	<p>Lack of modified duties more likely in small business.</p> <p>Lack of modified one major factor for delay in returning to work.</p> <p>Perceived lack of choice or control over modified duties.</p>		<p>Difficulties returning to pre-injury role because of pain and reduced function.</p>	<p>Flexibility from employers to allow time off for medical appointments.</p> <p>Reduced or flexible working hours.</p> <p>More flexibility in higher status roles.</p> <p>Ability to stay in work influenced by whether adaptations could be made.</p>

<p>'System' issues</p>	<p>Those in dispute with employers or considering compensation claim were particularly keen to receive a diagnosis.</p> <p>Company 'bonus' schemes effect decision to return to work.</p>	<p>Waiting periods in the health care system.</p>	<p>Waiting periods in the health care system was cited as an external barrier to programme effectiveness.</p> <p>When patients evaluated a treatment programme as ineffective, this made them feel desperate.</p>	<p>Lack of control when attempting to coordinate services with health professionals, insurer and employer.</p> <p>Concerns regarding compensation, labour market, employment options and retirement.</p>	<p>Employer responses were often contrary to the Accident Compensation Corporation advice provided in New Zealand.</p>	<p>Back injured individuals frustrated with the system.</p> <p>Lack of faith in organisational procedures.</p> <p>Change in political system assisted injured workers to adapt to their roles (South Africa).</p>	<p>Organisational structures can affect co-worker support.</p> <p>Lack of support from union and employer.</p> <p>Complex relationships with compensation system, unions, workplace and health care system can delay return to work.</p>	<p>Treatment seen as ineffective if it didn't remove pain, offer a 'cure' or restore work function.</p> <p>Significant others report long waiting periods for a diagnosis and treatment.</p>	<p>Welfare systems may promote the problem of disability by rewarding sickness absence.</p> <p>The ability to retrain or obtain further educational qualifications can be limited by financial constraints, existing educational level and ill-health.</p>	<p>Employees should be fully informed about their rights and responsibilities.</p> <p>Welfare systems in the UK may be seen as punitive measures.</p>
<p>Second-order interpretations (by the authors)</p>	<p><i>"Most participants in this study perceived that their back condition might be viewed negatively ...for example that having time off work with a bad back as acquired 'moral stigma' ... because of fraudulent benefit claims"</i></p>	<p><i>"these findings provide evidence of the importance of addressing Blue Flags constructs, such as colleague support ... using simple Cognitive Behavioural Therapy [CBT] techniques"</i></p>	<p><i>"...the MOC [multidisciplinary outpatient care] programme was successful in changing LBP-patients' goal setting from pain elimination towards function restore and RTW [return to work]"</i></p>	<p><i>"These injured workers struggle with varying degrees of uncertainty in every aspect of their daily lives, from the discovery of new limitations ... to fear of re-injury or, worse, the possibility of disability due to pushing the boundaries of these new limitations"</i></p>	<p><i>"...initial responses from work supervisors were typically passive at the commencement of the sick leave... Contact by the employer with the employee during a period of absenteeism has been noted ... as a factor in a successful return to work"</i></p>	<p><i>"Adaptation to the worker role was facilitated by constant interaction between the BII [back injured individual] and the environment... participants that depicted dysfunction or maladaptation presented with an inability to manage the latter systems within the environment"</i></p>	<p><i>"Looking 'upstream' to what may have created or influenced the psychosocial factors associated with poor work outcomes, we get a holistic representation of the organizational structures within our social context that shape how individuals see and emotionally respond to lower back pain and return to work"</i></p>	<p><i>"Rather than focusing solely on individual risk factors for work disability, it may also be important to understand how significant others and wider social circumstances might contribute"</i></p>	<p><i>"It may be important to understand how others and wider social circumstances might contribute both to the propensity of persistent back pain and to its consequences"</i></p>	<p><i>"Patients will encounter a range of psychosocial obstacles to work participation and there is a danger both they and their significant other will perceive these obstacles as insurmountable especially in the face of socio-cultural scepticism about their condition"</i></p>

Table 3. Synthesis: concepts, second and third-order interpretations

Concepts	Second-order interpretations	Third-order interpretations
<p>The worker's personal characteristics, attitudes and perceptions</p> <p>Significant others</p> <p>Modification of work duties, activity and environment</p>	<p>"Adaptation to the worker role was facilitated by constant interaction between the BII [back injured individual] and the environment... participants that depicted dysfunction or maladaptation presented with an inability to manage the latter systems within the environment" (Soeker, Wegner and Pretious, 2009).</p> <p>"Rather than focusing solely on individual risk factors for work disability, it may also be important to understand how significant others and wider social circumstances might contribute." (McCluskey et al. 2014).</p> <p>"It may be important to understand how others and wider social circumstances might contribute both to the propensity of persistent back pain and to its consequences" (McCluskey et al. 2011).</p> <p>"...the MOC [multidisciplinary outpatient care] programme was successful in changing LBP-patients' goal setting from pain elimination towards function restore and RTW [return to work]" (Buijs et al. 2009)</p>	<p>Enabling injured workers to return to work safely: Back injured individuals and significant others should be well informed about their back condition, with a particular focus on function rather than diagnosis. Interventions to support workers and their significant others to re-appraise unhelpful beliefs would be beneficial. Employers and small business should be supported to provide necessary modifications and rehabilitation time to effectively return people to work. The provision of equipment and alternative work duties may assist in combating fear of re-injury among injured workers.</p>
<p>Credibility</p> <p>Uncertainty</p>	<p>"Patients will encounter a range of psychosocial obstacles to work participation and there is a danger both they and their significant other will perceive these obstacles as insurmountable especially in the face of socio-cultural scepticism about their condition" (Brooks et al. 2013)</p> <p>"Most participants in this study perceived that their back condition might be viewed negatively ...for example that having time off work with a bad back as acquired 'moral stigma' ... because of fraudulent benefit claims" (Coole et al. 2010)</p> <p>"These injured workers struggle with varying degrees of uncertainty in every aspect of their daily lives, from the discovery of new limitations ... to fear of re-injury or, worse, the possibility of disability due to pushing the boundaries of these new limitations" (Stewart et al. 2012)</p>	<p>Challenging negative assumptions: Workplaces should implement interventions to tackle negative assumptions by providing education to staff regarding back conditions, and their consequences. Anti-discrimination laws should be strictly adhered to in order to protect workers from stigma and worry about future work capacity and job security.</p>
<p>Communication</p> <p>Workplace relations</p> <p>'System' issues</p>	<p>"...initial responses from work supervisors were typically passive at the commencement of the sick leave... Contact by the employer with the employee during a period of absenteeism has been noted ... as a factor in a successful return to work" (Wrapson and Mewse, 2011).</p> <p>"these findings provide evidence of the importance of addressing Blue Flags constructs, such as colleague support ... using simple Cognitive Behavioural Therapy [CBT] techniques" (Ryan et al. 2014).</p> <p>"Looking "upstream" to what may have created or influenced the psychosocial factors associated with poor work outcomes, we get a holistic representation of the organizational structures within our social context that shape how individuals see and emotionally respond to lower back pain and return to work" (Soklaridis, Ammendolia and Cassidy, 2010).</p>	<p>Overcoming organisational barriers: Improved communication and transparency between healthcare providers, employers, employees and compensation systems is necessary to ensure workers return to work at the appropriate time. Interventions to improve workplace relations should also be implemented to help injured workers feel better supported by colleagues.</p>

Findings

Enabling injured workers to return to work safely

The worker's personal characteristics, attitudes and perceptions

This theme relates to how the personal characteristics, attitudes and perceptions of each injured individual can effect certain aspects of the return to work process. For example, across several studies factors such as 'motivation' and 'taking responsibility for one's self', positively influenced people's ability to return to work (Buijs et al., 2009; Soeker et al., 2009; Stewart et al., 2012). Soeker et al. (2009) noted that workers who were more competent in their roles, saw themselves as assertive, and who were proactive in their care and were more likely to experience positive outcomes.

Similarly, participants in the study by Brooks et al. (2013) described the benefits of working, such as contributing to positive self-identity and offering a welcome distraction from back pain. However, other studies found the perceptions that workers hold about themselves may also limit their ability to engage with rehabilitation. For example, self-doubt, fear of re-injury, despair, lack of control and lack of confidence influenced people's beliefs about their ability to return to work (Brooks et al., 2013; Buijs et al., 2009; Coole et al., 2010; McCluskey et al., 2011; Ryan et al., 2014; Stewart et al., 2012). Where attitudes such as these originate, was explored in the study by Soklaridis et al. (2010) who found that people's attitudes towards injuries, recovery times and compensation are inherited from the family they grew up in and the culture of their community.

Significant others

Consideration of wider systems and the influence of significant others is discussed in several studies. For example, significant others may reinforce claimants unhelpful beliefs regarding their lower back condition including fear of pain, re-injury and pessimism over their ability to return to work (Brooks et al., 2013; McCluskey et al., 2011; McCluskey et al., 2014; Ryan et al., 2014; Soklaridis et al., 2010). Brooks et al. (2013) found that the appraisal of injured workers by significant others, such as a relative, was different depending on whether their relative was working or not. Those who were working were perceived as "stoical" and "heroic", whereas relatives in the non-working sample, were perceived as "blameless victims" and more likely to be labelled "disabled". A potential limitation of these findings however is that all patients in the out of work sample had to attribute their lack of work

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3 participation to their back condition to be eligible for the study. It is therefore, unsurprising
4 arguably, that the relatives of these people were more likely to label them as “disabled”.
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6 Furthermore, the mean age of the non-working sample was 7.8 years older for patients, and
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8 24.9 years older for significant others compared to the working sample. There is a possibility
9 that differences exist in how this older group perceive their abilities due to age.
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14 Nonetheless, similarities exist regarding treatment expectations and beliefs between
15 significant others and their injured relatives. It is possible that expectations among the parties
16 are mutually reinforcing and may further contribute to work disability. By working with
17 back injured individuals, as well as their social network, it may be possible to better support
18 injured workers to return to work.
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23 24 *Modification of work duties, activity and environment*

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26 In addition to psychosocial interventions, adapting the physical environment and making
27 changes to work duties is a further way injured workers may be enabled to continue in their
28 work. A number of positive modifications to work duties and practices were noted across
29 studies (Brooks et al., 2013; Buijs et al., 2009; Ryan et al, 2014; Soeker et al., 2009; Wrapson
30 and Mewse, 2011). This included the implementation of a phased return, the usefulness of
31 graded activity programmes, provision of equipment or advice on ergonomics and light or
32 reduced duties. Other factors that supported participants to modify their work duties included
33 having multiple skills and being able to do alternative tasks that did not aggravate their
34 symptoms, being aware of utilising ergonomics and energy conservation and being in jobs
35 which enabled participants to find a balance between sedentary positions and physical
36 movement.
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46 Conversely, a number of barriers to return to work were also noted across studies (Ryan et al,
47 2014, Soklaridis et al., 2010; Stewart et al., 2011; Wrapson and Mewse, 2011). Lack of
48 modified duties was one major factor that could delay return to work, particularly in small
49 businesses due to a lack of availability of appropriate duties. For some participants, the
50 experience of modified duties led to feelings of guilt and the possibility of being a burden to
51 colleagues. Soklaridis et al. (2010) found that modified duties were felt to be socially
52 inappropriate in one instance whereby male workers were expected to undertake duties
53 ordinarily done by female workers. However, one could argue that this view does little to
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3 challenge the occupational segregation by gender that already exists and appears to be
4 becoming more entrenched within current work practices (Huppatz and Goodwin, 2013).
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8 ***Challenging negative assumptions***

9 *Credibility*

10 Lower back pain is described as an “invisible” disability in several studies and it is noted that
11 conditions such as lower back pain can be viewed as ‘bogus’ in the workplace or by health
12 professionals and insurers (Brooks et al. 2013; Coole et al., 2010; McCluskey et al., 2011;
13 Ryan et al., 2014; Soklaridis et al., 2010; Stewart et al., 2012; Wrapson and Mewse, 2011).
14 The absence of visible injury in some instances can lead to workers experiencing negative
15 appraisals of their injuries from others, and may result in a fear of disclosing their back pain.
16 One participant relayed that her employer had stated “. . . you planned all this” in response to
17 her providing sick certification (Wrapson and Mewse, 2011). As a consequence of not
18 feeling believed, many participants felt the need to justify or prove their symptoms through
19 seeking medical investigations or obtaining a diagnosis (Coole et al., 2010; McCluskey et al.,
20 2011; Stewart et al., 2012).
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32 For some participants, the fear of disclosing a lower back injury may be due to anticipation of
33 discrimination in the workplace. Coole et al. (2010) and Stewart et al. (2012) noted how
34 injured workers may be unfairly penalised due to their injuries (e.g. regarding future work
35 opportunities), and may be perceived as being ‘to blame’. This concept is also noted by
36 Soklaridis et al. (2010) who question whether emphasis on psychosocial factors may place
37 the fault with the injured worker and consequently perpetuate the stereotyping and
38 stigmatising of injured workers. These judgements could lead to discriminatory practice
39 occurring in the workplace, which creates fear and uncertainty about the future for injured
40 workers. It is possible however, that the concept of credibility of illness is something that is
41 imagined, and not based in reality. For example, Ryan et al. (2014) reported that one strategy
42 for mediating work-condition conflict is re-appraising the views of others, including
43 colleagues and management:
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55 . . . it was mostly my mental state . . . imagining that they were thinking the worst of the
56 situation rather than they would be supportive and just glad to have me back, which in reality
57 it turned out to be . . . (participant in Ryan et al. 2014).
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Uncertainty

A number of uncertainties were reported regarding the return to work process and future work capacity across several studies. For example, some participants described feeling lost, anxious and insecure about the future and others relayed concerns about earlier than anticipated retirement and future work capacity (Coole et al., 2010, McCluskey et al., 2014; Ryan et al., 2014; Soeker et al., 2009; Stewart et al., 2012; Wrapson and Mewse, 2011).

I've still got another – 21 years left at work . . . The concern is if me [sic] back's killing me [sic] now, what am I going to be like in later times? (participant in Coole et al. 2010).

It seems that some of these uncertainties are driven by fears of being discriminated against if the true nature of their injuries is disclosed or if they feel their employers will not understand the difficulties they experience or how best to support them. By challenging negative assumptions and educating employers and colleagues, workers may be better protected from stigma and discrimination and have fewer fears regarding their future work capacity.

Overcoming organisational barriers

Communication

The predominance of feedback across the studies was that there was often a lack of communication and coordination in the return to work process. This was particularly highlighted for those seeking compensation in relation to workplace injuries (Soklaridis et al. 2010). Even when employers did communicate with workers, this was sometimes perceived as superficial with one participant suggesting that employers had ulterior motives for having contact rather than a genuine interest in the worker's recovery (Ryan et al. 2014). However, Buijs et al. (2009) found that protocolled communication fostered information sharing between health professionals, and with their patients which influenced patient compliance and provided clear explanations, advice and goal setting. Having improved communication and transparency between parties is one way of overcoming organisational barriers to return to work, provided this is done in a way that is viewed as being supportive rather than punitive.

Workplace relations

Another way of overcoming organisational barriers to return to work, is to foster positive workplace relations. Several participants expressed feeling supported by employers in

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3 returning to work and it was noted that having good personal relationships with line
4 managers often facilitated flexible working arrangements (Brooks et al., 2013, Ryan et al.,
5 2014; Wrapson and Mewse, 2011). However, not all participants had a positive experience
6 of workplace relationships. Many described a pressure to return to work and feelings of guilt
7 associated with taking time off (Coole et al., 2010, Ryan et al., 2014). Others reported that
8 employers responded negatively or apathetically regarding sickness leave which in some
9 instances made workers feel their jobs were in jeopardy (Wrapson and Mewse, 2011). From
10 the employer's perspective, passive behaviour may be the consequence of not wanting to
11 push employees too hard. Soklaridis et al. (2010) stated that small employers were concerned
12 about creating feelings of resentment and frustration from the employee.
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22 *'System' issues*

23 Further organisational barriers were noted by Soklaridis et al. (2010) who use the term
24 'system' issues to describe the components of a large organisational system that can
25 contribute directly and indirectly to the management of lower back pain and return to work.
26 System issues can include dysfunction within and between compensation systems, unions,
27 workplace and health care systems, which may include waiting periods within the healthcare,
28 punitive measures, or poor implementation of occupational health advice (Buijs et al., 2009;
29 Coole et al., 2010; McCluskey et al., 2014; Ryan et al., 2014; Soeker et al., 2009; Soklaridis
30 et al., 2010, Stewart et al., 2012). Positive system factors include continued education and
31 training of workers and in one instance, changes in political systems which assisted back
32 injured workers (Soeker et al., 2009).
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42 **Discussion and implications**

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44 Although many people successfully return to work following lower back injury or episodes of
45 back pain, there are improvements that could be made to the return to work process that could
46 potentially benefit injured workers, employers and the wider economy (Soklaridis et al.,
47 2010). In this review, there were several key findings, which employers and return to work
48 professionals may wish to consider. Firstly, injured employees should be enabled to return to
49 work as soon as possible to avoid deconditioning and the development of intrinsic barriers
50 such as fear of re-injury or self-doubt (Stewart et al., 2012). This is supported by research that
51 suggests returning to work is beneficial for health (Health and Safety Executive, 2004;
52 Waddell and Burton, 2006). For those who argue that an early return to work could cause
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3 more harm (MacEachen et al., 2007), any early return to work should make use of phased
4 return to work programmes or modified work duties to minimise the risk of aggravating
5 lower back conditions and exacerbating the worker's experience of pain (Ryan et al., 2014).
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7 Particular attention should be given to small businesses who may be unable to offer
8 appropriate alternative duties or feel that they are putting pressure on workers to return
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10 (Soklaridis et al., 2010).
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14 A pressure to return to work is often felt by workers who either feel guilty due to the extra
15 burden on their colleagues in their absence, or are fearful of losing their jobs. In some
16 instances, these internal or external pressures can result in injured workers returning to their
17 usual duties too quickly, potentially exacerbating their condition or jeopardising their
18 recovery (Ryan et al., 2014). Soklaridis et al. (2010) report that this is particularly the case
19 for some immigrant workers who may be fearful of losing their jobs, or experience difficulty
20 explaining their injury due to language barriers.
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24 The research suggests that in order to address this issue of pressure to return to work,
25 healthcare providers need to do more to support injured workers by gauging when those
26 living with back pain are truly ready to return to work (Buijs et al., 2009; Ryan et al., 2014).
27 Individuals should be given education about their back condition with emphasis on function
28 rather than diagnosis, as a means to empower individuals to make better informed decisions
29 regarding their recovery and return to work. This may address some of the difficulties with
30 regards to injured workers perceiving a need for a diagnosis (Coole et al., 2010) and may
31 combat a perceived lack of control in their return to work (Stewart et al., 2012).
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35 A further way of challenging perceptions that may exist, is to foster openness in the
36 workplace and encourage people to reappraise situations. For example, Ryan et al. (2014)
37 suggest using cognitive behavioural therapy techniques to encourage workers to re-appraise
38 the views of others and openly discuss their relationships with others. This allows for any
39 potential conflicts to be identified and addressed to support the return to work process. This
40 could also be used with significant others to challenge the possibly entrenched views that
41 they hold and to break the cycle of reinforcement that may occur between injured workers
42 and their significant others.
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46 Employers, compensation providers, health professionals and human resources staff need to
47 be aware of the reasons injured workers may not be candid about their symptoms. For
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3 example, Brooks et al. (2013) noted that workers and their significant others are more likely
4 to emphasise the impact of their illness due to the stringent tests and assessments they
5 experience when applying for benefits. Conversely, some injured workers are likely to play
6 down their symptoms due to fear of stigma, discrimination, job loss and lack of future work
7 opportunities (Coole et al., 2010).
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12 Crucially, socio-cultural stereotypes around “malingering” and “benefit cheats” need to be
13 challenged (Brooks et al., 2013), and anti-discriminatory laws need to be strictly followed.
14 Despite anti-discrimination and equality laws, such as the Equality Act (2010) in the UK or
15 the Employment Equity Act (1998) in South Africa, this review found that the injured
16 workers’ experience was that discrimination in the workplace was common (Coole et al.,
17 2010; Stewart et al., 2012).
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24 Several studies noted that work practices contradicted guidance on return to work. For
25 example, Soklaridis et al. (2010) noted that there were delays in return to work procedures
26 and poor communication between parties. Coole et al. (2010) noted that absence management
27 procedures were viewed as “punitive”. Improvements should be made to the way absences
28 are managed and the return to work procedure needs to be more supportive to enhance the
29 employee’s experience. As suggested by Soklaridis et al. (2010), one aspect of this support
30 could relate to effective communication, whereby health care providers and compensation
31 systems work together to ensure the worker is receiving timely care.
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39 Employers, and small businesses in particular, should be supported to provide necessary
40 work modifications and allow sufficient time for recovery (Soklaridis et al., 2010). Other
41 strategies to support early return to work would be to consider the range of possible duties
42 workers may be able to undertake. By considering a broader pool of jobs, there may be more
43 opportunity for injured workers to return to lighter roles and for employers to be able to
44 implement recommended modifications. This could also tackle the issue of fear of re-injury
45 among injured workers which is reported in several of the reviewed studies (Brooks et al.,
46 2013; Coole et al., 2010; McCluskey et al., 2011; Stewart et al., 2012). The focus of such
47 interventions is to enable workers, employers and return to work professionals to find
48 solutions that may facilitate early return to work and reduce the risk of prolonged
49 absenteeism which could lead to a state of occupational deprivation.
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Towards a strengths-based approach

One finding of this meta-ethnography, is that the research often emphasises the barriers injured workers face and the things they are unable to do, often feeling at the mercy of the systems that exist. Pessimism regarding the future is evident in a number of studies, for example McCluskey et al. (2011) noted that workers were doubtful about the likelihood of returning to work, and had become increasingly self-limiting and fearful of work activity.

Taking an alternative approach, Brooks et al. (2013) were of the opinion that having a “can-do” attitude may be associated with better functioning in terms of work participation.

Similarly, Soeker et al. (2009) emphasise the importance of maintaining a positive attitude in order to facilitate rehabilitation. These views are congruent with having a strengths-based approach, which emphasises the individual’s strengths, what they can do, and the support that is available to them (Social Care Institute of Excellence, 2015). This way of working has been commonplace in UK social care systems since the introduction of the Care Act (2014).

For occupational therapists working in health and social care settings, supporting workers to understand their condition and focusing on function rather than disability may foster a sense of control. This in turn, could act as a protective factor against the development of intrinsic barriers such as fear of re-injury or self-doubt. Within vocational rehabilitation, occupational therapists can support workers and employers to adapt work duties, identify lighter roles, provide ergonomic equipment and modify work schedules. This expertise is crucial in enabling workers to return to work and prevent long term absenteeism, or unemployment.

Strengths and Limitations

This review draws together the experiences of injured workers, significant others, healthcare providers and other professionals involved in the return to work process, allowing for different perspectives on return to work to be compared and synthesised. The review included studies pertaining to workers who had returned to work, as well as those who were absent or unemployed. The review also highlights that some of the experiences mentioned are not exclusive to people in the UK, but also to workers in other parts of Europe, South Africa, Canada and New Zealand. However, it is acknowledged that all participants in the studies were from countries with developed healthcare services which may limit the transferability of these findings.

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3 The inclusion of grey literature may have allowed access to a more diverse evidence base. It
4 is possible that by including grey literature, issues around publication bias could be reduced,
5 however, new challenges can emerge related to appraising methodological quality (Paez,
6 2017).
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11 Future research could distinguish between chronic and acute lower back pain to allow for
12 more specific identification of barriers and facilitators to return to work at various stages of
13 rehabilitation. Similarly, focussing on particular groups of workers (e.g. factory or
14 agricultural workers) might enhance the transferability of findings. Exploring differences
15 between workers who sustained injury at or outside of work may also have a bearing on
16 return to work practices, particularly if the former adds a further layer of complexity due to
17 involvement of workplace compensation factors.
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25 ***Conclusion***

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28 This review suggests that there are shared experiences among back injured workers from
29 different work settings and countries, who are attempting to return to work. This meta-
30 ethnography supports previous findings which emphasise consideration of wider
31 organisational and psychosocial influences in supporting a person to return to work, rather
32 than placing blame with the injured worker. The review highlights that some existing return
33 to work practices might not comply with legislation thereby hindering progress towards
34 greater equality and anti-discrimination. The review provides some suggestions for
35 modification of current return to work practices, and emphasises the need for a strengths-
36 based approach to rehabilitation. Suggestions are made for occupational therapists who
37 might work with people living with back pain.
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Key findings

Challenges in returning to work relate to person characteristics, social support and the workers' organisation return to work process.

Socio-cultural stereotyping is harmful for injured workers.

What the study has added

A greater understanding of how people with lower back injuries can be best supported when attempting to return to work.

Consideration as to how occupational therapy practice can facilitate the return to work process.

For Peer Review

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