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Fear, William J. (2009) Return to work revisited. *The Psychologist* 22 , pp. 502-503. ISSN 0952-8229.

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'Return to work' revisited

William J. Fear argues that people on incapacity benefit need a psychosocial intervention rooted in self-efficacy

Being out of work can have harmful effects on both physical and mental health, and nobody wants to hear that they are too ill to work. Yet the number of people on incapacity benefit (IB) has more than trebled since the 1970s to 2.7 million (DWP, 2002), without a corresponding decrease in the nation's health.

This wider focus is bringing together (among others) the once disparate and vague constructs, and sectors, of 'stress', 'health and well-being at work', 'the happy and productive worker', 'sickness absence management', 'occupational health', 'return-to-work (RtW)', and 'welfare-to-work'. At the same time there is a growing recognition that the health-related elements of these sectors have been largely dominated by a clinical or medical model, and this has not proved effective.

This development is particularly important in relation to the UK government's 'Pathways to Work' policy, which aims to support people in receipt of IB to find and retain competitive employment (see DWP, 2002); that is, people claiming welfare support on grounds of long-term ill health, including and especially psychological distress. There appears to be little or no reason why most people in receipt of IB could not work (see Waddell & Burton, 2006, for a review). Waddell and Aylward (2005) found that in the IB population 65–75 per cent of people have only a limited or inconsistent pathological basis for incapacity. Furthermore, 90 per cent of

new claimants initially expect to return to work in due course (Green et al., 2000).

It is now widely acknowledged that an improvement in health alone is not sufficient to bring about an occupational outcome – a 'return to work'. However, we are becoming increasingly sure that, generally speaking, an occupational outcome tends to bring about an improvement in health (e.g. see Ballard, 2006). By an occupational outcome, I mean a return to competitive employment: working in the labour market for at least the minimum wage for 16 hours or more per week and for a continuous period of 13 weeks or more. This is an important distinction as it is now widely accepted that other forms of work, such as voluntary work, do not, overall, bring about the same health-related benefits as competitive employment. This may especially be the case when mental health and well-being is taken into account (e.g. see King & Lloyd, 2007).

A recent review of vocational rehabilitation (VR) found that while health care has a key role, treatment by itself has little impact on work outcomes. This was especially the case for mental health: 'Sickness absence and long-term incapacity associated with mental health problems are unlikely to be improved simply by providing more healthcare...' (Waddell et al., 2008; p.23). And a recent (draft) review by NICE found that 'there was a lack of evidence of a sufficient quality to demonstrate the effectiveness of [healthcare] interventions that help

people receiving incapacity benefit (or similar benefits) return to employment (paid and unpaid)' (NICE, 2008, p.7).

Indeed, the VR community has been critical of its own role. King and Lloyd (2007, p.149) noted that 'there is now a substantial amount of evidence that rehabilitation practitioners do not focus clearly on working with clients to achieve vocational outcomes'.

The current emerging paradigm for RtW, especially in relation to common health problems, including mental health problems, is a psychosocial one. (For an excellent practical resource see King et al., 2007.) An argument has been made for a 'biopsychosocial' paradigm. Unfortunately this biopsychosocial model has remained a largely clinical model that lacks full and appropriate consideration of psychological, psychosocial, and organisational factors.

I'm not suggesting that we should ignore peoples' health conditions when assisting them to return to work, especially in the case of personal injury. Indeed, for someone whose health impacts on their functional ability then, in the short term, addressing that element of their health in relation to function may well bring about a resolution of the problem. However, this cannot be taken for granted. Furthermore, this paradigm can arguably do more harm than good when iatrogenic effects occur.

An iatrogenic effect is described as an unwanted effect that is inadvertently introduced by a healthcare professional, or their treatment (see Gatchel, 2004). One example is when advised to rest to relieve pain, a person may continue to rest for longer than necessary. This can change the person's behaviour and/or beliefs in response to their condition and alter their routine. The consequences of this can be extreme debilitation (for further examples and discussion see Audy, 1970; Kouyanou et al., 1997; Lucire, 1986; Spillane, 2008).

Iatrogenic effects can also be created when clusters of symptoms that commonly occur in the normal population are

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labelled as 'conditions' that require treatment. This can result in 'iatrogenic epidemics' of medical/clinical conditions that previously would not have been debilitating.

As a simple way of thinking about this, many people, probably around 30 per cent of the normal population, experience 'common health problems' – combinations of stiffness, soreness, widespread and enduring pain, lower back pain, fatigue, headaches, an inability to concentrate, stomach upsets, mobility difficulties, sleeplessness, the triad of 'depression-anxiety-stress', and so on. While most people continue their normal lives regardless, a small percentage of people are debilitated by these clusters of symptoms and may cease work as a consequence (or take extended time off work with worsening symptoms).

The importance of psychosocial factors is paramount in relation to 'Pathways to Work' as in the majority of cases of IB claims (perhaps as many as 75 per cent by government statistics: DWP, 2002) there is no debilitating condition that does not occur in the rest of the working population. This is not to say that people in receipt of IB are not experiencing distress and lack of functional ability, and in some cases this is severe. What it does mean is that for many people the level of distress is in part a function, and in part a consequence, of the person's behaviour rather than their health *per se*: cognitive, emotional and social behaviour, including perception and expectation, are considered behavioural mechanisms for this article. (For an example of the relevance of illness perception, see Pietrie & Weinman, 2006). In many cases, there is a set of entrenched beliefs about the severity and impact of the symptoms. These beliefs are held not only by the individual but also by members of their communities, including line managers, GPs, family, friends, and others.

We see the importance of this in the work of Baily et al. (2007). They showed

that while there was an objective set of long-standing variables that predict whether and when an IB claimant will return to work, the two strongest predictors were the person's perception of their own health and their 'distance from work' or time out of competitive employment. In addition, perception of health, not actual health, was found to be one of the biggest barriers to sustained employment (see Baily et al., 2007, and Dixon et al., 2007).



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Arguably the most extensive theoretical framework we have to address this combination of psychosocial factors, and for developing practical interventions for behavioural change, is social cognitive theory (SCT) and in particular the work of Albert Bandura on self-efficacy (see, for example, Bandura, 1977, 1997). The importance of perceived self-efficacy in relation to IB claimants, and especially in relation to iatrogenic effects and iatrogenic epidemics, is clear when we consider that skills or abilities alone do not predict performance but that 'what you believe you can do with what you have under a variety of circumstances' has the greatest impact on performance (Bandura, 1997, p.37). It follows that what a person believes they cannot do due to the perceived (by self and others) severity of their symptoms under a variety

of circumstances will greatly impact on their perceived (by self and others) ability to function.

With regard to RtW in its own right, Roger James and David Booth have demonstrated that self-efficacy is one of the most important facilitators/barriers to successful job outcomes. There are strong indications that self-efficacy is important in terms of maintaining good mental health at work (see Bartley et al., 2005; Booth & James, 2008; James, 2007).

There is a bigger argument here about the persons' beliefs in relation to their symptoms, their ability to manage them in their everyday life, and especially their ability to manage their symptoms in relation to return to work and to stay in work. Both the individual and the 'system' within which they work need to be addressed. If only one side is addressed then we have a 'clean fish, dirty pond' scenario where the individual is supported to manage their health and well-being, but then enters a work environment that is harmful to their health and well-being, and is 'powerless' to address the situation. Note that a harmful environment is not necessarily a physically harmful environment: it is one where there is a perceived uncontrollable threat. The only way to address that, other than changing the environment, is to improve self-efficacy.

The massive social experiment that was incapacity benefit cannot be addressed by 'fixing broken individuals' and in particular cannot be addressed by interventions based on the 'cult of the individual'. It needs to be addressed now, as worklessness is becoming one of the biggest causes of inequality and social morbidity not only in the UK but worldwide. Psychology as a discipline, and especially as a discipline with an expert understanding of both psychosocial factors and the world of work, has much to contribute.

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