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This chapter analyses work and its influence on the worker from anthropological, psychological, health and clinical perspectives.

2.1 From an Anthropological and Psychological Perspective

2.1.1 What Is the Meaning of Work?

Studies in the anthropological and psychological field have documented “the meaning of work” people attribute to their jobs and, to some extent, how this can impact well-being. There is no consensus on the definition for the meaning of work. A synthesis review on the meaning of work defined it as the part that work plays in one’s personal life (Baldry et al. 2007). According to specific contexts of work and social position, some individuals may be oriented to the fulfilment of economic needs while others focus on career development and commitment, and will develop or present a

strong occupational identity (Baldry et al. 2007). Despite being less studied in the field of work rehabilitation, a few authors also identified religious beliefs as a factor influencing the meaning of work. Thus, some workers may view their work engagement in terms of a “calling” or “predestination” (Davidson and Caddell 1994) or attach ethical behaviours to it (Weaver 2002). The context of work will influence the process leading to the elaboration of the meaning of work. This context will provide the material and relational grounds for developing, among other things, feelings of self-achievement, recognition, positive relationship and purposeful activity (Morin 2008).

Morin (2008) identified three components in the meaning of work. The first is the presence of significance in work. It is the value of the work from the worker’s perspective and representation. A representation can be defined as a set of values, opinions and ideas about something or a specific object constructed through various life experiences in interactions with others, and built on information models acquired through education and socialisation processes (Coutu et al. 2007; Jodelet 1989). Significance in work underlies the importance that is given to work in the totality of personal life and the possible interference with other domains of life such as family, leisure or community involvement. Moral correctness may also play a role in work significance by questioning the consequences of a work activity (Morin 2008). Is it harmful to someone’s integrity, health or safety? Does it cause environmental hazards? Work significance is idiosyncratic, since it must meet

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criteria defined by the individual. The second component of work is orientation in terms of providing goals and expectations for the worker. Work orientation is the worker's direction at work, what he/she is seeking in a specific work activity. For example, a socially valued occupation may provide a sense of self-worth and usefulness and, therefore, be a source of motivation, pride and satisfaction (Baldry et al. 2007). The third component of work is a sense of coherence. This component provides integration between a person's expectations and values, and the work activities he/she performs (Morin 2008). Work coherence may be viewed as the balance between one's own representation of work significance and the actual conditions of work, and the balance between one's own expectations and values and the actions performed every day in the work environment. For example, a worker's strong family commitments may be incompatible with working long hours; a worker's sense and aptitude for autonomy may be at odds with an authoritative managerial style and may result in dissatisfaction and distress.

2.1.2 Socio-Historical Aspects of Work

Every person will create their own meaning attached to work, but this meaning is shaped and influenced by the environmental contexts from which they evolved. World views regarding paid work may be subject to variations according to social and historical norms and cultural values (Gill 1999). Consequently, the meaning of work has significantly changed over time and geographic area (Baldry et al. 2007). In Western societies, work was progressively depicted in a more positive sense, especially from the medieval epoch with the rise of craftsmanship, trades and technicians, all of which have a strong sense of professional/occupational identity (e.g. guilds, corporations) (Popper 1966). The rise of the industrial era in the West from the eighteenth century has initiated major changes in labour (Guest et al. 1997). This period also witnessed many changes in family structure (nuclear), community and territorial organisation, law, etc. In changing from domestic- or household-based manufacturing

to factory and larger scale production, work activities became amalgamated to wage-earning activities or "paid labour" (Godelier 2000). Work progressively began to be a specific activity, distinct from leisure (to which it might be opposed), family or community life, which underlined a division between private and public space, and between family/community life and workplace/professional engagements (Godelier 2000). The meaning of work also reflected changes with the rise of liberal democracies, a politically influential class of entrepreneurs ("bourgeoisie") and the concomitant growth of a working class (Baldry et al. 2007; Winkelmann 2009). Work became a central vector of socialisation, contributing to the definition of social position and integration and, to some extent, stressing the features of self-worth (usefulness) (Castel 1996).

Virtanen et al., a Finnish team of researchers, studied the sickness absence practices at the level of the community and work organisation (Virtanen et al. 2000). They described generative and structuring schemes of practices and representations prevalent in three Finnish towns where sickness absence problems were highlighted by local authorities. Virtanen et al. were inspired by Bourdieu's notion of "habitus" defined as a set of acquired body schemes, sensibilities and tastes generating and structuring practices and representations (Virtanen et al. 2000). Sickness absence practices were analysed in this way, leading to "community diagnoses" in correlating sickness absence frequencies and attitudes toward it. Distinctive "class-related body schemas" emerged from the data, showing different styles of being incapacitated, reflecting, on one hand (working class), an "alienated relationship to work" and, on the other hand, a strong "commitment" to work (middle class) (Virtanen et al. 2000) which can be associated with the contemporary concept of meaning of work. Strong commitment to work was discussed in light of the ideals and values of work where virtue has been made necessity or "individual obligations" (Virtanen et al. 2000). In this case, it may be more difficult to disengage from work responsibilities, and therefore, the meaning of work may disrupt the balance between work and other important social domains, such as family.

Paid work has become a central institution of modern advanced industrial societies, providing or fulfilling psychological needs that were provided for outside paid work in earlier or traditional pre-industrial societies where social status was given by birth or through the channelling of hereditary functions and lineage (Jahoda 1982). In modern times, people have the possibility/freedom to choose what they want to do and to make themselves the person they want to be according to their own tastes, preferences, expectations and beliefs, despite strong cultural and social environmental influences on choice (Cross and Gore 2003). This is the construction of the self as a worker.

While work engagement can be associated in some aspect to the pursuit of happiness and the development of a positive and gratifying self-identity, the reality of work is not always “idyllic”. Changing patterns of work in a globalised economy reminds us about the harsh reality of contemporary work conditions: precariousness, increased work demand, insecurity, etc. (Lallement 2010). For example, job dissatisfaction (Notenbomer et al. 2006), dysfunctions in organisational dynamics (MacEachen et al. 2010), and larger systemic and organisational issues (D’Amato and Zijlstra 2010) can play a significant role in the process of resuming work after an occupational injury. Environmental, ergonomic or psychosocial hazards can also have negative health effects (Ahonen et al. 2010). In such a situation, the positive effects of a rehabilitation programme may be dampened by an inauspicious climate at work (e.g. relations with employer/supervisor, relations with colleagues) and are likely to predict longer work absence (Notenbomer et al. 2006). Also, a recent population survey on working conditions and occupational health and safety in Québec (Canada) showed that physical and psychosocial stresses are more prevalent in job categories located at the bottom of the hierarchy (Vézina 2011). Consequently, pre-injury jobs may be considered as an inherent feature of the situational vulnerability to which workers are exposed when elements for a positive meaning for work are not met (Morin 2008).

2.1.3 Work, Construction of Self- and Social Integration

Self is generally defined as the way people see themselves in relation to their personal life expectations and goals and in relation to their social environment (Oyserman 2004). Along with financial security, work activities provide a sense of self-worth, a sense of identity and social role, social relationships and networks (Gill 1999; Godelier 2000; Leufstadius et al. 2009). In terms of social role, the component of coherence in work will fulfil identity, such as who am I and to which group do I belong to that address the sense of belonging and relationship (Morin 2008), or how do I fit in (Oyserman 2004). Self-identity as a worker can change over a lifetime, according to social interactions, personal experience and life circumstances, some of which may be disruptive or even tragic when they affect the sense of self in its projective dimension or how do I see myself in the future (Lawton 2003).

Job loss or prolonged sickness absence due to work disability may take a tragic turn in one’s personal life (Docherty and McColl 2003; Johansson and Tham 2006; Shaw et al. 2002). Feelings of self in such a context become entangled with a feeling of “loss”, a diminished self, so that a positive self-image must be re-channelled or “rediscovered” (Charmaz 1994).

Rebuilding a positive self-image through illness and healing is an important issue in the process of occupational rehabilitation, and work re-entry may be central in that process (Vrkljan and Miller-Polgar 2001). The meaning of work is set in a similar way in a study in medical anthropology among chronic pain sufferers who were described as active professionals (DelVecchio Good 1992). In this study, work was described as “an arena for self-realisation and effective performance”. However, those who are not professionals or those who are working in an adverse or harmful climate might see work in a different way. Also, in a qualitative study performed with workers undergoing cardiac rehabilitation and working on an assembly line in the automobile industry, performance was mentioned but work was also seen as an important life activity and a

part of recovery. Nevertheless, in some cases it was also seen as an undesirable necessity (O'Hagan 2009; O'Hagan et al. 2012).

Another qualitative study found that for injured occupational therapists the meaning of work was associated with helping others, which contributed to having a sense of importance, accomplishment and satisfaction (Alnaser 2009). The concept of centrality of work was again noted: it was described as an opportunity to socialise with co-workers and patients and to further develop relationships (Alnaser 2009). In a context of prolonged work disability, a person may be particularly vulnerable to experiencing at least a feeling of "loss" of self-image, possibly even a collapsing self-image, with no or few acceptable options to replace it (Charmaz 1994). Long-term work absence may lead to identity gap, filled by self-depreciation, loss of significance of previous accomplishment and loss of social relationships (Alnaser 2009; Martin and Baril 1996). Chronic or persistent conditions of illness influence the meaning of life, in general, and provoke a reconsidering of one's own values attached to work engagement, especially when professional identity is strong (Alnaser 2009; Johansson and Tham 2006; Ockander and Timpka 2003). Rebuilding a self-image through illness may then pass through the reconsiderations of life priorities so that work centrality may be reconsidered and social dimension may become more important, such as family, friends and community volunteer work (Coutu et al. 2010; Johansson and Tham 2006; McCloughan et al. 2011; Svajger and Winding 2009).

In terms of reconsideration, Coutu et al. (2010) observed a process called an "illness transformation" through which the illness identity (handicapped, crippled, etc.) was abandoned during the work rehabilitation programme, even when pain symptoms persisted, because these symptoms were now seen as controllable. This illness transformation implies that participants may be mastering pain-coping strategies and that pain may be seen as "normal" even if some aspects of their lives are not, or never will be, "the same as before". However, this "transformation" was only

observed in workers who successfully returned to work, after an average of 1 year off work.

Being engaged in work activity and the making of self-image are well entangled in the process of social integration. Social integration is linked to social role, identity and the perception of doing something useful, or being productive in the context of a highly competitive market economy which values commitment, productivity and adaptability, and where the workplace tends to be transformed into a "community" (Baldry et al. 2007; Vrkljan and Miller-Polgar 2001).

2.2 From a Health Perspective, What Is the Value of Work on Health?

From an anthropological and psychological perspective, the centrality of work and the meaning of work have a positive influence on a worker's life. However, from an occupational health and safety perspective, work has been studied in terms of possible hazards to one health. Therefore, one can wonder, "what is the value of work on health after all?" Waddell and Burton (2006) performed a best evidence synthesis covering the literature from 1990 to 2006 on adults of working age, which enabled them to rate a level of evidence regarding the effects of work on health. Their synthesis took into account age, by specifically looking at young adults (16–25 years old), middle working age (25–50 years old) and older workers (50 years old and over). They also included the more prevalent disorders associated with work disability, including mental health disorders, musculoskeletal disorders and cardiovascular disorders. The added value of this synthesis is its neutral assumptions. Compared to occupational health and safety literature, that may see work as a potential hazard and with adverse effects on health, this synthesis searched for the positive and negative effects of work and, ultimately, aimed at analysing whether the benefits outweighed the risks.

When comparing work and unemployment, Waddell and Burton (2006) found strong levels of

evidence that employment is associated with physical and psychological well-being as well as health. In order to have these positive effects the authors stress the importance of a safe work environment. Also, the pay must be sufficient and a low level of job insecurity is needed (Waddell and Burton 2006). It is important to note that some studies have found a healthy worker effect. The effect is that the healthiest workers are more likely to work and experience well-being, when compared to unemployed individuals (Claussen et al. 1993; Hamilton et al. 1993). However, other studies were unable to support this hypothesis (Graetz 1993; Kessler et al. 1989; Mathers and Schofield 1998; Tiggemann and Winefield 1984). For example, when comparing data on school leavers at baseline and 1-year follow-up, those who were employed at 1 year rated higher self-esteem, lower depressive moods and greater adjustment. At baseline, there were no significant differences. In this case, results seemed to have improved for the employed participant rather than having deteriorated among the unemployed participants (Tiggemann and Winefield 1984). A review performed by Mathers (Mathers and Schofield 1998) on the healthy worker effect found some evidence of this effect, but for these authors, a review of longitudinal studies provided reasonable evidence that the lack of employment had a stronger effect than socio-economic status, risk factors and prior ill health.

2.2.1 What Are the Consequences of a Sickness Absence due to Work Disability?

Sickness absence may undermine workers' mental health. In general, studies of individuals experiencing persistent pain due to a musculoskeletal disorder (MSD) have observed mixed anxiety and depressive symptoms (Hellström et al. 1999; McCracken et al. 1999; Naidoo and Pillay 1994; Plehn et al. 1998; Turner et al. 2002; Von Korff and Simon 1996; Walker and Sofaer 1998; Waters et al. 2004). The prevalence of anxiety (35.1% vs. 18.1%, $p < 0.0001$) and mood (20.2% vs. 9.3%, $p < 0.0001$) disorders among individuals with

persistent low back pain is significantly higher than in a general American population (McWilliams et al. 2003). Similarly, in the Canadian population, the prevalence of mood disorders in those experiencing persistent low back pain was 19.8% (Currie et al. 2002). The anxiety component in workers with a persistent MSD is far from negligible. Generalised anxiety disorder (GAD) is 2.5 times more prevalent in individuals with low back pain, i.e. 6.2% vs. 2.5% in the general population of Americans (McWilliams et al. 2004). A population survey revealed a 6.9 times greater risk of having a GAD in individuals with an interview-diagnosed somatoform disorder, after controlling for age, gender, depression, substance abuse and physical comorbidities (Beesdo et al. 2009). In these studies, the level of disability was not specified; however, the prevalence was similar to the Von Korff et al. study (2005), carried out in the context of the National Comorbidity Survey Replication (NCS-R) on 9,282 respondents over age 18. In this study, the prevalence, at 12 months, of respondents reporting chronic pain was 19%. Of these, 6.4% were found to meet the GAD diagnostic criteria according to the DSM-IV, using the World Health Organization's Composite International Diagnostic Interview (CIDI). This study population mainly involved workers, with 76.5% reporting no disability days.

A recent study (Coutu et al. 2013) using participants with a work disability for an average of 1 year and who were actively involved in a 10-week rehabilitation programme found a very high percentage of participants who met the GAD diagnostic criteria. Based on the results of the Worry and Anxiety Questionnaire (WAQ) (Dugas and Freeston 2001), 50% of the participants presented with the symptoms of a GAD as defined by the DSM-IV (American Psychiatric Association 1994). By including the participants with subclinical symptoms, this rate increased by 14%, representing a total of 64% of the sample (Coutu et al. 2013). The subclinical aspect refers to symptom intensity, i.e. that the participants indicated a rating of "3" rather than "4" on a scale ranging from 0 to 8, on the WAQ. Interestingly, despite the presence of high levels of anxiety in

the participants a significant reduction in anxiety levels at both clinical and subclinical levels was observed during the rehabilitation programme, specifically during the first hours of the graduated work exposure (Coutu et al. 2013).

As this study reveals, an additional proportion of workers reported being in distress, when considering the subclinical level of GAD. In fact, many workers may not be diagnosed with a specific psychiatric disorder, but still display significant levels of distress. Distress can be defined as negative reactions to an adaptive demand, which is perceived as taxing and exceeding a person's resources (Dysvik et al. 2005; Haugli et al. 2003; Lazarus and Folkman 1984; Matthews 2000). These reactions include depressive, anxiety and irritability symptoms, as well as cognitive problems (Préville et al. 1992). Many studies have observed greater distress among individuals who are not working (Averill et al. 1996; Ektor-Andersen et al. 1999; Feuerstein and Thebarg 1991; Grotle et al. 2004; Jackson et al. 1998; Magni et al. 1994; Vowles et al. 2004). Also, Jackson et al. (1997) found that even if pain-related factors are important determinants of distress, the characteristics of unemployment, such as perceiving oneself as having less structure and no day-to-day routine through work, predicted more emotional distress in individuals experiencing persistent pain due to an MSD.

When the level of distress was assessed in participants having a work disability for an average of 1 year due to persistent pain, very high levels of distress ($M=39.15$; $SD=21.38$) were found. In the general Quebec population, a score greater than 30.95 corresponds to the 85th percentile, which is indicative of very severe distress (Boyer et al. 1993; Légaré et al. 2000). When compared with normative scores, 64% of the workers had scores over the 85th percentile. Only 16.6% of them were under the mean score (BenDebba et al. 1997; McWilliams et al. 2003) of the Quebec general population (Coutu et al. 2007). In this study, factors associated with high levels of distress included having more than 181 days of absence from work, perceiving high occupational stress, perceiving high disability and higher fear avoidance behaviour. The studies

reviewed highlight the association between sickness absence and psychological distress or disorders. Unfortunately, there is little evidence for the mechanisms that could explain the association (Waddell and Burton 2006).

For individuals having a work disability, work re-entry may prevent degradation of psychological well-being and sustain social relationships (Vrkljan and Miller-Polgar 2001). In fact, Waddell and Burton (2006) have found strong evidence supporting an improvement in well-being (Ferrie et al. 2001; Kessler et al. 1989). However, in order to have a positive impact, the workplace must have health policies to manage absenteeism and return to work (NICE 2009a, b; Pomaki et al. 2010; Seymour and Grove 2005; Waddell et al. 2008). When the conditions are optimal, getting back to work may become a healing and recovery process, restoring lost social bonds and reinserting individuals into a valued social existence (Vrkljan and Miller-Polgar 2001).

Expert opinion tends to view work as therapeutic for people with disabilities since it promotes recovery and health outcomes and may reverse the negative consequences of being on sickness absence (Waddell and Burton 2006). In a qualitative study, work was defined as a means toward a therapeutic end, but, for musculoskeletal patients, it was considered as "a haven from pain and loss" and as "a vehicle for control over the intrusiveness and daily intrusiveness of pain" (DeVecchio Good 1992). Other studies have not found a direct link between return to work and well-being or quality of life (Franche et al. 2005; Guzman et al. 2001). Several hypotheses can explain the lack of association. First, it depends on the timing of the assessment. When work-disabled individuals are assessed during their first week of full return to work, they may still be in an adaptation period and, therefore, have not fully reached recovery and optimal quality of life. In fact, a population-based study found higher levels of distress in the first 6 months of an employment transition (Benzeval et al. 2005). Moreover, there are currently no gold standard measures of quality of life. Many health-related quality of life instruments are available, but these focus on health and functional status (Farquhar 1995).

However, in the case of musculoskeletal disorders, the consequences go well beyond the dysfunction (Wood-Dauphinee 2001). When assessing a dynamic construct such as quality of life, a valid instrument should capture the possible shift in the person's perspective in terms of personal priorities and goals (Plehn et al. 1998). The Quality of Life Systemic Inventory quantifies the gap between a person's present state and the state they aspire to, as well as his or her perception of the impact of the disease. It also takes into account whether a person is moving away from or toward the aspired situation. Using this inventory, a study found in individuals who successfully returned to work an improvement in their quality of life, when compared to the beginning of the work rehabilitation programme (Coutu et al. 2005). Another study using the same inventory was performed with individuals at an average of 6 months post-discharge from work rehabilitation. Working participants had better quality of life domains requiring physical capacities, such as house maintenance, physical health and leisure, when compared to nonworking participants having similar income and educational levels (Moliner et al. 2007). To increase the level of evidence about the therapeutic nature of work, future studies adopting the perspective of the worker should consider using longer follow-ups, such as 1 year after discharge from the work rehabilitation programme. Also, quality of life outcomes need to be carefully considered to take into account the dynamic nature of this concept.

2.3 From a Clinical Perspective

2.3.1 Workers' Representations of Pain and Disability Embedded in a Social Context

When considering the whole worker and taking into account the self and the interaction with the environment, it is important to go beyond the workers' beliefs about the disease and consider the work disability representations. In this regard, a study of 1,591 patients with low back pain revealed that pain representations constitute a

better predictive factor for disability than do fear avoidance, catastrophism and depression (Foster et al. 2010). Moreover, the results of a systematic review of the literature on "illness" representations suggest that they could impact the work participation of patients suffering from somatic diseases. "Illness" refers to the subjective experience or personal perception of the presence of a disorder, discomfort, functional limitations and distress (Toombs 1987). Therefore, workers may still report pain, even if the initial injury no longer shows objective signs of "disease". An injured worker experiencing work disability resulting from persistent pain could thus be considered "ill" but not "diseased". Differentiating between "illness" and "disease" may seem to be too much detail. In practice, however, it may help explain gaps in understanding and miscommunication between health care professionals and patients/injured workers, since each has their own perception of reality (Courvoisier and Mauron 2002). For example, a physician may not see any sign of a specific disease for a persistent pain and conclude that the patient can start an interdisciplinary work rehabilitation programme. Conversely, the patient may feel the physician is not taking him seriously because the patient is in an illness paradigm when he observes that pain intensity did not decrease as expected. The patient may see the pain as "abnormal" and begin to worry about the duration of the pain and its consequences. Therefore, workers may start to look for answers to eradicate the pain, by searching for second opinions or asking for additional tests (Coutu et al. 2010). A negative emotional experience with health care professionals was also found to be an important obstacle to return to work in low back pain patients (Svensson et al. 2003).

Based on the common-sense model of self-regulation of health and illness (Leventhal et al. 2003, 1980), patients will create their own representation/understanding of their illness, based on varying sources of information, then develop an action plan to resolve the situation and, lastly, assess whether the gap between their current situation and their target goal has increased or decreased (Leventhal et al. 2003). An illness representation is defined as all the thoughts, beliefs

and attitudes associated with (a) the perceived diagnosis and symptoms (Leventhal et al. 1984); (b) the causes of the illness (Leventhal et al. 1992); (c) the course of the illness (acute, cyclical or chronic); (d) the illness' immediate and long-term consequences (Croyle and Jemmott 1991); and (e) the control exerted over the illness, including treatment (Bandura 1977) and self-efficacy expectancies (Bandura 1977, 1997), and the actual skills required to cope with the situation (Leventhal and Diefenbach 1991). Self-efficacy is defined as the belief a person has in his or her own abilities to successfully adopt a behaviour regarded as necessary to attain a given result (Bandura 1977, 1997). Self-efficacy is one of the best-known and most frequently investigated concepts in the field of behaviour change in health psychology (Kaplan and Simon 1990). A person's self-efficacy will affect the choices and efforts made, response to stress and persistence shown in the face of difficulties (Bandura 1977). Work-related self-efficacy, which is the belief that one is able to successfully return to work, was found to be a main determinant of return to work in low back pain patients after 2 years of follow-up (Dionne et al. 2004).

The components of illness representations are shaped by prior illness episodes experienced or witnessed by individuals and by their perception or anticipation of somatic sensations. Their interaction with the social environment, including friends, family, health professionals and the media, will also have an important influence (Leventhal et al. 2003). Representations help us to understand people's reasoning behind their behaviours. This reasoning process is not necessarily "rational" as it can be based on various experiences and conflicting information. Therefore, the originality of the common-sense model of self-regulation lies in the fact that it allows for a decentralising of the individual perspective and allows for its relocation in the context of broader personal experience by integrating environmental factors such as work, family and social network. Previous studies have found illness representations of various diseases, as defined by the common-sense model of self-regulation, to be associated with the degree to

which patients adopted health behaviours (Buick 1997; Heijmans 1999; Moss-Morris et al. 1996; Petrie et al. 1995, 1996; Scharloo and Kaptein 1997), substantiating the validity of the model.

In health psychology, illness representations are also referred to as illness schemata or illness prototypes (Baumann et al. 1989; Bishop 1991). These studies identified three implicit rules of illness that help a person to assess if she or he is "ill". The first *symmetry rule* refers to the need to have symptoms associated with a diagnosis and vice versa (Easterling and Leventhal 1989; Meyer et al. 1985). The patient's need for symmetry helps explain why they may not report being ill or comply with treatment recommendations if they feel they do not have the symptoms of the condition. Conversely, workers may experience symptoms of a work-related musculoskeletal disorder (WRMSD), but no specific diagnosis can be given. This can trigger the search for a diagnosis for the worker and further promoting miscommunication between the worker and a health care professional. The second *age-illness rule* (Croyle and Jemmott 1991) was identified by Beaton et al. (2001). Workers having a WRMSD did not define themselves as ill because they associated their low level of pain with the normal aging process. The third *duration rule* (Mora et al. 2002) was also observed in Beaton et al.'s study: participants mentioned being ill after experiencing long-standing and intense pain. What is interesting in Beaton et al.'s study (2001) is that participants experiencing a WRMSD did not necessarily define themselves as ill. When describing an illness, many stated influenza (the "flu") as the classic example of illness because it encompasses several characteristics used to define the state of sickness or the signs of illness (Baumann et al. 1989; Bishop 1991; Coutu et al. 2011). The main characteristics defining an illness are identified as having specific and circumscribed symptoms that could be associated to a diagnosis and time frame, if the illness is not chronic (Baumann et al. 1989; Coutu et al. 2011). With a diagnosis also comes social legitimacy, allowing the person to withdraw from responsibilities, such as work.

As in Beaton et al.'s study (2001), another qualitative study conducted with individuals

having a work disability, on average, once per year also found that participants did not define their current WRMSD as an illness. However, in the latter, representations of health and illness were generally found to be important (Coutu et al. 2011). In fact, they served as a guide and point of reference in the workers' discourse related to their current state and to their rehabilitation trajectory. In fact, in Coutu et al.'s study (2011) the workers saw health as a state which, more often than not, depicted them in the pre-injury stage or in the future they aspired to at the end of the work rehabilitation process. Illness was also seen as a state representing them during the period immediately following their injury. The components of this representation then served as reference points for evaluating the evolution of their current WRMSDs. For example, participants who noted that fishing and other leisure activities were consequences of health used these activities as a reference point when asked whether their situation had improved. Health and illness representations are, therefore, more than just attitudes (Radley and Billig 1996). Consequently, a clinician needs to understand the injured worker's reference point, since it will serve as a comparator in assessing if he/she is reducing the gap between the actual situation and the aspired goal (e.g. fishing, holding grandchildren, being able to work overtime). By systematically assessing the worker's health, illness and current WRMSD representations, clinicians can avoid imposing their own representations, such as the level of culturally contextualised independence and autonomy. In fact, differences have been found in East Asian culture where independence and autonomy do not emerge in health representations (Iwama et al. 2009; Kondo 2004). On the other hand, in Western society independence and autonomy have been identified as important themes in the discourse of participants having a work disability problem due to an MSD, a stroke or a severe mental health problem (Chan and Spencer 2004; De Souza and Frank 2011; Laliberté Rudman 2002; Soklaridis et al. 2011).

In various studies over time with various populations, health and illness have been represented as a functional model (capacity/incapacity;

independence/dependence) (Coutu et al. 2011; Herzlich 1969; Radley and Billig 1996). In this model, the level of activity constitutes an important indicator of illness (Coutu et al. 2011; Herzlich 1969). In Radley and Billig's study (1996), illness was directly related to employment status, namely, sickness absence was an indicator of illness. However, Coutu et al. (2011) revealed a more complex view. Participants who were work disabled with a prolonged sickness absence found themselves in-between classical health and illness. The important message here is that when workers experience pain or work disability, it does not necessarily mean that they do not consider themselves healthy. Their perception of their health will rely on the results of weighting capacity/incapacity or autonomy/dependency in their functional model.

As mentioned, representations are built through interaction with the environment. Thus, representations that are incongruent with the current illness episode can trigger a disruption in a person's life trajectory (Bury 1982). A disruption may be defined as a turning point that may provoke discontinuity in the person's daily routine (Becker 1997). This may lead patients to doubt their own representations, which they previously accepted without necessarily going through a conscious process or systematic thought (Baril et al. 1994; Jodelet 1989). This disruption may, therefore, force the individual to develop new strategies to cope with the situation (Bury 1982). From a clinical perspective, this disruption may constitute a good opportunity for an intervention designed to introduce new adaptive behaviours that may contribute to reduce work disability. However, the strategies used by the clinician must make sense to the worker for them to adhere to the recommendations (Coutu et al. 2012). It is thought that the positive results observed by the worker may then help change the representations of the current WRMSD (Coutu et al. 2010). In fact, in Coutu et al.'s study (2010), workers who returned to work after work rehabilitation programme, they experienced positive results in their physical capacities and in their tolerance or reduction of pain intensity. These workers

experienced a new way of thinking and changed their current representation of pain. This reconstruction of meaning helped them “rationalise their experience” (Herzlich 1969) and, in retrospect, find some overall sense to their pain and their episode of long-term disability. Participants who failed to return to work did not find any sense in their current experience. They did not differ in terms of type of job, but more workers who did not return to work had a perception that the legitimacy of their pain was questioned.

What would, therefore, be the relation between the meaning of work and the meaning of illness, especially when the latter disrupts the personal life and jeopardises future plans? Anthropology and sociology of health and illness explored religious/spiritual coping (Johnstone et al. 2006; Thuné-Boyle et al. 2006) to help people “normalise” and endure pain and impairment with serenity instead of fostering anger and resentment (Lofvander 1999). In psychology, the concept of resilience is also emerging as a social concept, where the environment, such as the community and social environment, may be an important facilitating factor that helps the worker bounce back from the work disability episode (Anaut 2005). This needs further consideration to better understand the return to work process, intentions, motivations and behaviours at the interface between inner psychological, socio-economical, political and cultural processes.

Gender issues are, among others, one interesting path for exploring the return to work process. It has been noted that gender role identification may delay RTW (Côté and Coutu 2010). As pointed out by (Ockander and Timpka 2003), gender role expectations may take a different tangent, with women often expected to be a mother, a spouse, as well as a (productive) worker. In a situation of long-term work absence, it is not clear which of those “identities” will prevail when the reconstruction process is in progress, and the centrality of work (and therefore the therapeutic value of work), regardless of financial incentives, is not at all clear. As a result, conflicting values in the meaning of work and the meaning of other socially rewarding activities may influence the return to work (Ahlgren and

Hammarström 2000; Baldry et al. 2007; Ockander and Timpka 2003). Depending on the values attached to one or the other, the portion of time allowed to full employment may also vary (Ahlgren and Hammarström 2000; Ockander and Timpka 2003). It is not clear what counts for being therapeutic in that context, but a positively reconstructed post-illness self may be valued as therapeutic, in itself.

2.4 Concluding Remarks

The aim of this chapter was to look at work and its influence on the worker. From a health perspective, work is a positive value for health and well-being, specifically when it provides good working conditions. Various studies have found that being on prolonged sickness absence, because of a work disability, is associated with greater psychological distress and disorders. From anthropological and psychological perspectives, various meanings have been attached to “work” through the ages, from one society to another and from various sets of predisposing conditions. From an anthropological point of view, the cultural category of “work”, as a category of meaning, is grouped with categories such as “leisure”, “family”, “education”, “socialisation”, “health and welfare”, “sickness”, “ideas about nature and man” or “religious practices”, among others (Bernard 1995), and may be subject to variations from one society to another as well as from one individual to another within the same cultural environment. Possible conflicts between work and family have been raised, and solutions proposed in the light of *work-family balance* (Gustafsson-Larsson and Hammarstrom 2005; Rossi et al. 2009). Religious values may also provide workers a set of normative representations about duty and commitments encompassing one’s own work activities and the socio-environmental settings that allow some types of meaning to develop. The meaning of work and the meaning at work encompass this dimension where work demand, work relations, work autonomy and, as Morin puts it, coherence between the workers’ expectations, values and

the actions they perform at the workplace exist (Morin 2008).

Work plays an important role in the making of self-identity, well-being and personal expectations in life. In the context of a changing world of work and economic uncertainty, individuals may feel more vulnerable and powerless toward the “quirks” of the market economy (e.g. downsizing, delocalisation, flexible hours and contract jobs). It means that a strong identification to work may force the workers to reconsider who they are and what they expect when passing through the adverse feeling and financial insecurity of a job loss. Is the meaning of work to change through that process? Is the meaning of work to change the same way in the adversity of a chronic illness? Is the meaning of work to change the same way when illness conditions are due to an occupational injury? Are there other elements to build one’s own identity upon? In the post-modern time, the centrality of work is challenged, and people attach core and structuring meaning to other dimensions of life equally quoted as significant and socially valuable.

In the context of a prolonged sickness absence due to a work disability, workers may experience a disruption in their illness representations that might have not been previously questioned. How they will be accompanied in the process of giving new meaning and coherence to their current work disability will have great impact, and the influence of work and other social agents in the workers’ life will be important.

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