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“How could I even think of a job?” – Ambiguities in working life in a group of female patients with undefined musculoskeletal pain

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Objective – To explore the meaning of working life for a group of women sick-listed because of undefined, musculoskeletal pain disorders.

Design – Repeated thematic interviews, analysed qualitatively according to grounded theory.

Setting and participants – Twenty female patients, impaired by biomedically undefined pain and musculoskeletal disorders, were successively recruited at an urban primary health care centre in northern Sweden.

Main findings – There were discrepancies between work aspirations and work experiences concerning economic maintenance, social interaction, and personal recognition. The women had low-income jobs in fields threatened by redundancy, such as cleaning, care, and service. Family considerations had a strong impact on organization and priorities in paid work. In a situation of pain and sick leave, family orientation strengthened and work aspirations declined. Social and personal recognition was sought in the unpaid duties at home, and economic refuge in ‘the state as supporter’.

Implications – To understand women with undefined musculoskeletal pain as patients, we must also understand their aspirations and experiences as workers, mothers, and spouses. ‘Family considerations’, ‘diminishing paid work’, and ‘the state as supporter’ are important concepts for understanding the women’s sick role process.

Key words: musculoskeletal disorders, sick role, gender, qualitative research, work, family.

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Women form the majority of primary health care patients, and many consultations concern musculoskeletal pain disorders, with pain in neck, shoulders, and back (1,2). A well-known clinical problem is the difficulty in finding a biomedical diagnosis corresponding with the pain symptoms. Some of these patients do not recover as expected and are long-term sick-listed (3). Patients with persistent pain but undefined musculoskeletal disorders (MSD) are poorly understood, and often perceived as frustrating by physicians (4-6).

In order to obtain a more comprehensive understanding of the life situation of women with MSD, an interview study was undertaken in primary care (7). To reach new aspects, the standpoint of the women themselves was considered a potential source of information (8-12). It was preconceived that, in order to obtain a deeper understanding of health condition and health behaviour, it is important to explore gender (13). Gender implies considering biological as well as social and cultural aspects of sex belonging, i.e. the relationship between the sexes and the position of the individual in society at large. The present paper presents one part of the findings – what working life meant to these women, and how they considered their difficulties in returning to work.

MATERIAL AND METHODS

Design

Our study was carried out between 1991 and 1994 at an urban health centre in northern Sweden, where two of the authors (EJ, KH) were working as GPs. Twenty-two female patients, sick-listed due to MSD, were invited to participate; 20 accepted. The pain was regarded as ‘undefined’ when no biomedical diagnosis was found despite thorough examinations. A strategic selection of participants was used to obtain information from women who differed with regard to age, family configuration, and pain duration.

Participants

A description of the participants is given in Table I. They were all born in Sweden. They had been sick-listed for two months to four years when the study started. About half were employed full-time, the rest part-time. Two women were childless when included, and all had been or were cohabiting with a man.

Data collection

Repeated thematic interviews were conducted (by either EJ or KH), focusing on the participant’s situation at the workplace, at home, and with regard to health care. The
Aim was to let the participant explain her situation in her own words. By answering open-ended questions, she could talk freely about her everyday life.

The women were interviewed when entering the study, after six to eight months, and finally after two years. Two women were interviewed only twice, due to practical circumstances; another withdrew after the first interview. Each interview, lasting 1-2 hours, was audio taped and transcribed.

The interviewing researchers were also the participants' family physicians; thus clinical observations, notes taken close to encounters, and medical records were additional sources of information.

**Qualitative analysis**
The analysis was based on grounded theory, a qualitative method for coding and conceptualizing complex data (7,14,15). The researchers first examined the transcripts separately, using open coding. The transcripts were read several times. Key-words and codes were noted and questions such as “What is the real meaning of this expression?” were posed to the text. The codes were then compared, discussed, and categorized. At the second stage, the data were reread and interpreted by means of selective coding. A systematic search was made for the categories derived from the open coding, and concepts summarizing the data were developed.

The collection and analysis of data went on simultaneously. Before interviewing a new participant, the previous interview was preliminarily analysed. Furthermore, each participant read the transcription of her first interview, made comments, and corrected misunderstandings. Thus the researchers were enabled to learn from one interview to the next, to concentrate gradually on specific topics, to choose strategic patients, and to saturate theoretical hints (7). For instance, when we

| No | Age | Education years | Local of pain symptoms | Occupation | Governmental insurance benefits | Working status at the end of the study
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<tbody>
<tr>
<td>1</td>
<td>21</td>
<td>11 (2 years US)</td>
<td>Neck, shoulders</td>
<td>Child-minder</td>
<td>–</td>
<td>part-time</td>
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<tr>
<td>2</td>
<td>21</td>
<td>10 (1 year US)</td>
<td>Shoulders, back</td>
<td>Nursing assistant</td>
<td>100% parental leave</td>
<td>–</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>9 (LS)</td>
<td>Back, neck, shoulders</td>
<td>Home help, cleaner</td>
<td>100% parental leave</td>
<td>–</td>
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<td>4</td>
<td>25</td>
<td>9 (LS)</td>
<td>Shoulder, arm</td>
<td>Cleaner</td>
<td>100% sick-leave</td>
<td>–</td>
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<tr>
<td>5</td>
<td>31</td>
<td>11 (2 years US)</td>
<td>Shoulders, headache</td>
<td>Cleaner</td>
<td>100% rehabilitation programme (studies)</td>
<td>–</td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>15 (3 years US, 3 years PS)</td>
<td>Legs, back</td>
<td>Shop assistant, nurse</td>
<td>–</td>
<td>– (left study)</td>
</tr>
<tr>
<td>7</td>
<td>33</td>
<td>10 (1 year US, 1 year PS)</td>
<td>Back, legs, arms</td>
<td>Child-minder, kitchen-maid</td>
<td>–</td>
<td>full-time</td>
</tr>
<tr>
<td>8</td>
<td>34</td>
<td>9 (LS)</td>
<td>Neck, arms, back</td>
<td>Cleaner, waitress</td>
<td>50% rehabilitation programme (work trial)</td>
<td>part-time</td>
</tr>
<tr>
<td>9</td>
<td>37</td>
<td>9 (LS)</td>
<td>Back, neck, shoulders</td>
<td>Textile worker, home help</td>
<td>25% sick-leave</td>
<td>part-time</td>
</tr>
<tr>
<td>10</td>
<td>38</td>
<td>9 (LS)</td>
<td>Back, general pain</td>
<td>Shop assistant, barmaid</td>
<td>50% sick-leave</td>
<td>part-time</td>
</tr>
<tr>
<td>11</td>
<td>40</td>
<td>9 (LS)</td>
<td>Shoulders</td>
<td>Industrial worker</td>
<td>–</td>
<td>full-time</td>
</tr>
<tr>
<td>12</td>
<td>42</td>
<td>11 (2 years US)</td>
<td>Neck, shoulders, back</td>
<td>Secretary</td>
<td>100% sick-leave</td>
<td>–</td>
</tr>
<tr>
<td>13</td>
<td>45</td>
<td>6 (P)</td>
<td>Back, head</td>
<td>Cleaner</td>
<td>–</td>
<td>part-time</td>
</tr>
<tr>
<td>14</td>
<td>46</td>
<td>7 (1 year LS)</td>
<td>Back, legs, arms</td>
<td>Cleaner</td>
<td>100% sick-leave</td>
<td>–</td>
</tr>
<tr>
<td>15</td>
<td>47</td>
<td>7 (1 year LS)</td>
<td>Back, legs</td>
<td>Child-minder</td>
<td>100% rehabilitation programme (work trial)</td>
<td>part-time</td>
</tr>
<tr>
<td>16</td>
<td>48</td>
<td>9 (LS)</td>
<td>Low back</td>
<td>Nursing assistant</td>
<td>50% disability pension</td>
<td>part-time</td>
</tr>
<tr>
<td>17</td>
<td>49</td>
<td>11 (LS, 2 years PS)</td>
<td>Neck, arms, low back</td>
<td>Teaching assistant</td>
<td>75% sick-leave</td>
<td>part-time</td>
</tr>
<tr>
<td>18</td>
<td>49</td>
<td>9 (LS)</td>
<td>Back, shoulders</td>
<td>Nursing assistant</td>
<td>100% rehabilitation programme part-time</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>58</td>
<td>7, (1 year LS)</td>
<td>Shoulders, back</td>
<td>Secretary, barmaid</td>
<td>50% disability pension</td>
<td>part-time</td>
</tr>
<tr>
<td>20</td>
<td>61</td>
<td>7 (1 year LS)</td>
<td>Legs, back</td>
<td>Nursing assistant</td>
<td>100% disability pension</td>
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found that the women described their work aspirations in relation to child care and family commitments, another childless woman was included in order to follow up that lead.

FINDINGS AND REFLECTIONS

Tensions and ambiguities in working life

At the very start of the analysis, our attention was caught by contradictory expressions concerning working life. We were astonished that a 40-year woman said, "I'm done as a worker", while she later in the interview expressed occupational aspirations contradicting signs of being physically worn-out, such as, "Drive a bus, that's what I want to do". Such conflicting expressions demanded an exploration of the participants' working life ambitions.

In the following, the step-wise analysis is displayed close to the data. In the open coding, sentences expressing aspirations and expectations in paid work were frequent. However, experiences mainly emphasized disappointments and difficulties. The findings were sorted into three main categories, reflecting the tensions between expectations and experiences of economic maintenance, social interaction, and personal recognition. When the participants' expressions and quotations appear in the text, they are set in quotation marks. Codes and concepts are set in single inverted commas.

"To get along moneywise?"

A job was seen as a possibility "to manage on your own", i.e. a way to become economically independent. However, many expressed that they had "no chance to survive" on their wage. In fact all the women in the study had low income jobs. Young as well as old had not chosen a career, but taken whatever job that had come in their way, in order to "earn a living". They were "stuck" in jobs with limited economic prospects.

Ideas about education as a way to obtain a well-paid job partly depended on the participant's age. For those who had attended school in the 1940s and 1950s an education was not self-evident. Many expressed educational ideals, but gave practical reasons for not having had the opportunity to carry them out:

"It still hurts when I see a college graduation cap. My parents were ill, so there was nothing to do but earn one's living as a maid." (Nursing assistant, 61 years old)

Some of the younger women hesitated at the thought of further studies, because it demanded sacrifice in both time and money.

"I could think of studying later on, when the boys are bigger. As it is now I would never get a minute over for studies at home." (Home help, 37)

"I have no educational ambitions, I'm not a climber. Not as long as I get along moneywise." (Cleaner, 26)

"Getting out to get stimulated"?

A job full of variety and stimulating human relations was a hoped for part of working life.

"First of all, a job is an economic matter. But then, also a habit, and it should be fun. Getting out, meeting other people and having working mates" (Nursing assistant, 49)

The women wanted a job to be "varying", "not too heavy", and to have "a purposeful content". The security and routine of a steady job were desired, but many had to accept temporary solutions:

"They could offer me a half year's contract at a time. But to take a job and then one day maybe stand there with nothing...you want to know where you stand." (Child-minder, 21)

The majority described social tensions at their workplace, involving workplace reorganization, threat of redundancy, and some even bullying:

"If you're at work and maybe you say you are in pain, then you hear, 'Who isn't?', all the time. It puts you in a bad mood...It's as if she wants to assert herself and make a fool of me in front of the others." (Cleaner, 45)

"To be somebody?"

A job was said to be important for self-esteem.

"If you don't have a job you're nobody." (Waitress, 34)

There were a lot of different codes characterizing 'working identity'. Those who had been at the same workplace for decades said they were persons who "did their duty", and they were proud to be "busy bees".

"I'm always on duty. When I'm at home I catch myself thinking of tasks at work, responsibilities that are really not mine." (Barmaid, 58)

Old as well as young expressed a wish to be needed by others at work; to be someone who is "useful" and takes care of the little ones:

"I know I have a lot to give. I'm a good listener, I care for others, I stand by." (Secretary, 42)

Most of these women went unnoticed at their workplace and they expressed frustration in their position of attending without getting recognition.

"I'm the kind that tries to please others...One has to wait, to adjust, to be likeable and...damn it!" (Barmaid, 58)
Of course, there were examples of personal reinforcement at work. Often though it was only when she had been absent that she was noticed:

"The nurses said: Oh wonderful that you're back. We haven't found out how to use the sterilizing machine" (Cleaner, 46)

Regardless of age and years at work, these women did not identify with their actual profession, but rather with the tasks: The cleaner said "I do the cleaning" and the waitress "I work at a lunch bar'. The paid work was not their main source of self-esteem and identity.

**Family oriented considerations**

When entering the study, all implications for the sick role were extended to their actual profession, but rather of women working on working days. The paid work was not supposed to interfere with family life. The mothers had made social manoeuvers in order to be available at home. They had chosen part-time jobs, working shifts and nights to piece together work and child care. They were not "too engaged" in the job, and not active in the trade union movement. By choosing unsociable working hours, they had to give up work aspirations, such as meeting people and gaining a "working identity'. Instead the family was a major source of both social and personal reinforcement:

"He wasn't interested in my job. But he always appreciated me for being a good mother and an excellent cook." (Teaching assistant, 49)

**Implications for the pain – sick role process**

When entering the study, all the women were full-time sick-listed for MSD and regarded their work capacities as restricted. After two years the picture partly changed (Table 1). The analysis of the follow-up interviews showed that the family-oriented priorities had implications for the sick role process. This woman signified the impact of home life and unpaid work on working life:

"I've tried to go in for my job, but... I couldn't stand it. I must have a life at home, too. I mean strength left over for the home duties." (Barmaid, 38)

As sick-listed, some reflected that with "an aching body", the money a job could bring in "wasn't worth it". Economically, the women were relying on 'the state as a supporter'. The older participants said they were ashamed of being sick-listed and "living on charity". Still, they also felt entitled to receive welfare, they had "done their share". Among the younger women, there were examples of thinking and acting towards the state, as if it was a 'suitor' worth trusting during motherhood or studies:

"I extended my duty, in case I would get pregnant. One's got to think of that [to make it possible to receive the maternity insurance] too. Somehow, somewhere, the money has to come in." (Cleaner, 34)

"I would never have managed the education unless they [the state welfare office] had let me study with sickness benefit. My husband wouldn't have let me go." (Teaching assistant, 49)

Being sick-listed and at home, many said they were "busy enough". Some even defined themselves as "worn out" and unfit for work. Images of the "true woman" and the "good mother", such as waiting in the kitchen with newly baked bread, were revaluated. In fact, the family commitments restricted the activities outside the family sphere:

"Now that I’m sick-listed and at home, I have to see to it that the house is clean and the dishes are washed. It's different when one is working." (Cleaner, 25)

This way of diminishing the importance of paid work and enlarging family engagements contributed to the sick role process, and stood in the way of clinical proposals of treatment and work trials:

"How could I even think of a job, when I'm not capable of keeping my own home neat and tidy?" (Secretary, 42)

**DISCUSSION**

**On findings**

Our study explored the meaning of working life in a group of women sick-listed for undefined MSD. The reader should keep in mind that, with two exceptions, the participants were unskilled wage-working women. The majority also had children and partners. Therefore it might be that the tensions and ambiguities we found are restricted to working-class women. Even so, recognition and transferability may be considerable. In Sweden, the number of women working outside the home reached 80% in 1992 (16). The majority of them are employed in unskilled jobs, e.g. service and care. The unskilled women workers have the highest rate of sickness absenteeism due to musculoskeletal disorders, of which a large part can certainly be explained by the working conditions (16). For a fuller explanation, it is important to reckon with multicausal reasons and their relationship with gender, e.g. bodily, psychological, and social work factors (17,18).
It is generally considered that long-term sick-listing per se contributes to the development of a sick-role. Our findings suggest that family-oriented considerations express gender-related demands that have an impact on the sick role process for women. To manage housework and care for children are unpaid duties that are not really taken into account when patients are sick-listed, or when work trials are planned. Segregation of family duties, norms of womanliness, and the gendered power structure in society place the rehabilitation within a framework (19). Whether the family-oriented sick role process applies to well-educated women in prosperous careers, or holds for other illnesses such as chronic fatigue syndrome or ischaemic heart disease, is still left to be investigated. Hall (20) gives some support for generalizability when she demonstrated statistically that gender-related demands, rather than "female sensitivity" or "willingness to assume the sick role", produce psychosomatic strain symptoms among women.

On method
The purpose of our study was to understand, not to prove causality. Even so, the validity problems should not be neglected. Precautions were taken to secure credible findings (7,15). In the analysis we tried to prohibit premature conclusions by use of codes for the opposite and a search for negative cases. For instance, when finding ambiguities in working ambitions, we tried to find out whether 'laziness' could provide a suitable explanation. Usually it did not, because the women described performing a lot of unpaid work and family undertakings.

The fact that the participants read their own interview transcripts and commented on interpretations, confirmed them as adequate and fair descriptions of their situation. Furthermore, we presented preliminary findings to women who were sick-listed because of MSD, but not connected with the study. They agreed that our concepts were applicable in their situation. The clinical observations during two years served as a triangulation of interview data. The women's statements were evaluated in the light of actual events and rehabilitation outcomes.

That the researchers were also the participants' family physicians initially caused considerable concern. What did she tell us, what did she hide, and why? We tried to be aware of these questions both during the interview and in the analysis. The setting might have restricted the data collection, but on the other hand, it widened the applicability of the findings because they are grounded in doctor-patient interaction.

What were the implications of women interviewing women? A female researcher can not guarantee a more 'true story', but she may elicit female aspects in an interview, by creating an atmosphere of shared understanding. A pitfall is that a strive for mutuality could keep the participant from revealing her own opinions. We therefore avoided giving evaluating comments, and only encouraged her to explain and deepen her reasoning.

As our point of departure was to look at the problem from a gender perspective, one may wonder whether the findings are biased, ending in circular conclusions. Our answer is no, because, although our analysis had a gender perspective, it was grounded in the participants' statements and can be confirmed in our data by others (21). On the other hand, yes, inasmuch as other researchers might interpret the data differently. Theoretical framework, focus of attention, and personal experiences certainly affect interview proceedings as well as data interpretations.

Clinical implications
As doctors we are eager to help our patients. At the same time we are obliged to minimize sick-leave costs, because we are also administrators in 'the supporting state'. Patients with persistent undefined disorders constitute a challenge. From a privileged doctor position, one may find it difficult to understand and deal with motives for abstaining from paid work. To understand female patients, we must gain an understanding of their aspirations and conditions as workers, spouses, and mothers. This awareness may help to steer away from misunderstandings and frustrations in clinical practice, and give new aspects in rehabilitation endeavours.

ACKNOWLEDGEMENTS
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