DOCTORAL THESIS

Navigating everyday life to promote occupational health – from an individual, group and organisational perspective

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Halmstad University | School of Health and Welfare
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MADE IN SWEDEN

To my beloved sons, Melker and Malte, you are, and will always be, what matters most to me.

Abstract

With the upcoming challenges of an aging population, it is crucial that individuals of working age experience good health and can work and contribute to society. Occupational ill health is a widespread issue in Sweden with many negative effects both on an individual, group, and societal level. Therefore, it is important to gain more knowledge on what is causing this ill health and, more so, how occupational health can be promoted.

The overall aim of this thesis was to broaden the knowledge regarding what is needed to promote occupational health in everyday life, including paid work, within the working population. In Study I, the aim was to analyse the relationships between sociodemographic factors, occupational value, occupational balance, and perceived health in people suffering from occupational ill health to explore the main risk factors for developing occupational ill health. The results showed that having a low sense of occupational balance, followed by a low number of occupations that had a high level of socio-symbolic values, were strongly connected to experiencing occupational ill health. Study II aimed to describe what is needed to improve/regain a balanced everyday life, including paid work, described by individuals who had/were experiencing occupational ill health. The results illustrated a highly relational process, where private life and work are difficult to separate, presupposing balance in everyday life in multiple dimensions. Therefore, the individuals included in the study had to take control of their everyday life as a whole. They needed to focus on structuring and prioritising social interactions, boundary settings, and occupational meaningfulness. In Study III, the aim was to describe the individuals' experiences of maintaining or regaining occupational health in everyday life, including paid work, two to five years after participating in Study II. The results showed that "flex-ability" in the workplace is crucial for regaining or maintaining occupational balance and health in everyday life. The term flex-ability (flexibility + capability) refers to the individual's need to be open to change and adapt to new challenges, both at work and in everyday life, but also to be met with flex-ability from their surroundings. To understand employers' perspectives on this, Study IV aimed to describe how a group of managers promote a healthy work environment and to what extent they consider their employees' everyday lives. The results showed the importance of viewing health promotion as a shared responsibility for occupational health beyond

the workplace, which included: Handling a multifaceted responsibility, tweaking the organisational culture, shaping supportive work conditions, and bridging boundaries between private and working life. The overall results illustrate the need to understand how occupations in everyday life influence not only each other and our lifestyle, but also the overall experience of health. Promotion of health in everyday life, including work, is a complex effort that involves navigating multiple, interwoven processes and roles. Central to this is the concept of perceived occupational balance, which this thesis identifies as a key component of occupational health. Therefore, it seems beneficial to value the concept of occupational health in the broader context of everyday life, as a whole.

Keywords: everyday life, health, health promotion, occupational balance, work

Table of Contents

Abbreviations

OT	Occupational Therapist
OP	Occupational Pattern
ReDO®	Redesigning Daily Occupations programme
ValMO	The Value and Meaning in Occupations Model
WHO	World Health Organisation
WHP	Workplace Health Promotion

List of scientific papers

This thesis is based on the following studies, referred to in the text by their Roman numerals. The articles have been reprinted with the permission of respective journal.

I. Karlsson L, Ivarsson A, Erlandsson LK. Exploring risk factors for developing occupational ill health - departing from an occupational perspective. Scand J Occup Ther. 2022 Jul;29(5):363-372. https://doi.org/10.1080/11038128.2021.1936160

II. Karlsson, L., Erlandsson, LK., Cregård, A. Nordgren, L & Lydell, M. (2023). Taking control of one's everyday life - a qualitative study of experiences described by participants in an occupational intervention. BMC Public Health 23, 605 https://doi.org/10.1186/s12889-023-15515-z.

III. Karlsson, L., Erlandsson, L.-K., Cregård, A., Nordgren, L., & Lydell, M. (2025). Flex-ability - A key concept to promote occupational health in everyday life beyond sick leave. WORK, 81(1), 2370-2379. https://doi.org/10.1177/10519815251317338

IV. Karlsson, L., Erlandsson, LK., Lydell, M, Nordgren, L & Cregård, A. (2025). Reasoning around promoting employees´ occupational health: A qualitative study among managers in healthcare, education, and IT sectors. [In manuscript]

Introduction

The Swedish society is facing challenges in terms of a shrinking workforce and an increasing number of people with ill health. Sick leave rates are unprecedentedly high, and the adverse trend appears to be persisting without indication of decline. Sick leave due to stress-related ill health, termed occupational ill health, leads to significant costs, both nationally and internationally (1), and is one of the fastest-growing causes of sick leave. Occupational ill health has severe negative effects on individuals and their social environment, in addition to placing a burden on the labour market and society at large.

Since 2016, I have worked as an occupational therapist and rehab coordinator within primary care in Region Sörmland, Sweden. My clinical work focuses on supporting people who struggle with diverse expressions of occupational ill health, and who are trying to regain both their health and get back to work. My clinical work has mainly been on the individual and group levels, but I often collaborate with employers or the Swedish Social Insurance Agency to try to find suitable solutions to get individuals back to work after sick leave.

One ongoing challenge within primary care and in society, is to provide high-quality care without increased costs. Sweden aims to contribute to this by continuing to transition to "person-centred and integrated care", which seeks to make primary care the hub of healthcare services (2). With both a decrease in resources and an increase in people in need of care, it is crucial to find ways of promoting health in society, ensuring that working-aged people are healthy and able to work and contribute to society.

According to Agenda 2030 (3), the 17 Sustainable Development Goals adopted by UN members, aim to provide a framework for sustainable social, environmental, and economic development within UN countries. The third goal, which focuses on promoting health and well-being for all ages, and the fifth goal, which aims for gender equality are the ones that are principally reflected in this thesis.

The research program in health and lifestyle at Halmstad University explores individual and structural aspects of health and lifestyle, as well as health risks and health-promoting factors. The subject field of health and lifestyle is interdisciplinary and can be explored based on various scientific theoretical approaches.

In this thesis, I aspire to provide a broader understanding of some key areas within everyday life that are important for promoting health among the working population.

Background

The concept of occupation and occupational patterns

The term occupation is often used to refer to paid work or a profession; however, it can also refer to activities an individual engages in within any everyday area of occupation, such as paid work, schooling, household chores, rest or leisure (4). The International Society for Occupational Science describes the concept as "*the various everyday activities people do as individuals, in families and in communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to, and are expected to do*" (4).

Everyday life is filled with a wide range of occupations that form occupational patterns that have diverse values and meaning (5). A recent concept analysis describes a person's occupational pattern as unique and complex, and which can offer insight into their lifestyle (6). According to Granholm and co-authors, an occupational pattern has two components. The first is the occupational pattern itself, which includes routines, habits, rituals, roles, and activity repertoires that are developed throughout life. The second component comprises the ways in which these patterns are shaped over time, influenced by internal and external forces that drive engagement and participation (6).

Occupational balance is a concept used to reason about the balance between all different occupations in everyday life. The concept is construed to mean the extent to which an individual's unique occupational patterns (in context) enable needs to be satisfied and are essential for well-being and quality of life (7). Occupational patterns and occupational balance are interrelated (8) and have been associated with perceived health, well-being, and paid work (4, 8-10).

In occupational therapy literature, stress-related ill health is sometimes referred to as occupational ill health. Wilcock and Hocking (4) highlight several factors and focus on what it is that individuals do in everyday life that risks the development of occupational ill health. Occupational ill health can be the result if, e.g., one's roles and habits change, or one is excluded from a social context such as work, due to sick leave. One example is stress-related ill health. According to the Organisation for Economic Co-operation and Development (OECD), mental health in the workplace is considered a challenge for the labour market that needs to be prioritised (11). The prevalence of various expressions of ill health that can cause occupational ill health and lead to sick leave, has been steadily increasing in the last decade. In December 2024, Sweden recorded a new peak in stress-related

sick leave. Statistical analyses indicate that this trend predominantly affects women, particularly those with children and those employed within the welfare sector, where sick leave rates are notably high (12). Therefore, more knowledge is needed about how occupations and occupational patterns interplay with lifestyle and work, to inform and promote health within the working population.

In this thesis, the concept of occupational health will be used with the corresponding meaning of occupational ill health. According to the World Health Organisation (WHO) (13), occupational health is a field within public health that focuses on promoting and maintaining the highest possible level of physical, mental, and social well-being of workers across all professions. However, given that this thesis posits work as an integral component of everyday life, the experience of occupational balance and overall health will be incorporated into the concept used in this thesis.

The concept of lifestyle

Lifestyle can be defined as a pattern of repeated occupations over time based on our perception of the world, our habits, and the intentions and desires that lie behind our patterns (14). To a certain extent, lifestyle is a result of individual choices but is also largely influenced by the social and societal context in which we find ourselves (15). In turn, 'lifestyle balance' can be interpreted as "a satisfying pattern of occupations that is healthful, meaningful and sustainable to an individual within the context of their current life circumstances" (7). The concept of lifestyle describes the importance of an individual's satisfaction with how s/he spends their time in a configuration of occupations, stress levels, well-being, and needs satisfaction. It highlights that the environmental context also influences lifestyle balance (16).

Furthermore, Jensen (17) underscores the importance of understanding lifestyle as a multi-layered concept, shaped by influences ranging from global and societal structures to individual identity, and marked by a dynamic tension between personal agency and structural constraints. He also argues that this nuanced understanding of lifestyle is essential to educators, policymakers, and researchers whose aim is to develop sustainable development practices (17).

Giddens (18) conceptualises lifestyle as a set of routinised practices that individuals adopt in relation to their self-identity. These routines encompass everyday decisions, such as choices about food, clothing, and behaviour, that are not merely functional but are also expressions of identity. Each seemingly minor decision contributes to the ongoing construction of the self, reflecting not just actions but also who one aspires to be. While lifestyles may appear to be chosen, they are often shaped or constrained by external factors, such as employment and socio-economic conditions, which limit the range of available options. Nevertheless, within the boundaries of these constraints, individuals still exercise

agency in shaping their lifestyle. For instance, a person might reject a medically recommended lifestyle if it conflicts with their preferred way of living. Lifestyles are therefore dynamic and subject to change; as life circumstances evolve, so too do the choices and routines that constitute one's lifestyle (18).

Trends in lifestyle and health-related behaviours have an impact on, for example, the foods we choose to eat, how much we move, or our hobbies. Research and interventions regarding lifestyle-related effects on health are often linked to, for example, obesity, diabetes, eating habits, and physical activity (19, 20). In this thesis, however, the concept of lifestyle is more closely associated with the subjective experience of occupational health. This may contribute to broadening the understanding of aspects of lifestyle that can enhance subjective experiences of health within the working

The concept of health

There are many different theories and concepts of health that could be applied in this thesis. As defined by Bowling (21), health is a broad, multidimensional phenomenon that is impacted by several different factors, such as physical, mental, and social well-being, and is not merely the absence of disease.

Individual physiological elements, such as body structure or functional capacity, are essential for health at a personal level, and, according to Marmot, it has long been well known that the most important indicators of health at the societal level comprise social and economic factors (22-24). Health is further affected by various factors across the life phases. The social determinants and indicators related to health include demographic factors, such as gender, age, ethnicity, and family structure, economic factors like income and employment, and social and cultural factors, including social participation, education, and practical support (25).

In addition to these, work-related factors may contribute to the onset of occupational ill health, such as job insecurity or lack of job resources (26-28). Departing from a pathological view also entails that mental health problems are often defined as dependent on individual lifestyle (29). However, this thesis acknowledge that even though individual behaviour can influence health, lifestyle choices are consistently embedded in a structural context (30).

To effectively promote health within the working population, it seems essential to acknowledge the diverse ways in which health is perceived across society. Haverkamp et al. (2018) discuss that there are five separate concepts of health, each of which captures something relevant to any discussion of health (31). One is the WHO definition: "a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity" (32). However, the definition has been further developed by WHO, with the addition that health should be seen as "a resource for daily life" and includes aspects of both social and personal resources and not merely physical capacity (13).

The WHO definition of health has been criticised over the years; for example, Huber et al. (2011) presented the limitations they found and proposed a new formulation of health as: “the ability to adapt and self-manage”. Huber's definition of health is more suitable for this thesis, because it moves away from an idealised notion of "complete well-being" and emphasises the capacity to cope with life's challenges (33). The concept takes a holistic approach, focusing on enabling individuals and communities to thrive – despite health challenges.

Another similar definition is the two-dimensional theory of health, by Tengland (34). The model includes two dimensions: ability–disability and well-being–suffering. It suggests that individuals can fall anywhere along each axis, regardless of whether they have a diagnosis. Together, these dimensions define the continuum of health, ranging from good health to ill health. The definition provides a pragmatic and humanistic view of health. Furthermore, according to Nordenfeldt's theory of health (35), health depends on people’s ability to realise their goals in life, and that they can direct resources to take health-promoting actions.

Hence, in this thesis, health is considered as the capacity to maintain well-being and function effectively across physical, mental, and social dimensions, while navigating life’s challenges and changes. It also adopts a salutogenic perspective on health, i.e. a focus on health assets and health factors, rather than on risk factors and disease. The salutogenic health theory suggests that an individual's life experiences and perception of life, whether positive or negative, significantly influence their health (36).

The connection between occupational patterns, lifestyle, and health

Everyday life is characterised by a range of occupations that form distinct occupational patterns, encompassing routines, habits, and roles, which collectively constitute an individual's lifestyle. These patterns are shaped over time and influenced by internal and external factors that can either facilitate or constrain an individual’s engagement in occupations. Motivation plays a central role in these dynamics. An individual's physical and social environment continuously influences their experience of health (6).

These choices are greatly affected by society, and by various trends and expectations. Lifestyle media is a relevant concept that partly describes this process (37), in that we live in an era where, often, the driving motivation of the media is that everything can and should be improved, with an attempt to influence people daily through social media, TV, and other public platforms. The concept suggests that we live in a “makeover” culture, where we all should strive to be the best version of ourselves in every way, and if you don’t have that mindset, you might be questioned (37, 38).

Understanding how everyday occupations, their meaning, and the balance between them influence health is essential for promoting health and well-being. For the working-age population, who spend a significant portion of their waking hours engaged in work-related occupations, the meaning and balance of occupations affect both work and non-work aspects of everyday life. How we use our time directly impacts our health perceptions, and in turn, our health influences how we are able to use our time (39). Despite its relevance, this area of knowledge often receives limited attention.

Given that this thesis seeks knowledge regarding health-promotive initiatives, it is important to understand the relationship between what people do and how it affects their subjective experience of health. Thus, this thesis suggests that occupational patterns are key to forming a lifestyle that, in turn, affects how people experience their health, as illustrated in Figure 1.

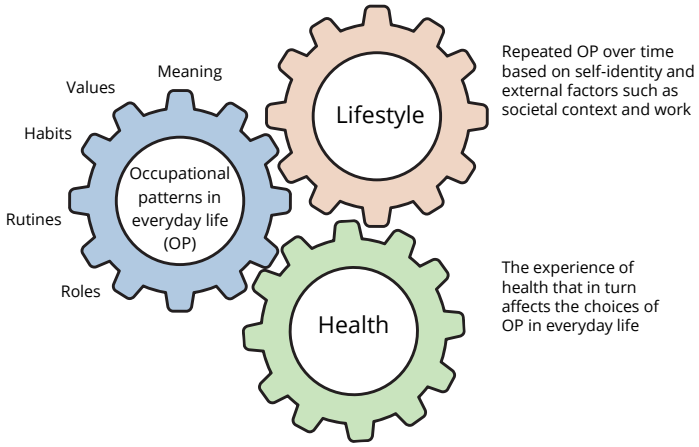

Figure 1. Illustration of the dynamic interplay between occupational patterns (OP), lifestyle, and health.

Health promotion

The WHO defines health promotion as "the process of enabling people to increase control over and to improve their health" (40). Health promotion is about supporting salutogenic health development through increasing resources that support the maintenance of good health. The WHO Ottawa Charter for Health Promotion emphasises that “health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love” (13). It explores how health is continually promoted within these everyday settings and

examines strategies for enhancing health through targeted interventions by fostering environments in which individuals can thrive. Compared to the salutogenic, the approach of disease prevention has a pathogenic focus, including health protection and health care in terms of cure and rehabilitation (41).

Health-promoting measures are more about creating an environment that enables a healthy lifestyle rather than preventing ill health or injuries. The positive and holistic view of health within the health-promotive perspective considers the whole individual in their wider context (42). Tengland (42) argues that, conceptually, health promotion and disease prevention differ because they focus on distinct goals. While health promotion aims to improve well-being and quality of life, disease prevention primarily focuses on reducing risks and avoiding specific illnesses. However, he also emphasises that, in practical terms, these two approaches often overlap (42).

The European Community Health Promotion Indicator Development Model (EUHPID) (41) is built around physical, mental, and social aspects of individuals' health, and demonstrates how health is created in an interaction between individual and environmental health determinants (41). More specifically, it deals with ways in which the different starting points of these two perspectives reflect interventions linked to, for instance, health promotion or disease prevention. The authors argue that the model and its application highlight the need for systematic salutogenic indicator development in the field of public health, and a strengthening of the health promotive perspective in the future (41)

Although there has been a global increase in mental health promotion and prevention programs, only 7% of such initiatives are workplace-based (43). A review of the effectiveness of workplace health promotion interventions concludes that more insight into facilitating factors in and barriers to the implementation of worksite health-promoting interventions is needed, to know what kind of practical toolkit is effective (44). Therefore, this thesis will also include the organisational perspective, to gain a broader perspective on promoting health within the working population.

Work and workplace health

Paid work is a crucial part of everyday life among most people of working age, and its impact on the perception of occupational balance can be a source of both health and ill health (45, 46). In addition to sleep, paid work is the area of occupations where adults spend most of their time and that affects their occupational patterns to the greatest extent (45). Work is an integral part of health; a Swedish study showed that individuals with paid work rated their overall health 10% higher than did unemployed people. Furthermore, 24% more of the unemployed experienced issues with anxiety and depression (47). According to a 2018 Swedish report, almost a third of the employed workforce in the Swedish

population has suffered from work-related health issues at some point in life (48). In a more recent report, the percentage has reduced to about 25% (49). However, this is believed to be a result of the COVID-19 pandemic, where many were allowed more flexible and remote work arrangements. The report shows that there is still a high degree of occupational ill health within the female-dominated professions, such as healthcare, childcare, and education (49).

The introduction of the Regulation on organisational and social work environment [AFS 2023:2] in Sweden clarifies the employer's responsibility to provide a healthy work environment and to encourage employees to take part in the workplace intervention that is offered in the organisation (50, 51).

Workplace health promotion (WHP) focuses on fostering healthy employees within healthy organisations, by addressing factors contributing to a safe, engaging, and enjoyable work environment (13). The concept of WHP originated from the Ottawa Charter's emphasis on health-promoting settings and is defined as a collaborative initiative, involving employees, employers, and society, to enhance the health of the workforce and establish healthy workplaces (13). Recognising the critical role of the work environment in promoting health, WHO and the Organisation for Economic Co-operation and Development (OECD) has identified WHP as a priority for the 21st century (52, 53).

The workplace represents a vital setting for health promotion because it engages a broad and diverse segment of the population. As the work environment plays a significant role in shaping employees' health behaviours and overall well-being, workplace-based health promotion initiatives have the potential to yield substantial improvements in health outcomes and organisational productivity. Such initiatives may encompass the development and implementation of supportive organisational policies (e.g., smoke-free environments and access to healthy food options), clear structures regarding work roles and responsibilities, delivery of health education programs that equip employees with the knowledge and resources to make informed lifestyle choices, the promotion of physical activity through structured programs such as fitness classes or walking groups, and the provision of mental health support aimed at addressing stress and enhancing psychological well-being (54).

There is limited alignment about the work-related effectiveness of various mental health interventions (55). However, finding ways to recover during work hours seems to promote health. This can involve small things, such as listening to music, laughing with a coworker, or going for a walk during a break (56, 57). In addition, having the opportunity to decide which occupation can assist recovery seems to be equally as important (58).

A review that examined workplace interventions to support mental health and well-being stated that it is essential that employees feel engaged and involved in the development of the intervention and implementation process (59). To do so, the workplace and the employer must promote and enable a good work environment and health-supporting occupations. With the upcoming challenge of

a reduced workforce in society, it is important to gain more knowledge on how to make employees feel engaged, and which occupations and interventions can have a positive effect on how they experience their occupational balance and health.

Organisational and leadership factors at work in relation to health

Managers and their leadership are important factors influencing employees´ overall and work-related health (60, 61). This has been established in several meta-analyses and research reviews. For example, Skakon et al. (62) show that managers' supportive behaviour, positive attitude, and a transformational leadership style have a positive effect on how employees perceive their own stress and health. Kuoppala et al. (63) revealed that leadership may impact employees' job-related well-being and sickness absence. Further, Harms et al. (64) concluded that leadership behaviours and managers' relationships with subordinates are determinants of employees' occupational ill health. In an article by Teetzen et al. (65), the authors investigated mediating factors between transformational leadership and employee well-being. They conclude that organisational resources, i.e., organisational core values such as fairness and justice, had a strong positive mediating effect on leadership and employees' well-being, while job demands (such as workload, time pressure, emotional strains, and role conflicts) mediated the link between leadership and negative well-being.

Bakker and de Vries (4) argue that there is a lack of a structural perspective, in which both job demands and resources would be considered. The imbalances between demands and resources, among other things in the work environment, are thus not addressed. Furthermore, they suggest that there are shortcomings in the understanding of employees ' wide range of personal abilities, which can influence the way the job tasks are carried out and therefore need to be offered individual and specific strategies.

Therefore, knowledge regarding how managers perceive health-promotive strategies, the extent to which they consider their employees' everyday lives, and how they work daily to promote health in the workplace are essential elements in the development of our understanding of how best to promote health in everyday life within the working population. The organisational level in this thesis is therefore delimited to managers and their leadership.

Conceptual framework

This chapter presents the conceptual framework of the thesis. It begins by outlining the methodological foundations, followed by a summary of the relevant theories that serve as a basis for guiding the research process and interpreting the findings in this thesis.

Scientific position

The research area "health and lifestyle" aims to explore both individual and structural aspects of health and lifestyle, as well as health risks and health-promoting factors. The area can be studied based on a range of scientific theoretical approaches. This thesis is grounded in a critical realist research philosophy, which acknowledges the complex relationship between reality and our knowledge of it. Critical realism combines ontological realism—the belief that a reality exists independently of our perceptions—with epistemological relativism, recognising that knowledge is socially constructed and fallible (66).

Critical realism supports the use of causal explanations to better understand social phenomena, emphasising the interplay between structure and agency. Social structures shape human actions, but individuals also have the capacity to reproduce or transform these structures through their agency (67). Consequently, Critical realism favours the use of a variety of research designs, and the use of both qualitative and quantitative methods is encouraged to uncover the complexity of social processes and promote meaningful change (68, 69).

This thesis aims to contribute to the field of health and lifestyle by generating knowledge on how to promote sustainable occupational health from individual, group, and organisational perspectives. These perspectives have been explored using different methodological approaches. The philosophy of critical realism supports the integration of diverse methodologies by providing a framework through which the results can be synthesised. This allows for the development of knowledge that extends beyond the sum of the individual studies.

Occupational science

Occupational science is an academic field of study that investigates the learning of humans as occupational beings – meaning that humans have both a need for and the capacity to engage in daily occupations in their environment (70). It was founded in the late 1980s by Yerxa (70), who stated that occupational science has great value in all experiences of life (71).

In the last 30 years, occupational science has been applied to many fields, mainly within occupational therapy. Wilcock (72) has defined it as "the study of being and doing in everyday life".

Wilcock (73) argued that occupational science has the potential to enhance both the human condition and the environment, by integrating diverse evidence from various disciplines that examine the connections between occupation and health. This potential stems from its holistic approach, which encompasses the purpose and outcomes of human occupational engagement, its relationship with health, and the implications for modern lifestyles (73).

In summary, occupational science is a multidisciplinary field that focuses on the study of human occupations. It aims to understand the complex relationships between people, their occupations, and the environment in which they live, with the overall goal of improving quality of life and well-being, all of which aligns with the aim of this thesis.

The ValMO Model

The Value and Meaning in Occupations (ValMO) Model (5) is a theoretical framework used in occupational science and occupational therapy to understand the complexity and meaning-making values of what people do. The model can be used to describe and understand what we do in everyday life, and how our actions affect our experiences of health. It focuses on how an individuals' occupational values influence their participation in various occupations and how these occupations, in turn, contribute to their well-being and sense of meaning in life (5).

The theory emphasises that people's occupations are not only functional or goal-oriented, but also hold emotional, symbolic, and societal value. The model describes the complexity of doing and suggests that the unique experiences in the performance of an occupation can be illustrated through the concept of occupational values. In the model, occupational value consists of three distinct dimensions: concrete, socio-symbolic, and self-rewarding occupational value (5, 74). The higher the amount of perceived occupational value, the greater the experience of overall meaning in life, which in turn has a strong link to perceived health and well-being (70).

To improve, maintain, or regain health, a person needs to be able to do what they want and need in their environment (4). It has been shown that having a variety of occupational values in occupational patterns is important to prevent ill health or maintain good health and well-being (74).

The salutogenic perspective

For this thesis, a salutogenic perspective is applied. Salutogenesis focuses on health assets and health factors, rather than risk factors and disease. The salutogenic health theory suggests that an individual's life experiences and perception of life, whether positive or negative, influence their health. Salutogenesis is a valuable approach to promoting health, both in everyday life and in the work environment (75, 76).

The salutogenic framework explores what creates health, focusing on how human resources and capacities can contribute to improved health (36). A key concept within this theory is the sense of coherence (SOC), which involves experiencing comprehensibility, meaningfulness, and manageability in life (77). A strong SOC is associated with better perceived health (78). Additionally, an individual's SOC level influences their ability to identify and utilize both internal and external resources. Health professionals adopt a 'salutogenic orientation' (79) when they focus their practice and research on enhancing salutary factors (resources) that empower individuals to maintain or improve their health and well-being, even in the face of stressors and adversity (80, 81). Furthermore, the salutogenic approach is a solution-focused way of working, on both the individual and organisational levels (80, 82).

By combining the salutogenic model SOC (76) and the occupational theory ValMO (5), a more holistic understanding of the factors that influence lifestyle, work, motivation, and health can be created. The interplay between how individuals perceive their world, believe they can manage it, and find meaning in their occupations can be directly influenced by their core values and intrinsic motivations. This integrated approach, taken in this thesis, provides valuable insights for understanding and improving both personal and organisational outcomes, particularly in identifying effective strategies to promote health.

Knowledge gaps and rationale

Research in the field of health promotion initiatives within the working population mainly focuses on either health at the workplace or strategies targeting eating habits, alcohol, smoking, or physical activity. There is a need to gain deeper knowledge about how certain occupations in everyday life, such as work, interact and affect lifestyle choices and overall health. To understand how occupational health can be promoted within the working population, it is necessary to gain deeper knowledge about how certain everyday occupations, such as work, interact with and affect lifestyle choices and overall health.

Despite current knowledge and interventions that aim to promote health within the working population, an increasing number of people still report poor health and/or sick leave. This suggests that current approaches may not be sufficiently effective or that there is a gap in understanding how to sustainably promote health in everyday life, with work included. While many interventions focus on supporting individuals in recovering from occupational ill health, there is limited knowledge on how to proactively create conditions that foster health – before ill health occurs – within the working population. Moreover, there is a lack of research exploring the perspectives of employer representatives on managing workgroups and their views on health-promoting leadership. Given that work constitutes a significant part of everyday life, understanding how to integrate health promotion into all aspects of life is crucial, if occupational health is to be achieved.

This thesis strives to address existing gaps by adopting a salutogenic perspective to explore how health can be promoted in everyday life, including within the context of work. By examining health promotion from individual, group, and organisational perspectives, the thesis contributes to a broader understanding of how proactive and preventive efforts can support occupational health in the working population. In addition, it offers insights into the subjective experience of occupational health and identifies key factors necessary for its promotion.

Overall aim

The overall aim of this thesis was to develop knowledge about what is needed to promote occupational health in everyday life, including paid work, within the working population. Furthermore, it aimed to identify key strategies for promoting sustainable everyday life and occupational health at the individual, group, and organisational levels.

Specific aims for Studies I-IV

Study I
The first study aimed to analyse the relationships between sociodemographic factors, occupational value, occupational balance, and perceived health in people suffering from occupational ill health, to explore the main risk factors for the development of occupational ill health that can lead to stress-related sick leave.

Study II
The second study aimed to describe what is needed to achieve/regain a balanced everyday life, including paid work, as described by participants following participation in a work rehabilitation program, due to occupational imbalance and ill health.

Study III
The third study aimed to describe the participants' experiences of maintaining or regaining occupational health in everyday life, including paid work, a few years after participation in a work rehabilitation program and returning to work.

Study IV
The fourth study aimed to describe what managers do to promote health in the workplace, and to what extent they consider their employees' everyday lives.

Methods

Study design

This thesis is a compilation of four separate studies; all conducted in Sweden. The four studies within the thesis utilize distinct research designs that are suited to their respective aims and contexts. For an overview of studies, I-IV, see Table 1.

Table 1. Overview of Studies I-IV

	Study I	*Study II*	*Study III*	*Study IV*
Study design	Cross-sectional descriptive (baseline)	Explorative qualitative (at the end of the intervention)	Explorative qualitative (2-5 years after the intervention)	Explorative qualitative (organisational perspective)
Participants	n= 218 (About to enter the WRI due to occupational ill health)	n=54 (Had participated in the WRI 2-5 years earlier)	n=9 (From study II who work within IT, health, and childcare)	n=11 (Managers and HR from the area of IT, health, and childcare)
Data collection	Questionnaires	Medical records	Semi-structured interviews	Focus groups and interviews
Data analysis	Descriptives and tree analysis	Qualitative content analysis	Qualitative content analysis	Thematic analysis

Study I adopts a cross-sectional descriptive design based on quantitative data. In cross-sectional studies, data are studied at a single point in time. This design is appropriate when, for example, studying the prevalence or distribution of specific characteristics in a population or establishing preliminary evidence for future, more advanced studies (83). Study I was designed to give a baseline view of the current study population and explore the main risk factors for developing occupational ill health.

Studies II and III employed an exploratory qualitative design with an inductive approach at the end of a work rehabilitation group intervention, and 2-5 years after the intervention ended. With an inductive approach, the participants' experiences were studied without any influence from previous theories (84), which gave the opportunity to understand the participants' perspectives (85). The studies were designed to understand how occupations in everyday life affected the participants' health, and to gain a deeper understanding of what they valued as important for experiencing good health. Study IV had a qualitative design with an abductive approach, meaning that the results from Study III were taken into consideration

when forming the interview guide and exploring the perspectives of health-promotive leadership and workplaces of a purposeful sample of managers and HR professionals (86).

Study setting and participants

The work rehabilitation intervention

The work rehabilitation intervention from which participants were recruited for study I-III was the occupational therapy group intervention called Redesigning Daily Occupations (ReDO®). The studies did not in any way evaluate the program, but participation in the program was an inclusion criterion and a way to recruit participants and data.

The intervention aims to support individuals experiencing occupational ill health in regaining and maintaining occupational balance and health, including time for paid work (87). The occupational therapy group intervention was developed and based on the ValMO model, and on research about relationships between complexity in daily occupational patterns and health.

The work rehabilitation programme ReDO®-16 in its original form consists of ten weeks of group sessions, seminars, and homework, followed by six weeks of a work placement (87). In previous studies, it has shown a good outcome effect (88, 89), including from a longitudinal perspective (90). The original ReDO® -16 program was adapted for primary healthcare in 2014, into a ten-week program, the ReDO®-10. Results from the ReDO®-10 showed significant improvements in perceived health, occupational balance, occupational values, and a sense of mastery at both the end of treatment and at 6-months follow-up (91). At 12-months follow-up, where 86 women answered questionnaires, the improvements remained regarding perceived health, occupational balance, occupational value, mastery, and work capacity (92).

The general inclusion criteria for participating in a ReDO® intervention are that the individual should be on or at risk of going on sick leave, i.e., of working age and experiencing one or more of the following problems: (a) high frequency of health care visits, (b) complex symptoms, (c) pain with varied diagnoses or symptoms, (d) mental illness that may be treated in a primary care setting or (e) other symptoms/disorders resulting in a perceived occupational imbalance. The exclusion criteria for the intervention are: (a) not able to speak or write in Swedish, (b) no steady medical treatment, (c) lack of cognitive ability to participate in a group and to self-reflect. The ReDO® intervention is manual driven, and all ReDO® interventions are led by occupational therapists (OTs) who are certified as ReDO® leaders. This means that all ReDO® groups follow the same set of sessions chronologically and with the same content.

Study I included quantitative data from 218 participants who all experienced occupational ill health and were about to enter the ReDO® intervention; of those, 192 were women, 22 were men, and 4 individuals did not specify their gender. The recruitment took place in three regions in the south of Sweden. Healthcare professionals, including physicians, physiotherapists, and OTs at primary healthcare centres in southern Sweden, could refer their clients to the ReDO® intervention if they met the inclusion criteria. Inclusion criteria for the study meant that the individuals would be on or at risk of going on sick leave, i.e. of working age, and they met the criteria for the intervention.

Study II recruited participants at the end of a ReDO® intervention, and a concluding note was written in the participants' medical records. This note summarised the participants' learning throughout the intervention and described how their everyday life and occupational patterns may have changed since they started. Study II included concluding notes from 54 individuals in Sweden: 10 men and 44 women. The inclusion criteria for this study were that the individuals finished their intervention between 2016 and 2021, were of working age, and had a concluding note in their medical record from the intervention.

Study III builds on the experiences of individuals from the second study who participated in the WRI ReDO® between 2018-2021 and have returned to work after sick leave, part- or full-time. Given that sick leave rates are highest within the health and childcare sectors, while the IT sector has the lowest number (Swedish Social Insurance Agency, 2021), the inclusion criteria were that they had participated in a ReDO® intervention between 2018 and 2021 and worked within one of the three sectors: healthcare, childcare/school, or IT.

Of the 54 individuals who participated in study II, 24 also consented to participate in the third study. Eighteen had submitted their contact information. Through purposeful sampling (Palinkas et al., 2015), a total of 12 individuals were considered suitable for the study and met the inclusion criteria. The 12 were contacted by telephone or email. Two did not reply, and ten individuals agreed to participate. Three reminders were sent out. One participant did not show up for the interview, nor did they answer by phone or email. Eventually, nine individuals were included, seven women and two men, aged between 37 and 56.

Healthcare, childcare and IT sectors

In Studies III-IV, the healthcare, childcare, and IT sectors were the setting for participant recruitment. These areas of work were purposefully chosen in connection with their sick leave statistics; health and childcare have the highest rates of individuals on sick leave, and IT has the lowest numbers (93). These fields offer diverse opportunities and challenges for both employees and managers. For example, there were differences in the number of employees the managers were responsible for and the opportunities they could offer their employees in terms of

flexibility in work hours or settings. The participants for Studies III-IV were recruited from these areas of work to gain the experiences of both employees and managers within these sectors.

Study IV is based on the experiences of managers and HR personnel to gain knowledge of their views on health promotion, what they do to promote a healthy work environment, and the extent to which they consider their employees' everyday lives in the process. Eleven participants were recruited from two regions in the Swedish public sector through either HR managers or heads of divisions. Seven women and four men were included in the study, representing the three sectors (school, healthcare, and IT). Nine participants were managers, and two worked in HR.

Data collection and procedures

For this thesis, four separate data collections were carried out, in chronological order. The first set of data was collected through another project (91), while recruitment and data collection for Studies II-IV were made by the author of this thesis. Study I was a quantitative study using questionnaires to explore the participants' self-assessed health and experiences of everyday life before entering the ReDO® intervention. Study II was a qualitative study using concluding notes drawn from their medical records to investigate the participants' everyday life experiences at the intervention's end. Study III was a qualitative study using interviews with follow-up participants from Study II who worked in healthcare, school/childcare, and IT sectors. Study IV used focus groups for data collection and targeted managers and HR within the same sectors as in Study III, see Figure 2.

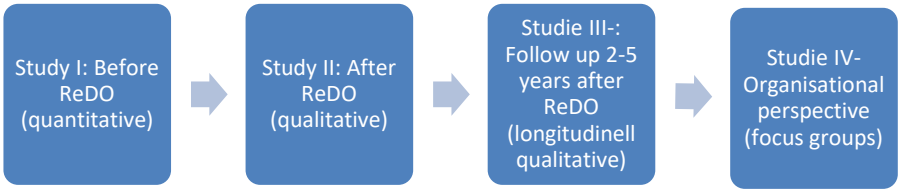

Figure 2. Overview of the chronological order of data collections, in study I-IV.

Questionnaires

For study I, data collected from two earlier studies were used. Data were collected in each of the studies before the ReDO® intervention started. Everyone invited to participate was provided with written information regarding the intervention and inclusion criteria. Individuals who met the criteria were informed about the specific study and were asked to answer two screening questions. If both questions were answered with a yes, the person was invited to the intervention and to participate in the Studies. The data was generated in the primary care sector in a region in the south of Sweden (73).

The data were collected at individual meetings between an occupational therapist and a participant, from September 2014 to March 2016 (73, 83).

Sociodemographic data

In study I, the sociodemographic data were collected using a questionnaire developed for the study, in which participants indicated age, gender, family situation (cohabiting/married or single), number of children living at home, level of education, country of birth, and occupational health. Work capacity was measured by one question where the respondent indicated (in percentage) the extent to which he or she was able to work.

In study II, age and gender were the sociodemographic data that was provided. In study III, age, gender, area of work and percentage of full time in work were collected, and in study IV, gender, area of work, years of experiences in their role as manager and numbers of employees were collected.

Occupational value

In study I, occupational value was assessed using the pre-defined occupational value instrument (OVal-pd) (94, 95), developed based on the ValMO model, to measure how frequently individuals experience various aspects of occupational value in their daily lives (5). The OVal-pd consists of 18 statements corresponding to the three occupational value dimensions of the ValMO model. Respondents rate how often they have experienced these occupational value aspects in their everyday occupations over the past month. Each statement is rated on a four-point Likert scale: 1) "not at all," 2) "quite rarely," 3) "quite often," and 4) "very often." A higher total score indicates that an individual engages in occupations with high occupational value across all three dimensions. The questions are grouped into the three occupational value dimensions when calculating scores: concrete value (6 questions x 4 = 24 points), socio-symbolic value (4 questions x 4 = 16 points), and self-rewarding value (8 questions x 4 = 32 points), with a total possible score of 72 points (94). The instrument has demonstrated good reliability and validity (94, 95).

Occupational balance

To measure occupational balance in study I, the OBQ (occupational balance questionnaire) self-assessment instrument was used (96), which includes 13 questions regarding occupational balance. The questions are answered on a four-point ordinal scale from 0 to 3: "totally disagree", "partly agree", "agree to some extent", or "totally agree", based on the options best corresponding to the participant's current situation. A high estimate indicates a high self-perceived occupational balance. Analyses can be carried out regarding both individual issues and points, with a total of 39 possible points (96). This instrument is based on previous research on the perception of balance in women recovering from stress-related problems (97), what is considered important for life balance (98), and a conceptual analysis of occupational balance (9). The instrument has shown good content validity, internal consistency, and test-retest stability (96)

Perceived health

To measure perceived health in study I, EQ5D (99) was used, which is a standardised instrument for measuring and describing a person's perceived health by means of self-assessment. The first two parts of the instrument have been used in the studies; the first part is a descriptive questionnaire highlighting five common health problems related to mobility, hygiene, main activities, pains/inconveniences, and fear/depressed mood. The participants are then allowed to choose which claim best fits their current health condition. The three available response options are: "no problems", "some problems" and "difficult problems." The second part of the instrument consists of a vertical VAS scale where participants estimate their current perceived health on a scale from 0 to 100, where 0 is by far the worst imaginable and 100 the best imaginable. This instrument provides a health indicator that can easily be displayed in a descriptive profile, and an index value that can be used for an economic and clinical evaluation of healthcare (100). In this study, only the second part of the instrument (i.e., index value based on the VAS scale) was analysed. The psychometric stability of the separated VAS-scale from the EQ5D has been evaluated and found acceptable (101).

Medical records

In study II, medical records were gathered from records made by 12 OTs across various regions of Sweden, each reflecting its specific demographic, geographic, and healthcare context. To gain access to the concluding notes, all OTs trained in the ReDO® intervention in Sweden were contacted. The OTs were listed at the Swedish Association of OTs, and approximately 300 individuals were contacted and asked to assist with the withdrawal of anonymised data from medical records.

The OTs were identified through a digital platform dedicated to certified ReDO® group leaders within the Swedish Association of OTs. Emails were sent out in July 2020, January 2021, and February 2021 through the digital platform. A final group of twelve OTs from various parts of Sweden joined to assist with data collection. The participating OTs had led at least one ReDO® group between 2016 and 2021 and had written concluding notes from the intervention, which were documented in their informants' medical records. In April 2021, written information and consent forms were sent to the volunteering OTs, who forwarded them in May 2021 to informants who had participated in a ReDO® intervention between 2016 and 2021. The signed consent forms were returned to the OTs, who printed de-identified copies of the concluding notes from the informants' medical records and sent them by post to the first author. To ensure that no connections could be made between the consent forms and concluding notes, they were sent in different envelopes. The author collected all 54 individual notes, totalling approximately 60 pages.

Interviews

In the third study, data were collected through semi-structured interviews. The interview guide was created with open-ended questions focused on the concepts of 1) everyday life, 2) health, and 3) work. The goal of the interviews was to explore the participants' experiences of maintaining or regaining occupational health in everyday life and returning to and remaining in work. Additionally, the interviews aimed to capture participants' experiences of how to promote health in everyday life.

The main questions included: "How do you experience your everyday life today?" "What has worked well in your return-to-work situation?" and "What makes you feel good in your everyday life?". These questions were followed by prompts, such as "Can you elaborate?" or "Is there anything that has made it more difficult?" to explore their occupational health experiences in greater depth.

The semi-structured format allowed for a participatory and reflective approach, enabling the interviewer to ask additional questions if necessary or if previous responses required further clarification (85). The interviews for this thesis were conducted between December 2022 and March 2023. Participants were given the flexibility to choose the most comfortable digital interview format, with options including telephone or web-based videoconferencing. All interviews were audio-recorded, transcribed verbatim, and lasted between 38 and 66 minutes, with an average duration of 50 minutes, resulting in a total of 249 transcribed pages.

Focus groups

For the fourth study, data were collected through two focus groups and two individual interviews, as some participants were unable to attend the scheduled focus group sessions. The focus groups had the form of group discussions and were chosen for the potential to elaborate on perspectives and experiences. The aim was to stimulate interaction between the participants so that a wide range of perspectives were discussed. The group process encouraged participants to clarify their perspectives, which is considered a strength of focus group interviews (84-88).

Focus group interviews were selected as an effective method to explore the range of experiences, perceptions, and opinions of promoting health in the workplace, from a manager and HR perspective, collectively. The last author and I facilitated the focus groups, one acting as moderator and the other as observer. A semi-structured interview guide was used, featuring open-ended questions such as, "What is health-promotive work?" and "What do you consider important in your role as a manager in creating a health-promoting workplace?" Participants were also prompted with follow-up questions like, "Can you elaborate?" or "Can you provide an example?". Additionally, they were asked to describe both promoting and limiting factors related to the ability to implement health-promoting practices at the workplace. The same interview guide was used in the individual interviews.

The first focus group was held in May 2023. The second focus group and the two supplemented individual interviews were conducted in April 2024. All interviews were recorded using a digital voice recorder and took place either in a private room of the participants' choice or via a digital Teams meeting. The average duration of each discussion was 110 minutes.

Data analysis

Quantitative analysis

To explore the relationships between sociodemographic factors, occupational value, occupational balance, and perceived health, quantitative data were analysed in study I, using regression and Classification and Regression Trees (CRT). Descriptive analyses were conducted using JASP, with coefficient H used to measure reliability (102). CRT was used to analyse risk factors predicting perceived health. CRT is a non-parametric statistical technique that identifies subgroups within a population based on shared characteristics influencing the dependent variable (103). This method allows for non-linear interactions among predictors and is effective in identifying factors that explain different outcomes.

In study I, the CRT tested relationships between predictors (sociodemographic data, occupational value, and occupational balance) and the outcome variable (perceived health). Certain categories, such as country of birth, education, marital status, children, and occupational health, were dichotomised to create more even groups, while continuous categories remained unchanged.

Data were first processed in relation to missing data. The total number of potential data points was 8,502 (218 * 39). There were no responses to 1,028 of these, which resulted in an internal dropout rate of 12.1% (1028/8502). All data collected with the selected instruments were included in the analyses, and missing data were addressed with surrogate splits. The CRT was conducted in SPSS Statistics version 26 (SPSS Inc., Chicago, IL). The decision tree model was constructed with a minimum parent node size of 70 cases (10% of the sample) and a minimum terminal node size of 35 cases (5% of the sample) (103). Model validity was assessed using tenfold cross-validation, and missing data were handled through surrogate splits. Differences in health levels between participants in the terminal nodes were evaluated using Cohen's *d* effect sizes with 95% confidence intervals.

The analysis generated a decision tree through stepwise variable selection, splitting the data based on the most significant predictors. Splitting stopped when the reduction in error fell below a threshold, and variables that did not meet the threshold were excluded from the final model. The result was a tree diagram showing homogeneous groups based on predictors and perceived health.

Qualitative analysis

Content analysis

In the second and third study, a qualitative content analysis was used. In study II, the aim was to describe the needs to achieve a balanced everyday life, with paid work included, based on the concluding notes focusing on the manifest content (104). This method was chosen because it is a systematic method to qualitatively analyse various kinds of empirical material (84).

In the third study, the content analysis was used to describe the need to achieve a balanced everyday life, with paid work included. Both studies had an inductive approach. The content analysis began by thoroughly reading the material several times to form an overall understanding. Next, I identified and extracted meaning units from selected texts relevant to the study's objectives. The remaining meaning units were sorted by content, condensed, and abstracted into codes. This was done using sticky notes on a board and digital tables for organisation. Similar codes were then grouped into categories, and an overarching theme was developed to capture all the categories.

One of the co-researchers was involved in every step of the process, receiving all the material as the analysis progressed. Through reflection and discussion, the

categories and overall theme were decided. The co-researchers and I primarily discussed coding and initial category formation. All involved researchers had access to the material through a secure digital platform, and their input was incorporated into the process during meetings and through comments on the material.

Thematic analysis

While Studies II-III used a qualitative content analysis (90), study IV was analysed using thematic analysis (TA) (105). Both methods share a focus on identifying patterns and themes in qualitative data, but they differ in their approach, depth of analysis, and flexibility. While content analysis is a more systematic and structured approach, which focuses on categorising and counting the frequency of themes or concepts in the data, TA is a more flexible, interpretive approach that focuses on understanding the deeper meanings and underlying themes within the data, with less emphasis on quantification (106).

To explore the multifaceted approaches that employers use to promote employee health, specifically focusing on the role of leadership practices the focus groups were analysed using TA. Following the work of Claeys et al. (107), the study has the intention of further developing their results concerning managers' understanding of how to promote employees' health in the three phases. The study also builds further on the results of the third study concerning 'flex-ability' related to the entire life situation. Hence, to understand how managers reason about what they do to promote health in the workplace, two main questions guided the empirical investigation: How do they act to support and enhance their employees' health? Why? and 2) Do they consider their employees' everyday lives in their health promotive work? How?

After transcribing and pseudo-anonymising the interviews, a reflexive thematic qualitative analysis took place (105), following the six steps: familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming the themes, and, finally, writing the scientific paper.

Reflexivity

Self-reflection is a critical component of all research, as a researcher's background and position inevitably influence the formulation of research questions, the investigative perspective, the choice of methods, and the interpretation of findings (108).

Critical realism (67, 68), which was used to help synthesise the results in this thesis, acknowledges that knowledge of reality is context-dependent and shaped by human representation. Consequently, empirical data and research findings should not be regarded as objective entities that simply "exist" and are waiting to

be discovered. Instead, knowledge is co-constructed through the interaction between the researcher and study participants.

In this thesis, the construction of knowledge emerged from the collaborative efforts of the research group and the participants. For instance, the quality of the empirical material obtained during interviews was influenced by the types of questions posed, participants' ability to articulate their thoughts, and the researcher's skills in listening and interpreting responses. My prior experience as an occupational therapist within the field proved beneficial in many respects. For example, I was able to relate to the participants even when they got emotional, as I have a clinical understanding of the process of trying to regain occupational health. However, it occasionally posed challenges in maintaining objectivity and balancing pre-existing knowledge, to avoid entering the "therapist" mode and trying to help them. My clinical background, combined with my active involvement in data collection and analysis, may have inadvertently led to assumptions or overlooked areas of significance. However, to minimise this risk of bias, all supervisors had full access to the data, enabling collaborative discussions and allowing the material to be examined from multiple perspectives.

Ethical considerations

Ethical approval for study I was given by Lund University (no. 20l4673), and study II - IV were granted ethical approval by the Swedish Ethical Review Board (no. 2021-01071). The studies were conducted in accordance with the Declaration of Helsinki (109) and followed the four ethical principles of beneficence, non-maleficence, justice, and autonomy (110). All participants received a letter with a written explanation about the purpose of the specific study, the meaning of their contribution, and how their anonymised participation would be used for analysis on a group level. Information about confidentiality, free participation, and an assurance that the participants could request to withdraw their consent and material from the studies at any time was included in the letter and oral information. Written informed consent was then obtained from the participants, along with supplementary oral consent at the interviews.

Findings

This chapter summarises the results from the four studies of the thesis, each conducted with a specific aim, and for which data were independently collected, analysed, and reported. The integrated results will then be presented in relation to the overall aim of the thesis, to explore what supports occupational health in everyday life, including paid work, and identify key strategies for preventing, but mainly promoting sustainable everyday life and occupational health at individual, group, and organisational levels.

The effort to sustain occupational health involves engaging with its key aspects, such as occupational balance and occupational values. This process requires a holistic management of everyday life, characterised by active efforts to establish structure and priorities, navigate social interactions, set boundaries, and make time for meaningful occupations.

Furthermore, the constructed concept of flex-ability (flexibility + capability) came to be a central phenomenon to promote occupational health in this thesis, based on the results in the third study (111). It refers to the individual's ability to understand their needs and abilities, and to be open to change and adapt to new challenges at work and in everyday life. The concept of flex-ability can also be seen from a group and organisational level, since it is a process where, for example, organisations need to understand needs and abilities to be flexible to form a health-promoting workplace.

The results illuminated a highly relational process, where it seems hard to separate life into private and work spheres, and where balance in everyday life seems essential to promote occupational health. The results include the formulation of perceived needs in the transition between intervention and return to work, maintaining occupational balance, and promoting occupational health, from both an individual and organisational perspective.

The results will be presented on the individual, group, and organisational levels, in line with the objectives of the project.

Prevention of occupational ill health

This thesis has a primarily health-promotive focus; however, the first study explored risk factors for the development of occupational ill health, applying an occupational perspective and using a quantitative method. This was done to guide areas of importance for the remaining studies.

The results showed that individuals who experienced imbalance in their everyday lives and had few or no experiences of daily occupations imprinted by socio-symbolic occupational value, reported lower perceived health (Study I).

Rather than sociodemographic factors, it seems that it is low levels of experienced balance in everyday life and few or no occupations with socio-symbolic values, that together constitute a crucial factor in the development of occupational ill health (Study I). The results of Study I provided an important first step in understanding what should be considered in the planning of health-promotive initiatives.

The results highlighted how occupational imbalance, characterised by a lack of control, reduced meaningfulness, and a mismatch between individual resources and contextual demands, can contribute to stress-related conditions and, over time, lead to sick leave. Therefore, the results indicated that there is a need to look beyond sociodemographic factors, such as gender, age, or family situation, and consider that sick leave statistics due to occupational ill health seem to be linked to how people spend their everyday live, and what occupations they do, rather than, e.g., what gender they are (Study I). This result highlights the importance of supporting and educating individuals in how to manage their everyday lives, and the importance of the experience of occupational balance and occupational values in relation to promoting occupational health and sustainable work participation.

Promotion of occupational health on an individual level

In the second study, taking control over everyday life and routines was found to be essential for improving occupational health. This was mainly done through four key strategies: structuring and prioritising daily tasks, managing relations, setting personal boundaries, and engaging in meaningful occupations. It was also described how expectations, both internal and external, affected the occupational choices in everyday life. These elements helped create a healthier balance between work and personal life, reduce stress, and promote occupational health in everyday life.

> "Nn now has a different use of time: Less time for cleaning, more time for the family. Not so thorough with everything, and lets her son in to help out more at home" (Paper II, page 6.)

Similarly, the concept of *flex-ability*, as discussed in Study III, underscores the ability to be flexible in all aspects of everyday life. Furthermore, it illustrates the importance of understanding what needs, abilities, and desires drive the individual's choices and decisions. It covers being able to be flexible both towards oneself and others, but also being met with flexibility in everyday life. For example, flexible work options, such as adjustable hours, remote work, and modifiable workloads, were described as health-promoting actions that facilitated occupational balance in everyday life, contributing to a greater experience of occupational health.

The results showed that individuals with greater control over their work described feeling more capable of managing their health, everyday life, and job responsibilities (Study III). One common denominator discussed throughout Studies II-IV was how social structures, norms, and perceptions seemed to contribute to unhealthy occupational patterns and negative pressure in everyday life for people of working age. These could include the belief in the need for a "fancy lifestyle" with a big, clean house, travels and that working full time or more is an absolute must, despite how negatively it affected one's occupational health. Therefore, it seems important to acknowledge and understand the effect these social elements can have and find ways to navigate them to promote occupational health.

Furthermore, the results from Study II-III illustrate an interconnected experience, where it seems impossible to separate life into private and work spheres, and where the experience of balance in everyday life seems essential for promoting occupational health. It highlights the importance of becoming more aware of the occupations that fill everyday life and the value they bring, which is key to the structuring and prioritising of occupations towards a more balanced, and therefore health-promoting way of living.

Promotion of occupational health on a group level

From a group perspective, particularly in shared environments, e.g., workplaces or families, the results from Study III-IV show that collective occupational patterns and norms shape what is seen as acceptable or achievable in everyday life. The studies highlight the importance of social support (Study III), open communication (Study IV), and overall shared responsibility in creating flexible and health-supportive group dynamics.

The results of Study I showed the impact of occupations with higher socio-symbolic value (5), and how those occupational values can contribute to better health. The socio-symbolic occupational value refers to the social and symbolic meanings that individuals can experience in doing occupations, often including participation and a sense of belonging. Therefore, health-promotive initiatives should also be directed on a group level. In Study II-III, the results also showed

that relationships both at and outside of work played a significant role in regaining and maintaining occupational health.

The results show that social belonging plays a significant part in relation to occupational health, and that, when relationships in everyday life are based on flex-ability, this can help support occupational balance and promote occupational health. For example, in study III, some individuals referred to their work as their "second home" and their co-workers as their "second family", while others regarded their work as a necessary occupation in life but with no desire to build meaningful relations that extended outside of work. However, the results illustrated that, regardless of their view of work, it did contribute to their experience of health and balance in everyday life.

> "We have great fun together, we are a nice work group and there is a lot of support for each other, through thick and thin. Yes, we are like a small family" (Paper III, page 5)

However, the results from Study IV also illustrated that offering individual arrangements to certain employees could lead to jealousy, or more stress for the other employees. The managers described it as a delicate balance, a search for ways to promote overall health in the workplace. To navigate that balance, support from the organisations such as HR, time and resources, and competence in health promotive strategies were described as important to the managers.

The results from studies II and III showed that group-based interventions can promote a sense of shared experience and mutual support, which seems to strengthen social cohesion and might help foster a stronger team dynamic.

In conclusion, supporting a workplace that values open communication, considers the individual's everyday life, and respects individual boundaries can help promote occupational health within the workplace. Finally, the overall result showed that, when flex-ability and occupational balance are embedded in daily routines at home and at work, groups may adopt more sustainable collective work practices. These can include respecting non-working hours, sharing responsibilities more equitably, and managing high workloads or home-related demands collaboratively. Lastly, promoting health through interventions that support flexibility and occupational balance in everyday life in a group setting, such as work, seems beneficial, offering a sense of community while supporting and inspiring each other. The result highlights the importance of addressing occupational health, not only at the individual level, but also on a group level, where work is an important area.

Promotion of occupational health on an organisational level

At the organisational level, the results highlighted the significant influence of occupational culture in either facilitating or hindering health-promoting practices. The American Psychological Association defines occupational culture as "a distinctive pattern of thought and behaviour shared by members of the same occupation and reflected in their language, values, attitudes, beliefs, and customs" (112). However, the concept as it emerged from Studies III–IV was broader and more nuanced and the results indicated that occupational culture encompasses not only shared professional norms and values, but also deeply embedded structures that shape individuals' behaviours and perceptions.

This broader understanding positions occupational culture as a central contextual factor influencing how health-related practices are conceptualised, implemented, and experienced within organisations. The studies in this thesis point to the need for organisations to embrace a culture of flex-ability, which can include the capacity to adapt to individual needs and life circumstances while maintaining shared goals and productivity. The results from the focus interviews with employers (Study IV) showed the importance of fostering a healthy work environment that included: tweaking the organisational culture, structuring formal work conditions, educating about health, and recognising the relation between private and working life.

A key conclusion regarding health promotion in groups and organisations based on the interviews and focus groups is the importance of addressing health-related issues at multiple levels – societal, organisational, and individual – and creating a supportive environment that fosters occupational health. At the societal level, the pressures from external demands (e.g., constant availability, high expectations, and a fast-paced work environment) were believed to contribute to occupational ill health (Study III-IV). The results of Study III-IV illustrated that managers can contribute to health promotion by encouraging self-care, offering health-related education, and fostering an environment that emphasises the importance of recovery, teamwork and manageable workloads.

Organisational factors, such as demanding workloads, limitless work expectations, and a lack of recovery time, can be addressed by customising work conditions – adjusting tasks, hours, and schedules to better support employees. Additionally, promoting occupational culture through encouraging a sense of joy at work, creating strong team dynamics, and setting realistic expectations was described as important to reduce stress and enhance resilience (Study II-III).

> “We have Dance Band Friday, so during lunch we play some dance band music to get in the mood, and that contributes a lot to having a pleasant working atmosphere together, which benefits you.” (Focus group 1, manager in healthcare, page 48)

> "We also have some, well, maybe not a dance band Friday, but we do have Friday fika [Swedish tradition of drinking coffee and eating something sweet or homemade], where people come together. We send out emails saying, 'Today it's fika, come join!' and sometimes it happens on other days too, spontaneously, just gathering for a bit. So, we try to do some enjoyable things together." (Manager in IT, Individual interview, page 49)

However, the focus groups with managers showed that there could be a lack of resources or knowledge that hinders the managers from offering the flexibility that employees seek (Study IV). The result from Study IV showed that different areas of work came with different challenges. For example, offering flexible work arrangements, such as remote work for managers within IT, was no problem, while those arrangements seemed almost impossible to offer when working as a manager within healthcare. Therefore, it seems important to find ways to be flexible within the range and facilities possible for different organisations, and to create clear structures and guidelines.

> “I have a lot of freedom in my work situation, which I am very grateful for in my job and which I like. I can control it” (Paper III, page 5)

Furthermore, the results from Study II-IV suggest that promoting occupational health requires both structural flex-ability within society, organisations and individual-level strategies that empower individuals to manage their everyday lives and prioritise occupational balance. Integrating such approaches into workplace policies, educational programmes and interventions seems to support long-term occupational health, reduce stress, and improve workforce sustainability.

To convey the integrated results of this thesis, I developed a visual model, a compass, to represent the dynamic interplay of factors that influence occupational health from the individual, group, and organisational perspectives (see Figure 3). Rooted in the field of occupational science, this model emphasises that "occupational health" encompasses the full range of occupations in everyday life and is not limited to employment.

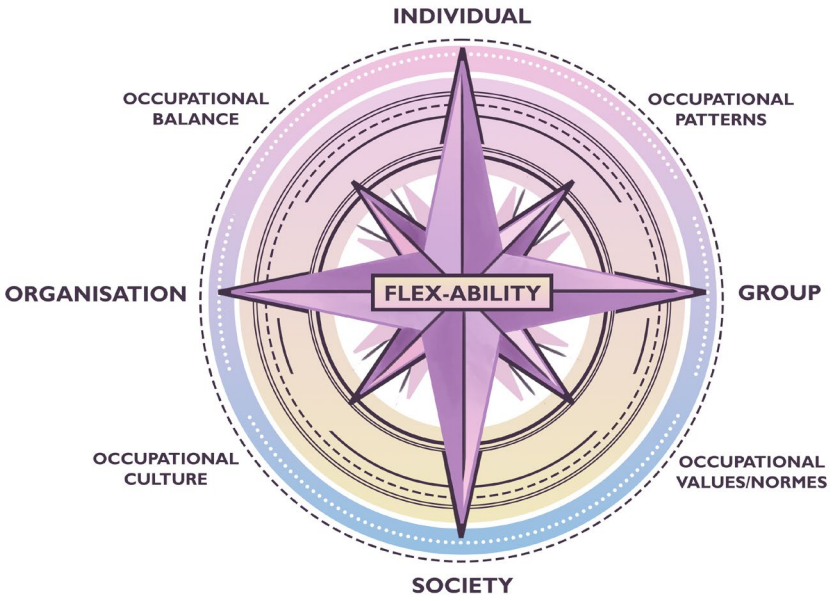

Figure 3. Illustration of a compass to navigate everyday life, to promote occupational health from an individual, group, and organisational perspective, in society.

At the centre of the compass is Flex-ability, a concept that emerged as a core factor in this thesis to support sustainable occupational health across all levels. Flex-ability can be applied to different contexts and includes the capacity to adapt, shift, and balance occupational engagement in response to changing circumstances, roles, and contexts. It is both a personal and collective resource that enables navigation through the complexities of modern everyday life.

The compass is oriented along two axes: Vertical axis: Individual ↔ Society. This axis reflects how personal experiences of occupational balance and societal norms influence occupational patterns, lifestyle choices, and the experience of occupational health. It represents the tension between personal autonomy and broader structural expectations. The horizontal axis: Organisation ↔ Group highlights how occupational culture within social contexts, such as organisations, and shared values/norms within groups, shape collective occupational patterns and practices. Surrounding the core concept of flex-ability are four interrelated domains that were found to be important when promoting occupational health: occupational balance, occupational patterns, occupational values, and occupational culture. Together, these dimensions form a navigational tool, supporting awareness, reflection, and responsiveness, to promote occupational health. Just as a compass guides orientation and movement, this model can help practitioners,

researchers, and policymakers to locate points of tension or support occupational health in everyday life, within the working population, and help create conditions that can enhance well-being across different contexts.

Discussion

The overall aim of this thesis was to develop knowledge regarding what is needed to promote occupational health in everyday life, including paid work, within the working population. Furthermore, the research aimed to find key strategies for preventing ill health but mainly promoting occupational health and sustainable everyday life, from an individual, group, and organisational level. This discussion is grounded in the understanding that the term occupation encompasses the broad range of everyday activities that individuals engage in – whether alone, within families, with friends, or as part of communities – to occupy time and create meaning and purpose in life (4). In this context, occupational health therefore refers to the overall experience of health as it is lived and shaped through everyday life and routines.

Together, the studies contribute to a developmental understanding of occupational health: beginning with the identification of risk factors for ill health, moving through the recovery process supported by intervention, and ending with the articulation of a conceptual resource, flex-ability, for sustaining long-term occupational health from an individual, group, and organisational perspective. This progression reflects an integrated, person-centred, and occupation-focused approach, where the individual's experience and active engagement in occupations in everyday life are central to both the prevention of ill health and, primarily, the promotion of occupational health. These results contribute to the broader field of occupational and health sciences by offering practical and conceptual tools that can inform interventions, workplace strategies, and health promotion initiatives.
The following discussion will focus on some main results from this thesis in relation to health promotion, which will be discussed, as in the result section, from the same three perspectives.

Promotion of occupational health on an individual level

From an individual perspective, the results of this thesis underscore the significance of experiencing occupational balance as a key factor in promoting occupational health. The results of Study I demonstrated the strong relation between occupational balance and health. Achieving such balance involves a conscious awareness of one's occupational patterns and occupational values, which facilitates the structuring of everyday life in a meaningful and satisfactory way.

The strong association between occupational balance and overall health is well-supported (4, 113, 114), and results from previous research suggest that occupational balance may also influence the effectiveness of other health-promoting lifestyle interventions. For instance, in sustainable weight loss programmes, integrating strategies that support occupational balance and occupational patterns – particularly those that emphasise meaningful occupations and alignment with personal values – may enhance both health outcomes and long-term lifestyle changes (115).

Promoting occupational health, therefore, implies supporting individuals in understanding and regaining agency over their time, occupational patterns, occupational values, and overall experience of occupational balance. As emphasised in the field of occupational science, humans are occupational beings, meaning they both need and have the capacity to engage in everyday occupations within their environment (70). The thesis suggests that, when individuals engage in occupations primarily based on others' expectations or to conform to societal norms, rather than their own values, this may lead to reduced well-being or even to adverse effects on occupational health. The concept of taking control of one's everyday life emerged as a powerful strategy in Study II for fostering well-being, enabling individuals to reflect on and adjust their occupations to align with personal goals and needs. Motivation has been shown to play a key role in these dynamics, continuously interacting with the elements of an individual's occupational pattern (6, 116). Additionally, a person's occupational pattern is constantly influenced by their physical, social, and temporal environments, along with the broader contexts of their life. These environments can either support and encourage the individual or, conversely, limit and restrain them (6). This dynamic is illustrated in the second study, through the category "Social support – to have and to handle". The results revealed that, through reflection, dialogue, and support, the study participants were able to re-evaluate their occupational patterns, clarify their values, and develop more sustainable strategies for managing everyday life. This supported both their recovery and their ability to re-engage in work and other meaningful occupations.

However, the results from Studies II and III highlight the challenges individuals face in both recognising their own needs and communicating them effectively to receive understanding and support. In Study III, the concept of flex-ability emerged to capture the importance of acknowledging the needs, abilities, and desires that influence an individual's choices and decisions. This concept reflects not only the capacity to be flexible with oneself and with others, but also the significance of being met with flex-ability in everyday life. Such environments and relationships can support adaptive and responsive interactions, which in turn promote occupational health. The importance of feeling accepted, understood, and validated has previously been identified as a fundamental component of psychological well-being and overall health, highlighting the significant influence of social environments on individual health outcomes (4, 117, 118).

The results of this thesis are in line with previous research that shows that work plays a pivotal role in shaping occupational patterns, influencing not only how adult individuals structure their everyday lives, but also how they experience meaning, identity, occupational balance and health (46, 47). Occupations related to work often serve as a focal point around which other daily occupations in everyday life are organised, such as recovery, social participation, leisure, and self-care occupations (76, 119). From a lifestyle perspective, work contributes to both material conditions and social positioning, which in turn affects opportunities for engagement in other occupations.

Work-life balance has become a dominant concept in addressing inter-role conflict, but, in neoliberal ideology, responsibility for managing these conflicts has shifted from organisations to individuals (119). This shift has led people to adopt workplace-inspired, performance-based coping strategies that may not effectively address their personal needs. To improve health outcomes, it is important to challenge public assumptions about work-life balance and consider alternative frameworks, like occupational balance or lifestyle balance, that are more aligned with individual goals (119). The results of this thesis highlight the challenges individuals face in navigating the complexities of everyday life and managing multiple roles and responsibilities. The results point to the need for greater understanding and support, recognising that difficulties in one's private life may necessitate increased flex-ability in both personal and professional contexts. Previous studies have shown that home-related demands and resources can influence the return-to-work process and, therefore, concluded that home-related demands need to be considered to a greater extent, even when work-related demands are experienced as the main reason for the sick leave period (120). Social support, efficacy, and empowerment, as interconnected salutogenic resources, seem to have an important place in health promotion approaches and need to be more closely considered in healthcare, given that the goal of the healthcare industry should be to treat illness while also actively promoting people's health (121).

In conclusion, the results of this thesis illustrate that the process of promoting health is highly relational and cannot be neatly separated into private and work domains. Instead, it reflects the interwoven nature of everyday life. These results underscore the importance of incorporating knowledge about occupational patterns and occupational balance across multiple dimensions when designing health-promotive initiatives. This supports the definition of occupational health that has been applied in this thesis, which emphasises a holistic and contextually grounded understanding of health in everyday life.

Promotion of occupational health on a group level

Based on the results of the studies in this thesis, promoting health in groups may involve re-evaluating occupational expectations and fostering environments where members can support one another's occupational balance and adaptability. The results of this thesis highlight the importance of socio-symbolic occupational values in everyday life. Occupations that embody these values, whether individual, cultural, or universal (5), play a crucial role in supporting health and occupational balance. Such occupations frequently involve social interaction, underscoring the relational dimension of meaningful and health-promoting occupations.

The results of Study II-III highlight the importance of support from family, friends and co-workers. A review (122) investigating the role of the family in health promotion concluded that effective health promotion requires the presence of supportive structural, social, and cultural conditions where the family plays a pivotal role, often exerting a greater influence on individual health outcomes, rather than individual-level factors alone. As a primary social unit, the social circle, such as family and friends, has the potential to facilitate meaningful and sustained behavioural change through shifts in shared values, norms, and occupational patterns. As emphasised by Ho et al,. (122), enhancing the understanding of the contextual and behavioural mechanisms that underpin family-based health promotion can inform the development of more effective public health policies.

Furthermore, the results of Study III-IV illustrated how health-promoting actions, when implemented within the workplace, can generate a range of positive outcomes at a group level through, for example, a higher sense of community. Within the category "workplace relationship dynamics" in the third study, feeling needed, and experiencing support and tolerance within the workplace, along with time for collegial cohesion, were described as important in the promotion of occupational health and work motivation. Similar results have been concluded in previous research (56, 123, 124). Therefore, interventions that support individuals in regaining control over their everyday lives and introduce greater flexibility in work arrangements may benefit not only individual employees, but also the collective functioning and well-being of teams.

Previous research has shown that incorporating opportunities for doing occupations that support recovery during the workday can contribute positively to employee health. These occupations may include simple actions, such as listening to music, sharing moments of laughter with colleagues, or taking a walk during breaks (125). Equally important is the opportunity for individuals to experience autonomy, by choosing the type of occupation that supports their recovery (58).

Furthermore, a review of workplace interventions aimed at promoting mental health and well-being emphasised the importance of actively involving employees in both the development and implementation of such initiatives. Employees' engagement in these processes is essential to ensure relevance, acceptance, and long-term effectiveness (59). The result of this thesis indicates that, when

employees are supported in balancing personal and professional responsibilities, overall stress levels within the workplace may be reduced. This can foster a more positive and psychologically safe work environment, strengthening interpersonal relationships and collaboration (Study IV).

To conclude, the results of this thesis support previous research and highlight that facilitating factors, such as occupational balance, occupational values, occupational culture and flex-ability, can contribute to the promotion of health on a group level. Group-based approaches offer numerous advantages in the context of health promotion. By leveraging the collective experience and peer support within groups, for example at work, these strategies can significantly enhance the impact and sustainability of health promotion efforts (54).

Promotion of occupational health on an organisational level

One of the main results of Study III-IV is the impact of occupational culture and its potential to promote health from an organisational perspective. The concept of occupational culture that emerged from the results in Study III-IV described the underlying norms and structures that influence individuals, not only in relation to work, but also in everyday choices, occupational patterns, and lifestyle. The broader concept of occupational culture, from an occupational science perspective, can help to contextualize how societal expectations and professional norms shape behaviour and perceptions of health.

The results of this thesis suggest that occupational culture remains a meaningful lens for understanding how people navigate occupational balance and health. The norms associated with occupations continue to influence not only professional behaviour but also individuals' ability to make health-promoting decisions in their everyday lives. One important element of work organisations is the manager, and their leadership. In Study III, the support, understanding and flex-ability of the manager were described as key, when it came to promoting health at the workplace. This result is supported by previous research (126-129) illustrating how leadership with a focus on communication, flexibility, and work-life balance can contribute to promoting employee health and wellbeing.

The results of Study IV explored perspectives on health-promotive efforts in the workplace and the concept of flex-ability from the viewpoints of managers and HR personnel. While managers expressed a genuine willingness to support and promote health at work, they also reported challenges. These included both a lack of knowledge about how to implement effective strategies, and insufficient support from organisational structures and conditions necessary to carry out such initiatives. A recent study concluded that managers often have complex responsibilities, and that organisational support is not always enough. The resources that were perceived as most helpful were those that could be adapted to

the unique needs of the situation (130). In other words: support should be more than routines – it must be flexible and practically useful.

The areas of work that were chosen for Study III-IV were IT, childcare and healthcare, as IT have the lowest, and childcare and healthcare have the highest statistics of ill health, respectively. Even though the studies did not compare the different organisations, there were some obvious differences in relation to the concept of flex-ability. For example, the managers and participants in Study III-IV working within IT reported fewer problems in being offered/offering flexible work arrangements, such as remote work, while the other two areas of work didn't have the same opportunities. Since the areas of education and healthcare do not seem to be able to offer such opportunities to the same extent, for example, remote work, other possible solutions need to be explored.

One recent review by Akerstrom et al. (131) examined risk and health-promoting factors from an organisational perspective within the healthcare sector. They highlighted that organisational decisions, such as how work hours are allocated, how tasks are structured, the use and accessibility of ergonomic tools, staffing practices, and attention to ethical challenges, all impact workplace health (131). The authors emphasise that organisations have the power not just to manage, but to eliminate work environment risks and actively foster a health-promoting workplace, even within sectors such as healthcare (131). One example of this is reduced worktime with full pay. A review of studies from 2000 to 2019, primarily focused on the healthcare sector, found that reducing working hours while maintaining salary can be an effective workplace intervention for improving employee well-being, particularly in terms of stress and sleep (132). In Study II-III, reducing work hours was described as a facilitator of improved occupational balance and overall health. However, because this reduction was undertaken without full pay, it had a negative economic impact on participants' lifestyles. As a result, this strategy may not be a feasible or accessible option for everyone.

Most participants in Studies I–III were parents and identified parenthood as a deeply meaningful and significant role. However, fulfilling this role also added to the complexity of managing daily life and posed challenges in maintaining occupational health. In this context, managerial attitudes and organisational flex-ability play a crucial role in supporting employees. Demonstrating understanding and accommodating needs, such as leaving work early for childcare responsibilities or staying home to care for a sick family member, could help to better navigate their dual roles and promote occupational balance and health. One study that examined the relationship between organisational factors and occupational balance among parents (133) found that having a clear structure for handing over responsibilities during absences from work was strongly linked to a higher sense of occupational balance. Additionally, supportive attitudes from colleagues and managers towards parenthood and parental leave were also associated with higher occupational balance.

Furthermore, Vargaz-Martinez et al. (134) concluded that such interventions are cost-effective for both employers and society. Applying an occupational perspective to leadership, with a pragmatic philosophy and an occupation-based approach, could be beneficial to achieving goals, but also to promoting health, through the knowledge and understanding from the innate human desire to engage in purpose-driven occupations that promote growth and productivity (135).

To summarise, the results of this thesis suggest that organisational factors may be linked not only to occupational balance but also to occupational health in a broader perspective, and that being aware of occupational culture and flex-ability may contribute to health-promoting initiatives.

Taking a broader societal perspective, the results of this thesis underscore the need for increased attention to occupational health at the societal level. Current societal norms and expectations placed on individuals of working age are extensive, and the results suggest that it is easy for individuals to lose sight of their own values and needs, in an effort to meet external demands. This highlights the importance of re-evaluating how society, policymakers, and healthcare systems approach health-promoting interventions and health literacy. Research has demonstrated that social media can have a significant positive impact on public health protection and health promotion, with the potential to influence individual behaviour and support the adoption of healthier lifestyles (136-138). However, developing effective strategies to influence health-supported behaviour remains one of the central challenges in health promotion initiatives. A recent review by Ghahramani et al. (139) concluded that evaluating the effectiveness of social media campaigns aimed at encouraging healthier lifestyles adds further complexity, given the multifaceted nature of behaviour change. Consequently, health promotion practitioners must strategically design their campaigns to ensure that messaging not only raises awareness but also translates into meaningful and sustained health behaviour change (139). The current faced-paced, digital society comes with many challenges, but also opportunities, as the results of this thesis illustrate.

One interesting concept relating to this subject is the concept of “ecopation”, introduced by Persson and Erlandsson (140). They were inspired by the philosophy of Skolimowski, who stated that the western way of life is based on the unconscious application of an ethic of doing that is suited better to machines than to humans. In such a machine society, everyday occupations are imprinted by multitasking, competition, and materialism, all of which may contribute to various forms of ill health. The results of this thesis show that this is a main contributor to occupational imbalance and ill health. By introducing the term “ecopation” (140), the authors suggested that everyday patterns of occupations need to be more focused on single-tasking, co-operation, and ecology, to promote health through a simpler way of living (e.g., allowing more time for meaningful interactions, play, and recreation). This approach fosters a more balanced everyday life, with a focus on "being and doing" rather than "having" (140).

In today's media-saturated environment, where most individuals are constantly exposed to messages about how to live and perform, it becomes even more critical to ensure that people of working age are equipped with the knowledge and tools necessary to support their occupational health. Moreover, this thesis supports a more integrated understanding of occupational health, one that acknowledges the inseparability of work and private life. While time can be compartmentalised, health cannot; occupational health must therefore be addressed as a holistic, everyday experience that spans all areas of life. In summary, applying an occupational science perspective, in which humans are occupational beings, can contribute to occupational health. By promoting environments, both organisational and societal, where people can engage in meaningful, balanced, and inclusive occupations. Its principles can guide policies, workplace strategies, and public health interventions that improve quality of life across populations.

Methodological reflections

General methodological considerations

Each study included in this thesis was driven by the results of the preceding study, forming a sequential research process. A range of approaches to data collection and analysis was applied, depending on the specific aims of each study. Reflecting the interdisciplinary nature of the thesis, the research team, including the author and supervisors, contributed their diverse backgrounds and areas of expertise, which is considered a methodological strength (141).

To explore risk factors for developing occupational ill health, Study I employed a quantitative design, using selected questionnaires derived from a previous project, administered before the intervention began. Study II aimed to identify factors contributing to the maintenance or recovery of occupational health. To this end, a qualitative approach was used, involving analysis of medical records written at the conclusion of the intervention. Building on these results, Study III sought to gain a deeper understanding of participants' everyday lives a few years after the intervention, with a particular focus on how they promoted occupational health, including at work. This was explored through a qualitative method using semi-structured interviews. Finally, Study IV aimed to deepen the understanding of health-promoting practices from an organisational perspective. This was achieved through focus group interviews with managers working in the same sector as the participants in Study III.

The methodological strengths and limitations of each of the four studies will be discussed, with attention to the specific methods and data collection used. A general limitation across the studies is the relatively small number of participants, which constrains the potential for broad generalisation of the results. However, each study contributes valuable insights that collectively enhance the overall understanding of how to promote occupational health in everyday life, including paid work, within the working population.

Quantitative Considerations

Statistics

In Study I, a quantitative cross-sectional design was chosen to analyse the relationships between the different predictors used before the participants embarked on a group treatment programme due to their occupational ill health. However, a cross-sectional study is a snapshot in which one can identify statistical relationships but cannot determine the direction of the relationship, i.e. causality. While a longitudinal-experimental study design would allow for causality to be investigated, cross-sectional studies are ideally used to describe features of a population, creating an understanding of determinants of health, and they allow for results that may guide further, more in-depth studies (83, 142).

The study aimed to investigate the role of gender in association with health outcomes. Because of the low proportion of male respondents, the generalisability of the results may be limited. However, the sample accurately reflects the existing ratio between men and women in the present Swedish sick leave statistics, which speaks in favour of the representativeness of the sample on a national level.

Data was collected from 218 participants. Not all respondents reported on all single items, in all instruments. However, to avoid exclusion of single participants due to incomplete responses i.e., external dropouts, all participants' data collected with the selected instruments were included in the analyses. This was done since an internal dropout rate (missing single responses) was calculated to 12.1% which still indicates a high response rate and, thus, a high level of reliability in the study (142). However, it could be beneficial to have a larger number of participants since it could have presented further factors related to health. Another limitation in the study was that some variables were dichotomized, which can make the scale less nuanced (for example, the category regarding children was dichotomized to children either living at home or not). If the study had included more participants, the categorising perhaps could have been avoided, and might have led to other results.

The questionnaires used in the study have all shown good reliability and validity. Although the psychometric properties of the separate VAS scales have been evaluated and found to be acceptable (101), the use of a more comprehensive instrument, such as the SF-36, may have provided a broader and more nuanced assessment of perceived health. However, it is equally important to consider the burden placed on participants. Administering extensive questionnaires may risk reduced concentration and response accuracy, potentially compromising data quality. Therefore, the selection of questionnaires used in the study was guided by the aim and considered suitable.

The participants answered the questionnaires before initiating an occupational therapy intervention aimed at promoting occupational balance and health in

everyday life. The specific occupational therapy intervention, the ReDO® programme (87), is not based on a specific diagnosis but can be used in general for people who want and need to make changes in their everyday lives. This can be seen as a strength and opportunity to capture many people with occupational ill health even at an early stage and help reduce medicalisation. A consequence of this strategy for inclusion is that the participants can not clearly be defined by diagnosis, and the possibility of duplicating the study with such a focus decreases. This is, however, only a problem if the diagnoses are in focus for evaluation of the study. If the focus for inclusion is the same as the target for the intervention, namely, to improve experiences of health and work ability through changes in patterns of daily occupations, the specific medical reason for challenges in everyday life is of less importance.

Qualitative Considerations

Qualitative studies seek a deeper understanding of the research area. In this thesis, three types of qualitative data were used – medical records, interviews, and focus groups – and analysed using content and thematic analysis.

Medical records

In Study II, a qualitative content analysis was used to deepen the understanding and description of participants' experiences. The data consisted of concluding notes extracted from medical records, which, while constituting second-hand data, offered a valuable, minimally burdensome source of information. It is important to acknowledge, however, that medical records often fail to fully capture the scope and complexity of interventions, particularly the nuanced interactions between patients and healthcare professionals (143). Although the concluding notes are intended to reflect the client's own words and require client confirmation before being finalised and signed by the OT, the potential for subjective interpretation or summarization by the OT cannot be overlooked.

The data were collected with the assistance of 12 occupational therapists from eight different regions in Sweden, each with varying levels of experience in documenting concluding notes. This variation, while possibly influencing transferability, also enhanced the breadth and richness of the data by including perspectives from diverse geographic and clinical settings (96). By involving multiple practitioners from different regions, the study gained insights that are likely to be relevant beyond a single local context.

The use of existing clinical documentation, rather than participant interviews, offered practical advantages. Specifically, it enabled access to data without placing additional demands on individuals already experiencing occupational ill health.

Furthermore, my prior experience with both the clinical population and the structure of concluding notes enhanced the dependability of the data collection and interpretation processes. Familiarity with the format and language used in these records helped maintain consistency in analysis, despite variability in the content, style, and length of individual notes. Interestingly, it was not always the longer notes that yielded the richest data; some of the shorter concluding notes provided remarkably insightful content.

To address credibility, an inductive, data-driven content analysis approach was applied (90, 104), with a strong emphasis on staying close to the original wording of the concluding notes. I conducted the main analysis, followed by iterative discussions with ML, and reconciliation meetings with the full author team. All authors had full access to the transcribed material, and themes were developed collaboratively until consensus was reached. This analytical process was deliberately designed to enhance both dependability and confirmability (84, 144), by reducing individual bias and ensuring that interpretations were grounded in the data, rather than influenced by preconceptions (145).

While the use of second-hand data presents inherent limitations, the methodological approach, triangulation of perspectives, and transparent analytic process all contributed to the overall trustworthiness of the study. In summary, the advantages of using medical records, such as their accessibility, and the minimal burden placed on participants, were considered to outweigh the associated limitations.

Interviews

In Study III, semi-structured interviews were conducted to explore participants' experiences in depth. The interview guide was pilot tested to ensure clarity and relevance, which contributed to the credibility of the data collection process. Although the interviews generated rich and nuanced material, a slightly larger sample size would have further enhanced credibility, by enabling additional perspectives to emerge. Nevertheless, the richness and depth of the nine interviews conducted were considered sufficient to address the research aim.

The use of digital interviews allowed participants to participate from environments of their own choosing, potentially increasing openness and comfort, and thereby contributing to more authentic and contextually grounded data. To support transferability, participants were purposively selected to represent diversity across three major work sectors, and variation in gender was also sought. Although the initial goal was to recruit 12 participants (four from each sector with a gender balance), the final sample of nine included individuals of both genders and from all three sectors, thus providing a broad basis for meaningful analysis.

Dependability was reinforced through the consistent application of the interview guide. All interviews began with the same opening question, and follow-up

questions were used systematically to encourage participants to elaborate on their experiences (104). This uniform approach helped ensure methodological consistency throughout the study.

To enhance confirmability, the data analysis was conducted with careful attention to transparency and reflexivity. Interview transcripts were reviewed and coded systematically, and analytical decisions were discussed in the research team to minimise bias and ensure that results were grounded in the participants' narratives rather than the researchers' preconceptions. Overall, the material was judged to be sufficiently robust and trustworthy to support the conclusions drawn.

Focus groups

In the fourth study, focus group discussions were conducted, supplemented by individual semi-structured interviews, to gain a more comprehensive understanding of the participants' perspectives. This methodological triangulation enhanced the credibility of the results by allowing data to be gathered in different formats and settings, thereby enriching the overall depth and scope of the material. The group dynamics of the focus group interviews enabled participants to reflect, respond, and build upon each other's input, while the individual interviews allowed for more detailed and personal elaboration. Together, these approaches contributed to a well-rounded data set.

Although the researchers' prior theoretical and clinical knowledge could not be entirely disregarded, efforts were made to manage potential bias through transparency and reflexivity. Importantly, the research team consisted of five authors from diverse scientific and empirical backgrounds, which ensured a multi-perspective approach to both the analysis and interpretation. This interdisciplinary composition supported a nuanced and balanced examination of the data, thereby strengthening confirmability.

The dependability of the study was enhanced by following a structured and transparent analytical process. Representative quotations were systematically used to support the results, providing a clear linkage between the raw data and the emergent themes. This practice of grounding interpretations in participant voices not only increased confirmability but also reinforced the study's credibility by making the analytical process transparent (146).

While the study did not aim for statistical generalisation, transferability was supported through the inclusion of participants with varied professional roles and from different organisational contexts. This variation allowed for the identification of patterns and divergences that may resonate across similar workplace settings. Overall, the combination of diverse data sources, methodological rigour, and analytical transparency contributed to the trustworthiness of the study's results.

Conclusion

This thesis explores how occupational health can be promoted within the working population from an individual, group, and organisational perspective. Promoting health in everyday life, including work, is a complex effort that involves navigating multiple, interwoven processes and roles. Central to this is the concept of perceived occupational balance, which this thesis identifies as a key component of occupational health. The results in this thesis indicate the importance of understanding the concept of occupational health in the broader context of everyday life, as a whole.

In this thesis, the concept of "flex-ability" was presented as a term for the ability to adapt occupations in response to shifting personal, social, and organisational contexts. Adopting a flex-ability approach may enable individuals to maintain occupational balance, help groups to support diverse needs, and allow organisations to respond to human variability without sacrificing function or well-being.

In addition, this thesis highlights the importance of increasing awareness and knowledge in society about occupational values, particularly the significance of occupations that carry socio-symbolic value. Although social belonging, community, and relationships can be hard to navigate, they have an important place in health promotion.

Finally, this thesis concludes that occupational culture, including norms, expectations, and values, not only within the workplace but also in society more broadly, shapes everyday choices and lifestyles. There is therefore a need for improved health literacy around how occupational patterns and occupational values construct our way of life, and how both occupational balance and occupational culture influence the lived experience of occupational health.

Study specific conclusions

- What we do, how we do it, and why we do it have a positive, statistically significant effect on how we perceive our health. Perceived occupational imbalance in everyday life and few occupations imprinted with socio-symbolic values seem to be a main risk factor for developing occupational ill health, rather than the traditional factors of gender, education, and work hours. (Study I)
- Returning to work means a process that is highly relational, impossible to divide into private and work, and presupposes balance in everyday life in multiple dimensions to promote health. (Study II)
- To return and stay in work after sick leave due to occupational ill health calls for "flex-ability" among both individuals and organisations. The result highlights the importance of health-promotive organisations where the individual factor is considered, both in the rehabilitation process and in everyday life. Thus, the results call for a broader view of health-promotive work in the society where work is included in everyday life, instead of being divided into work and outside work. (Study III)
- Promoting employee health requires an integrative approach, where organisational culture, work conditions, leadership, and everyday life are interconnected. Health promotion is not solely an individual responsibility but a shared, structural, and cultural process that demands flexibility, managerial engagement, and a shift toward health as a core value in sustainable work life. (Study IV)

Implications

Practical implications

The results underscore several important implications for occupational health practice and workplace development.

- Integrating the concept of “flex-ability” into workplace structures. There is a need for organisations and employers to recognise and integrate the concept of flex-ability, the capacity to adapt and manage everyday occupations, in the design of workplace policies. This may include implementing flexible work schedules, hybrid work arrangements, or individualised task distribution, all aimed at supporting employees’ occupational well-being and responsiveness to changing life circumstances.
- Promotion of occupational health beyond sick leave - A shift in focus is warranted from reactive interventions (such as return-to-work programs) toward more proactive strategies that sustain occupational balance and well-being. By addressing occupational strain before it escalates into occupational ill health, early identification and preventive support can be enhanced. Collaboration between occupational therapists, human resource professionals, and managers seems essential to detect early signs of imbalance and intervene accordingly.
- Implementing person-centred occupational interventions- Occupational health interventions should be grounded in the individual's lived experience and specific needs. Empowering individuals to gain control over their everyday lives is central to promoting sustainable health. Tools such as time-use diaries, occupational analysis, and structured dialogue (e.g., coaching or reflective conversations) may assist individuals in navigating conflicting demands across life domains, including work, home, leisure, and self-care.
- Facilitating environmental and organisational adaptations - Creating supportive environments that mitigate occupational stressors and facilitate meaningful engagement in occupations through occupational culture. This involves not only optimising physical and social conditions in the workplace but also addressing broader structures such as workload distribution, caregiving support, and the cultivation of organisational cultures that value recovery, participation, and occupational balance.

On an individual level, while personal circumstances (e.g., family stress or health issues) can influence health, the primary focus should be on creating conditions that allow employees to manage their occupational health more effectively. The thesis emphasises that effective occupational interventions to promote health must address not just the work environment, but the individual's whole life context.

Research implications

The present results highlight several areas for further investigation to deepen the understanding and application of occupational health concepts:

- Explore the concept of flex-ability - There is a need for continued research to further define, refine, and validate flex-ability as a theoretical and measurable construct. Investigating its predictive value in relation to occupational health outcomes can contribute to evidence-based frameworks for preventive and promotive interventions.
- Longitudinal research on everyday life interventions - Future studies should explore the long-term effects of person-centred interventions aimed at enhancing control and balance in everyday life. Such research can clarify the preventive potential of these interventions in reducing the risk of occupational ill health and promote occupational health over time.
- Inclusion of diverse populations and contexts - Given that occupational challenges may manifest differently across demographic and contextual factors, it is essential to examine how risk factors and intervention efficacy vary across age groups, occupational sectors, and socio-economic backgrounds. This would support more tailored and equitable health promotion strategies.
- Integrating intersectional perspectives- Research should consider how intersections of gender, social roles, and cultural expectations influence occupational engagement and health risks, particularly in relation to managing competing demands and achieving occupational balance in everyday life.
- Investigating organisational-level interventions - There is a need to evaluate the outcomes of structural and policy-level strategies, such as flexible work arrangements, employee support programs, and workplace health promotion initiatives. Understanding their impact on occupational well-being, retention, and productivity can guide more sustainable organisational practices.

Svensk sammanfattning

Stressrelaterad ohälsa utgör en växande folkhälsoutmaning, och antalet sjukskrivningar till följd av stress ökar kontinuerligt i Sverige. Denna utveckling har långtgående konsekvenser, inte bara för individens hälsa och livskvalitet, utan även för arbetsplatsers funktionalitet och samhällets socioekonomiska hållbarhet. Enligt Försäkringskassan kännetecknas denna grupp ofta av högutbildade kvinnor i 30-årsåldern som har barn, vilket lyfts fram som en riskprofil för stressrelaterad sjukskrivning. Samtidigt väcker detta frågor om huruvida dessa faktorer är de verkliga orsakerna till ohälsa, eller snarare indikatorer på bredare strukturella och kulturella mönster.

Vi lever i dag i ett digitaliserat och prestationsinriktat samhälle där effektivitet, produktivitet och ständig tillgänglighet ofta premieras både i arbetslivet såväl som i privatlivet. Normer som uppmuntrar multitasking, prestationsinriktad självutveckling och konstant uppkoppling formar våra vardagsmönster och våra uppfattningar om vad som utgör ett ”hälsosamt liv”. Samtidigt översköljs individer med hälsorelaterade råd och rekommendationer, vars faktiska nytta eller anpassning till individens livskontext sällan problematiseras. I denna komplexa livsmiljö blir det en utmaning att skapa balans mellan arbete, familjeliv, fritid och återhämtning – särskilt när gränserna mellan dessa områden suddas ut.

Agenda 2030:s tredje delmål, som handlar om att säkerställa ett hälsosamt liv och främja välbefinnande i alla åldrar, tillsammans med omställningen till en god och nära vård i Sverige, understryker vikten av att arbeta hälsofrämjande på både samhälls- och individnivå. Trots detta kvarstår viktiga frågor: Hur kan vi konkret främja hälsa i ett samhälle som i grunden formar villkor som riskerar att undergräva den? Och hur kan insatser och strategier bättre utgå från människors faktiska livsvillkor och vardagliga verklighet?

Med de kommande utmaningarna kopplade till en åldrande befolkning är det av stor vikt att personer i arbetsför ålder upplever god hälsa, kan arbeta och bidra till samhället. Aktivitetsohälsa är ett begrepp inom arbetsterapi som beskriver ohälsa utifrån individens vardagliga aktiviteter och göranden. Ur detta perspektiv inkluderas stress och sjuklighet som uppstår till följd av utmaningar, obalanser eller andra svårigheter i vardagen – inklusive lönearbete – som en form av ohälsa.

För att kunna möta dessa utmaningar är det viktigt att öka kunskapen om de bakomliggande orsakerna till aktivitetsohälsa. Ännu viktigare är att utveckla en djupare förståelse för hur aktivitetshälsa kan främjas.

Det övergripande syftet med denna avhandling var att bredda kunskapen om vad som krävs för att främja aktivitetshälsa i vardagen, inklusive lönearbete, hos den yrkesverksamma befolkningen.

Studie I syftade till att analysera sambanden mellan sociodemografiska faktorer, aktivitetsvärden, aktivitetsbalans och upplevd hälsa hos personer som upplevt aktivitetsohälsa, för att identifiera riskfaktorer. Resultaten visade att upplevelse av låg aktivitetsbalans, följt av få aktiviteter med socio-symboliska aktivitetsvärden, var starkt kopplade till upplevd aktivitetsohälsa.

Studie II syftade till att beskriva vad som krävs för att uppleva eller återfå en balanserad vardag, inklusive arbete, enligt personer som upplever eller har upplevt aktivitetsohälsa. Resultaten visade på en starkt relationell process där arbete och privatliv är svåra att särskilja, vilket förutsätter balans i flera dimensioner av vardagen. Deltagarna beskrev behov av att ta kontroll över hela sin vardag genom att strukturera och prioritera sociala relationer, sätta gränser och finna samt prioritera meningsfullhet i sina aktiviteter.

Studie III syftade till att beskriva individers upplevelser av att upprätthålla eller återfå aktivitetshälsa i vardagen, två till fem år efter deltagande i Studie II. Analysen resulterade i ett nytt begrepp; ”flex-ability”. Begreppet flex-ability handlar om en öppenhet för flexibilitet. Det innefattar både individens egen förmåga att vara flexibel och anpassningsbar, men också att bemötas med flexibilitet och förståelse från omgivningen – både i arbetslivet och i privatlivet. Resultatet visade att flex-ability var centralt för att uppnå och bibehålla balans och hälsa i vardagen.

Studie IV syftade till att beskriva chefers erfarenheter av att arbeta hälsofrämjande, och i vilken utsträckning de tog hänsyn till sina anställdas vardag som helhet. Resultaten visade att chefer inte enbart är utförare av organisationers hälsopolicys, utan att de även tolkar, anpassar och omsätter dem utifrån sina värderingar, sin kunskap och de kontextuella förutsättningar som finns. Centrala delar i detta handlade om att justera organisationskulturen, skapa en stöttande arbetsmiljö, erbjuda hälsoinformation samt skapa broar mellan arbetsliv och privatliv. Resultatet visade också att hälsofrämjande insatser behöver vara ett samarbete mellan aktörer i samhället, inte endast mellan individer och organisationer.

Sammanfattningsvis belyser avhandlingens resultat vikten av att förstå hur vardagliga aktiviteter och dess aktivitetsvärden påverkar varandra, skapar en livsstil som i sin tur påverkar människors upplevelse av aktivitetshälsa. För att på ett hållbart sätt främja aktivitetshälsa krävs insatser på individ-, grupp- och organisationsnivå, med ett helhetsfokus på vardagen, där komponenter som flex-ability, aktivitetsbalans och meningsfullhet i vardagen är centrala. Resultatet i denna avhandling föreslår dessutom en mer integrerad förståelse av aktivitetshälsa, som erkänner att arbetsliv och privatliv är sammanlänkade. Aktivitetshälsa bör

därför beaktas som en holistisk, kontinuerlig upplevelse som spänner över livets alla dimensioner.

Avslutningsvis dras slutsatsen att en bredare användning utav aktivitetsvetenskapliga perspektiv inom organisation och samhälle kan bidra till att främja aktivitetshälsa hos den arbetsföra befolkningen. Detta genom att skapa organisatoriska och samhälleliga förutsättningar för människor att få kunskap om vikten av aktivitetsmönster, aktivitetsvärden och aktivitetsbalans. Detta perspektiv kan även stötta i policyutveckling, arbetsplatsstrategier och folkhälsoinsatser med syftet att förbättra den upplevda hälsan och livskvaliteten i befolkningen.

Nyckelord: Aktivitetsbalans, arbete, hälsa, hälsopromotion, vardagsliv

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