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Rehabilitation and everyday life in people with stress-related ill health

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ABSTRACT

The overall aim was to explore and describe knowledge of the perceived occupational repertoire in people with stress-related ill health and their experiences from the rehabilitation process, with a specific focus on rehabilitation in a therapeutic garden and how the rehabilitation experiences are connecting with everyday life.

Study I was a cross-sectional study that aimed to describe and compare how occupational gaps were reported in everyday occupations in a rehabilitation group of people with musculoskeletal pain or stress-related ill health and in a reference group from the Swedish population. **Study II** used a grounded theory approach to describe how former clients with stress-related disorders and rehabilitation team members experience the rehabilitation process and to describe how experiences from the rehabilitation have been integrated into the former clients' everyday lives. In **Studies III and IV**, a qualitative longitudinal design was used and analyses were done using a constant comparative approach (Study III) and the empirical phenomenological psychological method (Study IV). The aim in **Study III** was to explore and describe how women with stress-related ill health, who are on sick leave, experience the rehabilitation process in a therapeutic garden and how these experiences connect to their everyday life. **Study IV** focused on describing and understanding how connecting rehabilitation experiences and everyday life was characterised in the lived experiences during rehabilitation in women with stress-related ill health.

The findings in **Study I** showed that occupational gaps were reported more often in the rehabilitation group than in the reference group. Instrumental ADL were more often reported as desired by the participants who had been on sick leave for more than a year compared to those who had been on sick leave for less than a year. Findings in **Studies II-III** highlighted the value of recurrently practicing creative occupations in a safe place during rehabilitation. This enabled an understanding and re-evaluation of the occupations based on the participants own practical experiences. Furthermore, it inspired the participants to start to prioritise enjoyable occupations in everyday life and to add them to their occupational repertoire thereby contributing to an occupational balance. In **Studies II-IV** it was found that the rehabilitation programme in the therapeutic garden facilitated recovery and occupational balance in the participants' private arena in everyday life. However, in **Study IV** difficulties in connecting rehabilitation experiences and the working situation were evident. Connecting rehabilitation experiences and the working situations created experiences of a sense of frustration and being left alone.

In conclusion, the findings showed that in order to promote occupational balance and return to work in people with stress-related ill health who have been participating in a rehabilitation programme, it is important to focus on creating a safe place for rehabilitation and on the participants' own understanding of occupations. Important clinical implications of this thesis concern the need for rehabilitation programmes to focus on the private as well as the work arenas in everyday life to achieve occupational balance and return to work. Furthermore, rehabilitation needs to include creative, relaxing and work-related activities, support in a constructive dialogue between the participant and the workplace, and continued support of the clients in follow-ups targeting the workplace after the intensive rehabilitation programme has ended.

LIST OF PUBLICATIONS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

- I Eriksson, T., Jonsson, H., Tham, K. & Eriksson, G. (2011). A comparison of perceived occupational gaps between people with stress-related ill health or musculoskeletal pain and a reference group. *Scandinavian Journal of Occupational Therapy*. Epub ahead of print.
- II Eriksson, T., Karlström, E., Jonsson, H. & Tham, K. (2010). An exploratory study of the rehabilitation process of people with stress-related disorders. *Scandinavian Journal of Occupational Therapy*, 17, 29-39.
- III Eriksson, T., Westerberg, Y. & Jonsson, H. (2011). Experiences of women with stress-related ill health in a therapeutic gardening program. *Canadian Journal of Occupational Therapy*, 78, 274-282.
- IV Eriksson, T., Jonsson, H., Johansson, U. & Tham, K. Connecting rehabilitation and everyday life – the lived experiences among women with stress-related ill health. In manuscript.

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LIST OF ABBREVIATIONS

ADL	Activities of daily living
CBT	Cognitive behavioural therapy
EPP	Empirical Phenomenological Psychological
ICD-10	International Classification of Diseases -10
MOHO	The Model of Human Occupation
OGQ	Occupational Gaps Questionnaire
SMBQ	Shirom Melamed Burnout Questionnaire

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BACKGROUND

Stress-related ill health is of great concern in our society. Conditions relating to stress-related ill health, such as burnout and acute reaction to stress, are among the most common causes of sick leave in both Sweden and Europe (Socialstyrelsen, 2008). In 2009, mental disorders (in which stress-related ill health is included) and musculoskeletal disorders accounted for the largest proportion (68%) of sickness insurance costs in Sweden (Försäkringskassan, 2011). This implies negative consequences for the society in terms of high public costs (Sveriges Kommuner och Landsting, 2008). Furthermore, this also brings about negative consequences for the people on sick leave, for example in terms of restricted participation in social, productive and enjoyable activities (Floderus, Goransson, Alexanderson, & Aronsson, 2005; Johansson & Isaksson, 2011; Sonnentag & Zijlstra, 2006), and the need for rehabilitation is explicit. Research within the field of rehabilitation of people with stress-related ill health has mainly focused on interventions relating to work, the main goal being to increase work capacity (van der Klink, Blonk, Schene, & van Dijk, 2001; Van Dierendonck, Schaufeli, & Buunk, 1998) even though the whole occupational repertoire is known to be affected during sick leave (Floderus, et al., 2005; Johansson & Isaksson, 2011). There is limited knowledge regarding how people with stress-related ill health experience rehabilitation and how these experiences relate to their everyday life. Even though a great deal of research today focuses mainly on work, it is important from an occupational therapy perspective to consider not merely the client's work but their everyday occupations in general. This thesis will focus on people with stress-related ill health, their occupational repertoires, their experiences of rehabilitation in a therapeutic garden, and on how these experiences connect with their everyday lives. My interest in the occupational aspects will most certainly be apparent in this thesis even though other aspects, such as psychological ones, will be touched upon briefly. By taking this point of departure it is important to clarify that this thesis does not provide a comprehensive description of all aspects that are affected by stress-related ill health and addressed in rehabilitation. Nevertheless, this thesis might contribute empirical knowledge of the occupational aspects in rehabilitation which can be applied in clinical practice concerning rehabilitation for people with stress-related ill health.

INTRODUCTION

The main focus in this thesis is on people's perceived occupational repertoire and their rehabilitation experiences in relation to everyday life when on sick leave due to stress-related ill health or musculoskeletal pain. In order to facilitate an understanding of the focus and rationale of this thesis, the introduction aims at providing an overview of the population in focus, i.e. people with stress-related ill health or musculoskeletal pain, the consequences in everyday life that arise due to these conditions, and a brief overview of the rehabilitation interventions that are offered to these people. Furthermore, the theoretical perspectives used in this thesis will be presented by an explication of the occupational perspective, the concept of occupational balance, and the phenomenological perspective.

Stress-related ill health and musculoskeletal pain

People that were involved in rehabilitation due to stress-related ill health or musculoskeletal pain were included in the studies and formed the basis for this thesis. The decision to include this heterogeneous group regarding diagnoses stems from the context of rehabilitation in clinical practice. Stress-related ill health and musculoskeletal pain are the two conditions that generate most sick leave in the Swedish society (Socialstyrelsen, 2008). These conditions are often experienced together (Honkonen et al., 2006) and the rehabilitation programmes share many similarities due to the congruent character of the symptoms (Gustafsson, Ekholm, & Öhman, 2004; Heiden et al., 2007). This thesis focuses on perceived rehabilitation experiences connected to everyday life rather than the medical perspective of these conditions. The following section provides a brief introduction to stress-related ill health and musculoskeletal pain and concludes with a short paragraph on how these conditions relate to each other from a clinical rehabilitation perspective.

Stress-related ill health

The term stress-related ill health is used as a generic term and includes various conditions related to stress, e.g. burnout, depressive episodes, and acute reactions to stress. In this thesis, the Conservation of Resources Theory (Hobfoll, 1989) has been adopted to understand the concept of stress. Stress is predicted to occur a) when individuals' resources are threatened with loss, b) when individuals' resources are actually lost, or c) where individuals' fail to gain sufficient resources following

significant resource investment (Hobfoll, 2001). Resources are defined as objects, personal characteristics, conditions, or energy resources that are valued by the individual, e.g. adequate clothing, motivation to get things done, good marriage or adequate financial credit (Hobfoll, 1989; 2001). In this theory, resources are products of any given culture and not individually determined.

Internationally, there has been a lot of research focusing on the concept of burnout but there is still a lack of consensus concerning which dimensions that should be included in the concept today (Cox, Tisserand, & Taris, 2005). In Sweden, the concept of burnout has been replaced by the term “exhaustion-syndrome” (In Swedish: utmattningssyndrom) which is the term officially recommended by the Swedish National Board of Health and Welfare (2003). The core symptoms of “exhaustion syndrome” are vital exhaustion and reduced endurance as a result of identifiable stress factors for at least six months. Stressors can be identified both inside and outside of work-related situations (Socialstyrelsen, 2003). Even though the definition of “exhaustion syndrome” has been present in the Swedish version of the ICD-10 with clear diagnostic criteria (Socialstyrelsen, 2003) it is still difficult to differentiate this condition from other stress-related conditions (Lytsy & Westin, 2008; Åsberg et al., 2010). In this thesis, the decision to include people with various types of stress-related ill health was made for this reason and also due to the clinical rehabilitation perspective taken.

The definition of “exhaustion-syndrome” bears some similarity to the definition of burnout presented by Shirom and Melamed (Melamed, Kushnir, & Shirom, 1992; Shirom, 2003). They view burnout as an affective state characterised by one’s feelings of being depleted of one’s physical, emotional, and cognitive energies (Shirom, 2003), and this greatly emphasises the dimension of exhaustion in the condition. Furthermore, this definition (Shirom, 2003) is based on the Conservation of Resources Theory (Hobfoll, 1989). For these reasons the Shirom Melamed Burnout Questionnaire (SMBQ) was chosen when measuring stress in the studies included in this thesis.

Musculoskeletal pain

In this thesis, musculoskeletal pain refers to conditions related to e.g. dorsopathies not caused by a current injury, or to fibromyalgia. There is a range of established definitions of musculoskeletal chronic pain within the contemporary literature. Some

definitions focus on the condition from a biomedical point of view emphasising the location and the duration of the pain (Carnes et al., 2007). According to the ISAP (the International Association for the Study of Pain), pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (Merskey & Bogduk, 1994). This definition emphasises the subjective experience of pain. Previous research has found that musculoskeletal pain is commonly experienced in multiple body sites (Carnes, et al., 2007) and it is known that people that are on sick leave due to musculoskeletal pain most often need some kind of rehabilitation before returning to work. In a study of 332 female patients, it was found that 80% of them were recommended medical and/or vocational rehabilitation (Brodda Jansen, Linder, Schüldt Ekholm, & Ekholm, 2011).

Stress-related ill health and musculoskeletal pain as associated conditions

The association between stress-related ill health (predominantly burnout) and musculoskeletal pain has been studied in previous research (e.g. Armon, Melamed, Shirom, & Shapira, 2010; Grossi, Soares, Ängeslevä, & Perski, 1999; Honkonen et al., 2006; Langballe, Innstrand, Hagtvet, Falkum, & Aasland, 2009; Miranda, Viikari-Juntura, Heistaro, Heliövaara, & Riihimäki, 2005). In a longitudinal study, Armon et al (2010) found that changes over time towards higher levels of stress, measured by the SMBQ, were associated with an increased risk of musculoskeletal pain. The reversed causation could however not be found. It has also been identified that burnout and musculoskeletal pain frequently coexist (Arman, Hammarqvist, & Rehnsfeldt, 2011; Grossi, et al., 1999).

There are also similarities in terms of clinical symptoms even in cases where stress-related ill health and musculoskeletal pain do not coexist. There is a range of clinical symptoms of stress, such as depression, aggressiveness, memory or attention impairments, fatigue and/or sleep disturbances (Währborg, 2002) which are often reported in people with musculoskeletal pain as well (Brodda Jansen, et al., 2011; Lavigne, Nashed, Manzini, & Carra, 2011). Still, despite the fact that a number of symptoms have been found to be similar, it is important to consider that the link between these two conditions is complex and needs to be further explored in research (McFarlane, 2007). However, from a clinical rehabilitation point of view the similarities in symptoms might be of importance since, irrespective of what has caused

the experiencing of these symptoms, they might lead to particular consequences in everyday life that need to be considered in rehabilitation.

Consequences in everyday life

As previously described, people with stress-related ill health often experience a range of clinical symptoms that might affect everyday life, e.g. cognitive impairment leading to not remembering how to perform familiar occupations (Ekstedt & Fagerberg, 2005; Jingrot & Rosberg, 2008) or fatigue leading to being too tired to maintain self-care (Ekstedt & Fagerberg, 2005). Empirical studies have paid considerable attention to the process leading to stress-related ill health (Ekstedt & Fagerberg, 2005; Gustafsson, Norberg, & Strandberg, 2008; Jingrot & Rosberg, 2008). Less attention has been given to research regarding how being on sick leave due to stress-related ill health influences everyday life (Johansson, Eklund, & Erlandsson, 2011). Below, previous research on the possible consequences for everyday life due to stress-related ill health will be presented.

Qualitative studies focusing on experiences of the process leading to stress-related ill health, such as burnout and exhaustion, have found that this process is characterised by a struggle to handle responsibilities and demands from oneself and others without having sufficient resources to managing everyday life (Arman, et al., 2011; Eriksson, Starrin, & Janson, 2008; Gustafsson, et al., 2008). This struggling process has also been found in people with pain (Råheim & Håland, 2006; Satink, Winding, & Jonsson, 2004). Previous research has shown that people with stress-related ill health could not recognise their former abilities at, for example, their work places and this threatened their self-image. Several actions might be undertaken to try to maintain one's former abilities, for example putting all effort into work-related tasks, or excluding social and leisure activities from the occupational repertoire (Ekstedt & Fagerberg, 2005; Eriksson, et al., 2008; Jingrot & Rosberg, 2008; Sandmark & Renstig, 2010). Furthermore, limiting participation in social and enjoyable activities and instead prioritising activities directed toward others has also been found in people with pain (Fisher et al., 2007; Satink, et al., 2004; Skjutar & Müllersdorf, 2010). Other consequences in everyday life relate to withdrawing from occupations regarding self-care, instrumental activities and childcare due to lack of energy (Ekstedt & Fagerberg, 2005; Jingrot & Rosberg, 2008; Verdonk, de Rijk, Klinge, & de Vries, 2008). Experiences of not being able to “be there” for others might confer feelings of shame,

guilt and disappointment (Gustafsson, et al., 2008; Jingrot & Rosberg, 2008; Råheim & Håland, 2006; Skjutar & Müllersdorf, 2010). When this struggle becomes overwhelming a collapse emerges and at this point, it is common to become totally inactive, to withdraw from others and to not be able to see any meaning in life (Arman, et al., 2011; Ekstedt & Fagerberg, 2005).

The empirical research focusing on the consequences in everyday life for people with stress-related ill health who have collapsed and are currently on sick leave is sparse. A few studies have focused on the time just after the collapse leading to a period of sick leave. One of these studies has found that the collapse might be experienced as a release, and a time of terminating many activities in favour of passive relaxation might follow (Arman, et al., 2011). However, it is also known that being on sick leave for reasons other than stress-related ill health changes people's roles, daily habits, and routines (Kielhofner, 2008), has negative influence on participation in occupations and a detrimental effect on social relationships (Johansson & Isaksson, 2011). In people with stress-related ill health it has been shown that social isolation might increase (Verdonk, et al., 2008) and experiences of not being understood or cared for by others might arise (Arman, et al., 2011; Johansson, et al., 2011). Furthermore, Johansson, Eklund & Erlandsson (2011) found that pain and lack of energy to do what one wished to do negatively influenced everyday life. When on sick leave, it is no longer time that is considered to be the problem for practicing enjoyable occupations, instead it is a lack of energy and difficulties in planning and structuring everyday life that might be problematic. It has also been found that leisure activities have been negatively affected when on long-term sick leave, by various conditions not specifically related to stress-related ill health (Floderus, et al., 2005). To our knowledge there is limited knowledge of how people experience their everyday life when on sick leave and when they are just about to enter rehabilitation.

Rehabilitation of people with stress-related ill health

The National Board of Health and Welfare defines rehabilitation as interventions aimed at regaining or maintaining the best possible functional capacity as well as creating good conditions for an independent life and active participation in the society based on the person's individual needs (Socialstyrelsen, 2007). Rehabilitation is a generic term that is used in various ways and can be targeting towards medical, occupational, vocational or social rehabilitation interventions (Vahlne Westerhäll, Bergroth, &

Ekholm, 2009). This research project was carried out in a rehabilitation clinic in the middle of Sweden, focusing on vocational multimodal rehabilitation in a therapeutic garden. The aspects of rehabilitation in the Swedish context, vocational rehabilitation, and rehabilitation in a therapeutic garden will be presented in order to provide an introduction to the research context in this thesis.

Rehabilitation in Sweden

Stress-related ill health and musculoskeletal pain have become the most prevalent causes of sick leave over the last ten years. In 2009, 27% of all long-term sick leave (60 days or longer) was attributed to mental disorders such as depression, stress-related conditions and anxiety, and 26% was attributed to musculoskeletal disorders (Försäkringskassan, 2010). These conditions account for the largest proportion of costs in sickness insurance in Sweden (Försäkringskassan, 2011). To cope with this issue, representatives from the Ministry of Health and Social Affairs and the Swedish Association of Local Authorities and Regions signed an agreement in 2008 constituting a rehabilitation guarantee for people with stress-related ill health or long-term pain in neck, shoulder or back. The aim of this guarantee was to prevent and/or confine the period of sick leave, i.e. to increase return to work, by offering effective rehabilitation interventions to those who are in the early phases of ill health. Multimodal rehabilitation (multidisciplinary rehabilitation) and cognitive behavioural therapy (CBT) are the interventions recommended (Socialdepartementet, 2011). Multimodal rehabilitation refers to a rehabilitation process that includes personnel from various professions working in teams with a number of structured and synchronised interventions over a longer period of time (Gerdle & Gullacksen, 2006). Below follows a short introduction to the characteristics of cognitive behavioural therapy and the prevailing degree of evidence for such interventions will be presented.

Cognitive behavioural therapy is a generic term for methods including cognitive interventions and interventions targeting behavioural changes (Socialdepartementet, 2011). CBT is commonly used in the treatment of various psychological and psychiatric disorders (Kåver, 2006). This form of intervention, in terms of stress management intervention, is often applied when treating people with high degrees of stress who thereby risk a period of sick leave and, in these samples, it has turned out to be effective (De Vente, Kamphuis, Emmelkamp, & Blonk, 2008; Gardner, Rose, Mason, Tyler, & Cushway, 2005; van der Klink, et al., 2001). However, no differences

in return to work and reduced sick leave have been found when comparing cognitive behavioural treatment with other interventions for people with stress-related ill health (De Vente, et al., 2008; Grossi & Santell, 2009; Heiden, et al., 2007; Stenlund et al., 2009). The recommendation for the use of CBT in the Swedish national rehabilitation guarantee refers to the existent evidence for such treatment in people with long-term pain in neck, shoulder or back (Socialdepartementet, 2011). Still, there is limited evidence for effective interventions targeting return to work in people with stress-related ill health.

Vocational rehabilitation

Vocational rehabilitation refers to rehabilitation interventions that aim at facilitating return to work. This rehabilitation is a complex process that often involves various actors and might comprise medical, social as well as vocational contributions (Vahlne Westerhäll, et al., 2009) leading to great variation in the designs of the interventions. For example, vocational rehabilitation might have a cognitive approach (Blonk, Brenninkmeijer, Lagerveld, & Houtman, 2006; De Vente, et al., 2008) or be integrated into a multimodal rehabilitation programme (Netterström & Bech, 2010; Wallstedt-Paulsson, Erlandsson, & Eklund, 2007). The process of return to work has been found to be complex and multifaceted (Blank, Peters, Pickvance, Wilford, & MacDonald, 2008). In previous empirical research, barriers and facilitators for a positive return to work have been found both in environmental and individual factors (Hansen, Edlund, & Bränholm, 2005; Haugli, Maeland, & Magnussen, 2011; Hillborg, Svensson, & Danermark, 2010; Noordik, Nieuwenhuijsen, Varekamp, van der Klink, & van Dijk, 2011) and these have all been found to interact and depend on each other in the return to work process (Holmgren & Dahlin Ivanoff, 2004). A successful return to work is crucial in the rehabilitation process and failure in this phase of rehabilitation might lead to long term consequences, such as disability pension (Perski, 2006).

To achieve a positive return to work, the importance of cooperating with persons from workplaces as well as other stakeholders involved in the return to work process during rehabilitation has been emphasised in previous research (Blonk, et al., 2006; Jakobsson, Bergroth, Schüldt, & Ekholm, 2005; Karlson et al., 2010; Verdonk, et al., 2008). Furthermore, focusing on facilitators and barriers in the actual life situation has been found to be important when producing a systematic plan for the process of return to work (Blank, et al., 2008; Lander, Friche, Tornemand, Hviid Andersen, & Kirkeskov,

2009; Perski, 2006). In addition, Holmgren and Dahlin-Ivanoff (2004) have stressed that mastering everyday life as a whole and being able to participate in self-rewarding, recreating and enjoyable activities is important for a successful return to work.

Rehabilitation in a therapeutic garden

Vocational rehabilitation in a therapeutic garden is the predominant context of research in this thesis. Ulrich (1999) defines a healing garden as a garden with real nature content such as green vegetation, flowers and water placed in either outdoor or indoor spaces. This environment promotes restoration from stress and has other positive influences on the people visiting the garden. To put it simply, a healing garden should have therapeutic or beneficial effects on the vast majority of its users. In this thesis, the concept of a therapeutic garden should be seen as interchangeable with the concept of a healing garden as defined by Ulrich (1999).

There are several nature-based interventions performed in health care. Typically, they involve features of being in, or doing activities in natural surroundings, such as gardens or forests (Grahn & Ottosson, 2010; Nordh, Grahn, & Währborg, 2009; Söderback, Söderström, & Schäländer, 2004; Thorsen Gonzalez, Hartig, Grindal Patil, Martinsen, & Kirkevold, 2010). In a recently performed systematic review it has been found that nature-based interventions can have positive effects in terms of reduced psychological, social, physical, and intellectual symptoms in diverse patient categories (Annerstedt & Währborg, 2011). Both the environment and the doing of activities have been found to reduce stress. Nevertheless, there is limited research on rehabilitation focusing on these features for people with stress-related ill health.

In theoretical literature it has been stated that a garden might reduce stress as it enables people to experience a sense of control and access to privacy and nature, social support, physical movement, and exercise. A prerequisite for enabling these feelings is that the garden must convey a sense of security (Ulrich, 1999). Empirically, it has been found that people with high levels of stress prefer to be in an environment that is safe, undisturbed, calm and silent and manifested in nature on its own terms (Grahn & Stigsdotter, 2010). Research on rehabilitation in forest environments has found positive effects on mental state (Nordh, et al., 2009; Sonntag-Öström et al., 2011) and that the place gave the participants opportunities to be by themselves, to have a sense of

freedom, for memories from their childhood and pleasant memories of fun occupations (Sonntag-Öström, et al., 2011).

Horticulture therapy refers to interventions that include different gardening activities (Thorsen Gonzalez, et al., 2010) and it is used in rehabilitation as well as in day-care settings for people with various diagnoses and disabilities (e.g. Gigliotti & Jarrot, 2005; Millet, 2008; Perrins-Margalis, Rugletic, Shepis, Stepanski, & Walsh, 2000; Wichrowski, Whiteson, Haas, Mola, & Rey, 2005). In research focusing on people with stress-related ill health it has been found that horticulture therapy may reduce depression severity in people with clinical depression (Thorsen Gonzalez, Hartig, Grindal Patil, Martinsen, & Kirkevold, 2009). Activities used in rehabilitation in a therapeutic garden are not always linked to horticulture; other activities that might include materials provided from the garden have also been described (Adevi & Lieberg, 2011; Grahn & Ottosson, 2010). Engaging in creative activities might be seen as a process-oriented experience in which creativity is not directed towards a specific product, but towards the enjoyment of doing (Blanche, 2007). In previous empirical research within occupational science, practicing creative activities has been shown to promote different positive experiences, e.g. an increased sense of being competent and feelings of enjoyment (Griffith, 2007; Reynolds, 2000; Reynolds, Vivat, & Prior, 2008). Furthermore, a literature review on the use of creative art occupations found that such occupations enhanced perceived control, built up a sense of self and expression, transformed the illness experience, provided a sense of purpose and built up social support in people with various diagnoses, e.g. mental illnesses and cancer (Peruzza & Kinsella, 2010). This emphasises the potential of activities in rehabilitation to facilitate a change towards recovery and occupational balance in everyday life.

The occupational perspective

This thesis builds upon an occupational perspective which is the core of occupational therapy and occupational science. Occupation has been defined in various ways internally within the field of occupational therapy and externally in other fields of research. For this reason it is important to clarify how the occupational perspective has been applied in this thesis when trying to understand the individually perceived experiences of rehabilitation and everyday life in people with stress-related ill health. In this thesis, occupation is defined in a broader sense than as only referring to work by applying the definition provided by Townsend and Polatajko (2007). They define

occupation as “groups of activities or tasks of everyday life, named, organised, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity)” (Townsend & Polatajko, 2007, p. 17). The characteristic of an occupation as being subjectively valued and meaningful to an individual, which is considered in this definition, is commonly agreed upon in literature within the field of occupational therapy and occupational science (Christiansen & Townsend, 2004; Hammel, 2004; Persson, Erlandsson, Eklund, & Iwarsson, 2001; Pierce, 2001; Wilcock, 1998). In this particular definition, as well as in others, occupations have been divided into various types, for example, self-care, leisure and productivity or work (Townsend & Polatajko, 2007; Kielhofner, 2008). Such categorisation has been critiqued for being too static and not considering the characteristics of occupations that are subjectively experienced (Hammel, 2009; Jonsson, 2008). In contemporary literature, an experience-based categorisation of occupation focusing on occupations as they are experienced by the subject has been suggested (Hammel, 2009; Jonsson, 2008). Hammel (2009) categorises occupations as providing experiences of restoration, achieving a sense of connectedness, and fulfilling duties, responsibilities, and interests rather than just dividing them into various types. The value of an experience-based categorisation of occupation is in accordance with a number of researchers’ corresponding views regarding occupational balance and well-being (Håkansson, Dahlin-Ivanoff, & Sonn, 2006; Håkansson, Lissner, Björkelund, & Sonn, 2009; Piskur, Kinebanian, & Josephsson, 2002; Stamm et al., 2009).

For this research project, it has been fruitful to consider both the type-based categorisation of occupation (Townsend & Polatajko, 2007) and the experience-based categorisation (Hammel, 2009; Jonsson, 2008). For example, the type-based categorisation was useful to increase the understanding of the participants’ perceived occupational repertoire in Study I. Occupational repertoire is defined as the range of all the everyday occupations that are performed and included in a person’s everyday life (Erlandsson & Håkansson, 2009). In Studies II-IV, the view of occupations as subjectively valued and meaningful to an individual (Townsend & Polatajko, 2007) and the experience-based categorisation of occupation (Hammel, 2009; Jonsson, 2008) have both been useful when focusing on the participants’ experiences from their rehabilitation programmes and everyday lives.

In addition to the understanding of occupation as a concept, it is also important to provide an understanding of people's choices of occupations and that can be done by applying the Model of Human Occupation (MOHO) (Kielhofner, 2008). The MOHO is based on a dynamical systems theory. In this model, the personal components of volition, habituation and performance capacity are considered to influence occupation. Volitional thoughts and feelings are influenced by the perceived values and interests of the person and they influence the motivation for occupation. Habituation refers to habits and roles that influence one's patterns and routines of occupations in familiar environments. Performance capacity is the objective physical and mental components in relation to the subjective experience of those that influence the ability to do things. In addition, it is not only the person that enables the occupational performance, but also the environment (Kielhofner, 2008).

A specific focus in this thesis is on rehabilitation programmes performed in a therapeutic garden. That environment provides additional features of green vegetation, flowers and water in comparison to other rehabilitation programmes conducted in traditional settings. This issue makes it important to clarify how the environment can be considered in rehabilitation and for occupational performance. Kielhofner (2008) defines the environment as "the particular physical and social features of the specific context in which one does something that impacts upon what one does and, how it is done" (p. 98). Occupational performance is considered as afforded or constrained through the person's interaction with the environment. Still, the personal components in the MOHO are considered to be continuously changing during life which impacts on how the environment is perceived and thus impacts on what influence the environment has on a person's occupational performance (Kielhofner, 2008). Additionally, this interaction might further be understood by the concept of place. Place refers to physical surroundings or environments that imply intrinsic or developed meanings to the individual (Cutchin, Owen, & Chang, 2003). It is through the individual experiences of what happens and how people interpret these experiences that the meaning of a place is shaped (Hamilton, 2004).

The concept of occupational balance

Occupational balance is a concept that has received much attention within the field of occupational science. Contemporary literature provides thorough theoretical reasoning concerning occupational balance and the concept has been seen as closely connected to

health and wellbeing (Townsend & Wilcock, 2004; Westhorp, 2003; Wilcock, 1998; Wilcock et al., 1997). One core dimension that is put forward both theoretically and empirically in definitions that deal with occupational balance seems to be the subjective experiences of the occupations performed (Håkansson, et al., 2009; Matuska & Christiansen, 2009; Stamm, et al., 2009; Wilcock, 1998).

In this thesis, the definition of a balanced lifestyle as proposed by Matuska and Christiansen (2008) in their theoretical model of life balance (Matuska & Christiansen, 2009) is applied. This definition has a clear focus on the occupational perspective of a balanced lifestyle and the terms of occupational balance and a balanced lifestyle will hereafter be used interchangeably. Matuska and Christiansen (2008) define a balanced lifestyle as “a satisfying pattern of daily occupations that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances” (p. 11). This definition emphasises how people have different roles, role requirements, personalities, values and interests and the fact that these change over time (Matuska & Christiansen, 2008) which is in concordance with the MOHO (Kielhofner, 2008). In this definition the term “satisfying” refers to the congruence between actual participation in activities and desired participation in activities. This notion is explicitly addressed in this thesis through the concept of “occupational gaps”. This concept has been used to identify the gaps that occur when an individual cannot participate in a desired occupation or participates in an occupation without wanting to do so. This concerns a situation in which there is a discrepancy between a person’s perceptions of what he or she wants to do and what the person actually does (Eriksson, Tham, & Borg, 2006).

In the theoretical model of life balance, five experience-based dimensions of activities have been identified which need to be achieved in order to attain balance. These dimensions of the activities enable people to: (1) meet the needs of biological health and physical safety, (2) have rewarding and self-affirming relationships with others, (3) feel interested, engaged, challenged and competent, (4) create meaning and positive personal identity and (5) organise time and energy to meet important personal goals (Matuska & Christiansen, 2008, p. 11). Empirical support for the model was provided in two qualitative studies; one of women who were recovering from stress-related disorders, and another of a Swedish working population. In both studies it was found that the participants described characteristics of occupations that met needs relating to

the five dimensions (Håkansson & Matuska, 2010; Wagman, Håkansson, Matuska, Björklund, & Falkmer, 2011).

It has been empirically found that the concept of occupational balance is related to occupational areas, to occupations with different characteristics, and to time use (Wagman, Håkansson, & Björklund, 2011). However, the view of occupational balance as being a balance between various types of occupations presents certain challenges when discussing the concept. Firstly, people might categorise various types of occupations differently, just as one person might categorise the same occupation differently at different times (Hammel, 2004; Persson & Jonsson, 2009). Secondly, there are a great number of people outside the labour market for various reasons, for example, due to unemployment or sick leave. In these cases work is not a part of their occupational repertoire but they might still experience occupational balance (Jonsson, 2008; Whiteford, 2009) even though not all people do. These people may also be occupationally deprived. Occupational deprivation is described as a state in which people are unable to participate in meaningful occupations due to factors which are beyond the control of the individual (Wilcock, 1998). Unemployment and sick leave are examples of conditions that might lead to occupational deprivation (Whiteford, 2004). Being occupationally deprived often results in a lack of routines with little variation in time use, and creates a feeling of not having control over one's occupational choices (Whiteford, 2000) thus placing the person at risk of experiencing occupational imbalance. The definition of occupational balance used in this thesis emphasises the experience-based categorisation of occupations (Matuska & Christiansen, 2008).

Recovery and work-life balance as concepts related to occupational balance

Within the field of occupational health psychology there are concepts that relate to occupational balance, e.g. recovery and work-life balance. These concepts mostly focus on how work and non-work activities interact and affect each other in order to promote well-being and life satisfaction in people who are still working (Guest, 2002; Meijman & Mulder, 1998).

Recovery refers to an individual's process of regaining the psychological, biological, and behavioural states that were drained during work (Meijman & Mulder, 1998). It is suggested that the process of recovery is facilitated through engagement in everyday

occupations (Iwasaki, Manell, Smale, & Butcher, 2005; Sonnentag, 2001) during workdays, weekends and when on holiday (Geurts & Sonnentag, 2006; Van Hooff, Geurts, Kompier, & Taris, 2007). Emphasis has been put on developing knowledge of which specific activities could reload the resources that might have been drained during work (Iwasaki, et al., 2005; Rook & Zijlstra, 2006; Sonnentag, 2001). Furthermore, research has focused on identifying recovery experiences rather than specific activities. The four experiences of psychological detachment from work, relaxation, mastery, and control have been found to promote recovery (Sonnentag & Fritz, 2007). These experiences have been empirically tested on 527 Finnish employees and they were all important for maintaining occupational well-being, especially psychological detachment and mastery (Siltaloppi, Kinnunen, & Feldt, 2009).

In research focusing on work-life balance, much attention has been given to how much time that could be spent on work without experiencing an imbalance between work and life but also on how balance can be perceived between work and the rest of life from a more subjective point of view (Guest, 2002). This research concerns the individuals' well-being as well as the societal perspective in which e.g. the social security systems are evaluated in order to identify factors to reduce the number of people on long-term sick leave (Crompton & Lyolette, 2006; Johansson, 2002).

The concepts of recovery and work-life balance raise important issues on which to focus research. However, in this thesis they are not totally applicable for various reasons. Firstly, the concepts focus on balance concerning people who are still working and that is not in total concordance with the population in focus in this thesis. Secondly, they provide a dualistic view of work and other activities in everyday life and how they contrast each other. This is incongruent with the view of occupational balance described by Matuska & Christiansen (2008) who emphasise a balance between various experience-based dimensions of activities rather than a balance between various activities. When studying people on sick leave it seems fruitful to use the concept of occupational balance in order to increase the understanding of how to promote well-being in everyday life.

The lived experience of rehabilitation and everyday life

In previous research it has been found that a positive return to work is crucial in the whole rehabilitation process (Perski, 2006). However, it is known that even though

constructive solutions and positive intentions for returning to work are identified during rehabilitation these intentions are difficult to implement at the workplaces (Noordik, et al., 2011). These issues imply a certain need for increased understanding of the personally experienced meaning of connecting rehabilitation experiences and everyday life in order to be able to support the clients in their return to work process. A way to reach such understanding is to use a phenomenological approach (Husserl, 1970/1936).

Phenomenology, which originates in the philosophy of Edmund Husserl, intends to analyse and explore things as they present themselves to us (Husserl, 1970/1936). The “things” refers to the studied objects or phenomena that are being studied (Bengtsson, 2001). In phenomenological research we are thus interested in the participants’ subjective experiences of certain phenomena and it is then important to take the life-world of individuals into account. Husserl (1970/1936) views the life-world as the concrete and practical world that people live in, which is taken for granted in everyday life and never questioned by the individual. An essential assumption in phenomenology in order to gain access to the subjective experiences is the concept of intentionality. It is through the intentional relationship that the subjects bestow meaning on the objects in the world which then become experienced as something (Dahlberg, Dahlberg, & Nyström, 2008). Thus, in order to gain access to the subjective life-world of the participants through their intentional relationship to the phenomenon that is studied, the researcher must be as open as possible to the original experience (Karlsson, 1995).

In Study IV, the phenomenon studied is *the experiences of connecting*, which is operationalised as a process of linking thoughts, feelings and practices back and forth between rehabilitation and everyday life. The way a person connects rehabilitation experiences and everyday life is closely linked to their historical, cultural, and social experiences from their present everyday life. The subjective life-world experiences are shaped through a person’s historical, cultural, and social experiences (Dahlberg, et al., 2008). By examining the lived experience in everyday life, we can better understand how to develop client-centred rehabilitation and thus be able to support the individual in the process towards a working life and increased wellbeing.

Summary of the introduction

Previous research reveals that stress-related ill health is of great concern for the individual and the society as conditions related to stress-related ill health are a major

cause of sick leave. Being on sick leave is known to negatively affect participation in everyday occupations in people with various diagnoses and they might experience decreased occupational repertoires including too few occupations to facilitate recovery. The need for recovery is essential in stress-related ill health, and in rehabilitation it is important to understand how to support the clients in their recovery process. Knowledge about how people with stress-related ill health experience their occupational repertoire is, however, sparse. In order to better understand aspects facilitating recovery and occupational balance, more research focusing on how people perceive their occupational repertoire and to elucidate to what extent they are involved in the activities they wish to be involved in is needed.

There are recommendations regarding which rehabilitation interventions that should be used for people with musculoskeletal pain and stress-related ill health. These interventions often apply a multidisciplinary cognitive approach with the main aim being a return to work. Yet, it is known that the whole occupational repertoire in everyday life is affected. The review of previous research showed that it is not clear how these interventions support the persons, particularly those with stress-related ill health, to achieve recovery and occupational balance in everyday life. Therefore, there is a need for increased knowledge on how people with stress-related ill health experience the rehabilitation process and how they connect rehabilitation experiences and everyday life.

RESEARCH AIMS

The general aim of this thesis was to explore and describe the perceived occupational repertoire in people with stress-related ill health and their experiences from the rehabilitation process, with a specific focus on rehabilitation in a therapeutic garden and how the rehabilitation experiences are connecting with everyday life.

The specific aims of the four studies included in this thesis were:

- To describe and compare how occupational gaps were reported in everyday occupations in a rehabilitation group of people with musculoskeletal pain or stress-related ill health and in a reference group from the Swedish population (Study I).
- To describe how former clients with stress-related disorders and rehabilitation team members experience the rehabilitation process and to describe how experiences from the rehabilitation have been integrated into the former clients' everyday lives (Study II).
- To explore and describe how women with stress-related ill health who are on sick leave experience the rehabilitation process in a therapeutic garden and how these experiences connect to their everyday life (Study III).
- To describe and understand how connecting rehabilitation experiences and everyday life was characterised in the lived experiences during rehabilitation in women with stress-related ill health (Study IV).

METHODS

Design

In order to explore and describe rehabilitation and everyday life in people with stress-related ill health different methodological approaches were used in this thesis, including both quantitative and qualitative designs. The four studies build on each other in order to increase the knowledge of how people with stress-related ill health experience their rehabilitation process. The first study (Study I) described perceived occupational gaps before entering a rehabilitation programme in people with stress-related ill health and musculoskeletal pain compared to a reference group from the Swedish population. Study II was designed to get a broad picture of various rehabilitation programmes for people with stress-related ill health and musculoskeletal pain from various perspectives (both former clients and team members). The aims and designs of Studies III and IV were based on the findings from Study II. As interesting findings regarding the practical activities practiced in the therapeutic garden emerged in Study II the forthcoming studies were designed to be able to further explore how rehabilitation programmes conducted in the therapeutic garden were experienced. Furthermore, interesting findings regarding how experiences from the rehabilitation programmes are integrated in everyday life were touched upon in Studies II and III and they guided the phenomenological analysis in Study IV. An overview of the studies and methods used are given in Table 1.

Table 1. An overview of the four studies included in this thesis.

	Study I	Study II	Study III	Study IV
Design & research approach	Cross-sectional, descriptive approach	Explorative, grounded theory approach	Prospective, longitudinal, explorative, constant comparative approach	Prospective, longitudinal, explorative, phenomenological approach
Data collection (occasions)	Before entering rehabilitation	1-7 months after completed rehabilitation	Three times during a 10 week rehabilitation programme and approximately three months after completed rehabilitation	
Data collection (methods and instruments)	Occupational Gaps Questionnaire	Semi-structured interviews and memo writings	Open-ended interviews	
Methods of data analysis	Descriptive statistics	Constant comparative method	Constant comparative method	Empirical Phenomenological Psychological method

Participants

The samples in this thesis included people on sick leave due to stress-related ill health or musculoskeletal pain that were referred to vocational rehabilitation at a specific clinic in the middle of Sweden; people with stress-related ill health clearly dominated in the samples. In Study I, the distribution between people with stress-related ill health and musculoskeletal pain was equal. The majority of participants included in Study II were referred to various rehabilitation programmes due to stress-related ill health and a few participants were referred to rehabilitation due to musculoskeletal pain. In Study III and IV only women with stress-related ill health were included. In addition, Study I also included participants who were randomly selected from the Swedish population and Study II included team members from various professions who were working at the clinic. The gender distribution of the thesis was due to the distribution at the rehabilitation clinic and there, the majority of the participants were women. The participants in this thesis ranged in age from 22-63 years. An overview of the participants in the four studies is presented in Table 2.

Table 2. Demographic characteristics of the participants in the thesis.

	Study I	Study II	Study III	Study IV
Number of participants in study samples	72 participants referred to rehabilitation 261 participants from the Swedish population	8 participants that had completed rehabilitation 7 team members	5 participants that were currently involved in rehabilitation in a therapeutic garden	
Gender F/M	51/21* 197/64**	7/1* 6/1***	5/0	
Age, years mean (range)	44 (22-63)	41 (32-59)* 44 (29-52)***	43 (36-52)	
SMBQ **** mean (range)	5.7 (4.4-6.8)*	5.3 (3.8-6.8)*	5.0 (3.6-6.0)	

* Information concerns the participants that were referred to or had been involved in rehabilitation

** Information concerns the participants from the Swedish population

*** Information concerns the team members working at the rehabilitation clinic

**** SMBQ = Shirom Melamed Burnout Questionnaire (instrument that measures degree of stress), cut-off score ≥ 3.75

Study I

The study included a consecutive series of 72 persons with stress-related ill health or musculoskeletal pain that were referred to vocational rehabilitation at a specific clinic in the middle of Sweden and 261 randomly selected persons from the Swedish population. Inclusion criteria for the rehabilitation group in the study were that the

subjects a) had “an unhealthy degree of stress” in the Shirom Melamed Burnout Questionnaire (SMBQ) verified by a cut-off score of ≥ 3.75 , and b) were in need of rehabilitation for reasons that were related to stress-related ill health or musculoskeletal pain. The mean value of length of sick leave was reported to be two years (range 0-9 years). The majority of the participants were born in Sweden (78%) and slightly less than half of them had a university education (42%). Seventy-two percent were married or living together with a partner and two thirds of the participants had children living at home (67%). The reference group was drawn from a larger group of 811 persons randomly selected from the Swedish population. This group was matched with the rehabilitation group according to age and stratified for gender distribution.

Study II

The sample in Study II comprised 15 participants; including eight former clients (named as participants in the result section) who had completed their rehabilitation, and seven team members working at the rehabilitation clinic. Theoretical sampling was applied when selecting participants (Charmaz, 2006). Inclusion criteria for the former clients were a) an “unhealthy degree of stress” when starting their rehabilitation at the clinic verified by a cut off score of ≥ 3.75 in the SMBQ, b) being on sick leave when starting their rehabilitation, and c) having completed the rehabilitation programme during the year prior to the interview. The former clients had worked in the following occupations: personal care worker, teaching professional, business professional, pre-primary education associate teaching professional, creative artist, nursing associate professional and computer associate professional. All of them were on full-time sick leave when starting the rehabilitation programme and six of them had increased their work capacity at the time of the interview. Criteria for inclusion of team members were that they had at least two years of professional experience in this particular area of rehabilitation.

Studies III and IV

The participants in Studies III and IV were five women with stress-related ill health who underwent a rehabilitation programme in a therapeutic garden. The participants were selected using a purposive sampling method (Polit & Beck, 2004). Inclusion criteria were that the participants a) were involved in a vocational rehabilitation programme in the therapeutic garden, b) were able to understand interview questions and, c) were able to share their experiences from the rehabilitation. Some variation

concerning gender, occupation and period of sick leave when entering rehabilitation was sought to provide richness in the data. However, all participants were women and they worked in the following professions: child minders, administrator, teacher and school assistant. They had been on sick leave to some extent for between 11 months and five years when entering the rehabilitation programme.

Study context

The context for the studies in this thesis was mainly *rehabilitation programmes conducted in a therapeutic garden*. One aim of this thesis was to generate knowledge of experiences from the rehabilitation process among people with stress-related ill health, with a specific focus on rehabilitation in a therapeutic garden. Therefore, all participants (except the reference group that was drawn from the Swedish population in Study I) were involved in various rehabilitation programmes at a specific clinic in the middle of Sweden. In Studies I and II, the participants were or had been involved in either a rehabilitation programme that was conducted in a traditional rehabilitation setting or in rehabilitation programmes that were conducted in a therapeutic garden. All participants in Studies III and IV were involved in a rehabilitation programme conducted in a therapeutic garden. All the different programmes used a cognitive approach. In addition to the cognitive approach, the rehabilitation programmes that were conducted in the therapeutic garden also offered engagement in practical activities that were designed for relaxation and enjoyment, such as flower arranging and planting cuttings.



A place for relaxation in the therapeutic garden.



A place for conversation in the therapeutic garden.

The rehabilitation programme in the therapeutic garden was led by an occupational therapist, a physiotherapist, a social worker and a gardener. The garden was situated in a 500 square metre greenhouse that was divided into several areas with a variety of characteristics in order to encourage different modes and activities (Stigsdotter &

Grahn, 2003). One area was designed with stones, a brook and hammocks to promote relaxation. Another area was separated by walls from the rest of the garden and equipped with blankets and cushions to facilitate awareness of how the body reacts to stress, e.g. how the breathing changes in character according to experiences of stress. Other areas were designed with chairs and tables and material to work with to encourage conversation and activation.

Data collection

Interviews

In Studies II-IV, data were collected primarily using interviews. All interviews were done in places that were decided on together with the participants (Kvale, 1998) and were conducted either at the rehabilitation clinic, at the participant's workplace or at the university where the researcher worked.

In Study II a semi-structured interview with open-ended questions was used with both former clients and team members working at the clinic. All participants were interviewed once and the interviews with the former clients were conducted 1-7 months after completed rehabilitation at the clinic. The interviews with former clients focused on their experiences from the rehabilitation programmes and on how these experiences related to their everyday lives. The data collection based on the team members concentrated on their experiences from working at the rehabilitation clinic and were highlighted by concrete examples of how they worked with the clients. The focus remained the same throughout the data collection using the same interview guide as a basis for the interviews. Nevertheless, interesting issues that arose during the initial interviews were added to the interview guide for the forthcoming interviews. Furthermore, theoretical sampling (Charmaz, 2006) was applied by including one more team member and asking directed questions about interesting issues in order to try to fill gaps in the categories that emerged during analysis. Each interview lasted for 35-75 minutes. All the interviews were digitally recorded except for one, on account of one former client's objections to being recorded. All digitally recorded interviews were transcribed verbatim into approximately 300 pages of written text.

In Studies III and IV interviews were carried out on four occasions in order to be able to study actions and experiences in the rehabilitation process over time. The first three interviews were held at the beginning, in the middle and at the end of the rehabilitation

programme, and the fourth interview was held approximately three months after completed rehabilitation. Two participants were only interviewed on three occasions due to illnesses that did not relate to their stress condition. The interviews focused on the participants' concrete descriptions of their lived experiences of the rehabilitation in the therapeutic garden in connection to their everyday life. The questions were open-ended. Each interview was carefully listened to between the data collection points and the questions were further developed based on what had arisen in the previous interviews in order to gather rich data (Charmaz, 2006). The data comprised 18 interviews that lasted between 30 and 60 minutes. The interviews were digitally recorded and transcribed verbatim (approximately 350 pages of written text).

Instruments

The Occupational Gaps Questionnaire

The Occupational Gaps Questionnaire (OGQ) is a self-report questionnaire that assesses the presence of occupational gaps, i.e. to what extent an individual does/does not do what he or she wants to do/does not want to do, and this instrument was used in Study I. The OGQ is developed by Eriksson and co-workers (2006) and internal scale validity and person-response validity has been demonstrated in research on people with acquired brain injuries (Eriksson, Kottorp, Borg, & Tham, 2009; Eriksson, et al., 2006). The instrument consists of 28 everyday activities in four domains, including 8 instrumental activities of daily living (instrumental ADL), 10 leisure activities, 6 social activities, and 4 work or work-related activities. Each activity/item consists of two questions; "Do you perform the activity now?" and "Do you want to perform the activity now?" Answering "yes" to one question and "no" to the other is considered to constitute an occupational gap. Based on the potential combination of responses from the questions in the OGQ, two dimensions of occupational gaps are discerned. The first dimension corresponds to a situation in which the participants do activities that they do not want to do, and the other dimension corresponds to a situation when the participants do not do activities that they want to do.

The Shirom Melamed Burnout Questionnaire

The Shirom Melamed Burnout Questionnaire (SMBQ) (Melamed, et al., 1992; Melamed et al., 1999) was used in all four studies to measure degree of stress. The SMBQ is a 22-item self-report questionnaire that is used to assess the four different aspects of 1) burnout, 2) tension, 3) listlessness and 4) cognitive fatigue of the burnout

syndrome. Each aspect consists of several statements, such as “I feel tired” or “I feel restless”. Respondents are asked to rate each of the statements in relation to how often these feelings have been experienced during most of the day on a seven-point scale, ranging from 1 (almost never) to 7 (almost always). The SMBQ is often reported by the mean of all items. In Studies I and II, a cut-off score of ≥ 3.75 was used as an inclusion criteria. There is no clear consensus on which cut-off scores that should be used to define a person as having an unhealthy degree of stress but one study that has used the SMBQ when comparing people that were on sick leave due to stress-related illnesses with healthy controls found that all participants with stress-related illnesses had a score of at least 3.5 and all healthy controls scored below that number (Heiden, Barnekow-Bergkvist, Nakata, & Lyskov, 2005). In all studies in the thesis, the SMBQ was used as one feature to describe the background characteristics of the participants.

Data analyses

Descriptive statistics

The data in Study I derived from ordinal scales and descriptive statistics have been used to describe and visualise the prevalence and patterns of occupational gaps within the rehabilitation group and the reference group. In order to describe the prevalence of occupational gaps, a dichotomous scale of the answers from the OGQ was developed which included the presence or absence of an occupational gap. Descriptive statistics were calculated for mean, median and percentage. In the second part of the analysis of Study I it was of interest to describe the patterns of occupational gaps within the two groups. In this case, all answers that constituted an occupational gap were divided into two dimensions; 1) the participants did activities that they did not want to do, and 2) the participants did not do activities that they wanted to do. By using descriptive statistics of percentages, frequencies and graphs it was possible to discern the various patterns of occupational gaps in the various domains and activities (Bland, 2000). The prevalence and patterns of occupational gaps within the rehabilitation group and the reference group were compared using percentages and graphs.

The grounded theory approach

The data analysis in Studies II and III was based on a constant comparative approach inspired by the principles of grounded theory (Glaser & Strauss, 1967) and the guidelines for analysis described by Charmaz (2006).

In Study II, the whole research procedure including data collection and analysis followed the principles of grounded theory. The analysis was carried out continuously throughout the data collection and memos were written during the whole process (Charmaz, 2006; Glaser & Strauss, 1967). Data from team members and former clients were, in the initial phase, analysed separately and thereafter consolidated and further analysed. The experiences of rehabilitation were analysed from the perspectives of both former clients and team members, but how these experiences were integrated into everyday life has been analysed from the data of former clients. In Study III, the digitally recorded interviews were listened to several times between the various data collection points with each participant and memos were written during the whole data collection period. However, no theoretical sampling of participants was performed and the analysis did not start until all interviews were done. The longitudinal aspects in the material have been highlighted in the analysis by using the guidelines described by Saldana (2003).

Open coding was performed as an initial step of the analysis and the transcripts were coded line-by-line. The coding procedure was guided by the participants' experiences from the various rehabilitation programmes with special emphasis on the rehabilitation process. The codes within the separate interviews were given names close to the data and were compared to each other. As a second step, the codes were subsequently consolidated into categories as they were explored in continuous memo writing and further developed in the analysis (Charmaz, 2006). In Study III, the researcher emphasised the longitudinal character of the data by organising the categories in a chronological order independent of in which interview the categories emerged (Saldana, 2003). The categories were identified through a constant comparison of codes and memos that had been written continuously during the initial phase (Charmaz, 2006; Glaser & Strauss, 1967) and by asking questions in the material that highlighted changes throughout the rehabilitation process (Saldana, 2003). As a third step, in the process of focused coding (Charmaz, 2006), the categories and memos from the separate interviews in Study II or interview series (one series represented one participant) in Study III were compared to each other, further explored and brought together. To ensure that the analysis remained close to the data, the categories and their properties were constantly compared with data from each interview. Each step in the analysis was peer examined by the co-authors. To enhance credibility, the other authors who worked at the clinic, but not directly with the participants, peer examined the last

steps in the analysis. In Study II, the preliminary findings were subject to a limited member check where categories were presented to a group of professionals working at the clinic and this aimed at evaluating whether the findings did actually fit and work in the particular setting in which the study had been carried out (Charmaz, 2006).

The empirical, phenomenological, psychological method (EPP)

The EPP method (Karlsson, 1995) was used in the qualitative analysis of data in Study IV. This method aims at tracing the meaning structure of the lived-experience related to a phenomenon. The phenomenon being studied in Study IV was the lived-experience of connecting rehabilitation experiences and everyday life. A five steps analysis procedure was done and steps one to four were analysed separately for each interview protocol. In step five all interviews from the five participants were brought together in the analysis.

In step one, all interviews with one participant were thoroughly read to achieve good comprehension and to understand the participant's original experience through the researcher's empathetic understanding (Karlsson, 1995). The attitude of the researcher was then to be as open as possible to the participant's experiences and to consciously bracket theoretical knowledge. The second step focused on discriminating meaning units in the interviews each time there was a shift in meaning. In the third step, each meaning unit was analysed and interpreted in the light of the whole interview protocol in order to describe the meaning imbued in the facts that were described by the participants. At this point, the researcher's interpretative understanding was used in combination with the researcher's empathetic understanding. As a fourth step, the described meaning units were synthesised into a summarised situated structure. Each interview was then presented as short summary describing various aspects of the phenomenon. Finally, in step five, the separate situated structures for each interview were compared and transformed into a general structure of the phenomenon studied, including experiences that ran across all situated structures from step four. Each step in the analysis was discussed with two of the co-authors. Furthermore, a third co-author was involved in the fifth step of the analysis in order to question the interpretations and discuss alternative ways of understanding the participants' experiences. The analyses were discussed and refined several times until a 'horizontally consistent interpretation' was reached. This means that the authors ensured that each individual characteristic fitted well together with the other characteristics shown in the analysis, and in that way the most valid interpretation was clarified (Karlsson, 1995).

FINDINGS

In this chapter the main findings of the thesis will be presented. Study I focused on describing the occupational repertoire in people with stress-related ill health and musculoskeletal pain before entering rehabilitation using a quantitative design. Studies II-IV focused on the participants' experiences of the actual rehabilitation process and how these experiences are connecting with everyday life using various qualitative methods. Findings from the four separate studies are presented together under the following three headings; perceived occupational repertoire, therapeutic aspects in rehabilitation, and connecting rehabilitation and everyday life.

Perceived occupational repertoire

The results from the analysis of the Occupational Gaps Questionnaire in Study I combined with data from the qualitative interviews in Studies II and III provided information of how the occupational repertoire was perceived by the participants in everyday life before and after participating in various rehabilitation programmes. The findings showed a progressive process moving from an occupational repertoire with limited variation of few activities to an occupational repertoire including a broader range of several activities.

Occupational repertoire before rehabilitation (Study I)

The analysis in Study I identified how the rehabilitation group perceived twice as many occupational gaps in most of the leisure, social and work-related activities as the reference group did. Nevertheless, the pattern of perceived occupational gaps seemed to be quite similar in both groups with most frequently reported occupational gaps in the same activities.

Occupational gaps were most frequently reported in leisure activities. For example, more than half of the participants in the rehabilitation group reported occupational gaps in sports (59%) and hobbies (55%). The majority of occupational gaps in the rehabilitation group (83%) were related to the participants not doing the activities that they wanted to do.

In the rehabilitation group, a smaller variation in activities with no reported occupational gap was reported by the participants who had been on sick leave for a

longer period of time compared to those who had been on sick leave for less than a year. The number of perceived occupational gaps in leisure activities and work or work-related activities increased as the length of sick leave extended. In social activities the number of occupational gaps remained quite stable irrespective of length of sick leave. The resulting number of occupational gaps reported in instrumental ADL was in line with the pattern identified in social activities, however in instrumental ADL the types of gaps changed. The participants that had been on sick leave longer than a year reported that they did not do instrumental ADL that they wished to do to a greater extent than those that had been on sick leave for less than a year.

Occupational repertoire after rehabilitation (Study II & III)

In Studies II and III, experiences from the rehabilitation process were explored and described from the team members' and the participants' perspectives. Furthermore, the studies described how these experiences were integrated into the participants' everyday lives. The findings from these studies revealed that the participants' experiences from rehabilitation inspired them to add relaxing and enjoyable activities to their everyday lives, thus contributing to occupational balance.

Findings from Study II showed that the participants changed their occupational repertoires by adding activities that they described as undemanding, inspiring and enjoyable. This was confirmed and further explored in Study III which showed that the participants in this study added activities that promoted recovery after the rehabilitation programme was completed. These activities were either new activities or previously performed activities that had not been performed for a long time (Studies II and III) or activities that the participants had wished to start performing but had not taken the opportunity to do (Study III). The majority of activities that the participants included in their occupational repertoire was self-rewarding and enabled the participants to experience enjoyment. For example, one participant started to restore furniture (an old interest that she once again started to engage in), and another participant took a course in playing the guitar (an occupation that she had many years longed for without realising her dreams). Several participants from both Studies II and III described how they continued with activities that were related to the specific context of the garden. The activities that were included in the occupational repertoires after completed rehabilitation were experienced by the participants as enabling them to gain new energy (Study II) and to become absorbed in the present moment with a clear focus on oneself

(Study III). Most of the activities that were described by the participants were performed alone even though some were performed together with others.

Therapeutic aspects in rehabilitation

The focus in Studies II and III was mostly on how the participants experienced the rehabilitation process during various rehabilitation programmes in a therapeutic garden. The analyses have identified a number of therapeutic aspects in rehabilitation. Furthermore, in Study IV the connection between rehabilitation and everyday life has been described and these findings further explained the therapeutic aspects in rehabilitation. The unitised findings from Studies II, III and IV revealed that; being in an accepting place and re-evaluating the meaning of occupations through experiences from doing can be seen as therapeutic aspects in rehabilitation. These aspects will be presented more in depth below.

Being in an accepting place (Study II & III)

Findings from Studies II and III revealed that the therapeutic garden was experienced as a place that was separated from ordinary everyday life and was aesthetically attractive. The participants experienced how environmental qualities of the therapeutic garden created a base for relaxation and appreciation of the moment and of oneself (Studies II & III). Furthermore, it served as a positive foundation for the forthcoming feature of engagement in enjoyable activities in rehabilitation and motivated the participants to embrace the rehabilitation which is an important aspect for positive progress in rehabilitation (Study III).

A place separated from ordinary everyday life

The walls that surrounded the therapeutic garden made the participants experience the therapeutic garden as a place that was separated from their ordinary everyday lives. At the beginning of the rehabilitation process it was important for the participants to experience that they were detached from their ordinary responsibilities to be able to embrace the rehabilitation fully and this was facilitated through the contrasting atmosphere that was experienced in the garden. Furthermore, the calm, undemanding and accepting features in the therapeutic garden helped the participants feel free to stop thinking of all troublesome thoughts when entering the garden. At the same time, they felt they were allowed to let all thoughts emerge and they experienced an opportunity to start processing thoughts that had been buried for some time. The participants described

how they got new insights into themselves and a better understanding of their own situations (Study III). They experienced the therapeutic garden as a place where it was okay to be, whatever mood they felt like being in, without thinking of anyone else (Studies II & III).

A place that was aesthetically attractive

All participants in Study III described their initial experiences of being in the therapeutic garden as significant moments. They emphasised the esthetical design of the garden and they described how the small esthetical changes that were made by the team members became meaningful to them (Studies II & III). This was also something that the team members deliberately worked with as they had recognised the participants' positive responses to such actions (Study II). The findings from Study III identified experiences of worth, joy and happiness when being given the opportunity to be in the garden. Furthermore, the participants appreciated that others engaged in making the garden pleasant just to make them feel comfortable (Study III). For example, the participants described how they valued all the new flower arrangements that were created for the various sessions and how the team members lit candles just before the participants entered the garden. The participants described the garden as a place in which an accepting atmosphere was embedded and which signalled respect as well as time for rest and relaxation (Studies II & III).

Re-evaluating the meaning of occupations through experiences from doing (Studies II, III & IV)

The rehabilitation programmes that were situated in the therapeutic garden included the practice of activities at every rehabilitation session which created an understanding of how occupations could enable well-being based on the participants own practical experiences (Study II & III). These activities could, for example, be to compose a bouquet of flowers, to create bowls in cement or to weave plates from willow branches. Furthermore, the analyses from Studies II- IV revealed that the re-evaluation of the meaning of occupations was further promoted by experiencing the creative nature of the activities and their recurrent practice. An experience-based understanding of occupations has been valuable for the recovery process, and practical engagement in occupations that enable various experiences to emerge during rehabilitation is therefore seen to be a therapeutic aspect.

Practicing creative occupations

Practicing creative occupations was mostly related to enjoyment, relaxation and inspiration. These experiences seemed to be facilitated by various features of the activities performed. The team members that were interviewed in Study II emphasised the importance of introducing the activities in an undemanding way and letting the participants make their own choices in order to promote their recovery. This is also found in the descriptions given by the participants in Studies II and III. Furthermore, both the team members and the participants emphasised the advantages of the possibility to engage in the occupations during rehabilitation on the participants' own terms and without feeling obliged to take care of anyone else. These experiences facilitated the participants in being absorbed in the present moment and fully involved in the actual occupation (Study III). Not having other responsibilities to think about enabled the participants to start to reflect on their previous experiences of feeling good when performing creative occupations (Studies II & III). Once again they experienced the same feelings of curiosity, happiness and creativity as they had done in their previous everyday lives and they described this as qualities in their personalities that they had previously appreciated but gradually lost (Study IV).

Working with natural materials that were already a finished product was also an important feature in the activities and was related to experiences of feeling more confidence in one's own capacity (Study III). The women in Study III described how they found it easy to practice occupations that included materials from flowers and willow branches as they were already so beautiful. They found it almost impossible to fail when working with them. When the participants experienced success while practicing activities during rehabilitation they became more self-confident in their way of regarding themselves in everyday life. To experience both success and failure increased the sense of being competent (Study II). These experiences also challenged the participants' previous attitudes towards performance and helped them to develop a more natural stance towards activities in general. The participants describe how they started to experience enjoyment in occupations that they had once appreciated in their previous everyday lives but that had lost meaning for them as they became progressively ill and later on sick-listed. The participants described how they once again had the desire to be involved in hobbies and leisure activities (Study II).

Recurrently practicing occupations

The participants did not describe the occupations as solely joyful and engaging. The findings in Study IV revealed that the participants experienced some occupations, such as relaxation and mindfulness, as uncomfortable and stressful at the beginning of the rehabilitation programme. However, these activities were recurrently practiced at every session during the whole rehabilitation programme and in the later interviews the participants had begun to change their perception of these occupations. The participants began to know the procedure of how these activities were carried out and what reactions in their bodies and minds they could expect while doing them. The women started to re-evaluate the meaning of relaxing occupations as they experienced them while recurrently performing them during the rehabilitation programme. They started to talk about the occupations as desired and valuable and described how they started to make plans for how to enable these occupations to be integrated in their everyday lives.

Connecting rehabilitation and everyday life

The aim of Study IV was to describe and understand how connecting rehabilitation experiences and everyday life was characterised in the lived experiences during the rehabilitation process in women with stress-related ill health. The analysis revealed that the participants connected their rehabilitation experiences in the therapeutic garden with their previous, present and future everyday life, influencing both rehabilitation and everyday life in a back and forth process. The findings from this study link back to the therapeutic aspects that have been identified in Studies II and III. The accepting atmosphere of the therapeutic garden seemed to facilitate the start of a connection in mind early in the rehabilitation process (Study IV). Furthermore, the re-evaluation of occupations that was achieved through the participants' own practical experiences (Studies II, III & IV) and the recurrent practices of occupations (Study IV) were seen as valuable aspects for promoting a practical connection between rehabilitation experiences and everyday life by introducing enjoyable occupations into everyday life. However, findings from Study IV also identified experiences of frustration and being left alone when the participants tried to connect their rehabilitation experiences and their working situations in everyday life.

Connecting in mind (Studies III & IV)

A connection in mind was initiated early on during the rehabilitation programme when being in the accepting atmosphere of the therapeutic garden. This connection was

characterised by a linkage between the previous everyday life before the participants were on sick leave due to their stress-related ill health, and the present experiences within the therapeutic garden (Study IV). Findings in Study IV revealed that the experience of feeling that all thoughts were allowed to be thought (Study III) facilitated a connection between the previous everyday life and the rehabilitation. Finding the way back to the former healthy self and experiencing feelings that had been unattainable during the time preceding rehabilitation created inspiration to initiate a change in everyday life and enabled a positive view of the future (Study IV).

Connecting in doing (Studies II, III & IV)

The tangible connection between the experiences from the rehabilitation programme and everyday life was facilitated through the participants' perceived experiences of practicing activities. This was first indicated in Study II where the participants had been involved in two different approaches of rehabilitation programmes, both applying a cognitive approach but one without practical activities in a traditional rehabilitation setting and one with practical activities in the therapeutic garden. The study showed that all participants integrated their experiences from rehabilitation into everyday life by changing ways of handling stressful situations irrespective of what rehabilitation programme in which they had been involved. In addition, those with practical activities also changed their occupational repertoire in everyday life by including activities that enabled recovery. This is further supported by the findings from Study III. The participants in that study described a desire to continue with enjoyable activities after the rehabilitation had ended because they had experienced these occupations as valuable during the practices in rehabilitation. The participants also described how they continued with various occupations in everyday life that enabled them to experience similar feelings as in the therapeutic garden. Findings from Study IV added some understanding of the process towards a tangible connection. It became evident that occupations that promoted rest and relaxation were experienced as unnecessary at the beginning of the rehabilitation programme. However, it was found that these occupations became integrated into the participants' everyday lives through the recurrent practices during the rehabilitation programme as their related experiences became incorporated into their bodies and minds.

Connection as a source of frustration and feelings of being left alone
(Study IV)

Connections that were difficult to realise in everyday life were mostly linked to the participants working situations and identified in the analysis of Study IV. This connection was characterised by an increased understanding of how the participants wanted their future working life to be, and their wishes and effort to enable that in everyday life. However, this connection was described by the participants as difficult to tangibly realise as the rehabilitation programme did not include any discussions of how to proceed with their return to work process after the rehabilitation programme had ended. The connection was further hampered as the participants did not experience any support from their managers or colleagues at their workplaces. On the contrary, the apparent contrast between their visions of a future working life and the actual situations strengthened the participants' feelings of disappointment towards their previous working situations rather than facilitated a tangible connection between rehabilitation and work-related activities in everyday life.

CONCLUSIONS

In Study I it was shown that occupational gaps were reported more often in the rehabilitation group than in the reference group. Most occupational gaps were reported in leisure activities. The occupational repertoire seemed to decrease as the period of sick leave extended. The number of activities with no occupational gaps decreased, particularly leisure and work-related activities. Instrumental ADL were more often reported as wished for by the participants who had been on sick leave for more than a year compared to those who had been on sick leave for less than a year. This indicates that the activities that were still included in the occupational repertoire became more valued when other activities were absent.

Findings in Studies II and III highlighted the value of recurrently practicing creative occupations in a safe place during participation in the rehabilitation programme. This enabled the participants to form an understanding of the value of such occupations as they experienced feelings of well-being while practicing creative and relaxing occupations in rehabilitation. These occupations provided experiences of inspiration, enjoyment and happiness which facilitated a re-evaluation of occupations in everyday life. Furthermore, they inspired the participants to prioritise enjoyable activities in everyday life and to add such activities to their occupational repertoire thereby enabling occupational balance.

Findings from Studies II-IV showed that the rehabilitation programme in the therapeutic garden facilitated recovery and occupational balance in the private arena in everyday life. However, in Study IV difficulties in connecting rehabilitation experiences and the working situation were evident. The participants did not seem to be sufficiently prepared for a return to work. Connecting rehabilitation experiences and the working situation was experienced as challenging by the participants and feelings of frustration and being left alone were experienced.

GENERAL DISCUSSION

The perspective of this thesis was grounded in occupational therapy and occupational science, the goal being to gain knowledge on how people with stress-related ill health perceive their occupational repertoire before rehabilitation (Study I), experience the rehabilitation process (Studies II and III) and the connection with everyday life (Study IV). By taken this perspective throughout the studies there has been a predominant focus on various aspects of the activities practiced at rehabilitation. Other important aspects of rehabilitation, e.g. discussions that focus on thoughts and behaviours, have not been in the foreground. However, there is a great body of knowledge regarding cognitive behavioural therapy interventions for people with stress-related ill health (e.g. Blonk, et al., 2006; De Vente, et al., 2008; van der Klink, et al., 2001). The findings from this thesis mostly consider the occupational aspect in rehabilitation and might be seen as a useful contribution to the already existing body of knowledge regarding cognitive behavioural therapy when developing future rehabilitation interventions.

In this section the main findings from the empirical studies in the thesis will be discussed. This discussion will be outlined by following a chronological time line of a person with stress-related ill health focusing on the time before, during and after the rehabilitation programme. Initially, the perceived occupational repertoire before rehabilitation will be discussed. Thereafter, therapeutic aspects in rehabilitation with an emphasis on the therapeutic garden as the place for rehabilitation and the practice of activities will be covered. In addition, the linkage between rehabilitation and everyday life will be commented on and the process of return to work outlined. The discussion will continue with a section on methodological and ethical considerations and conclude with a summary of clinical implications together with suggestions for future research.

Perceived occupational repertoire

Findings from Study I showed that people with stress-related ill health and musculoskeletal pain (the rehabilitation group) perceived more than twice as many occupational gaps as did the reference group. All participants in the rehabilitation group reported occupational gaps and this can be compared to the reference group in which 86% reported occupational gaps, and to a group of people with acquired brain injury in which 74% reported occupational gaps (Eriksson, et al., 2006). Furthermore, the findings indicated that most occupational gaps were perceived in leisure activities.

According to the definition of occupation proposed by Townsend & Polatajko (2007), leisure activities are those that mostly bring enjoyment to a person's life. It is important to include such activities in the occupational repertoire as these activities are considered to enable recovery (Iwasaki, et al., 2005; Sonnentag, 2001) and promote several of the dimensions that need to be achieved in order to attain occupational balance (Matuska & Christiansen, 2008).

The findings indicated that the occupational repertoire included fewer activities in people who had been on sick leave for a longer period of time compared to those who had been on sick leave for less than a year in the rehabilitation group. This is in line with previous research which found that a period of sick leave might lead to social isolation (Verdonk, et al., 2008) and loss of valued occupations (Johansson, et al., 2011). The results from Study I and previous research indicate a process of decline towards occupational deprivation when on sick leave due to stress-related ill health, (Whiteford, 2004; Wilcock, 1998). A consideration of the findings regarding how the occupational repertoire is perceived when entering rehabilitation and the process towards occupational deprivation indicate the need to focus on the whole occupational repertoire in rehabilitation.

In Study I, it was found that the occupational arenas that were left in the occupational repertoire, such as instrumental ADL, became more important. This is an interesting result to reflect upon since such occupations are seldom desired in healthy people's everyday lives when there is a wide range of occupations included in their occupational repertoires. In the reference group for example, 19% reported that they washed clothes without wanting to and over 30% reported that they did shopping without wanting to (Study I). One interpretation of the results might be that occupations included in this domain may be perceived as desirable when other occupations are excluded from the occupational repertoire as such occupations maintain routines in everyday life and are characterised by having tangible value resulting in tangible and visible outcomes (Kielhofner, 2008; Persson, et al., 2001). This interpretation is supported by previous research indicating that people with chronic pain start to re-evaluate occupations that remain in the occupational repertoire when the ability to perform previously valued occupations is limited (Persson, Andersson, & Eklund, 2011). The result could also be interpreted in relation to the assumption that occupations are valued based on traditions and cultures (Eklund, Erlandsson, Persson, & Hagell, 2009). In Sweden, working

women report being responsible for most of the household chores (Krantz & Östergren, 2001). Thus, in a process in which the occupational repertoire is decreasing, one reason for wanting to continue with such activities might be to maintain one's perception of oneself and a sense of control of everyday life (Hammel, 2004). These are important aspects that need to be considered in rehabilitation.

Therapeutic aspects in rehabilitation

The findings in Studies II-IV elucidated important aspects that seemed to contribute to recovery and occupational balance in everyday life during the rehabilitation. These aspects will be discussed in the following section.

The therapeutic garden as a safe place

In Studies II and III it became evident that the participants emphasised their gratitude for being in the calm and accepting place of the therapeutic garden and highlighted how they immediately felt more relaxed when they entered the garden. This is in line with previous research which found that people with high levels of stress prefer to be in an environment that is safe, undisturbed, calm and silent (Grahn & Stigsdotter, 2010), and also with theoretical writings focusing on the stress reducing qualities of therapeutic gardens (Ulrich, 1999). Furthermore, findings from Study III revealed that the place of the therapeutic garden was central for the participants to fully embrace their rehabilitation and feel comfortable when engaging in creative activities. This finding further supports previous research on rehabilitation in a therapeutic garden which found that team members working at rehabilitation experienced this environment as a safe place that enabled the participants to "prepare, receive and open up" for therapy and activities in rehabilitation (Adevi & Lieberg, 2011).

The place of the therapeutic garden in which the rehabilitation programmes were situated seemed to have an implicit meaning to the participants. The meaning of the place being experienced as calm and safe (Study III) might be understood by reflecting on how a person with stress-related ill health struggles to accomplish all tasks and demands in everyday life without having enough resources to manage all responsibilities (Arman, et al., 2011; Gustafsson, et al., 2008; Sandmark & Renstig, 2010). To enter a place with no demands or responsibilities implies a considerable contrast to previous everyday life which comprised of a lot of stressful events. In earlier research, it has been found that the meaning of a place is often experienced through

distinctions to other places and is often associated with a positive or a negative valuation of a place (Gustafsson, 2000). In Study III it became evident that being in the therapeutic garden provided the participants with a welcome contrast and feelings of freedom and relief when they did not have to live up to all the obligations of their ordinary everyday lives. Similar findings have been found in a study in which the rehabilitation is situated in a forest (Sonntag-Öström, et al., 2011). These findings indicate that an environment that is experienced as a significant contrast to the environment in everyday life, e.g. a therapeutic garden, is valuable in the early phase of rehabilitation.

Even though the findings in this thesis identified the therapeutic garden as being experienced as a safe, calm and accepting place these particular characteristics do not have to be experienced by other people who are in a therapeutic garden. Rather, these characteristics might be experienced in other places by other people due to the subjective meaning attached to various places (Cutchin, et al., 2003; Hamilton, 2004). Still, it seems important to experience the place in which rehabilitation is conducted as safe, undemanding and free in order to provide a solid base on which to fully embrace the rehabilitation and to enable engagement in activities and the recovery experiences of psychological detachment and relaxation (Sonntag & Fritz, 2007). This reflection emphasises the importance of locating rehabilitation for people with stress-related ill health in a physical environment that enables the participants to experience these characteristics.

Objects and activities as means for creating valued places

The findings from Study III revealed that the therapeutic garden was a place that became valued by the participants and impacted on their views of their environments. Previous writings have found the meaning of place being attributed to the self, others, the environment (Gustafsson, 2000) and to the occupations performed in the particular place (Hamilton, 2004). In Studies II and III it was found how the participants tried to change their physical environments in everyday life. For example, they changed colours at home, put up attractive pictures on their walls at work and placed candles in their bathrooms to enable a sense of being in a calm and undemanding place.

In Studies II and III, it was found that the participants used the objects that were made while practicing creative activities at the rehabilitation to create a supportive

environment which enabled recovery in their everyday lives. Similar findings concerning making use of objects in order to recreate a place that supports the practice of valued activities during rehabilitation have also been presented in qualitative studies of people with acquired brain injuries (Erikson, 2009). These two results can be seen as targeting the same process of connecting rehabilitation and everyday life, but the direction of the process seems to vary dependent on the different situations and conditions surrounding people with stress-related ill health and acquired brain injuries. In the studies by Erikson (2009) it was found that the people with acquired brain injuries took objects from home to their place for rehabilitation. These findings might be understood by considering the notion that volition and environment interact (Kielhofner, 2008). People with stress-related ill health might perceive their previous everyday lives in a different light compared to people with other diagnoses and that might impact on their views and meanings of various places. For example, people with stress-related ill health do not strive to be as they were just before sick leave which might be the case in people with other diagnoses, e.g. acquired brain injuries. This interpretation is supported by the understanding of the physical aspect of place as being connected with memories of experiences that can connect past to the future (Hamilton, 2004). Connecting different places with objects that have a symbolic meaning seems to support the participant's view of his/her desired future. This is irrespective of whether it is a desire to go back to the previous everyday life or if it is to strive towards an everyday life recently experienced at rehabilitation, (that is, the experiences from the therapeutic garden in Studies II and III) and this seems important to acknowledge when designing various rehabilitation programmes.

Re-evaluating the meaning of occupations

The findings from Studies II-IV indicated that an important feature in connecting rehabilitation and everyday life was to create an understanding of how occupations could enable well-being based on the participants own practical experiences during the rehabilitation programmes. Being engaged in doing relaxing or creative activities seemed to create an emotional understanding of the value of such activities and facilitated an inclusion of these activities in everyday life. It is stated in the MOHO that “volition, habituation, and performance capacity are maintained and changed through what one does and what one thinks and feels about doing” (Kielhofner, 2008, p. 27). This statement underscores the view that the re-evaluation of the meaning of

occupations through practical experiences is a valuable therapeutic aspect in the rehabilitation of people with stress-related ill health.

The findings from Studies II-IV revealed that the re-evaluation of occupations was developed through the recurrent practices, the undemanding character of the activities and the feelings of competence that became apparent through the doing. These aspects are apparent in the MOHO when describing occupational change as a process in three stages (Kielhofner, 2008) and this emphasises the importance of them in rehabilitation. The first stage refers to exploration and occurs when people try new things and learn about their own capacities and values. This stage was experienced as quite unpleasant by the participants in Study IV as their own roles and values became questioned and these feelings have been identified as commonly present in the first stage. Therefore, this exploration requires a safe and undemanding environment (Kielhofner, 2008) and this supports the benefits of having rehabilitation in a therapeutic garden. The second stage is about experiencing competency and that was frequently experienced by the participants in their continuing process of practicing undemanding creative activities (Studies III and IV). The third stage focuses on achievement. In this last stage, sufficient skills, values and habits are achieved to fully engage in the activity. This process requires recurrent practice which was a predominant aspect described by the participants (Study IV).

Engaging in the practical activities during rehabilitation not only resulted in a change in the participants' occupational repertoire, the insights and thoughts that became apparent in the practicing of occupations also influenced the participants self image, their sense of being competent and reflections on their former interests and hobbies (Studies II-IV). These findings are also highlighted in previous research focusing on people with various diagnoses (Griffith, 2007; Peruzza & Kinsella, 2010; Reynolds, 2000; Reynolds, et al., 2008). From the findings in Study III it seemed that working with natural materials, such as for example flowers and willow branches, was important for the occurrence of these insights. It also evoked feelings of hope for a positive future and happiness about being able to create those lovely objects. The importance of working with natural materials has also been found in other rehabilitation programmes for people with stress-related ill health that have been performed in a therapeutic garden (Grahn & Ottosson, 2010).

The experiences of being absorbed in the doing and enjoying the practices enabled the participants to leave all troublesome thoughts behind for a while which was important for embracing the rehabilitation (Study III). This experience has also been found in elderly people engaging in joyful activities at a day-care centre (Andersson Svidén & Borell, 1998) and might be linked to the concept of flow (Csikszentmihalyi, 2002). Commonly, one important characteristic for achieving flow is the balance between the challenge of the occupation and the skill of the individual but that was not the case in the findings from this thesis. Instead, the participants described experiences of being absorbed in the undemanding occupations that did not require any great skills (Studies II and III). This has even been found in studies by Wright, Sadlo and Stew (2006, 2007) who found that the state of flow was also experienced in activities that not only promoted a balance between challenges and skills but also provided feelings of relaxation and mindfulness. Such occupations might be highly valued by people with stress-related ill health due to their previous experiences of not being able to balance their skills to the occupational challenges they perceive in everyday life (Ekstedt & Fagerberg, 2005; Gustafsson, et al., 2008). This is further supported in previous theoretical writing which argues that a therapeutic occupation needs to provide a mix of experiences of pleasure, productivity, and restoration. It is further stated that clients who are discouraged and exhausted might need occupations that are more restorative than highly productive (Pierce, 2001). In the performance of relaxing, creative and enjoyable activities at rehabilitation the recovery experiences of mastery and control became apparent (Sonntag & Fritz, 2007) and that reflection is further supported in previous research (Piskur, et al., 2002). This reasoning emphasises the importance of including undemanding and relaxing occupations in rehabilitation in order to promote feelings of flow and well-being.

The re-evaluation of relaxing and creative activities through practical experiences, engagement in these activities and the accepting atmosphere in the therapeutic garden enabled the participants to experience feelings that facilitated occupational balance as it is defined by Matuska & Christiansen (2008). These experiences were, for example, getting enough time for relaxation, having a reciprocal relationship with others during coffee breaks, starting to recognise their former selves and feeling engaged and competent while working with natural materials in creative activities. These examples derive from all the qualitative studies in this thesis (Studies II-IV) and it might thus be

concluded that many of the needs that are proposed by Matuska and Christiansen (2008) are met through the joyful doing of creative activities at rehabilitation.

Everyday life after rehabilitation

Literature within the field of occupational science and occupational health psychology states that occupational balance and recovery are related to health (e.g. Meijman & Mulder, 1998; Townsend & Wilcock, 2004; Westhorp, 2003; Wilcock, 1998). Based on these assumptions and the findings from this thesis discussed so far, it seems important to focus on engaging in creative activities during the rehabilitation of people with illnesses that affect occupational balance in everyday life. Still, an important issue to reflect upon is whether experiences that enable occupational balance during rehabilitation are transferred to the participants' everyday lives and whether the rehabilitation experiences facilitate return to work.

Occupational balance in everyday life

The findings from Studies II-III showed how the participants chose to add social and leisure occupations that promoted relaxation in their everyday lives, and how they took control of their everyday lives again. One interpretation of these findings could be that the participants attained recovery (Iwasaki, et al., 2005; Sonnentag, 2001; Sonnentag & Fritz, 2007). However, these aspects all influence occupational balance or imbalance as well (Jonsson & Persson, 2006; Matuska, 2010; Matuska & Christiansen, 2008). Below the concept of occupational balance will be discussed in relation to the findings from Studies II-IV.

In Study IV, which focused on the connection between rehabilitation experiences and everyday life, all the participants were engaged in work to some extent. Furthermore, it was found that they had added relaxing and enjoyable occupations to their occupational repertoire after completing the rehabilitation programme. Similar findings were seen in Study II. These findings can be viewed in various ways in relation to occupational balance depending on how occupational balance is considered, i.e. in relation to occupational areas, time use or characteristics (Wagman, Håkansson, & Björklund, 2011). When looking at occupational balance as a balance between various areas of activities (Meyer, 1922), it might be said that the participants had achieved the basic conditions for experiencing occupational balance. Furthermore, some of the participants seemed to be satisfied with the time they spend on each of these activities

while others wished to be able to spend more time on work or activities on their own. However, approaching occupational balance through the time use of occupations has been discussed and it has been found that time use is often similar for people who perceive balance and for people who perceive imbalance (Harvey & Singleton, 2009). In this thesis it was found that even though some participants seemed to spend sufficient time on various types of occupations and others did not, most of them were not satisfied with their actual participation in occupations. They did not experience their work as satisfying or meaningful nor did they experience control of that occupation. That is, in concordance with the experience-based perspective of occupational balance that is used in this thesis (Håkansson, et al., 2006; Jonsson & Persson, 2006; Matuska & Christiansen, 2009; Stamm, et al., 2009), it might be said that the participants had not achieved the basic conditions that are needed to experience occupational balance in everyday life even though they had started a progressive process towards occupational balance by including activities that were self-rewarding and relaxing. Nevertheless, they described frustration and feelings of being left alone in their process of returning to work and that is an important issue for discussion.

The return to work process

The findings from Studies II-IV revealed that the rehabilitation facilitated experiences that increased the participants' well-being. However, some barriers to returning to work became apparent in Study IV even though the rehabilitation clinic practiced vocational multimodal rehabilitation. The main goal of vocational rehabilitation is to facilitate return to work (Vahlne Westerhäll, et al., 2009). For people with stress-related ill health it is known that a positive return to work is crucial in the whole rehabilitation process and that failure in this phase of rehabilitation might lead to long term consequences (Perski, 2006). This knowledge makes the findings regarding return to work from this thesis particularly important to discuss.

Findings from Study IV deepened the understanding of what barriers the participants experienced in their return to work process. They described feelings of being misunderstood by their managers and they felt left alone in the communication concerning their future work situations. This finding supports previous research which emphasises the need of interventions focusing on starting a dialogue between the individual and the work organisation (Karlson, et al., 2010). Furthermore, the support from rehabilitation in which the person feels seen, heard and understood needs to

continue in the insecure situation of returning to the place in which the working conditions were perhaps the cause of their stress-related ill health.

In Study IV, the participants experienced a gap between the rehabilitation experiences and the workplace. This is already known from previous research, indicating that a barrier to returning to work might be specific environmental factors such as an indistinct work organisation, unsolved conflicts at work and low degree of influence at work (Holmgren & Dahlin Ivanoff, 2004). In MOHO the environment is viewed as constantly interacting and impacting on a person's capacity to perform an occupation by either being supportive or demanding (Kielhofner, 2008). People with stress-related ill health often experiences difficulties in handling responsibilities and demands from themselves and others (e.g. Arman, et al., 2011; Eriksson, et al., 2008; Gustafsson, et al., 2008) and in Study IV the difficulty handling demands from their managers at work was still apparent after the rehabilitation programmes. During rehabilitation there was a great deal of emphasis put on the undemanding character of the therapeutic garden and the activities practiced there, and the studies in this thesis showed that this was important in the initial phase of rehabilitation. However, in our findings it also seems important to consider the environmental aspects of the workplace and gradually increase the demands on the participants during rehabilitation to help prepare them for the demands that are mostly apparent in a workplace. This is congruent with previous research which emphasised the need to include interventions targeting the workplace in the rehabilitation of people with stress-related ill health by including work practices, (Wästberg, 2011) and is further supported by Pierce (2001) who argues that it is in the client's own actual setting that the highest potential for problem solutions is to be found.

Still, the participants' progress towards recovery and occupational balance in their private arenas in everyday life (Study IV) is also valuable in the process of return to work. In previous research on healthy people it has been found that the private arena is seen to be more important than work for perceiving occupational balance, and a good private arena is also seen as something that could make work easier (Wagman, Björklund, Håkansson, Jacobsson, & Falkmer, 2011). Furthermore, it is known that a positive view of the future (Hansen, et al., 2005; Hillborg, et al., 2010) and engagement in self-rewarding, recreation and enjoyable activities is important for a successful return to work (Holmgren & Dahlin Ivanoff, 2004). Practicing relaxing and enjoyable

activities was called for by women who participated in vocational rehabilitation without such activities (Wästberg, 2011). Considering the aggregate knowledge from previous research and the present thesis, it might be concluded that rehabilitation that includes relaxing and enjoyable occupations provides a solid base for the continuing process towards return to work by enabling experiences that facilitate occupational balance and promoting changes in the private arena in everyday life. This supports the conclusion that a person's private life needs to be considered and given higher priority in vocational rehabilitation.

Methodological considerations

The four studies in this thesis contribute new knowledge on how people with stress-related ill health perceive their occupational repertoire before rehabilitation, how they experience the rehabilitation process and how these experiences connect with everyday life by using various designs and methods. In the following section, some of the main methodological considerations will be discussed and critically reflected upon.

Inclusion of participants

Four different samples have been used in this thesis. Three samples included people with stress-related ill health or musculoskeletal pain and these participants were recruited from the same rehabilitation clinic in collaboration with the personnel working there. This sampling strategy has led to some consequences that need to be considered.

The SMBQ has been used to measure stress in all the participants included in this thesis. Furthermore, it has been used as inclusion criteria in Studies I and II. This choice was made due to the fact that people with various diagnoses of stress-related ill health and musculoskeletal pain were to be included. The cut-off score was set at ≥ 3.75 . The use of SMBQ as inclusion criteria might be seen as a limitation since there is no consensus regarding the cut-off scores that should be used to define an unhealthy degree of stress and 3.75 might be considered to be quite low. Still, it has to be observed that even though the cut-off score was set to 3.75, the mean range of SMBQ was ≥ 5.0 in all the studies which reflects the high degree of stress perceived by the participants.

The participants who were former clients in Study II had all completed their rehabilitation programme as they were recruited after the rehabilitation programme had ended. That might have affected the findings as the persons that did not fulfil their rehabilitation programme were excluded. By also including these people a broader variation of experiences from the rehabilitation could have been found and thus enhanced the representational generalisation (Lewis & Ritchie, 2003). Nevertheless, the aim of this qualitative study was not to generalise the findings to a larger group of people, rather, it was to explore and describe experiences from the particular rehabilitation process.

The participants in Studies III-IV were selected by purposive sampling (Polit & Beck, 2004) and recruited from the same rehabilitation group. A possible limitation might be that the participants reflected on the interviews together and thus influenced each other during the longitudinal data collection procedure. Still, theoretical sampling (Charmaz, 2006) was applied in the sense that the development of the interview guides was based on the individual interviews with each person and that might have deepened the individual understanding of each person's own experiences.

The participants included in this thesis are predominantly women. This is in line with the national incidence of men and women with these problems (Socialstyrelsen, 2008). Still, it would have been enriching to include more men in the studies to gain insight into their experiences of rehabilitation and everyday life.

Methods for data collection

The Occupational Gaps Questionnaire measures to what extent individuals perceive a discrepancy between what they want to do and what they actually do and thus it provided valuable information for targeting the aim of Study I. However, it has to be acknowledged that the instrument has been quite recently developed in the research on people with acquired brain injuries (Eriksson, et al., 2006) and has previously not been used in people with stress-related ill health. To include a reference group from the Swedish population was one action taken in order to validate the findings. This inclusion enabled a comparison and a better understanding of the results for the rehabilitation group and strengthened the results of this study.

In Study II the interviews were conducted on only one occasion which is viewed as a limitation in qualitative research. Performing one single interview limits the opportunity to follow-up interesting descriptions and restricts the possibility to create a relationship based on trust between the researcher and the informant. This may limit the richness and the credibility of the data (Dahlberg, et al., 2008). However, the possibility to explore interesting descriptions more in-depth was given by applying theoretical sampling in the data collection procedure (Charmaz, 2006).

The longitudinal design (Saldana, 2003) of Studies III and IV with recurrent interviews during the participants' rehabilitation programmes and three months after completion made it possible to identify changes in their experiences of the rehabilitation process. This design enriched the data and might be seen to be a strength of the studies. However, the findings from Study III revealed that the process was still ongoing at three months after completed rehabilitation and in order to be able to study the whole process, follow-up interviews at perhaps six and twelve months after completed rehabilitation would have been valuable.

Methods for analysis

In Study I, the fact that the OGQ has been quite recently developed in the research on people with acquired brain injuries (Eriksson, et al., 2009; Eriksson, et al., 2006) and had never been used within a group of people with stress-related ill health also implied some challenges in the process of analysing the data. In previous research on people with brain injuries it has not been considered that a gap exists if the person answers that he/she does not do activities that he/she does not want to do. In people with stress-related ill health and musculoskeletal pain there might be a possibility that such an answer could be due to lack of initiative and various defence mechanisms in order to cope with their present situation, and the participants might thus not be satisfied with not doing activities that they at that moment do not want to do. This needs to be further studied in qualitative research.

In Study II, the inclusion of various perspectives (former clients and team members) through theoretical sampling could be seen to be a strength as it might deepen the knowledge of the particular research question (Charmaz, 2006). Still, to analyse data from various perspectives poses some challenges. In this study, the data from the former clients and the team members was first analysed separately and then

consolidated at a later stage of the analysis. This seemed to be the proper way to perform the analysis as it might be difficult to adopt two perspectives at one and the same time. However, this action might also be the reason for the unbalanced focus of the findings, which predominantly reflect the former clients' perspective. By focusing more attention on the team members' perspective important findings could have been identified and thus strengthened the clinical implications of the study.

The data collection procedure for Studies III and IV was the same even though two different qualitative methods were chosen for the data analysis. To re-use the same set of data with another research question and another method of analysis could imply bias and an intrusive pre-understanding that could be difficult to bracket (Karlsson, 1995). The reasons for this choice need therefore to be explicated. The application of grounded theory is suitable in areas in which there is a lack of knowledge and which have not been explored in research (Glaser & Strauss, 1967). Furthermore, it is a suitable method to apply when studying processes (Charmaz, 2006; Glaser & Strauss, 1967), which was the aim of Study III. The findings from Study III provided information about the participants' experiences of their rehabilitation process. Nevertheless, further questions regarding the phenomenon of connecting rehabilitation experiences and everyday life were raised and that became the focus for Study IV. The use of the EPP method in Study IV was a good complement to the grounded theory approach in Study III as it made it possible to deepen the understanding of the subjective experiences of a particular phenomenon (Dahlberg, et al., 2008; Karlsson, 1995).

In the analysis in Study IV, it was challenging to bracket and disregard any pre-understanding as the data already had been analysed once. However, the focus of this study derived from the findings in Study III, and guiding the design of a study based on what had been found in previous research might also be regarded as a strength rather than a weakness. By applying phenomenological reduction a true attempt to handle the pre-understanding and make the participants' original experiences explicit was made (Karlsson, 1995). This method made it possible to use the empathetic understanding and to enter each participant's unique life-world as far as possible, which was not the case in Study III as it focused on their actions in the processes they experienced. Furthermore, the analysis was discussed and refined several times until a 'horizontally consistent interpretation' was reached. Two of the authors in Study IV were not particularly familiar with the data from the previous analysis. Still, it has to be

recognised that they had to bracket their own pre-understanding from previous experiences and knowledge about the field (Dahlberg, et al., 2008; Karlsson, 1995). For practical reasons it was not possible to start analysing data during the data collection in Study III as is proposed in grounded theory (Charmaz, 2006; Glaser & Strauss, 1967). That might be seen as a limitation in Study III; however this limitation made it possible to apply a phenomenological method in the analysis of the data in Study IV.

Generalisation of findings

The findings in this thesis mostly derive from qualitative research and the issue of generalisation is thus important to discuss from that perspective. This discussion is based on the three aspects of generalisation proposed by Lewis and Ritchie (2003), namely representational generalisation, inferential generalisation and theoretical generalisation. The samples used in the thesis were all included from one specific clinic and all participants completed the rehabilitation programme in which they were involved. Thus, the samples cannot be considered to be representative of all people with stress-related ill health and musculoskeletal pain and this limits the representational generalisation. Inferential generalisation refers to whether the findings from this particular research can be generalised to other settings or contexts. The rehabilitation clinic used in this research project offered a quite unique context as the rehabilitation programmes were mostly situated in the therapeutic garden, and the results might therefore be difficult to transfer to other settings. It would have been preferable to recruit participants from different rehabilitation clinics in order to enhance inferential generalisation (Lewis & Ritchie, 2003). Phenomenological findings (Study IV) are contextual but the findings might have meaning for other contexts as well (Dahlberg, et al., 2008). Thus, the findings raise important aspects that can be applied in rehabilitation programmes that are not situated in a therapeutic garden. Theoretical generalisation refers to the contribution of a theory or concept more generally (Lewis & Ritchie, 2003) and the unitised findings from this thesis might be seen as providing valuable knowledge regarding the concepts of occupational balance and thus contribute to the development of this concept.

Ethical considerations

All the studies (I-IV) in this thesis were approved by the Research Ethics Committee at Karolinska Institutet. The participants received written and verbal information prior to their participation in the studies, and all the participants consented verbally to

participation. In addition, they were given information regarding the opportunity to withdraw their participation from the studies at any time.

One ethical dilemma in Study I was that the inclusion procedure was performed by the team members working at the rehabilitation clinic. This choice was made based on the decision to not involve another new/unknown person at the time when the participants were entering the rehabilitation programme as this period might be experienced as insecure for them even without being asked to participate in research. However, this line of action might have made some participants feel obliged to participate in the study due to their involvement with the team members in the forthcoming rehabilitation programme. It should however be noted that the researcher and the team members that performed the inclusion procedure were aware of this risk and emphasised the voluntariness of the participation in the study.

All data collection in Studies II-IV was carried out by the researcher who did not know the participants. This may have constituted a possible ethical dilemma in Study II in which only one interview was conducted and there was limited opportunity to establish a good relationship between the researcher and the participant prior to the interview. However, in this study the interviews were performed retrospectively and most of the participants had progressed through their most vulnerable period. The interview questions focused on concrete experiences from their rehabilitation period and their everyday lives and the participants seemed to appreciate the opportunity to recount their experiences.

In contrast to Study II, the researcher was able to follow the participants in their ongoing rehabilitation process over a period of nearly six months in Studies III and IV, which introduces another ethical dilemma. The qualitative interviews in these studies that were conducted during the initial phase of the rehabilitation programme aroused emotional reactions as the participants experienced sadness and grief when talking about their everyday life situations. The researcher was aware that such reactions could emerge and made sure before the interviews that there was enough time scheduled to allow the interviews to end in a positive way. After some interviews that had been particularly emotional the researcher made a phone call to the participant the day after to ensure that they were feeling alright. Even though these negative reactions emerged during the data collection procedure the participants expressed how the interviews felt

therapeutic in that they helped them to reflect on their experiences of the rehabilitation process and they also expressed interest in continuing with additional follow-up research projects.

CLINICAL IMPLICATIONS

The empirical findings of this thesis provide knowledge that can be implemented in occupational therapy practice as well as in multimodal rehabilitation services. The perceived occupational repertoire in people with stress-related ill health has been explored. Both knowledge of valuable aspects in rehabilitation and an increased understanding of how rehabilitation experiences and everyday life connect have been generated through the participants' own experiences. Below, clinical implications of this knowledge will be discussed.

- Based on the findings in this thesis, it seems that there is a lack of enjoyable leisure activities in the occupational repertoires of people with stress-related ill health. It has been found that valued and enjoyable activities enable recovery and occupational balance and thus provide a solid base for starting the return to work process. These results emphasise the need to consider the whole occupational repertoire in the rehabilitation of people with stress-related ill health.
- In rehabilitation, it is crucial to include the practice of enjoyable activities in order to enable the client to re-evaluate the meaning of occupations and to create an understanding of how occupations can enable well-being. In this thesis, it was found that such experiences enabled occupational balance as the participants started to introduce relaxing and enjoyable activities in everyday life. This indicates the need to include creative and enjoyable activities in rehabilitation programmes.
- When designing rehabilitation programmes for people with stress-related ill health it seems to be valuable to consider the environment in which the rehabilitation is situated. A place that is experienced as safe, calm and undemanding seems to be important to enable the client to fully engage in the rehabilitation programme. This indicates a certain need for creating a safe and accepting atmosphere in a rehabilitation programme even when the rehabilitation is not situated in the specific environment of a therapeutic garden.
- Based on the findings from Study IV, it seems crucial to maintain the contact established between the client and the rehabilitation team after the rehabilitation programme, and to involve the rehabilitation personnel in the communication

between the client and the manager at the workplace in order to minimise the client's sense of being left alone in the forthcoming process of returning to work.

- In clinical practice it is central to acknowledge the actual situation of the clients, including personal resources and preferences as well as barriers and facilitators in occupations practiced in the private and the working arena. This might be achieved by combining cognitive behavioural therapy with the practicing of activities in rehabilitation and such a combination seemed to be useful in this research. Thus, to consciously use both approaches in rehabilitation is one suggestion for clinical practice.

To summarise the clinical implications that have been identified in this thesis based on the unitised findings, it might be recommended that rehabilitation for people with stress-related ill health needs to focus on the private as well as the work arenas in everyday life to achieve occupational balance and a positive return to work.

Furthermore, rehabilitation needs to include creative, relaxing and work-related activities, support in a constructive dialogue between the participant and the workplace, and continued support of the clients in follow-ups targeting the workplace after the actual rehabilitation programme.

FUTURE RESEARCH

Research related to the occupational repertoire, the rehabilitation process, and occupational balance for people with stress-related ill health is an important area which needs to be further explored. This thesis generated knowledge in these issues but also provided new questions that would be interesting to explore in future research. Some of these issues will be elaborated on below.

In this thesis, people with musculoskeletal pain or stress-related ill health reported occupational gaps in everyday life to a greater extent compared to a normal population and to people with acquired brain injury. However, the underlying reasons for reporting occupational gaps was not explored in this thesis and it would be interesting to provide future studies that aim at deepening knowledge of the reasoning around perceiving gaps and the meaning of gaps in everyday life from a qualitative point of view.

It was also found in Study I that the desire to perform instrumental ADL differed between the people from the rehabilitation group who had been on sick leave for less than a year and the participants who had been on sick leave for more than a year. This result has been discussed and reflected upon in the discussion. Still, the design of the study did not provide any thorough knowledge regarding the reason for this result. It would be interesting to explore what this difference actually means to the participants and in what way the instrumental ADL become more desirable when on sick leave for a longer period of time.

The activities performed during rehabilitation were experienced as important features for enabling recovery and occupational balance in everyday life. These results are of high clinical relevance. Still, what must be taken into account is the fact that the rehabilitation programmes studied in this thesis were performed in the specific context of a therapeutic garden which is not a common context in the field of rehabilitation of people with stress-related ill health. For this reason it would be of great interest to explore rehabilitation programmes including creative activities in a context other than a therapeutic garden to further explore the value of occupations in rehabilitation.

The findings from Studies III-IV identified a need for continuous follow-ups after the rehabilitation programme. In the interviews performed three months after the

rehabilitation programme had ended, the participants described how they still struggled to achieve occupational balance in their everyday lives even though this had improved during the rehabilitation programme. These findings generate questions regarding when the rehabilitation process could be considered to have ended and how the participants' continuous struggle was experienced. These questions highlight the need for longitudinal follow-ups when studying the rehabilitation process and they need to be focused on in future research.

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