EDITORIAL

Communication style: help or hindrance in facilitating return to work?

‘Unless people believe they can produce desired effects by their actions, they have little incentive to act’—Albert Bandura, Self-Efficacy: The Exercise of Control.

Bandura’s theory states that ‘Perceived self-efficacy refers to beliefs in one’s capabilities to organise and execute the courses of action required to produce given attainments’ [1]. In the workplace setting, self-efficacy is an individual’s belief that they can do what is needed to do the tasks of the job in hand, whatever that is, whether it is returning to work after sick leave or looking for a job. It is a useful concept that has attracted significant attention with regard to unemployment people [2] but its application to return from sick leave has been little researched.

It is known that the longer people who have chronic health problems are absent from work, the less likely they are to return. This is particularly well described for conditions such as low back pain [3]. Recent research has also found that self-efficacy is significantly lower among those with sickness absence compared to the general working population [4]. The authors conclude that lower self-efficacy among those off sick is a result of the sickness absence rather than a precursor to it.

If being absent from work lowers self-efficacy and low self-efficacy is linked to inactivity and inability to take positive steps to return to work, occupational physicians should avoid lowering individual self-efficacy through the use of inappropriate language. It can be argued that to speak to an individual of having ‘barriers’ and overcoming their ‘barriers’ may be detrimental to that individual and impair their chances of a successful return to work.

There are different conceptualizations of disability or the ‘disablement process’ [5] including the medical and biopsychosocial models and the ‘interaction’ approach of the recently adopted UN Convention of Disability [6]. There is also the ‘social’ model, described by Oliver in 1996 [7] which describes how it is society or more specifically the environment (including attitudes, organization, communication and other factors) which disables people with impairment by creating barriers to full social and economic participation. These result in disabled people being unable to move, function and communicate as effectively as people without impairments. As a great deal of the environment we live in is designed consciously or unconsciously by non-impaired people, for non-impaired living, disabled people are thus prevented from full participation. Discussion of this issue has resulted in the word ‘barriers’ becoming one of the most commonly used words in the language around disability and impaired work capacity. Barriers are defined by the Oxford Dictionary of Current English as a ‘fence etc. that bars advance or access’ or an ‘obstacle’ [8]. The very word and definition conjures up images of a physical structure that prevents an action we might wish to do. Therefore, whilst elements of society might be a ‘barrier’, we question whether this is the right language to use to talk to people about their health and work. An individual could enter a consultation or work related interview with back pain or anxiety but leave with a ‘barrier’. The question is whether language can help or whether it hinders the return to work process. It certainly changes a specific issue into a general negative concern of uncertain influence and range. Bandura [1] notes (citing Cervone) ‘Dwelling on the formidable aspects of a (specific) task weakens belief in efficacy, but focussing on the do-able aspects of the same task raises self-efficacy beliefs’. Other authors have pointed out the problems associated with both the implications of the word barriers (with a preference for the term ‘obstacles’) and the difficulty in expecting individuals to dismantle what it means for them given that the term has social origins [9]. Alternative suggestions have included terms such as challenges or constraints.

Whatever the term, if it is negatively phrased it introduces immediate limitations in thinking and perceptions of ability. The net effect is convergent thoughts that limit the scope for problem solving and solution-focused thinking. Similarly locating the issue with the individual restricts the role of broader factors that may assist a return to work such as workplace adaptations and adjustments. There is therefore an argument to avoid using inappropriate language or terms such as ‘barriers’ whilst working with people. We believe it reinforces their perception of the difficulties they may have in taking action to gain or retain employment. Such language can inflate the individual’s negative perception of the challenges to be faced for a return to work simply by emphasizing the potential difficulties.

So if this is ‘bad’ communication, what does ‘good’ communication look like?

Researchers agree that the key to ‘good’ communication is empathy, the two stage process involving firstly an understanding of another person’s situation and secondly communicating that understanding back in a supportive way [10]. An empathetic style is aided by good ‘technical’ communication skills, including active listening to ensure messages are received correctly, careful articulation to ensure messages are transmitted effectively and sensitive exploration to check if the message was understood appropriately.
[11]. Good interviewers know it is important for individuals to be able to make a choice about their next step and to be aware of the advantages and disadvantages of going in different directions [11]. They also know it is important for individuals to feel an equal partner in the discussion and that superior language skills are not guiding them toward a goal choice that they have doubts about [12].

Within medicine, research has distinguished between ‘good’ and ‘poor’ communication in several settings including medical education [13] where good communication is described again as empathic. In this scenario, the individual is engaged and there is attentive responding, sign posting, putting things into context, and very importantly, sequenced statements or questions, which gradually build up in a logical fashion. It is a positive approach aimed at producing an effect/restoring health and re-engagement with normal functions like work. Conversely, poor communication is like a scattergun and it distances the individual. Characteristics of poor communication include, inappropriate responding, use of lists and a failure to store replies. It is a negative approach that is insensitive to the individual’s understanding of their condition, i.e. acts as an inhibition to action limiting scope for adjustment and re-engagement/resumption of normal activities such as work.

There is evidence that clearly shows the power of communication. Good communication by doctors can improve the physical and emotional health of patients and even reduce the costs of healthcare [14]. How doctors communicate also influences their likelihood of being sued for medical negligence [15]. If we believe that health outcomes influence individuals’ own perceptions of work capacity then how occupational physicians talk to patients could influence the likelihood of return to work. This is fertile territory worthy of further attention particularly the potential benefits of positive enabling discussions that concentrate on capability and translate solutions that work at home and socially into solutions that work at work. The concept of identifying capability and not concentrating on incapacity is a fundamental underlying principle of the new Statement of fitness (the ‘fit note’) that was introduced into Great Britain on 6 April 2010.

It is not just communication and language that are important. Interviewers’ verbal and non-verbal behaviour also influences interviewee behaviour, and not just the smiles and nods that many practitioners use to encourage responses. Job applicants with disabilities were found to be able to perceive the judgements made by employers in employment interviews [16] and then behaved in accord with the judgement. So good communicators need to select an appropriate level of language, interview people with empathy and avoid sending verbal and non-verbal messages that may be perceived by interviewees to be negative and thus undermine the individual’s beliefs and their ability to act.

We believe that practitioners should direct their efforts to enabling the individual to visualize the way forward to work based on the solutions that will enable them to succeed and not create a picture of barriers that will impact negatively on their self-perception and underlying beliefs. We recognize that ‘barrier’ is a term in widespread usage and appears in the UN Convention but we would argue that its inappropriate use can have negative consequences for individuals—usage needs to be managed so it is appropriate—and practitioners need to take care with their selection of words within the context of attendance management discussions, return to work interviews and organizational sickness absence policies. We believe there is appropriate usage within the social context in order to remove social barriers but that at an individual level the term should be avoided lest it inadvertently gives the message that work is a more distant possibility than it truly is.

After all, as Epictetus, the 1st century Greek philosopher pointed out ‘Perception is truth because people believe it’.

Nerys Williams and Richard Birkin
Health, Work and Wellbeing Directorate, Department for Work and Pensions
e-mail: nerys.williams2@dwp.gsi.gov.uk

Conflicts of interest
Both authors work for the Department for Work and Pensions. The views are their own and not those of any employing organization.

References