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A five-phase process model describing the return to sustainable work of persons who survived cancer: a qualitative study

Abstract

Purpose: We investigated persons who survived cancer (PSC) and their experiences in returning to sustainable work.

Methods: Videotaped, qualitative, in-depth interviews with previous cancer patients were analyzed directly using “Interpretative Phenomenological Analysis” (IPA). Four men and four women aged 42–59 years participated. Mean time since last treatment was nine years. All participants had worked for more than 3 years when interviewed. An advisory team of seven members with diverse cancer experiences contributed as co-researchers.

Results: The entire trajectory from cancer diagnosis until achievement of sustainable work was analog to a journey, and a process model comprising five phases was developed, including personal situations, treatments, and work issues. The theme “return-to-work” (RTW) turned out to be difficult to separate from the entire journey that started at the time for diagnosis. PSC were mainly concerned about fighting for life in phases 1 and 2. In phase 3 and 4, some participants had to adjust and make changes at work more than once over a period of 1–10 years before reaching sustainable work in phase 5. Overall, the ability to adapt to new circumstances, take advantage of emerging opportunities, and finding meaningful occupational activities were crucial.

Conclusions: Our process model may be useful as a tool when discussing the future working life of PSC. Every individual’s journey towards sustainable work was unique, and contained distinct and long-lasting efforts and difficulties. The first attempt to RTW after cancer may not be persistent.

Keywords: Survivor, Cancer, Return to work, Psychological adaptation, Health promotion, Qualitative research

Introduction

Although the incidence of cancer is increasing, earlier diagnosis and improvement of cancer care have led to an increase in survival rates in the Western world (Cancer Registry of Norway, 2016; Engholm et al., 2016; Torre et al., 2015). Further, according to Norwegian 2015 statistics (Cancer Registry of Norway, 2016), almost three out of four cancer patients (71%) now survive more than five years after treatment and about 40% of cancer patients are of working age (20–59 years) at the time of diagnosis. These numbers are comparable with other European and Nordic countries (Engholm et al., 2010; International Agency for Research on Cancer, 2017).

A substantial amount of research has reported the complexity of return-to-work (RTW) processes. Physical and psychological effects after cancer treatment influence the process, as well as psychosocial, economic, and environmental factors at work and in private life (Feuerstein et al., 2010; Mehnert et al., 2013). According to Mehnert (2011), approximately 60–70% of persons who survived cancer (PSC) who are of working age return to work. They demonstrated that cancer survivors have a higher risk of ceasing work than others have. Clinical factors such as advanced cancer stage, chemotherapy and sociodemographic factors may increase the risk of unemployment (Mehnert, 2011). Working life is in itself considered valuable because it is associated with identity, normality, and a contribution to the community (Dorland et al., 2016; Kennedy et al., 2007); therefore, being unable to RTW can represent a personal defeat that may lead to lasting obstacles (Little et al., 2002; Wells et al., 2013).

PSC may need to change their occupation, type of work, or reduce working hours for successful RTW (Mehnert, 2011; Torp et al., 2012). Mehnert (2011) found that, on average, approximately half of employed PSC report changes in occupational role. In Norway, Torp et al. (2012) found that one fourth of employed cancer patients make adjustments at work. Research also shows that close collaboration and dialogue between the employer, the workplace, and healthcare providers in the planning of RTW has profound impact on positive RTW results (Grunfeld et al., 2010; Kennedy et al., 2007; Mehnert, 2011; Torp et al., 2012). However, despite this substantial amount of knowledge, there is more to learn about RTW after cancer.

Sustainable work is defined as a situation where “living and working conditions are such that they support people in engaging and remaining in work throughout an extended working life” (Eurofond, 2016 p. 1). In previous research, the aims in investigating RTW processes have often

considered the initial phases of RTW and have rarely examined the lasting outcomes (Barnard et al., 2016; Mehnert et al., 2013; Torp et al., 2012). This represents a gap in the knowledge, because the entire RTW processes may be of longer duration and one's initial RTW may not always be successful or enduring.

Wells et al. (2013) suggests that the concept of RTW may be too simplistic, and points to the importance and need for individualized support for PSC in processes of defining work-related goals. Several other researchers also underline the importance of self-assessment regarding ability to work—independent of clinical factors and age—and note the importance of individualized support, techniques, and cooperation in the quest of RTW (Barnard et al., 2016; Boerger-Knowles and Ridley, 2014; de Boer et al., 2008; Keesing et al., 2015; Mehnert et al., 2013; Stergiou-Kita et al., 2016).

Little is known about RTW-promoting factors and the individual abilities of PSC to adapt to altered circumstances and the resources they need in divergent phases of the entire RTW process towards lasting and sustainable work. Therefore, due to the increasing number of people who live many years with the chronic effects from cancer, we investigated RTW factors and the long-term perspectives involved in sustainable RTW. Specifically, we explored experiences of PSC after they had re-established normality and returned to sustainable work.

Method

We applied Interpretative Phenomenological Analysis (IPA) as our research design (Smith et al., 2009) and performed recruitment of participants, in-depth interviews and case analyses as parallel processes, which endured approximately one year before the search for nuances and patterns across the cases began. During the interview and analysis phase, an advisory team with experience relevant to RTW after cancer participated in the research process. The members included former cancer patients, health and social work personnel, an immediate supervisor, a medical doctor, and next of kin. This team contributed with comments and questions and thereby heightened the quality of the study in the development of the theme guide and the analysis (Borg and Kristiansen, 2004; Mjøsund et al., 2017).

Sample and recruitment

Twelve volunteers responded to our advertisements on Facebook, the websites of the University College of Southeast Norway, and the Norwegian Cancer Society. Three did not fill the inclusion criteria, and one withdrew because he could not find time for the interview. After interviewing eight participants, we found the information power to be satisfactory (Malterud et al., 2015). The persons selected were aged 25–59 and had experienced long-lasting, or invasive, cancer treatment with surgery, radiation, and/or chemotherapy (Table 1). Three participants were diagnosed with breast cancer, and the others had various diagnosis: brain cancer, leukemia, testicle & lymph cancer, kidney & non-Hodgins lymphoma, giant cell tumor & lung cancer. Except for the participant with leukemia, who was on medication when the interview took place, all the other participants were cancer free. Moreover, we prioritized sociodemographic and cancer type diversity and occupations/work tasks. Participants had all achieved sustainable work (i.e., working more than 3 years (part-time or full-time) after their last treatment) and had no recurrent cancer or new diseases influencing their work in that period. The mean time since the last treatment was nine years.

(Insert Table 1 about here)

Data collection

The videotaped interviews lasted 96 minutes on average. The participants chose the location; three preferred their homes and five preferred their workplace. Three participants were re-interviewed after the initial analysis process. We chose Britt, Grete, and Carl because we had some additional questions for them from the first interviews that needed clarification. In addition, we wanted to discuss our abstractions and the process framework to determine participants' opinions.

The first author performed all interviews, using a theme guide as a mental guide only and aimed to obtain participants reflections through reflexive dialogues (Borg et al., 2012; Malterud et al., 2015; Smith et al., 2009). The theme guide contained questions about the entire process from diagnosis, including treatment and how it affected working life, towards the process of RTW and what factors the participants stated as important for RTW and life normality. After initial conversations about the interview and its content, the opening question was, "Will you please tell me what you consider to be your most crucial factors in the process of successful RTW after cancer and cancer treatments." Hence, the intention was to conduct almost entirely open interviews, and the interviews were thoughtful dialogues. The interviewer was aware of possible unequal power dynamics between the

interviewer and the interviewee during the conversation and focused on respectful and empathic behavior (Malterud, 2001).

All videos, notes, conceptual maps, memos, abstractions and data gathered during the process were organized, coded, and filed in the database and NVivo 11 program (QSR International, 2016). Transcribed statements from the interviews illustrate the results of this study.

Data analyses

The IPA methodology was applied in accordance with Smith et al.'s (2009) recommendations. We analyzed each interview thoroughly before sampling and interviewing the next participant. Immediately after interview completion, the interviewer taped her reflections on the total impression of the interview. Thereafter, the complete case analysis of the current case was performed before the next interview took place.

To maintain closeness to the original data, we analyzed video directly without transcription (Beich et al., 2002), which allowed us to incorporate both tone of voice and body language in statement interpretation. Key statements were transcribed verbatim and added to the textual notes. Codes were inductively developed and interlinked. Finally, codes were abstracted into a mind map of categories for each case.

After the eight interviews were analyzed, we searched for nuances and patterns across the cases. In the final stage of the analyses, we utilized the NVivo mind maps and project maps of the coding from the eight case analyses. This process resulted in a mind map containing the overall themes and abstractions. The advisory team was engaged in the analyses process and contributed with comments and critical questions to the initial interpretations from the researchers (Malterud, 2001).

Ethics

The Norwegian Regional Ethical Committee (REK) evaluated and approved the project in April 2015 (reference no. 2015/1232). Orally and in writing, we informed participants about the project aim, interview content, use of videotaping, and confidentiality of the project (pseudonyms were used for participants' names). Participants provided informed, written consent and could withdraw from the project at any time without consequence. In accordance with the REK, only the main researcher had

access to the raw material and videos that were stored on a secured area at the University server. All written material and video copies were stored in a locked safe.

Results

The primary category from the analyses was the total trajectory with all its difficulties, often referred to as one's "journey." Gradually, it became apparent that work issues were difficult to separate from the total cancer experience. Although each participant was unique, and their situations showed complexity and diversity, all stories had striking parallels. Common themes were recognized and, slowly, a process model containing five phases was developed (Figure 1). The phases in the process model overlap and the timeline and importance of the phases differed between participants. A prominent sense among the participants was that they temporarily felt detached from "reality" or their normal life. We named this perceived reality as "the World of Cancer":

"The issue is returning to work, right? (...) or returning to reality..." (Anne)

"It is important not to dwell too long along that way, but to keep moving." (Carl)

"It was an extremely long journey." (Frank)

(Insert Figure 1 about here)

Figure 1. The five-phase process of return-to-work from "the World of Cancer." It was not possible to return to one's former reality from the World of Cancer or the new reality. The double-headed arrow between the new reality and the World of Cancer shows that both directions are accessible.

The main finding from the re-interviews, performed with three of the participants, was that all of them recognized the possibility for a quick return directly to "the World of Cancer" (e.g., by experiencing a new illness) and agreed with the model structure:

"Yes, this is true. I was suffering from pneumonia last December, and, instantly, I felt like standing by the gate to the World of Cancer when they told me to check for new cancer cells. I felt standing by this gate—or entrance to the World of Cancer—until January, when I received the message I was still cancer free." (Grete)

Phase 1. Departure to "the World of Cancer"

Departure time to “the World of Cancer” seemed to be immediate upon receiving the diagnosis (Figure 1). Two key issues emerged in this phase: facing death and being alone. Doubts about survival started with the great shock of facing the reality of possible death. The participants stated that the general knowledge that we are all going to die one day seemed completely distinct from realizing that that time could be *now*:

“It was a shock. It felt like being punched... in the stomach... I had this picture of a very serious disease... and of course, I was afraid to die. ... Time ceased to exist, and ... I felt like... being in limbo. ...My existence was ripped away from under my feet when I received the diagnosis ... and I thought.... Shit... now I’m going to die.” (Henrik)

Loneliness was also common during this phase, and participants avoided revealing to their loved ones their thoughts about their anxiety or death:

“It was impossible to explain my situation to the family. They would not understand.” (Finn)

“The first thought that crashes into your head is, ‘Am I going to die now?’ My daughter broke the ice by asking, Mom, ‘are you going to die now?’ I answered, I’m going to die one day; but, not from this.” (Anne)

Caring about work had limited or no place in this phase of shock. Work issues were put “on hold” in this phase.

Phase 2. Fighting for life

The shock from phase 1 transformed into hope and to mobilization of inner strength in the efforts of fighting for life. Surgery, radiation therapy, and chemotherapy led to adverse side effects and kept participants from leaving the World of Cancer. They described feelings of vulnerability, especially when the doctors described risks and statistics. At this phase, returning to work was still a distant thought; however, some participants decided to stay in contact with their immediate superior during or before treatment started, while others did not find room for anything else than dealing entirely with the disease. The treatments and being a patient were foremost in their minds:

*“At that time (from the initial surgery and during radiation therapy), I phoned my superior once a week and told him I wasn’t ready yet (...) Inside I felt unsure if I **ever** could walk through that door...I couldn’t stand the thought of anything else than being in survival mode.”* (Britt)

To cope in this phase, participants focused on what gave them a reason to live. They all expressed that their strong inner drive to fight for their lives had to do with key matters in their lives that they had yet to fulfil, or something/someone they could not yet leave: a child, spouse, dream, or project. Overall, existential questions arose, and family was more essential than work issues at this phase:

"My wife was crucial for my doing so well." (Daniel)

Phase 2 overlapped with phase 3, where participants changed from survival mode to aiming for a sense of normality.

Phase 3. The transformational phase

Participants all recounted how they managed to re-focus from fighting for life during phase 2 to fighting for work and a renewed sense of normality in phase 3. Now, meaningful activities and/or work became more important. Therefore, this phase represented turning points and transformation.

Movements forward felt vulnerable, and they could easily fall back into the World of Cancer when experiencing setbacks like adverse effects of treatment or failures at work:

"It feels, in a way, very fragile. If you experience only small setbacks at this point, everything comes apart." (Britt)

First, the need to detach from having an almost sole focus on the disease became important. The participants made conscious and active choices in the process of detaching themselves from the disease and looking forward. They avoided negative influences from situations where other people had a negative focus or were complaining about the illness:

"I could not stand listening to people moaning or talking about their illness; so, I turned away from them." (Grete)

*"When it comes to the end of the day, I think we love life so much we do what must be done to live. Mobilizing. I found that I could fix that! Being ill. It did not take over my life. I did not **let it** take over my life. Ok. I got ill. I have to deal with that. It's not who I **am**."* (Henrik)

Although most participants went back to work immediately after their treatment was finished, the reason for this was not solely economic. It was socially stimulating for participants to engage with people without cancer. It was helpful for them to put the disease to one side and embrace other aspects of life; for instance, by commencing work as soon as possible because they missed work and

colleagues. The participants reported being ready for more collaboration with their employer and evaluating work ability and opportunities due to their own interest.

“I was bored at home, missed my colleagues, and wanted to return to work as soon as possible. I was completely open about the cancer. The fact that people at work did know I was not well, helped me in allowing myself to stay at work even though I did not always feel so well. The most important thing is always to look forward.” (Carl)

Unfortunately, discrepancy between perceived ability to work and managing at work became clearer for many of them; they sometimes misjudged their own strength and ability to work. Almost all participants said that they started to work too soon, irrespective of adaptations at work. Even though they felt ready for it, they experienced the start as extremely tough and tiring:

“I started working too early. I was so tired in the beginning; I thought I was almost going to die. Since I was a manager, I could work at home some days. That represented a feeling of flexibility and freedom.” (Eva)

Participants found strength and endured the exhaustion and feelings of failures; then, slowly, the situation changed and small steps towards feelings of success and mastery moved them forward. Hence, work became increasingly valuable. Encouragement at work was a key contributing factor. All participants appreciated support from family, friends, and/or work colleagues/supervisors; however, few felt public support services to be valuable or even crucial for their success. Their inner determination, desire to work, and the strength to manage, on the other hand, were essential.

“This will perhaps sound a bit strange, but I did return to work because I decided to do so. I learnt that I received the strength I needed to deal with it. I do not have that strength now. But, if I receive cancer again, I am sure I can find it once more.” (Grete)

If they felt the workload to be manageable and that they had flexibility, it did not seem to matter at what point they started. Some started part-time, others full-time. To work at their own pace and not having too lofty expectations from their employer and colleagues, made work more manageable. While not all participants had the possibility of adjusting their work to their needs, those who managed to make adaptations felt that it helped them move forward faster. Trials and tribulations lasted longer than expected for some, including up to 10 years after the last treatment. One was still not capable of working at all after one year on sick leave:

"It was easy to say I was able to work; but, I could not. I felt ready for work; but, my psyche was not. Being at work was very unpleasant. (...) Terrible, actually." (Britt)

Some participants had to redefine their former work-related identity. When their previous work did not suit them well, was no longer meaningful, or was too demanding, participants reoriented and adjusted towards a new path and career. Some even had to change direction more than once. They made decisions about their working future in acceptance of what had happened. Saying yes to opportunities presented to them, when it felt right, was essential for successful RTW. Although one participant tried for some years to adapt in his former position, which looked promising from the start, he gradually felt his shortcomings. He slowly realized that his identity as an electrician in a prestigious and well-run business had to end:

"I decided my own workload in the beginning. After a while, I looked almost like before, and then I increasingly received the same amount of workload as before, too. ... I knew and understood for a long time I had to quit my job, because it was physically too demanding; but, I did not want to give up work. ... Luckily, I was offered another opportunity in the municipality."
(Finn)

Phase 4. Creating a new reality

Consequently, the participants built self-confidence and increased their workload. Three participants found new paths towards sustainable work at their former workplace. Others had to change occupations. For example, Finn found a new occupation that suited him better. As a janitor, he felt valuable, socially stimulated, and welcomed in a different environment where he could work at his own pace. After a new course of study, Anne quit her former job and experienced the realization of a dream she had a long time ago: buying and running her own shop:

"I saw myself at my former workplace, older, with grey clothes and briefcase. I had to find something else. ... (Later in the interview): I found this store and bought it... It's like living an adventure ... I would never have bought that store, if it hadn't been for the cancer." (Anne)

However, rather long or intermittent sick leaves did still occur and appreciation and to feel the right level of expectations at work was still important. When motivated by meaningful activities and positive feedback at work, the participants managed more and increased their work hours. Britt

completed a new course of study as a volunteer and, after some years, gradually increased her working hours until she finally could work full time:

“In (my) work as a volunteer, there was somebody who appreciated and believed in me... After all the resistance, I'd lost almost all my self-confidence ... So, even though I was so exhausted that I threw up in the hotel room, I put up with it! ... (laughs) ... I loved my new job. I was on fire.” (Britt)

Phase 5. The new reality

Participants completed their journeys from the World of Cancer in phase 5. They entered a renewed reality, and experienced sustainable work. Regular life and a sense of normality were re-established, and that relieved them:

“Now I am ‘healthy-Britt’, (I) can get annoyed about trifles like everybody else, and, that feels just wonderful!” (Britt)

However, participants' situations were not quite the same as before, and they perceived themselves as somewhat changed persons after completing the journey. Most felt a vulnerability related to a possible recurrence of cancer; however, it felt more distant after some years:

“Every time I take down the Christmas decorations at home, I wonder if I'm going to be able to open that box next year.” (Anne)

“After the first interview, I was surprised how close the experience felt—even if it happened many years ago. I am not thinking of this (on) a daily basis anymore, but the experience has defined me. It is perhaps natural that some small pushes will bring back the emotions I had at that time. It was really an overturning process—it was like fighting through something and coming out on the other side.” (Grete, in re-interview)

Discussion

Participants' adaptive RTW journeys lasted up to 10 years and comprised five distinct phases. The journeys were not straightforward. Some participants increased their workload slowly and others changed their professions, sometimes more than once. Some found new and meaningful work tasks through continuing education. The crucial contributing factors for returning to sustainable work depended on participants' strength and determination. We found that their ability to accept and adapt

to the situations that arose was also crucial, and that they willingly grasped and adjusted according to emerging opportunities at work or in their environment. Family, friends, and work colleagues represented key assets in this quest.

A five phased process model

We did not use any theory as a point of departure before collecting data. Still, our results and our five phased process model (Figure 1) are in accordance with Lazarus and Folkman's (1984) transactional theory of stress. This theory claims that the processes following a stressful situation (such as being diagnosed with cancer in phase 1) depends on the persons' cognitive appraisals of the situation and what types of coping strategies are performed. The "primary appraisal" concerns whether a stressor is regarded as a challenge or threat, whereas the "secondary appraisal" is related to how to manage the situation and what resources and control over the situation the person has (Lazarus and Folkman, 1984). We found that the latter reflects mainly in phase 2 and 3 in our model.

Following the appraisal phase, the theory distinguishes between "emotion-focused" and "problem-focused" coping (Lazarus, 1993; Lazarus and Folkman, 1984). In emotion-focused coping, the person tries to reduce the negative emotional state by changing the relational meaning about what is happening; whereas problem-focused coping aims to change person-environment relationships by acting on the environment or oneself (Lazarus, 1993). Our participants made use of emotion-focused coping strategies in phase 1 and partly in phase 2, where work was not a prominent part of their life (primary appraisal). However, in the transition from phase 2 to 3, all participants employed a more problem-focused coping style as part of their secondary appraisal, where they consciously aimed and acted towards RTW as soon as possible. During this quest, they also searched for support from colleagues and supervisors, service support personnel, family, and friends.

Initial RTW and exhaustion

Our results highlight the importance of encouragement, self-assessment, and in planning for RTW with one's immediate superior for RTW to be successful (Grunfeld et al., 2010; Mehnert, 2011; Stergiou-Kita et al., 2016; Torp et al., 2012). Cooperation with employers was successful for some and resulted in working fewer hours per week or a possibility to perform other work tasks that suited the person better. Earlier studies demonstrated how effects from the disease and treatment may result in

work overload and periodic or lasting exhaustion and reduced work ability (Mehnert, 2011; Spelten et al., 2003). Most participants in our study experienced exhaustion when they returned too early, and they sometimes misjudged their working capabilities.

The initial exhaustion our participants experienced may well be because of eagerness in performing actions, an example of utilizing problem-focused coping (Lazarus, 1993). However, the participants managed to stay at work when tasks were meaningful and expectations were low. In addition, work and being with colleagues represented a major success factor because being at work helped participants distance the feeling of being a cancer patient, and increased their sense of movement towards normality—unless the burden at work was too heavy. The outcomes from this initially troubled those using problem-focused coping; however, it turned out to be beneficial for most participants. This is consistent with what Dorland et al. (2016) found—that work functioning is affected by psychosocial and work-related factors, not only cancer-related symptoms. However, when the burden of being at work became too heavy, the participants demonstrated a new appraisal phase of “challenge.” Emotion-focused coping (Lazarus, 1993) was utilized when distancing the former work or workplace. Due to effects from cancer and treatments, two of our participants could not manage for long at work before they had to re-consider their position.

Adaptation and coping processes

Notably, when our participants could not manage their previous work, they did not quit working altogether. On the contrary, the participants accepted and adapted to the situations that arose in phase 3 and 4. Instead of giving up, they grasped emerging opportunities and they acted to change their situation when necessary. They either reduced their working hours, changed type of work, or sought education in their search for another type of job. They all demonstrated both emotional-focused and problem-focused coping (Lazarus, 1993) in that they chose and adapted towards what represented new and meaningful tasks and they actively utilized resources in their environment and in themselves. Per Lazarus (1993), our participants entered “positive re-appraisal,” which resulted in personal growth through new and important decisions to live a more meaningful life and/or achieving the sustainable working situation they wanted.

Our participants stated their most important asset was their own strength and determination in RTW. Consequently, this facilitated support from family, health personnel, friends, colleagues, and

others, resulting in demonstrating a combination of both emotion-focused and problem-focused coping. Our results support earlier findings that it is critical to understand the individual complexity concerning work identity and what participants regard as meaningful tasks (Barnard et al., 2016; Little et al., 2002; Wells et al., 2013). Furthermore, our study demonstrates the importance of necessary action and adaptation skills to achieve changes towards sustainable work.

Outcomes, individuality, and sustainable work

Based on the theories of Lazarus and Folkman (1984), Barnard et al. (2016) developed a 4-phased process model describing the longitudinal RTW process among cancer patients (from a repression phase/avoidant coping (1), through an acceptance/comprehension phase (2), towards activation/problem-focused phase (3), and meaning making and lifestyle changes in the re-integration phase (4). This model resembles our process model and the 5 phases we describe; however, Barnard et al. (2016) focused on psychological processes, whereas our study includes richer concrete descriptions of the outcomes from the coping strategies performed by PSC. In addition, compared to our process model, Barnard et al. (2016) did not distinguish between initial RTW and sustainable work. That is, we showed how PSC RTW and the key reappraisal phases that may occur (Lazarus, 1993), which influences their situation/working life and thereby creates new work-related decisions. For some, this process can be interpreted as a change from a “threat” appraisal to a “challenge” appraisal (Lazarus and Folkman, 1984), because the persons experienced that the stressful situation led to an opportunity for growth and development. The final phases in our process model towards sustainable work also demonstrate that returning successfully to sustainable work involves finding and juggling a new reality where embracing one’s vulnerability towards death is vital (Baker et al., 2005). However, we found that fear of cancer recurrence did not influence our participants as much at the end of this journey as it did earlier in the process.

Strengths, limitations, and recommendations for future research

We interviewed PSC who succeeded in returning to sustainable work and who were still working more than 3 years after their RTW. Consequently, we revealed essential RTW processes from a long-term perspective and developed a process model illustrating the struggle in returning towards sustainable work among PSC.

Some would argue that including more participants would have provided more perspectives and improved the trustworthiness and transferability of the results. Still, according to the IPA method (Smith et al., 2009), the number of participants included in our study is sufficient since this method argues for high reflexivity during the interviews and a deeper in-depth analysis of richer data material rather than including more participants. Per Malterud et al. (2015), this development of richer data material compensates for and therefore requires a lower sample size.

We selected participants with diverse backgrounds (i.e., age, sex, diagnosis, and occupation), which provide us with rich descriptions across a variety of experiences. Nevertheless, it may be that a more homogeneous group of participants would have increased the information power and the transferability of the findings to a more specific group of PSC (Malterud, 2001; Malterud et al., 2015). The aim of this study was primarily to identify and understand factors and processes promoting, rather than inhibiting, return to sustainable work. Therefore, one of the inclusion criteria was that the participants should have succeeded in accomplishing sustainable work. If we had included a comparison group of PSC that failed in returning to sustainable work, we might obtain a better overall understanding of RTW processes among PSC.

Strengths in our methodology were the transparency of the study, the purposely sampled participants, and the strong focus on reflexivity during all phases (from recruiting to analysis) (Malterud, 2001). Three participants were re-interviewed and the advisory team, with their wide experiences of cancer and cancer survival, ensured the trustworthiness of the data, as they provided correctives and nuances in our analyses.

We recommend more qualitative and quantitative research on the long-term aspects of RTW after cancer. A focus might be on developing practical tools for supporting individual cancer patients along their journey towards sustainable work.

Conclusion

The long-term perspective in our study allowed us to follow individual RTW processes to completion. The journeys described points to an immense variety of changes and prolonged duration, and ends where a new sense of normality is re-established and sustainable work is present. The entire process described in Figure 1 showed great diversity in time—up to 10 years. During these phases, participants demonstrated personal growth through re-appraisal and by utilizing both emotional-

focused and problem-focused coping (Lazarus, 1993). Some participants even changed occupation more than once before they achieved sustainable work. The transformational phases of changes (Phases 3 and 4) may therefore be repetitive and/or last longer and be more divergent than expected.

In practice, it is vital for PSC, health, and support service personnel, to be aware that the first attempts to adjust to new circumstances may not be enduring even though they look promising in the beginning. If things do not go as planned, PSC may have to explore new paths, which may take several years. In line with Lazarus (1993), who posits that individuals' thoughts and actions during coping processes require attention, our results indicate that asking relevant questions and providing support to PSC, based on the World of Cancer phase they are working through, is essential towards helping them return to sustainable work.

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Table 1. Participant overview

Name¹	Sex	Years since diagnosis	Years since last (main) treatment	Working status (%)	Occupation before cancer	Occupation at interview	Interview time (mins)
Anne	F	6	5	100	Management and senior advisor	Shop owner	83
Britt²	F	15	12	100	Customer advisor, Shop	Education: Marketing, Advisor, office	103 + 68
Carl²	M	7	5	100	General Manager	General Manager	100 + 62
Daniel	M	5	4	40	Consultant and general manager in his own company	Consultant and general manager of his own company	92
Eva	F	16	14	100	Teacher and project manager	General manager, private company	87
Finn	M	15	14	50	Craftsman	Janitor	105
Grete²	F	8	7	100	Office worker/ receptionist	Manager, office	90 + 60
Henrik	M	9	8	110	Artist and teacher	Artist and teacher	103

¹The participants were given fictitious names; the first letter of this name represents the order of the interviews. ²Participants who were re-interviewed.