MENTAL COMPLAINTS:
SYMPTOM OF PROTEST?

WOMEN AND THE WAO
EXPERIENCES AND INTERPRETATIONS OF YOUNG WOMEN WORKING IN THE HEALTH CARE SECTOR OVER LIFE, WORK, ILLNESS AND DISABILITY.

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WIES DULFER

Supervisor: Dr. R. M. van Daalen

November 2000

The Amsterdam Master's in Medical Anthropology (AMMA)
Faculty of Social Science, University of Amsterdam
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The following is a study of young women in the workplace who, as a result of mental health problems, were deemed medically unable to work and became eligible for disability benefits under the Disability Insurance Act (WAO). The number of people receiving disability benefits has risen dramatically in the last decade and is still on the increase. It is a topic of political and social significance. This body of work is concerned with women who enter the WAO, especially those with mental health issues.

The research contained herein is the first medical anthropological study regarding this subject. It was accomplished in cooperation with eleven female participants who shared detailed accounts of their experiences. I am grateful to them for their courage, candour, and willingness to tell their stories. I am also grateful to the staff at Cadans Insurance Company for their assistance and cooperation period.

This thesis is the final step in my journey toward a Masters Degree in Medical Anthropology. The last year has been challenging, intense, and enriching. The lecturers of the AMMA introduced me to and taught me the principles of medical anthropology. Fellow students gave me insight into different cultural perspectives by providing additional information from their own backgrounds: India, Bangladesh, Indonesia, Ethiopia, Zimbabwe, Macedonia, Italy, and Norway. The AMMA staff was always prepared to listen and assist me. I extend my thanks to all of the lecturers for their friendship, inspiration, and support.

I am extremely indebted to Rineke van Daalen, lecturer in the Department of Sociology of the Faculty of Political Science and Social-Cultural Science at the University of Amsterdam. Her conscientious supervision and useful suggestions stimulated me tremendously in conducting this research. Rineke, thank you for your support.
Summary

Mental illness is currently a common phenomenon in the Netherlands. Statistics show that the occurrence of mental health diseases has risen sharply in recent decades. Research indicates that an increasing number of people have been determined to be permanently unfit for the workplace as a result of mental health problems. More women are affected than men, especially women under the age of 35 who work in the health care sector. Absence from work due to illness is higher in this sector than in any other. Almost quarters of the total number of permanently disabled employees have been diagnosed as suffering from mental health problems. Under Dutch law, employees become eligible for disability benefits when they have been off work due to illness for a period of twelve months.

The focus of this study is the problematic nature of the inability to work caused by mental illness. The topic begs the following questions: Why are there so many women with mental health concerns? Why is the health care sector affected by this problem to such a great extent? What are the experiences of women working in this sector? What have been their experiences in the profession, in the workplace, with the insurance company, in their personal lives? How do these women account for their present situations?

In order to answer these questions, interviews were conducted and insurance files were thoroughly reviewed. The data obtained revealed that many factors contributed to the development of mental illness and subsequently long-term disability. This became clear upon analysis of the situation from three perspectives: the work environment, the insurance company and the process of applying for and receiving benefits, and the personal experiences of the respondents.

The main factors identified with respect to the work environment are complications at work, conflicts with superiors and co-workers, and too little support, appreciation, and financial reward for services rendered. The key factors concerning the insurance company are the confrontation with instructions and bureaucracy, poor communication between the insurance company representatives and the claimants, and the stigma associated with long-term disability. Negative experiences during childhood and adolescence, the inability to come to terms with traumatic life events, and insecure relationships with their partners all play a significant role in the personal histories of the respondents.

To further analyse these findings, I have made use of two theoretical models: the Loss Model and the Deprivation-Domination Model. Both models analyse the course of the illness, and both theories maintain that
social-environmental influences also determine the causes of illness. Illness is thus one of the by-products of the conflict between individual and society.

This conflict is further illuminated in the personal accounts of the respondents. They convey anger about having become ill in the first place. This can be interpreted as protest: a protest against the limitations of their own creativity and initiative. According to the women interviewed, their illness can be blamed in part to trauma, insecurity, and the ignorance of others in their lives.

The medical anthropological research conducted in this study indicates that mental illness and long-term disability among young women are linked by a combination of factors. By breaking down these factors and the experiences that lead people into long-term disability, adequate preventative measures can be developed. This study attempts to identify the factors, establish a relationship between them, and provide a basis for developing methods to prevent further decay of the system.

The research has been organised in the following manner to make it more accessible to the reader. In chapter one, I describe the problem of women and the WAO. I also outline the perspective, the objective, and the specific questions of the research. I explain how the research is organised, as well as the ethical considerations and limitations that were faced when conducting it. In chapter two, I present background information regarding women and the WAO. This is done by broadly describing the development of women in Dutch society, the emancipation process, and the legal aspects of sick leave and the health insurance benefits provided in the WAO in general. Chapters three and four relate the experiences of the respondents from the three perspectives mentioned previously: the work environment, the insurance company, and personal experiences. The conclusions of the research, discussion, and recommendations can be found in chapter five.
1 The Problem of Women and the WAO

1.1 Introduction

The problems surrounding the WAO (Wet Arbeidsongeschiktheid: Disability Act) have been discussed in detail for many years, and several solutions have been suggested. The number of people receiving disability benefits shows no sign of decreasing. The figures are staggering, which is a problem for society. It is also a pressing problem for politicians. "The Netherlands is ill," stated Prime Minister Ruud Lubbers and others with him in the beginning of the nineties. In the year 2001, this is still a common problem: There are almost one million disabled people in the Netherlands, and more than half of them are women. The health care and educational sectors account for the majority of disability benefits claimed. Most of the people receiving these benefits suffer from mental health problems.

More people suffer from ill health and mental illness, per capita, in the Netherlands than in surrounding countries or the United States\(^1\). This 'open nerve' needs treatment as soon as possible, the root has to be cured (Knepper: 1999). What is the problem? Are the disabled, the root of the problem or is it inadequate implementation of the Disablement Insurance Act? How can we prevent people from entering the WAO in the first place\(^2\)? Many professionals have voiced possible solutions. In addition, financial incentives have been implemented on the part of employers to slow the increasing numbers of disabled\(^3\). However, prevention is the best medicine.

The purpose of the study is two-fold: to get information about the situation of young women in the WAO and to look into the factors, which affect their situation and cause mental illness. It is a topic of political and social significance, and the personal history of the women interviewed should provide valuable data. The

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2 Solutions such as requiring medical examiners to be more thorough, imposing financial penalties on employers, reducing the amount and/or duration of social benefits, improving career opportunities, and providing part-time work when necessary. (HN 56, nr. 34:12)

3 Among other things, the possibility to work during this time while receiving full social benefits and a premium of ten percent; regulations which make it easier for companies to hire recipients of disability insurance benefits; imposing financial penalties on employers who do not take enough initiative to accommodate ill employees who are able to return to work in some capacity. (NRC: April 2000)
reality of the problem and the many reports and studies of the WAO provide insight into the complexity of it, but many questions remain unanswered. Why are there so many women unfit to work? Women are more emancipated than they have ever been and working conditions and opportunities have never been better. Women in their most productive years should have enough energy for both a career and family life.

The complexities of the WAO question are not fully elucidated. Therefore, the problem must be tackled from its roots. It is important to analyse the experiences and viewpoints of the target group -- the young women who have been deemed medically unable to work and thus depend on state benefits. That is the main motivation of this study. The voices of the women in question should be heard and their stories should be read. This study was done with a critical eye from the social-structural viewpoint, from a medical-anthropological perspective. It is a holistic approach to the problem with emphasis on social, cultural, economic, and political aspects.
1.2 Statement of the problem: WAO and Young Women

At present, the high enrolment of women into the WAO is a very real problem, especially for women aged 25-35. There are different causes of their disability. One of the main symptoms is mental illness. Why are there so many women receiving disability benefits? Twice as many women receive WAO benefits as men, and those in the health care sector are four times as likely to enter the system than those from other sectors (Appendix II).

Below, I will discuss the increasing numbers of people entitled to disability benefits under the WAO in general, the growth in the number of women receiving disability benefits, and a comparison of the numbers of women and men entering the WAO. I will then present figures of the number of people from various sectors in the WAO due to mental illness.

The Increase in the WAO
Many studies have been carried out by the Lisv\(^1\). In an annual survey of the development of disability, statistics showed that the number of long-term disabled, those unable to work for 12 months or more, rose to almost 905,000 in December 1998. (Lisv 1999: 16).

At the beginning of the 90s, the rate of entrance into the WAO decreased. However, the numbers have increased steadily since 1996 (see appendix II). The 1998 increase resulted from a rise in illness-related work absence in 1997 and a growth in the number of employees in the same year. Social benefits for people aged 25-45 was also increased and was awarded to women in particular (LISV 1999: 12).

The Increase of Women in the WAO
The number of women receiving disability benefits has increased significantly during the last decade: in 1991, 45% of WAO benefit recipients were women. By 1998, this number had risen to 59%. This cannot be blamed on low labour participation, as this has increased in the Netherlands by 14%. From 1990 to 1997 the male workforce had risen to 7% and the female workforce to 24%. In 1990 women made up 38% of the workforce; in 1997 the percentage was 42. Women who entered the labour market worked largely part-time. The increase of women in the WAO cannot be blamed on women\(^2\).

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1 Lisv (Landelijk instituut sociale verzekeringen) is the National Institute for Social Insurance.

2 In Opzij, a monthly magazine, Astrid Feiter wrote about the question of women and the WAO. She emphasised that this is a social and cultural problem which needs further study (March 1999).
Difference in Increase of Men and Women in the WAO

The increase of the number of people receiving disability benefits under the WAO is higher for women than men (see appendix II). Statistics show that 9.8% of the labour force of 6,957,000 is disabled. Disabled men account for 9.6% of the labour force and disabled women for 10.2. An analysis of the category of ages 25-35 indicates a larger difference between men and women: 1.3% (1,225,000) of male employees is medically unable to work and receiving disability benefits and 3.2% (914,000) of female employees is medically unable to work (Lisv 1999: 49). More women work part-time than men do: 8899 and 1768, respectively. (Lisv: 50). Women make up 42% of the workforce while men make up 58%.

The Increase in the WAO According to Sector

The number of employees in the WAO varies per sector. The majority of benefit recipients come from the education and health care sectors. In the health care sector, a total number of 12,365 men and 77,746 women are currently receiving disability benefits. In the category aged 25-35, 561 men and 9204 women are under the WAO. In comparison with other sectors, absence due to illness in the health care sector is the highest (see appendix II). The figures speak for themselves. The sharp rise of women in the WAO began in 1996. The figures for the healthcare sector are considerably high, and the difference between men and women is enormous considering that the majority of health care workers are women.

The risks of disability are enhanced by a number of factors. Studies have been carried out to explain why women are at a higher risk for entering the WAO. A study of long-term disabled employees, the EPI'98 study¹, was conducted and researchers concluded the following: 1) working in the health care sector involves significant pressure due to deadlines as well as mentally and physically demanding tasks; 2) these issues are more evident in the health care sector; 3) women account for a greater share of the staff in this sector than men. (Lisv 1999: 18).

Another study conducted by the Ministry of Social Affairs, shows that disability for women is caused by the dissimilarities between male and female employees (age, health, private life) and that their area of work varies (work load, work situation and sector)². In addition, there are indications that the risk for women working in the health care sector to enter the WAO is even higher because they work in the executive sector.

¹ EPI'98 is an epidemiological study on the origin of long-term disability. The purpose of this ‘epidemiological project’ was to continuously monitor the many changes and regulations which occur in the social security system with regard to disability. For this project, people who had been ill for twelve months were surveyed. (Lisv January 1999).

² This study: ‘Vrouwen vaker in de WAO?’ was conducted by Giezen A.M. van der, Culenaere B, Prins R. in 1998.
such as home help, nursing and caring. More men work in management positions. The executive sector is more susceptible to physical and emotional stress\(^1\). Women in this sector work twice as hard, which increases the risk of absence from work due to illness. (Medisch Contact 1998: 1582).

The increase of women receiving disability benefits under the WAO has still not been sufficiently explained. The following have already been proven: childcare does not enhance the risk of long-term disability; relationship status (single, married, divorced, etc) influences the risk - more people without a partner enter the system than those with a partner; level of education and job position are strongly related to long-term disability. (Lisv 1999: 16). The data obtained by the respondents in this study further confirm these findings.

**Specific Symptoms**

The two main groups of benefit recipients in the WAO are those suffering from mental health problems and those suffering from illnesses of the bone-joint system (Lisv 1998). People with mental health problems make up the majority of recipients. Disability as a result of mental illness increased from 11% in 1968 to 33% in 1996. Approximately 7587 men and 12,187 women, aged 25-35, were diagnosed as mentally ill in 1998. (Lisv 1999: 50) In the health care sector, a total number of 24,933 people are suffering from mental health problems (Lisv 1999: 54-56). Almost 25% of the total number of long-term disability cases in the health care sector are related to mental illness.

Mental illness is usually the result of stress, depression, etc. As previously indicated, mental illness affects women to a far greater extent than men. Women show such symptoms as depression, anxiety syndrome, headache, hyperventilation, and phobia and sleep disorders.

In the case of psychosocial issues, women are particularly affected by problems within the family and in partner relationships (Lisv 1998: 21-26).

According to data from 1998, inability to work due to mental problems can be attributed to the work situation itself (50-70% of permanent sick leave) and to conflicting situations in the work environment (5-30%) such as conflicts with co-workers and the amount of the workload. Stress and pressure in the workplace have increased in the last few years.

However, it is difficult to measure mental illness. Therefore, it is hard to determine when somebody with mental problems is disabled. There are no well-defined criteria, and medical professionals often find pinpointing diagnoses difficult. Hence, the diagnosis is often classified as 'unknown' in statistical figures.

Further research into the mental condition of human beings still has to be conducted. It is especially necessary to perform a study about the environmental influences on the human condition. It is also important to gain more knowledge about the influences that work environment, personal problems, and life-events have on the mental condition.

\(^1\) See: “Facts about Nursing and Caring in the Netherlands” by Windt W. van der, Calsbeek H., Hingstman L.
In this study, I will describe the different environmental influences on the mental condition of women who work in stressful situations with time deadlines, who work long hours, and who are influenced by the male culture at work, a prestigious culture as a rule. Another important source of conflict may be within the WAO system itself -- the negative experiences and confrontations the women have with the social insurance companies and the bureaucracy of the organisations.

Little research has been done with regard to absenteeism from work due to mental illness. Some researchers have stated that, "one should not enter the WAO as a result of mental health problems. Of course, there are exceptions such as serious psychiatric disorders. Mental illness is reversible if treated in time and supervised well" (HN 2000: 12-13). The stories of the women respondents in this study and the insight they provide will hopefully contribute to reversing the effects of mental illness and prevent women from entering the WAO.

1.3 Study Perspective

1.3.1 Medical Anthropological Character

"The methods of western science are essentially reductionist, that is to say, they seek to understand organisms or nature by studying the smallest or simplest manageable part or sub-system in essential isolation.... The non Western forager lives in a world not of linear causal events but of constantly reforming, multidimensional, interacting cycles, where nothing is simply a cause or an effect, but all factors are influences impacting other elements of the system as a whole...."

Milton M.R. Freeman, professor of Anthropology at the University of Alberta (Ross, 1996: 62)

This medical anthropological study, with a critical anthropological perspective, is a synthesis of different perspectives -- the politico-economic, the cognitive, and symbolic perspectives. These critical theories try to connect the points of view of social processes on micro and macro levels.

In the article, 'The Mindful Body', the authors emphasise that illness is not just an isolated event, but that it can be caused by an interaction between individual, nature, society, and culture. For instance, medical doctors recognise that back pain is real even when no abnormalities can be found in an X-ray. They are aware that back pain can be an expression of social protest. Illness is presented as the 'embodiment' of society's most basic problems and conflicts (Scheper-Hughes & Lock 1987: 41).

In medical anthropological studies, researchers focus on special social groups in different cultures: how people explain the causes of illness, which type of treatment they believe in, to whom they will go for
treatment. Researchers use the Explanatory Model\(^1\) to record people's ideas and interpretations. Medical anthropologists study how acts and behaviour of human beings and their interpretations are related to the biological, psychological, and social changes within their culture. They are especially interested in how people experience changes when they are healthy or ill. A continuous interaction exists among all these aspects. Therefore, a medical anthropologist makes a holistic study of people (Helman 1984). They study how the interaction between biological and social-cultural aspects in the behaviour of people influences health and illness over the course of time.

Through language, people are able to express themselves and describe their symptoms. In many cases, a social problem is based on illness so it is important to study the context. Through the experiences of patients, it is known that many illnesses are the result of small behaviour and that there is a direct correlation with a rapidly changing society. We can only understand 'illness' in its specific social context. An analysis of the context can clarify the information given by the patient. Patient experience has also taught us that there is a relationship between the behaviour of people and living in a stressful society (Byron J. Good 1977: 78).

The context of individual experiences can be obtained by studying the cultural and social aspects of society as a whole, as well as those in families in local villages or towns. Personal histories provide a wealth of data that can help us to improve our knowledge of health and illness.

"Sickness is a form of communication through which nature, society and culture speak simultaneously. The individual body is the terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity and struggle."

(Scheper-Hughes & Lock 1987: 41)

The first anthropological publications about health and illness were written in the 1930s and 40s. At that time, anthropologists studied psychological and psychiatric phenomena. They tried to obtain knowledge about adult personality and about the character moulded in a particular social-cultural environment. They asked questions such as, are adults what they are in general because of the way in which they were educated and shaped in

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\(^1\) An Explanatory Model (EM) is a concept introduced by A. Kleinman (1980). This is defined as 'the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process'. EMs explain the aetiology or cause of the condition, the duration and onset of symptoms, the patho-physiological processes, the history and severity of the illness and appropriate treatments (Helman 1998: 111).
childhood and how they learned to adapt to their environment? Are adults shaped by the influences of life experiences later in life? Or is the mental condition of adults a natural one based on biological factors that are determined for the culture and the personality? (Foster and Anderson 1978)

These questions are real (the nature-nurture discussion continues) even for John E. Carr in his study about the phenomenon of 'Amok' in Malaysia. Amok is '...an acute outburst of unrestrained violence associated with homicidal attack, preceded by a period of brooding, and ending with exhaustion and amnesia' (Carr 1978: 270). The personal amok is known as a sudden shift in mood and as a way of social protest by people against rulers who abused their power. Amok is recognised as the most severe form of mental illness, an unacceptable behaviour. This is associated with depression and condemnation, an attack on someone's self-respect. The Malay are taught to be quiet, without showing emotions, to be obedient and avoid confrontation, and to be non-aggressive, assuming a passive attitude. This behaviour is accomplished through the socialisation process that involves a complex system of social values. This education was given in a society characterised by tradition and order without pressure and stress. Influenced by modernisation and urbanisation - which can result in psychological conflicts and stimulate ill behaviour - normal behaviour of some people changed into ill behaviour such as Amok (Carr 1978: 270-273).

In the 1950s, the psychoanalyst and philosopher Erich Fromm discussed the interrelation between man and society and man's reaction to extreme change. In his book, The Sane Society, he states that the drive towards increasing production and the need to make bigger and better things affects people's behaviour. Work seems to become alienated from the working human being (Fromm 1955). People have the power to create extremely complex machines and systems, but they are losing the wisdom of how to use these things. Fromm links the empirical world, the objective, which can be explored by the individuals, with the subjective, the inner experience, the feelings and emotions, which give the individual the possibility to see things from an inner perspective (Fromm, 1955: pg156). Currently, in most occupations there is more emphasis on the intellectual capacities of the human being than on manual labour. The mental over-burden is increasing. Fromm stated that if people choose to focus on 'robotism' and on an automated society, mental illness would be the outcome in the long run. Now, fifty years later, we are witnesses to this truth as mental illness is on the increase across society - young and old, employers and employees.

The incidence of mental illness is increasing in the Netherlands. In the Dutch society, people are confronted with continuous change. Are people currently well prepared to lead productive and healthy lives in today's society? Are they provided with enough know-how and is their knowledge sufficient to handle the norms and demands of the times? It is essential for people to be immune to stress, immunity acquired by learning to adapt to their environment and how to solve existential problems. What are the experiences of the respondents? Are there indications in their stories that the increase of mental illness is caused by educational, personal, or environmental factors?
1.3.2 Illness and Two 'Explanatory Models'

By all accounts, mental illness is the new epidemic of the 21st century. It is the result of economic, social, and cultural changes, but it can also be a motive to social change. Man is a 'social animal' that participates in and is part of a social-cultural system in which individuals are expected to play all sorts of roles.

Health is one aspect of functional human needs. Healthy people can shape and continue the existence of society. They want to achieve something in society much more than sick people. Illnesses disturb the balance and people are prevented from making a valuable contribution to society. Mental illnesses are the most disrupting aberration: they create both an emotional disorder and a disturbance of reality at the same time. This can cause problems in social relationships as well.

The problem stated above is studied and described in 'Ideas about Illness', an intellectual and political history of medical sociology written by Uta Gerhardt and published in 1989. Through this work, Ms. Gerhardt made a considerable contribution to the development of sociological theories. She used theoretical paradigms such as structural-functionalism, interactionism, phenomenology, and the conflict theory to conceptualise aetiology and treatment. She attempted to clarify the close connection between sociological problems, community problems, and development. She also tried to characterise the level of the problems in the social order and the 'sick' society.

As I am impressed and inspired by Gerhardt's views and attempts to explain illness, I will make use of two 'explanatory models' to analyse the problems of mental illness in young women.

1.3.3 Conflict Theory and Two Explanatory Models

The social-medical examination of patients with mental health problems is difficult and an objective diagnosis is very hard to make. In this respect, I refer to Uta Gerhardt (1989), who writes about the meaning of medical practice and the counter-productivity of medical care in a modern, technological and industrial society. Many people become ill because of their lifestyles and/or their work environment. There is an unbalanced relationship between the workload and the resilience of many individuals (Bergen: 2000). Healthcare focuses on the sick individual and hardly pays any attention to the social structure surrounding the workers. Gerhardt refers to the perspective of the conflict-theory, a critical view to the modern society, which is characterised by

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1 Mental health can be defined in accordance with the formulated norms of important world leaders: ‘mental health is characterised by traits such as love and creativity; by emancipation from incestuous bonds with the species and the land; by identifying with the self based on the recognition of the self being the true origin of personal power and possibilities; and lastly by the understanding of the reality outside and inside ourselves, namely by the development of objectivism and rationality” (Fromm 1955: 60-61; translated from the Dutch version of the book by the author).
diversity and contradictions (Gerhardt 1989: 335). She made use of two models to explain the causes and treatment of illnesses. These two explanatory models are the Loss Model and the Deprivation-Domination Model.

The Loss Model concentrates on illness caused by mental and/or physical collapse or by loss of social support. In other words, the individual's experience of a loss by changes in life or life-events can cause illness. The individual is vulnerable and lacks the energy and spirit to cope with the crisis. The painful effects of giving up one's particular social status, losing a sense of self, and feeling out of control are disastrous. The state of being ill clashes with the individual's environment. If there is enough support from the social environment, then the person is protected and will undergo a quick recovery.

The Deprivation-Domination model asserts that the breakdown of health is due to environmental deficiencies. Simply stated, illness is caused by pollution, poor working conditions, low educational standards, and/or poor housing. According to this model, there is tension between the ruling class and the powerless, working class. This creates conflict between the individual and society due to the unequal distribution of power resources. While the individual is by nature interested in health and well being, the illness reflects the hardship and difficult nature of the social order (Gerhardt 1989: 340). It is a sign of suffering and repression, while good health is an example of a better state of mind of the individual and of society as a whole.

Both models emphasise that illness can be caused by social environment influences. Both views also state that inequality is a main feature of the modern social structure; moreover, that it is a source of suffering and that ill health is an expression of a hidden or obvious social conflict (Gerhardt 1989: 275, 339). These approaches contribute to the search for explanations regarding changes in the psyche, depression, and the mental illnesses of people in today's society.

This study uses the Loss Model and the Deprivation-Domination Models to analyse the situations of the women interviewed. The women are in their most productive years. They have many responsibilities such as studies, work, career ambitions, and children. Many changes over a short period of time can create a serious mental burden. Traumatic or other events can be the straw that breaks the camel's back. This study represents just a small group of the alarming numbers of young women who enter the WAO due to mental illness. The respondent's problems arise out of issues in the home and community and the interaction between the two.
1.4 Objectives and Research Questions

1.4.1 The General Objective:

To shed light on the causes of the inability to work due to mental illness in women aged 25-35 who were formerly employed in the health care sector.

1.4.2 Specific research questions:

- How do the women experience their ill health, their inability to work, and their dependence on state benefits?
- How do the women account for their ill health and their actual situation? What factors do they think were important?
- Do the women see a difference between their own expectations and the reality of working life?
- Do the women see a discrepancy between the expectations of others and the actual situation?
- Do the women find it difficult to combine private and professional life?
- What were the expectations of the performance at work and the success achieved?
Methodology

1.5 Study Type and Study Design

This study is a descriptive, qualitative study. I will describe the views and experiences of women who are receiving full or partial disability benefits under the WAO. I will write an account of the respondent's definition of the situation — the way in which the women see their world in relation to their behaviour. The life stories of the women are a key source of information for the content of the case studies, which will extensively describe the characteristics of the respondents and the way in which they cope with mental health problems. The stories may reveal social problems and processes, which will be analysed. By analysing information on behaviour, personal experiences, and underlying issues, I will gain a clear understanding of the factors that contributed to the causes of the mental health and disability problems faced by the respondents.

The main questions that need to be researched are the following: How do young women with mental health problems working in the health care sector become disabled, thus entering the WAO? What did they experience at work, at home, with the insurance providers that may have contributed to their situation? How do they account for their illness, and how have they dealt with the transition from being employed to being WAO benefit recipients?

I have conducted interviews with the participants to obtain the answers to these questions. I have also studied Cadans Insurance Company client files as Cadans deals primarily with the health care sector and is responsible for the implementation of social healthcare benefits. From these documents I gathered data regarding the clients, their problems, and the interaction between medical doctors of the Arbo1 service, the insurance company, and other employment officers.

Many aspects of the problem became clear after content analysis of the interviews and the discussions with informants. In addition, I studied available data (qualitative as well as quantitative) such as statistical figures, reports and other analyses. I also collected information from articles and publications concerning people suffering from mental disorders. Most of the information described people's opinions about their problems. These opinions represent how the people affected communicated their situations. The main purpose of the interviews conducted for this research was to get a very clear idea of the opinions of the respondents concerning their current situations.
1.6 Sample of Research Population

The selection of the participants for the study emerged through a combination of strategies ('purposeful sampling'). In order to obtain as many and as varied respondents as possible, I used several methods to contact them. Through an advertisement, letters to a hospital and an insurance company, and numerous contacts, I was able to find eligible participants for the study based on the following criteria:

Criteria for Selection

- Gender: Female
- Age: 25 to 35
- Employment: Public Health Sector
- Illness: Mental Health Complaints
- Current Status: Benefit Recipients under the WAO
- Marital Status: Married or single
- Dependants Status: With or Without Dependants

It proved to be rather difficult to find respondents who fit all of the requirements of the criteria. Through the assistance of Cadans, I was able to obtain six respondents. I contacted one respondent via a staff manager of a hospital in the region of Noord-Brabant. I acquired four other names by various contacts as word got around that I was doing this study ('snowball effect method'). During my research, I also met several experts in the field of women and employment who provided me with the names of potential candidates for the interviews.

All respondents had been working in the public health sector prior to entering the WAO. They worked in hospitals, psychiatric clinics, convalescent centres, and youth welfare organisations. They all live in Noord-Brabant, a region in the south of the Netherlands. All women were diagnosed with mental illness in one form or another, and three of the eleven suffered initially from physical complaints and were only later diagnosed with mental disorders.

The respondent's ages vary from 25-41. Thus, not all criteria requirements were met. Had certain participants been excluded due to age, the study group would have been too small to make an analysis with meaningful conclusions.
1.7 Data collection method

The data in this study comes from existing reports and literature on the WAO and related issues (see Appendix I), from personal interviews with the respondents, from Cadans Insurance Company client documents, and from discussions with informants.

I used the study of reports and literature to present background information on the subject. The themes of this study focus on the WAO questions, the insurance companies, the work situations, and the personal characteristics of the women. The interviews provided data regarding the socio-economic characteristics of the respondents' environment, of their behaviour in public and private life, their knowledge, attitudes and beliefs, and their medical and personal histories.

In order to find out which factors can be singled out as causes of the illness, I analysed the interviews and studied background variables. These variables are age, ethnicity, educational level, socio-economic status, marital status, religion, and intervening variables such as having children, special complaints, occupation before sick leave, part-time work, enthusiasm for and attitude towards paid work, the employer-employee relationship, and the physician-patient relationship.

The main data collection technique was the unstructured interview: an oral questioning of individual respondents conducted in in-depth interviews. An interview itinerary ensured that all issues were discussed. The timing and order of questions remained flexible according to the flow of the conversation. By informing the women that their accounts would remain anonymous and by asking open-ended questions, I allowed them the opportunity to freely explain their situations and tell their stories. I made use of elements of the ethnographic interview technique, a conversation technique in which the respondents can spontaneously reflect and narrate their experiences. This technique enables people to say what they think and feel. However, it can be difficult to elicit objective information because in some cases the questions of the interviewer influence the interviewee too much. Moreover, the fact that the respondent knows the exercise is a study can also influence their responses. Furthermore, the use of the tape recorder may impact the overall objectivity as well.

The basic format of the interviews and the types of questions asked are presented in Appendix IV, followed by a Problem Diagram.

At the outset of the study, I discussed the proposed thesis with key informants such as other researchers and the staff of organisations involved in WAO proceedings. Before the interviews took place, I discussed the WAO problems with a medical doctor from the insurance company and a manager of Cadans. They provided me with information that is elaborated on and integrated into the study as well.
1.8 Research history

As previously indicated, obtaining appropriate respondents for the study proved to be a challenge. Various methods of approach finally produced eleven candidates. An advertisement was placed in two regional newspapers, which resulted in only one response by someone who wanted more information about the research. The personnel manager of a hospital in the province of Noord-Brabant sent three letters (see Appendix III) to female employees on sick leave who were receiving disability benefits under the WAO. One candidate resulted from this attempt. Four women were referred to me by a sociologist who works with various women's groups.

Various other organisations were also asked for their cooperation with regard to the selection of the sample. I contacted Cadans Insurance Company, a UVI (Uitvoeringsinstelling of the LISV: the National Social Insurance Company), and the chief of staff agreed to assist in the selection of the respondents. The method for selection was as follows: the chief of staff contacted the managers of Cadans in Eindhoven and Den Bosch who agreed to collect addresses from the WAO files. I then followed-up with the managers to discuss the purpose of the study and the main assumption that the causes of mental illness among young women are multi-faceted.

A random selection was made based on the above criteria. Twenty letters were sent to prospective candidates (see Appendix III). The letter included an explanation of the purpose of the research and a request for participation in the study. The women were asked to contact me on their own accord. After a reminder was sent, six women replied and agreed to be interviewed.

In most cases, the interviews took place at the respondent's residence, with the exception of one woman who preferred to come to my home. Most women were very enthusiastic and gave the impression that their stories and problems were not fully understood. Before each interview, I informed the respondent of the purpose of the research and the interview structure. I emphasised anonymity, and obtained informed consent. The respondents were asked to tell their life-stories in order to get their 'ethnographic context'. Because much of this information can be incredibly personal, I attempted to create an open atmosphere and to be attentive, both verbally and non-verbally. By 'echoing', I was able to determine whether or not I had understood the respondent correctly. I asked additional questions to complete the interview.

As stated earlier, Cadans allowed me to study files of clients with regard to the selected criteria. These files included information about the contact between the clients and the Arbo-service, questionnaires for medical information and for employment searches, medical examination reports, disability assessments, information from an FIS (Functie Informatie Systeem), copies of letters which were sent to the clients about inspections or disability orders, and records of social benefit allowances. The files contained written responses from the clients with regard to their own assessments of their ability to work and available job opportunities,
as well as corresponding statements by medical professionals. This information provided better insight into the WAO system and additional knowledge about the contact between insurance medical officers, clients, and employment officers (see Appendix VI: table II).

I researched twenty-three files of which eighteen were relevant for this particular study. All of the files were of women between the ages of 24 and 44. They were married, unmarried, with or without children, and all suffered from mental health disorders. The files were studied with particular attention to life-events, working situations, medical histories, and the interaction between the client, the insurance medical officers, and employment officers.

I discussed the WAO problems with one insurance medical doctor and posed the following questions: What are your experiences with the assessment of complaints of mental illness of young women? What factors play an important role in this category? How is the contact between the patient and the insurance medical doctor? How is the co-ordination between Arbo-medical doctors, Arbo officers, and insurance medical doctors? The data from this discussion has been integrated into the study within the themes of the different chapters.

1.9 Ethical considerations

In an effort to ensure the validity of the outcome of the research and to increase the acceptability and participation of the respondents, I adhered to basic ethical principles when conducting the research: respect for the respondents, the principles of beneficence, and justice. Before the collection of data, I followed several strategies: obtaining informed consent from the respondents, which involved explaining the purpose of the research and requesting permission to interview them and use their taped testimonies in the study; ensuring the confidentiality of the participants, emphasising anonymity; creating an environment of trust so the respondents felt comfortable responding to personal questions; and allowing the respondents to end the interview at any time should they feel too emotional. (Direct quotes from the interviews were incorporated into this text only after receiving consent from the respondents. I also agreed to share the results of the study with the respondents.)

1.10 Limitations of the Study

Due to various influencing factors, the study does not claim to be completely representative. The following played a part in limiting the scope and applicability of the study: 1) because the research was conducted over a short period of time, the months of May and June, the number of interviewees was limited; 2) a selection bias
resulted as a result of the inability to fully comply with the age criteria; 3) the respondents were only interviewed one time and their testimonies were subjective which could result in information bias.

Given these limitations, however, I am still of the opinion the testimonies contain valuable enough information to meet the purpose of the study. The in-depth interviews gave the women the opportunity to tell their stories in their entirety. Most of the interviews took 1 1/2 - 2 1/2 hours. The interviews were both informative for the study and therapeutic for the participants. The women found the process a useful avenue for communicating their experiences to the authorities.

Solutions for the WAO problem can be found by observing and listening to the 'source'. Thus, this study contains first-person accounts of the experiences of women suffering from mental illness. The results of the analysis of the various parts of the study can contribute to the development of measures that seek to prevent the onset of the illness, and hence create a roadblock to the path of long-term disability in these cases. Improvements and preventative measures may even be conducted with the target-group used here, should the possibility arise.
2 Women and the WAO

2.1 Introduction

Chapter two presents background information about the situation of women and work in general and the WAO problems in specific. It is only appropriate to analyse the findings after having studied the development of the emancipation process and women in employment in the Netherlands over the last twenty years. I will first outline the participation of women in the labour market and the road to economic independence. I will then describe how one goes from employability to injury to becoming a WAO benefit recipient.

2.2 Women and Emancipation in the Netherlands

In this section, I will present some information regarding the history of the emancipation process of women in the field of work, labour, and care and their economic contribution to society. I will describe how their employment opportunities improved, and I will illustrate this with statistical figures. I will then discuss the participation of women in the labour market and how they balance work, family, and economic independence. This information should serve to place the stories of the respondents into the context of today’s environment of employability, gender equality, and career opportunity.

2.2.1 The Participation of Women in the Labour Market

One of the reasons that the participation of women in the labour market has increased during the past decades is improved facilities for childcare. Their access to jobs at all levels has been greatly enhanced by this. The percentage women working twelve hours or more per week in paid positions increased from 36% to 51% from 1988 to 1999. In the long-term, there are many advantages for women in labour market. There are already shortages in sectors that are popular with women such as social services, education, retail trade, and the catering industry (SZW (a) 2000: 11-23).

In today’s economy, women have many more opportunities to develop their talents. An increase in the mean educational level for women implies that more and more women find it a feasible and attractive option to combine work and family responsibilities. Women with a higher level of education participate much more in the labour market than less-educated women. Education also influences the number of women with children who choose to seek employment. In 1997, 74% of young women with university education were employed, compared to 17% of women with only primary school education. This can be explained by the fact that a
A higher level of education generally generates a higher salary. In that case, domestic help can be contracted out. Many women with children also have part-time jobs. Highly educated women have more high-level, highly paid part-time jobs than women with low levels of education. Highly educated women occupy key positions and have more influence on society (SZW (b) 2000: 9-15).

While material rewards are important for working women, intellectual factors such as independence, personal development, and career ambitions are also motivators. The higher the educational level, the more possibilities there are to have a satisfying profession. Women choose to remain in the workforce because the quality of the job and the contact with other colleagues and professionals are important to them.

### 2.2.2 Combination of Work and Family

More and more women are working outside the home, but they must take into consideration their responsibility for caring for children or other family members. Many women choose to work part-time in order to juggle these responsibilities. In the Netherlands, 93% of women work part-time. In Europe, this figure is 80%. From 1990 to 1997, the number of part-time working women increased from 51.2% to 58.6%. When their first child is born, 30% of working women stop working and 42% choose to work part-time, usually less than twenty hours per week. Only one quarter of the total number of working women continues with full-time employment. (SZW (b) 2000: 9-15).

### 2.2.3 Economic Independence of Women

Women are increasingly economically independent. Some factors that contribute to this situation are the fact that women are more highly-educated now than in the past and seek to pursue a career before family, the so-called 90's generation views economic independence as freedom, and child care and maternity and parental leave make it feasible to combine work and family obligations.

The emancipation process has influenced the very foundation of the Dutch social system. Today's social system contains elements of three family income models: the Breadwinner Model, the Outsourcing Model, and the Combination Model. In the Breadwinner Model, the family income is earned by the male partner and is the basis of payment rights and the health insurance of the dependent partner is free. Breadwinner services make it uninviting for women to have jobs and form a hindrance to their becoming economically independent. The Outsourcing Model requires the employee to be available for full-time employment. In this model women are forced to choose between child and career. Many highly educated women delay having children or choose not to have children at all for this reason. The Combination Model takes into consideration the fact that an employee has a responsibility to her family (SZW (a) 2000: 20).
This model is still rare and has not yet become the norm. There are still questions about the redistribution of paid and unpaid labour.

In the Netherlands, the main family income model is the 'One and a Half Earners Model': the man is responsible for the majority of the income, and the woman is the "half earner". From a macro-economic perspective this is not an ideal situation, as the woman's potential is not being reached. The Combination Model allows for this, but new regulations would have to be enacted and collective thinking adapted in order for it to become the main income model. Among other things, the Working Hour Law, the Flexibility and Security Law, the Law on Work and Care, and the Law on Basic Child-Care Services would have to be revised to meet the needs and circumstances of employees with family-care obligations.

2.3 Path: Employment - Dutch Health Law - WAO

In this chapter, I will describe the various phases of the path people follow before entering the WAO. This will clarify the procedures women have to go through once they have been diagnosed with a long-term illness and are unable to work as a result. I will discuss the Dutch health law, namely the Disability Insurance Act, the WAO, and the path from disability to the WAO.

2.3.1 Disablement Insurance Act and the WAO

Under Dutch law, if an employee is diagnosed with a protracted illness, he/she is entitled to financial support. A comprehensive social insurance system regulates the benefits to which employees are entitled. The Disability Insurance Law ensures benefits to employees up to the age of 65 in the event that they are unable to work due to illness or injury. This law also provides maternity benefits of 100% of the daily wage for a determined period (16 weeks). In the case of long-term illness, disability benefits are paid for 52 weeks in the amount of 70% of the last earned wage. (Mudde 1995:2). After a period of 52 weeks, the employee is then entitled to benefits under the WAO. The implementation of the disability law and benefits is carried out by authorised UVIs (Uitvoeringsinstelling), such as Cadans and Uszo Insurance Companies.

In order to fund the WAO, premiums are paid by both the employers and employees with the lion's share of the costs going to the employers. Disability benefits are awarded only to those people who were in employment at the onset of disability or who had already been receiving unemployment benefits.
2.3.2 The WAO Path

What is the normal course of events leading to entitlement of disability benefits? An employee is injured or becomes ill and goes on sick leave. The employer is responsible for benefit payments for the first year in the case of long-term injury or illness. The employer engages an Arbo-service and both attempt to prevent the employee from entering into the WAO. They set up a project for reintegration into the workforce. It is possible for the employee to return to work on a therapeutic basis, part-time work and limited duties, while still receiving benefit payments in the place of normal wages. In this case, an employee who is unable to take on all of his/her original work duties is still able to contribute to the workforce, re-establish him/herself in the workplace, and a sense of self even after a long absence due to illness.

In week thirteen of sick leave, the first consultation between the industrial medical officer and the insurance medical officer takes place in accordance with the law. It is the duty of the insurance company to monitor the progress of the ill or injured employee. When an employee is off work for more than 35 weeks, the WAO procedure is started even though the re-integration project is being developed and carried out at the same time. The insurance medical officer of one of the UVIs determines the workload an employee can cope with. Vocational counsellors determine which duties the employee is capable of performing. The extent of disability and the amount of the WAO benefits are based upon these findings. The employer is responsible for finding alternatives to reintegrate the employee into the workplace during the period of temporary disability. Once an employee has recuperated, he/she will usually return to the same position he/she was in prior to the injury or illness. If attempts to accommodate the employee are unsuccessful after 18 months, the employer may begin procedures of dismissal. The insurance professionals analyse the situation and make sure that all possible avenues for accommodation and reintegration have been exhausted. If the employee is still deemed unable to work after two years, he/she will be dismissed from employment.

Should the employee disagree with the findings and/or decisions of the medical officers, he/she may file protest. The employee also has the right to inspect and verify the information in the documents on file. During the protest period, the employee waives his/her rights to benefit payments because the illness or disability is not in question, because he/she was already declared disabled at the start of the insurance period, due to non-compliance with regulations, or because the illness or injury was not reported timely. (Mudde 1995: 3).

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1 The extent of disability varies and is given by percentage. On one end of the spectrum, someone can be determined to be partly unable to work with an extent of disability less than 80%, and at the other end a person can be determined to be fully disabled with an extent of disability of 80-100%. In order to receive benefits, the percentage of disability must be more than the minimum set by law. For the WAO, this minimum is 15% and people whose disability percentage is less than this minimum are not entitled to WAO benefits. (Lisv 1999: 125).
3 Women in the Picture

Female employees say:

'They have not done a damn thing to prevent my illness'; 'I am fed up with the home care' or 'I have been let down by the trade union' (Opzij 1999: March)

Remarks of women who became ill:

'...You determine that I cannot manage that job. You let me down'; 'I was always able to manage because of my perseverance; with a will one can carry on. Now I am worn out'.

Complex problems such as work, pregnancy, children and a divorce, can also cause burnout:

'...I told the company medical officer...I am not ill, I am a bit crazy'. And after ending the WAO period the same woman stated, 'if you're on time, you don't have to sink so low' (HP/De Tijd 2000: July).

3.1 Introduction

I will now present the findings of my fieldwork: the testimonies of women suffering from mental illness and receiving WAO benefits. The aim is to create a picture of their situations that is as true to life as possible. The research questions enabled the women to piece together this picture for us and answer key questions: How do young women with mental health problems, working in the health care sector, fall under the Disablement Insurance Act? What were their experiences in the workplace, in the social service sector, and at home? How do they account for their illnesses and the process of going from employment to being WAO recipients? These questions provided a guideline for the interviews and stimulated the women to speak about their experiences and give their interpretations of the entire process (see Ch. 1.4.2).

The respondents are made up of eleven women aged 25-41 (see table I in Appendix VI). At the time of the study, three of them were receiving full disability benefits, among which one of them was in the process of a work-mediation project. Two women were receiving benefits according to the Dutch health insurance laws, and one of them was involved in a re-schooling project. Two women had been determined to be partially disabled, one between 15%-25% disabled and the other 45% disabled. They both worked part-time. Four women were working part-time or full-time again.

In chapter three, I will describe the experiences and expectations of the work situation, the illness, the process of becoming eligible for Dutch health insurance benefits, and the experiences with the consultations and the WAO. The main issues will be outlined in a summary.
In chapter four, I will explain the women's interpretation of their situations, their personal experiences and traumatic life stories, their views on their education and careers, and their experiences with the environment, all which have influenced their mental illness. The main issues are summarised at the end of the chapter.

3.2 Work Experience

The eleven stories about work experience are presented separately to get a clear picture of the complexity of the problems. Out of fairness and objectivity to the participants, each woman's story is reported. One of the key points of the interviews was to ensure that the respondents were co-operative in the attempt to find reasons and factors that contributed to their difficult situations. I believe these reasons can only be discovered by obtaining information directly from the source.

Empirical Testimony 1:

The respondent works in geriatric care, and emphasises the workload in this sector.

"I have worked in geriatric care for eight years. I have changed positions several times within the institute, and have taken on additional tasks in the last few years such as being the contact person for six elderly people. You have the duty to keep in contact with other family members.....I liked the work very much, but it became more and more difficult. The people are getting more difficult. At first, the home was only a home for the elderly, but now it is a nursing home. It is physically very difficult work... Usually, two of us lift the people together. They weigh between 80-90 kilos. There is a hoist we can use, but the rooms are too small and too full and often you just say we'll do it without the hoist... Helping people in and out of the bath, raising and lowering the bath chair with such heavy people has got harder over the years. There are waiting lists for the nursing homes and therefore people stay much longer here...These days the people who come here are more suitable for a nursing home".

Empirical Testimony 2:

The respondent is a nurse who worked in a hospital and then in a convalescent centre.

"I wanted to stop working in the hospital, it was too hectic. The care one could give to the patients was in my opinion too minimal. For instance, patients with abdominal pains: you yourself know that they have cancer and there isn't time to talk about. I accepted a job in a nursing home as nursing team leader...I had to manage others and I felt very lonely in that
position. In the beginning, they regularly organised counselling and supervision sessions with the head nurse, but later there wasn't time for this anymore due to reorganisation. There was too little time to communicate and the tasks and responsibilities were not clear to me. To me, It wasn't a nice atmosphere."

**Empirical Testimony 3:**
The respondent worked as a nurse in a psychiatric hospital.

"......It is fairly difficult. People who have attempted suicide or who are schizophrenic are brought here... We had a nice team. The psychiatrist didn't do much. Once a week he held consultations with patients and wrote them prescriptions for medication. There should have been more support for the nurses. There is a culture that we'll manage together: continue to work, do overtime work, and just go on! Psychiatrists and doctors, some of them take the nurses seriously and some don't. They speak more for their own interests. The doctors deal with a problem for an hour, but the nurses do this 24 hours a day. There are meetings to discuss the patients, but we should be able to talk more informally about the 'why' of the patient. Not only pills, but more attention. Now it is only basic care. For example, you can't do much with 'borderliners' so it's better not to begin. The best treatment is no treatment... In 1977 I was already working in psychiatry and then there was still time to go for a walk or to play games. Nowadays even basic care involves more tasks and responsibilities. More work with less personnel."

With reference to the department serving young chronic psychiatric patients 16–40 years old, the respondent stated:

"......The number of patients more than doubled, from 16 to more than 32 people, but the team is still the same".

And she continued about the extent of the burden:

"......There is a lot of tension among the team... They don't accept the team leader. He is a good man, but he's not good socially. He says one thing to the patients and other things to the team. Team and leader do not work together... More work, more borderliners with pills, injections and violence...... sometimes there is an acute problem: I am going to jump before the train! And at that moment you are all alone. The leader is sick and the assistant has already been sick for a long time. The nurses take over. One student intern (HBO=Higher Vocational Education Nursing) ran away crying because it was so stressful. There was little time for supervision. I was a student nurse and I had to supervise other student nurses. Too difficult. How could I manage? It was not fun. I did not have a thorough command of nursing yet. Very complicated. Psychiatrists often did not know and neither
did the qualified nurses. You did what was expected of you... you were alone and once in a while you got a pat on the back. You weren't allowed to show fear. You had to support the patients. A feeling of failure. For example, there are open and closed units. There are patients who take 50 seresta-forte pills at one time. Others are suicidal and want to hang themselves or light themselves on fire...... It was a new department that had to be set up. There was a feeling of helplessness among the team workers and even among the psychiatrists. Plus the distance between the psychiatrists and the nurses. Unresolvable problems. In the health-care sector you are inclined just to give, unconditionally, and to be there because it is necessary. You end up feeling empty because you get too little in return.”

Empirical Testimony 4:
The respondent worked as a nurse in the department of cardiology and in her opinion gave it her all. She helped establish a polyclinic heart rehabilitation unit. She had a double task: nursing and temporary senior nurse. She was enthusiastic and she was creative with plenty of new ideas. She did all kinds of work in addition to her other duties. At a certain point, she collapsed and was deemed 45% disabled. As soon as she was able to work part-time she tried to return to cardiology, but she had several limitations and was not allowed to work in high-pressure situations. This created problems. She tells her story:

"What I have done in the department of cardiology is enormous. I still want to work in cardiology; my heart is in it and I was and I am still a valuable person, but they let me go. The reason: I did not fit in anymore. But I insisted on fitting, not taking a step down. They have done a lot for me, but when I asked for something, a meeting was okay, no problem. But I asked for accommodation, something really for me. Because otherwise I’d have to go. Then it was over and that was painful. Apparently only the fixed, regular norms are applicable in that profession. Things can be changed temporarily, but not structurally. Rationally I can understand this, but not emotionally.”

Empirical Testimony 5:
The respondent is a child-care assistant. She believes she can make use of her creativity in this sector. She feels accepted as well. After some time, she was promoted to the function of group leader. The nursery's management formed self-guiding teams that had to implement their tasks independently. The respondent believes she was chosen to lead a team as a result of her capabilities. She finds it very important that:

"When interaction between people is good, you can do anything. If that's clear, then you have a team. A basis to work from. During our meetings, I had the feeling that I was on the same level of thinking as the other team-leaders."
Despite her unfinished HBO study in medical social work, she feels that she is no less talented than the others with a higher education are. She was even promoted to co-manager of the nursery. However, the remuneration for this work was not appropriate in her opinion.

"I asked to be placed in a higher pay scale. I wanted a permanent contract, but that was not possible. I spoke with the interim manager for an hour. I argued my case and told her, 'It's a new group, an independent group and you chose me and not one of the others with 4 or even 9 years of experience. Apparently, I have the qualities that dared you to do this. And I would like these qualities to be recognised'. That was the first blow. There was no appreciation for my qualities."

Empirical Testimony 6:
The respondent works as a group educator at an institute for children with behaviour or learning disabilities. In the beginning, she worked in a team whose duties varied. They worked in a pavilion, and the youth group lives in two semi-detached houses. As a result of restructuring and other problems with the team, she changed jobs. She became the creativity leader for leisure activities. She finds the work difficult and has to regularly bring work, such as report writing and preparation, home. She explains:

"I work 32 hours, but in reality it is 40 hours. And then there is work pressure as well. Every hour I have a new group of children and there are 2 minutes in between to clean up and get everything ready...The children are more and more complex...the groups are getting bigger. The maximum is 12, but 14 are allowed in."

Empirical Testimony 7:
The respondent is the head of department in a nursing home. She worked 40 hours per week until she had children, when she reduced her hours to 28 per week. Her experience is as follows:

"I was busy, but I enjoyed the work. In that time I even did a lot of volunteer work at the youth centre. I've since then stopped with that. I realised that I wasn't performing well at work or home. I wanted to try to work the nightshift permanently."

When she became pregnant with twins, she was out of the work arena for the time being. Once the twins were born, she began working the nightshift again until she started making mistakes. She realised that she was exhausted and had to call in sick. A severe depression, caring for the children and the confrontation of issues from her past seemed to be more than a full-time job and required too much time and energy.
Empirical story 8:
The respondent began working at an institute for children with behaviour/learning disabilities when she was a student. Subsequently she also worked there as a replacement until she received a permanent contract. She is group leader and has the following to say regarding her experience:

"They were... youth with very difficult and aggressive behaviour... a few boys that needed strict boundaries. There was a man in the team who didn't perform his duties well... I had to work with him a few times and it was a disaster. A man who didn't take responsibility and who left you to figure everything out alone and of course, I didn't accept this. Even when there was a great deal of tension in the group, he continued to carry on mentor conversations. I told him that I was not prepared to deal with this tension alone. I have the idea that it's going to crack, and then I want you to be around. Okay, then just call me. Yeah, but you're two floors up and I'd prefer that you sit down here. Then at a certain point I yelled for him, and then somebody hit him. He wanted to keep it a secret, but I wrote it down in the logbook. And in the meeting, he denied it."

The friction in the team and the internal problems became too much for the respondent, and ultimately she went to work at another location.

Empirical Testimony 9:
The respondent is a psychologist. In order to gain experience, she worked for five months as a volunteer in a therapy centre. After that, she began working in the centre for the minimum salary. The workweek is in theory 29 1/2 hours, but in reality she works 36 hours per week at such a salary. At first she considered it to be a good place to get work experience and supervision. She states:

"...There were all kinds of problems. A colleague of mine was basically shown the door. She had back pain and was on sick leave too often... After that it turned out that there were financial problems and we had to move. That took about six months. They promised me extra training and the possibility to work outside the centre for a period. There was no time for it. I had to conduct the consultations and take over those from a colleague of mine who was away. I was supposed to be able to follow a course, but that also wasn't possible. In January '99, we were informed that the foundation was in serious financial trouble... Once a week I had a conversation with the director who was also my supervisor. Most of the time was spent discussing the clients, and there was never time to discuss my situation. She was diagnosed with breast cancer and one day just wasn't there anymore. I had to take over her consultations even though I hadn't been there long and had only spoken to her about the patients a few times. I had to take this over all at once in addition to my own work... 20 clients plus the group session. And a course about women and stress
had to be developed immediately as well. My colleague and I developed it. Then it had to be conducted, which we also had to do. It all just became too much.”

As a result of the stress, the respondent is unable to work. She has remained in contact with her superiors while she has been off work. She feels she has been forced into maintaining this communication. She explains: "...It is written in the contract that the training costs of 10,000 guilders per year will be paid by the employer if I work there for two years. However, if I leave earlier, thus breaking the contract, then I have to repay the outstanding amount. The first year is mostly learning and the second is mostly working... I received a letter that stated that I had to pay back the 10,000 guilders under the circumstances. I left at about a year and the contract stated that I had to repay 10,000 guilders... or I had to contact them and tell them how I planned to pay back the amount and that from this month 200 guilders from my salary would be withheld to repay the amount. That they did. At the time, I was receiving the minimum salary. After that, I sought legal advice. They [the lawyers] found the situation ridiculous and wrote a letter... that I had not broken my contract, but that I was ill. And then I told my story and they wrote it down... in the first place, I didn't have any training and very little supervision. And in the second place, that the workload was in large part responsible for the stress. Because if the matter is taken to court it has to be documented or it won't be allowed later. A rather inconspicuous letter was sent to the employer and a few weeks later a firm reply was received. Oh yeah, he [the lawyer] also wrote that they didn't have the right to withhold 200 guilders from my salary and it was withheld for two months... In the [reply] letter they wrote about what I had done wrong according to them, and decided that they could not withhold the 200 guilders. They sent back 400 guilders. But they still wrote that they had the right to reopen the case if they found it necessary."

Empirical Testimony 10:
The respondent's first job, a so-called Melkert job, was working in a surrogate family unit. She is an assistant and helps the mentally handicapped people in their daily life:

"I need to look after the mentally handicapped and guide them in doing the household work, cook and eat with them, talk with them about their problems... Normally I am occupied with the daily activities. Sometimes I do the shopping with them, make something, or do the cleaning. A very practical job".

She is not really motivated. In the past she lived off social security benefits. She is an artist and did several short-term courses. She accepted this job because she thought it was necessary to change her life:
"I imagined that this job would be interesting for me, but the work seemed too much of a burden in the end. Oh yes, this handicapped people, they totally drained me......"

Empirical Testimony 11:

The respondent is an occupational therapist working for two institutions with mentally and physically handicapped people in the region. She stopped working for one institution due to the following:

"......I felt I could not use all my professional qualities. In the institution they didn't want to create the conditions so that I could use my professional practical knowledge. We occupational therapists have to give a lot for the benefit of patients. We concentrate on their daily activities such as teaching the handicapped how to wash and to dress themselves, how to eat and drink, to live and work. We focus on the improved functioning of handicapped people. In the nursing home they only focus on the aspects of washing and dressing oneself, sitting, and wheelchair use. We also have to offer something in the neuropsychological field. For instance, when somebody is demented and has forgotten the plan of action, we are able to assist them. Of course, we overlap with the work of the psychologist, but practically we have a lot to offer. But we weren't allowed to do this. It was a pity. I worked twenty hours in the other institution. I was the only one and I worked in close co-operation with doctors and physiotherapists. In special cases, I contacted the group leaders as well. In general, an occupational therapist works alone. You build up a network. You have professional discourse regularly...."

"I also find that setting priorities is good, but only if they apply to the entire team or management, not individual priorities. In my opinion, it is important that every handicapped person can sit well. The major function of a perfect wheelchair is to support a sitting position, but for me that is not the nicest part of the job. If I do what I like best, who can say that the quality of the occupational therapy is good? I think I want some feedback from the management of the institution that they stand behind me in my work. All occupational therapists have the possibility to give the profession a highly personal interpretation. In order to ensure the quality in the institution, you need to make clear appointments..... It is good to work with colleagues, but it is not necessary. Yes, during the merger of two institutions one colleague arrived, but she left very soon thereafter. She did exactly what I'm doing, and she didn't want to fight it anymore. I did this for years, and nothing has changed...I am frustrated. I love my profession, and I really want to continue doing it as best I can. I want to do as much as possible for the handicapped, but I was up against the disinterest of the management of the institution."
3.2.1 Experiences of respondents in their relations with superiors

In this chapter, I will describe the interaction between the employees and their superiors at the workplace; specifically, the communication between the respondents, their managers, and other high-level staff within the various institutions the respondents worked for. I am aware that the descriptions are subjective, as they have been related by the respondents. The statements of the respondents during the interviews adequately describe the atmosphere at the workplace from the respondent's point of view. Below is a summary of the experiences, with reference to the testimony upon which each statement is based.

In general, the women are satisfied with their work in the social services sector. They discuss the negative and positive interactions at the workplace. The following are some of the negative aspects of the job that they encountered:

- There is not enough supervision or support. There is too much pressure, and not enough time to talk about the cases and the situation. In general, the communication between senior nurses and staff nurses is very poor, and is even poor among the senior nurses themselves. They are only focused on the organisation and don't provide enough feedback to their personnel. (Testimony 2)
- For most employees, it is unpleasant to work in an institution with a strong hierarchy. The contact between various professionals within the institution is superficial. Communication is poor, and responsibilities are unfairly delegated. (voiced in several of the testimonies)
- While the employee were out on sick leave, they were not contacted by colleagues. When they returned to work, they were not given duties appropriate to their skills. (Testimony 4)
- Performances are evaluated and appreciated once in a while, but there is a misunderstanding of how to reward the work financially. Though the educational levels of the employees in an institution may be different, if they perform the same duties, they should be compensated equally. This can be very demoralising when it does not occur. (Testimony 5)
- Poor organisational and reporting structures within institutions can cause dissatisfaction and lead to problems between the employees and management, and even among the employees themselves. (Testimony 8)
- Understaffing and poor management can create an overburden on the staff. In the case of the respondent in Testimony 9, the employer accused the worker of being disloyal to the centre when she was expected to do far more duties than simply her own. Her mental condition suffered due to unpleasant correspondence with the employer and the demand that she repay training expenses. When the employee began to make deductions from the respondent's paycheck, the situation worsened. Finally, the respondent sought the advice of legal counsel. (Testimony 9)
• Miscommunication between manager and employee can cause frustration and de-motivation. In the case of the respondent in Testimony 11, she believes that her superiors did not appreciate her field of expertise in occupational therapy or its value to the institution and its patients. Additionally, she doesn't think that her manager understood the reality of what happens daily on the work floor. The respondent also indicates that she ended up with the most difficult cases. Attempts to resolve these issues were unpleasant and unsuccessful. (Testimony 11)

3.2.2 Conclusion

The respondents have clearly illustrated their problems in the workplace. In the convalescent centres, the workload is far too demanding because many of the patients need additional medical care and should be admitted to nursing homes that provide this care. The mental and emotional stress is too high in the psychiatric sector as a result of the fact that the working conditions are unsafe for the employees. Safety has to be a priority and must be guaranteed by the employer. In youth welfare work, group sizes are often larger than they are supposed to be and responsibilities are not evenly shared which increases the probability of unpleasant incidences and causes tension among co-workers. Due to restructuring in hospitals and institutes, fewer resources are allocated for supervision and staff. Consequently, employees are overworked and lack communication and support from management. Flexible forms of work tasks for reintegrated nurses can stimulate a full recovery.

3.3 Experiences with Health and Illness

3.3.1 Respondents

The progression of illness was different for every respondent. Three women had physical problems as a result of which they were forced to stop working. Two of these women had problems and pregnancy aggravated their situation. The respondents emphasised that being on sick leave and staying at home, which confronted them with their physical inability, contributed to their mental illness.

Among the eleven women, there were four cases of burnout and four women felt very depressed. Two of them were hospitalised for treatment for a short period of time. Others obtained relief from medicine and psychotherapy. (See table III in Appendix VI)
The Respondents

They narrate the development of the mental illness, the symptoms, the course of the illness, and the way they coped with it:

"First I was physically ill, an injury of the shoulder caused by heavy lifting. Because there was little hope of recovery and the orthopaedist could not do anything more, I was troubled by it and anxious about the future". (Interview 1)

Another woman was confronted with physical problems during pregnancy and went back to work on a therapeutic basis after 9 months. She had to stop after a time because she could not manage. This woman states that she developed mental problems because she had to fight for suitable work at the workplace:

"My heart is in this work and it is a choice that you make...After the delivery I wanted to work regularly for twenty-eight hours a week, and I also wanted to be on duty. We were used to this".

However, concern about the future, insecurity, and an inability to manage everything created too much mental anxiety. (Interview 2)

This respondent is forty-one, highly trained, and had the possibility to become deputy head of her department. She has had number of frustrating personal experiences as well as professional issues that caused her depression. Despite complaints of fatigue, stomachache, psoriasis, and heart problems, she worked until exhaustion forced her to stay home. She is burned out, and very disappointed:

"I felt full of anger and asked myself, 'Why did you work so hard?'"

She took the time to fully recover and decided to spend her time raising her children. (Interview 3)

Another respondent, aged thirty-seven suffered from depression in the past. She explains that she worked hard and intensively until the point of exhaustion. With the help of therapy, she expects to overcome her mental problems and to start working again. She is ambitious and wants to be retrained. She is now studying naturopathy. (Interview 4)

The respondent worked in childcare. She is thirty-eight years old, and has been deemed unable to work especially with children. She is receiving full unemployment benefits and hopes to work full-time again after retraining. Her mental problems resulted from successive negative experiences in her private life and an unbearable workload. She expects to recover through help and therapy. (Interview 5)
One respondent, overstrained by her work, describes her experiences:

"Every autumn I had a depression, but this time I realised I could hardly cope with the problems. Normally I let it happen and the depression goes away after some time. I think that things accumulated this time: I continued to work all the time and told myself: come on, do not complain... In the past years, I have noticed that there is less time and money, but you have to work more and more with less means and fewer people. Yes, my attitude is: I will do it, I will stay a little longer and finish the work or I will come back for half a day to complete it. In fact, I have no opportunity to prepare at the workplace. If I started work in the afternoon, I had to prepare in the morning at home. I think I worked five full days".

She indicates that past experiences play an influencing role in becoming ill and contributed to the illness. The recovery process is slow. (Interview 6)

Some women find work to be the most important thing in life, and that this can be accomplished in combination with raising children. One respondent, who had several physical complaints such as allergic reactions and inflammation, which were aggravated during pregnancy, continued her job part-time after delivery. She tried to combine work and care but as time went by, the physical and mental problems became too much. She suffered from depression and realised that something was terribly wrong:

"Suddenly I realised that I had made mistakes in my duties at work. I also experienced that I panicked more often and was afraid. I was desperate and dead tired. My daughter looked at me and asked, 'Mama, what are you doing?'... I was restless... I went to see a general practitioner and told him that I felt very depressed. We discussed the situation and he concluded that I needed help. So I had therapy. This year was extremely difficult because of the intensive treatment."

She was not on sick leave during the therapy. Many negative experiences from the past came up again:

"Suddenly I realised that I was physically and mentally in a poor condition. It seemed that I didn't deal properly with negative experiences from the past. I am thirty-six now and it was twenty years ago that I had those terribly frustrating experiences. I have my own children and I get very emotional when I see how my daughter Emy behaves. I went to see a psychotherapist, but I didn't stop working. I felt like this would mean I was a failure... They advised me to stop working, but I didn't want to give in. First, I thought I would wait until vacation is over and after that it will be better. But then things really went wrong. I was panicking and was overcome by fear... Last year in August I told the director that I was going on sick leave".
After a period of therapy she explains:

"I recovered in a rather short time. Last Friday (July 2000) I reported that I had recovered. I went off work in August 1999. That is altogether eleven months. It was an intense period of recovery. For half a year, I could see no end in sight. I had no choice. The therapy took a lot of time and energy. I had to learn a lot. I was off work, but didn't take real rest... until the psychotherapist forced me to do so. I was able to be patient and to wait calmly. Just easy, step by step". (Interview 7)

One respondent became depressed because there were too many problems in the field of social work at the institute for uneducable children. The situation became too complicated. In spite of the fact that her work was well appreciated, she went out on sick leave after facilitating a lecture about how to cope with emotion and stress. The respondent was teaching SPH students who receive training in social pedagogic assistance.

She states:

"During the introductory lesson, each student had to talk about personal experiences. For instance, about mothers who had died and even children who died while the babysitter was there. At that moment I collapsed. I was in a cold sweat. I didn't know what happened to me. I thought, 'I have to keep the situation safe for this group and I have to protect myself.' This didn't go well. I stopped the training of these groups, but continued with the groups who were trained in caring for the sick. But then it appeared that, as I heard from my therapist later, I didn't know what was wrong with me. Crying for no reason, depression, unable to face the day and get out of bed. It appeared that I was severely depressed. Then I called in sick."

She experienced that something was fundamentally wrong. Traumatic events from her youth came to the surface. The psychotherapist helped her deal with these issues, and she expects to recover and to return to her former job. (Interview 8)

Another respondent suffered burnout as a result of her workload, personal problems, and traumatic life-events:

"I was too tired so I had to lay down during the break at midday, because otherwise I could not manage to finish the work in the afternoon. I did this for a month and then went to see a general practitioner. He asked me about my work. I immediately started crying. I explained to him that it was too much and that I was not able to cope. He suggested that I stop working for a short time. But I told him that this was impossible because there was no replacement for me. The same week, one of my colleagues went on holiday. One of the managers was seriously ill and accompanied by the other manager when going for check-ups, so I was solely responsible for the work. Sometimes there are even suicide crises. One
has to take action immediately. This responsibility landed on me. I had panic attacks; I found it difficult to breathe. That Tuesday morning, I realised that I was overworked".

She went for clinical psychotherapy and learned a lot. She feels more in balance now. She wants to start working again. (Interview 9)

Another women worked in a home for the mentally and physically disabled. She is thirty-seven and states that her exhaustion was the result of difficult and uninteresting work. She indicated that she has also gone through some traumatic personal experiences and that growing up was not easy:

"I found it interesting getting to know this group of people, the mentally disabled. But not as much as my ex-boy friend who has worked with these people for fourteen years. I am not really partial to this group. It won't be my target group in the future. I realised I need to talk and work with people who understand me. I want more brainwork. I know I have intellectual gifts and know how to use these on a great many levels. But I am not a person who can do this job year in year out. I knew this very soon. Moreover, I did not know my own limits. When I gave them an inch, they would take a mile. I was drained by all that had happened. There was a deaf-and-dumb woman who was difficult to deal with and the male group was very aggressive. I got very nervous by that suppressed aggression. One night a week I had night-duty, which I didn't like. I slept downstairs and a tall man lived in the same corridor. An awful experience. Fortunately, I could close my door. If you met this man going to the bathroom at night, he would attack you for sure. I learned a lot".

She was admitted for psychiatric treatment and followed therapy based on anthroposophic ideas. She discusses her experiences:

"Yes, we worked hard the past year. I have never worked that hard in my life. I have never seen so many things or got better insight. I have never experienced so many interesting moments. I was nearly dead because of misery. I couldn't eat anymore and I collapsed. I discovered many things about myself. I grew and I dealt with all my traumas. I used my time as effectively as possible". (Interview 10)

She is ergotherapist and cares for the mentally disabled. She is 32 years old. She did the job to the best of her ability. Her superiors failed to support and appreciate her work and that discouraged her. During this stage of her life she has to combine work as well as care for children and tend to the housekeeping. Problems in the work situation were the straw that broke the camel's back. She explains:

"...Yes, I have the feeling that I had to fight hard. At a certain point enough is enough. I asked myself if the influence of the home front was too much. I am not able to separate home and work. I have two children. Finally I stopped working because the situation at
home ...... I let off steam on the children. I thought why should they suffer because at work the situation is stressful and difficult? That is a situation I don’t want.

Several attempts were made to change the situation at work. The director and the company doctor arranged discussions with her and her manager but this became the source of even more frustration:

"........ I agreed to have this interview because I want to tell about how the matter proceeded in the institute. It overcomes you. It is an unpleasant feeling to be at home in such a way. People make annoying remarks to you and they are totally off target. The people around me understand very well. They always asked me why I still work there. When they asked me about my work, I said it was fine, but with the organisation I had such and such problems and they’ve been going on since 1996. Yes, I experienced a very rough time. The manager of the institute asked me, 'How is it to be at home on holiday?' I thought 'I'm not at home on holiday!' Yes they make such remarks! Even the company doctor said while checking my medical history, 'Oh, I see you were also ill for four months last June.' He was mistaken, he was looking at last year's information. Yes, at that time I was on maternity leave. That was the last time I was on sick leave. I thought, 'Yeah, look good before you make such remarks.' I am very sensitive to these kinds of things. A little precision and you know where you stand."

This respondent has the experience that the circumstances at work were the direct cause of her illness.

(Interview 11)

Reaction and Experiences of the Insurance Company Medical Officer

The medical officer of the insurance company reported that mental complaints are most common among women aged 21-45. The younger women usually have physical complaints as well, and they have specific personality characteristics. These women can be categorised during the training period. It is a special group of people that chooses to work in the health care sector. There are A- and B-nurses and they are very different types of people. Among the A-nurses, who mostly work in hospitals, we see an increased incidence of depression. Among B-nurses, who work in psychiatry, youth welfare work, and mentally handicapped care, we see an increased incidence of burnout. The main types of mental illnesses are burnout, depression, adaptation problems, and post-traumatic stress-syndrome.

The causes of illness have to be searched for in all aspects of the work situation. The circumstances in youth welfare work are especially difficult. The social workers have to deal with young people with behavioural disturbances. Often they have to manage without assistance or support from their managers. The medical officer emphasised that the personality of the employee is also a main factor in the case of disability due to mental health problems.
3.3.2 Experiences with Therapy

All eleven respondents consulted a general practitioner, specialist, or therapist and all received treatment. Three women had severe mental health problems and had to be admitted to a psychiatric clinic or other institute for clinical psychotherapy for a short time. Four women were not satisfied with the treatment they got at the RIAGG\(^1\). During the psychotherapy, some had the feeling they were not taken seriously. There was no improvement at all. Others explained that the psychologist taught her to think positively about herself and make the switch. There were also positive experiences with the social service institute. The consultations with the social workers were satisfying for the women. They learned how to be active and repair themselves, which aided in quick recovery.

Some of the women underwent lengthy treatment by the psychotherapist before they felt mentally balanced again. They experienced that through psychotherapy they were able to gain better insight into themselves, but that this treatment is so intense that it is impossible to do your job at the same time. Women with incest experiences went to a special 'incest group' where they learned how to cope with their experience. A number of the respondents went for alternative treatment such as meditation, yoga, and 'chakra healing'.

The documents studied did not give information regarding special treatment. Clients with professional counselling were in most cases treated by psychotherapists. Some chose alternative therapy, others went to the RIAGG for treatment. The documents contain very little information about the clients' personal experiences with mental illness. Among the eighteen cases reviewed, there were three patients with physical complaints and two with pregnancy complications. Two women had mental health problems caused by personality disorders. In eleven cases, a combination of factors caused the mental illness: family circumstances and depression; work and childlessness and surmenage; work, burnout and family circumstances; work, traumatic events, and personality disorder. The combination of situations together contributed to the onset of the illness.

According to the insurance medical officer, mental illness can be triggered by troubles at work. Often problems develop when two institutions merge with one another:

"It is truly sad. For example, individuals who held management positions at the hospital even though they weren't capable of doing the work had to face demotions after the merger. They work for several years, but then just can't anymore. They also leave with psychological complaints."

\(^1\) RIAGG is the Regionaal Instituut voor Ambulante Geestelijke Gezondheidszorg (Regional Institute for Ambulant Mental health care).
The medical officer also stated that the effects of pregnancy and delivery are also related to mental illness:

"...This can be attributed to various situations: just before delivery, a parent dies; difficulty during pregnancy; the child has a postnatal injury or the woman has a postpartum depression. A child with even a blemish is reason enough for some women to develop mental illness."

The medical officer indicates that a third cause of mental illness is the combination of work and childcare:

"I have my doubts, though I know that the research refutes them, about women who take on a double function of running a household, having children, and a job. Certainly the double function is a problem for women. I think that some of them fail to generate effective psychological coping mechanisms in response to stress. To have a double load takes its toll. Many women think, 'In the past I could do a lot so'... But having children is quite different from following courses and working, etc."

3.3.3 Respondents and Their Experiences with Arbo-Services

As soon as the women went out on sick leave, they were contacted by a representative of the Arbo-service who is hired by the employer to assist and support the injured or ill employees. Arbo-services also serve to identify activities, which are safe and healthy for the employees to perform. Additionally, the Arbo representative is responsible for doing everything he/she can to facilitate a speedy recovery of the injured employees so that they can return to their jobs. The company medical officer also assists in this task and supports the employees in the resumption of their work. If an employee is not able to return to his/her regular job duties, it is possible to return to work on a therapeutic basis, meaning that the employee returns to work and performs only the duties he/she is capable of. The employee may only work a few hours a week in the beginning and then work up to full employment. The period of time is determined in co-operation with the employer.

The respondents had positive as well as negative experiences with the company doctors. They also had high expectations for support by the Arbo-doctors and their ability to solve the problems at work. What did the respondents experience with the Arbo-services and their medical officers?

The Relationship Between the Respondents and Arbo-Doctors

One of the respondents discusses her experience with the Arbo-doctor:

"You don't get much out of this contact. They just listen to your story. If you were to go there with an amputated leg, they wouldn't notice it unless you told them".

Because the Arbo-doctors change duties frequently, the communication between patients and doctors is inefficient. They are often unaware of the patient history and have little or no knowledge of what treatment the
other physicians have prescribed. In the story below the respondent explains that she can not say what the Arbo-doctor has done for her:

"I went to see people and authorities because I had reached the end of my rope in my department. I thought maybe that he could help me to resolve this. Nothing happened. Nobody came to me to discuss the matter.... No, when you talk about authorities, then you're on your own. Everybody only thinks of him or her own self...There is no mutual communication. At one moment you are the middleman. The personnel officer doesn't know what Cadans wants and the Arbo-doctor doesn't have a clue. They don't communicate despite the fact that they meet with one another. But they don't know what the other one is doing." (Interview 4)

The Arbo-doctor provides consultations in the workplace. One respondent felt that this was inappropriate and not at all personal or private. She ran into her colleagues and the children she worked with while going to see the doctor. She complained about this, and the place of the next consultation was changed. On the whole, her experience with the doctor was positive, and the other members of her work team were supportive while she was on sick leave. She believes that these factors contributed to her quick recovery. Arbo-doctors can offer valuable assistance in the process of reintegration. They show appreciation for the will and perseverance of the clients:

".....The Arbo-doctor points out the problem and identifies it: incest and maltreatment. He/she facilitated the return to work for just a few hours a week, on a therapeutic basis. The first attempt at a therapeutic return to work was unsuccessful and then the Arbo-doctor advised me to do only work that was safe for me and that meant only work without responsibility and stress." (Interview 6)

The next respondent was ambivalent about her contact with the Arbo-doctor. Her mental illness was the result of a severely traumatic experience as well as many problems at work and in her personal life:

"I have had many different company doctors. The first one took notes of all my stories. He said, 'If I were you I would drop by work for a cup of coffee'... I panicked. He just wants me to return to work as soon as possible. The next visit I had another doctor who really gave attention and listened well. He said that it was good that I was working on myself. He even gave me titles of books. It was nice that he listened to what was wrong....You are always nervous before such a consultation. In fact, you should not have the feeling that you have to answer for your illness. If the consultation goes well, then it's not so bad. If doctors tell you that you are doing well and to take your time... but just a few are like that. Most of the time they ignore your illness and only give advice". (Interview 8)
Different doctors have various ways of doing things and react to the patients differently. This can be stressful for the patients and can even cause them to panic. One woman had such an experience. She was overworked and had to stay home. She felt as if her problem wasn't taken seriously which caused further mental anxiety:

"The first Arbo-doctor checked me and told me to stay home for the next three months. The second consultation, I had another doctor. He didn't even introduce himself and said, 'It is most important that you return to work as soon as possible'...... I was completely confused... 'I want to see you again in four weeks time. And go get treatment,' which he apparently realised was necessary. 'Go to a psychologist.'... The next time I went to the Arbo-service, I was prepared to see the same doctor as the time before. But this time the Arbo-doctor, who had seen me the first time, did the consultation. So I told him the whole story and about the discussion with his colleague and my superiors. He said, 'That's crazy and you're not to see the other doctor, only me. He gave me his mobile telephone number and said, 'Call me if there's a problem. As long as you're not better, you don't have to work.' It was a real relief for me." (Interview 9)

The next respondent had the experience that the procedures at the Arbo-service are not always followed. She was on sick leave for five weeks, and had not been contacted by the Arbo-service during that time. Thus, she phoned them herself. Apparently, the management at her place of work did not think it was necessary to contact a doctor. However, the respondent wanted a consultation because she felt that part of her condition was the result of the situation at work:

".....The company doctor is somebody who could do something where I work. I got the impression that he didn't take my problems seriously. He asked some questions and I answered; he didn't ask any more, just told me to come back in three weeks time. I had the feeling that we hadn't discussed everything. He didn't ask what I thought or how I felt or what I was experiencing. I was very emotional, and had a lump in my throat. At the next consultation he again asked me a few questions, listened, and then said, 'Go back to work on a therapeutic basis in 10 days.' I was completely shocked... I felt like saying that I absolutely couldn't go back to my old job, which meant that I would have to do administrative work. Then when the day came closer, I knew that it wouldn't be good for me to return to work."

It was unclear to the respondent what "therapeutic basis" meant for an ergotherapist:

"In my opinion, it is impossible to work on a therapeutic basis in ergotherapy. I've always said that therapeutic work is work in which in the end you're not responsible for. I can't
help the client unless I'm responsible for him or her. Thus, the Arbo-doctor didn't understand the nature of my work."

She found the doctor's consultation technique to be poor as incapable of asking additional questions. She had the impression that she was simply being judged in place of supported or helped:

"I phoned the Arbo-service to tell them that I could not go back to work even on a therapeutic basis. The next visit we discussed the matter and I told him about my experiences in the first two consultations. I told him that we were speaking on completely different wavelengths. That meeting cleared the air. He then understood what was going on."

After 3 months of working on a therapeutic basis, 2 days per week, she wanted to make an appointment with the Arbo-doctor. A month after her request, she began to get the feeling that they had lost interest in her case now that she had been out of the system for 4 months. She said, "It's like they just give up on you." She continued to work on a therapeutic basis and found a way to work with her manager. She reported this to the doctor who said that this wasn't a healthy way to work. Hence, he proposed the following:

"Let's all get together to discuss the matter (Arbo-doctor, manager, and ergotherapist). In the meeting, they only spoke of my vulnerability and way of solving problems. The doctor certainly saw that I had gone through a very difficult time. I have been very vulnerable.... And you wonder is it just me or would this have been difficult for anyone? It came out in the discussion that he [the manager] found me extremely vulnerable. I thought, why didn't you do something about it at the time? You could have done something or tried to change the workplace so that it wouldn't be such a problem. Then they decided that I could report back to work the first of August. I wasn't really happy about this. The compromise was that I would go to work at another location. I would begin at the new location for 4 hours. I thought, I'm not going to work like this while I'm sick. And I really didn't want to work someplace else while I was sick. I called in and said I was better. That was mid-June."

(Interview 11)

The respondent began looking for another job, and in August began working for another organisation. Thus, she found her own solution to the problem.

3.3.4 The Respondents' Experiences with the Insurance Company

The relationship between the respondents and the company medical officers

Cadans is the organisation, which is responsible for the disability benefit programs for the social service and welfare sectors. Once an employee has been off work for 10 months due to sick leave, he/she receives an
invitation for a visit by the insurance medical officer. The doctor examines the employee and completes a report regarding the employee’s health. A vocational counsellor also determines which functions the employee is capable of performing. The experiences the respondents have had with the insurance representatives varied from positive to negative.

After a productive experience with the Arbo-doctor, one respondent had a frustrating discussion with the insurance doctor and felt that she was not taken seriously:

"After one and a half-hours the doctor asked me, while looking at me with a penetrating stare, 'Are you prepared to work forty hours a week?' I couldn’t move. I can’t see anybody and I can’t make appointments. But still under the pressure I said yes and that meant that I had to apply for jobs. I can’t work. Then I heard that the following function would be appropriate for me: a packer in a candy factory! I was offended. In a discussion with the Arbo-doctor I appealed to him to disagree with the decision of the insurance doctor who was forcing me back to work. I didn’t agree with the results of the tests that said I could do simple work for forty hours a week. The psychotherapist told me to relax but I couldn’t. I have 3 appeals at district court. You receive confusing legal letters that are difficult to understand. I also got pregnant during this period and needed domestic help."

She is exhausted and hardly able to care for her children:

"I was obligated apply for jobs so I applied for stupid jobs. I knew I wouldn’t be hired anyway. I received a lot of letters from the insurance company, but I didn’t read them. I didn’t know that I could report in sick!"

She was finally accepted into the WAO and began receiving benefits. This continues to be a frustrating situation:

"The feeling that your complaints are not taken seriously... I can hardly read or watch TV or make many appointments. The Arbo-doctors take you seriously, but the WAO doctors don’t. Money is more important.” (Interview 3)

The visit by the insurance doctor occurs at random. The employee is examined to determine the impediments to working at that time, also with regard to mental complaints. One of the respondents had this to say about her first check-up with the WAO:

".... Yes, the check up is after a year, oh now, I was shocked... You can think this stigmatises you, but I didn’t..."

Another respondent is content with her status in the WAO. She receives her disability benefits and is no longer under any mental strain. She has the following opinion:

".... There’s a stupid list of conflicting situations, no work pressure and no time pressure. Then I think, I can do that if I have the right job.".
She wants to be allowed to go into mediation because she would like to return to work. She feels that the WAO decision was a godsend, but now she is sure of that with support she can and will start to work again.

The next story is about a woman who is burned out, physically and mentally. She describes her experience:

"I was with the insurance doctor for fifteen minutes and he said that it was clear that I was 80-100% disabled. Yes, I was speechless. He saw it for himself; I didn't have to spell it out for him... Still it was shocking. On the one hand it was a relief because I was afraid that they'd pressure me into going back to work. I knew that I couldn't. On the one hand, it was liberating and on the other hand I found it difficult that I again ended up in such an unusual position. The feeling that I didn't belong."

(Interview 10)

3.3.5 Conclusion

The respondents' mental problems are not only the result of their concerns about their physical conditions, but also a product of their personality traits, past experiences, and problems at work. For some of them the combination of maintaining a household, children, and work is too much. Mental illness in these cases is caused mainly by problems at work, which is also indicated in the data of the studied documents. The expert whom I consulted confirmed this as well.

Nearly all respondents consulted general practitioners and medical specialists. They also benefited from various therapies such as clinical treatment, psychotherapy, assistance of social workers, and alternative therapies.

Regarding the Arbo-services, the respondents noticed a difference in the attitudes of the various physicians. They were also witnesses to the problem of miscommunication among the doctors. Their problems were not given enough time and attention.

There was positive and negative feedback with reference to the experiences the respondents had with the medical advisors from the insurance company. They felt as if they were being pressured to return to work. They also believed that the results of the random examination were given too much emphasis and the background problems weren't addressed.
3.4 The WAO: Experiences and Confrontations

3.4.1 Introduction
In this chapter, the respondents describe their experiences with the vocational counsellors, their discussions with the Arbo-doctors about reintegration and their conversations with other authorities regarding their financial situations. They also talk about the letters they received concerning the WAO examinations. They describe the expectations they had about supporting activities, and about the problems they encountered during light-duty, therapeutic work. The chapter will close with a summary.

3.4.2 Respondents and Their Experiences
Nearly all the women had a negative reaction regarding the determination of the degree of their disability and the determination of whether or not they were entitled disability benefits under the Disablement Insurance Act. They indicated that the first letter sent by the insurance company was intimidating. Some of the women waited a few days before opening the letter. They felt a stigma in being a disability benefit recipient. Memories of a relative who was in the WAO in the past and who also had such negative experiences added insult to injury, and encouraged them to do their best to avoid the WAO.

The respondents state that the WAO examination and the discussion with the vocational counsellor officer made them uncomfortable:
"The WAO, I'm not in a hurry to get in because you're stigmatised, no?"

Then the medical examiner tells you that you are disabled:
"...First, you have to try to accept this decision. This is a stigma!! Though you have been determined to be 25-35% disabled, you are still disabled. You still feel like this can't apply to you."

The follow-up and direction by the insurance company was for most of the women very frustrating:
"...... When you are in the WAO, you are confronted with rules and bureaucracy. If you want to do something, you have to ask the insurance company, Cadans, for permission. You receive all kinds of job advertisements and job offers and this is so frustrating because you really only want one job and that's nursing. When this is no longer possible, you would expect to be offered positions, which are suitable for your level... Many discussions and consultations with medical officers and vocational counsellors were not related to one another and had no follow-up. They were often only concerned with your physical capabilities... What are you able to move and what not". (Interview 2)
In the next interview excerpt, the respondent tells about the positive effect of being in the WAO:

"At first I was shocked by the fact that I could be determined disabled. I had already made appointments with the Arbo-doctor about a special course for reintegration. I was working on a therapeutic basis at that time. The insurance doctor said that if you don't make it and you fall ill again, then you would still be determined disabled. Now it is okay for me; I will be on disability benefits only for half a year and I am sure that then I will be approved for work again...I'm taking care of myself now and if it is necessary to be in the WAO, then it's necessary. Once I gave myself this freedom, everything went much faster...I had no annoying experiences. All reports were sent to me. They consulted me about everything and nothing was hidden". (Interview 7)

The WAO can be threatening as well as a bureaucratic nightmare. The following story is of a woman who was determined to be 15-25% disabled. As for the remaining 75%, she falls under the WW law:

"...Knowing your rights is quite a job. It's a question of figuring out what all the papers mean.".

As soon as she was approved for disability benefits, she indicated that she wanted to return to work:

".....The WAO letter is quite technical. I thought, I don't want this. At first, my idea was that before that happens (entering the WAO), I'll be working again. When I'm finished in Zeist (where she attended psychotherapy), and that's the beginning of May, then I have 11/2 months to look for work and thus avoid the WAO because I don't want to be in the WAO. And then I also thought that if I'm still not better then I'll have to go into the WAO. The WAO also has several regulations that are very advantageous such as the REA act, which means that if I take a job the employer, isn't at risk. That was the overriding factor that made me thinks that I could do it. Because I could avoid the WAO, but then I'd have to go to an employment agency and there's no use going to an employer after having been sick for a year. They'll just think that soon you'll be sick again". (Interview 9)

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1 WW is the 'Werkloosheids Wet', the unemployment act.
2 REA is an act established in 1998 to reintegrate the disabled into the workforce.
out of the WAO. No way. They didn't submit a request. Seventy-five percent of the costs for training are paid by Cadans and 25% by the institute. It is about 4000-5000 guilders. If it were up to me, I'd pay for it myself. The letter of dismissal was sent to the director of the employment office. They think they have behaved as a good employer: they offered me various positions, gave me support... They didn't mention the offer to do the R&G training or the fact that the intake had taken place already and that they had accepted me into the training. As member of the union for nurses, I phoned a lawyer and told him my story. 'You are right; we will start a procedure.' Protesting the fact that you are in the WAO and should get WW benefits, this is not my style. If they would have called me to ask how things were going and how they had come this far, I might have changed my mind. But they showed no interest... Ultimately, they had to withdraw the dismissal”.

(Interview 2)

Reintegration into a former position is a difficult task. One first returns to work on a part-time, therapeutic basis, a few hours a week and then a few hours a day, working gradually up to full-time work again. Fitting back into the team is also very important. Working as a nurse without being able to carry out all the duties in reality is not possible. Instead, duties are offered which suit the employee's abilities at the time.

The following testimony begins on a positive note. The respondent, a nurse, was able to return to work and showed her dedication by doing so. In the end, she felt that this was not appreciated and was even underestimated:

"I was a nurse responsible for the intake of new patients in the Admissions Department. Yes, I worked 50% while retaining unemployment benefits. If this would work out well, I would get a contract. Basically indefinitely. Everything worked excellently and everybody was satisfied. I was so happy to work again. Even my colleagues were happy. One day I was called to the Personnel Department. I was offered an indefinite, temporary contract, but this would affect my benefits. I had to make an appointment with the personnel manager, but it would be a while before I could get an appointment. There was a difference of 200 guilders a month. I was receiving 70% and otherwise I would get 100%. For two months that's not so bad, but now it was long enough. Oh yeah, and it was after Christmas. I found this so annoying and you can imagine that it was costing me money. 'Yes, but we have doubts.' Doubts? You try to prove yourself and then they shoot you down. There are no doubts. Everyone is satisfied. 'Yes, but I don't want to discuss this now. Come back after New Year's.' I was completely upset. Finally I saw her again and she said that they have doubts for the future considering my history. I explained that for me the matter is terrible and asked whether or not they realised what they were doing to me. Maybe they...
didn't consult my colleagues. It sounded so contradictory, something just wasn't right. It was impossible to have doubts, yet they were focusing on the past. I just got out of the past, please let's just let it go.... Of course I have heard that they are prejudiced against people in the WAO, but I didn't expect this from a personnel manager. I have proven my abilities and that's that. They said I would stay in the same position until March 1st as a probation period. I was really angry. Then it hit me again that if you're not in the system then you just don't fit in. I shouldn't think that way because they had done so much for me. Later on I wrote a letter and made my point. They received it, but there was no discussion about it. But, as of March 1st, I got my contract". (Interview 4)

3.4.5 Respondents and Financial Matters

One of the respondents reported that suddenly her unemployment benefits were reduced, and she received a thousand guilders less. She recounts:

"I phoned Cadans and asked them how this was possible and they said, 'Maybe the pension fund will supplement this. Please phone your employer. They are probably insured through the pension fund.' I called my employer and asked about the supplementation. They didn't know anything. Then I called PGGM (pension fund) stating that I believed that I had a right to supplement my benefits. They said there was something about that. Yes, I had a right to 600 guilders per month."

The financial regulations are extremely complicated, and the various channels one has to go through make it all the more confusing. As heard in previous testimony, one respondent was offered a part-time contract with a probation period and her salary was reduced by 200 guilders. She had to fight for her financial rights, and wanted to be paid according to her abilities. (See interview 4: experiences with integration)
3.5 Summary

All of the young women were enthusiastic and dedicated to their professions, professions that they chose to pursue. The problems at work arose when the women were faced with major changes in scheduling, duties, etc. They were unable to change the situation, which had a severe impact on their lives. At the onset of illness, they had to deal with medical officers, specialists, and therapists. In the case of long-term illness, they also had to deal with Arbo-services and insurance representatives. The following is a summary of the respondents' experiences with these organisations.

The respondents explained the difficulties encountered at work. Problems arose due to heavy work loads, uncertainty about tasks to be performed, existing hierarchical relationships, reorganisations and mergers within the institutions, lack of appreciation and no recognition for job performance, and lack of financial reward based on the quality of care provided. In addition to this, they also experienced difficulties with colleagues and superiors who involved miscommunication, disinterest of employers/managers in their staff, too much responsibility placed on personnel, lack of feedback and time to evaluate functions and performance, and overbearing management.

Regarding the contact with the insurance medical officers, the respondents did not always feel as if they were taken seriously, that their illness was not recognised, and that the doctors jumped to conclusions and automatically advised resumption of work. Most of the women felt that the ability assessment examination was the only means used to determine disability. In this context the conclusion of Frank (1997:131) "that biomedicine has difficulties to recognise the moral life of ill persons" might be applicable. Frank emphasises that the ill person is only aware of the problem when he/she maps out his/her moral world once again. This could help the ill person to recover, to better adapt to the environment, and to engage in stable relationships with colleagues, family, and friends.

The respondents had both positive and negative experiences dealing with the authorities of various institutions. With reference to the Arbo-services, some of the women were encouraged and supported during reintegration into their former job. Others experienced miscommunication among the Arbo-doctors, and found that different doctors can interpret the same case very differently. They didn't feel that the doctors really listened, asked appropriate questions, or followed productive discussion techniques. The respondents felt alone and that nobody was really interested in their cases or the root of the problem at work. They believe that the procedures in the system aren't streamlined, and that everything they did was controlled by the UVI. Some feel that in order to protect yourself and your rights, you have to take legal action and that ultimately, money is the deciding factor.

The women found that confrontation with the WAO can be very threatening. They felt that being placed in the WAO leaves a permanent mark on your record, and that people do not take into account that they...
are dealing with people who are ill. They talk about handicaps and disabilities, which are negative words in the minds of some of the respondents. Other respondents, however, found that being in the WAO is not a dead-end and includes possibilities and opportunities that can lead to a full recovery.

The availability of the medical and employment reports was highly appreciated by the respondents. However, some of the women reported that they were disappointed by the service of the vocational counsellor, and that they had expected more support from them. They felt that they were offered positions that were not suitable to their qualifications or abilities in an attempt just to get them back to work.

Reintegration into the workplace, whether into the old position or a new one, can present many difficulties. Some of the respondents reacted to these situations by filing legal protests to protect their interests. They found that the employers weren't willing to adapt positions or offer flexible solutions. They felt as if they had to accommodate the employer and not vice versa.

According to one insurance doctor, an employee who has a good history with the company and a record of good performance has a better chance at reintegration than an employee who does not have this history. When the social climate at work is positive, employers and employees are more flexible and tend to create situations in which women can successfully combine work and family obligations. Obtaining part-time work after sick leave can be a problem, however, due to the fact that so many people already work part-time. This seems to be the main cause of conflict in such cases. A good employer-employee relationship goes a long way in resolving problems at the workplace. Research indicates that employees who have a good relationship with their employer are generally able to follow a long-term employment reintegration course (Cuelenaere, 1997:67).

Bureaucratic procedures of institutes and authorities are often the cause of confusion and misunderstanding. Knowledge of financial aspects is also necessary in order to understand the benefit schemes. Not all of the respondents were equipped with this knowledge, and that left them frustrated.

A personal counsellor may be the answer to this.
4 Explanations and Interpretations of the Respondents

4.1 Respondents and Life-Events

Effects of 'life story telling' in general

Life stories can give a complete picture of a life and its history, especially when told at length. 'Life stories cannot retrieve real life, only the current interpretation of it' and 'are current narrative constructions as well as a process of explanations and justifications' (Nijhof, 1995:9). The respondents recount their life experiences and they give interpretations by means of telling the story. All the ups and downs of life are revealed. Additionally, telling one's life story can have a therapeutic effect. All the respondents indicated that they were happy to tell their stories because they still feel frustrated about the course of events. To go through the points once again can clarify the whole process.

Arthur W. Frank, a professor in sociology at the University of Calgary in Canada, emphasises the morality of illness. He indicates that illness is a moral occasion for the ill person. It is a process in which the sick individual asks questions about her/his own doing, about norms and values of certain uses. He thinks that the moral life of the ill person needs to be discussed. He explains that potential consciousness of illness "teaches that experiencing suffering in moral terms helps to make it tenuously endurable. Silence protects no one" (Frank 1997:143). We can understand the consciousness of illness of a person by listening to 'first-person accounts of illness experience', or the history of illness from the person affected by it. During the illness period, people are able to learn something about themselves, about the world in which they live and work what they do and create. The ill person has the task to work hard on his/her own recovery.

We need to become conscious about the illness and the environment. Illness can be caused by something one doesn't remember, by suppressed problems. A central question is raised: who am I? Symptoms of illness are related to experienced events in the past. Illness makes it possible for people to reflect on their lives; to get a picture of how they have lived in their world including both what has been inflicted upon them - via genetic material, personal history, and environment - and what they have chosen (Frank 1997:141).

Frank's sociological view does not differentiate between physical and mental illness. He cites examples of people suffering from cancer as well as those who were victims of sexual abuse. Which approach can be used in the case of undetectable physical complaints, or those often diagnosed as psychosomatic illnesses?

Two neurologists, Klaver and Baart, indicate that it is a matter of a limbic dysfunction in the case of undetectable physical complaints. The symptoms are 1: somatisation (tiredness and weak concentration);

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1 A Limbic Dysfunction is a limbic reaction: a hypersensitive reaction of the limbic subsystems, a complex of the brain area in which functions are related to emotions.
2: behaviour (ill-behaviour and negative coping-mechanism); 3: hidden cognition (false images) and 4: hidden emotions (anxiety and insecurity). One can influence limbic dysfunction through cognitive intervention. These experts have found that recovery can be stimulated by a consciousness-raising of the patient's undesirable images and mentality such as to be firm, to force oneself to do too many things (Klaver and Baart, 2000:1648). Medical doctors can stimulate patients to do self-examination by taking undetectable physical complaints seriously.

Through the stories of the patients who explain their experiences, feelings, and behaviour, we learn that illness and health can be looked at as a process in which the individual's first responsibility is to gain self-awareness. Only then are they able to maintain relationships and to secure a position within their environment. Thus, it is important for ill people to tell the life stories. This is the foundation for a conscious future. 'Life story telling' helps patients find their own solutions so they can live with the illness or with wounds from the past (Frank 1997:131-146).

In this chapter, I will recount the life-events of the respondents. They all are of the opinion that these events have had a great impact on their mental condition¹. Next, I will describe the socialisation and schooling period, traumatic life events, and the career opportunities. I will then present the respondents' interpretations of their experiences with the institutions and the often bureaucratic and confusing regulations. Finally, I will provide a summary and some concluding remarks.

4.1.1 Experiences during the Socialisation Period

Experiences and expectations in education period

When the relationship between parents and children during upbringing is harmonious, the foundation for stable and self-conscious behaviour of the children is laid. They are equipped with information, which helps them know how to live, how to behave, and how to approach life's complicated questions. They have to organise their own lives, to know their limits and capabilities, how to react to and communicate with others, how to adapt to various situations, and which values to use.

¹ The influence of memories is essential. According to Klaver and Baart 'sensory sensations are being brought together in codes, affiliated with certain affective elements. These complex coded activities are stored as an experience. Under certain conditions an individual experiences that an unpleasant feeling or physical discomfort is associated with a certain remembrance.' (translated from Dutch by the author)
While listening to the stories of the respondents it became clear that the upbringing period at home and the training at school had strongly influenced their lives. During a time of crisis or mental stress, all negative experiences are remembered. The respondents described in detail the situations at home, their relationships with friends and colleagues, and private and public events. They explain that all these bad experiences had something to do with their current dysfunctionality.

Some of the problems that occurred are as follows:

- In some families one of the parents was very dominant or there were quarrels and fights.
- Some children were overly protected.
- Families in which the father received disability benefits (WAO) had financial and emotional problems. Little attention was paid to the children who felt very lonely.
- Negative experiences at school made them feel like outsiders. One respondent was dyslectic and had a feeling of inferiority.
- The situation at home involved authoritarian education and ill treatment. The child found a safe haven with neighbours or an aunt. The child grew up in an insecure surrounding, which caused insecurity. Marks at school were a reflection of this as well.
- Serious relationship problems between the parents left the child without a real home. Divorce of parents resulted in the child missing the absent father. The young child had to bear the responsibility for the whole family.
- One respondent experienced the suicide of one of her parents while she was still very young, causing anxiety and depressive periods. She fears being a victim of heredity.
- Death by drowning of a younger sister.
- Suicidal tendency of respondent in adolescence period because problems at home and in the environment became too much to bear.

The respondents gave different explanations for their problems. They stated that they have a poor sense of identity, which caused them to be even more insecure after their traumatic experiences. They indicated that feelings of insecurity and inferiority and the lack of self-confidence were already created in early youth and intensified during puberty. They made the following comments:

'I was nobody. I could only follow in my sister's footsteps, they thought. I didn't receive any support from my mother who was very controlling and didn't show any emotion toward me.'....

'I was brought up without feelings and couldn't be myself'......
'Emotions were never talked about.'

'You always hid things. Nothing was brought out into the open and many secrets were kept.'

'You think that you've been through it, the mistreatment, and put it behind you. When things started going wrong for me, it became apparent that I had not yet dealt with the past events at all.'

4.1.2 Life events

During the interviews, focus was given to traumatic events such as years of maltreatment in childhood and adolescence, dominance of a partner, sexual abuse, parental suicide, and suicidal tendency in puberty. In eight of the eleven accounts, the respondents told their stories and emphasised the traumatic period of their lives. In nine of the eighteen documents that were reviewed, we encountered shocking experiences (see ch.4.1.1). In many cases, negative experiences had been suppressed and then reappeared at the onset of the injury, illness, or depression, and thus adding to its severity.

One of the respondents recounts:

"I always had fights with my oldest brother. We always had a difference of opinion. Later on I realised that he was taking on the role of my parents. If I didn't feel like eating potatoes, he would throw some on my plate and my parents never intervened. When I turned twenty-three, I realised that he had molested me in the past. I had always tried to push these memories aside, to forget them, and then suddenly it became clear to me. It happened when I was about 9 years old. Then it stopped and he moved on to my younger sister. Yes, that was also horrible. I only realised it later. When I was 23, I was watching a documentary and I thought, I've also been through that."

While in therapy the respondent discovered that in addition to the incest, the relationship she had with her mother had also influenced her illness:

"..... My brother abused me physically but my mother abused me mentally. I was so indoctrinated I could not think freely. I didn't know myself and I could not develop my own identity" (interview 5).

The respondent whose father committed suicide when she was only three years old cannot really remember that period. However, subsequent to her recent depression she spoke with her mother about the past, which brought back a lot of memories. She is now worried that perhaps she is a victim of heredity (see interview 6).
The next story is of a woman who was mistreated at home when she was a child. She was forced to work in the fields as the family was in the horticulture business. Even at a very young age, she had to work for hours either at home or with her older sister. She became suicidal in adolescence. She held onto the dream of becoming a nurse and going through training. When she was accepted, she thought she could leave the family and its memories behind her. Unfortunately, she became ill, developed mental problems, and during therapy fully remembered this terrible period in life and suffered a breakdown (see interview 7).

The following respondent recalls the death by drowning of her nine-year-old sister. The respondent blames herself for this awful event. She was only eleven and was responsible for taking care of her sister when they went swimming. After the drowning, the respondent states that her parents made her feel like it was her fault. At that time they didn't talk about it, but later she became depressed and the memory haunted her. Such an event can certainly determine the course of one's life, especially when it has not been dealt with accordingly. The respondent indicated that recovery involved difficult and painful therapy that could not be accomplished while holding a job. She had to redraw the moral map of her life and her world:

"I am glad I finally confronted this [in therapy]. Now it's beginning to pay off. I thought, what have I done, digging so deep. Going to places that you don't want to be. A few weeks ago, the therapist took me back to the swimming pool -- I hadn't been there since [the drowning]. Such an event determines your whole course of life." (Interview 8)

Some respondents explain that a number of intrusive events played a role in their becoming ill and the development of mental problems. In the next story, the main factors involved in the respondent's mental illness were deterioration of the home situation, the divorce of her parents, and the suicide of her father. She explains her illness:

"...Work was important [and made up for] what I missed and didn't learn as a child. I simply grew up way too soon. Not because I had that feeling inside me, I just copied what others did. I was missing a lot inside. How could I know what I was feeling? I was always aware of everything. This went against my feelings. [At therapy] I learned to listen to my feelings... and that my feelings and reasoning can go together. Before that I also had feelings and that's what I reacted on, because if I was angry then I acted angrily and if I was nervous or hyper then I ran around doing everything. I couldn't talk about it. I didn't know how. Now I can stop and look at the situation and think about what I'm going to do about it. That's really essential, everyone needs that in his or her lives and that's what I didn't have. I didn't learn this at home. I didn't see it at home; either they didn't talk about it or I didn't understand it." (Interview 9)
The following respondent experienced many changes in her life. She was still very young when she had to witness the destructive relationship of her parents. They divorced when she was just twelve years old. She missed her father so much that it became an obsession. She states:

"There were two shocking experiences in my life. It doesn’t make a lot of sense, but as a result I am who I am [as a result of the experiences]. The first trauma was from my father. I had a very close relationship with my father. How can I say this? He wasn’t really approachable for me, but it was a hidden feeling. He was very important and I was his little girl. My mother was very distant, stiff and strict, but my father was emotional and passionate. He couldn’t be himself at home. After the divorce, my father disappeared from my life. Then we moved again to a place where I didn’t know anyone. When I was twelve, I had the feeling that my world was falling apart. I couldn’t confide in my mother or my friends. I also felt responsible for my family, for my mother. Don’t cause any problems because mom has it difficult enough already, while I walking around contemplating suicide. Ultimately, my survival strategy was to close myself off and just paint."

The second trauma occurred during pregnancy, when the respondent’s mother required surgery. This trauma became apparent during a 're-birthing' session at therapy. (Interview 10)

4.1.3 Career and Network : Interpretations

Interpretations of respondents over special contacts

During school and in the process of building their careers, the respondents came into contact with many teachers, mentors, fellow students, and colleagues. Most women made a conscious decision to work in the social sector. They all had different training at various levels (see table I appendix VI). For those women who had a difficult situation at home, some of the mentors played a very important role. They became mediators and assisted the respondents through rough times. They were able to encourage the respondents to continue their studies. As a result of the traumas they had been through, the respondents found it difficult to build relationships with other students. Making long-lasting friendships and getting involved in intimate relationships was for some of the women extremely trying.

One of the respondent’s states:

‘If you have bad or no relationship with a partner, then you don’t have any support. Dealing with these problems takes a lot of energy... After six years with my current husband, I am still really surprised that it can be so normal and good. When you’re going through a tough time in your life and your work is quite difficult as well, you get stuck. I was always alone at home and I didn’t have anyone to talk to. I thought I could do it alone."
Relationship problems take a lot of energy. There was no chance to recharge or get new energy." (Interview 3)

In general, the respondents had good relationships with their colleagues. They did, however, have more problems with managers, especially when a merger of the business was involved. Relationships were also strained when the work situation and duties were left unstructured. Some of the respondents also complain of too much responsibility and too little support and supervision which turned the responsibility into a burden and made the workplace unbearable.

During a work-placement program as part of the Microjel training (training for social workers), the following respondent experienced a number of problems:

"I did my internship and worked 32 hours a week in a home for autistic youth. We were responsible for a group of seven children. The home provided accommodation for 30 children. In a way I liked the work, but so many strange and troublesome things happened there among the personnel and in the work situation. I didn't know what to do ... I saw so much: I observed that some didn't want to do their jobs at all, that they were not motivated at all, that they preferred their own interests to the interests of the children. There was a lot of friction in the team and there was a kind of occupational disability...I worked in a project with a girl who was preoccupied with sound. I made a slide presentation with her with sound and this was a successful project. I had enough freedom there... Later on I was an intern in a 'Blijf van mijn lijf' home... also a place where a lot was going on within the team. All this bureaucratic nonsense and contacts with so many authorities. Partly due to the fact that so many volunteers were working in that home. There were only two paid workers. The women living in the home had all kinds of questions and problems. They were trying to find out what the best thing for them to do in society was. It should be required for people who work in such a home to have a year contract. That is the best for the continuity of the work and for the women. But not everybody wanted that. I worked extra hours and often stayed late. Therefore, I had more contact with a number of the women. I felt very alive there. I could really give a lot of myself." (Interview 5).
4.2 Interpretations: Institutions and Instructions

How are you regulated and controlled? The respondents asked themselves this question many times. In dealing with legal issues, they realised that there were many regulations that had to be adhered to. Regarding contact with the social benefits institutions, they were confronted with many procedures and instructions as well. Their testimonies illustrate the fact that the respondents often found the instructions and the red tape confusing and hard to accept. To obtain disability benefits, they often had to follow extremely bureaucratic procedures, which were very frustrating:

"I cannot follow what is going on. I don't care where on earth the money is from. For instance, when I go on holiday, I have to report this to the authorities that deal with the WW. Once every four weeks I have to fill out a declaration of income. I have to inform them where I got the information about job vacancies... You're treated like a child! I'm going on holiday next week and I have to fill out a form... Oh yes I crossed out the whole page.... First the soft number and then my name. Numbers are more important than people...... (Emotional reaction)..... I find that so thoughtless... If I get more letters from Cadans, I'll leave those on the cupboard for a week or so. I don't want to be confronted with these dumb instructions. Money for nothing, that's nice, but I don't want it this way. Yeah, that's the game in the Netherlands. I've crossed this out literally and figuratively."

(Interview 3)

In addition to the frustration that the respondents felt concerning the rules, instructions, and bureaucracy they encountered while trying to obtain benefits, they also often found working with the various benefit institutions very challenging. The number of letters regarding appointments to be scheduled, forms to be completed, or income regulations to be complied with often created pressure on the women that they found incredibly difficult to deal with. They indicated that this pressure would affect anyone, mentally ill or not. The situation of being checked and rechecked without explanation only exacerbates the problems in the long run.

They recommended that somebody be appointed to assist with these procedures: 'In fact there should be someone who can coach you with questions of rights and duties for clients and who can clarify the difficult information presented in the hand-outs and brochures.' Frustration and anxiety could be reduced by appointing a coach, guide, and/or legal assistant.
4.3 The Environment: Interpretations and Reactions

A number of the respondents concluded the interview by providing further commentary on their jobs, illnesses, and society in general. They discussed society's high demands: employees have to be able to deal with many and quick changes, high work pressure, and high expectations about quality of work. They have to be prepared for modernisation in all different sectors of society. People are currently caught up in the global rat race, the competitive struggle for wealth and power. This means that they need to be able to be productive, efficient, and fast.

'It is like modern slavery'
They comment.

'We're all running a continuous race. It's just a fact that you have to meet the expectations of work and society to do your job in which the duties and responsibilities have increased and become more difficult while at the same time the amount of work has also increased or the number of people doing the jobs has decreased. This is unhealthy for people.'

The respondents found working in the social sector to be very challenging and often difficult work. There are many people in social institutions who require help and attention. The nurse, the group educator, the childcare assistant, the psychologist, and the ergotherapist all took their jobs personally and indicated that it takes heart to do such work. Because of the lack of personnel, the employees weren't able to be ill and were even regarded as a-social if they were because illness meant that the other colleagues would have to bear the burden and take on more work as a result. Some of the respondents stated that for this reason they didn't report their illness until it was too late. (Interviews 1 and 3)

A few of the respondents had doubts about the combination of children and work. Although the government has improved existing childcare facilities and the number of private childcare centres has also increased, some women often still experience a double burden. The following testimony exemplifies a situation in which a woman found it difficult to balance work and childcare:

"I like to come home to my kids after a day at work. Every day is different. If I get energy from my work, then the combination is great. I don't think it's always an even balance, and it's not a solid base. If you only have to work, then you have a steady base. If you only have to work and you have problems, then you come home (the situation without children) and figure that everything will work out. But now (a situation with children) you come home and you have to give everyone attention. If the situation is reversed, it's the same story. If there's a problem at home, then you have to put it off and go to work. This I experience causes hardship and worries. It's my experience that enjoying my work is an important aspect for me personally, and I think that if I feel good then I am also a good
mother. Look, you're actually very healthy. You know very well what you want, but because of a bad situation at work you become sick, due to miscommunication and lack of recognition at work on the whole. When there's a time that a lot is happening at home such as the emotional event of having children, it's a very special and incredible experience in your life. At this time it is very important that everything is balanced so you can deal with it all." (Interview 11)

The respondents received mixed reactions to their illness and disability from friends, relatives, and neighbours. They often felt as if they were treated with little or no compassion or understanding. They even felt discriminated against and stigmatised because they were receiving disability benefits. The following testimonies point out how painful dealing with this type of distrust and accusation can be. The respondent's situations were made more difficult by the fact that they suffered from mental complaints, which could not be blamed on an accident or event at the workplace. The comments they received from others added to the frustration they felt being in the WAO:

"A number of people can understand the seriousness of the situation. Many others don't take it seriously. In the beginning, everybody understands. After a while, there are people who think, 'Is there really something wrong with her' or 'we don't know what you're doing.' Yeah, and this makes me furious. You don't see anything wrong with me on the outside. Yeah, and there are people who were really awful and I had a lot of difficulty with that." (Interview 11)

According to the following respondent, it is very difficult to tell others that you are on sick leave or that you are receiving disability benefits under the WAO:

"You hear things even from those closest to you like, 'Now you have to put this behind you and start over.' People in the commercial sector cannot imagine that somebody could stay at home sick for so long and that the causes of the problem haven't yet been resolved. Yeah, if you're high in the hierarchy then you have the opportunity to protect yourself. You can push the problems down onto your employees." (Interview 11)

4.4 Summary

The respondents candidly described how they became ill and entered the process of receiving disability benefits under the WAO. They recounted what the most remarkable and influential factors and events were for them during this time. They all emphasised the complexity of their mental illness. Their life stories and
traumatic experiences provided a wealth of information. Six main factors were prominent in the testimonies and clearly affected the mental health of the respondents.

Firstly, all of the respondents dealt with negative experiences in childhood and puberty. Many past experiences came up in the interviews. Some of the negative aspects of childhood were lack of love and attention, a parent who was not around, traumatic life events such as incest, maltreatment, and death or suicide of a family member. It is striking that in more than half of the interviewed cases (eight of the eleven respondents), a very serious, life-altering event took place. This is also the case in half of the files studied for this research (nine of the eighteen cases). Those traumatic experiences require the attention of the moral self of the patients (Frank 1997) (see chapter 5.1). In my opinion, the parents and educators of the respondents didn't create a stable base for their children and students so that they could adequately explore the world and develop during the period of socialisation. The respondents emphasised their insecurity and feelings of inferiority.

Secondly, the respondents indicated that a stable relationship with a partner is of utmost importance. Positive "solutions" to difficult childhood situations were found: unfit mothers were replaced by neighbour women or an aunt who was very good for the respondent. While at school or in the process of building their careers, the respondents found support and guidance from teachers and mentors. On the other hand, dominant managers left them demoralised and frustrated. Negative experiences with dominant partners, which created, tension, anxiety, and depression left them without any energy.

Thirdly, the personality of the individuals also influenced their situations. For example, some of the respondents experienced conflicts within their own personalities: conscientious yet melancholy; perfectionist yet little self-confidence; perseverance yet low self-esteem; creative yet with a feeling of a great sense of responsibility. These conflicting factors also influenced the respondents' personal and professional lives.

Fourthly, the bureaucratic and time-consuming Arbo-service and insurance company procedures left the respondents feeling rather helpless. The exhaustive letters, documents, phone calls, and appointments that they had to deal with without any outside support exacerbated the mental illness. A coach could have guided them through the bureaucracy, explained the complex instructions, and provided support.

Fifthly, the double function of work and care added to the respondent's problems. When circumstances at work or home are stressful or chaotic, trying to balance these priorities can often become too much to bear. Ultimately, the burden takes its toll at work, home, or both.

Sixthly, the stigma associated with long-term sick leave and disability is difficult to face. The respondents became the targets of prejudice and bias as a result of their mental illness. Even by those close to them, the illness was often trivialised or not recognised as a serious condition.
5 Conclusions and Discussion

5.1 Conclusions

The objective of this study was to analyse the problematic nature of the inability to work due to mental illness. I have already described the respondents' experiences and their interpretations of these experiences. The following conclusions were made after extensive discussions with the respondents. They were given the opportunity to check the text and give additional remarks. Only five of the eleven respondents provided this feedback. They were satisfied with the testimonies with the exception of a few minor changes relating to age, profession titles, and intimate details, which they preferred not to have printed. Interviews resulted in testimonials, which give a 'real life' accounts of the women and their situations. The data has been analysed based on the interview items. The findings were obtained from a relatively small number of respondents which should be taken into account. Moreover, the conclusions drawn may only be relevant to the problems faced in the healthcare sector.

I studied the problem on three levels: A. the work situation, B. the insurance companies and C. the private situation. Each section below contains the basic conclusions from the interviews.

A The Work Situation

- Increased and more arduous workload and/or decrease of staff
- Conflicts with executives and officials
- Insufficient support from managers and colleagues
- Low appreciation and remuneration

In the eighteen documents studied, the following causes of illness were described: location directed problems; heavy physical work; unsafe working environment; irregular duties; too much responsibility; work pressure; enormous changes such as mergers and reorganisations; domination of managers; extra work through lack of personnel and conflicting function requirements.

The eleven interview respondents pointed out problems of workload and work pressure, hierarchical relations at work, problems caused by mergers, low appreciation and remuneration.

Four of the eleven respondents explained that a conflict at work was the main contributing factor to their mental illness. In the eighteen documents, I found four obvious cases of conflicting situations at work and
four more cases in which the conflict became apparent after carefully studying the records and comments of the ill employees.

The work pressure in the healthcare sector is high. The patients are more demanding, require a great deal of attention, and need quality treatment. Career opportunities in this sector are few and salaries are low. The respondents complained that a substantial amount of work has to be done by a decreasing number of employees. They also stated that working in the social welfare sector requires solidarity among the workforce. In general, employees in this sector have an enormous sense of responsibility. In sum, the situation at work is a major factor in the search for causes for mental illness.

B The Insurance Company

- Confrontation with instructions and bureaucratic rules
- Lack of communication between Arbo-doctors and insurance company medical officers
- Stigma of the WAO

Some of the respondents either had to take their cases to court as a result of their disagreement with the authorities or asked for assistance from a law centre as a consequence of a conflict with superiors.

The Arbo-doctors were not well informed of each case, and they did not work in close enough cooperation when handing over cases. Communication between the doctors was poor.

Two respondents found that their problems were increased due to the bureaucracy of the system. They believe that their depressive condition was the result of difficult insurance company procedures.

Five respondents commented positively with regard to treatment by the Arbo and insurance medical officers and the assistance of the vocational counsellors. Their attention and advice was encouraging. The other respondents had negative experiences in this regard. They pointed to the fact that the procedures are difficult and time consuming, the paperwork is incomprehensible, they had to complete too many forms, and they were not taken seriously and received little understanding by the authorities. They believe that a personal coach could prevent stress and misunderstanding.

The respondents avoided contact with WAO authorities when possible as a result of the stigma associated with being in the WAO.

C Private Situation

- Negative experiences in the period of socialisation

Nine of the eleven respondents experienced deprivation such as lack of love by parents, a dominant mother, and an absent father due to divorce.
• Traumatic life events such as incest, maltreatment, suicide of a parent, and death of a family member. The negative impact of these experiences was tremendous. The respondents could not sufficiently cope with their traumas. Traumatic experiences are found in eight of the eleven cases. Although the documents studied didn't contain elaborate stories, data about youth traumas and severe life events were found after analysing medical reports. In five of the eighteen cases, serious childhood trauma was a factor and in nine cases a severe life event occurred.

• Troubled relationships and/or partnerships

With reference to the findings of the study on the private level, the conclusion is that depression can be brought on or exacerbated by inconsistent, unstable relationships. In three cases, the respondents explained that as children they had difficulties in maintaining long lasting friendships and that they felt excluded. In three other cases, they had difficulties in finding a suitable, long-term partner. Some relationship problems can be attributed to significant age differences, dominant partner behaviour, and even mistreatment.

Traumatic life events were discovered in half of the documented cases studied. The testimonies of the respondents indicate that certain personality traits, as well as negative experiences, are conducive to a long-term mental illness.

The final conclusion is that to adequately explain the causes of mental illness, one has to take into consideration a combination of factors on three levels: work, bureaucratic institutions, and private life.

An analysis of the 18 documents indicated that mental illness was caused by a combination of factors in ten cases. The analysis of the 11 personal testimonies indicated that various factors contributed to the mental illness in eight cases.

5.2 Discussion

The general objective of this study was to broaden the perspective as to the causes of the inability of young women in the healthcare sector to work due to mental illness. From a scientific perspective, the study focused on two key medical-anthropological aspects influencing illness. Firstly, the influence of (pathological) social structures (Gerhardt: 352) in society on the well being of individuals. Secondly, the influence of negative experiences and traumatic life events on otherwise healthy people.

The first subject of discussion is the pathological social structures in society, in today's modern welfare state, and especially the structures in the social welfare sector, the structures within institutions and insurance companies. The healthy individual holds a position in society and is influenced by the often-ill conditions under which he has to work. Individuals can be subjected to contradictions at work or to
bureaucratic rules. They are exposed to many negative influences caused by overtime work, work pressure, and overburdening. These circumstances impact individuals in such a way that they can develop psychosomatic symptoms while working under stress. A disharmonious environment and a disproportionate distribution of work can also cause illness. The accounts of the experiences and interpretations of the respondents in this study are real-life examples of the ill effects of stress at work. Critical theory proponents argue that conflict, caused by domination and inequality, is extended to all realms of life and is basic to social life. They state that people are influenced by the disorders in social structures and that they live and work in susceptible situations. Within the framework of the conflict theory, the Deprivation-Domination model indicates that illnesses can be understood as caused by social evils and the shortcomings of society.

Medical officers distinguish between patients with physically evident symptoms and those without physically evident symptoms (which submit to a limbic dysfunction, which is originated on the base of unconscious psychosocial factors such as negative emotions and passive attitude). Patients in the latter category exhibit mental illness symptoms and their illness can be explained as a social protest (see Chapter 1.3.1). This could be a protest against a dominance of negative forces. Body and mind can become disordered in such a way that an individual becomes so exhausted and estranged from oneself that he has to stop working. At that moment, a thorough problem-analysis should be made by professionals who not only recognise and diagnose the condition, but also pay attention to the patient's thoughts, opinions, and attitudes (Klaver and Baart 2000: 1646). Through that analysis the patients can be made aware of the factors that played a role in their illness. Instead of taking control of the patient and treating him as ignorant, comprehensive treatment could stimulate changes and have a positive effect on the outcome. The patient should not be seen as an object without any personal responsibility, but should be actively involved in his own recovery. This can work preventively and as such the numbers of people receiving disability benefits will decrease.

The second subject of discussion concentrates on the individual experience at the onset of the illness or sick leave, and especially the lack of support received. Proponents of the Loss Model state that illnesses can be understood as a loss of balanced environment and a well-structured life. Negative experiences can be compared to losses and find their source in traumatic life events. These events can disturb and disorder someone's life to the extent that they lose control of it completely. The individual is in conflict with the environment. If enough social support and protection are available, the person is less vulnerable. Through psychotherapy and affirmation of capabilities, an individual can recover.

Obviously, traumatic life experiences negatively impact the mental well being of individuals. In my opinion, more attention needs to be placed on acknowledging these experiences, and special therapies need to be developed and implemented to teach patients how to deal with the pain.

Currently, medical specialists often simply diagnose the mental condition and place the patient into a category. The patient is given a certain 'identity', prescribed medicine, and silenced. A more appropriate
method of treatment would be to analyse the symptoms and the patient, stimulate self-examination, and emphasise the patient's responsibility for his recovery.

The stories in this study were personal testimonials of the course of events from becoming ill to recovery. In co-operation with medical doctors and therapists, the respondents did their best and many were able to prevent themselves from entering the WAO.

Is mental illness a symptom of protest? The women have recounted their stories and stated that their mental illness only can be understood if looked at comprehensively. They have gone through many traumas caused by a difficult family life, lack of parental love, maltreatment, incest, suicidal behaviour in adolescence, problems in partner relationships, conflicts at work, and the confrontation with disability. They stated that the situation at work was very tense, that there was little flexibility, and that they felt oppressed by the system as a whole. They were highly indignant about the situation. They cried for real, serious attention and wanted to be treated fairly. Their reactions could be interpreted as protest - a protest against social abuse.

The respondents' explanations of their illness were strongly influenced by personal and cultural factors. Both models, the Deprivation-Domination Model and the Loss Model, share the same explanation of the aetiology of illness: that inequality is the main source of suffering in modern society and that negative influences of the environment and personal losses are causal factors as well. My opinion is that contradictions and negativity in someone's social environment and the suffering of traumas become an obsession. Therefore, I explain illness on the basis of the Protest Model: protest against social abuses.

5.3 Recommendations

We can collect invaluable data from life stories from which we can develop measures to prevent and treat mental disorders. Special attention should be given to personal testimonials of the research target group. By analysing these experiences, medical and employment professionals could identify the situations and places where changes need to be implemented either at the workplace or in the system in general. I am aware of the small scale of this study, however, I believe enough information emerged from it to warrant further study of the following:

- Inquiry into the communication at the different levels at work; inquiry into the value of the human factor in the working process.
- Inquiry into the policy of Arbo-doctors and insurance medical officers; inquiry into the interest of knowledge of patient's own ideas about their illness.
- Inquiry into the influences negative experiences during the socialisation period and traumatic life events have on individuals.
Appendix I: Biography

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SZW (a en b)  

Wester, F.
Appendix II: STATISTICS

**Toename WAO veroorzaakt door vrouwen**
Verschil tussen in- en uitstroom WAO naar geslacht, x 1.000

* eerste negen maanden

**Aantal arbeidsongeschikten nadert één miljoen**
Aantal arbeidsongeschikten, x 1.000

*Het LISV (Landelijk Instituut Sociale Verzekeringen) bouwt het per 1 januari 2000 op 922.500 'uitkeringen' arbeidsongeschiktheid*

Figuur. De kans op instroom in de WAO van vrouwen en mannen werkzaam in de gezondheidszorg en in de overige bedrijfsectoren.
Appendix III: Letter to respondents

Drs. L.G. Dulfer
Dennenlaan 4
5263 GZ Vught
073 6840955

Vught, mei 2000

Geachte mevrouw,

In verband met mijn studie Medische -Antropologie aan de Universiteit van Amsterdam, bereid ik een onderzoek voor over de ervaringen van jonge vrouwen, werkzaam in de gezondheidszorg, die in de WAO terecht zijn gekomen.

De hoofdvraag in dit onderzoek is: Wat is er voorafgegaan aan het arbeidsongeschikt worden en wat zijn uw persoonlijke ervaringen hierbij.

In Medisch-Anthropologisch onderzoek gaat het om de totale samenhang van sociale- culturele, economische en politieke omstandigheden. In mijn onderzoek gaat het om uw interpretatie van het totale proces van het ziek en vervolgens arbeidsongeschikt worden.

Het is de bedoeling dat er een open interview wordt gehouden bij u thuis of op een nader te bepalen plaats. Na verwerking van de gegevens, stuur ik u het verslag toe en zal u telefonisch vragen of u daarmee kunt instemmen. Uw gegevens worden anoniem verwerkt.

Dit onderzoek is van belang voor uzelf, de werkgevers, de therapeuten en de overheid om meer inzicht te krijgen in de oorzaken van arbeidsongeschiktheid. Daarnaast kan het een bijdrage leveren aan het ontwikkelen van preventieve maatregelen.

Ik zou het op prijs stellen als u contact met mij opneemt.

Alvast mijn hartelijke dank voor uw aandacht en eventuele bereidheid mee te doen.

Met een hartelijke groet van

L.G. Dulfer (Wies)

P.S.
Belangrijke gegevens:
Cadans is op geen enkele wijze betrokken bij dit onderzoek.
Cadans geeft deze brief namens mij aan u door.
Ik beschik niet over uw gegevens.
U bepaalt zelf of u wel of niet aan het onderzoek wilt meedoen.
U bent vrij om contact op te nemen met mij.
Appendix V: PROBLEM DIAGRAM

Perception of situation and experiences of complaints of Women in the WAO

Personal history Experiences pos/neg
- family
- education
- socialisation
- relations

Education Experiences pos/neg
- schooling
- study
- professional training

Medical circuit Diagnosis and treatment
- medical history
- dr.-patient relation
- alternative health care

Workside (dis)advantages
- work
- colleagues
- sphere
- autonomy
- dependency
- mobility

Support and/or demand of home-front
- care
- relation
- children
- parents

Forced or relaxed free-time
- sports
- social contacts
- holidays

Socio-cultural experience and demands
- community
- Society
- religion

Life - events Stressfull or sad
- privat
- public
- problems
## Appendix VI: TABLE’s

### Table I: gegevens onderzoekspopulatie n = 11

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<th>Leeftijd</th>
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<th>Beroepsopleiding</th>
<th>Leef situatie</th>
<th>Kinderen</th>
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### Table III: Mogelijke oorzaken ziekteverzuim onderzoeksgroep (n =11)

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*H=hospitaal
*JHV=Jeugd Hulpverlening