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ORIGINAL ARTICLE

Explanations for sickness absence due to common mental disorders: A narrative study of young health and social care workers

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Abstract

Over recent decades, sickness absence due to common mental disorders has increased among young workers. The phenomenon is mostly understood on the basis of epidemiological research, and knowledge regarding the viewpoints of young workers themselves is lacking. Our study explored the explanations for mental health-related sickness absence in the narrative accounts of young workers in high-risk health and social care occupations. Semi-structured narrative interviews were conducted with 23 Finnish young workers (aged 21–34), with self-reported sickness absence related to common mental disorders over the previous year. Our analysis identified three narrative explanations for the onset of mental health problems leading to sick leave: work as the sole cause, work as an additional cause and work as a trigger. These findings indicate that mental health-related sickness absences form a complex phenomenon related to various life and work-related circumstances. More comprehensive preventive measures are needed in the health and social care sector to help tackle mental health problems among young workers.

KEYWORDS
common mental disorders, health and social care work, qualitative research, sickness absence, young adults

INTRODUCTION

Common mental disorders such as depression and anxiety are the leading cause of work disability in many developed countries (Harvey et al., 2009) particularly for young adults, among whom the rates of both sickness absence and disability pension due to mental disorders has been rising in recent decades (Blomgren & Perhoniemi, 2022; Kaltenbrunner Bernitz et al., 2013; Laaksonen et al., 2021). For example, in Finland, the number of long-term sickness absences related to mental disorders increased by 57% among 16- to 34-year-old women and 48% among 16- to 34-year-old men between 2016 and 2019 (Blomgren, 2020). As the periods of sickness absence due to mental disorders are particularly long (Hensing & Wahlström, 2004) and highly recurrent (Koopmans et al., 2011), they may have far-reaching effects on the wellbeing of young workers.

Despite the worrying trend of young adults' work disability and the long tradition of sociological research on mental disorders in general, qualitative research on the subject is scarce. So far, the knowledge regarding the underlying causes of young workers' mental health-related work disability is mostly based on quantitative research on sickness absence and work disability, according to which the phenomenon is strongly associated with social inequality (Björkenstam et al., 2022; Harkko et al., 2018; Merikukka et al., 2018). In addition, several work-related factors, such as psychosocial working conditions, contribute to sickness absence due to mental disorders (Duchaine et al., 2020). The risk is also higher among workers in female-dominated, human-service occupations such as those in the health and social care sector (Björkenstam et al., 2022; Heinonen et al., 2022; Kokkinen et al., 2019). Health and social care workers are at an almost twofold risk of sickness absence due to mental disorders than workers in other occupations (Kokkinen et al., 2019). In their work, they are exposed to several adverse conditions, for example, threats of violence, awkward lifting (Aagestad et al., 2016), high job demands, low job control (Gray-Stanley & Muramatsu, 2011) and high emotional demands (Aagestad et al., 2016; Madsen et al., 2010), which have been associated with poorer health outcomes.

These findings call for more comprehensive approaches to examining the underlying causes of sickness absence due to common mental disorders in high-risk occupational settings such as health and social care work. More information is needed from the perspective of the young workers themselves, as they have long been underrepresented in qualitative studies on work ability and occupational health (Boström et al., 2016). Furthermore, some evidence indicates that younger workers exhibit different patterns (Sumanen et al., 2018) and more liberal attitudes towards sickness absence (Holmås et al., 2008) than their older counterparts. We addressed these knowledge gaps by interviewing young health and social care workers about their own mental health-related sickness absences and how they understood the causes leading to them. The empirical setting was Finnish health and social care work in the context of a Nordic welfare state. We considered workers aged between 18 and 34 young adults, in line with previous studies (Harkko et al., 2021; Rikala, 2018; Torvik et al., 2016).

ILLNESS NARRATIVE APPROACH TO COMMON MENTAL HEALTH-RELATED SICKNESS ABSENCE

Sickness absence is a commonly used indicator of work disability. It is a multidimensional phenomenon affected by medical, psychological, social, and economic factors (Marmot et al., 1995). Sickness absence represents a temporary inability to accomplish and perform one's job (Laaksonen et al., 2010; Prins, 2013). As a social construct, sickness absence is viewed as a situational and negotiated state of work disability, which is affected by the values, norms and goals of society at a specific historical time (Martimo & Takala, 2020). This negotiation involves several stakeholders in addition to the claimant: the employer, physicians and other health-care professionals, as well as representatives of insurance agencies (Kangas, 2001). Work characteristics and working conditions also affect sickness absence, for example, the extent to which workers are able to modify their work (Dodier, 1985).

To be granted sick leave, a worker must justify their work disability and explain what caused it (Korhonen & Komulainen, 2019; Mik-Meyer & Obling, 2012). In the case of mental health problems, which are not as clear cut as most physical complaints, such legitimation may be particularly challenging (Korhonen & Komulainen, 2019; Shimizu, 2021). Previous sociological research into health and illness has explored the explanations for depression (Danielsson et al., 2009; Kangas, 2001; Shimizu, 2021) and mental health problems being work induced in the context of seeking sick leave compensation (Shimizu, 2021) in working-age populations. Explanations have also been examined from the perspective of justifying burn-out-related sickness absence (Korhonen & Komulainen, 2019).

Previous research has indicated that in adult populations, explanations for, that is, understandings of, common mental disorders are multifaceted and that they tend to associate with environmental exposures, disturbing events in a person's past and situational stressors in life. Kangas' (2001) study of explanations for depression in the working-age population found three distinct storylines: childhood adversity, work-related difficulties and hardships in adulthood. Another narrative study by Danielsson et al. (2009) found that sources of depression included stressful work-related situations, heavy life burdens, 'inner demons' and personality. Furthermore, Issakainen and Hänninen (2016) found that young people often understood the causes of their depression to be a struggle to meet the normative expectations of life, childhood adversities and series of unexpected adversities and difficulties later in life.

Some explanations involve the negotiation of normality (Korhonen & Komulainen, 2019) and responsibility, or 'blame' (Kangas, 2001; Shimizu, 2021) and can be placed on either an 'internal' or an 'external' axis (Danielsson et al., 2009; Kangas, 2001). Danielsson et al. (2009) studied the narratives of depression among primary care patients with clinical depression and found that while internalising explanations focused on self-blaming, externalising explanations presented the aetiological factors outside the body (Danielsson et al., 2009). Applying the theory of narrative reconstruction (Williams, 1984), Shimizu (2021) identified three work-related explanations for the aetiology of mental health problems among male workers: objectivising stressful events as psychological symptoms, non-faulting of the self, emphasising work stress as an unavoidable occurrence and negotiating blame with reference to individual causes. In Kangas' (2001) study of lay narratives of depression, internal and external causes were discussed in terms of responsibility.

Few qualitative studies have examined how sickness absences are understood by young workers, as prior sociological research on mental health problems of young adults has mostly focused on non-working or marginalised young adults' experiences of common mental disorders

(Munson et al., 2018; Rikala, 2018), or gendered experiences of mental health problems (Danielsson et al., 2011; Verdonk et al., 2008). The current study explored the understandings of sickness absence related to common mental disorders and its causes from the perspective of employed young adults. We utilised a narrative approach that enabled us to scrutinise the first-hand experiences of mental health-related work disability manifested as sickness absences, and which shed light on the broader social contexts in which they are constructed (Murray, 2002) and how they embody 'how illness processes are linked to the broader social and structural contexts of a person suffering from illness' (Le et al., 2017).

We approached this task in an interpretive framework of illness narratives (Bury, 2001; Hydén, 1997). The theoretic-methodological approach of illness narrative (Bury, 2001; Frank, 1995; Hydén, 1997; Williams, 1984) emerged as a response to the hegemonic biomedical explanations of ill-being (Bell, 2000; Mishler, 1984) to give voice and power to defining conditions to those suffering from illness (Frank, 1995; Hydén, 1997). While illness narratives have traditionally focused on physical chronic diseases (Bury, 1982; Williams, 1984), recent studies have utilised the approach to explore (lay) the understandings of the aetiology of common mental disorders (Danielsson et al., 2009; Kangas, 2001) and related sick leave (Korhonen & Komulainen, 2019; Shimizu, 2021).

The current study understood the illness narratives as a means of 'discussing possible explanations for the illness', which enable and involve the sufferer to answer questions such as 'why me?' and 'why was I afflicted?' (Hydén, 1997). In this sense, by formulating illness narratives, the individual is able to make sense of their ill-being on their own terms (Hydén, 1997). We call these narrative explanations; they provide information on the understandings related to the causes of mental health-related sickness absence.

METHODS

Data

The data comprised 23 semi-structured narrative interviews with women and men working in health and social care in Finland. This sector is strongly female-dominated, and the majority of the participants were women. Less than five participants were men, and no other gender identities were reported. All the participants were native Finnish-speakers, with a mean age of 29, ranging from 21 to 34 years. On the whole, the participants were relatively highly educated, as the majority of them had at least a bachelor's degree, and about half of them had a master's degree. Slightly more than half ($n = 14$) of the participants worked in social care and the rest in health care ($n = 9$). The most common occupations were social worker and registered nurse. The majority of the participants worked in practical positions in the field, and a few did office work and held specialist positions. All the participants worked primarily in the public sector. Work experience in the sector varied: some had only recently entered the labour market, whereas others had up to 10 years of work experience. Similarly, the length of sickness absence varied from 2 days to 6 months during the year preceding the interview. Thus, both longer, physician-certified sick leave attributable to mental disorders and shorter self-certified sick leave spells were represented in this study.

Data were collected between March and December 2021. The target group included 18- to 34-year-old adults who worked in health and social care in Finland, and who reported having had at least one day of sickness absence related to common mental disorders such as depression,

anxiety or other general and mild-to-moderate self-reported symptoms over the past year (2020–2021). The participants were recruited via the Internet and multiple social media channels. The invitation letter was shared by the social media accounts of different health and social care unions, as well as the informal social media groups of health and social care.

All the interviews were conducted in Finnish, on a single occasion, and carried out and recorded via Zoom (due to the COVID-19 pandemic) over a secured connection provided by the University of Helsinki. Due to technical issues and to ensure data security, the interviewees were asked to turn off their cameras during the recording. The interviews lasted an average of 69 min, ranging from 38 to 96 min. The participants were instructed beforehand to choose a private, calm and relaxing place for the interview. The final data consisted of about 26 h and 30 min of recordings. All the interviews were conducted and transcribed by the first author.

We used a narrative approach and open-ended questions to promote participant-oriented narration. The interview protocol included one narrative question and four thematic issues, based on empirical literature: one's own sickness absence due to common mental disorders, the workplace, the future, and other young workers' mental health-related sickness absence. These main themes were split into sub-categories: work-related needs and expectations and reactions to sickness absences at the workplace. The interviewer (the first author) started by asking the narrative question on which the interview was based: '*In this research we are investigating mental health-related sickness absences among young health and social care workers, and their background factors. Could you please tell me your story?*'. The interviews proceeded on the basis of this main account, and each thematic issue was discussed accordingly.

Sickness absence and social security system in Finland

We did not collect data on diagnoses. Hence, participation was based on the respondents' own estimation, as in a previous study (Kangas, 2001). In addition to anxiety and depression, self-reported common mental disorders may include varying levels of stress- and burn-out-related problems. The inclusion criterion of at least one day of sick leave was chosen because, as reported in a previous study, young workers tend to have more short-term self-certified sick leaves for which no medical certificate is needed (Sumanen et al., 2018). According to the Finnish social insurance system, sickness allowance is a social benefit to which all citizens aged 16–67 are entitled as compensation for loss of income during absence. Shorter spells (less than 12 calendar days) are covered by the employer, and longer spells (up to a maximum of 300 days) are covered by The Social Insurance Institution of Finland.

Ethics

The research protocol was approved by the University of Helsinki Ethical Review Board in Humanities and Social and Behavioural Sciences (Statement 38/2020). Participation was voluntary and based on sufficient knowledge of the purpose of the study, the methods, the participation criteria, data management and protection and the participant's rights. Written informed consent was collected from all participants. Only individuals with mild or at most moderate symptoms of common mental disorders were invited to the study. The participants received an introductory letter informing them of the aims and nature of the study, data management and data security. We followed the University of Helsinki research ethics guidelines strictly, and fully complied with the Declaration of Helsinki.

During the interviews, we asked the participants to recall and discuss their sickness absence experiences, which could include mentally exhausting and emotionally charged issues and events. To avoid causing them any additional stress, we gave them the opportunity to discuss their feelings at the beginning and the end of the interview. The information letters advised all the participants to seek professional help in health centres if necessary, and phone numbers for various mental-health support helplines were provided. No fee was paid for participating in the study. As an incentive to participate, we held a draw in which four participants won a Finnish supermarket chain gift card (EUR 25 each).

Analysis

The analysis focused on the narrative accounts that emerged in the interviewees' accounts on how they ended up on mental health-related sick leave. The narratives were identified on the basis of verbal hints, 'the entrance and exit talk' (Jefferson, 1979) by which the interviewees indicated the beginning and ending of their story. In general, the participants had no ready-made stories and the identified narrative explanation was based on the responses to the first question that prompted the interviewee to tell their story. Only in a few cases was the narrative outlined throughout the interview when we asked the interviewee more detailed questions.

As the first step in the analysis, each interview was coded separately. Coding was conducted inductively, and the following subject areas were identified and coded: contexts, key events and their interpretations, temporal dimensions and turning points concerning the emergence of mental health problems. We asked what the primary scene of the narrative was, what kinds of events and issues related to mental health symptoms and sickness absence were raised, and how these events and issues were interpreted as being causally related to mental health problems. Based on the coding, we outlined simplified storylines for each individual interview. Second, the identified storylines were re-examined more closely and grouped together on the basis of their similarities. After this iterative process, we formed distinct narrative explanations. Analysis was conducted with the help of the Atlas.ti software.

RESULTS

The narratives of sickness absences for common mental disorders were complex and rich. We found that they were formed mainly on the basis of descriptions of the onset of mental health-related issues, 'where it all began', and not on the sick leave as such. They described the events associated with the emergence of symptoms and mechanisms through which the participants' ill-being developed. Sickness absence was discussed in diverse ways and one narrative could include several sickness absence periods that occurred at different times and in different contexts. Thus, we focused on the explanations for the onset of mental health problems in the narratives.

The narratives began and were situated in different life stages and scenes, and these formed a frame for each explanation. Accordingly, we identified three distinct narrative explanations describing the causes for the emergence of mental health problems: work as the sole cause, work as an additional cause, and work as a trigger. They all address work-related factors, but in different roles.

Work as the sole cause

The explanation of work as the sole cause presents mental health problems as work induced. This narrative was limited to either a specific period of employment or, more broadly, the worker's career in the health and social care sector. It provided detailed descriptions of the shortcomings encountered in daily work, which dominated the narrative as main events relating to the emergence of mental health problems. These included continuous excessive workload due to lack of staff, starting in a new position without sufficient induction to the work, dealing with traumatic events at work without adequate support and conflicts at the workplace and no support or active intervention by the supervisor. Through the prolongation of problems, these issues lead to the development of mental health problems. Importantly, these work-related issues were discussed more broadly in the context of health and social care work, portraying them as overarching challenges within the sector, as exemplified in the excerpt provided below.

> ***I***: Okay, let's start. So, in this study, we're investigating mental health-related sickness absences among young workers, and their background factors. Could you please tell me your story?
> ***P17***: Yes! So, I can start from the fact that I suffered real burnout in [year] and it was totally work induced, as I had to do the work of [an assistant], and two [other professions] and (sigh) it was a little, it was just too much, so that, I'd worked far too much overtime. So, that led to burnout, of course... [--] So that (sigh) it's about leadership, the leadership is just so insufficient and so (sigh), and there is no supervisor support available so you're left totally alone, you try to resolve everything all by yourself and you find yourself in a situation where you have to do the work of several people at the same time, more than once. So that... It is what it is, but there's also a lack of staff [in the health and social care sector], so [they] haven't been able to give us substitutes. So, you're left alone to do the work, I mean, that's part of it, there are many things that lead to it in the long run.

In this narrative, poor working conditions, such as lack of support and excessive workload in efforts to compensate for staff shortages, were presented as constant and common issues in the sector. As examples of the current state of the health and social care, these descriptions of daily difficulties at work were used to illustrate how working under these circumstances ultimately leads to the development of mental health problems. In this context, the workers, including the supervisors, were portrayed as victims of the system and personal characteristics, such as a tendency to work hard and being conscientious, were presented as problematic.

In explaining the emergence of mental health problems within the context of health and social care, the work was characterised by a strong ethical obligation and a high level of responsibility for other peoples' lives. This was highlighted in the descriptions of starting in a new job without adequate induction to the work.

> ***I***: [--] so please tell me, in your own words, what is your story?
> ***P4***: [--] Er... I had to... like, I had to start working, kind of, without any induction to the work, I mean, to work in [a specific unit]... Or, I did get some, I got [a couple of hours] (sniffing) of a quick briefing, I got a sort of a bundle of hand-outs and... And then, er, (moved to tears)... And, then I just had to take care of [patients/clients], very [really ill] and... Then, at the same time, I had to train other [new workers] for the [job], even though I hadn't received any guidance myself either. So... It's left its mark on me, definitely. And, er... I managed to work there about [duration of time] and then... I went on sick leave because I burned out... And (I) couldn't sleep anymore. [--]

In the above excerpt, the worker was left to carry out tasks of great responsibility alone and to make decisions regardless of uncertainty or not knowing exactly what to do. The absence of opportunities for learning and support for newcomers, coupled with the expectation of full responsibility at work, was described unfair and unreasonable. In the context of heavy ethical burden and the high level of difficulty of the work tasks, this was described as resulting in deteriorating mental health in the long run.

Similarly, lack of support was reported in connection with traumatic or severe events at work, for example, facing a violent incident. This narrative described the underestimation of a worker's need for support, or the absence of appropriate debriefing after such events. This formed a mental burden that the worker was left to carry alone. Being left without appropriate support was described as causing insecurity at work, and fear of similar tasks in the future and associated with the emergence of mental health problems.

The prolongation of problems and supervisors' indifference to support requests were also apparent in the descriptions of workplace conflicts. Here, the lack of support manifested as poor management and resulted in daily cooperation problems, as illustrated in the excerpt below. Supervisors were depicted as invisible or unable to intervene in workplace issues, leaving the workers to resolve the problems on their own. The prolongation of such problems in the workplace was described as wearing the worker out.

> ***I*:** Yes. And, then you said that, err, the latest absence was in [a period of a year], right?
> ***P13*:** [--] we had incoherent instructions to [work], we had arguments, conflicts between colleagues, situations that I experienced as unjust? No clear instructions for the work, [although] we had asked for them ... (sigh) There was yelling, arguments, the supervisor did not intervene... Mm... The work itself is okay... [--] But it was really tough to be in the middle of [arguments] and listen to colleagues crying and... (sigh) We shouldn't get to that point at work, that it escalates to yelling. But it did and... There was... The exercises... In all the places I've worked, there's been so much haziness, you don't get answers... [--] it feels like no one wants to make decisions about how to do things.

In conclusion, the explanation of work being the sole cause presents mental health problems in the context of a workplace or one's career in the health and social care. The narrative described fundamental shortcomings in working conditions and told a story of being left alone in difficult situations at the beginning of a worker's career, even during an internship. According to the explanation, mental health problems occur due to long-term exposure to adversities in health and social care work, where workers face considerable ethical responsibility and demands.

Work as an additional cause

In the explanation of work as an additional cause, the narrative was framed in a period of the person's private life. Placed between home and work, this narrative describes multifaceted, simultaneous problems or taxing demands in their private life in addition to work-related stressors. These private-life issues included different types of stressful situations and crises related to family life such as divorce and taking care of family. Thus, the explanation suggests that to be able to work in the health and social care sector one must have a balanced private life.

According to this explanation, mental health symptoms stem from an imbalance between the individual's inner resources and outer demands within the worker's current life situation. In the narrative, the individual's inner resources were described as limited and hence, difficulties

in private life, combined with demanding work, consumed all their disposable energy. When life outside of work became more stressful and required more inner resources, there was little opportunity for recovery or to regain resources, as described in the excerpt below.

> ***I*:** [--] Could you please tell me your story?
> ***P6*:** [--] It was [time of year] when I returned to work from [a leave]?... To work, and that last [season] was, it was a tough life phase, so that then I was over a month on a sick leave? ... The reason I was on a sick leave, is maybe related more to everything else than work. I, er... I mean it was due to symptoms of depression and anxiety, for which I finally sought sick leave as I could no longer even sit at the dining table at home without crying, so then I just said I'm not in any condition to work in any way at all. [Describes diverse challenges and misfortunes in private life, mainly related to family life], [--] It was finally all too much, the combination of [work] and [a health condition] and [laughter] with all the other things, so that... I just couldn't take it anymore... at all anymore.... And now, that's the reason I stayed... stayed at home to rest and recharge, to recover from the last year.

As in the excerpt above, the explanation emphasises the temporary nature of mental health problems, as ill-being is described as a result of a challenging life situation and a critical approach is taken to mental health problems as illnesses. For example, the mental illness diagnosis was discussed in a distant manner, as 'a received diagnosis', emphasising the externally given judgement of their situation:

> ***I*:** [--] So, would you please tell me, what is your story?
> ***P22*:** Well, I've been [--] for almost [duration of time] on sick leave? ... Er, officially labelled ... burnout? But I mean, of course, depression and non-organic sleep disorders, what's said in the diagnosis... on paper. So that... Mm, I've had like... a very stressful life situation for a long time. Both in my personal life and then... Also, my job is stressful, so it felt like the walls started to fall down, so ... I started having sleeping problems, so that I was awake at night and couldn't fall asleep again and, other things, so that it got me... to get help from occupational health services, so, [I can't] survive alone any longer? [Describes the situation in detail, listing things related to a family crisis] So, it kind of felt that even working was too much, and I needed to stop a bit and take time for a while...

Lastly, the explanation of work as an additional cause adopts a broader perspective and focuses on the overall burden of life's demands. It proposes that, in addition to work-related demands, the heightened multiple strains in private life contribute to the development of mental health problems. The narrative indicates that one's private life becoming a source of stress can overconsume one's inner resources. This kind of imbalance was associated with running out of energy and with the emergence of mental health problems. In this sense, the explanation highlights the importance of life outside of work for the worker's mental health.

Work as a trigger

In the work as a trigger explanation, the emergence of health problems was made understandable within a broader life course context, triggered by work-related stressors. The narrative dated back to childhood and adolescence and began by describing a personal life story related to mental health problems. It included, for example, history of care, problems in one's childhood family

or bullying at school and describes how these experiences were reflected later in life and in the present. This way, mental health problems were discussed as a continuum for earlier experiences.

The narrative describes how different work-related adversities caused mental health problems to resurface. As the onset of the mental health problems was presented in relation to the individual's past, it was portrayed as 'resurfacing'. Work was discussed in terms of health and social care work characteristics and their relationship with the worker's own experiences, as well as in terms of the burden caused by poor working conditions in general. The latter referred to activation of mental health problems because of exposure to poor working conditions, such as poor leadership and other organisational problems, lack of support and induction to work, also discussed in other explanations. The former is illustrated in the following excerpt, showing how a worker's own personal life history and the work stressors of health and social care were interconnected in the explanation.

> ***I***: [--] So, would you please tell me, what is your story?
> ***P8***: Well, I guess my story is that I was [diagnosed with common mental disorders in youth] [describes family background] [--] And oh, every now and again they become active and have complicated my life in many situations. But regardless of these, I've ended up in this tough sector and I've trained to become a professional in [this sector]. There's a lot of talk about callings and unfortunately this is my calling... Every now and then I wonder why I had to have a calling like this when I have these kinds of... like, life-destructive illnesses, but. It is what it is. And I've also come to think that because of these illnesses and, oh, kind of personal, difficult experiences, I am, in quite many ways, a better worker than I would be without them.

As in the excerpt above, personal experiences were described as a strength and a source of motivation for working in the health and social care sector to help others. However, having personal experience on adversities in life was also described as stressful, if a situation at work reminded the worker of, or was too close to, their own experiences. This relationship, characterised as a 'conflicting calling', illustrates how the characteristics of health and social care work itself contributed to the resurfacing of mental health problems, alongside poor working conditions.

To summarise, in this narrative explanation, the onset of mental health problems is contextualised and made understandable in one's broader life course, suggesting that while the mental health problems may have started earlier in life, they can resurface due to work-related stressors. Thus, work-related adversities were interpreted as bringing back—'triggering'—mental health problems associated with past experiences.

DISCUSSION

The aim of this qualitative study of young health and social care workers was to clarify how young workers understand their sickness absences due to common mental disorders, and their causes. We approached the task narratively and asked the interviewees to tell the story of their sickness absence. We found that these narratives focused on events and circumstances associated with the emergence of mental health problems and were linked to a set of longer-term, broader events in life. Based on our findings, young workers' mental health-related sickness absences can be understood as a long-term process, and the causes of ill-being may date back far into the past.

As our main finding, we identified three narrative explanations by which the onset of mental health problems was made understandable: work as the sole cause, work as an additional cause and work as a trigger. Whereas the work explanation suggests that mental health problems are

work induced, the trigger explanation presents adverse work-related issues as factors that cause past mental health problems to resurface. The explanation that work is an additional cause of mental health problems presents the demands of work as part of generally demanding life circumstances contributing to mental health problems. These findings reflect those reported in previous narrative studies of (lay) understandings of the causes of common mental disorders (Danielsson et al., 2009; Issakainen & Hänninen, 2016; Kangas, 2001). It appears that the explanations share similarities in different target groups, in different age groups more broadly, and in occupational and patient groups.

Although in different roles, adverse working conditions in the health and social care sector were central to all the explanations. They included an excessive workload due to inadequate staffing, poor management and workplace climate and insufficient support and induction to work. They were embodied in the impression of being left alone to deal with excessive demands and insufficient support. These findings share similarities with findings from prior research conducted among health-care professionals. For example, in the study by Wahlberg et al. (2020), being left alone with an emotional surge was a dominant theme in midwives' and obstetricians' experiences of severe work events. It was related to receiving little support, working with insufficient staffing, and control and safety at work (Wahlberg et al., 2020). In addition, previous studies have found that home care workers' stress can be caused by working alone (Ruotsalainen et al., 2020; Swedberg et al., 2013). These findings indicate the critical importance of occupational support for those performing ethically demanding work in the health and social care sector.

Although these problems and shortages at work are likely to influence all health and social care workers, experiencing adversities at work can be particularly harmful to early-career workers. This is especially the case when induction to work at the beginning of a person's career is inadequate. Work-related adversities at the early-career stage may have far-reaching negative effects not only on mental health (Mortimer & Staff, 2004) but also on working careers. In a prior study conducted in Finland, turnover intentions in the health and social care sector were more common among younger workers and among those reporting higher psychosocial strain and a lack of supervisory support (Olakivi et al., 2021). Therefore, our findings suggest that workplaces have significant potential to prevent young workers' mental health-related sickness absences.

Our results also show that work is identified and understood as a key contributor to the development of mental health problems. As people tend to tell socially acceptable stories about health and illness (Radley & Billig, 1996), this could also serve as a way to legitimise ill-being while maintaining the status of a respectable worker, as has been found in relation to burn-out-related sickness absence among working-age adults (Korhonen & Komulainen, 2019). A strong sense of responsibility and conscientiousness at work have been previously associated with burn-out among women in particular (Rikala, 2013). Our findings of emphasising organisational problems in the sector and presenting oneself as a hard-working and conscientious worker reflect the ways by which burn-out-related sickness absence was externalised in a previous study (Korhonen & Komulainen, 2019). On the other hand, adverse experiences in childhood and in adulthood have also been described as providing 'an external view of the aetiology of depression' because they illustrate involuntary exposure to adverse circumstances and events that cause depression (Kangas, 2001). In this study, the explanations could not be unequivocally categorised into external and internal causes, although they appear to reflect more external than internal views on the onset of mental health problems. Furthermore, we were not able to explore gendered patterns in the explanations. These issues should be addressed in future studies.

Our findings regarding work as an additional cause of mental health problems demonstrate how these problems develop when life outside of work becomes a source of stress. Private life

burden included mainly various stressful situations and accumulating demands in family life. This multiple strain due to increased demands in both work and private life may be particularly emphasised among those who are in their 20 and 30s. This period is characterised by multiple key life events, such as entering the labour market and starting a career, forming partnerships and starting a family (Rindfuss, 1991; Shanahan, 2000). Further, a previous study by Lehmuskoski et al. (2022) similarly described young workers' mental health-related work disabilities arising due to poor resources and possibilities both at the workplace and in daily life outside of work. These findings underline the importance of quality of life outside of work, as well as the overall burden of life for a person's inner resources.

Our findings concerning the trigger explanation confirm and complement epidemiological knowledge of the associations of childhood adversity and mental disorders (Björkenstam et al., 2021) and related disability pension (Merikukka et al., 2018) in young adulthood. The trigger explanation demonstrates that although mental health problems may be rooted in the distant past, environmental factors such as working conditions could affect whether these symptoms resurface or not. This has been also illustrated in a study by Rikala (2018). These findings underscore the need for more specialised supportive measures in workplaces to support young workers with mental health problems, and at the level of social policies to promote family wellbeing, as Merikukka and colleagues (2018) have also suggested.

To the best of our knowledge, this is the first study to explore the underlying causes of sickness absence due to common mental disorders on the basis of firsthand accounts of young health and social care workers. Our findings present distinct understandings of the phenomenon and demonstrate how mental health problems are constructed in multiple areas of life. Three narrative explanations described how certain life circumstances and environmental conditions are transformed into individual mental health problems. This is of particular importance given that these non-health-related causes behind sickness absence are also important targets in its prevention (Sumanen et al., 2018) and that such social factors may constitute an even greater barrier to going to work than the mental health condition in itself (Irvine & Haggar, 2023). Furthermore, as young workers' mental health-related work disability is related to complex institutional and cultural factors, the solutions should not only limit to workplace and occupational health-care interventions, but also involve changes on a broader societal level (Lehmuskoski et al., 2022). This information can be used to find new, more comprehensive ways to tackle young workers' mental health problems.

We were able to capture a variety of manifestations of the most common mental disorders in the occupational context and describe them from the perspective of young workers. We focused on the causes of the emergence of mental health problems that were emphasised in the narratives of sickness absences due to common mental disorders. However, ill-being as such does not automatically lead to sick leave. Sickness absence is rather a process defined by various contextual factors and involves negotiation of the status of both 'credible patient' and 'respectable worker' (Korhonen & Komulainen, 2019). This way, the evidence distinguishes between experiencing mental health problems and actually taking sick leave. Hence, more research is needed to examine the transition to sick leave and the meanings it is associated with in terms of young workers' mental health problems. Prior studies have found that sickness absence may have several meanings in relation to mental health and work (Simpson et al., 2015), and our study found similar indications. However, these should be further investigated.

When interpreting the results of this study, the following factors should be taken into consideration. We were not able to present the results on the basis of profession, age or gender. Accounting for this background information could have provided a more sophisticated inter-

pretation of the results, especially regarding gender. Prior studies have demonstrated how gender norms are intertwined with experiences and explanations of mental health problems (Danielsson et al., 2011) and related sickness absence (Verdonk et al., 2008). It is also worth noting that the interviewees of this study were mainly well-educated health and social care professionals, who are expected to be more aware of the background and nature of sickness absence and mental health problems than lay people. This in turn may affect how they narrate their own experiences.

CONCLUSIONS

This study provides a more comprehensive understanding of the causes underlying sickness absence related to common mental disorders from the perspective of young health and social care workers. Our findings confirm those of previous studies: that the development of mental health problems is complex and constructed in multiple areas of life. The role of poor working conditions in the health and social care sector was highlighted. This information can be utilised to develop workplace interventions to prevent sickness absences. Future studies should further investigate the transition to sickness absence due to common mental disorders and the meanings with which it is associated among young workers and different occupational groups.

AUTHOR CONTRIBUTIONS

Noora Heinonen: Conceptualization (equal); Data curation (lead); Formal analysis (equal); Funding acquisition (supporting); Investigation (lead); Methodology (equal); Writing – original draft (lead). **Anu Katainen**: Conceptualization (equal); Formal analysis (equal); Funding acquisition (supporting); Methodology (equal); Supervision (equal); Writing – review & editing (equal). **Tea Lallukka**: Conceptualization (equal); Funding acquisition (supporting); Supervision (equal); Writing – review & editing (equal). **Hilla Nordquist**: Conceptualization (equal); Funding acquisition (supporting); Methodology (equal); Supervision (equal); Writing – review & editing (equal). **Anne Kouvonen**: Conceptualization (equal); Funding acquisition (lead); Methodology (equal); Supervision (equal); Writing – review & editing (equal).

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CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

Supporting data is not available due to the sensitive nature of the research. Participants of this study have not agreed for their data to be shared publicly.

ETHICS STATEMENT

The research protocol was approved by The University of Helsinki Ethical Review Board in Humanities and Social and Behavioural Sciences (Statement 38/2020).

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