

Supporting and retaining employees with rheumatoid arthritis: The importance of workplace social support

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Abstract

Social support at work is important to individuals' health, wellbeing and employee retention. Evidence suggests employees may be more willing to offer support to co-workers they already have strong friendships with or if they perceive support-giving will be reciprocated. However, the support relationships of workers with chronic health conditions, who may have variable but long-term need for practical and emotional support, have rarely been studied. We conducted in-depth interviews with workers employed when diagnosed with rheumatoid arthritis (RA), an inflammatory and progressive musculoskeletal disorder, to explore how RA affects work relationships, the willingness of employers and co-workers to offer support, and the importance of support for continued employment after RA onset. Participants' accounts revealed evidence of receipt of sustained social support, but also its withdrawal. The nature of pre-existing relationships influenced the willingness of others to offer support. Employers demonstrated support and understanding, particularly if they had personal knowledge or experience of disability, and their implementation of workplace modifications helped workers with RA to remain employed. However, modifications could be withdrawn if they disrupted workflow or negatively affected relationships with co-workers. We identify implications for organizational policy and practice.

Key words: Workplace social support; musculoskeletal disorders; rheumatoid arthritis; workplace modifications.

Introduction

Previous research has revealed the important role workplace social support can play in protecting workers from the adverse health effects of stressful working conditions (e.g Ducharme and Martin, 2000; Chamberlain and Hodson, 2010; Nahum-Shani and Bamberger, 2011). However, little is known about the reverse relationship, specifically how chronic illness affects work relationships and the willingness of others to offer support in the workplace; and in addition, the importance of social support for continued employment after the onset of chronic illness. This is a particularly important area of research as the UK, along with other high-income countries, is seeing growing numbers of older workers in the workforce as well as an increasing prevalence of chronic health conditions that may impact upon the ability to work (Shaw, Tveito and Boot, 2013). Evidence regarding the benefits of good quality work for health and wellbeing (Waddell and Burton, 2006), and the corresponding stance that working can aid recovery from poor health (Black, 2008), underpin recent UK policy initiatives aiming to promote work retention in workers with disabilities and health conditions and reduce long-term sickness absence. The *Fit Note* and *Fit for Work* service¹ highlight the role of employers in promoting job retention and early return-to-work from sickness absence by implementing workplace adjustments (Black, 2008; DWP 2015a; DWP 2015b). The implementation of reasonable workplace adjustments by employers is also required by the UK Equality Act 2010. These initiatives, however, rely on the willingness of employers to implement required adjustments and other forms of support and to manage their potential impact on co-workers. This paper contributes to the social support literature by exploring the workplace relationships of employees with rheumatoid arthritis, a chronic and fluctuating musculoskeletal disorder associated with high rates of work disability (Burton et al, 2006).

¹ The Statement of Fitness for Work ('Fit Note') allows clinicians to state a patient 'may be fit for work' if employers implement appropriate workplace adjustments to working hours, duties or equipment (DWP, 2015a). Employers and general practitioners can refer workers on sick leave to Fit for Work for free occupational health and return to work support (DWP, 2015b).

Workplace social support

Social support refers to access to help and assistance from others which makes the recipient feel “cared for and appreciated” (Kossek, Pichler, Bodner and Hammer, 2011:291). Social support can take varying forms, namely, instrumental support (practical help with work tasks), emotional support (the expression of care, empathy or esteem) or informational support (the provision of advice or guidance) (House, 1981; Cohen and Wills, 1985). Research suggests that the ability to draw upon social support from significant others, friends and family members is beneficial to health and wellbeing (Cohen and Wills, 1985). Workplace social support is support received from organisational sources such as supervisory staff and co-workers (Kossek, et al., 2011). From a social exchange theory perspective, research suggests that workplace social support relationships tend to develop over time and depend on both parties abiding by the rules of exchange (Cropanzano and Mitchell, 2005), such as implicit expectations of support provided through ‘reciprocal exchanges’: the notion that *‘if a person supplies a benefit, the receiving party should respond in kind’* (Cropanzano and Mitchell, 2005:876). Thus, if individuals give more social support than they receive it may lead to a sense of unfairness and support may become a burden, while those receiving greater support than they give may experience guilt (Bowling, Beer and Swader, 2005). Certainly, evidence suggests workplace social support may be only offered between colleagues under certain conditions. For example, employees may be more willing to help co-workers if they already have a strong friendship with them (Bowler and Brass, 2006; Venkataramani and Dalal, 2007). Furthermore, organisational policies and procedures, and how they are enacted, can also influence social exchange relationships. For example, organisational outcomes which are perceived to be unfair or unjust can lead to some individuals adopting negative behaviours towards the source of the perceived injustice, which can be the organisation, a supervisor, or a

co-worker (Cohen-Charash and Mueller, 2007). This has important implications for workers with chronic health conditions who may need long-term practical and emotional support from co-workers and employers. Thus this study explores these issues in the context of rheumatoid arthritis.

Rheumatoid arthritis and work relationships

Rheumatoid arthritis (RA), a common musculoskeletal disorder, is an inflammatory and degenerative auto-immune chronic condition (NRAS, 2014). RA is more common among women than men and peak onset occurs between ages 40-60 (NRAS, 2014). Symptoms include painful and swollen joints (particularly upon waking), limited mobility and chronic fatigue. People with RA often experience flare-up of symptoms followed by periods of remission. The invisibility and fluctuating nature of most RA symptoms can make it hard for managers to understand the work difficulties experienced by individuals with RA, leading to disbelief and conflict (Holland and Clayton, 2018). Several studies have reported how employers' lack of sympathy or distrust of workers with RA can lead to their dismissal or resignation (e.g. Holloway, Sofaer-Bennett and Walker, 2007; Holland and Collins, 2016). Although continuing to work after onset of RA is important to most individuals of working age (NRAS, 2007), the difficulty of fluctuating symptoms, and the uncertainty this causes for individuals and their employers, causes high rates of work disability: between 20-70% of individuals with RA become work-disabled 7-10 years post-onset (Burton et al., 2006). Thus, organisational support for workers with RA is particularly crucial as implementing flexible working arrangements and modifications to the workplace or work tasks improves their work retention rates, reduces sickness absence and avoids productivity loss (Codd et al., 2010; Holland and Collins, 2016; Holland and Clayton, 2018).

While the onset of RA can impact negatively on relationships with employers, less is known about how it affects social relationships with co-workers and supervisors. Co-workers play a key role in providing practical support with work tasks but instrumental support may not always be forthcoming, even for visibly obvious illness. In their study of presenteeism, Collins and Cartwright (2012) found that while some individuals willingly provided practical assistance with work tasks to co-workers experiencing short-term illness or injury, others were less eager, not perceiving it as part of their job role. It is unclear, however, to what extent co-workers are willing to provide support to colleagues who have a *long-term* illness or disability, or whether being expected to offer support over a sustained period negatively affects relationships between the recipient and giver. This is an important area of research as social support is a key resource for individuals. For example, from a wider health context, low co-worker support has been implicated as a risk factor for neck pain (Ariëns et al., 2001), back pain (Hoogendoorn, van Poppel, Bongers, Koes and Bouter 2000) and depression (Oksanen, Kouvonen, Vahtera, Virtanen and Kivimäki, 2010). In contrast, emotional support from supervisors and co-workers, in terms of showing interest, concern and acceptance of the individual's limitations, can aid return-to-work for disabled employees (Lysaght and Larmour-Trode, 2008). Furthermore, research suggests that social support is an important factor in workplace interventions for workers with disabilities (Williams-Whitt et al., 2016). However, it is likely to have even greater importance for employees with *fluctuating* health conditions, not just because they may need long-term practical and emotional support from employers and co-workers, but because their support needs may vary considerably over time. Thus, this study explores employees' accounts of workplace social relationships in the context of a) how the onset of RA affects relationships with employers and co-workers; b) the circumstances in which social support is offered to workers with RA experiencing difficulties performing their

work role; c) whether, and how, the provision of workplace support affects relationships with others.

Method

Study sample and procedure

Following ethical approval from Lancaster University Research Ethics Committee the study was advertised on the website of the National Rheumatoid Arthritis Society (NRAS) with permission from the Chief Executive. Individuals expressing interest in participating were sent a participant information sheet explaining the study's aims, sampling criteria and procedures for ensuring confidentiality and anonymity. Participants who had personal experience of working following onset of RA were selected using purposive sampling. The inclusion criteria were that participants should be of working age (18-65 years) with a diagnosis of RA and in employment when symptoms first appeared (there were no restrictions regarding current employment status). Participants completed and returned their consent form prior to interview. Given that around a quarter of people with RA leave employment within a year of diagnosis, and those that remain in work often experience chronic fatigue, which has a significant impact upon their quality of life and their ability to work (NRAS, 2014b), it is perhaps not surprising that we found it difficult to recruit participants. In all, ten NRAS members met the inclusion criteria and one further participant was recruited via snowball sampling. All those interviewed had experience of working following onset of RA and provided in-depth accounts of their comprehensive interview data on this issue which was relevant to our research, referred to by Malterud, Siersma and Guassora (2016) as "information power". Therefore, in finalising our sample size we focussed on the quality of the information the participants provided, rather than the number of participants recruited for the study. Thus, our final sample consisted of 11

participants who were interviewed by the first author in their homes (n=10) or by telephone (n=1).

In-depth semi-structured interviews, lasting around one hour, were used to explore the employment experiences of participants since RA onset. The interviews followed a topic guide of pre-defined open-ended questions but with sufficient flexibility to allow participants to raise issues they perceived as important. Interviews explored work history since illness onset; the nature of symptoms and whether/how they affect(ed) the completion of work tasks or relationships with employers and colleagues; whether participants were offered modifications to their workplace, tasks or working hours; and factors perceived by participants as important in their maintaining employment (where relevant). Sample questions from the interview guide are shown in Table 1. All participants consented to the interviews being digitally audio-recorded and interviews were transcribed verbatim. Participants were followed-up by email six months after interview for an update on their work situation. Five participants responded and emailed a written update: one participant reported their health was stable with no employment issues, the remaining four participants reported health and employment developments. The follow-up data gave a longitudinal element to the study, and provided data relating to the ongoing employment situation of five participants, and these data were analysed along with the interview data. All participants have been assigned pseudonyms. Our findings relating to the employment experiences of people going to work while ill (sickness presenteeism) are published elsewhere (Authors, 2016).

[Table 1 here.]

Data analysis

The transcribed interviews, and subsequent emailed updates from participants, were analysed using thematic analysis, a method for identifying, organising and analysing textual data into patterns or themes (Braun and Clarke, 2006). The first author coded the printed transcripts manually using highlighters and initially organised the codes into basic themes. Basic themes similar in content and meaning were then further classified into sub-themes. Relationships between codes were highlighted, and data relating to identified sub-themes were collated into separate word-processing documents, to facilitate the identification of over-arching themes. Key themes consisted of data that captured important elements of the participants' work experiences or where several participants raised an issue. Through discussions with the second author, the data coding process and content of the final themes and sub-themes were reflected upon, and reviewed.

We sought to ensure the credibility of the data in a variety of ways: we clarified key issues with participants at interview and follow-up; the second author independently confirmed the themes identified by the first author; and we paid attention to diverging accounts.

Study participants

Nine women and two men were interviewed and participants were white British and born in the UK. Their ages ranged from 32 to 53 years for women (mean age 41), while the two male participants were aged 43 and 58 years. Median time since diagnosis was 3 years (range 1-15 years). Most participants reported experiencing pain, fatigue and periodic flare-ups; only two participants appeared to have good medical control of their symptoms, reflecting the fairly recent diagnosis of RA for most of the sample, with the exception of the oldest participant who had been diagnosed with RA 15 years ago. A profile of the respondents is presented in Table 2.

[Table 2 here.]

Nine of the 11 participants were still employed at the time of interview, one was a home-maker caring for her children, and one had retired early from a nursing career in the National Health Service (NHS) at the age of 46. Of the nine still in paid work, three were on sick leave and keen to return to work as soon as possible, four were working full-time and two part-time. Of the full-time workers, one had become self-employed between diagnosis and interview, while at 6-month follow-up another reported having left their job since interview to become self-employed. Only two participants worked in manual (semi-skilled) occupations: one as a postal worker and the other as a nursery cook. Participants worked in professional/administrative and semi-skilled occupations across the private and public sectors.

Results

Four key themes developed from the data relating to workplace social support: 1) Valuing supportive relationships with co-workers; 2) Employers' support through the provision of workplace modifications; 3) Co-workers' negative reactions to workplace modifications; 4) Withdrawal of employers' support, which are summarised in table 3.

[Table 3 here]

Valuing supportive relationships with co-workers

Participants described the value they gained from social relationships at work. Sometimes this was expressed in terms of the social isolation experienced during spells of sick leave: the desire to avoid isolation (as well as for financial reasons) was a motivation to keep working. Participants who had experienced long-term spells of sick leave spoke of missing their work friends.

All participants reported that their symptoms interfered with their capacity to work to some degree; stiff joints, pain and fatigue made them struggle to complete work tasks as competently as before the onset of RA. However, most participants described their colleagues as providing

instrumental support and helping with physical tasks such as lifting and carrying heavy objects, or with workload in general. In most cases co-workers appeared to do this willingly and sometimes offering support also had tangible benefits for the giver. Clive, a postal worker, described how when unable to walk his round and post letters his 'walk' would be covered by colleagues who saw it as a welcome opportunity to earn overtime. Rachael, a nursery cook, described how the nursery assistants would come into the kitchen to prepare the children's fruit when she could not cut it herself - a mutually agreeable arrangement that provided an opportunity for social interaction.

The willingness of co-workers to offer support appeared to be influenced by how well they knew their colleague before they developed RA. Co-workers were more likely to offer support and understanding when the worker was known well, valued and trusted, as summed up by one participant:

'The ones that I work closely with have been fantastic. I think it's the ones that I don't work as closely with [who are less so] even though I've been very friendly with them over the years.' Sarah, age 33, production planner.

Lisa described how having a good relationship with office colleagues pre-onset of RA not only made them willing to offer her occasional help lifting boxes of stationery, but led her job sharer to provide sustained support by lightening her workload, even though it added to her own:

'.....[I] see her socially so she knows when I'm tired etcetera so she would be more prone to making sure my workload for that week wasn't as much as it could be so she'd work her socks off to make sure that she wasn't leaving me loads to do.' Lisa, age 44, sales co-ordinator.

Conversely, although Dawn had supportive employers the nature of her work environment meant she was unable to develop supportive relationships with her co-workers. In the call centre where she worked desks were not personally allocated so employees did not sit with the same people each day, staff took breaks at different times and rarely had downtime to talk to each other. She stated '*...as much as you chat with [co-workers] I didn't have any friendships at all*'.

For most participants, co-workers appeared willing to help when they had difficulties with work tasks. One contrasting case stands out however. Although some participants expressed feelings of guilt for needing support with work tasks this was described most poignantly by Charlotte, a retired staff nurse, who, when working in the public arena of a hospital ward had visibly struggled when preparing injections or measuring blood pressure and had sometimes asked staff or even patients to help her. Following wrist surgery for tendons damaged by RA, her co-workers had been initially supportive and helped her with tasks she could not do. While Charlotte was on sick leave she had told her colleagues that she was returning to work but '*there will be a lot I won't be able to do.*' [They said] "*Oh come back, we'll help you.*" However, after several weeks, this support was withdrawn:

'.... they soon got fed up of "can you lift this, can you do that" ... I even found that I couldn't lift heavy notes (Patient records)...and people were really off with me...the first week I went back I said to the girl on the desk "I can't lift those heavy notes, I'll get one of the other girls to come and get them" ...I went back again and got another lot of notes and she said [sarcastic tone] "oh, you can lift those can you?" So this is the sort of attitude that you are up against....' Charlotte, age 53, retired staff nurse.

Her co-workers' withdrawal of support, in addition to the unwillingness or inability of her employers to offer her a less physical role, led Charlotte to take involuntary early retirement from nursing at age 46.

Employers' support through the provision of workplace modifications

All participants employed when their first symptoms appeared described taking an active role in trying to stay in work. Those experiencing a period of sick leave after RA onset liaised with their employers and (in larger companies) occupational health services concerning their return to work, some recommencing through a phased return. In addition, all participants had to make changes to the way they worked. The employers of all participants appeared willing to implement at least some workplace modifications. In general, participants in larger companies were assessed by occupational health personnel who recommended modifications to equipment or working hours. Participants working in smaller organizations made direct requests to their employer for modifications. Costs of some specialist equipment (for example, adjustable chairs and desks, modified computer keyboards and mice, voice recognition software to help with typing) could be claimed back by the organization from the UK government's *Access to Work*² scheme.

The willingness of employers to implement modifications to their work or working conditions was crucial in enabling participants to remain working. Some organizations, such as the NHS, had policies and guidelines in place to support workers with chronic conditions. However, whether and how those policies were implemented depended on the individual's manager. For example, one participant requested special leave for hospital appointments, which he felt he

² *Access to Work* is a UK government scheme to support people in work with a disability or chronic health condition. The scheme provides funding towards costs of special or adapted equipment, workplace adaptations, personal assistance and travel to work.

was entitled to according to the organizational policy, but was turned down by his manager: *'whilst that was a Trust policy my immediate line manager certainly had other ideas about what actually should happen'* (Martin, 58, NHS medical instructor). It appeared that managerial support was partly influenced by their knowledge or personal experience of RA or similar chronic conditions. For example, Clive, a postal worker, reported that his manager had gout and so felt he was more sympathetic to his difficulties posting letters and had reassigned him to indoor tasks when necessary. Dawn, employed as an NHS call-centre advisor at the time of her diagnosis, recalled that one manager's personal knowledge of RA led her to offer her emotional support. Sarah worked in a small organisation and described how her supervisor educated other managers about the difficulties she was experiencing completing work tasks because he was personally aware of arthritis as his sister had a similar condition. Finally, Rachael's manager revealed that her mother also had RA and therefore understood the difficulties it imposed. Thus, when the nursery she worked in moved into new premises the removal of the original kitchen gave the manager the opportunity to redesign her workspace to accommodate Rachael's needs, *'because she said 'I want you to stay working for me''*:

'I got [the builder] to put the shelves at a height where I don't have to reach up; he put taps on that I just do that to [motions], I don't have to twist the taps. They got a big tin opener that I can turn with my hand and not with my fingers, they did think of a lot of things for me. And they put the toilet right next door so I've not got to go upstairs...everything is at a nice level for me; I'm not bending down. They even put the cooker on stilts so it was higher up.' Rachael, age 46, nursery cook.

Sometimes an employer's previous experience of accommodating a chronically ill or disabled employee appeared to smooth the way. Sarah and Suzanne offered examples of how co-workers with disabilities in their organization had previously been supported by their managers

through workplace modifications and this reassured them the organization would continue their own support of them in the future.

Some participants whose employers had accommodated requested changes referred to the length of their relationship with their manager or the importance of their reputation as a hard worker as reasons for receiving support. Sarah had kept up-to-date with her computer training and could complete tasks faster than her colleagues, despite having RA. Another participant expressed relief, and surprise, that she had kept her job while other colleagues had been made redundant; she perceived that her good reputation, long service and excellent sickness absence record had outweighed any concerns the organization may have had about her health:

'We had to all be re-interviewed for the positions that were available...I really did think to myself I am going to be fighting here for my job because they know I've got a chronic illness...but they judged me on the merits of...my work ethic' Lisa, age 44, sales co-ordinator.

Co-workers' negative reactions to work modifications

Whilst workplace modifications supported participants to stay in work, in some cases modifications negatively affected relationships with colleagues. Co-workers often did not understand why their colleague had been given specialist equipment or modified hours or working conditions and this could result in negative reactions. Sarah, on sick leave at the time of interview, found her co-workers had resented her leaving work early or arriving late because of pain and fatigue, despite her supervisors allowing her to only work as many hours as she felt able:

'... the only place I have got a bit of stick about it is other people, colleagues who are like "it's unfair that they are not getting", "I am tired why can't I go home?" comments

like that. Another one was “I’ve got an in-growing toenail and I’m in pain so why can’t I go home” silly comments like that which did get to me a bit at first but then I just thought “well stuff them”. Sarah, age 33, production planner.

Resentment could also arise when specialist equipment was provided to make work easier. After her diagnosis, Mandy, a call-centre administrator, was given an ergonomic keyboard and mouse and voice recognition software through *Access to Work*. However, she often came into work to find that the chair, which had been set to her specific needs, had been adjusted. She stated that her co-workers’ behaviour escalated to bullying; when colleagues posted her photograph and personal comments about her on a social networking website she raised a formal grievance and started tribunal proceedings. This experience and the subsequent investigation led to Mandy being signed off work again with work-related stress, which in turn worsened her condition (*‘at the moment my blood tests are very high all the time’*). Jackie, a hospital pharmacist, also experienced negative reactions from co-workers after she had been given her own computer chair and terminal to ease her spinal pain while her colleagues had to hot-desk. She surmised that the invisibility of RA was the root of the problem:

‘...some have been like “oh, why have they given you a chair? I am going to put my backside on it even though it’s your chair”, the attitude does vary quite considerably really. I have experienced some degree of bullying actually [and] some intimidation from some of the other colleagues...they resent the fact that I’ve got my own chair, it’s pathetic’ Jackie, age 46, pharmacy technician.

Most respondents also referred to the difficulties posed by the invisibility of symptoms; like Jackie, some perceived their invisible and fluctuating symptoms explained others’ lack of

understanding. Several spoke of the difficulty of trying to explain to others they felt ill but looked fine on the surface:

'You wonder if people believe you sometimes, 'cause I'll go back to work the next day after having wrist problems and [they'll say] "your wrists aren't swollen", well they don't swell up in a comedy style way; it's just noticeable to me, they feel hot and I can't move them'. Suzanne, age 38, administrator.

Fatigue, a common (and invisible) symptom of RA, was cited by most participants as more problematic than their pain or stiffness, using terms such as *'absolutely horrendous'*, *'you just feel like a zombie'* and being *'unplugged, you have no energy'* to describe the all-pervasive exhaustion associated with periods when the disease is active. Sleeping did little to ease the feeling of fatigue and colleagues and other people often found it hard to understand the difficulty it posed. The problems caused by invisible symptoms led some participants to remark on how work life might be easier for them if their illness was more visible. Martin, a medical instructor, felt that having a limp would make him feel less *'fraudulent...that I have actually got something'*. Lisa contrasted how she was sometimes treated at work dealing with the invisible symptoms of her RA with the way she was helped after hurting her knee in a fall:

'...when I went back [to work] I was still strapped up [and had] two crutches. Now I actually felt better then, with just that knee injury, than I probably do some days generally, but yet people couldn't do enough for me because I had two crutches...it was quite an eye-opener really 'cause "I'll help you", "let me get the door"...it was such a marked difference....' Lisa, age 44, sales co-ordinator.

Withdrawal of employers' support

While most participants were granted the workplace modifications they requested, some arrangements were short-lived. All participants who requested reduced hours or a later start in the day were at least initially granted these changes by their employers. However, Charlotte, a former NHS nurse had negotiated to reduce her hours yet found in practice this was hard to keep to without line manager support. When Charlotte's department introduced Saturday morning clinics she refused to take on this extra work as it exceeded her negotiated hours, resulting in her manager being *'really off with me'*:

'She asked me in front of [the consultant and other staff] would I do this clinic and I said "I'm sorry but I'm not doing it; I have negotiated these hours and that's it, I am digging my heels in and I'm not doing it" and she didn't speak to me for two weeks, it was horrible, the most horrible atmosphere to work in' Charlotte, age 46, retired nurse.

The agreement to reduce Charlotte's working hours became inconvenient when new clinics were introduced and her refusal to increase them caused conflict with management. Sarah, an office worker, also found her employers withdrew previously agreed workplace modifications. While on sick leave her supervisor had asked if she could do some spreadsheet work at home on a laptop, which she welcomed, as working flexibly around her symptoms kept her occupied and feeling productive. However, in a follow-up email six months after her initial interview for the study, Sarah stated that the homeworking arrangement had been withdrawn by her supervisor *"as there was a bit of jealousy from other workers so they put a stop to that"*. Sarah's initially supportive supervisors also withdrew their agreement that she could work flexibly around her pain and fatigue when it became apparent this arrangement might be needed long-term. In her email she expressed disappointment that a new medication had failed to bring her symptoms under control and that her *'employers are saying if I can't commit to more than two hours a day then they want to change my contract to only work two hours a day'*, which she could not afford to do financially.

Discussion

Most research on workplace social support has been limited to healthy populations or workers with acute health conditions. Less is known about workplace social support for people with fluctuating chronic health conditions who may have long-term variable support needs. The findings from this qualitative study expand social support theory by exploring the impact of RA, a chronic, inflammatory and progressive health condition, upon established workplace relationships. This is an important area of research, given that the proportion of workers with chronic health conditions is expected to rise (Shaw et al., 2013) and Human Resource (HR) professionals will have to ensure that organizations support and manage these workers. Supervisors and co-workers play a key role in supporting individuals with health conditions or disabilities, yet employers rarely involve them in the provision of adjustments or return-to-work processes (Williams-Whitt et al., 2016) and their contribution is seldom acknowledged. However, there is often the expectation that co-workers must change their day-to-day work routines to accommodate workers with health conditions or disabilities (Dunstan and MacEachen, 2013). Our findings provide new understanding for HR professionals of the vital role employers and co-workers play in supporting workers with chronic conditions and the circumstances whereby sustained support to workers with chronic conditions is given and withdrawn.

Although the participants in this study required sustained instrumental support, some reported that colleagues who worked closely with them were more willing to provide long-term instrumental support, even though it increased their own workload, than members of the wider team, echoing results from studies of return-to-work after injury (e.g Lysaght and Larmour-Trode, 2008; Dunstan and MacEachen, 2013). However, not all employees have good pre-

existing relationships with colleagues. In our study for example, Dawn's experience of working in a 'hot-desking' work environment made it difficult for her to form friendships with colleagues. Within the broader workforce, social exchange theory emphasises the importance of reciprocal support for positive work relationships (Molm et al., 1999; Cropanzano and Mitchell, 2005). However, as outlined above, if co-workers feel that they are giving more support than they are receiving in return, providing support can become burdensome. Certainly, for most study participants the colleagues who provided support simply added to their own workload, rather than being part of 'reciprocal exchanges'. This additional workload, and the realisation that such support would be required long-term, is likely to have influenced Charlotte's nursing colleagues to withdraw their support after only two months. This echoes research by Dunstan and MacEachen (2013), who found that sympathy for workers returning to work declined when support was needed for more than two weeks. Thus, our findings indicate the greater vulnerability of workers who experience a long-term illness, particularly those requiring co-worker social support for the duration of their employment, and those who are unable to rely on pre-existing relationships with others because they are new to the organization.

Employers' implementation of workplace modifications is crucial to support work retention for employees with RA (Codd et al., 2010; Holland and Collins, 2016; Holland and Clayton, 2018). In this study workplace modifications and flexible working arrangements, were, at least initially, made available to participants. A key point here is that for our participants such arrangements were either a requirement by the Equality Act 2010 or were common work-life balance arrangements (such as flexible working hours, reduced hours or the ability to work from home) which all employees have the legal right to request (Tipping, Chanfreau, Perry and Tait, 2012). Our analysis, however, reveals that workers with RA perceive that the invisibility

of their disability played a key role in causing resentment and friction with co-workers when workplace modifications were provided but the rationale for their implementation was not understood. Thus, our findings extend the work of previous authors who noted that invisible disabilities elicit less compassion and acceptance than more visible conditions, and that employers and co-workers may be less willing to assist and support employees with invisible disabilities (Holloway et al., 2007; Gewurtz and Kirsh, 2009).

Previous research suggests that negative social exchange can occur when co-workers blame the accommodated person for their advantage rather than the organisation or supervisor who may have provided the advantage (Cohen-Charash and Mueller, 2007). In this study, it would appear that in providing workplace modifications or special equipment the organisation had unwittingly set the individual apart from their peers, causing envy amongst co-workers. As Cropanzano, Anthony, Daniels and Hall (2017) point out, poor social exchanges can arise from negative initiating behaviours such as incivility or bullying, to which the recipient may then respond with positive or negative behaviour in response. However, our analysis suggests that the provision of workplace modifications may also act as an initiating behaviour for poor social exchange relationships which, for one participant, led to their being bullied, and for another the withdrawal of their homeworking arrangement. Managers are key agents in the social exchange process who can influence the quality of relationships between co-workers (Sherony and Green, 2002) but may also unintentionally cause difficulties between co-workers by treating an employee differently (Cohen-Charash and Mueller, 2007). In this study although some organizations had policies and guidelines in place to support workers with chronic conditions, their implementation often depended upon the manager's interpretation. Thus our findings highlight that although devising policies is important, how they are implemented in the workplace is also key. As Cropanzano et al (2017:2017) point out, fairness can be seen as

‘trickling’ down through the organisational layers, and if managers treat subordinates fairly it can lead to a “beneficial cycle” which promotes a supportive workplace and ultimately more positive social exchanges. Therefore, our analysis highlights that although organizations are required by law to make reasonable adjustments for people with disabilities, their introduction needs careful managing. Withdrawing workplace modifications and working arrangements if they upset co-workers or become inconvenient to the organization is potentially problematic for both workers with chronic conditions and their organizations because employees may not receive the workplace adjustments they are legally entitled to. This can lead to grievances being lodged by the employee or legal action, which could cost the organization both financially and in terms of reputation.

Our findings have implications for the UK policy initiatives outlined above which promote the role of employers in encouraging job retention and early return-to-work from sickness absence through workplace adjustments (Black, 2008; DWP 2015a,b). Although workplace adjustments are introduced by employers, they often rely upon the goodwill of co-workers to provide social support to succeed. Despite supervisors and co-workers being an important element in the success of return-to-work plans they are not generally included in the planning process, although research by Dunstan and MacEachen (2013) suggests a more positive outcome if they are. Indeed, our findings suggest that the success of workplace adjustments can potentially be undermined if social support is withheld or withdrawn by colleagues. However, in the UK, employers must not disclose an employee’s disability unless the individual gives permission for it to be shared with colleagues (ACAS, 2017). Thus the employee’s right to privacy and confidentiality in the workplace make it difficult to include supervisors and co-workers in interventions and return-to-work processes.

While the privacy of an individual requiring workplace modifications needs to be respected, however, there is a danger that introducing such measures without discussion may work against the recipient, especially for those with invisible disabilities. Although Molm et al., (1999) suggest implicit support exchanges produce more trusting relationships than those characterised by formally negotiated exchanges, formal support arrangements are likely to be more beneficial to workers with invisible chronic conditions or disabilities and their co-workers. In the UK, the Health and Safety Executive (HSE) (2004) suggests organisations should promote a culture of understanding and tolerance around disability and health conditions generally, which would encourage an environment of support for employees with either short-term illnesses or chronic conditions without breaking confidentiality. If employers acknowledge, reward and value a group culture of social support and teamwork, workers are more likely to help each other to meet organizational goals (Lysaght and Larmour-Trode, 2008; Dunstan and MacEachen, 2013). Certainly, our analysis suggests that organisations cannot rely on employees to help co-workers with RA through discretionary prosocial behaviours that are not formally recognised or rewarded. Rather, our findings highlight the importance of organizations implementing a more formal support system rather than expecting social support to develop on an ad-hoc basis, in order to spread support provision across a wider group of employees and prevent the onus being put on colleagues who have a close working relationship with the individual.

This exploratory study produced in-depth accounts from respondents on the impact that RA had on their workplace relationships. The sample contained more women than men, reflecting the epidemiology of RA. Previous studies indicate that experiences of social support are gendered. Traditional gender roles may make it easier for women to seek and offer social support than men (Barbee et al., 1993) and women tend to perceive receiving greater levels of

social support from colleagues compared to men (Sloan, Newhouse and Thompson, 2013). The majority of our study sample were women and they offered narratives of social support being offered, as well as support being withheld or withdrawn. Literature regarding the gendered experiences of workplace social support would imply that, if men find it harder to seek support and perceive lower levels of support at work, it is possible we would have encountered more negative perspectives on the availability of social support among a larger sample of men with RA. Further research exploring the social support experiences of men with chronic conditions is needed to explore this.

The transferability of our findings to other contexts may be limited. In our study most participants were recruited through an online discussion group on employment issues hosted on the NRAS website. Although NRAS is the only UK charity dedicated to supporting people with RA, recruiting in this way will have excluded individuals with RA not familiar with NRAS and those who are not internet users. Rates of work disability are high after onset of RA but it is possible that our sample were experiencing more employment difficulties than other people with RA who were not users of the site, and this should be taken into account when considering the results.

Following Malterud, et al's (2016) concept of "information power" we consider that the sample size was large enough to provide sufficient "information power" given the high specificity of the sample to the aims of the study, the first author's experience as an interviewer, and the 'strong dialogue' (Malterud *et al*, 2016) gained during interviews with participants who were able to clearly articulate their workplace experiences at length. In addition, participants represented sedentary and manual occupations from the private and public sectors and from organizations varying in size and yet reported similar experiences, despite the different

organizational contexts. Thus our findings provide valuable insights into the workplace social support of employees with the fluctuating chronic condition of RA.

Conclusion and future research agenda

This study has provided insights into the role of workplace social support in helping employees with chronic health conditions remain in work. Our study highlights the pivotal role co-workers play in supporting employees with RA, who are often reliant on the goodwill of core co-workers. However, we found that the introduction of workplace adjustments can negatively affect social relationships. Furthermore, we found there was also a risk that co-workers may undermine organisational support by voicing their resentment towards workplace modifications and adjustments. This aspect of workplace social support is worthy of further study as our research findings suggest respondents with chronic conditions who received social support from colleagues and supervisors were more likely to remain in work. In particular, it would be useful for future research to explore what organisational conditions promote supportive and unsupportive social behaviours towards co-workers given workplace adjustments. Such future research would be enhanced by differentiating between visible and invisible chronic conditions to explore how this influences social exchange relationships, and the social support of workers with such conditions. Furthermore, by adopting a longitudinal approach, further research would help to inform organisational policies and procedures in terms of the retention of employees with chronic conditions over time, as our findings suggest instrumental and social support from managers and co-workers can be short-lived.

Our findings also suggest that a manager's previous knowledge of RA or similar chronic health conditions influences how they support employees with these conditions, which has implications for how they interpret HR policy around return-to-work and workplace modifications. Previous research has highlighted the role of training for managers to help

promote a supportive workplace (Cropanzano et al., 2017) and our work suggests that future research should explore this aspect further for workers with chronic conditions. Potential areas for further research and training development include what level of knowledge about chronic health conditions is appropriate for each level of supervisory staff, how to engage and communicate with staff about chronic conditions that may be invisible and the role of fairness when introducing organisational policies and workplace modifications for staff with chronic conditions.

Given the importance of supervisory and co-worker support for workers with chronic health conditions, our findings suggest that formal initiatives are needed to facilitate the development and maintenance of supportive relationships for employees with RA. Formal initiatives which promote general understanding and empathy of chronic conditions through workforce education and training will help to promote acceptance of workplace adjustments and flexible working, thereby reducing conflict. In addition, initiatives which facilitate a culture of social support and teamwork will help to widen support so that key co-workers are not overburdened. Future research should explore the influence of such initiatives in promoting social support towards co-workers with chronic conditions. A longitudinal approach could also explore whether such initiatives sustain workplace support over time and facilitate staff retention. In the UK context, the government's *Access to Work* service provides disability awareness training for the employers and colleagues of disabled workers (GOV.UK, 2015), and the Health and Safety Executive (2009) provides guidance on how organizations can promote health, well-being and productivity by implementing policies that encourage social support. These may be useful starting points for organizations seeking to implement policies and practices that facilitate a supportive work culture.

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Table 1 Sample Interview Questions

<p>Can you describe to me how your illness started? When they first started how did your symptoms affect your daily life? Were you employed when you first experienced these symptoms? If yes: What was your occupation? What did your duties/responsibilities include? Full or part time? Did you tell your employer about your symptoms/diagnosis? If yes, what was their reaction? Did you continue to work at this time? How did your symptoms affect you at work? Did your employer try to accommodate your illness? Probe: duties/responsibilities; workload; hours of work; pace of work; travel to work Did these alterations occur because you asked for them, or because your employer offered them themselves? Did these alterations help you continue to work? What was your colleagues' reaction to the modifications/alterations? Have your colleagues been supportive of you at work? If so, how? Did your GP make any recommendations about your work?</p>
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Table 2. Participants' details

Pseudonym	Age	Marital status	Time since diagnosis	AT DIAGNOSIS		AT INTERVIEW	
				Occupation (public/private sector)	Full- or part-time	Employment status	Full- or part-time
Charlotte	53	Married, 2 children at home	15 years	Hospital staff nurse (public sector)	PT	Ill-health retirement aged 46	N/A
Amy	32	Partner, 2 children at home	3.5 years	Nursery assistant (private sector)	FT	Looks after family & home	N/A
Sarah	33	Lives with parents	18 months	Production planner (private sector)	FT	No change	PT; on sick leave
Dawn	40	Married, 2 children at home	3.5 years	Health advisor (public sector)	PT	Self-employed company director (private sector)	FT
Jackie	46	Single	14 months	Pharmacy technician (public sector)	FT	No change	PT; on sick leave
Rachael	46	Married, 1 child at home	3 years	Nursery cook (private sector)	PT	No change	PT
Mandy	34	Single	1 year	Call-centre administrator (public sector)	FT	No change	PT; on sick leave
Martin	58	Married	3.5 years	Medical instructor (public sector)	FT	No change	FT
Suzanne	38	Married	18 months	Administrator (private sector)	FT	Employed in same occupation	FT
Clive	43	Married, 1 child at home	18 months	Postal worker (private sector)	FT	No change	FT
Lisa	44	Married, 2 children at home	3 years	Sales co-ordinator (private sector)	PT	No change	PT

Table 3 Number of respondents who identified with themes and sub-themes from the interview data

Themes and sub-themes	Number (%)
Relationships with co-workers	10 (91)
Experiences of positive support	8 (72)
Unsupportive relationships	5 (45)
No co-worker support	2 (18)
Co-worker support withdrawn	1 (9)
Workplace adjustments and modifications	10 (91)
Changes to work environment/specialist equipment	6 (54)
Modified duties/responsibilities	4 (36)
Working from home	2 (18)
Temporal flexibility	2 (18)
Reduced hours of work	3 (27)
Co-worker reactions to work modifications	10 (91)
Supportive	2 (18)
Invisibility of symptoms	9 (81)
Modifications resented	6 (54)
Withdrawal of Employer support (due to co-workers reaction or disruption of work flow)	5 (45)

Note: Themes and sub-themes developed from the interview data. The second column indicates the number and percentage of respondents who shared the theme. Respondents shared across more than one sub-theme.

