

Psychosocial Semiotics: The Specific Paradigm of Work Rehabilitation **Semiótica Psicosocial: O Paradigma Específico da Reabilitação do Trabalho**

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Abstract: *In his semiotic analysis of the medical diagnosis with a biopsychosocial approach of disease and illness, de Silveira indicates that when analysing observed signs "conflicts may result due to the fact that all health care providers do not share the same values or the same language than the patients and their relatives" [free translation]. In the field of work disability prevention and rehabilitation, the presence of multiple stakeholders makes an even more complicated case. Work disability prevention and rehabilitation addresses the problem of persons not returning to work after an illness or accident. They adopt a new behaviour including pain exacerbation, activity withdrawal, often depressive symptoms and social isolation. These persons have poor health indicators and generate considerable costs from compensation, treatments (direct costs) and work disorganisation (indirect costs). Recent advances in this field have shown that disability predictors differ from disease causes and are related to the complex system surrounding work absenteeism and including the workplace (employers and unions), the insurance system and the healthcare system. Multiple stakeholders from this complex system observe the signs generated by the patient/worker and the situation generated by the disability process and analyse these signs through their grid of analysis which depends on their specific objectives and their knowledge and culture. For example, the physician attentive to the signs of pain, will try, by the means of ordering multiple tests or specialized consultations, to find and cure a specific disease, even if this "disease" is simply the result of natural degenerative changes due to ageing. This will result in reinforcing in the patient's mind that he/she may be affected by a severe disorder (that "nobody finds ..."), enhance fears of resuming activity including work, and perpetuating the disability process. Simultaneously, the employer, knowing that the worker looks to have normal activities at home, may consider this pain as simulated, also considers the economic losses and work disorganisation due to the worker's absence, and appeals the validity of this absence. This leads to legal actions that will reinforce the worker's fears, introduce frustration and sense of denial of justice, also contributing to perpetuating the disability process. In this system, multiple stakeholders have their word to say on the diagnosis and management of the disability and act with their own interpretation and comprehension of the disability. The patient/worker is exposed to these conflicting opinions and actions, due to a diverse interpretation of the same signs, or to a biased observation of different signs, and gets lost from this complex situation. Activity withdrawal is the result of this misunderstanding of this complexity. Interpretation of signs is obviously more important than the signs themselves and may severely impact on human beings behaviour. This includes important social and ethical issues.*

Keywords: *Psychosocial semiotics. Work rehabilitation. Signs. Disability diagnosis.*

Resumo: Nesta análise semiótica do diagnóstico médico através de uma abordagem biopsicosocial da doença e enfermidade, de Silveira indica que quando analisando signos observados "conflitos podem resultar devido ao fato que todos aqueles que são responsáveis pela saúde não compartilham dos mesmos valores ou da mesma linguagem que os pacientes e seus parentes" (tradução livre). Na área do trabalho de prevenção de invalidez e reabilitação, a presença de múltiplos "apostadores" ("stakeholders") torna o caso muito mais complexo. O trabalho em prol da prevenção de invalidez e reabilitação trata do problema de pessoas que não retornam ao trabalho após enfermidade ou acidente. Elas adotam um novo comportamento incluindo exacerbação de dor, retraimento da atividade, freqüentemente revelando sintomas depressivos e isolamento social. Estas pessoas têm pobres indicadores de saúde e geram custos consideráveis em termos de compensação, tratamento (custos diretos) e desorganização do trabalho (custos indiretos). Dados recentes nesta área mostraram que previsores de invalidez ("disability predictors") diferem das causas de doenças e estão relacionados ao sistema complexo que gravita em torno do absentismo no trabalho, incluem o próprio local de trabalho (empregados e sindicatos), o sistema de seguro e o sistema de saúde. Múltiplos "apostadores" deste sistema complexo observam os sinais

gerados pelo paciente/trabalhador e a situação gerada pelo processo de invalidez e analisam estes sinais através de sua grade de análise ("grid of analysis"), que depende de seus objetivos específicos e de seu conhecimento e cultura. Por exemplo, o médico atento aos sinais de dor, tentará, através da solicitação de uma bateria de exames ou consultas a especialistas, encontrar e curar uma doença específica, mesmo que esta "doença" seja simplesmente o resultado de mudanças degenerativas naturais devido ao envelhecimento. Isto resultará no reforço, na mente do paciente, de que ele/ela pode estar acometido por uma terrível doença (que "ninguém descobriu..."), favorecerá temores quanto à retomada das atividades, incluindo o trabalho, perpetuando, assim, o processo de invalidez. Por sua vez, o empregador, sabendo que o trabalhador parece estar realizando atividades normais em casa, poderá achar que o mesmo está a dissimular a tal dor, leva em consideração perdas econômicas e a desorganização do trabalho devido à ausência do trabalhador, e apela baseado nesta ausência. Isto leva a ações legais que reforçará os temores do trabalhador, introduzindo frustração e um sentimento de falta de justiça, o que contribui, também, para a perpetuação do processo de invalidez. Neste sistema, múltiplos "apostadores" têm algo a dizer a respeito do diagnóstico e gerenciamento da invalidez e agem a partir de sua própria interpretação e compreensão da mesma. O paciente/trabalhador está exposto a estas opiniões e ações conflituosas devido à diversidade de interpretações do mesmo signo ou, a uma observação preconceituosa de diferentes sinais e, perde-se em tal complexidade. Retraimento da atividade é o resultado deste mau entendimento desta complexidade. A interpretação de signos é, obviamente, mais importante que os próprios sinais e podem ter um impacto tremendo no comportamento dos seres humanos. Isto inclui importantes questões de ordem social e ética.

Palavras-chave: Semiótica psicosocial. Reabilitação no trabalho. Signos. Diagnóstico de invalidez.

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In his semiotic analysis of the medical diagnosis with a biopsychosocial approach of disease and illness, Barbosa de Silveira indicates that when analysing observed signs "conflicts may result due to the fact that all health care providers do not share the same values or the same language than the patients and their relatives" [free translation] (SILVEIRA, 2005). In the field of work disability prevention and rehabilitation, the presence of multiple stakeholders makes an even more complicated case.

Work disability prevention and rehabilitation addresses the problem of persons not returning to work after an illness or accident. As work is a survival need for most human beings and a highly ranked value in many societies, work disability is a tragedy that has been generally misinterpreted for centuries. Those who were not able to work were formerly dependant of family support or public charity whose modern expression in many countries is government welfare. The modern trend to help work disabled people has been financial compensation of wages, at a level that may considerably vary from a country or state to another. However, this financial compensation does not compensate for the loss of feeling of being useful and the social role of being a worker. Work disability is not only an individual problem, it is also an economic burden and modern societies spill an important part of their resources to pay for the consequences of this problem. For example, the International Labour Organization estimated that the overall economic losses resulting from work-related disease and injuries represent 4% of the world's gross national product (WORLD HEALTH ORGANIZATION, 1999). This productivity loss resulting from poor employee health and/or work disability is a major concern to workers, employers, policy makers, insurers, and occupational healthcare specialists. Although the burden of work disability is substantial, a large part is preventable and could be avoided through management changes that bring together the various multiple actors involved in the work disability process.

Until recently, when someone declared that he/she was unable to work due to a disease or an accident, it was thought that by directly addressing and curing the disorder the disability would disappear and normal work might be resumed. The cases of failure of this approach were considered very severe and leading to definitive work disability, symptom amplification or even malingering. Recent research has shown a very different picture of the problem. In fact, epidemiological studies have shown that the largest part of the disability was explained by determinants NOT related to the original medical disorder (TURNER, FRANKLIN, & TURK, 2000; WADDELL, BURTON, & MAIN, 2003). Instead, they were related to psychosocial and environmental factors such as fears of the condition, difficulties encountered in the workplace or failure of the stakeholders in the work disability problem to have a common attitude towards the management of the disability episode (FRANK et al., 1998). For example, when a worker is absent from work, he/she adopts a new behaviour including pain exacerbation, activity withdrawal, often depressive symptoms and social isolation. This person has poor health indicators and generates considerable costs from compensation, treatments (direct costs) and work disorganisation (indirect costs).

Recent advances in this field have shown that disability predictors differ from disease causes and are related to the complex system surrounding work absenteeism and including the workplace (employers and unions), the insurance system and the healthcare system (LOISEL et al., 2001). This emerging evidence has led to a shift of conceptual models from the classical biomedical model to the biopsychosocial models (WADDELL, 1992) and even person-environment models (LOISEL et al., 2001). In fact, the biomedical paradigm holds that symptoms and disability are related to biological pathology. Therefore, the elimination of pathological causes should result in cure or improvement (SCHULTZ, CROOK, FRASER, & JOY, 2000). However, this paradigm cannot be applied to work-related disorders since various factors other than the initial biological pathology are involved, exacerbate the pain and make returning to work a difficult and fearful experience. In other words, the return to work will depend on the complex interaction of biological (e.g. medical status, physical capacity), psychological (e.g. fear, anxiety) and social (e.g. work environment, family) factors. These factors are mediated by a specific kind of language that may either help or impede the return to work process. The biopsychosocial and person-environment models bring a new approach and allow to consider the evolution of the disability process in a similar way for various disorders (musculoskeletal, mental health, etc.) and to look for the causes and solutions not only close to the language of the subject but also to the language used by the people from his/her environment (workplace, healthcare, compensation system).

The process of returning a disabled worker to work presents numerous challenges to the employees, employers, health care providers, and insurers. It is essential that all parties work together to achieve a common representation of the determinants of what would be for the different parties involved a safe and sustainable return to work. The multiple stakeholders from this complex system observe the signs generated by the patient/worker and the situation generated by the disability process and analyse these signs through their grid of analysis, which depends on their specific objectives and their knowledge and culture. Healthcare providers have disciplinary knowledge and codes and keep on addressing directly the disease and consequently miss most of the determinants of the disability problem. For example, the physician attentive to the signs of pain will try, by the means of ordering multiple tests or specialized consultations, to find and cure a specific disease, even if this “disease” is simply the result of natural degenerative changes due to ageing. The resulting language and interpretation will result in reinforcing in the patient’s mind that he/she may be affected by a

severe disorder (that “nobody finds ...”), enhance fears of resuming activity including work, and perpetuating the disability process. Simultaneously, the employer, using different knowledge and codes and knowing that the worker looks to have normal activities at home, may consider this pain as simulated. He may also consider the economic losses and work disorganisation due to the worker’s absence, and appeal the validity of this absence. This leads to legal speeches that will reinforce the worker’s fears, introduce frustration and sense of denial of justice. In this way the language used contributes to perpetuating the disability process.

In this system, multiple stakeholders have an important influence on the diagnosis and management of the disability and act with their own interpretation and comprehension of the disability. The patient/worker is exposed to these conflicting opinions and actions, due to a diverse interpretation of the same signs, or to a biased observation of different signs, and gets lost from this complex situation. Activity withdrawal is the result of this misunderstanding of this complexity. Interpretation of signs is obviously more important than the signs themselves and may severely impact on human beings behaviour. This includes important social and ethical issues because sometimes this interpretation tends to reduce the worker to a passive object lost inside a complex system.

In most countries, little information flows between the different systems for many reasons, practical, financial and even ethical. Some of them are: busy practice of doctors allowing little time for patient’s reassurance and communication with employers; different values of these stakeholders (healing versus maintaining productivity); protection of patient information limiting transit of information from treating physicians to occupational physicians; payment for medical and not for occupational interventions, and other possible factors. Successful intervention of the rehabilitation team can be reached by recognizing the discrepancy between the different systems (workplace and medical system) and establishing the communication by allowing circulation of information.

Addressing work disability directly (instead of addressing it though a disease) is very far from common practice Evidence in work disability prevention indicates that most isolated treatments are ineffective returning workers at work, that complete and definitive healing is often impossible, and that most people function with some degree of pain (WADDELL, 1998). Also, successful intervention studies have used an approach of disability prevention through patient’s reassurance and interventions linked to the workplace, instead of using a medical model of pain treatment. We have shown that bringing together in a same team a physician, an occupational therapist, an ergonomist, a kinesiologist and a psychologist, sharing the same common disability paradigm, vision of safe and sustainable return to work and work rehabilitation values (LOISEL et al., 2005) has allowed to explain the reality of the situation to the worker, the employer and the physician in their own language. In fact, it is building a common meaning for all parties involved. This has led to worker’s reassurance, return to fitness and appropriate recognition by his employer with the consequence of immediate return to work and resumption of his worker’s role. This common meaning tends to encourage autonomy and restore the integrity of the person able to resume an appropriate, productive and pleasant functioning in the workplace.

Restoring integrity and role of the working human being needs the building of a common understanding and wording. Sharing this meaning should be an effort included in the dialogue of all stakeholders, from the intimacy of the patient physician encounter to the community of all the parties involved. This complex social system that may create work

disability will restore work ability in a humanistic way by sharing the meaning of the signs.

References

- SILVEIRA, L. F. Barbosa da (2005). "Semiotic Analysis of Medical Diagnosis". In: *Cognitio*, 6 (1), 94- 101.
- FRANK, J, SINCLAIR, S., HOGGJOHNSON, S., BOMBARDIER, C., BEATON, D., et al. "Preventing Disability From Work-Related Low-Back Pain – new evidence gives new hope – if we can just get all the players onside". In: *Cmaj*, 158 (12), 1625-1631.
- LOISEL, P., DURAND, M.J, BERTHELETTE, D., VEZINA, N., BARIL, R., GAGNON, D., et al. (2001). "Disability Prevention – new paradigm for the management of occupational back pain". In: *Disease Management & Health Outcomes*, 9 (7), 351-360.
- LOISEL, P., FALARDEAU, M., BARIL, R., JOSE-DURAND, M., LANGLEY, A., SAUVE, S. (2005). "The Values underlying team decision-making in work rehabilitation for musculoskeletal disorders". In: *Disability & Rehabilitation*, 27 (10), 561-569.
- SCHULTZ, I. Z., CROOK, J., FRASER, K., & JOY, P. W. (2000). "Models of diagnosis and rehabilitation in musculoskeletal pain-related occupational disability". In: *Journal of Occupational Rehabilitation*, 10 (4), 271-293.
- TURNER, J.A., FRANKLIN, G., & TURK, D.C. (2000). "Predictors of chronic disability in injured workers: a systematic literature synthesis". In: *American Journal of Industrial Medicine*, 38, 707-722.
- WADELL, G. (1992). "Biopsychosocial analysis of low back pain". In: *Baillieres Clinical Rheumatology*, 6 (3), 523-557.
- _____ (1998). *The Back Pain Revolution*. Edinburg: Churchill Livingstone.
- _____, BURTON, A.K., & MAIN, C.J. (2003). *Screening To Identify People At Risk Of Long-term Incapacity For Work*. The Royal Society of Medicine Press Limited.
- WORLD HEALTH ORGANIZATION (June 1999). Fact sheet No. 84. Occupational Health: Ethically correct, economically sound. Retrieved 23-07, 2003, from <http://www.who.org/inf-fs/en/fact084.html>