
Article:
Nielsen, K. and Yarker, J. (2024) "It's a rollercoaster": The recovery and return-to-work experiences of workers with long COVID. Work & Stress, 38 (2). pp. 202-230. ISSN: 0267-8373

https://doi.org/10.1080/02678373.2023.2286654

Routledge
Taylor & Francis Group

Work & Stress

An International Journal of Work, Health & Organisations

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/twst20

"It's a rollercoaster": the recovery and return to work experiences of workers with long COVID

Karina Nielsen & Jo Yarker

To cite this article: Karina Nielsen & Jo Yarker (24 Nov 2023): "It's a rollercoaster": the recovery and return to work experiences of workers with long COVID, Work & Stress, DOI: 10.1080/02678373.2023.2286654

To link to this article: https://doi.org/10.1080/02678373.2023.2286654

Published online: 24 Nov 2023.

WORK & STRESS
https://doi.org/10.1080/02678373.2023.2286654

Routledge
Taylor & Francis Group

"It's a rollercoaster": the recovery and return to work experiences of workers with long COVID

Karina Nielsen[a] and Jo Yarker[b]

[a]Institute for Work Psychology, Sheffield University Management School, University of Sheffield, Sheffield, UK; [b]Department of Organizational Psychology, Birkbeck, University of London, London, UK

ABSTRACT

Research on long COVID is still in its infancy with the primary focus being on symptoms, treatment, and prevalence. Due to the severity and longevity of long COVID that has also affected the working population, an important question is how organisations can support workers with long COVID to stay and thrive in the workplace. In the present study, we used Interpretative Phenomenological Analysis to explore the lived experiences of workers with long COVID and the barriers and facilitators to them working while managing their symptoms. Using purposeful sampling, we recruited participants through social media and conducted semi-structured interviews with 12 workers with long COVID in Spring/Summer 2021. Three higher-order themes revolved around suffering, identity work and belongingness, and 12 subthemes, which were seen as barriers and facilitators to sustainable return to work at the individual, group, leader, organisational and overarching contextual levels. Our findings highlight the urgent need for research that considers work outcomes of those with long COVID and have important implications for how organisations can support workers suffering from long COVID and prevent sickness absence and reduce worklessness.

ARTICLE HISTORY
Received 9 September 2022
Accepted 19 November 2023

KEYWORDS
Long COVID; sustainable return to work; interpretative phenomenological analysis; qualitative; UK; work psychology

The COVID-19 pandemic has had a significant impact on the way we work and live. In the UK, the focus has been on the number of COVID-19 cases and the number of deaths, but long COVID may be a ticking bomb (Briggs & Vassall, 2021). It is estimated that one in ten who contract COVID-19 continue to experience symptoms after 12 weeks (WHO, 2021) and the younger population are more likely to suffer long-term health consequences than to die of COVID-19 (Briggs & Vassall, 2021). Reuschke and Houston (2023) estimated that .5% of the working population suffered from long COVID in March 2022 with numbers expected to rise. In a large survey of long COVID sufferers, Walker et al. (2023) found that 50% of workers in the survey reported having had at least one day off sick in the last four weeks and 20% reported not being able to work at all, while other research has found that 3.7% of the workforce suffering from long COVID have left employment (Reuschke & Houston, 2023). Together these figures

CONTACT Karina Nielsen k.m.nielsen@sheffield.ac.uk

suggest that long COVID generates a major burden on the workplace and society (Thompson et al., 2022). The national labour shortages in the UK, and the potentially devastating financial, personal, and social consequences for workers with long COVID calls for research on understanding the lived experiences of workers with long COVID and the barriers and facilitators to retaining employment they experience.

To the best of our knowledge, no studies have explored workers' lived experiences of their return to work (RTW) journey after one or more long-term sickness absences due to long COVID. In the present study, we conducted Interpretative Phenomological Analysis (IPA) to explore 12 workers' lived experiences of their post-return to work (RTW) journey to understand their sensemaking of their long COVID condition and the barriers and facilitators for sustainable RTW (SRTW). IPA enables the exploration of first-hand experiential accounts of the transition from being healthy individuals, over long-term sickness absence to return at work and explores convergence and divergence in these experiences (Smith, 1999). IPA has been widely used to understand patients' interpretations of their bodily experiences (Brocki & Wearden, 2006) and has recently been used to understand returning workers' experiences following mental health-related sickness absence (Nielsen & Yarker, 2023).

Working with long COVID

Long COVID is defined as

> signs and symptoms that develop during or following an infection consistent with Covid-19, continue for more than 12 weeks and are not explained by an alternative diagnosis. It usually presents with "clusters of symptoms," often overlapping, these may fluctuate and change over time and may affect any system in the body. (NICE, 2020)

Clusters of symptoms include cardiovascular (e.g. fainting, palpitations, tachycardia), gastrointestinal (e.g. diarrhoea, nausea, abdominal pain), dermatologic (skin allergies, rashes), immunologic (e.g. new allergies, anaphylaxis), musculoskeletal (e.g. tightness chest, muscle aches, joint pain), neuropsychiatric (brain fog, speech/language issues, headaches, insomnia), respiratory (e.g. breathing issues, coughs), reproductive/genitouterine (e.g. menstrual, bladder issues), HEENT (head, ears, eyes, nose, throat, e.g. sore throat, hearing and vision issues) and systemic (fever, chills, fatigue) symptoms (Davis et al., 2021). Individuals in the working age group have been found to be at the highest risk of developing long COVID (Thompson et al., 2022) and long COVID has been found to be associated with reduced work functioning (Lunt et al., 2022).

Little is known about *how* long COVID influences work functioning. A recent NIHR study found that 80% of those in paid employment reported that long COVID had influenced their ability to work (NIHR, 2021). Walker et al. (2023) found that more than half of the surveyed population of long COVID sufferers reported having severe functional impairment with work and social leisure activities being the most severely affected domain. Fatigue, cognitive impairment, and depression were the strongest predictors of functional impairment (Walker et al., 2023). A recent TUC survey of workers with long COVID found a major impact on cognitive functioning; nine out of ten reported fatigue, 72% experienced brain fog, 70% reported shortness of breath, 62% reported difficulties concentrating and 54% experienced memory problems (TUC, 2021).

Furthermore, 83% experienced at least one of a range of pain-related symptoms and 32% reported experiencing depression (TUC, 2021). Davis et al. (2021) found 45% of surveyed patients with long COVID reported requiring a reduced work schedule and 22% reported not being able to work at all after six months. Only 27% reported having returned to their previous working hours after six months. The remainder of the sample had either retired, been dismissed, had resigned, or provided insufficient information to determine their employment status (Davis et al., 2021). In qualitative supplements, workers reported working from home to be crucial to their SRTW (Davis et al., 2021).

The lived experiences of workers with long COVID are poorly understood. One study presented a case report on one nurse's journey to return to work, focusing on symptom management with no consideration of the work adjustments needed to accommodate for these symptoms (Uchiyama et al., 2021). In interviews, Ladds et al. (2020) found that long COVID hampered participants' prospects of returning to work or finding new employment. Also in interviews, Callan et al. (2021) found that workers with long COVID often felt guilty about not being able to work or not working to full capacity and that others around them lacked understanding of their illness. Callan et al. (2021) also found that self-management strategies included limited return to work. In a survey study among workers with COVID-19, not all of whom suffered from long COVID, Lunt et al. (2022) included open-ended questions. Key obstacles for workers with COVID-19 returning to work included fatigue and reduced cognitive functioning, which reduced work ability and raised concerns about own and others' safety. Recommendations for RTW included workplace support and work accommodations such as reduced workload and flexible working patterns (Lunt et al., 2022). These findings provide valuable information about the challenges workers with long COVID face, however, provide little insight into long COVID workers' sensemaking of their lived experiences and the types of support which may be useful. Understanding long COVID workers' RTW journeys is important to develop organisational and national policies and practices to support workers maintaining employment.

Previous knowledge on RTW after long-term sickness absence may not be easily translatable to workers with long COVID for four reasons. First, the varied symptomology sets long COVID workers apart from other chronic illnesses (Lunt et al., 2022). Long COVID presents with sustained or recurrent multi-organ symptoms (Davis et al., 2021; Thompson et al., 2022) and symptoms fluctuate (NICE, 2020), whereas as current RTW research has assumed a linear return journey with gradual recovery (Young et al., 2005) and may not help us fully understand the complex needs of returning workers with long COVID. Second, the prevalence of after-effects of the COVID-19 pandemic, i.e. long COVID, is much higher than in previous pandemics (ONS, 2023), and pathways to effective treatment options for long COVID are less clear (Wolf & Erdös 2021; Thompson et al., 2022), making it difficult to compare with previous experiences (Lunt et al., 2022). Third, long COVID is not covered by existing legislation such as the Disability Discrimination Act (1995), thus workers are not protected in law and cannot easily request reasonable work adjustments. Fourth, existing RTW research has primarily focused on the sickness absence and the re-entry periods, rather than the post-return phases (Corbiere et al., 2022; Nielsen et al., 2018; Nielsen & Yarker, 2023). We therefore conducted a qualitative study to understand the lived experiences of workers who had returned to work after one or more periods of long-term sickness absences due to long COVID.

The IGLOo framework: understanding the barriers and facilitators to long COVID workers' recovery and return to work journeys

We base our study on the IGLOo framework; Nielsen et al. (2018) suggested that resources at five levels, i.e. the Individual (resources inherent within the individual), Group (e.g. colleague support), Leader (e.g. work adjustments), organisational (e.g. sickness absence policies) and overarching (e.g. national policy or healthcare support) (IGLOo) levels are needed to support workers with common mental disorders return to and thrive at work. The IGLOo framework draws on Conservation of Resources theory (COR; Hobfoll, 1989). Resources are defined as "anything perceived by the individual to help attain his or her goals" (Halbesleben et al., 2014, p. 6).

According to COR theory, individuals are motivated to protect and accumulate resources, however, both positive and negative spirals may occur (Hobfoll, 1989). In a situation where long COVID workers experience having sufficient IGLOo resources to cope with the demands of the job and manage their symptoms, resource caravans will be the result; returned workers can invest their IGLOo resources in gaining additional resources and thus resources at the five IGLOo levels may synergistically enable them to recover and stay at work. In a situation where long COVID workers experience they have insufficient resources and experience barriers at one or more of the five IGLOo levels, resource depletion may be the result and long COVID workers may find themselves hindered in their recovery and return to work. In their qualitative study of workers with common mental disorders who had returned to work in the past five months, Nielsen and Yarker (2023) found support for both the resource caravan and the resource depletion pathways. Returned workers who possessed the personal resources to re-adapt to work and felt supported by colleagues, line managers and organisational policies and practices stayed and thrived at work while those do did not experience such resources, planned to exit their workplaces. Those who experienced support at some levels but not all, maintained employment, but struggled (Nielsen & Yarker, 2023). We propose that the IGLOo may be applied to understand the barriers and facilitators (resources) that workers with long COVID experience in their recovery and RTW journey, however, we do not make any assumptions as to which barriers and facilitators returned workers may experience.

Understanding the lived experiences of workers with long COVID

Due to the lack of research on workers' experiences with long COVID, we used an inductive approach to the research. The narrative around recovery from long COVID relies on workers' sensemaking and interpretations and we therefore employed IPA as our qualitative methodology. IPA has previously been used to study the RTW journey of mothers returning to work after maternity leave (Millward, 2006) and of workers' RTW after long-term sickness absence due to common mental disorders (Nielsen & Yarker, 2023). While legislation is in place to support maternity leave (Employment Rights Act, 1996) and common mental disorders (Disability Discrimination Act, 1995), no existing legislation covers long COVID in the UK where the study was conducted.

The purpose of IPA is to examine how individuals make sense of their experiences and is increasingly used to understand topics that have an existential impact (Nizza

et al., 2021) and are emotionally sensitive and complex such as experiences of illness (Peat et al., 2019). Brocki and Wearden (2006) suggested that IPA is suitable for understanding the importance of participants' perceptions and interpretations of their bodily responses and the meanings they assign to them. This is of particular interest for people with long COVID as little is known about the condition (Walker et al., 2023). IPA is suitable to understand life transitions such as adjusting to life with a fluctuating condition such as long COVID, which has profound effects on our participants' identity. As long COVID is represented by as many as 165 different symptoms which may fluctuate over time, we do not assume a singular depersonalised reality (Davis et al., 2021).

IPA has been criticised for being theoryless (Shinebourne, 2011), however, IPA rests on *phenomenological, symbolic interactionistic, hermeneutic*, and *idiographic* principles (Larkin et al., 2006). IPA is *phenomenological* in that it focuses on the lived experiences of participants, who take a step back from their taken-for-granted world to systematically reflect on everyday experiences and how they are embodied and embedded in a social and cultural context (Shinebourne, 2011).

Symbolic interactionism assumes that people make sense of their experiences in relation to their identity, interpersonal relationships, and the wider social context (Shinebourne, 2011). IPA therefore is a suitable method to understand how working with long COVID influences workers' experiences and their interactions with colleagues and managers and the wider Occupational Health (OH), Human Resources (HR) and extra-organisational systems during their recovery and RTW journey. As IPA is *hermeneutic,* the focus is on the interpretation of both the workers' understanding of their experiences and the researcher's interpretations (Larkin et al., 2006). The hermeneutic approach offers opportunities for interpretative analysis, contextualising participants' accounts in reflections and relevant theoretical material, thus making it possible to link the findings to the psychological literature (Larkin et al., 2006). IPA is *idiographic* due to its emphasis on a very specifically defined experience (Smith & Shinebourne, 2012), in this case, the experience of long COVID workers' recovery and RTW journey. We are interested in how workers with long COVID balance their recovery and RTW journey. We interviewed workers who self-identified as having long COVID and who had had one of more sickness absence periods due to long COVID since the start of the pandemic. The lived experiences of returned workers can be placed in a wider context (Neale, 2021) and we therefore explore the contextual factors at work that our participants had experienced either facilitated or hindered their recovery and SRTW. Due to the complexities of the condition, national labour protections and the lack of knowledge that can be transferred from the wider RTW literature, we need to understand what work adjustments may be suitable for these workers.

In the present study, we interviewed workers with long COVID who had experience returning to work to understand their lived experiences of the post-return journey and the barriers and facilitators to SRTW. To guide our analysis, we formulated one research question:

What are the lived experiences of workers with long COVID who have been on long-term sick leave, and what are the barriers and facilitators they encounter in their journey towards recovery and SRTW?

Method

Data collection method and participants

The aim of IPA is to produce an in-depth examination of certain phenomena, rather than generating a theory to be generalised over the whole population (Larkin et al., 2006; Pietkiewicz & Smith, 2014). The IPA methodology employs three key principles. First, according to the inductive principle, meaning is derived from individual accounts, rather than from existing theory (Smith & Fieldsend, 2021). In the present study, we used the IGLOo framework as a guiding principle to ensure we capture the complex organisational context, however, we made no assumptions as to what barriers and facilitators our participants may face in their recovery and RTW journey. Second, the ideographic principle involves the in-depth analysis of a small sample (Smith & Shinebourne, 2012). Central to IPA is the exploration of every single participant's unique experiences (Eatough & Smith, 2008), as opposed to assuming an objective reality outside of the lived experience (Smith, 1999). Third, the interrogative principle refers to the interpretative engagement of the researcher, striking a balance between allowing the participant to cover anything they feel is important exploring their own experiences and the interviewer focusing down on particular elements through paraphrasing, checking interpretations and clarifying probing (Smith, 2004).

Sample sizes in IPA studies are small to ensure an in-depth analysis of each participant's experiences (Larkin et al., 2006) and participants are selected purposively from a homogenous group (Smith & Shinebourne, 2012). In the present study, our inclusion criteria were workers living in the UK, who had returned to the same workplace after sickness absence due to long COVID as reported by themselves. In the UK, testing was not possible for many people in the early stages of the pandemic, and therefore many of our participants had not been tested for COVID-19, but their symptomology is in accordance with long COVID, and they were treated as workers with long COVID by their employers and the healthcare system. We included 12 workers that met these criteria to observe converging and diverging themes from this fairly homogenous group. In recognition of the potential prevalence of fatigue in our participants (Davis et al., 2021), we recruited 12 participants which is considered a large sample size in IPA to ensure that we had a variety of experiences considering that some participants may need to cut the interviews short due to fatigue. Participants had an average age of 45 and 92% were female. The majority worked in the healthcare sector, which has been identified as a high-risk sector (Davis et al., 2021). Many of our participants had multiple long-term sickness absence spells due to long COVID, most of them lasting several months. All presented with multiple clusters of symptoms according to Davis et al.'s (2021) definition, most with brain fog and fatigue and various musculoskeletal symptoms. For an overview of participants, see Table 1.

Procedure

We conducted confidential semi-structured, one-to-one interviews online. Interviews are recommended for IPA as they enable researchers to explore participants' sensemaking of their experiences (Frost, 2021) and enable the researcher and the participant to enter a

Table 1. Participants' details.

Pseudonym	Age	Gender	Sector	Contracted COVID-19	Number of formal long absences	Longest period of sick leave	Symptoms
Anne	41	Female	Healthcare	03/2020	1	5 weeks	Cardiovascular, neuropsychiatric, respiratory, musculoskeletal, respiratory, HEENT, systemic
Beth	55	Female	Healthcare	04/2020	3	Few months	Cardiovascular, neuropsychiatric, musculoskeletal, respiratory, systemic
Chloe	30	Female	Healthcare	03/2020	3, still on sick leave	4 months	Cardiovascular, gastrointestinal, neuropsychiatric, respiratory, HEENT, systemic
Diana	33	Female	Retail	03/2020	1, dismissed	5 months	Cardiovascular, gastrointestinal, musculoskeletal, neuropsychiatric, respiratory, systemic
Eve	55	Female	Healthcare	10/2020	2	4 months	Neuropsychiatric, gastrointestinal, dermatologic, respiratory, musculoskeletal, reproductive/ genitouterine, systemic HEENT
Fiona	58	Female	Local government	04/2020	4	3 months	Cardiovascular, gastrointestinal, immunologic, musculoskeletal, respiratory, neuropsychiatric, systemic
Gail	49	Female	Social care	03/2020	2	2 months	Cardiovascular, gastrointestinal, dermatologic immunologic, musculoskeletal, neuropsychiatric, systemic
Holly	48	Female	Civil service	09/2020	2	4 months	Cardiovascular, gastrointestinal, immunologic, musculoskeletal, neuropsychiatric, HEENT, systemic, reproductive/ genitouterine,
Ila	51	Female	Civil service	04/2020	1	6 months	Musculoskeletal, neuropsychiatric, HEENT, systemic
John	45	Male	Education	12/2020	1	2.5 months	Musculoskeletal, neuropsychiatric, systemic
Kath	35	Female	Higher education	03/2020	3	5 months	Cardiovascular, gastrointestinal, neuropsychiatric, respiratory, musculoskeletal, systemic
Lara	36	Female	Healthcare	12/2020	2	3 months	Cardiovascular, musculoskeletal, neuropsychiatric, respiratory, HEENT, systemic

Note: HEENT = Head, Ears, Eyes, Nose, Throat.

dialogue where the researcher can modify questions and pursue themes as they emerge in the interview (Frost, 2021).

Sample

Participants were recruited through social media and through a long COVID support group's network communications advertising for workers who self-identified as having long COVID. Inclusion criteria included participants who had been on long-term sickness absence, defined as more than three weeks in the UK, due to suffering long COVID symptoms. Participants were screened for fitting the inclusion criteria, were provided information sheets and a consent form was signed prior to the first interview. Ethics approval was obtained from the University Department's Ethics Committee of the first author. To ensure confidentiality and to protect sensitive information, we use pseudonyms in this paper.

Interviews

The semi-structured interviews were employed around a loosely structured interview guide asking the participants about their recovery and RTW journey, and the barriers and facilitators to working with long COVID, with probing questions about each level of the IGLOo framework. The interviews were divided between three Occupational Psychologists, all of whom were experienced in interviewing. We made notes on our observations and reflections on the interview experience. Interviews were conducted in June–September 2021 and lasted between 39 and 67 min, with an average of 51 min. Each interview was scheduled for an hour to allow time to establish rapport and for a rich open conversation to evolve. Pietkiewicz and Smith (2014) emphasised that due to the existential nature of IPA, interviewers need to monitor how interviews are affecting the participant. Acknowledging that fatigue is experienced by many people with long COVID, the interviewers made it explicit at the beginning of the interview that participants could stop the interview at any point should they become tired. The interviewers were also aware that participants might not want to voice or notice their own fatigue, so made efforts to notice subtle cues such as changes in body language, and tone and speed of speech. When any change in participant behaviour was noted, the interviewer reminded the participant that they could stop the interview to rest and complete the interview at another time. A few participants chose to finish the interviews early but, on all occasions, it was felt that the most important detail regarding their experience had been covered.

Analysis

We followed the recommended procedure for conducting IPA (Larkin et al., 2006). Two trained Occupational Psychologists who had also conducted interviews coded the data. In IPA, interpretations are formed by first examining each participant as a single case before moving on to making interpretations across cases (Smith, 2004). First, we read the transcripts of the interviews twice to familiarise ourselves with the data, analysing each interview as an individual case of the long COVID recovery and RTW journey to identify meanings that make interpretative sense of this journey. We made notes of potential meanings and recorded keywords capturing what was being said, grounded in participants' own words. All interviews were treated as individual cases, but notes were made about any cross-case patterns to establish convergence and divergence in experiences of the recovery and RTW journey. In the second stage, we transformed the initial notes into emerging themes. We aimed to formulate phrases that balanced between the transcribed text and abstract themes to offer a conceptual understanding. In the third stage, we examined emerging themes and clustered them according to their conceptual similarities. In response to our research questions, we contrasted and compared individual participants' interviews to identify commonalities that explained the higher-order themes, and differences that explained variations among participants in terms of their experiences at the same time as taking care we did not lose sight of the ideographic origin. In the fourth phase, we developed a narrative of the emerged themes. At each stage of the analyses, the two coders met in person and discussed their findings. Discrepancies were resolved by discussion and consultation of data.

Table 2. Overview of themes.

	Subtheme				
Higher theme	Individual	Group	Leader	Organisational	Overarching context
Long COVID suffering	Long COVID suffering		Understanding long COVID suffering	Organisational validation of long COVID suffering	Societal validation of long COVID suffering
Identity	Identity struggle				
	Identity work		Managing through identity transformation		
Belongingness		Work group belongingness	Workplace belongingness	Employment belongingness	Long COVID community belongingness
				Long COVID staff support group belongingness	

Findings

The results include an analysis of the barriers and facilitators to recovery and SRTW at the IGLOo levels (see Table 2), representative quotes, and a table of who experienced the three higher-order themes and 12 subthemes (see Table 3).

Barriers and facilitators to recovery and return to work

In answering our research question about the lived experiences and barriers and facilitators to return to work of workers with long COVID returning to work, we identified three cross-cutting themes that spanned the five levels of the IGLOo framework: suffering, identity work and belongingness.

Individual-level barriers and facilitators

Long COVID suffering. One major barrier to SRTW was the severe and fluctuating nature of long COVID symptoms, which created suffering. Participants felt long COVID had hit them so hard they did not know whether they were alive or dead. The severe symptoms were difficult to overcome, and the struggle continued long after the first return.

Gail and Eve used metaphors to describe the severity of their symptoms: "It's not natural to feel like your arms and legs and heads is being ripped off. Like those pictures where they show people being pulled between two horses" (Gail). Eve described people with long COVID as "people who aren't dead but are not really living either." Our participants reported their recovery and RTW journey as a rollercoaster ride, with ups and down.

Anne, Beth, Chloe, Diana, Eve, Fiona, Ila, and Kath struggled through only to be hit harder and crash completely resulting in long-term sick leave, despite initial expectations that they would recover quickly: "You think you're just gonna get better and you push through" (Fiona). This seemed to be the case even when they could feel something was not right: "I was definitely not working at my best about at that point, but I thought was going to be a short-term thing. I was still managing to do everything I needed to do to keep the ship afloat" (Kath).

Participants continued to experience peaks and troughs post-return:

> It's just like a roller coaster, it's not been a very smooth return by any stretch. It's not as if week by week, I've got better, or I've got worse. Some weeks, I'm better than others. I've had weeks where I've been so unwell, I've not been able to do anything at all. (Beth)

The fluctuating nature meant that participants lacked confidence that they could continue working, and they struggled to develop strategies for managing their symptoms at work.

Beth and Lara reported they were slowly getting better, and they experienced fewer triggers of their symptoms:

> I'm probably more capable of doing more now than I was back in March, and I still have the same symptoms. I get headaches if I do too much. My muscles hurt, and I get really fatigued. But the triggers are probably less, I can get away with doing more, but I get the same response. (Beth)

Even if the physical symptoms improved, the cognitive symptoms persisted, making a full return and recovery difficult in a cognitively challenging job:

> The physical side of things I'm better with. I think physically, I'd be at the stage where I could do what I needed to at work. But cognitively, from the thinking side of things, there's no way I could take responsibility for somebody else's healthcare at the moment. (Beth)

Despite some recovery, cognitive work functioning continued to be limited and as a result participants doubted their ability to do their job in a satisfactory manner, leaving them to feel threat, fear and concerns about their future. Suffering was thus a key theme for our participants. Suffering has been defined as "a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted" (Cassell, 1999, p. 531). The returned workers struggled to comprehend the impact of their long COVID symptoms on their working life and this impact caused suffering as they struggled to find strategies that enabled them to manage the symptoms of long COVID so that they were able to work. The extreme suffering they experienced also meant that it made them question whether working was the path forward to help them recover.

Identity struggle. A second central theme at the individual level revolved around our workers seeing long COVID as a threat to their occupational identity and struggling to align their pre-long COVID occupational identity with their identity as long COVID sufferers. Identity refers to how individuals see themselves in a social context (Haslam et al., 2004) and as a reflexive project (Giddens, 1991). Social identity theory suggests that individuals see their identity based on group membership and as their individual characteristics (Tajfel & Turner, 1979). One particular social identity is occupational identity, which refers to the conscious awareness of being a worker (Skorikov & Vondracek, 2011).

Anne, Beth, Chloe, Diana, Fiona, Gail, Holly, John, Kath, and Lara had a strong occupational identity and wanted to contribute to their workplace:

> My logic was the pandemic was not a good time for somebody in my job to be going off sick. My logic was that, you know, if I was lying in bed not doing my work, then I was nesting. (Lara)

Table 3. Return to work and recovery and barriers and facilitators.

	Anne	Beth	Chloe	Diana	Eve	Fiona	Gail	Holly	Ila	John	Kath	Lara	SUM
Individual level													
Long COVID suffering	B	B	B	B	B	B	B	B	B	B	B	B	**12**
Identity struggle	B	B	B	B	B	B	B	B		B	B	B	**11**
Identity work	F	F	B		F	B		F	B			F	**8**
Group level													
Work group belongingness		F	F	F	B	F	B	F			F	B	**9**
Leader level													
Understanding long COVID suffering					B	B		B	B	B		B	**6**
Managing through identity transformation	F, B	F, B	F	F	F, B,	F	F, B	F, B	F	F	F	B	**12**
Workplace belongingness		F	F, B		B		B	F		F			**6**
Organisational level													
Organisational validation of long COVID suffering	B							B			B		**3**
Employment belongingness		B			B		B	B	B			B	**6**
Long COVID staff support group belongingness		F					F	F					**3**
Overarching context level													
Societal validation of suffering	B	B			B	B				B			**5**
SUM	**6**	**9**	**6**	**4**	**9**	**7**	**7**	**10**	**5**	**6**	**5**	**11**	

Note: B = Barrier, F = Facilitator.

Diana, Anne, Beth, Chloe, Diana, Eve, Fiona, Gail, and Kath felt guilty about having been on sick leave and not being able do all their regular tasks when they returned as they saw the consequences on their colleagues:

> I've never had time off, other than one or two days with the odd something ever since I've been working. It's really unusual for me to be ill. I had actually to have two weeks off at the beginning, which was really unusual. I felt incredibly guilty being off work. (Beth)

and

> I think as an employee, you feel so bad at messing them (colleagues) around, because you've been off for so long, you've probably worked yourself like slave to try and get back in the good books to your own health detriment. (Eve)

Beth, Fiona, and Lara found it hard to accept that they needed time off work to recover: "Internally, I put that pressure on myself to go back to work. Because that's all I've ever known and done. I've never ever spent so much time at home. I set myself up to fail indirectly in March" (Lara).

Suffering from long COVID and its invalidating symptoms threatened participants' occupational identity as strong, healthy workers who could make a significant contribution to their workplace and to society. Their RTW journey became a struggle between their self-view and the demands of their body to recover (Alvesson, 2010). These participants felt their occupational identity as hard workers threatened and perceived an ongoing struggle between their self-view as valuable workers and their physical limitations. In many ways, they felt they failed the societal script of being healthy workers, contributing to society during times of crisis. As such their strong occupational identity was a barrier to their SRTW. Returned workers struggled to accept their emerging identity as long COVID sufferers that contrasted with this occupational identity.

Identity work. Identity work refers to the activities, individuals engage in to construct and revise their identities (Caza et al., 2018). An emerging facilitator to recovery and SRTW was that over time, participants realised that to stay at work they needed to redefine and relinquish their strong occupational identity and began to rework their identity and realign their occupational identity with their long COVID sufferer identity, with a recognition that their health was crucial to their being.

The slow recovery made Chloe, Fiona, and Ila question their occupational identity and whether working hinders their recovery: "I have been from eight weeks on a phased return and then the rest of it four months, I've been working full time. I don't think that's been helpful at all." Fiona is wondering whether working is the right thing for her recovery: "I'm still trying to work on my computer and I'm thinking should I be doing this? Is this making it worse? That's the thing, your health should come over anything."

Identity work, i.e. ongoing attempts to reshape their self-identity, was required (Watson, 2008). Individuals reconstruct their identity based on the stories they tell themselves (Watson, 2008) and our participants started questioning whether work was all and whether working was in fact harmful for their health rather than health is being something that enabled them to be good workers. In particular, our nurses redefined their identity as someone looking after others to someone looking after themselves (Kirpal, 2004).

Participants started questioning their occupational identity and realised that rather than work giving them a standpoint in life, work could be a hindrance to their recovery.

Anne, Beth, Eve, Fiona, and Lara became aware that they needed to prioritise their health over work: "I've had to learn to look after myself, which has also been a bit of a lesson. I think the things that have helped in terms of putting yourself and your own health first" (Beth). Beth, Holly, and Lara saw themselves as valuable workers who still had something to offer, but on different terms than before: "I still think there's lots of value I can add, although it might be in a different way." Eve, Holly and Lara reflected on how they had had to come to terms with being a changed person: "It's also been a change for me to recognise that I'm never might never be the same as I were before. And that that's a really big psychological thing to get over" (Lara).

Occupational identity is a dynamic process that is altered by individual experiences, ability, and peer relationships (Skorikov & Vondracek, 2011). The suffering participants faced changed the way they see their occupational identity and they started to focus their long COVID sufferer identity and how they may recover. Over time, some returned workers redefined their occupational identity to develop their self-worth as making a contribution within their limited work functioning (Kirpal, 2004).

Group-level barriers and facilitators

At the group level, returned workers identified both barriers and facilitators. In addition to their occupational identity, workers sought to establish their social identity through reworking their belongingness to their work group. Colleagues who demonstrated support and flexibility and a concern for the returned worker's wellbeing were perceived to be facilitators to SRTW, whereas colleagues who demonstrates a lack of understanding created belongingness uncertainty. Returned workers' belongingness played a key role in their social identity work.

Work group belongingness. A facilitator to recovery was the understanding and support from colleagues. Beth, Chloe, Fiona, Holly, and Kath felt colleagues had been understanding and accepting of reduced work functioning:

> I'm the manager … . everybody has been really nice and encouraging and kind of always really pleased to see you back. I think people gripe to me less about little things, you know, before people would come to me … nobody comes to me with that kind of crap at the moment. I think they think well, you actually got other things to worry about. (Chloe)

Returned workers identified both instrumental and emotional support as key facilitators to recovery and SRTW. Beth formed a WhatsApp group with two colleagues who offered emotional support and one of Holly's colleagues offered sitting in at work adjustment meetings with their line manager. A few of our participants reported getting instrumental support from colleagues. Diana asked one of her colleagues to change her password so she would stay off the computer and Chloe called for her colleagues to make sure she took breaks. Holly lost a lot of confidence while on sick leave and upon return got support from colleagues to check her decisions:

> I didn't feel like I was particularly confident in my decision making either and we make decisions on whether patients are admitted to hospital or we prescribe. So, I really felt I needed that backup of a colleague with me for a while. And even after that I started running with decision making through people just to say I'm doing this would you have done … So that sort of helped build that confidence back a bit.

The feelings of connectedness and support from colleagues relate to participants' belonginess to the workplace and enabled them to integrate their long COVID sufferer with limited work functioning with their occupational identity. The belongingness hypothesis proposes that human have a need to form and maintain strong and stable interpersonal relationships (Leary & Baumeister, 1995). Colleagues' frequent and affectively positive interactions sustained over time helped create a feeling of belonginess and reinforced returned workers' occupational identity as valuable workers who could make a contribution, even with their reduced work functioning. Returned workers sought to secure belongingness through seeking interpersonal relationships, reinforcing their identity as individuals who had something to offer to the community and exposing their vulnerability. For the purpose of this study, we define work group belongingness as the "connectedness to and support from colleagues in the workplace."

Lack of understanding by colleagues and a toxic climate were seen as barriers by Eve, Gail, and Ila. Ila felt that her colleagues lacked understanding and showed little interest in understanding:

> I don't think they get it. It's like when they ring me. It's chatting about work, really. And so how were you and nothing? They don't want to hear about my health. Yeah, it's hard. It's like they don't really want to know … they probably don't understand the word but they're also not trying to understand.

Eve found herself working in a toxic environment where she felt colleagues suspected her of skiving off: "I found a lot of toxic positivity from work. So it would be masked as like oh my god, are you still unwell … We definitely think you should be at work by now."

Where colleagues did not confirm the returned worker's work group belongingness and showed little consideration for their wellbeing, returned workers felt alienated. Their occupational identity as valued workers were threatened and they felt belongingness uncertainty (De Cremer et al., 2008); they felt they had few friends in the workplace and were made to feel that they did not belong in the workplace as they were unwell. The social context at the group level thus played a key role in the identity struggle between returned workers' occupational identity and their emerging identity as long COVID sufferers.

Leader/line manager barriers and facilitators

Leaders or line managers were perceived to play a key role in facilitating recovery and SRTW in making work adjustments, in terms of agreeing adjustments in workloads/tasks, part-time working and working from home. Where such support was not offered and participants felt that some line managers lacked understanding of what long COVID is and what support workers needed, leaders were seen as a barrier. Line managers played a key role in returned workers aligning their occupational identity with their identity as long COVID sufferers who needed support to readjust to work.

Understanding long COVID suffering. Line managers' lack of understanding of the suffering of long COVID workers was seen as a barrier to recovery and SRTW. Eve, Fiona, Holly, Ila, John, and Lara reported their line manager had little understanding of long COVID, whereas Fiona felt her line manager's understanding developed after two failed returns. Lara provided an example of how her line manager putting her through the system as having mental health issues:

> I don't think she's (line manager) fully appreciated who I am, as a worker or as a colleague. And for me, to have somebody tell you it's all mental health, and then try putting reasonable adjustments in for purely mental health alone … you're fighting for your long COVID that nobody knows about.

Ila explained how her line manager tried to be supportive but did not understand the implications of long COVID on her work functioning:

> My manager will send me bits from news articles about long COVID. That's about what he does. And he'll say, Oh, can I do anything for you? But then again, as I keep saying in the next breath, it's like here's some more work.

Understanding the issues relating to long COVID and acknowledging the suffering that goes with living and working with a condition that is unknown, fluctuating and with the presentation of many diverse symptoms were seen as key to workers feeling validated in their RTW and recovery.

Managing through identity transformation

A key theme as the leader level, was line managers' ability to make returned workers feel that with adjustments to allow them to manage their long COVID symptoms at work, returned workers could maintain their occupational identity. Striking the balance between performing tasks that workers could do with the reduced work functioning and tasks that were meaningful was important to Beth and Fiona:

> Between me and my manager, we can work out what I'm able to do. Because it's also important to be able to feel like I can do things and I'm valuable. I need to be able to have tasks that are achievable, that I feel I'm contributing something rather than things that are too hard that I'm never going to be able to do. And it's almost like graded in those small steps. And I think the steps have to be really small. (Beth)

Work adjustments revolved about enabling workers to retain employment despite their reduced work functioning. A major facilitator to deal with fatigue was perceived to be line managers agreeing to *reduced workload and changed responsibilities*. Anne, Beth, Chloe, Diana, Eve, Fiona, Gail, Holly, and Ila reported the fatigue they suffered meant they could only work few hours before needing a break. Concentrating on reading and screen time was a major issue, Beth, Chloe, Diana, John, and Ila became fatigued working in front of the screen and working with patients or pupils. Their roles changed to mainly performing administrative tasks:

> Non-clinical work would normally make up about 20% of my work role. So my normal split would be 80% patients and 20%, non-clinical … Whereas now, that's 100% of what I'm doing. So I'm doing the things that I can do in my own time. (Beth)

For long periods of time, the UK faced lockdowns which has enabled workers to *work from home*, however, also between and after lockdowns line managers agreed to workers working from home, bar Chloe who felt pressured to go to work to see patients. Anne, Beth, Chloe, Eve, Fiona, Gail, Holly, John, and Kath reported working from home was a facilitator enabling them to take breaks and avoiding being overwhelmed so they could manage their long COVID symptoms and maintain employment. Fiona felt that

allowing her to work from home and at reduced hours was a signal she was considered a valuable worker despite suffering from long COVID:

> I'm lucky in that work have been supportive. And they have given me things to do to work from home. They probably would give me some as well now if I wanted extra … I think they'd rather have me three good days than not have me at all.

These work adjustments played a major role in the identity work of returned workers, enabling them to align their occupational identity with their long COVID sufferer identity and helped them feel they belonged in the workplace.

A major threat to aligning the identity as a long COVID sufferer with their occupational identity was the pressure from line managers to ignore their symptoms, which had a negative impact on their recovery. Anne, Beth, Eve, Gail, Holly, and Lara felt pressurised by their line managers to take on a high workload and work tasks, which made their health deteriorate:

> I was doing fairly well, I thought but I don't think I was progressing as fast as my managers and work would like me to have been. I felt a bit pushed into doing more than I thought I was capable of … I spoke to a couple of people (patients) on the telephone and the concentration required was far too great and I crashed. So from thinking too hard … all my physical symptoms got worse. I got chest pain, tachycardia. I couldn't walk upstairs without holding myself up on the bannisters and I'd need to sit on the top step for a couple of minutes to recover. (Beth)

At the leader level, the social context plays a key role in enabling returned workers to align their emerging long COVID sufferer identity and their occupational identity through line managers' role in supporting work adjustments over time. Making work adjustments in different areas of working life enabled workers to workers to maintain their occupational identity and contribute at the same time as managing their fluctuating and unpredictable recovery. Where such adjustments were not made, returned workers struggled to align their occupational and long COVID sufferer identities.

Workplace belongingness. Important to recovery is that long COVID workers were able to *work part-time*. Leaders agreeing to them working part-time, made returned workers feel some connection to the workplace and as part of the community at work. Chloe, Holly, Lara and John missed their colleagues:

> I like my colleagues. And I like their sense of purpose … Just sort of sense of camaraderie because it's quite, you know, it's quite mad time. But we're kind of in it together. So that was the positive part of being back at work. (Chloe)

Working even a few hours makes Beth feel she is still part of the community: "I think it's been better to, for me to have had some contact with work than none at all. Because doing what I'm doing at the moment, prevents the isolation with being off."

Working part-time, however, could also be seen as a barrier to recovery and SRTW if it went against the needs of the returned worker and felt it threatened their occupational identity and the membership of their work group. Beth. Gail and Holly felt pressurised to go part-time but refused:

> I've come back quite openly saying, I'm not the person that went off. I'm not capable of everything I did before I went off. But there is lots I can do. And I'm here. So, you know, on that side of things, well, why should I take a pay cut? (Gail)

Although some line managers facilitated workplace belongingness, the opposite was also the case. Chloe was told her contract would not be renewed and Eve and Gail felt they were given additional work to force them to out of their job, in Eve's case successfully so: "It was very clear that he (the line manager) didn't know how to handle someone who had a medical condition. And he wanted me out of that business ASAP."

Workplace belongingness, which we define as "belongingness to the workplace and feeling valued for their contribution" was facilitated by line managers through part-time working. Where such adjustments were not made, returned workers felt they were forced to give up their occupational identity and felt ostracised from the organisation.

Organisational barriers and facilitators

At the organisational level, key themes were validation of long COVID suffering and long COVID specific policies relating to the specific nature of suffering from long COVID. Participants highlighted barriers and facilitators revolving around participants' experiences with OH and HR, in particular RTW policies.

Organisational validation of long COVID suffering. A mixed picture was seen in the support offered by OH services and the way in which organisational policies were implemented. Some participants felt organisational support systems validated their identity as long COVID sufferers, while others felt services were lacked basic understanding and failed to acknowledge their specific challenges relating to long COVID.

Anne, Holly, and Kath felt supported by OH, they felt that OH had facilitated their return and felt validated in their needs as long COVID sufferers:

> She (an occupational therapist) was horrified that I was trying to work and told me that I couldn't even imagine trying to go grocery shopping or any of this stuff, because you've got to work out what your baseline is. This is what she kept talking about … I guess it was helping gave me that kind of justification, I guess, a verification or validation. (Anne)

Kath felt things got better as more research emerged and OH developed their understanding of long COVID:

> I also have spoken to occupational health, in our university, and, you know, that was really useful, and that was really helpful. And they've been super flexible … once there was advice from the medical professionals the institution has been very, very good.

Regardless of the personal experiences of HR support, existing return-to-work policies were seen as inflexible and not fit for purpose. Anne, Beth, Eve, Fiona, Gail, Holly, Ila, John, Kath, and Lara reported that existing return-to-work policies assumed that workers got better within the first 4–5 weeks of return and then it was expected they could return to full-time work and full duties, however, this was not the case for workers with long COVID: "HR sort of put you through the phased return, you're meant to try and hit certain goals at certain weeks. But that didn't work. The recommendation isn't for long COVID" (Fiona).

Gail explained that OH lacked the necessary knowledge to deal with the mental health aspects of long COVID:

> It's a tick box exercise; we've done occupational health and physical disabilities. Yes, we can give you computer equipment. But for the invisible things like fatigue, brain fog, depression,

> mental health, mental illness. There doesn't seem much accommodation for that type of thing.

Returned workers thus emphasised the importance of occupational support systems and policies validating the challenges of managing long COVID symptoms in the workplace and the uncertainty of not knowing what could support their recovery. The experiences of the reactions and support from OH and HR emphasise the importance of acknowledging the suffering of long COVID workers. Participants experienced that support functions attended to the body rather than the person and failed to acknowledge suffering (Cassell, 2004), which was seen as a barrier, however, where the suffering and the struggles of the participants were acknowledged, they felt validated and supported and perceived the functions as a facilitator to recovery.

Employment belongingness. Beth, Eve, Gail, Holly, Ila, and Lara felt poorly supported by organisational support systems that did not understand their need to belong to the world of work. Beth described her negative experiences with OH not understanding that she wanted to make a contribution to the extent possible:

> The person I spoke to had no knowledge of post-viral syndromes and her advice was very generic, rather than personalised to me. She said I needed to have two months off work and not do anything at all. That was a real shock at the time because I was still of the mindset that I should be getting better within a couple of weeks and I really wanted to be at work. (Beth)

The recommendation from OH that Holly should be put on the Equality Act was ignored by HR. Eve felt HR failed in their care of duty when they did not question her line manager putting her on a development plan (plan for underperformers with a view to dismissal):

> I said to HR when I left, if someone had recovered from a long term illness or hadn't recovered, but returned, and their boss has come to you and said, oh, we're a little bit concerned about her output. Why was the first thing you didn't think we've got to check in with her that she's okay, you know, hopefully she's not having another relapse or anything can't feel she can take time off because all her pay will run out. Nothing didn't hear from them … I've never been in trouble at work before.

At the organisational level, organisational support systems play a key role in enabling returned workers juggle their conflicting occupational and long COVID sufferer identities. For the purpose of this study, we define employment belongingness "as feeling participants can stay in employment." Participants felt threatened in their right to work and felt that the support systems did not live up to their duty of care.

Long COVID staff support group belongingness. Beth, Gail, and Holly joined long COVID support groups at their workplaces where they met people with similar experiences:

> It's been quite helpful being part of a group of people who are advocating for a fair return rather than the typical four-to-six-week return. It's been useful to know what is the ideal return in terms of how you should do it, and to have the support from people who absolutely know what it's like, because all of us have a struggle to go back to work, which I think is why we're also part of the advocacy group. I've got people who are going through a similar journey to mine, which has helped. But I've also got people to say, how about doing it this way? Or how about asking for this? It's sensible advice from people in the know. And that's also been helpful. The peer support has been hugely useful. (Beth)

Belongingness was also a key theme at the organisational level. Participants sought membership of new groups that could help them come to terms with their new identity as workers with reduced work functioning. Finding belongingness with colleagues who also suffered from long COVID gave returned workers a sense of identity as long COVID sufferers who could hold down a job despite their reduced work functioning. They felt participation in these groups helped them balance their work with their reduced work functioning, enabling them to understand and voice what work adjustments they needed to stay at work.

Barriers and facilitators in the overarching context

Outside the organisational context, participants experienced a lack of validation of their long COVID suffering, both from the policy and from media, which was seen as a barrier to their recovery.

Social validation of long COVID suffering. Beth, Eve, Holly and John called for *government action* in shaping policy to accommodate for the rollercoaster nature of long COVID:

> I think it's really important that there are government policies that are put in place to support people because there's a huge amount of the workforce that are struggling at the moment. I think the extended phased return is a good example of the need to have something like this. Because the longer people are off sick for we know it's harder to return. If I was still off sick, I'd be coming up to 12 months now, if I had to do a six-week phase return, which is the historic healthcare return if you are off sick, I think it'd be really difficult to go back. (Beth)

Returned workers also felt that the lack of information about long COVID resulted in a lack of knowledge in organisations about what can and needs to be done to support workers with long COVID:

> But there needs to be information or some guidance for employers, for education, for schools, on what to do when you've got, people who, who are in this position, because, again, they don't know that, they'll make the right noises in one way, but then there's no support coming off the back of that. (John)

Anne and Eve felt there had been a focus on people dying in media with little information on long COVID and its debilitating effects which was a barrier to SRTW:

> People still even to this day don't have any understanding of what it's like. You can't really expect them to but they very much think it's a condition you die from or will you survive. And I think the media's portrayal of it echoes that. And the government's is exactly the same. I mean, they never talked about long COVID so people think: Yeah, you either survive or you're dead. (Eve)

Participant felt the need for recognition of the complex nature of long COVID suffering and the uncertainty around their pathway to recovery. The lack of recognition at the national level, both from government and media, was a major barrier to them feeling validated in their identity as long COVID sufferers.

Long COVID community belongingness. In response to the lack of information available through government and media, Anne, Eve, Fiona, and John were at loss with their slow and unstable recovery and joined support groups on social media

where people shared their experiences, giving them a feeling of belonging to a community beyond that offered by their workplace where such groups were not always available:

> Anyway, I began to read that people were feeling exactly the same and you know, are not exactly the same, necessarily, but very similar. And so yeah, it wasn't really and then I then I was kind of, well, I suppose I was to try to do little bits of research, actually, you know, my own kind of thing. What's going on? (Anne)

As a response to the lack of recognition at the overarching contextual level, returned workers sought support to enhance their feelings of belongingness with a group of societal members outside the organisation who understood their struggles.

Discussion

We conducted an IPA study to understand the lived experiences of workers who self-identified as suffering from long COVID. To date, research has focused on long COVID symptoms, treatment, and prevalence (Akbarialiabad et al., 2021), rather than workers' experiences of working with long COVID. Our study provides valuable insights into how long COVID workers make sense of their RTW journey and engage in identity work to align their occupational identity with their emerging identity as long COVID sufferers and how the social context facilitated or hindered this identity work through belongingness to different groups in and outside the workplace.

Implications for long COVID identity work

Our findings align and extend existing research on long COVID workers' return to work journeys. Like the Ladds et al. (2020) study, we found a "chaos narrative" (Frank, 2013); our participants reported a recovery and RTW journey characterised by uncertainty and confusion and our participants felt guilty and stigmatised. Ladds et al. (2020) found that their patients felt their activities and routines were threatened. We found similar results in relation to work. Our participants felt it difficult to accept that they were no longer healthy individuals who were able to contribute and be part of a work community. Unlike the participants in the Ladds et al.'s (2020) study, most of our participants had managed to keep their jobs and return on a phased return, however, this is likely to be due to our inclusion criteria of workers who had returned to the same workplace. Like Lunt et al. (2022), we found that participants experienced that fatigue and reduced cognitive functioning impacted work ability.

Our findings, however, also extend existing research. We identified three cross-cutting themes that spanned the five levels of the IGLOo framework: suffering, identity work, and belongingness. Suffering refers to the lack of control over actions and events that define one's self (Drew, 1987) and has been described as a complex negative and affective state, resulting from a perceived threat to an individual's body, identity, life experiences and relationships and a perceived helplessness in the face of that threat and a lack of psychosocial and personal resources (Krikorian et al., 2012). Suffering relates not only to physical symptoms of disease but to the life changes, the hopelessness, the guilt, job losses and the limitations of activity resulting from disease. Our participants reported immense suffering as they experienced threats to their livelihood, identity, and their ability to manage their long COVID condition in the workplace. Participants described how

their fluctuating condition left them bewildered and out of control of their recovery journey and they felt unable to achieve their work goals. On their RTW journey, participants struggled when they did not feel that the social and structural context acknowledged the suffering arising from long COVID, the complexity of their symptoms and their struggles to adjust to their changed life situation.

We found that suffering had a profound impact on returned workers' identities and required significant identity work. We build our identity work around narrative identity theory (Bruner, 1991) and social identity theory (Tajfel & Turner, 1979). Narrative identity theory focuses on personal identities and how individuals create and update stories about their individual identity (Caza et al., 2018), while social identity theory concerns collective identities and how individuals define the groups in which they are members (Caza et al., 2018; Tajfel & Turner, 1979). Returned workers engaged in cognitive identity work (Caza et al., 2018); they expended mental efforts in construing and making sense of their occupational identity and their emerging long COVID sufferer identity. In doing so, developed their social identities seeking belongingness in multiple groups that enabled them to align their long COVID sufferer identity with their occupational identity, addressing the tensions between two conflicting identities (Carollo & Guerci, 2018).

At the level of individual identity, returned workers felt their occupational identity threatened. Narrative identity theory suggests that identity work is about telling the story about who we were, who we are and what we may become (Ibarra & Barbulescu, 2010). Occupational identity refers to "the conscious awareness of oneself as a worker" and "represents one's perception of occupational interests, abilities, goals, and values (Skorikov & Vondracek, 2011, p. 696). Prior to contracting long COVID, participants had a strong occupational identity and identified themselves as strong, physically healthy individuals who made a significant contribution in their workplaces. After returning to work, identity work took place to integrate their new identity as long COVID sufferers into their occupational identity redefining their occupational identity as someone who could still make a contribution despite their reduced work functioning. Previous research on occupational identity has primarily focused on how occupational identity is developed in the transition from adolescence to adulthood, little research has focused on occupational identity transitions in adulthood (Skorikov & Vondracek, 2011). Our findings suggest that suffering from a complex and unpredictable health condition such as long COVID may threaten workers' occupational identity and challenges workers to realign their values and aspiration to reflect their reduced work functioning. Contradictory identities can co-exist within the same person (Sveningson & Alvesson, 2003). We found an internal struggle between being a vulnerable person (long COVID sufferer identity) and being a "good" worker, (occupational identity). Returned workers developed their narrative of their identity to make sense of the unexpected event suffering from long COVID and having reduced work functioning as a result. This identity work took place to integrate their long COVID experiences into the story of their lives and redefine themselves as workers who still could make a contribution despite suffering from long COVID (Caza et al., 2018), thus aligning their occupational identity with their long COVID sufferer identity.

At the social identity level, our returned workers engaged in identity work to develop multiple identities and create belongingness with groups that supported their identity work. Social identity theory suggests that individuals engage in identity work as they

change the way they see themselves as members of a collective and by changing the meanings they associate with the group (Caza et al., 2018). We saw social identity work at four levels. Returned workers sought to change the meaning of existing the group memberships as they redefined their occupational identity and they sought belongingness through membership of new groups to enable them to understand their long COVID sufferer identity and align the conflicting identities. The social identity work process took place in a context where the interactions with colleagues, leaders, and organisational support systems either hindered or facilitated the alignment of the occupational identity with the long COVID sufferer identity. Changes to returned workers' social identity, i.e. their perceptions of group membership were influenced by their validation of their belongingness in the workplace, and they extended this belongingness to different social groups to support their identity work. Social identity work happens when group membership is threatened (Caza et al., 2018). First, returned workers saw their belongingness to the work group threatened by their diminished work functioning and ability to contribute, but they felt the need be part of their work group and be seen to still make a significant contribution. Hagerty et al. (1992) identified three key elements of belongingness, the extent to which an individual feels they are an integral part of the system, the extent to which an individual feels valued, needed, and accepted and the extent to which the individual feels their characteristics align with the system or environment. Returned workers expressed a need to be acknowledged by their colleagues as workers who were part of the social group and were valued for their work contribution, diminished as it may be (Caza et al., 2018).

Second, we identified workplace belongingness, leaders played a key role in enabling work adjustments that allowed returned workers to maintain their occupational identity and realign with this identity with their identity as long COVID sufferers who were able to achieve work goals, despite their reduced work functioning, fulfilling the need for making a contribution to the organisation. This social identity had not been prominent prior to contracting long COVID. Third, at the organisational level, we identified employment belongingness or belonging to a social group of being employed, with workers needing to feel that they were able to stay in employment and support systems lived up to their duty of care. Also at the organisational level, long COVID workers sought belongingness in new social groups such as the long COVID staff support groups, where workers felt connectedness with colleagues within the organisations who also suffered from long COVID. Belonginess to such groups gave returned workers validation in their right to be work and a shared understanding of the challenges of managing work with long COVID in the organisation. The membership of this social group gave them a sense of belonging different to that of their non-long COVID colleagues. While work colleagues made them come to terms with their redefined occupational identity, the belonginess they sought in this group helped them develop their long COVID sufferer identity; their long COVID characteristics aligned with those in a similar situation. Belonging to this group enabled participants to challenge the status quo by developing a better understanding of what support was available and they needed (Spears, 2021), enabling them to raise claims of work adjustments and changes to policy thus also reworking their occupational identity. Fourth, at the overall contextual level, belonging to a long COVID community outside the organisational context enabled workers to feel part of the greater whole, feeling part of a group that shared their

experiences and understood their struggles, thus supporting them in the development of their long COVID sufferer identity.

Transformation of returned workers' identity took place as they acknowledged their physical health had deteriorated, they negotiated work adjustments and sought new groups to whom they belonged, i.e. the long COVID staff support groups and community groups. They sought to assume control over their situation by seeking attachment to workers with similar experiences to their own. Together, these findings offer insights for RTW theory development suggesting the belonging to several social group memberships may support workers struggling to rework their occupational identity and align their long COVID sufferer identity with their occupational identity.

Implications for RTW research

Our findings contribute not only to the sparse literature on working with long COVID, but also to the wider RTW literature. We used the IGLOo framework as a heuristic platform to analyse our data. Underlying this framework is COR theory (Hobfoll, 1989), which suggests that individuals strive to maintain and gain resources in resource caravans. Previous research on SRTW focusing on worker with common mental health disorders has found that resources at the five IGLOo levels create synergistic effects allowing returned workers to thrive at work, despite still being in remission (Nielsen & Yarker, 2023). This was not the case for our long COVID participants. Although participants reported resources at the group and leader levels, individual, organisational, and outer contextual factors that they felt supported by were mainly in the form of validation of their suffering, creating a sense of identity and belongingness, which together did not seem sufficiently powerful to enable them to thrive at work, and we saw little evidence of resource caravans. Their suffering prevented a smooth return to work.

Young et al. (2005) suggested the RTW journey goes through four phases. In the first phase, workers are off sick due to their condition. In the second phase, workers re-entry and work adjustments are made in consideration of workers' limited work functioning. In the third phase, workers thrive to maintain their work status, this has been termed the maintenance phase (Young et al., 2005) or the sustainable phase (Tjulin et al., 2010) to emphasise relapse prevention. In the final phase of RTW, returned workers seek advancement, however, workers may never progress to this phase. None of the long COVID workers interviewed had progressed to the third and fourth phases. The linear thinking implied by these phases did not apply to our participants; they cycled between the first and second phases, with recurring sickness absence, return, and work adjustments, and had been unable to move to the sustainable phase.

Studying RTW trajectories 12 months post return among workers with anxiety and depression, Arends et al. (2019) found three RTW pathways: slow recovery, characterised by high anxiety and depressive symptoms, moderate to low work functioning and fast RTW, gradual recovery (decreasing anxiety and depression, increasing or low work functioning and fast RTW), fast recovery (low anxiety and depressive symptoms, high work functioning and fast RTW). Our study extends Arends et al. (2019) which used quantitative survey data to identify RTW pathways but offered no insights into the experiences of workers on these pathways. Despite it being more than 12 months since some of our participants returned to work the first time, they all reported a slow recovery, they still

reported many, fluctuating symptoms, low work functioning and although RTW had been fast, it was perhaps too fast as many had recurring sick leave and they may have returned before they had learned how to manage symptoms. None of our participants had a smooth RTW journey, which raises the question of what characterises SRTW. In the case of our participants, their RTW journey was still unstable, and they continued to need work adjustments. Future research should follow workers over time to understand the long-term implications of long COVID. As the pandemic took off in March 2020 and many of our participants contracted COVID at this time, we do not know what the trajectories of workers with long COVID are, nor the factors influencing these trajectories.

Implications for policy and practice

In line with the TUC report (2021), we propose policy and practice recommendations. At the overarching level, our results call for an inclusion of long COVID in the Equality Act 2010, ensuring that workers with long COVID are protected are protected from discrimination and to enhance rights to flexibility in working practices, for example, supported by enhanced statutory sick pay. Timely access to primary care and rehabilitation pathways, through General Practitioners and long COVID clinics will not only benefit recovery but also likely improve the likelihood of SRTW. Educating healthcare practitioners involved in the recovery journey in the importance of work for their patients' identity, self-worth, mental health, and financial stability, and how to access work accommodations, could help those who do not have access to OH services to access work-relevant advice and enable them to stay in work.

At the individual level, workers with long COVID would benefit from developing self-care and pacing strategies to support their recovery, and knowledge and skills to enable them to ask for and maintain accommodations at work. This guidance could usefully be integrated into the recovery journey alongside primary care provision to ensure that all workers are able to access these opportunities. Furthermore, guidance should be provided for employers on how to make suitable adjustments and inclusive return-to-work policies. Returned workers may also benefit from counselling enabling them to engage in identity work and seek to redefine their occupational identity to encompass their reduced work functioning, and facilitating their understanding of who they were and develop a sense of desired and possible directions for the future (Skorikov & Vondracek, 2011).

At the group, leader, and organisational levels, also in line with the recommendations of TUC (2021), we recommend employers review existing return-to-work policies, record long COVID-related sickness absence separately from other absence to avoid workers hitting performance management targets. Employers should also review flexible working policies and conduct return-to-work assessments and provide suitable work adjustments. In addition to these recommendations, our data also point to the importance of training and raising awareness of long COVID and its impact on work functioning. Training should target work teams, line managers, HR and OH to raise awareness about long COVID to reduce stigma. Furthermore, line managers, HR and OH should be trained in conducting return-to-work assessments and how to agree suitable flexible working arrangements. In this training, making clear the need for ongoing adjustments is crucial to take into consideration the fluctuations in symptoms and health.

Importantly our findings also indicate that suffering, the distress caused by the threat to the long COVID worker's integrity as a working individual, should be acknowledged by line managers, HR and OH and training should include spotting the signs of suffering, for example, by exploring whether workers are worried and frightened about what is happening to them.

Strengths and limitations

The main strength of our study is the in-depth analysis of 12 workers with long COVID of their experience of the recovery and RTW journey and the barriers and facilitators they face in this journey. The quality of the findings can be evaluated based on Smith's (2011) guidelines for conducting IPA. First, semi-structured interviews were conducted by experienced psychologists with training in conducting semi-structured interviews supporting the quality of the data collected. Second, we evidenced the rigour of the analyses by reporting the prevalence and incidence of themes and including quotations from all participants in our sample. Third, we devoted sufficient space to each of the three themes and 12 subthemes. The results focus on participants' experiences and our interpretations, and we discuss converging and diverging perspectives within each profile. Finally, we aimed to write a paper that stays true to the essence and experiences of returned workers. IPA recognises that the researcher interprets people's emotional state from what they say and therefore that researchers are largely dependent on what participants disclose, however, we felt participants were open about their experiences and our results at the individual level reveal similar themes to previous research (e.g. Callan et al., 2021; Ladds et al., 2020).

Our study is not without limitations. First, we included a sample size of 12 workers with long COVID. The main focus of IPA is a detailed account of individual experiences, such studies usually include a small number of participants. In their review, Brocki and Wearden (2006) found sample sizes range from 1–30, however, a consensus towards the use of smaller sample sizes is emerging. Our sample size of 12 enabled us to provide a rich account of the experiences of these workers and we were able to replicate the previous qualitative studies that have explored the impact on identity (e.g. Ladds et al., 2020).

Although IPA is not meant to be representative, we must make note that most of our participants were female and working in healthcare. There are three possible explanations for this. First, healthcare was and is hard hit by COVID-19 as employees are in close and extended contact with COVID-19 patients. Furthermore, the lack of personal protection equipment in the earlier phases of the pandemic meant higher exposure. Second, healthcare is a female-dominated (78% according to Eurostat, 2020). Third, we can assume that working in healthcare means staff are particularly interested in health and therefore more likely to want to share their health experiences. The studies by Ladds et al. (2020) and Lunt et al. (2022) included a similar domination of females working in healthcare.

Conclusion

Existing research of the lived experiences of workers with long COVID has primarily focused on the impact on their self-image as patients and their experiences with the healthcare system (Callan et al., 2021; Ladds et al., 2020; Rushforth et al., 2021),

limited attention has been paid to how identity and self-image play out in the work setting. The key contribution of our study is the development of nascent theory of how long COVID workers rework their occupational identity to align with their emergent identity as long COVID sufferers. Our findings show how social identity and group memberships play a major role in this identity work. Long COVID workers felt a need to both belong to both the immediate work context and being in employment, enabling returned workers to belong to groups that understood and validated their reworked occupational identity as workers who could still contribute and enabled them to better understand what role they could play in the workplace, despite their long COVID struggles. Finally, our findings suggest that the rigid national policies currently in place, particularly around absence management, do not serve workers with long COVID who are suffering a "rollercoaster" journey of recovery and return. With ever-increasing numbers reporting long COVID, there is need to take action to change the way workers' return-to-work journeys evolve.

In conclusion, our study contributes to the sparse body of knowledge about the experiences of workers with long COVID, with a specific focus on their workplace experiences. We believe that our findings underscore the importance of recognising the impact of social identity, the need for supportive group dynamics, and the necessity of revising workplace and national policies to better accommodate the unique challenges faced by workers suffering from long COVID. By addressing these issues, we can create a more compassionate and effective work environment for individuals struggling with long COVID.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This project was funded by the Research Stimulation Fund, Sheffield University Management School.

References

Akbarialiabad, H., Taghrir, M. H., Abdollahi, A., Ghahramani, N., Kumar, M., Paydar, S., … Bastani, B. (2021). Long COVID, a comprehensive systematic scoping review COVID, a comprehensive systematic scoping review. *Infection*, *49*, 1163–1186. https://doi.org/10.1007/s15010-021-01666-x.

Alvesson, M. (2010). Self-doubters, strugglers, storytellers, surfers and others: Images of self-identities in organization studies. *Human Relations*, *63*(2), 193–217. https://doi.org/10.1177/0018726709350372

Arends, I., Almansa, J., Stansfeld, S. A., Amick, B. C., Van Der Klink, J. J. L., & Bültmann, U. (2019). One-year trajectories of mental health and work outcomes post return to work in patients with common mental disorders-year trajectories of mental health and work outcomes post return to work in patients with common mental disorders. *Journal of Affective Disorders of Affective Disorders*, *257*, 263–270. https://doi.org/10.1016/j.jad.2019.07.018

Briggs, A., & Vassall, A. (2021). Count the cost of disability caused by COVID-19 the cost of disability caused by COVID-19. *Nature*, *593*(7860), 502–505. https://doi.org/10.1038/d41586-021-01392-2

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, *21*(1), 87–108. https://doi.org/10.1080/14768320500230185

Bruner, J. (1991). Introduction narrative construction of reality. *Critique Inquiry*, *18*(1), 1–13. https://doi.org/10.1080/03017609108413334

Callan, C., Ladds, E., Husain, L., Pattinson, K., & Greenhalgh, T. (2021). "I can't cope with multiple inputs": Qualitative study of the lived experience of 'brain fog' after Covid-19. *medRxiv*, https://doi.org/10.1101/2021.08.07.21261740

Carollo, L., & Guerci, M. (2018). 'Activists in a suit': Paradoxes and metaphors in sustainability managers' identity work in a suit': Paradoxes and metaphors in sustainability managers' identity work. *Journal of Business Ethics of Business Ethics*, *148*(2), 249–268. https://doi.org/10.1007/s10551-017-3582-7

Cassell, E. J. (1999). Diagnosing suffering: A perspective. *Annals of Internal Medicine*, *131*(7), 531–534. https://doi.org/10.7326/0003-4819-131-7-199910050-00009

Cassell, E. J. (2004). *The nature of suffering and the goals of medicine* (2nd ed.). Oxford University Press.

Caza, B. B., Vough, H., & Puranik, H. (2018). Identity work in organizations and occupations: Definitions, theories, and pathways forward. *Journal of Organizational Behavior*, *39*(7), 889–910. https://doi.org/10.1002/job.2318

Corbière, M., Mazaniello-Chézol, M., Lecomte, T., Guay, S., & Panaccio, A. (2022). Developing a collaborative and sustainable return to work program for employees with common mental disorders: A participatory research with public and private organizations. *Disability and Rehabilitation*, *44*(18), 5199–5211. https://doi.org/10.1080/09638288.2021.1931481

Davis, H. E., Assaf, G., McCorkell, L., Wei, H., Low, R. J., Re'em, Y., Redfield, S., Austin, J. P., & Akrami, A. (2021). Characterizing long COVID in an international cohort: 7 months of symptoms and their impact. *The Lancet*, https://doi.org/10.2139/ssrn.3820561

De Cremer, D., Brebels, L., & Sedikides, C. (2008). Being uncertain about what? Procedural fairness effects as a function of general uncertainty and belongingness uncertainty uncertain about what? Procedural fairness effects as a function of general uncertainty and belongingness uncertainty. *Journal of Experimental Social Psychology of Experimental Social Psychology*, *44*(6), 1520–1525. https://doi.org/10.1016/j.jesp.2008.07.010

Disability Discrimination Act. (1995). https://www.legislation.gov.uk/ukpga/1995/50/contents July, 25th, 2023

Drew, F. L. (1987). Suffering and autonomy. *Loss, Grief & Care*, *1*(1-2), 19–24.https://doi.org/10.1300/J132v01n01_02

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton Rogers (Eds.), *Handbook of qualitative psychology* (pp. 179–194). Sage.

Employment Rights Act. (1996). https://www.legislation.gov.uk/ukpga/1996/18/contents on July 25th 2023

Eurostat. (2020). Majority of health jobs held by women. Retrieved November 20, 2021, from https://ec.europa.eu/eurostat/web/products-eurostat-news/-/edn-20210308-1

Frank, A. W. (2013). *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.

Frost, N. (2021). *Qualitative research methods in psychology: Combining core approaches 2e*. McGraw-Hill Education (UK).

Giddens, A. (1991). *Modernity and self-identity*. Polity Press.

Hagerty, B. M., Lynch-Sauer, J. L., Patusky, K., Bouwsema, M., & Collier, P. (1992). Sense of belonging: A vital mental health concept. *Archives of Psychiatric Nursing*, *6*(3), 172–177. https://doi.org/10.1016/0883-9417(92)90028-H

Halbesleben, J. R. B., Neveu, J. P., Paustian-Underdahl, S. C., & Westman, M. (2014). Getting to the "COR". *Journal of Management*, *40*(5), 1334–1364. https://doi.org/10.1177/0149206314527130

Haslam, S. A., Jetten, J., O'Brien, A., & Jacobs, E. (2004). Social identity, social influence and reactions to potentially stressful tasks: Support for the self-categorization model of stress. *Stress and Health*, *20*(1), 3–9. https://doi.org/10.1002/smi.995

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*, *44*(3), 513–524. https://doi.org/10.1037/0003-066X.44.3.513

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review*, *35*(1), 135–154.

Kirpal, S. (2004). Work identities of nurses. *Career Development International*, *9*(3), 274–304. https://doi.org/10.1108/13620430410535850

Krikorian, A, Limonero, J. T., & Maté, J. (2012). Suffering and distress at the end-of-life. *Psycho-Oncology*, *21*(8), 799–808. https://doi.org/10.1002/pon.v21.8.

Ladds, E., Rushforth, A., Wieringa, S., Taylor, S., Rayner, C., Husain, L., & Greenhalgh, T. (2020). Persistent symptoms after COVID-19: Qualitative study of 114 "long COVID" patients and draft quality principles for services. *BMC Health Services Research*, *20*(1), 1–13. https://doi.org/10.1186/s12913-020-06001-y

Larkin, M., Watts, S., & Clifton, W. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. https://doi.org/10.1191/1478088706qp062oa

Leary, M. R., & Baumeister, R. F. (1995). The need to belong. *Psychological Bulletin*, *117*(3), 497–529. https://doi.org/10.4324/9780367198459-REPRW57-1

Lunt, J., Hemming, S., Elander, J., Baraniak, A., Burton, K., & Ellington, D. (2022). Experiences of workers with post-COVID-19 symptoms can signpost suitable workplace accommodations. *International Journal of Workplace Health Management*, *15*(3), 359–374. https://doi.org/10.1108/IJWHM-03-2021-0075

Millward, L. J. (2006). The transition to motherhood in an organizational context: An interpretative phenomenological analysis. *Journal of Occupational and Organizational Psychology*, *79*(3), 315–333. https://doi.org/10.1348/096317906X110322

Neale, B. (2021). *The craft of qualitative longitudinal research: The craft of researching lives through time*. Sage.

NICE guidance. (2020). https://www.nice.org.uk/guidance/ng188/documents/final-scope

Nielsen, K., & Yarker, J. (2023). Thrivers, survivors or exiteers: A longitudinal, interpretative phenomenological analysis of the post-return to work journeys for workers with common mental disorders. *Applied Psychology: An International Review*. https://doi.org/10.1111/apps.12479

Nielsen, K., Yarker, J., Munir, F., & Bültmann, U. (2018). IGLOO: An integrated framework for sustainable return to work in workers with common mental disorders. *Work & Stress*, *32*(4), 400–417. https://doi.org/10.1080/02678373.2018.1438536

NIHR. (2021). A dynamic review of the evidence around ongoing Covid19 (often called Long Covid**).** https://doi.org/10.3310/themedreview_45225

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369–386. https://doi.org/10.1080/14780887.2020.1854404

ONS. (2023). *Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 30 March 2023.* Retrieved November 22, 2023, from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/30march2023.

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence Based Nursing*, https://doi.org/10.1136/ebnurs-2018-103017

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7–14.

Reuschke, D., & Houston, D. (2023). The impact of long COVID on the UK workforce. *Applied Economics Letters*, *30*(18), 2510–2514. https://doi.org/10.1080/13504851.2022.2098239

Rushforth, A., Ladds, E., Wieringa, S., Taylor, S., Husain, L., & Greenhalgh, T. (2021). Long COVID – The illness narratives. *Social Science & Medicine*, *286*, Article 114326. https://doi.org/10.1016/j.socscimed.2021.114326

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, *22*(1), 16–31.

Skorikov, V. B., & Vondracek, F. W. (2011). Occupational identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity, theory and research* (pp. 693–714). Springer.

Smith, J. A. (1999). Identity development during the transition to motherhood: An interpretative phenomenological analysis. *Journal of Reproductive and Infant Psychology*, *17*(3), 281–299. https://doi.org/10.1080/02646839908404595

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9–27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., & Fieldsend, M. (2021). Interpretative phenomenological analysis. In P. M. Camic (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 147–166). American Psychological Association.

Smith, J. A., & Shinebourne, P. (2012). Interpretative phenomenological analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 73–82). American Psychological Association.

Spears, R. (2021). Social influence and group identity. *Annual Review of Psychology*, *72*(1), 367–390. https://doi.org/10.1146/annurev-psych-070620-111818

Sveningsson, S., & Alvesson, M. (2003). Managing managerial identities: Organizational fragmentation, discourse and identity struggle. *Human Relations*, *56*(10), 1163–1193. https://doi.org/10.1177/00187267035610001

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–48). Brooks/Cole.

Thompson, E. J., Williams, D. M., Walker, A. J., Mitchell, R. E., Niedzwiedz, C. L., Yang, T. C., Huggins, C. F., Kwong, A. S. F., Silverwood, R. J., Di Gessa, G., Bowyer, R. C. E., Northstone, K., Hou, B., Green, M. J., Dodgeon, B., Doores, K. J., Duncan, E. L., Williams, F. M. K., Walker, A. J., & Steves, C. J. (2022). Long COVID burden and risk factors in 10 UK longitudinal studies and electronic health records. *Nature Communications*, *13*(1), 3528. https://doi.org/10.1038/s41467-022-30836-0

Tjulin, Å, MacEachen, E., & Ekberg, K. (2010). Exploring workplace actors experiences of the social organization of return-to-work. *Journal of Occupational Rehabilitation*, *20*(3), 311–321. https://doi.org/10.1007/s10926-009-9209-9

TUC. (2021). Workers' experiences of long COVID: A TUC report. Retrieved November 15, 2021, from https://www.tuc.org.uk/research-analysis/reports/workers-experiences-long-covid

Uchiyama, Y., Sasanuma, N., Nanto, T., Fujita, K., Takahashi, M., Iwasa, S., Koyama, T., Kodama, N., & Domen, K. (2021). COVID-19 patient returned to work after long hospitalization and follow-up: A case report. *Progress in Rehabilitation Medicine*, *6*, Article 20210025. https://doi.org/10.2490/prm.20210025

Walker, S., Goodfellow, H., Pookarnjanamorakot, P., Murray, E., Bindman, J., Blandford, A., Bradbury, K., Cooper, B., Hamilton, F. L., Hurst, J. R., Hylton, H., Linke, S., Pfeffer, P., Ricketts, W., Robson, C., Stevenson, F. A., Sunkersing, D., Wang, J., Gomes, M., & Living With Covid Recovery Collaboration. (2023). Impact of fatigue as the primary determinant of functional limitations among patients with post-COVID-19 syndrome: A cross-sectional observational study. *BMJ Open*, *13*(6), e069217. https://doi.org/10.1136/bmjopen-2022-069217

Watson, T. J. (2008). Managing identity: Identity work, personal predicaments and structural circumstances. *Organization*, *15*(1), 121–143. https://doi.org/10.1177/1350508407084488

WHO. (2021). New policy brief calls on decision-makers to support patients as 1 in 10 report symptoms of "long COVID". Retrieved November 21, 2021, from https://www.euro.who.int/en/health-topics/health-emergencies/pages/news/news/2021/02/new-policy-brief-calls-on-decision-makers-to-support-patients-as-1-in-10-report-symptoms-of-long-covid

Wolf, S., & Erdös, J. (2021). Long COVID care pathways: A systematic review. In *Aihta projektbericht Nr.: 135b*. HTA Austria – Austrian Institute for Health Technology Assessment GmbH.

Young, A. E., Roessler, R. T., Wasiak, R., McPherson, K. M., Van Poppel, M. N., & Anema, J. R. (2005). A developmental conceptualization of return to work. *Journal of Occupational Rehabilitation*, *15*(4), 557–568. https://doi.org/10.1007/s10926-005-8034-z