

Work–family interference and long-term sickness absence: a longitudinal cohort study*

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Background: Alongside work environment factors, interference between work and domestic life has been proposed as an important explanation for long-term sickness absence, particularly for women. The aim was to investigate the association between work-to-family interference, family-to-work interference and long-term sickness absence among women and men in different family- and work-related settings. **Methods:** The study population was a random sample of 2867 gainfully employed adults in Sweden aged 25–50. In 2004, telephone interview data were collected that included questions about family, work and health. The outcome measure was having at least one spell of long-term sickness absence (>14 days) in 2005 based on social insurance register data. Associations were analysed by logistic regression. **Results:** Work-to-family interference was more common than family-to-work interference and more often reported by women. The overall associations with long-term sickness absence were weak. However, after adjustment for age and self-reported health, work-to-family interference was associated with long-term sick leave among men with higher socioeconomic status (odds ratio 2.87; 95% CI 1.36–6.07), and there was also a tendency to association among women bearing the main responsibility for housework and family (1.59; 0.99–2.54). **Conclusions:** These findings suggest that work-to-family interference is associated with long-term sickness absence in the working population, but in a gender- and situation-specific manner. Hence, extensive work responsibilities for men, and probably extensive family responsibilities for women, could hamper the balance between work and family and increase the risk of long-term sick leave. Further studies are warranted within this area.

Keywords: work–family conflict, work-to-family interference, family-to-work interference, sickness absence, gender

Introduction

The significance of adverse physical and psychosocial work environments for workers' health and sickness absence is well documented.^{1–6} Family conditions and private circumstances such as cohabitation and children living at home could also constitute an extra workload and additional stress, especially for women,^{7,8} although that negative influence may be alleviated by personal and situational factors, including material and social resources.⁹ Some studies have indicated that double burden (i.e. the combined load of paid and household work) accounts for the higher rates of sickness absence among women,^{10,11} whereas other investigations have found only weak relationships in that context.^{12–15} Thus the research results concerning the effects of a double burden on sickness absence are inconclusive.

In most studies addressing the double burden hypothesis, degrees of exposures have been determined using objective measures such as total number of hours in paid and unpaid work, number of (young) children in the family, responsibility for care of sick or dependent relatives and the number of social roles a person has. A different approach would be to directly measure work–family conflicts or interference in order to determine whether the subjects consider themselves as having

role conflicts between the work and family domains, in the sense that the role pressures from these domains are mutually incompatible in some respect.¹⁶ The importance of taking into account the specific direction of an association between work and family (i.e. whether it represents work-to-family or family-to-work interference) has also been emphasized regarding outcomes such as life satisfaction, distress and depression.^{16,17}

Much research on work–family interference has focused on antecedents, and factors at work as well as in the domestic sphere are potentially important predictors.^{18–20} Associations involved in work–family interference have been found to include stress-related outcomes such as burnout,²¹ need for recovery from work and fatigue,²⁰ poor self-assessed health²² and perceived stress.^{21,23}

By comparison, little attention has been paid to the relationship between work–family interference and sickness absence. Nonetheless, some studies have indicated that there is a connection with increased absence. For example, positive associations have been found between work-to-family interference (WFI) and repeated or extensive sick leave among Dutch university employees of both sexes.²⁴ A longitudinal investigation of Dutch private sector employees also revealed associations between WFI and duration of sickness absence in both women and men,²⁵ and a longitudinal study of Finnish municipal employees demonstrated that WFI predicted a higher rate of sick leave spells among both women and men.²⁶ Furthermore, a longitudinal investigation of female municipal employees in Sweden detected higher risk of long-term (≥ 28 days) sick leave for those exposed to work–family conflicts, regardless of the direction of the problems.¹⁵ In as much as the association between family-to-work interference (FWI) and sickness absence has been reported to be none²⁴ or weak,²⁵ it is expected in the present study that WFI should be more strongly associated with long-term sick leave than FWI.

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The aim was to investigate the association between work-to-family interference, family-to-work interference and medically certified sickness absence exceeding 14 days among women and men in different family- and work-related settings.

Methods

Study population

The study comprised a representative random sample of 4929 individuals from the eligible Swedish population aged 25–50, ~3.1 million people in 2004.²⁷ In the spring of 2004, these people were contacted by telephone to answer questions raised by experienced interviewers working at Statistics Sweden. In all, 3579 individuals (73%) completed the interview; dropout was due to unavailability (770) and refusal to participate (580). The analyses were restricted to subjects who were gainfully employed (545 were excluded due to being unemployed) and were not on disability pension at baseline in 2004 (67 were excluded due to receipt of such benefits). This gave a sample of 2967 people, and complete data on all variables were available for 2867 of those individuals who were finally included for analysis. Since the dropout rate was higher among individuals with weaker attachment to the labour market, i.e. unemployed and low income groups, the actual response rate in the working sample is higher than the overall response rate of 73%.

Measures

Compensated sickness absence, sex and age were retrieved from registers, and information on all other variables came from the interviews. The interview protocol was structured and included the areas of family, work and health situation, and in general referred to situations relevant to the time of the interview.

Long-term sickness absence

Follow-up of sickness absence during 2005 was based on information from the national social insurance registers compiled by Statistics Sweden in the LISA database. The outcome variable was having at least one continuous period of medically certified sick leave >14 days in 2005, which was referred to as long-term sickness absence (LTSA) in this study (as compared to shorter sick spells or no sickness absence at all). Compared to short-term sickness absence where the decision to stay away from work can be made by individual itself, LTSA is less voluntary and more closely connected to illness and disease. Due to lack of information about the first and the last day in individual sick leave spells, it was not possible to achieve more precise measurement of the time span between exposure and LTSA or measure the precise length of the sick leave period. All individuals included were covered by the Swedish national sickness insurance, in which the requisite for compensation is impaired ability to work due to illness or injury. In 2005, compensation for the first 14 days of a sick-leave spell was paid by the employer (the sick pay period), with the exception of the first qualifying ('waiting') day. Also, a doctor's certificate is required from the eighth day, and only spells exceeding the sick pay period is recorded in the national social insurance registers.

Work-to-family interference and family-to-work interference

The following items concerning WFI and FWI were adopted from the General Nordic Questionnaire for Psychological and Social Factors at Work (QPS Nordic): 'Do the demands of

your work interfere negatively with your home and family life?' (WFI) and 'Do the demands of your home and family life interfere negatively with your work related activities?' (FWI).²⁷ Responses were given on a five-point scale: happens every day, every other day, at some time during the week, more infrequently or never. WFI or FWI was considered to have occurred for responses indicating demands at some time during the week or more often.

Family- and work-related factors

The other variables were grouped into family- and work-related factors. The former group included cohabitation (single or living with spouse/partner), children <16 years living at home (yes/no), main responsibility for household and family (mine/shared/someone else's), caring for sick or handicapped relative (yes/no) and employed spouse/partner (yes/no). The work-related factors comprised the following: socioeconomic status (SES) based on occupation and employment status and dichotomized into low (lower white collar or blue collar or lower) versus high (mid-level white collar and above, including self-employed); permanent or temporary employment; part- or full-time paid work (<35 or ≥35 h a week); shift work (yes/no, i.e. more than 5 h a week between 6 p.m. and 10 p.m. or more than 1 h a week between 10 p.m. and 6 a.m.); experiencing planned workplace closure or downsizing or expansion (yes/no) or reorganization at the workplace during the last year (yes/no). Poor self-reported health was defined as a rating of 4 or 5 on a five-point scale (very good, fairly good, neither good nor bad, fairly bad, very bad).

Statistical analyses

Prevalence proportions (percentages) of the different characteristics of the study population were calculated, and differences between cases and non-cases and between women and men were assessed using χ^2 -tests for all variables except mean age differences, which were analysed with *t*-tests. The analysis was conducted for men and women separately in order to allow gender-specific effects.²⁸ To scrutinize the associations between WFI, FWI and LTSA in different work- and family-related settings, stratified logistic regression was used. Crude and adjusted odds ratios (ORs) with 95% confidence intervals (95% CIs) are presented. Significant associations were adjusted for age (as a continuous variable) and self-reported health at baseline. All statistical analyses were performed using SPSS (release 15.0.0).

The study was approved by the Regional Ethical Review Board in Stockholm, Sweden.

Results

The characteristics of the total sample and of women and men with and without LTSA in 2005 are presented in table 1. Considering the entire sample, LTSA was more prevalent among women (18%) than among men (10%). WFI was also more common among women (31%) than men (25%), whereas FWI was equally distributed and less prevalent for both sexes (12% and 13%, respectively). In this study, the combination of WFI and FWI will not be analysed. However, there is some overlapping and 9% women and 10% men experience both WFI and FWI (figures not presented in table 1).

Living with a spouse/partner, having children younger than 16 years, shouldering most of the household work and family matters, having the responsibility for a sick or handicapped relative and having an employed spouse/partner were also

Table 1 Prevalence (%) of characteristics of women and men at baseline in 2004 stratified for having or not having a period of LTSA^a

n	Women			Men			Total sample		
	No LTSA 1108	LTSA 251	P-value	No LTSA 1358	LTSA 150	P-value	Women 1359	Men 1508	P-value ^b
<i>Work-family interference</i>									
WFI	30.5	34.3	0.246	24.6	31.3	0.071	31.2	25.3	<0.000
FWI	11.6	13.9	0.312	13.1	13.3	0.938	12.1	13.1	0.393
Poor self-reported health	4.0	15.1	<0.000	3.6	13.3	<0.000	6.0	4.6	0.081
Age, mean (SD)	38.4 (7.0)	38.1 (7.2)	0.614	37.8 (7.2)	38.9 (6.8)	0.071	38.3 (7.1)	37.9 (7.2)	0.101
Age groups (years)			0.681			0.361			0.307
25–30	17.0	20.7		20.3	14.7		17.7	19.8	
31–35	18.6	16.7		20.3	18.0		18.2	20.0	
36–40	23.6	21.9		21.0	24.0		23.3	21.3	
41–45	20.1	20.3		19.3	20.0		20.2	19.4	
46–50	20.7	20.3		19.1	23.3		20.6	19.6	
<i>Family-related factors</i>									
Living with spouse/partner	77.5	81.7	0.150	75.0	74.0	0.796	78.3	74.9	0.031
Children <16 years living at home	63.5	66.5	0.383	56.3	66.7	0.015	64.1	57.4	<0.000
Single parent with children <16 years	8.5	7.2	0.495	6.7	13.3	0.003	8.2	7.4	0.379
Responsibility for housework and family matters ^c			0.388			0.073			<0.000
Mainly respondent's	47.7	48.3		2.8	6.3		47.8	3.1	
Shared	49.0	50.2		56.7	59.6		49.2	57.0	
Mainly someone else's	3.3	1.5		40.6	34.2		2.9	39.9	
Responsible for sick or handicapped relative	6.6	8.4	0.316	4.1	6.0	0.283	6.9	4.3	0.002
Employed partner ^c	92.8	92.2	0.772	80.8	74.8	0.127	92.7	80.2	<0.000
<i>Work-related factors</i>									
Blue collar or lower white collar	52.7	55.4	0.444	58.4	78.7	<0.000	53.2	60.4	<0.000
Middle-upper white collar or self-employed	47.3	44.6		41.6	21.3		46.8	39.6	
Permanent employment ^d	88.7	86.7	0.381	91.2	89.8	0.593	88.4	91.1	0.023
Full-time paid work	71.0	73.7	0.396	93.0	90.7	0.294	71.5	92.8	<0.000
Shift work	22.7	26.7	0.172	32.9	41.3	0.039	23.4	33.8	<0.000
Workplace closure/downsizing/expansion	47.3	53.8	0.063	51.5	56.7	0.234	48.5	52.1	0.057
Reorganization at the workplace	53.5	60.2	0.056	46.5	42.0	0.290	54.7	46.1	<0.000

a: LTSA = at least one period of sickness absence >14 days in 2005

b: P-values for differences between cases and non-cases and between women and men

c: Refers to subjects living with a spouse/partner

d: Refers to employed subjects

more common among women. In addition, fewer women than men had permanent employment, worked full-time or had shift work, but a larger proportion of women had higher socioeconomic status and experience of reorganization at the workplace.

Having at least one period of LTSA in 2005 was significantly more prevalent among individuals with poor self-reported health. Men in the long-term sickness absence group more often had children at home, were single parents, had a lower socioeconomic status or were shift workers. Women who had experienced workplace closure or reorganization of the workplace had also a tendency to have higher prevalence of LTSA.

Crude ORs with 95% CIs for the stratified analysis according to different family- and work-related factors for the associations between WFI, FWI and subsequent long-term sickness absence are presented in table 2 for women and in table 3 for men. The overall associations between WFI, FWI and LTSA were weak for both women and men (tables 2 and 3, row 1). However, a relationship between WFI and LTSA was found among women living with a spouse or partner (1.40; 1.01–1.92), had the main responsibility for housework and family (1.72; 1.09–2.71) or had an employed spouse/partner (1.39; 1.00–1.94). An association between FWI and LTSA was observed for women without young children (2.35; 1.07–5.16).

The results presented in table 2 were further adjusted for age and self-reported health at baseline. After this adjustment there was still a tendency to association between WFI and LTSA among women carrying the main responsibility for housework and family matters. The association between FWI and LTSA among women without young children at home turned insignificant when age and self-reported health were accounted for.

For men, WFI was associated with LTSA among those with higher socioeconomic status (3.26; 1.57–6.74) or permanent employment (1.72; 1.14–2.59), whereas no association was found between FWI and LTSA among those in different family- or work-related strata (table 3). After adjustments for age and self-reported health, the relationship between WFI and LTSA remained evident among men with higher socioeconomic status.

Discussion

The overall associations between WFI, FWI and LTSA were weak. However, for specific categories, the associations were stronger. Thus, WFI was associated with LTSA among women who were living with a spouse/partner, had the main responsibility for housework and family or had an employed

Table 2 Crude and adjusted ORs with 95% CI for associations between WFI and FWI and LTSA, stratified by family- and work-related factors among women

Women	n	Associations between WFI and LTSA		Associations between FWI and LTSA	
		Crude OR (95% CI)	Adjusted ^a OR (95% CI)	Crude OR (95% CI)	Adjusted ^a OR (95% CI)
Across all strata	1359	1.19 (0.89–1.59)		1.23 (0.82–1.84)	
<i>Family-related factors</i>					
Living with spouse/partner	1064	1.40 (1.01–1.92)	1.24 (0.89–1.72)	1.30 (0.82–2.05)	
Single	295	0.56 (0.26–1.17)		1.13 (0.49–2.61)	
Children <16 years at home	871	1.16 (0.82–1.64)		0.98 (0.61–1.58)	
No children <16 years at home	488	1.21 (0.71–2.06)		2.35 (1.07–5.16)	1.99 (0.88–4.50)
Single parent with children <16 years	112	0.42 (0.14–1.27)		0.67 (0.20–2.23)	
Responsibility for housework and family matters ^b					
Mainly the respondent's	509	1.72 (1.09–2.71)	1.59 (0.99–2.54)	1.56 (0.83–2.95)	
Shared	524	1.18 (0.75–1.86)		1.08 (0.55–2.11)	
Mainly someone else's	31	–		–	
Responsible for sick or handicapped relative	94	1.20 (0.45–3.23)		3.25 (0.98–10.77)	
Employed partner ^b	986	1.39 (1.00–1.94)	1.24 (0.88–1.76)	1.33 (0.82–2.15)	
<i>Work-related factors</i>					
Blue collar or lower white collar	723	1.24 (0.82–1.89)		1.06 (0.56–2.00)	
Middle-upper white collar or self-employed	636	1.20 (0.79–1.81)		1.42 (0.84–2.40)	
Temporary employment ^c	150	0.86 (0.34–2.19)		1.15 (0.35–3.81)	
Permanent employment ^c	1138	1.22 (0.89–1.68)		1.38 (0.89–2.16)	
Full-time paid work	972	1.14 (0.82–1.59)		1.44 (0.93–2.22)	
Part-time paid work	387	1.30 (0.71–2.37)		0.48 (0.14–1.62)	
Shift work	318	0.94 (0.53–1.66)		0.89 (0.35–2.26)	
Regular working hours	1041	1.28 (0.91–1.79)		1.36 (0.87–2.12)	
Workplace closure/ downsizing/expansion	659	1.07 (0.72–1.58)		1.43 (0.87–2.34)	
Reorganization at the workplace	744	1.33 (0.92–1.91)		1.29 (0.78–2.12)	

– No results presented due to few cases in strata

a: Adjusted for age and self-reported health

b: Refers to subjects living with a spouse/partner

c: Refers to employed subjects

Table 3 Crude and adjusted ORs with 95% CI for associations between WFI and FWI and LTSA, stratified by family- and work-related factors among men

Men	n	Associations between WFI and LTSA		Associations between FWI and LTSA	
		Crude OR (95% CI)	Adjusted ^a OR (95% CI)	Crude OR (95% CI)	Adjusted ^a OR (95% CI)
Across all strata	1508	1.40 (0.97–2.02)		1.02 (0.62–1.68)	
<i>Family-related factors</i>					
Living with spouse/partner	1129	1.35 (0.89–2.06)		1.06 (0.61–1.82)	
Single	379	1.60 (0.76–3.38)		0.89 (0.26–3.08)	
Children <16 years at home	865	1.38 (0.89–2.14)		0.90 (0.51–1.60)	
No children <16 years at home	643	1.26 (0.64–2.48)		1.06 (0.37–3.08)	
Single parent with children <16 years	111	1.27 (0.44–3.68)		0.48 (0.10–2.29)	
Responsibility for housework and family matters ^b					
Mainly the respondent's	35	–		–	
Shared	643	1.17 (0.65–2.10)		0.83 (0.38–1.81)	
Mainly someone else's	451	1.82 (0.93–3.57)		1.06 (0.43–2.64)	
Responsible for sick or handicapped relative	65	0.83 (0.19–3.69)		1.50 (0.33–6.80)	
Employed partner ^b	906	1.39 (0.86–2.24)		0.95 (0.50–1.81)	
<i>Work-related factors</i>					
Blue collar or lower white collar	911	1.24 (0.78–1.96)		0.80 (0.42–1.55)	
Middle-upper white collar or self-employed	597	3.26 (1.57–6.74)	2.87 (1.36–6.07)	2.12 (0.95–4.74)	
Temporary employment ^c	119	0.34 (0.04–2.74)		0.65 (0.08–5.48)	
Permanent employment ^c	1211	1.72 (1.14–2.59)	1.49 (0.98–2.29)	1.17 (0.66–2.07)	
Full-time paid work	1399	1.43 (0.98–2.10)		1.02 (0.61–1.72)	
Part-time paid work	109	1.17 (0.30–4.62)		0.96 (0.20–4.78)	
Shift work	509	1.22 (0.70–2.13)		0.56 (0.23–1.34)	
Regular working hours	999	1.46 (0.89–2.38)		1.44 (0.78–2.63)	
Workplace closure/downsizing/expansion	785	1.52 (0.94–2.44)		1.12 (0.61–2.06)	
Reorganization at the workplace	695	1.52 (0.89–2.60)		0.71 (0.31–1.60)	

– No results presented due to few cases in strata

a: Adjusted for age and self-reported health

b: Refers to subjects living with a spouse/partner

c: Refers to employed subjects

spouse/partner. After adjustment for age and health, there was still a tendency of WFI being associated with LTSA among women bearing the main responsibility for housework and family. For men, WFI was related to LTSA among those with higher socioeconomic status and men in permanent employment. The study indicates that both objective and subjective measures should be accounted for in studies aiming at explaining the relation between work–family interference vis-à-vis long-term sickness absence. In the analysis, WFI or FWI was considered to be present, if the condition was perceived at least once a week. More conservative cut-off points for WFI and FWI at ‘happens every day/every other day’ were tested and gave equivalent results.

The findings correspond well with results reported by Donders²⁴ and Jansen *et al.*²⁵ indicating associations between WFI and the length of sickness absence for both women and men. Jansen and colleagues also found that the observed associations disappeared after adjustment for psychological job demands, decision latitude and social support, and thus their results also support the concept that the relationship between WFI and sickness absence operate mainly through factors associated with the psychosocial work environment. Hence, psychosocial work environment factors could operate through work-to-family interference. However, adjusting for psychosocial work environment factors in the analysis would mean overadjusting if WFI is considered to lie in the pathway between work environment factors and sickness absence. Adjusting for self-reported health could also be considered as overadjustment if deteriorated health could be considered to be in the pathway between WFI and LTSA. Still, adjusting for self-reported health at baseline reduces the effect of reversed causality, i.e. bad health leading to WFI and consequently the presented estimates are conservative.

WFI was more common than FWI in the Swedish working population, which agrees with studies conducted in the Netherlands.^{24,25} Furthermore, the observation that WFI occurred more often among women than men complies with a Finnish study²⁶ but contradicts the Dutch findings that WFI was not higher among women.^{24,25} A plausible explanation for this incongruence is that the number of working hours and employment in qualified jobs were more similar between women and men in Sweden and Finland than in the Netherlands due to a ‘family-friendlier’ policy in the two Nordic countries.²⁹ The observation that WFI was more prevalent than FWI for both men and women may be related to the fact that Sweden is a highly work-oriented society, where both women and men are expected to have gainful employment.²⁹ Nevertheless, due to prevailing norms concerning gender division of household tasks, women in Sweden experience more WFI than men. On the other hand, women and men do not differ regarding the prevalence of FWI, which agrees with the above-mentioned Dutch studies.^{24,25}

The results regarding WFI and socioeconomic status disagree with a recent study by Väänänen and colleagues,²⁶ in which it was found that work-to-family spillover was more strongly associated with repeated sickness absence among blue collar and lower white collar workers. However, the cited study was restricted to public sector employees and used a different outcome measure. Clearly, future research should take into account the socioeconomic position and occupational status of both adults in a family relationship.

The findings suggest that gendered work and family life is manifested in the conditions of life associated with WFI and LTSA, which are more family related for women (i.e. associated with the main responsibility for housework and family) and more work related for men (i.e. connected with

higher socioeconomic status). This agrees with the study of academics conducted by Donders, in which the strongest association between WFI and sickness absence was found for work pressure among men and for role conflicts among women.²⁴

The strengths of the present study were the relatively large sample of the working population, the use of register data on sickness absence and the prospective cohort study design. The large population-based sample and the high response rate suggest good generalizability. A limitation of the study is the relatively low number with LTSA. However, the generalizability to the working population (25–50 years of age) implies that these rather common exposures of work-to-family interference, despite relatively moderate odds ratios with somewhat broad confidence intervals, have implications for public health in Sweden. The facts that it was not possible to achieve more precise measurement of the time-span between exposure and LTSA or measure the length of the sick leave period may also be a weakness. Nonetheless, as previously reported,³⁰ the outcome measure used is crude but robust. Another limitation is the use of single items on WFI and FWI, which may have reduced the measurement validity.

There could be a selection bias in terms of study-dropout from working conditions involving higher work–family interference, especially for women, which would have led to underestimation of the associations reported for women.³¹ Elevated levels of work-to-family conflict have been reported for both women and men with higher status occupations,^{11,31} and thus selection bias might explain why an association between socioeconomic status and WFI was found only for men. On the other hand, Berntsson *et al.*³² studied Swedish white collar employees and found that men focused mainly on their work role and seemed to be fairly resistant to feelings related to conflicting demands. However, the subjects in that study were somewhat older than the subjects in the present study (ages 32–58 versus 25–50), and it is possible that attitudes and norms are gradually changing so that resistance to conflicting demands is decreasing among male white collar workers. The overall association for WFI found for men in the present study could indicate that there is an increasing propensity for men to bear domestic responsibilities which could get into conflict with prevailing norms in society concerning gender division of labour.

Subjective measures of WFI and FWI were used and associations with LTSA in different family- and work-related situations were found. Therefore, the results suggest that future research aimed at explaining the relationship between double workload, work–family interference and LTSA should take into account indicators of actual workload or double burden, as well as measures of perceived interference between work and family. Furthermore, consideration should be given to other outcomes and coping patterns associated with work–family interference, such as partial and full withdrawal from the labour market, the use of temporary parental cash benefit to care for sick children and different health-related outcomes. It is also important to perform more in-depth analysis of the pathways underlying work–family interference and sickness absence of varying duration for both women and men.

Conclusions

The findings of this study indicate that work-to-family interference has generally weak relationships to long-term sickness absence among women and men in a Swedish working population aged 25–50 years. However, for specific categories of men and women, subjective views on work to family interference are of importance even after controlling

for health and age. The differences in the results for women and men imply that gendered work and family life is still prevalent in Sweden. Hence, the extensive work responsibilities of men, and probably the extensive family responsibilities of women, hamper achievement of balance between work and family in the working population.

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Conflicts of interest: None declared.

Key points

Interference from work to family is more common than interference from family to work and more often reported by women than men. Interference from work to family is associated with long-term sickness absence among men with higher socioeconomic status and there is also a tendency to association among women with the main responsibility for housework and family. The gendered work and family life seems to be manifested in the conditions of life associated with work-to-family interference and long-term sickness absence: i.e. for men excessive demands at work, and for women probably excessive demands at home.

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