Journal of Clinical and Nursing Research, 2026, Volume 10, Issue 4
http://ojs.bbwpublisher.com/index.php/JCNR
Online ISSN: 2208-3693
Print ISSN: 2208-3685

Research Advances in Return-to-Work Readiness Among Young and Middle-Aged Hospitalized Patients: A Review

Wenxin Li[1], Huiru Wang[1], Wenjie Wang[2]*

[1]Hubei University of Medicine, Shiyan 442000, Hubei, China
[2]Nursing Department, Taihe Hospital, Hubei University of Medicine, Shiyan 442000, Hubei, China

***Corresponding author:** Wenjie Wang, pywwj522@163.com

Abstract: This review synthesizes current evidence on return-to-work (RTW) readiness among young and middle-aged adults hospitalized for acute or chronic conditions. We clarify the conceptual foundations of RTW readiness, critically evaluate existing assessment instruments, including their psychometric properties and clinical applicability, and delineate the multilevel determinants shaping readiness: disease-related factors, individual attributes, workplace characteristics, and sociocultural supports. This study further assess the empirical basis and implementation feasibility of prevailing interventions, namely, integrated vocational rehabilitation, cognitive-behavioral support, and condition-specific health literacy programs. While substantial progress has been made in identifying correlates of RTW readiness, critical gaps persist in longitudinal measurement, cross-cultural validation of tools, and theory-driven, scalable interventions. This synthesis aims to inform evidence-based practice and policy aimed at strengthening sustainable RTW outcomes in this high-need population.

Keywords: Return-to-work readiness; Hospitalized patients; Assessment tools; Influencing factors

Online publication: Apr 30, 2026

1. Introduction

With advancements in medical technology and demographic shifts, the issue of return-to-work among young and middle-aged hospitalized patients has garnered increasing attention [1]. Return-to-work is not only related to patients' economic independence and quality of life but also significantly impacts socio-economic development. However, due to the effects of illness and treatment, many young and middle-aged hospitalized patients face numerous challenges upon returning to work [2]. The World Health Organization (WHO) has repeatedly emphasized the importance of work for personal health, considering work a core component of people's lives; it not only provides financial resources but also gives meaning to life, promotes personal

growth, and facilitates social integration [3]. Disease recovery involves not merely the restoration of physical function but comprehensive biopsychosocial recovery. Return-to-work readiness refers to the degree of preparation a patient feels to re-enter the workplace and effectively perform job duties after experiencing illness or trauma. This process encompasses not only physical recovery but also psychological adjustment, access to social support, and adaptation to the work environment across multiple dimensions. The biopsychosocial model provides a comprehensive perspective for understanding return-to-work readiness [4]. This model emphasizes that returning to work depends not only on the patient's physiological recovery status but is also influenced by psychological state, social support, work environment, and other factors. Therefore, studying return-to-work readiness holds significant practical importance.

This article aims to systematically review recent research advances on return-to-work (RTW) readiness among hospitalized young and middle-aged adults. Specifically, it examines four key domains: validated assessment tools for RTW readiness; current prevalence and patterns of RTW readiness in this population; individual, clinical, occupational, and psychosocial factors influencing RTW readiness; and evidence-informed intervention strategies. By synthesizing extant literature, consolidating empirical findings, critically identifying persistent knowledge gaps, and proposing concrete directions for future research, this review seeks to inform clinical practice and support the development of targeted, theory- and evidence-based RTW interventions.

2. Assessment tools for return-to-work readiness in young and middle-aged hospitalized patients

A wide range of validated tools is available to assess return-to-work readiness, broadly categorized into self-report scales, clinician-administered assessments, and work ability evaluations. Widely used self-report instruments include the Readiness for Return-to-Work Scale (RRTW), the Return-to-Work Self-Efficacy Questionnaire (RTW-SE), the Lam Assessment of Stages of Employment Readiness (LASER), and the Work Ability Support Scale (WSS). Collectively, these instruments evaluate key domains, including physical functioning, psychological well-being, work motivation, and environmental adaptability providing complementary, multi-dimensional insights into patients' readiness for sustained employment.

2.1. The readiness for return-to-work scale (RRTW)

The Readiness for Return-to-Work Scale (RRTW), developed by Canadian researcher Ronald L. Franche and colleagues on the theoretical foundations of the Stages of Change Model and the Readiness for Return-to-Work Model, was culturally adapted and validated for use in China by Chinese scholar Cao Huili [5]. The core 13-item subscale comprises four theoretically grounded dimensions: Precontemplation (items 1, 2, and 13), Contemplation (items 9, 11, and 12), Preparedness for Action–Self-Evaluation (items 4, 7, 8, and 10), and Action (items 3, 5, and 6), specifically intended for patients who remain absent from work due to illness or hospitalization. Psychometric evaluation supports its robust internal consistency, with Cronbach's α coefficients ranging from 0.78 to 0.831 across dimensions. Responses are rated on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree), and the dimension yielding the highest mean score identifies the patient's predominant stage of readiness. Empirical evidence confirms the RRTW's clinical utility and feasibility in hospitalized patient populations.

2.2. Return-to-work self-efficacy questionnaire (RTW-SE)

The Return-to-Work Self-Efficacy Questionnaire (RTW-SE), developed by Dutch researcher S. E. Lagerveld and colleagues in 2010, is a theoretically grounded instrument rooted in Bandura's social cognitive theory and the transtheoretical model of behavior change [6]. The original version has undergone rigorous cross-cultural adaptation and psychometric validation in diverse populations worldwide, establishing its robust reliability and construct validity. In 2021, Gao Yaxin and colleagues conducted a comprehensive cultural adaptation and validation study specifically for mainland Chinese cancer patients, confirming measurement invariance and clinical utility in this population [7]. The RTW-SE comprises 11 items, three of which are reverse-scored (items 2, 6, and 9) assessing confidence in performing work-related tasks despite illness-related barriers. Respondents rate each item on a 6-point Likert scale (1 = completely disagree, 6 = completely agree), and the mean item score (range: 1–6) serves as the primary indicator of return-to-work self-efficacy; scores ≥ 4.5 reflect high self-efficacy, consistent with empirically established clinical thresholds. In young and middle-aged Chinese cancer patients, the scale demonstrated excellent internal consistency (Cronbach's $\alpha = 0.932$), strong split-half reliability ($r = 0.925$), and satisfactory test–retest reliability ($r = 0.827$) across treatment phases, from active therapy to survivorship, thereby substantiating its reliability, structural validity, and practical applicability in oncology rehabilitation settings.

2.3. Lam assessment of stages of employment readiness (LASER)

The Lam Assessment of Stages of Employment Readiness (LASER), developed by American researcher M. K. Lam and colleagues in 1997, is a stage-theoretic instrument grounded in the Transtheoretical Model of Behavior Change. The original scale was subsequently adapted and validated for Cantonese-speaking populations in Hong Kong in 2006, yet its applicability to mainland Chinese patients was constrained by linguistic variation, sociocultural norms surrounding work disability, and structural differences in vocational rehabilitation systems. To address this gap, Xu Yanwen and colleagues (2014) undertook a systematic cultural adaptation and rigorous psychometric validation of the LASER specifically for mainland Chinese injured workers recovering from work-related limb fractures [8]. The revised 18-item version preserves the core four-stage structure, Precontemplation, Contemplation, Preparation, and Action, while ensuring conceptual equivalence and item relevance within the mainland Chinese occupational health context. Items are rated on a 5-point Likert scale (1 = no confidence, 5 = full confidence), and dimensional mean scores determine readiness classification: confident (≥ 4.0), intermediate (3.0–3.9), or non-confident (≤ 2.9). Empirical evaluation confirmed acceptable internal consistency across dimensions (Cronbach's $\alpha = 0.696–0.768$), supporting the scale's reliability and structural validity for use in early-phase vocational rehabilitation among young and middle-aged Chinese workers.

2.4. Work-ability support scale (WSS)

The Work Ability Support Scale (WSS), developed in 2015 by J. K. Fadyl and K. M. McPherson, is a theoretically informed, multi-stakeholder instrument designed to capture the complex interplay between individual capacity and environmental support in return-to-work processes following stroke [9]. Grounded in in-depth qualitative interviews with stroke survivors, employers, and rehabilitation professionals and integrating conceptual elements from the Work Ability Index (WAI) and the Occupational Role Questionnaire, the WSS uniquely bridges clinical assessment and vocational contextualization. Its Chinese adaptation (Guo Yawen et al., 2020) underwent rigorous cross-cultural translation, cognitive debriefing, and

psychometric validation among community-dwelling young and middle-aged stroke survivors, confirming strong measurement equivalence and clinical relevance [10]. The scale comprises two complementary modules: Part A (16 items) assesses perceived support for work ability across three empirically derived domains, Physical Functioning, Thinking and Communication, and Social Behavior, rated on a 7-point Likert scale (1 = lowest independence, 7 = highest independence); Part B (12 items) evaluates modifiable facilitators and barriers to return-to-work readiness across three contextual domains, Personal Factors, Work Environment Factors, and Barriers to Return-to-Work, scored on a 3-point bipolar scale (−1 = unlikely, 0 = uncertain, +1 = likely). Psychometric evaluation demonstrated acceptable to excellent internal consistency (Cronbach's $\alpha = 0.645–0.933$), robust test–retest reliability (ICC = 0.86), and strong convergent validity with the WAI ($r = 0.72$, $p < 0.001$), supporting its utility as a comprehensive, context-sensitive measure of return-to-work readiness.

Critically, no single tool comprehensively captures all dimensions of return-to-work readiness. While the RTW-SE excels in measuring domain-specific self-efficacy beliefs, and the LASER delineates behavioral stages of readiness, the WSS distinguishes itself by explicitly quantifying the environmental and interpersonal supports essential for translating capacity into actual work participation. Consequently, tool selection should be purpose-driven: the RTW-SE is optimal for evaluating psychological readiness interventions; the LASER best informs stage-matched counseling; and the WSS is uniquely suited for assessing and targeting modifiable workplace and systemic barriers, particularly in early-phase vocational rehabilitation for physically impaired populations.

3. Current status analysis of return-to-work readiness in young and middle-aged hospitalized patients

Empirical evidence consistently indicates that return-to-work readiness among young and middle-aged hospitalized patients remains suboptimal, with prevalence estimates ranging from 32% to 47% across recent cohort studies. Marked heterogeneity is observed across diagnostic categories: patients diagnosed with malignancies or cardiovascular conditions demonstrate significantly lower readiness levels than those with orthopedic injuries, particularly spinal or major joint impairments, reflecting differential impacts of disease chronicity, symptom burden, and functional prognosis. Beyond clinical diagnosis, sociodemographic determinants, including younger age (within the 18–45 range), female gender, and lower educational attainment exert independent and statistically significant effects on readiness scores, underscoring the multifactorial nature of this construct. Longitudinally, readiness exhibits a nonlinear but generally progressive trajectory during inpatient and early outpatient rehabilitation; however, interindividual variability is substantial, driven by factors such as comorbidity load, psychosocial support, and workplace accommodation availability. While some patients achieve functional work capacity within 3–6 months post-discharge, others require ≥ 12 months of structured vocational rehabilitation to attain sustainable employment outcomes [11]. Critically, both premature return-to-work, before achieving minimum functional safety thresholds and delayed re-entry beyond evidence-based recovery windows, pose dual risks: exacerbating physical deconditioning or symptom recurrence, and undermining occupational identity, skill retention, and long-term career mobility.

Internationally, theoretical frameworks of return-to-work readiness emerged from interdisciplinary research investigating how macro-level structural factors, including healthcare policy, workplace accommodations, and social insurance design, interact with individual biopsychosocial determinants to shape injured workers' return-to-work trajectories [12]. Empirical evidence robustly links readiness

levels to a constellation of theoretically coherent, empirically validated constructs: physical health status, functional capacity (e.g., mobility, endurance), pain intensity and interference, mental health functioning, clinically significant depressive symptoms, and fear-avoidance cognitions specifically related to work tasks and physical exertion. Wisenthal et al. applied the LASER staging model to identify distinct behavioral phenotypes: individuals in the active maintenance stage demonstrated superior physical functioning, lower kinesiophobia, and greater engagement in vocational goal-setting, whereas those classified in the rumination and uncertainty maintenance stages exhibited heightened depressive symptomatology, maladaptive illness perceptions, and reduced self-efficacy for work-related activities [13]. Jarvis et al. reported that among young adult stroke survivors (aged 18–45 years), 44% remained unemployed or on permanent disability at 2-year post-stroke follow-up, contributing to an estimated £1.9 billion in annual UK productivity losses, equivalent to 0.07% of national GDP [14]. Collectively, these findings underscore that the persistent work disability burden among young adult stroke survivors reflects not merely residual impairment, but a complex systems failure spanning clinical rehabilitation, occupational health services, and socioeconomic policy; thus, effective solutions must be multilevel, evidence-informed, and developmentally tailored to this life-stage.

Domestically, a study by Chen Xiaoping et al. on factors influencing return-to-work (RTW) among 228 postoperative renal cancer patients revealed statistically significant associations with educational level, surgical approach, anxiety, depression, and self-efficacy [15]. These findings are consistent with those reported by Zhang Gengzan et al. [16]. In a qualitative investigation, Zeng Qingwei et al. explored the experiences of adolescents with cancer returning to school and found that successful reintegration into the educational setting is critical not only for clinical recovery but also for enhancing overall quality of life in this population. Gong Aiping's study of 425 hemodialysis patients indicated that 105 (24.7%) had resumed employment; among these, 75.2% were classified in the "uncertain maintenance" stage of the transtheoretical model (TTM), suggesting fragile or unstable RTW status [17]. Conversely, among those not yet returned to work, the majority were situated in the "precontemplation" stage, indicating low RTW readiness. Similarly, Zhao Xinna's investigation of 103 young and middle-aged patients who had undergone percutaneous coronary intervention (PCI) but had not resumed work found that, among the 212 non-RTW cases assessed, the highest mean score was observed in the "contemplation" stage, further supporting the conclusion that most patients remain in early stages of behavioral change and exhibit limited RTW readiness [18]. Notably, a substantial proportion of participants across these studies lacked adequate disease-related knowledge and demonstrated poor understanding of self-care management strategies.

Return-to-work serves as a key indicator of patients' successful reintegration into society following illness. Numerous factors influence return-to-work outcomes, yet readiness for return-to-work remains suboptimal among certain patient populations.

4. Factors influencing return-to-work readiness in young and middle-aged hospitalized patients

4.1. Personal factors

Personal factors encompass age, gender, educational attainment, average monthly family income, and place of residence. These variables significantly shape patients' perceptions of their illness and their capacity to cope with it. Zhao Yajie et al. reported higher return-to-work (RTW) readiness among young and middle-aged lung cancer patients aged 18–44 years, a finding corroborated by Zhao Xinna et al. [19,20]. This trend

may be attributable to the central familial role assumed by individuals in this age group, coupled with heightened occupational demands and greater perceived family responsibilities, which collectively foster proactive engagement in rehabilitation and a stronger motivation for early societal reintegration and RTW. In contrast, younger patients, particularly those who are unmarried or live independently, may exhibit lower RTW readiness due to diminished awareness of familial obligations or greater adaptation to solitary living arrangements. Wang Yujie et al. identified substantial economic strain as a key barrier, reporting that higher average monthly family income was associated with "lower" RTW readiness, an inverse relationship also observed in the present study [21,22]. Specifically, limited capacity to cover medical expenses contributed to prolonged hospitalization and an elevated risk of job loss, consistent with findings among nasopharyngeal carcinoma survivors reported by Wang Juan et al. [23]. This paradox may reflect structural inequities: low-income patients often lack both stable financial reserves and access to workplace-based social support services, leading to treatment delays secondary to insufficient medical funding, factors that ultimately impede timely RTW. Furthermore, marital status emerged as a salient predictor: unmarried patients demonstrated significantly lower RTW readiness compared with their married counterparts. This disparity may stem, in part, from the psychosocial buffering afforded by spousal support; however, marriage may also entail added pressures related to caregiving responsibilities (e.g., childcare or eldercare). Importantly, robust family support can facilitate favorable living conditions, enhance adherence to rehabilitation regimens, and promote broader health-related outcomes conducive to successful RTW.

4.2. Disease characteristics

Disease characteristics, including disease severity, treatment modality, functional exercise capacity, and comorbid complications, directly influence patients' physical functioning. In Wang Liangliang's study on return-to-work outcomes among patients with myasthenia gravis, 198 individuals had not resumed employment; of these, 51.8% remained in the precontemplation or contemplation stages of behavioral change and had not advanced to the action stage [24]. Owing to the pathophysiological nature of myasthenia gravis, patients frequently experience proximal limb weakness, which impairs their ability to sustain standard working hours. Moreover, exposure to complex or physically demanding work environments, particularly without adequate symptom monitoring or workplace accommodations, may precipitate myasthenic crises, thereby posing a significant threat to patient safety and survival.

4.3. Psychological factors

Psychological state encompasses a range of psychological factors, including sense of coherence, positive coping, perceived stigma, anxiety, and depression. Positive coping and self-efficacy have been identified as protective factors for return-to-work (RTW) readiness among patients with cirrhosis who had not yet resumed employment [25]. Among young and middle-aged lung cancer patients who had not returned to work, family resilience exerted a direct effect on RTW readiness and an indirect effect mediated by sense of coherence; in contrast, among those who had already resumed work, sense of coherence influenced RTW readiness only indirectly. Healthcare professionals should therefore enhance disease-related health literacy, reduce illness uncertainty, and strengthen patients' self-efficacy, thereby facilitating adaptive coping strategies and supporting non-returned patients in advancing toward higher levels of RTW readiness. In breast cancer survivors who had successfully returned to work, positive coping was positively associated with RTW readiness [26]. Adaptive coping styles enable patients to confront illness with greater resilience, maintain a

constructive outlook on life, and proactively pursue early reintegration into social and occupational roles. To sustain high levels of RTW readiness among those who have resumed work, healthcare professionals should actively mobilize family support, guide the adoption of positive coping strategies, mitigate illness uncertainty, and reinforce psychosocial resources. Arends et al. conducted a cluster randomized controlled trial evaluating a problem-solving intervention among individuals with common mental disorders (CMD) who had returned to work (N = 158) [27]. Information on anxiety and depressive symptoms, work functioning, and return-to-work (RTW) status was collected at baseline and at 3-, 6-, and 12-month follow-ups. Latent class growth analysis identified three distinct recovery trajectories:

(1) Slow recover

Characterized by persistently high levels of anxiety and depressive symptoms, moderate-to-low work functioning, and rapid RTW;

(2) Rapid recovery

Marked by low anxiety and depressive symptoms, high work functioning, and rapid RTW; and

(3) Gradual recovery

Defined by declining anxiety and depressive symptoms, variable (i.e., increasing or decreasing) work functioning, and rapid RTW.

Participants reporting higher baseline work engagement and greater willingness to continue working were significantly more likely to be classified in the rapid recovery trajectory. Notably, many individuals with common mental disorders (CMDs) continue to experience elevated mental health symptoms and substantial work functioning difficulties throughout the first year following RTW. Therefore, establishing realistic, evidence-informed recovery expectations, shared jointly by patients, clinicians, employers, and other stakeholders is essential to support successful, sustained recovery and long-term work participation.

4.4. Work-environment factors

Work-environment factors, including job demands, schedule flexibility, and employer support, also significantly influence patients' readiness to return to work. A supportive work environment can facilitate the provision of necessary accommodations and allow adequate time for role adaptation and functional recovery. Social support encompassing familial, peer, and community-based resources plays a critical role in both rehabilitation and the return-to-work process [28]. These interrelated factors collectively shape patients' return-to-work readiness.

5. Intervention measures to enhance return-to-work readiness in young and middle-aged hospitalized patients

Researchers have proposed a range of evidence-informed interventions to enhance return-to-work (RTW) readiness among hospitalized young and middle-aged adults. Vocational rehabilitation represents one of the most widely implemented approaches, encompassing structured work ability assessments, individualized vocational training, and workplace accommodations. Collectively, these components aim to restore functional work capacity and strengthen occupational adaptability [29]. Psychological support constitutes another critical intervention domain, particularly cognitive-behavioral therapy and stress management techniques, which helps patients effectively navigate the psychosocial challenges inherent in the RTW transition.

Health education constitutes another evidence-based intervention strategy, which enhances patients'

self-management capacity and work-related confidence through the provision of disease-specific knowledge, evidence-informed rehabilitation techniques, and occupation-relevant information training. Moreover, multidisciplinary team collaboration and structured case management have demonstrated efficacy as intervention approaches. These strategies may be implemented independently or synergistically, with selection guided by individual patient characteristics, functional status, and psychosocial needs [30].

Cognitive Work Hardening (CWH) is a multifactorial, work-focused intervention grounded in empirical evidence and designed to support successful return-to-work (RTW) following depressive episodes. Wisenthal documented the application of CWH to prepare an individual for RTW after a disability leave attributable to major depression [13]. The participant engaged in a structured 4-week CWH program targeting key functional barriers, including fatigue and diminished physical endurance, cognitive inefficiencies (e.g., impaired attention, processing speed, and working memory), outdated digital literacy, and elevated anxiety. Through graduated, ecologically valid work simulations, the program facilitated the systematic rebuilding of cognitive capacities while concurrently enhancing work tolerance and stamina. Task-based mastery experiences bolstered self-confidence and perceived self-efficacy, whereas targeted instruction in adaptive coping strategies, particularly stress regulation and assertive interpersonal communication, addressed critical psychosocial needs. At program completion, the participant reported clinically meaningful improvements in perceived work capacity, alongside significant reductions in both fatigue severity and core depressive symptoms. Objective clinical assessments of occupational functioning indicated readiness for resumption of pre-disability employment duties. At the 3-month follow-up, the participant maintained full-time employment, consistently managing full workdays with sustained energy and focused attention. This case illustrates the pragmatic utility of CWH as an evidence-informed, functionally oriented intervention to optimize RTW outcomes following depression.

6. Conclusion

This paper provides a comprehensive review of recent research on return-to-work (RTW) readiness among hospitalized young and middle-aged adults. The analysis reveals that RTW readiness is a multidimensional construct shaped by interrelated biomedical, psychological, social, and occupational factors. While extant literature has advanced understanding in three key domains, namely, the development and validation of assessment instruments, identification of salient determinants, and design and evaluation of targeted interventions, several critical gaps persist. Notably, the field lacks consensus on standardized, psychometrically robust assessment criteria; longitudinal studies tracking RTW trajectories beyond six months remain scarce; and cross-cultural comparative research, particularly across diverse healthcare systems and socioeconomic contexts, is markedly underdeveloped.

Future research should prioritize the development of more comprehensive and psychometrically robust assessment tools, the implementation of longitudinal follow-up studies to rigorously evaluate the sustained efficacy of interventions, and the conduct of cross-cultural comparative investigations. Furthermore, fostering multidisciplinary collaboration and systematically integrating medical, psychological, vocational, and social support resources is critical to delivering holistic, patient-centered care. Sustained investment in both empirical research and evidence-informed practice will deepen our understanding of return-to-work readiness among young and middle-aged hospitalized patients, thereby advancing their vocational rehabilitation and facilitating successful social reintegration.

Disclosure statement

The authors declare no conflict of interest.

References

[1] Buchanan H, Van Niekerk L, 2022, Work Transitions after Serious Hand Injury: Current Occupational Therapy Practice in a Middle-Income Country. Australian Occupational Therapy Journal, 69(2): 151–164.

[2] Aasdahl L, Fimland M, Røe C, 2022, The Readiness for Return-to-Work Scale; DoesIt Help in Evaluation of Return to Work? Journal of Occupational Rehabilitation, 32(3): 426–437.

[3] Fang L, 2023, Analysis of Self-Transcendence Status and Factors Influencing Work Engagement in Rectal Cancer Patients with Permanent Enterostomy Returning to Work.Clinical Medical Research and Practice, 8(19): 56–62.

[4] Lyby P, Johansen T, Aslaksen P, 2021, Comparison of Two Multidisciplinary Occupational Rehabilitation Programs Based on Multimodal Cognitive Behavior Therapy on Self-Rated Health and Work Ability. Frontiers in Psychology, 12(6): 669–770.

[5] Cao H, He K, Qi Q, 2019, Reliability and Validity Test of the Chinese Version of the Readiness for Return-to-Work Scale in Breast Cancer Patients. Chinese Journal of Rehabilitation Medicine, 34(7): 801–807.

[6] Lagerveld S, Blonk R, Brenninkmeijer V, et al., 2012, Work-Focused Treatment of Common Mental Disorders and Return to Work: A Comparative Outcome Study. Journal of Occupational Health Psychology, 17(2): 220–234.

[7] Gao Y, Qu Q, Wang B, et al., 2021, Sinicization of the Return-to-Work Self-EfficacyQuestionnaire and Its Reliability and Validity Test in Cancer Patients. Journal of Nursing Science, 38(7): 52–55.

[8] Xu Y, Luo X, Lu X, et al., 2014, Reliability and Validity of the Lam Assessment ofStages of Employment Readiness in Occupational Rehabilitation for Work-Related Injuries. Chinese Journal of Rehabilitation Theory and Practice, 20(6): 592–596.

[9] Fadyl J, McPherson K, Schlueter P, et al., 2015, Development of a New Tool to Evaluate Work Support Needs and Guide Vocational Rehabilitation: The Work-Ability Support Scale. Disability and Rehabilitation, 37(3): 247–258.

[10] Guo Y, Lin B, Zhang Z, et al., 2020, Reliability and Validity of the Chinese Versio of the Work-Ability Support Scale in Working-Age Stroke Patients. Chinese Journal of Rehabilitation Theory and Practice, 26(9): 1076–1082.

[11] Zhang W, Xue P, 2023, Correlation Between Latent Classes of Resilience and Return-to-Work Readiness in Nurses Returning to Work After Second Childbirth. Chinese Nursing Research, 37(9): 1522–1527.

[12] Buerger W, Nuebling R, Streibelt M, 2022, Work-Related Medical Rehabilitation Carein Psychosomatic Medicine in Comparison with Other Indications. Rehabilitation, 61(4): 264–275.

[13] Wisenthal A, 2021, Case Report: Cognitive Work Hardening for Return-to-Work Following Depression. Frontiers in Psychiatry, 12: 608496.

[14] Jarvis H, Brown S, Price M, et al., 2019, Return to Employment After Stroke in Young Adults: How Important Is the Speed and Energy Cost of Walking? Stroke, 50(11): 3198–3204.

[15] Chen X, Liu W, Chen Y, et al., 2023, Factors Influencing Return-to-Work in Postoperative Renal Cancer Patients and Construction of a Predictive Model. Military Nursing, 40(11): 9–13.

[16] Zhang G, 2022, Current Status and Influencing Factors of Return-to-Work Readiness in Young and Middle-Aged Patients with Post-Stroke Sequelae. thesis. Shandong University of Traditional Chinese Medicine.

[17] Gong A, Xu J, Ji X, et al., 2023, Current Status and Influencing Factors of Return-to-Work Readiness in Young and Middle-Aged Hemodialysis Patients. Chinese Journal of Modern Nursing, 29(36): 4939–4944.

[18] Zhao X, 2022, Current Status and Correlation Analysis of Return-to-Work Readiness and Social Function in Young and Middle-Aged Patients after PCI. Chinese Nursing Research, 36(1): 118–121.

[19] Zhao Y, 2023, Current Status and Influencing Factors of Return-to-Work Readiness inYoung and Middle-Aged Lung Cancer Patients, thesis.

[20] Zhao X, Zhao L, 2022, Social Function Status and Its Influencing Factors after Return-to-Work in Young and Middle-Aged Patients with Coronary Heart Disease after PCI. Chinese Nursing Research, 36(18): 3328–3332.

[21] Colasanti C, Akpinar B, Rynecki N, et al., 2023, Poor Psychological Readiness Inhibits Return to Play Following Operative Management of Superior-Labrum Anterior-Posterior Tears. Arthroscopy Sports Medicine and Rehabilitation, 5(2): e359–e366.

[22] Wang Y, Wu Z, 2022, Effect of Fear of Disease Progression on Return-to-Work Readiness in Young and Middle-Aged Patients with Chronic Heart Failure. Prevention and Treatment of Cardiovascular and Cerebrovascular Diseases, 22(3): 80–82.

[23] Wang J, Qin H, Huang Z, et al., 2022, Research Progress on the Status and Influencing Factors of Return-to-Work in Nasopharyngeal Carcinoma Survivors. China Health Standard Management, 13(14): 194–198.

[24] Wang L, Xie M, Yao N, et al., 2023, Current Status and Influencing Factors of Return-to-Work Readiness in Patients with Myasthenia Gravis. Chinese Nursing Research, 37(19): 3587–3591.

[25] Wang J, Wen F, Zhu M, et al., 2024, Current Status and Influencing Factors of Return-to-Work Readiness in Liver Cancer Patients after Hepatectomy. Journal of Hepatobiliary Surgery, 32(3): 196–200.

[26] Xiao C, Zhang C, 2022, Current Status and Influencing Factors of Return-to-Work Adaptability in Lung Cancer Survivors. Journal of General Nursing, 20(15): 2116–211.

[27] Cheng H, 2023, Correlation Between Social Support, Sense of Coherence, and Return-to-Work Readiness in Breast Cancer Patients, thesis.

[28] Arends I, Almansa J, Stansfeld S, et al., 2019, One-Year Trajectories of Mental Health and Work Outcomes Post Return to Work in Patients with Common Mental Disorders. Journal of Affective Disorders, 257: 263–270.

[29] Zhang Y, 2022, Correlation Between Social Support, Illness Perception, Hope, and Return-to-Work Readiness in Young and Middle-Aged Patients with Rhegmatogenous Retinal Detachment, thesis.

[30] Heikinheimo S, Puustinen N, Kuoppala J, et al., 2024, Use of the Return-to-Work-Readiness Questionnaire with Patients Undergoing Psychiatric Assessment of Work Ability: A Pilot Study. Nordic Journal of Psychiatry, 78(8): 668–674.