Towards a Dynamic Understanding of Burnout

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS

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Introduction to the portfolio

This portfolio seeks to provide an understanding of burnout. It focusses on examining burnout from the context of the nurse working in the high intensity fields of cancer care and intensive therapy. It has three components to it; first I present an empirical piece of research which provides an understanding of the dynamic process by which a nurse becomes vulnerable or resilient to burnout; secondly I present a case study of my clinical work with a young nurse who showed marked signs of burnout and was struggling to manage the demands of her work; finally I present a paper which I hope to publish in a nursing journal.

Before embarking on the main body of this portfolio, it is worth taking a moment to share my reflections of my journey, to help understand why I became interested in burnout and why I chose to focus this enquiry on nurses specifically. I recall my interest in nursing began as a 17 year old girl on work experience, shadowing a nurse at my local hospital. I found I naturally engaged with the patients and was fascinated by their stories. I remember being particularly fond of one old lady who had no relatives to visit her, I enjoyed simply spending time listening to her. However, I returned on my last day to find she had died alone in the night. I recall crying and reflected upon the harsh realities of nursing. I left this post, having complete admiration for nurses but recognising it wasn't for me and wondering how on earth nurses manage to remain compassionate and caring when having to face the grim realities of illness, dying, and others pain and suffering on a daily basis. This experience did however, light a spark in me which left me recognising a desire to find a career that allowed me to engage with others and share their life stories whilst trying to help them in some way, perhaps by piecing together their life jigsaws and helping them to find ways to move forward positively with their lives.

Hence my interest in psychology was realised, although I became diverted post-graduation and channelled my interest in understanding others behaviour through my work as a qualitative researcher, specialising in health relate issues. Whilst this career proved rich and varied, I increasingly became frustrated by a feeling this work rarely made a meaningful enough difference and gradually lost interest in this field. I finally knew I had to move into a field that I valued more and began my training as a counselling psychologist. I chose my placements carefully to ensure I gradually and carefully moved into my new caring role, as such I decided

I'd like to work in a field which supports the mental health and wellbeing of healthcare professionals. My placement in the second year of my training in the Staff Psychological and Welfare Service (SPWS), [redacted], brought the challenging nature of nursing back into sharp focus and my admiration and recognition that both the nurses role and that of counselling psychologists are not that dissimilar in that we both have to manage and learn to effectively process the more challenging aspects of our work. I wanted to learn all I could about how to do this, not only from my own point of view of trying to become a more resilient practitioner, but also to ensure my practice with other healthcare professionals could be as effective and long-lasting as possible.

When contemplating the subject for my research, I was struck by the nurses walking through my door, some were highly experienced, largely resilient nurses, who for many years managed and enjoyed the pressures of their work. However, increasingly they had lost enthusiasm and started to suffer from deteriorating mental health and a general loss of their sense of well-being. Some reduced their hours to cope, others contemplated leaving the profession. In comparison I also noticed how some of the younger nurses I saw, seemed more vulnerable to the pressures they faced and hadn't yet managed to find effective means to cope with the impact of their work, but were able through our work together to recognise the need to develop strategies to adapt and manage the pressures of their work more effectively. Whilst they often presented with what appeared at first glance to be anxiety or mood related problems, it became apparent these 'labels' didn't seem wholly fit for purpose. These labels failed to acknowledge the significance of contextual factors on the development of their problems or the interpersonal and attitudinal changes that were occurring primarily in relation to their work. I also felt the need to develop a formulation and treatment plan which didn't just function as a mere band aid but acknowledged these factors and found ways to address them. I worked hard to find appropriate therapeutic approaches which enabled the nurse to re-connect with their reasons for becoming a nurse, more effectively manage the anxiety generated by the daily pressures they faced and build greater resilience to face the demanding nature of their work. I was encouraged to develop and run a series of resilience workshops at [redacted] which proved very popular. I based this program on Acceptance and Commitment Therapy (ACT), as outlined in *The Mindful and Effective Employee* (Bond et al, 2013). I also increasingly worked with individual clients by integrating ACT and CBT which felt particularly effective in this setting and with the type of presentations I was dealing with primarily. This set me

thinking about the nature and relevance of burnout, and I wondered whether by conducting a piece of research exploring burnout, I would be able to begin to help the nurses showing signs of burnout to reverse its effects. I also felt burnout as a construct would resonate with nurses and prove less stigmatising than other labels in common use, serving to increase engagement with the need to more effectively manage their own mental health and well-being, a challenge we often faced as a team when trying to reach out to nurses and encourage them to consider their own mental and physical health needs more. Hence my research question finally began to take shape.

This portfolio represents the culmination of my development as a counselling psychologist; whilst my practice was invariably weighted in favour of intuition in the early stages of my training, this has now shifted and my practice is increasingly research led and evidence based, a necessary requirement when working in the NHS. I also began to appreciate the value of what it means to be a counselling psychologist and wanted to ensure I reflect our pluralist positioning through both my clinical practice and research. I feel I am much more able to appreciate the benefits of being open to different approaches and feel increasingly comfortable in finding ways to manage the conflict and challenges this can bring. My choice of adopting a mixed method approach in my research and use of an integrative approach in my case study reflects this. I also felt that whilst my method of working with nurses and other healthcare professionals was proving efficacious I wanted to ensure that I moved forward with my career and interest in burnout by generating a piece of research which could add value to my practice and be true to the value I hold dear about wanting to bring about lasting change in my clients and help to ensure greater health and well-being as they pursue their chosen paths. I believe the way to do this is through ensuring our practice is research led, hence my reasons for this study.

Each element of this portfolio is linked by the desire to provide insight into what we can do as counselling psychologists, to help to ensure the health and well-being of healthcare professionals, focussing on this occasion on the perspective of the nurse. I hope to continue working in this field and to disseminate the findings of this study in such a way as to bring about more effective ways of building resilience to burnout and so reduce the threat it poses to our modern workforce, particularly to those working in the healthcare professions.

Section A: Doctoral research

The main body of this portfolio comprises the Doctoral Research entitled *"The nurse's journey: How does a nurse become vulnerable or resilient to burnout?"* The research aimed to provide a retrospective exploration of the nurse's journey identifying the factors/ processes and psychological mechanisms which influence vulnerability and resilience to burnout. A mixed methods approach with qualitative focus, using an amended version of classical grounded theory, was used to explore burnout within the context of nurses working in the high intensity fields of cancer care and intensive therapy at [redacted] sites. The quantitative element helped to identify burnout levels but most importantly identified nurses for the qualitative phase who either showed signs of resilience to burnout, vulnerability to burnout or were burnt out. This was established using the Maslach Burnout Inventory (MBI:Maslach and Jackson, 1981), the most widely used tool to measure burnout. By exploring burnout from opposite ends of the burnout spectrum, a theory and model was developed which provides hope that wherever on the burnout spectrum you are, the process can be reversed and greater resilience to burnout fostered. The findings are set against the body of knowledge that currently exists and how this theory complements this body of evidence explored. The role counselling psychologists can play in tackling burnout is discussed and the implications findings have for nursing policy, practice and intervention development is presented. I hope this research will have relevance not only to the clinical practice of counselling psychologists, but given an appropriate platform it can have far wider reach in terms of offering a strategy for a multi-level program of support, which emanates from counselling psychologists, through to nurses, nursing management and organisational policy makers. I have grown professionally and hope to add impetus to the need to offer more informed support to tackle the threat burnout can have on our modern healthcare workforce if left ignored.

Section B: Client case study

This section presents a case study of my clinical work with a nurse working in a high intensity field. She was referred to the Staff Psychological and Welfare Service, where I was on placement. She had recently had to take time off work as stress related leave. She describes no longer recognising herself as the nurse she once felt she was, she presented with anxiety and compulsive tendencies. Since

carrying out this research I realise my formulation could have benefited from inclusion of her burnout status, because she showed signs of burnout on two dimensions of the MBI, emotional exhaustion and reduced personal accomplishment whilst retaining compassionate care with low levels on the depersonalisation scale. Whilst this case does not provide a classic case of burnout, it being more appropriately viewed as an outlier, it does illustrate the fluid, dynamic and continuous nature of the burnout process. It encourages a sense of hope that by offering tailored therapeutic approaches, we are able to move even the more vulnerable nurses to a more resilient position on the burnout spectrum. This case study also serves to illustrate how I have grown into a counselling psychologist who has the ability to flexibly adapt to my clients unique presentation and develop an integrative therapeutic approach, combining ACT with CBT which serves to address her underlying anxiety whilst also helping her to function more effectively within the context of her role as a specialist, high intensity nurse. This approach is compatible with one of the approaches I feel is necessary to combat the effects of burnout whilst having to be realistic about functioning in an environment like the NHS which currently faces huge pressures.

Section C: Publishable paper

In this section I present a paper with the aim of submitting it for publication to the journal; *Applied Nursing Research*. I have chosen to present the emerging model from my research. It is hoped that this will provide compelling evidence as to why it is necessary to address burnout on multiple levels, if support is to have lasting impact. It is hoped that the recommendations made in this paper can help produce a nursing workforce which is more resilient to the demands of high intensity nursing and able to withstand the current pressures faced within the NHS and yet encourage a nursing workforce that can remain compassionate, caring and committed to their roles. The review of the background literature has been chosen because it is felt to be the most engaging and interesting to this target audience, the readership of whom will be the nursing community primarily. I have chosen this journal because whilst articles cover all clinical nursing issues it also includes papers dealing with nursing care delivery and job stress, two themes relevant to this paper.

Section A: Doctoral Research

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The Nurse's journey: How does the nurse become vulnerable or resilient to burnout?

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Nicola Dawson

Supervised by: Professor Carla Willig

Abstract

Nurses in the UK currently face significant challenges: Austerity measures and efficiency drives have led to staff shortages (Nursing Times, 2013), and nurses suffering from higher rates of stress-related sickness when compared to other sectors (Foureur et al, 2013). The nature of the nursing role leaves nurses particularly vulnerable to burnout (Farrington, 1995). A pragmatic epistemological framework was adopted to conduct a mixed methods study, with qualitative focus, which set out to retrospectively explore how the nurse becomes vulnerable or resilient to burnout. Initially 100 nurses working in the high intensity fields of cancer care or ITU, in a leading UK, NHS Trust, were invited to take part in a quantitative study exploring burnout levels, using the MBI. 100 took part, 53% showed burnout on at least 1 dimension of burnout, ie. emotional exhaustion. 16 nurses were interviewed qualitatively: 10 showing various degrees/patterns of burnout and 6 showing high levels of resilience to burnout. A modified, analytical approach of classical grounded theory was adopted. Findings suggest burnout is a continuous, multi-faceted process involving a complex interplay of *internal/interpersonal/external* factors. The process is mediated by how *reflective, insightful and adaptable* a nurse is to work-based stressors, with marked differences being found between the vulnerable and resilient nurse positions. Of note the inherent preference for task-focused or emotionally-driven nursing orientations variably influences how burnout develops. The pervasive culture of communication was also identified as significant with the optimum culture being one of understated stoicism, acceptance and collective management of vulnerability. Findings suggest far reaching implications for nursing training policy, selection, nursing practice and intervention development, which should function at the individual/interpersonal and organisational level, taking into account the impact of nursing orientations and the pervasive culture of communication on burnout.

Chapter 1: Introduction

1.1 Overview and context

Nurses in the UK have faced significant challenges in recent years: Austerity measures and efficiency drives have led NHS trusts to cut frontline staff and training places, whilst an ageing population has also increased demand (Nursing Times, 2013). Perhaps unsurprisingly health care professionals in general and nurses in particular suffer from higher rates of stress-related sickness when compared with other sectors (Cottrell, 2001, Foureur et al, 2013), putting the annual direct cost of absence to the NHS at £2.4 billion a year (Public Health England, 2015). The Francis Inquiry (2013), set up to explore the extreme failings found at the Mid Staffordshire NHS Foundation Trust suggested this was in part caused by staff shortages and suggested the need to create a culture of care within the NHS, which puts the patient first and is both compassionate and committed. To enable this there is apparent need to support our nursing force too. In Autumn 2015, the chief executive of the NHS, Simon Stevens acknowledged that *"when it comes to supporting the health of our own workforce, frankly the NHS needs to put its own house in order"* (Guardian, 2/9/15) and pledged a £5m solution to create healthy and supportive workplaces to reduce the NHS bill for staff sickness. Whilst this policy is to be welcomed, another recent government spending review proposes to scrap bursaries for trainee nurses in 2017, fuelling further uncertainty amongst the nursing community. It is acknowledged that this will serve to remove the cap on the number of student places, potentially helping to alleviate the nursing shortage, however, it has been condemned by nursing unions. Janet Davies, chief executive of the Royal College of Nursing has also voiced deep concerns (Guardian, 7/12/2015); trainee nurses could face considerable financial pressures, in part because clinical placements are outside term time, prohibiting the uptake of part-time work to support the cost of training, adding strain and potentially acting as a barrier to those from lower income backgrounds. This policy will also increase demand for qualified nurses to act as mentors, if this need is not actively supported by trusts this may place extra strain on the existing nurse force adding to the burden of their job roles and potentially raising the risk of burnout.

On first entering the NHS, as a trainee counselling psychologist on placement in a service at [redacted] offering staff psychological support, [1]I was struck by the pressures the nurses walking through my door faced day in day out, and how some were more able to effectively cope with these pressures than others. I became increasingly aware of the relevance and usefulness of burnout as a construct, the original and commonly held burnout definition often more appropriately fitting my clients than a formulation which defined their problems as anxiety/stress or depression. The definition adopted states that burnout is a '*prolonged response to chronic emotional and interpersonal stressors on the job*' (Maslach and Jackson, 1983:1), typically experienced by those working in the caring professions, and characterised by emotional exhaustion, a sense of depersonalisation and feelings of reduced personal accomplishment. I was all too aware that the nature of the nursing role can leave nurses particularly vulnerable to burnout (Farrington, 1995, Schaufeli & Janczur, 1994), because healthcare professionals have the additional burden of continuously working in emotionally charged situations involving death, trauma and feelings of uncertainty, anxiety and fear on a daily basis (Sarafino, 1990, Ifeagwazi, 2005). Many of the tasks they carry out can be under-valued, unrewarding, frustrating and distasteful (Farrington, 1995). The nurse's role is also often complicated by overwork, under-staffing, role conflict and ambiguity, tight schedules and complex hierarchies of authority (Ifeagwazi, 2005). A growing body of research links burnout with: High rates of absence; job dissatisfaction; increased employee turnover and worse patient outcomes (Tarantino, 2013., McHugh et al, 2011). This poses a threat to the successful running of healthcare facilities. As such, burnout remains a pertinent topic, especially in the context of nursing. The added uncertainty generated by the current political climate surrounding withdrawal of nurse funding suggests burnout is an issue in need of solutions based on sound context specific research.

This being the context, I found myself recognising more is needed to help support our nursing workforce to remain resilient to burnout and retain compassionate care, I set out to develop a research project which examined the burnout process more fully. A number of studies have shown that nurses working in high intensity wards, for example ICU units (Ifeagwazi, 2005, Mealer et al, 2009) and oncology nurses (Taris et al, 2005), are at increased risk of burnout, hence

[1] I chose to use the first person after much deliberation because it was felt to best suit the reflective approach I adopted throughout the research and the position I hold as a clinician first and foremost.

these fields became the focus of this study. My experience in clinic, led me to appreciate the value of talking not only to those suffering from burnout, but also nurses more resilient to it. Hence I adopted a pragmatic epistemological frame of enquiry whereby I adopted a mixed method approach with a qualitative focus. Using the Maslach Burnout Inventory (Maslach & Jackson, 1981), I was able to measure burnout levels and identify where each nurse fell on the burnout spectrum. From this, I identified 16 nurses who fell at different points on the burnout spectrum and conducted qualitative interviews in order to provide a retrospective exploration of the nurse's journey identifying the factors/processes and psychological mechanisms which influence vulnerability and resilience to burnout.

I begin by reviewing the literature in the burnout field. I introduce and discuss the complexities of defining and measuring burnout and go on to review theories which explore the process by which burnout develops. I then explore influencing factors, consequences and key theoretical models offered to explain burnout before moving on to review intervention developments in this field. Whilst I discuss foundational research, it is beyond the scope of this study to review all the literature, hence I primarily focus my review on research trends that have emerged over the last 20 years. Finally I explain my rationale for conducting this study, how it has relevance to counselling psychology and how counselling psychologists can meaningfully contribute to the burnout field.

1.2 Towards an understanding and definition of burnout

Burnout first emerged as a psychological construct in the USA in the 1970's. Herbert Freudenberger, a psychiatrist was considered to be the founder of the burnout syndrome. He described a phenomenon, whereby he observed gradual emotional depletion, loss of motivation and reduced commitment amongst the volunteers working in his drug clinic. His clinical approach saw burnout as a mental disorder, mainly caused by personal characteristics, such as dysfunctional personality traits or cognitions, intrapersonal conflicts and negative coping patterns and led to research involving clinical observation identifying 'symptoms' and development of individual focused interventions (Schaufeli & Buunk, 2003).

At the same time, Maslach, an American social psychological researcher also stumbled across burnout, when she was studying emotional arousal in the workplace. She carried out extensive research including qualitative interviews and surveys with a wide variety of helping professionals, she focused on the individuals relational exchanges within the workplace and on the influence of the situational context and job factors as the root causes of burnout (Maslach, Schuafeli and Leiter, 2001). Maslach and colleagues went on to develop the multidimensional model of burnout, characterised by emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach & Jackson, 1981), this became the most enduring definition and model used to explain burnout and provides the definition explored throughout this study. This led to the development of the Maslach burnout Inventory which became the most widely used measurement tool (Maslach & Jackson, 1981).

However, definitions of burnout have proved ambiguous, with opinions varying widely about what burnout is and what can be done to tackle it. In a review, Perlman and Hartman (1982) identified more than 48 definitions. Early work often defined burnout by simply summing up the 'symptoms', (eg. Freundenberger, 1975). As Schaufeli and Enzmann (1998) suggest this proved problematic because lists were either inevitably selective, gleaned through observation and lacked empirical validity or so extensive they become a static, meaningless 'laundry list' which failed to recognise the notion that burnout is a dynamic process that develops and evolves over time. Such drawbacks were tackled by defining burnout by identifying and highlighting 'core' symptoms, as adopted by Maslach's (1981) dominant definition or by describing burnout as a process. Despite this confusion and whilst some initially accused burnout of being mere popular psychology and lacking scholarly origins and a sound theoretical base, from the 1980's onwards Maslach's work stimulated considerable systematic research in this field, enabling burnout to be considered an increasingly useful psychological construct.

1.2.1 Critique of the dominant definition of burnout

The Multi-dimensional model versus unidimensional and two-factor models

Despite varying conceptions of what constituted burnout, by the mid 1980's, consensus maintained that the burnout experience has three core dimensions to it. Subsequent research on this issue by Maslach and colleagues, (Maslach, 1982;

Pines and Maslach, 1980; Maslach & Jackson, 1981) led to the development of the multi-dimensional model which described burnout as a *'prolonged response to chronic emotional and interpersonal stressors on the job*' and as a syndrome which comprises three core components of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind (Maslach & Goldberg, 1999:64). Burnout was viewed as *'an individual stress experience which is embedded in a context of complex social relationships, and it involves the person's conception of both self and others'* (Maslach & Goldberg, 1998:64). 'Emotional exhaustion', the stress dimension of burnout, refers to the depletion or draining of emotional resources due to interpersonal demands. 'Depersonalisation' represents the interpersonal dimension and refers to the development of callous, negative and cynical attitudes towards recipients of their services (Maslach & Jackson, 1996). 'Reduced personal accomplishment' is described as the tendency to evaluate one's work with recipients negatively, believing objectives are not achieved; this is accompanied by poor professional self-esteem and feelings of insufficiency.

As mentioned above, Maslach & Jackson (1981; 1986) initially claimed burnout exclusively occurred in the 'helping' professions and the original MBI was specific to measuring burnout in these professions. However pragmatic concerns and growing interest in the concept outside the helping professions led to the construct being expanded and measurement tools designed (eg. MBI- Educators survey and the MBI- General Survey, Maslach, Jackson & Leiter, 1996) to explore burnout in education and other occupations which are not people orientated. In this more general sense burnout was redefined as *"… a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's capacity to perform" (*Maslach et al, 1996: 20), in recent years Maslach (2003) refers to the three dimensions as 'exhaustion', 'cynicism' and 'feelings of inefficacy'. Concerns have been raised about over-extending the construct to such an extent that it loses distinctiveness. However, many scholars and practitioners have argued and shown that burnout is not restricted to the helping professions (Golembiewski, Munzenrider & Stevenson, 1986; Pines, Aronson and Kafry, 1981; Taris, Schreurs and Schaufeli, 1999) and a study by Leiter and Shaufeli (1996), containing nearly 4,000 participants in various broad reaching occupations, found support for consistency of the MBI dimensions across occupations, suggesting burnout has broader reach than the helping professions (Schaufeli, 2003). It has also been suggested burnout may occur outside the occupational domain with some beginning to explore such

terms as marriage burnout (Pines, 1987); parental burnout (Pelsma, 1989) and athlete burnout (Fender, 1989).

Maslach's three dimensional model of burnout was later challenged on conceptual and methodological grounds (Shirom, 2003). Some have argued that rather than being viewed as a multidimensional construct, burnout should be viewed as unidimensional, with a broader definition of exhaustion at its core, with Pines and Aronson, (1981) suggesting exhaustion comprises physical, emotional and mental exhaustion, and Kristenson et al, (2005) differentiating between physical and psychological exhaustion; Shirom and Melamed, (2005) define exhaustion as involving physical fatigue, emotional exhaustion and cognitive weariness. Opponents of the multidimensional model suggest that because this model emerged via inductive factor analyses of an arbitrary set of components, it is inferior to constructs derived from theoretical frameworks (Schaufeli, 2003). Maslach, Schaufeli & Leiter (2001) counter this criticism by suggesting this criticism denies the fact that the MBI was derived iteratively, involving the development of the three dimensional model from a long process of analysis of in-depth interviews to produce items which were reflected in the three dimensions. They argued that there is no scientific basis to use the term burnout to refer to exhaustion alone. They argue that if burnout is viewed as a singular component construct, this position fails to recognise the critical nature of the relationship people have with their work and how exhaustion prompts actions to distance oneself emotionally and cognitively as a means of coping with work overload (Maslach, Schaufeli & Leiter, 2001). Whilst this may be the case I agree with critics that the burnout construct as defined in the multidimensional model and measured by the MBI, may be too prescriptive and narrow in focus. Challenges faced by the measurement of burnout and how this has affected our understanding of the burnout construct will be discussed in the next section.

Despite these debates, numerous studies have provided support for the three factor structure of burnout across occupations and nationalities (Lee & Ashforth, 1990. Gorter et al, 1999). In contrast, Schaufeli (2003), suggested the supremacy of the three-factor model has been consistently challenged by those advocating a two-factor model, whereby exhaustion and depersonalisation are seen as the core elements of burnout. It has also been suggested that both of these factors collapse into one process (Green et al, 1991), exhaustion implies an employee is 'incapable' of performing because of low energy whereas depersonalisation/cynicism implies the employee is 'unwilling' to perform. This

process of mentally distancing from the task is viewed as an adaptive coping mechanism, however, when this coping mechanism becomes habitual as in depersonalisation/cynicism this becomes dysfunctional and symptomatic of burnout. As such, incapacity and unwillingness to perform are viewed as part of the same process (Schaufeli, 2003) when faced with excessive job demands and exhaustion. Research has shown that the link with personal accomplishment is less clear and works differently to the other two dimensions, leading some to question its inclusion in the definition of burnout (Kristenson et al, 2005, Harlesleben & Demerouti, 2005). Relatively low correlations have been shown to exist between reduced personal accomplishment and exhaustion and depersonalisation whereas these two latter dimensions are relatively strongly correlated (Lee & Ashforth, 1996). However, Schaufeli and Taris et al, (2005), suggest that this may be a statistical artefact, due to the accomplishment items being positively rather than negatively worded. Schaufeli & Salanova (2007) found when personal accomplishment items are converted to be negatively worded in line with the other two dimensions, correlations between dimensions improve markedly. Leiter (1993) suggests that whilst depersonalistion may develop in response to exhaustion, personal accomplishment develops in parallel. Others have argued that personal accomplishment represents a personality characteristic rather than a burnout component (Shirom, 1989; Cordes & Dougherty, 1993).

1.2.2 The Measurement of burnout

As alluded to, Maslach and Jackson (1981) developed the Maslach Burnout Inventory, a measurement tool which by 1998, became the most widely employed tool to measure burnout, used in over 90% of studies (Schaufeli and Enzmann, 1998). The MBI has been translated into many languages and remains the most common, internationally used tool today (Maslach, 2003). It has been tested extensively for reliability, validity and internal consistency. Previous reported values for Cronbach's coefficient α have been in the range of 0.71-0.9 (Mealer et al, 2012a); the MBI manual (Maslach Jackson & Leiter 1996) documents its full psychometric properties. On balance this measure was felt to be the most robust measure to use in this study.

However, whilst the psychometric properties are largely considered satisfactory and have elevated the MBI to a position of dominance and usefulness diagnostically, it is not beyond criticism. Kristensen et al (2007) felt it necessary to develop the Copenhagen Burnout Inventory as a consequence of reservations they

held about the MBI and how its dominance may constrain our understanding of burnout. They suggest the burnout concept has gradually become too narrow in focus, and the MBI and Maslach's definition of burnout '*have become two sides of the same coin'* (Kristensen et al 2007: 193), burnout basically becomes what the MBI measures (Schaufeli, 2003). This is a concern I also share. Like Kristensen (2007), I was also concerned that the MBI contains *'unacceptable questions'* (2007: 194) particularly in relation to the depersonalisation scale. For instance questions such as *'I don't really care what happens to some recipients' 'I feel I treat some recipients as if they were impersonal objects,' 'I feel I'm at the end of my rope' 'I have accomplished many worthwhile things in this job' (*MBI-HS, Maslach & Jackson, 1981) were either extreme and difficult to admit or culturally specific. Kristensen et al (2007) and Schaufeli and Taris (2005) all agree that such comments can alienate respondents, lead to anger or lack cultural relevance. However, Schaufeli and Taris (2005) suggest, despite reservations, a strong growing body of studies document the cross-national validity of the MBI, citing studies by Schaufeli & Janczur, (1994) and; Schutte, Toppinen, Kalimo & Schaufeli (2000). I decided for the purposes required for this study these limitations would not prove prohibitive or outweigh the strength of research supporting validity of this measure. One further issue relates to the personal accomplishment items being positively worded in comparison to the negative wording of the other two dimensions, potentially confusing research participants, thus reducing correlations between personal accomplishment and the other two dimensions causing some to erroneously conclude that this dimension lacks relevance in the burnout process (Kristensen et al, 2007. Schaufeli & Taris, 2005).

In consideration of other measures I reviewed the Burnout Measure (BM), developed in 1988 by Pines and Aronson, which became the second most popular measurement tool. However, the BM was conceived as a one-dimensional questionnaire whilst their definition of burnout was multidimensional. Whilst this measure has been proven to be a reliable and valid, because it is not based on an appropriate operationalization of their definition of burnout I excluded it (Schaufeli, Enzmann & Girault, 1993), I also felt their definition is not distinct enough as whilst it provides a single measure indicative of whether an individual is burnt out or not, I felt it was too general and would fail to isolate the process of burnout or distinguish the depersonalisation and reduced personal accomplishment elements of the definition of burnout I adopted in this study.

The MBI was chosen for this study because of its strong psychometric properties but also because researchers and practitioners now use it as a dichotomous diagnostic tool that discriminates between burnout cases and none burnt out cases (Schaufeli, Leiter and Maslach, 2009). This enabled identification of nurses who fall at both ends of the burnout spectrum ensuring burnout and its positive antithesis were the focus of this study. Research has demonstrated the validity of the cut-off points for high, medium and low levels of burnout, on each of the three MBI dimensions and established a rule for combining the scores on each of the dimensions; for instance an individual is thought to be burnt out when they have a highly negative score on exhaustion in combination with a highly negative score on either of the other two remaining dimensions (Brenninkmeijer and Van Yperen, 2003; Roelofs et al., 2005). Note, frequently studies take high scores on the emotional exhaustion scale of the MBI as evidence of burnout (Bekker, Croon, & Bressers, 2005).

This development in the burnout field allows for transformation of the multidimensional continuous burnout inventory into a useful dichotomous tool which has been used by practitioners to diagnose burnout. This process of dichotomization has allowed burnout to move from being a useful psychological construct to an assessment tool that can be used to produce a medical diagnosis, as in The Netherlands and Sweden. In Sweden an ICD-10 burnout diagnosis was introduced in 1997, upon which burnout soon became one of the five most common diagnoses with the sharpest increase within the public sector (Friberg, 2006, cited by Schaufeli, Leiter and Maslach, 2009).

As discussion of these issues shows, the definition of burnout varies according to the context and the intentions of those using the term: Some apply the term to exhaustion; psychologists tend to see burnout as a continuous phenomenon, viewing it as chronic distress resulting from a highly stressful working environment whereas medical professionals can view burnout dichotomously and as a medical condition (Schaufeli, Leiter and Maslach, 2009). This raises the question of whether it is advantageous for the individual and organisations to view burnout as a medical condition or not, Shirom (1989) suggests that in North America, where burnout remains a non-medical, socially accepted label this avoids the stigma associated with a psychiatric diagnosis, although as Schaufeli, Leiter and Maslach (2009) point out paradoxically in Northern Europe burnout is popular because it has a medical diagnosis, allowing sufferers to access support from the welfare state via compensation and treatment programs.

1.2.3 Process definitions of burnout

In trying to define and improve our understanding of burnout many researchers began to shift their focus by trying to explore and understand how burnout develops. This involved exploring the interrelationships among the three components and how they develop over time. Evidence exists to suggest that the three individual components of burnout as envisaged by the MBI are not co-concurring phenomena but rather interrelating dimensions reflecting a causal process (Taris et al, 2005).

Two process models dominate the literature. The Leiter and Maslach model (1988) is the most well known and draws on the view that chronic high job demands lead to emotional exhaustion (EE), a stress response which in turn leads the individual to adopt a coping mechanism whereby they withdraw psychologically either from the people they work with, in the case of the helping professions or from their work, in the case of occupations involving non-contact. In the case of professions involving people contact, this can involve moderating their compassionate response to patients by distancing oneself emotionally; as early research by Lief & Fox (1963), suggest a sense of 'detached concern' can be an effective way of detaching oneself from intense emotional arousal which may interfere with effective functioning at work (Maslach et al, 2001). This model suggests, this excessive detachment and low concern can lead staff to respond in a callous, negative, dehumanised and 'depersonalised' way. As feelings of depersonalisation and cynicism towards clients and their work persists, it becomes increasingly difficult to achieve work goals and the workers sense of self-efficacy and achievement diminish. The sequence of burnout development in this model is said to involve high levels of exhaustion (EE) lead to high levels of depersonalisation/detachment (Dp) a dysfunctional way of coping with exhaustion which leads to low/reduced levels of personal accomplishment (rPA): (EE -> Dp) -> rPA. Studies by Leiter & Meechan (1986) and Leiter & Maslach (1988), used regression and correlation techniques and found support for this model. However, later models by Leiter (1990;1991a; 1991b; 1993), found reduced personal accomplishment, developed independently of the other two dimensions, which fits other research challenging the relationship with this dimension cited earlier. This work also noted the importance of resources such as social support, opportunities for skills enhancement and participative decision making on personal accomplishment with a lack of these being linked to a reduced personal

accomplishment. Suggesting support for the notion that DP occurs through EE and lack of resources can lead to the parallel development of reduced personal accomplishment.

In contrast, Golembiewski et al (1986), developed the 'phase model'. They argue that the burnout process is more complex and variable. They suggest the three MBI dimensions divide into high and low levels and by crossing these dimensions eight burnout phases emerge, each pattern providing a meaningful index of the level of burnout. They also identify two types of burnout: Chronic and acute; acute burnout being triggered by personal trauma, while chronic burnout is likely to derive from factors in the workplace. They note that the pattern of chronic burnout development is different to Leiter and Maslach's model and starts with depersonalisation which is followed by exhaustion and reduced personal accomplishment respectively.

Whilst these models had been developed, few had tested the models and Cordes and Dougherty (1993), suggested the process studies were problematic because they were based on cross-sectional designs rendering their conclusion regarding causality or the process of burnout questionable. In response to such criticisms, Lee and Ashforth (1993), compared the two leading process models, using a longitudinal research design. Their analysis resulted in a variation on the Leiter and Maslach model in which emotional exhaustion and depersonalisation were positively related but where personal accomplishment developed independently from depersonalisation, and elevated levels of exhaustion directly evoked decreases in personal accomplishment rather than indirectly through depersonalisation. However, as appears common in the burnout literature, unequivocal empirical findings are hard to establish. Taris et al (2005), suggested that whilst many researchers have attempted to provide insight into the causal sequence of the MBI components, few adopted longitudinal designs, the only means by which to provide strong evidence on the causal order of variables. As they go on to argue even then sequential development of burnout remains equivocal and variable. Of the longitudinal studies reviewed by Taris et al (2005), a study by Leiter (1990) amongst mental health workers found low levels of personal accomplishment were associated with high levels of emotional exhaustion, partially supporting Golembiewski et al's model (1986); Leiter and Durup (1996) found high levels of personal accomplishment were longitudinally associated with low levels of depersonalisation amongst healthcare professionals as did McManus et al (2002) in a study amongst Medical Doctors. Schaufeli and Enzmann (1998), conclude that

burnout profiles may also vary by occupational field when broken down to compare each dimension. As Taris et al (2005) conclude there is no convincing support for any particular causal order of the MBI dimensions as yet a definitive model remains elusive and perhaps reflects a bigger challenge about whether it is an unrealistic ideal. They suggest the dimensions should be seen as separate concepts that affect development of each other over time and offer some support to the notion that exhaustion prompts withdrawal strategies of cynicism and depersonalisation. However, Shirom (2007), in his review of the literature, concludes that personal accomplishment develops largely independently of the other dimensions again raising the question as to its intrinsic relevance to burnout and whether it is needed to measure burnout. Schaufeli (2003) concludes that although longitudinal results have not clarified the sequential development of burnout, most cross-sectional studies assume that exhaustion leads to depersonalisation/cynicism, but personal accomplishment/professional efficacy is assumed to develop in parallel (eg. Toppinen-Tanner et al, 2002; Bakker et al, 2000).

As research into the causal process is equivocal perhaps it is more useful to acknowledge that the process of burnout development is variable. However, insight into where an individual is on the burnout continuum or whether there are typical patterns within a team showing high levels of burnout, is helpful and useful to build into therapeutic formulations and strategy which can target the key problem in the burnout presentation (Lee & Ashforth, 1993; van Dierendonck et al., 2001).

1.3 Influencing factors

Whilst research into the burnout field is prolific, it has often been criticised for being predominantly quantitative in nature and overly dominated by the use of cross-sectional research designs, which can only allow us to speculate as to which factors are ‘related’ to burnout whilst it is inappropriate to draw definitive conclusions about the ‘causes’ and ‘consequences’ of burnout (Schaufeli, 2003). Whilst many studies emerged in the early empirical phase of research exploring influencing factors, I have chosen to review the key factors of relevance to this study or to contemporary thinking on burnout today. These have been grouped into individual and situational factors influencing burnout.

1.3.1 Individual factors

1.3.1.1 Demographic characteristics

Demographic characteristics are considered to be co-factors of burnout. Of all the biographical features, age is most consistently associated with burnout, higher levels are reported among younger employees than those aged over 30 or 40 years (Schaufeli and Enzmann, 1998, Maslach, Schaufeli & Leiter, 2001), suggesting that burnout is most likely to occur at the beginning of one's career. Micklevitz (2001) suggests the young are often more idealistic and may become crippled by the effects of burnout. However, Schaufeli and Buunk (2003), suggest this should be interpreted with caution because burnt out employees may selectively drop-out of employment, they also note that in the Netherlands burnout is more prevalent in older age groups (Schaufeli and Van Dierendonck, 2000). They suggest this may be due to European social security systems and cultural values restricting mobility in comparison to the US.

There is some evidence that married employees are less prone to burnout and consistent evidence that those with children show lower levels of burnout (Maslach & Jackson, 1981, 1985).

Gender differences prove equivocal as too many confounding factors and contradictory findings prove prohibitive to confidently making a gender connection. Etzion and Pines (1986) reported higher levels amongst women; however, Price and Spence (1994) found the opposite. Effects of ethnicity has been under-researched, a key gap in the research which could benefit from being explored particularly given the multi-national nature of nursing staff-forces. Without this insight we lack understanding about whether burnout as a construct has cross-cultural relevance within a workforce or not.

1.3.1.2 Personality characteristics

Personality traits have been explored to establish whether certain types are at more risk of burnout than others. Several personality factors have been linked to a propensity to burnout. People who show low levels of hardiness (ie. characterised by involvement in daily activities, a sense of control over events and openness to change), have been shown to be more vulnerable to all three aspects of burnout, but particularly the emotion dimension (Nowack, 1986, Pierce and Molloy, 1990).

Burnout has been found to be higher amongst people who have an external locus of control ie. a tendency to attribute events and achievements to others or chance; a review of 11 studies by Glass and McKnight (1996) found that 10% of variance of emotional exhaustion, 5% variance of depersonalisation and personal accomplishment was explained by external locus of control.

Schaufeli and Enzmann (1998), reviewed twelve studies and found that those who cope with stressful events in a passive, defensive way were more likely to be burnt out, versus those who demonstrate active and confronting coping styles (Enzmann, 1996). However, some have argued that coping styles are a state which is situation specific rather than a constant personality trait (Lazarus and Folkman, 1984) and overlap conceptually with the depersonalisation dimension of burnout (Schaufeli and Enzmann, 1998).

However, findings from burnout research have served to confirm the personality profile of a stress-prone individual characterised as having low levels of hardiness, an external locus of control and avoidant coping styles (Taylor and Cooper, 1989; Semmer, 2009). Studies have also found the dimension of 'neuroticism,' one of the 'Big Five' personality dimensions from the Five-Factor model (McCrae and John, 1992) to be linked to burnout (Deary et al., 1996). Neuroticism includes trait anxiety, vulnerability, self-consciousness and depression. 'Type-A' behaviour has also been linked to the exhaustion dimension (Nowack, 1986) and stress induced illness (Millar et al., 1996).

In a study by Pfennig and Husch (1994) all three burnout dimensions were negatively correlated to self-esteem, ie.self-appraisal of one's competence and personal worth, although the only longitudinal study to explore this relationship failed to establish conclusive evidence to support this causal order (Rosse et al., 1991). It must also be noted that environmental factors could influence self-esteem and be a consequence of burnout rather than a predisposing factor.

Studies by Garden (1988, 1989), also explored the importance of 'feeling types' and 'thinking types' as defined by Jung. Garden's study suggest 'feeling types' are more prone to burnout, particularly to depersonalisation. However, on examination this study selectively included the dimensions they preconceived as important to their study, only including two out of a possible eight personality types, the thinking-feeling dimension. They also only included measurement of emotional exhaustion and created the Energy Depletion Index, a tool lacking the psychometric properties of the MBI and redefining burnout as unidimensional. Schaufeli and

Enzmann (1998), also suggest that the personality types are poorly operationalised in this study, suggesting further research is necessary.

Interestingly recent research has suggested that there is a key relationship between 'psychological flexibility' and workplace behaviour. Whilst not a personality trait, psychological flexibility has the advantage of being an individual characteristic which can be enhanced; it is defined as an individual's ability to focus on their current situation and take action to reach their goals and values, even if challenged by difficult psychological factors (Hayes et al, 1999). Higher levels of psychological flexibility have been shown to correlate with and longitudinally predict better mental health and job performance (Bond & Bunce, 2003; Bond & Flaxman, 2006). Recently, research by Lloyd, Bond & Flaxman (2013) has found that burnout can be reduced by improving psychological flexibility via intervention programmes which adopt Acceptance and Commitment Therapy (Hayes et al, 1999), and places psychological flexibility as its core goal.

1.3.1.3 Personal expectations

Researchers have suggested that employees' expectations about their own personal efficacy, the profession and the organisation, make a significant contribution to burnout (Cherniss, 1980; Jackson & Schuler, 1983; Maslach & Jackson, 1984). Jackson et al (1986), distinguished between 'achievement expectations' relating to individual beliefs about what they can accomplish, 'organisational expectations' which refer to individual's expectations about the nature of the professional system in general and to the job in particular and 'unmet expectations'. However, research in this field is inconclusive, in part because concepts are not clearly defined and vary considerably to include concepts such as idealism, omnipotence, and unmet expectations (Schaufeli and Enzmann, 1998).

1.3.2 Situational factors

1.3.2.1 Job characteristics

Work demands ie. work overload and time pressure have been consistently shown to be a key factor in burnout (Maslach, Schaufeli and Leiter, 2001). Meta-analysis by Lee and Ashforth (1996), showed these factors were most highly correlated with emotional exhaustion, with their relationships with the other two dimensions proving much weaker.

Demands such as role conflict and role ambiguity were shown to be moderately to highly correlated to burnout (Pfennig and Husch, 1994). In the case of nurses role ambiguity may occur if inadequate information is provided by a doctor and role conflict may occur, if the nurse feels conflicted about the need to attend to a patient and update paperwork.

Lack of social support has also consistently been researched. Although the link is less clear in comparison to job demands, there is evidence nonetheless which supports the view that there is a relationship between lack of social support and burnout, particularly from supervisors (Lee and Ashforth, 1996). Such findings were not found longitudinally however (Dignam, 1986). Theories to explain this put forward the 'buffering' hypothesis, which suggests social support serves to moderate the relationship between job stressors and burnout. To date however, studies have failed to show the buffer effect or have been equivocal (Schaufeli and Enzmann, 1998).

A lack of feedback has been shown to be related to all three dimensions of burnout (Pfennig and Husch, 1994). A lack of autonomy and participation in decision making is correlated with burnout, although the former is less clearly related (Lee and Ashforth, 1996).

1.3.2.2 Occupational characteristics

Research has tried to establish whether the nature of the work impacts on burnout levels. In part interest was generated because of the fact that burnout originated in the helping professions and the conceptual claim that the emotional stressors of people work were uniquely related to burnout. Early research however, did not find evidence to support such a claim, instead common job related stressors (ie. workload, role conflict or time pressure) correlated more highly with burnout than client-related factors (Cordes et al, 1997). A study by Mallett et al (1991), explored the relationship between the fear of death and emotional exhaustion and depersonalisation encountered by nurses in intensive therapy units (ITU) and hospice care. They found no such correlation; nurses in hospice care showed lower levels of burnout than ITU nurses and all stated that the lack of staffing and having to work with inexperienced staff were the most stressful factors in their work.

1.3.2.3 Organisational characteristics

The healthcare environment has changed considerably since the early studies of burnout as alluded to earlier. Economic uncertainty, staffing shortages, increased workload and loss of professional autonomy are all stressors facing healthcare workforces today (Rupert & Morgan, 2005). Recent research developments have seen a shift from a focus on the individual's immediate experience of their work to exploring the organizational and managerial environment and how this relates to burnout. Admittedly this focus proves complex methodologically, as it involves the relationship between subjective (burnout) and objective variables measured at group level ie. performance, efficiency (Schaufeli, 2003). As such this important area has been under-researched. Nonetheless, this is an area that needs further exploration, perhaps a realm more appropriate for occupational psychologists, however, counselling psychologists need to begin to integrate and recognise the importance of these issues in their research and clinical practice. There are early signs to suggest researchers are beginning to recognise the importance of leadership behaviour on prevention or promotion of burnout, with constructive leadership, supervisory support, guidance and inspiration serving to reduce employee burnout and encourage the positive anthithesis of burnout referred to in the literature as work engagement (Breevaart, Bakker, Hetland & Hetland, 2014). They suggest that more research is needed in this area in order to better understand leadership behaviours and employee functioning on burnout and to inform the development of leadership training courses.

1.4 Differentiating consequences

The perceived consequences of burnout vary depending on the conceptualisation of burnout adopted. As alluded to earlier, initial definitions were characterised by long 'laundry lists of symptoms' (Schaufeli & Enzmann, 1998). Results from empirical studies supporting these factors as consequences of burnout are equivocal, confusing and contradictory, in much the same way as for the causes of burnout, with few longitudinal studies to demonstrate causation or qualitative studies to provide deeper understanding. Schaufeli (2003), clusters consequences into ill-health, negative job attitudes and impaired organisational behaviour. He states that cross-sectional studies have found evidence to suggest burnout is related to ill-health indicators such as depression, psychosomatic complaints, distress and physical health problems. In terms of negative job attitudes, a

longitudinal study by Wolpin et al, (1991) suggests that burnout causes diminished job satisfaction. Burnout has also been shown to be related to absenteeism and job turnover and poor performance, although this is equivocal (Schaufeli, 2003).

Whilst listing consequences is relatively meaningless in isolation and is beyond the scope of this study, it is important to try to clarify what differentiates burnout from other similar conditions. This is necessary particularly because emotional exhaustion, typically established as the core of the construct (Shirom, 2007) crosses over with 'symptoms' seen in depression, stress and fatigue leading some to suggest that burnout is interchangeable with these constructs and to question burnouts discriminate validity (Maslach, Schaufeli & Leiter, 2001). This is the case with depression in particular (Hemingway & Marmot, 1999). Studies using the MBI and various depression measures have since empirically established the distinction between depression and burnout, suggesting burnout is a problem that is specific to the work context, whereas depression is a global state that pervades every aspect of a person's life (Bakker et al, 2000, Glass & McKnight, 1996, Leiter & Durup, 1994). However, a meta-analytic review by Glass & McKnight (1996) suggests that depressive symptomology and burnout share common factors, leading Shirom (2003) to suggest that researchers should also include a well validated measure of depression in their research designs to avoid the relationship between burnout and its correlates not being due to the effects of depression.

Burnout, defined as depleting ones resources, has also been likened to the work of Selye (1967) on stress, proposing that exposure to stress leads to a general adaptation syndrome, resulting in physiological resources being depleted however, this is a temporary response, whilst burnout is seen as a breakdown in the adaptation response leading to chronic malfunctioning. Suggesting that stress and burnout can not be distinguished on the basis of symptoms but only in respect to the process, proving justification for exploring and viewing burnout as a process that develops over time, rather than a state (Schaufeli, Maslach and Marek, 1993).

Debates about whether burnout is another label for chronic fatigue has led to clarity being achieved as to whether burnout should be viewed as a uni or multi-dimensional construct. Burnout differs from CFS in that, CFS is pervasive affecting nearly all major bodily systems and being physical in focus: neurological, immunological, hormonal, gastrointestinal and musculoskeletal problems are identified (Jason et al, 1995), whereas burnout symptoms are primarily psychological although physical symptoms are not uncommon. Burnout is also

primarily job related whereas CFS is not restricted to any one particular area in life. If burnout is reduced to a single definition of exhaustion, it fails to capture the notion of withdrawal being a functional coping mechanism initially, in the context of occupational fatigue only, to becoming dysfunctional when it becomes a problem and turns into depersonalistion. The third component of the MBI, professional efficacy is thought by some to either act as a precursor or consequence of occupational fatigue (Schaufeli and Taris, 2005).

In exploring the consequences of burnout it helps to establish burnout as a multidimensional construct distinct from depression, chronic fatigue and stress in that its process (time) and multidimensionality (domain) typically being viewed as linked to the work context from which it emerged. Yet it is different to job stress in that it refers to a breakdown in the adaptation process to prolonged stress.

1.5 Theoretical explanations of burnout

Much of the early research into burnout was criticised for being atheoretical. However, over the last twenty-five years research has sought to redress the balance. A review by Schaufeli and Enzmann (1998), identified nineteen different theoretical approaches to burnout, categorised into: Individual, interpersonal, organisational and societal approaches. In more recent years theories have sought to integrate these theoretical concepts whilst seeking to position burnout as distinct from other psychological constructs. It is beyond the scope of this review to discuss all of these models of burnout, rather I intend to select those models which have most relevance to this study and which reflect more recent developments in this field.

1.5.1 Individual theoretical approaches

Schaufeli and Enzmann (1998), identified eight individual theoretical approaches. A common theme across these theories is that a strong unconscious or conscious drive to help, coupled with highly valued goals, expectations and aspirations are necessary conditions for burnout to develop. They also often reference a mismatch between an individual's psychological characteristics and the experience of the job leading to job stress and burnout when inadequate coping strategies are adopted or when the organizational coping resources fail.

1.5.1.1 Failed quest for existential meaning

Informed by existential psychology, Pines (1993) and Pines & Aronson, (1988), developed a model to interpret her research findings and integrate clinical observations. She proposed the individual's need for meaning and significance plays a crucial role in burnout. Implicit is the assumption that "*in order to burn out, one has first to be 'on fire'. A person with no such initial motivation can experience stress, alienation, depression, an existential crisis, or fatigue, but not burnout"* (Pines 1993: 41). The individual expects to derive a sense of existential meaning from their work and gradually becomes disillusioned as they strive to achieve this. A mismatch of intentions and expectations leads to burnout. The existential perspective holds that failure to meet deeply rooted goals and expectations are at the heart of burnout. This conception of burnout allows for the extension of burnout to other non-work related spheres of one's life. Pines later extended the theory to include 'couple burnout' (Pines, 1996).

1.5.1.2 A psychodynamic perspective: an imbalance between conscious/ unconscious functions

Garden (1991) used Jungian, psychodynamic theory to explain burnout. At the heart of the theory lies the distinction Jung made between there being 'feeling types', characterised by empathy, concern and awareness of others, better at handling emotional demands; and 'thinking types', who are achievement orientated and more likely to neglect others and better at handling mental demands. It is noted that these psychic functions are present simultaneously in each individual, but one of these functions is preferred and conscious whereas the other function remains unconscious. Typically individuals orientate towards jobs that favour one or the other functions/personality types. In the helping professions it is hypothesized by Garden (1991) that the ratio of feeling types is 4:1, versus 1:4 in occupations such as engineering. Surprisingly, Garden observed that regardless of type of job, emotional demands predict burnout in feeling types and mental demands in thinking types, suggesting burnout is not linked to lack of job fit. Psychodynamic theory suggests a self-regulatory process explains this, whereby relying too much on one process eg. feeling, creates an imbalance in the psyche which is counteracted by an increase in the opposite function in the unconscious. If the repressed function surfaces, the negative effect can be profound and result in burnout; it is claimed this is a highly energy consuming process that depletes the individual's mental resources. However, as for many theoretical models empirical evidence to support it is lacking. This theory raises the suggestion that psychophysiological advances

could be used to explore the phenomenon of burnout. In the field of Chronic Fatigue/ME the Psychoneuroimmunological model has provided helpful insight to further our understanding of affective factors in modulation or enhancing our immune system (Friedberg & Jason, 1998).

1.5.2 Interpersonal theoretical approaches

Interpersonal approaches to burnout have received considerable empirical investigation and support in comparison to individual theories (Schaufeli, 2003) and focus on exploring how interactions within the workplace influence burnout. A key theoretical model in this category is Maslach's multi-dimensional model; however, this has been discussed extensively elsewhere and will not be discussed again here. I have chosen to add to this body of information by briefly introducing three further theories which explore the importance of underlying social psychological processes such as social exchange (ie.lack of reciprocity), social comparison and emotional contagion in the development of burnout.

1.5.2.1 Burnout as lack of reciprocity and social comparison

Bunnk and Schaufeli (1993), based their theory on social comparison theory (Schachter, 1959) and Equity theory (Walster et al., 1978), suggesting burnout develops primarily in the organisational social context. To understand its development, it is necessary to explore the way individuals perceive, interpret and construct the behaviours of others at work. At the heart of equity theory is the notion that we all have a deep-rooted desire to pursue reciprocity in personal relationships, which stems from an evolutionary process at the heart of human life and is essential for health and well-being. The theory holds that what is invested and gained should be proportional on each side of the relationship. They hold that lack of reciprocity results in negative emotions and stimulates attempts to restore reciprocity. In the context of the helping professions for which burnout evolved, clearly a mutually reciprocal relationship between carer and recipient is unbalanced in terms of cost and benefits/ investments and outcomes. It is suggested that over time it is likely that a lack of reciprocity develops whereby the carer invariably puts in much more than is given back which may deplete the professional's emotional resources. It is inferred that lack of reciprocity and the resulting emotional exhaustion can be dealt with by becoming depersonalised when interacting with recipients.

Schaufeli and Buunk (2003) note that significant correlations have been found to support lack of reciprocity and burnout in several occupations, notably

general hospital nurses (Schaufeli and Janczur, 1994), student nurses (Schaufeli et al, 1996) and critical care nurses (Bakker et el 1997). It is suggested by Schaufeli and Enzmann (1998) that nurses who have high expectations of reciprocity are at increased risk of burnout.

According to this theory, similar processes occur in relation to the relationship the employee has with their organization. Schaufeli et al (1996) proposed a dual level social exchange model of burnout, which stated that in addition to an unbalanced interpersonal relationship, burnout is also caused by lack of reciprocity at organisational and team level. Empirical evidence for this theory has been found both cross-sectionally and longitudinally (Bakker et al, 2000; Taris et al, 2001) providing strong support for this process.

Buunk and Schaufeli (1993) also considered the relevance of social comparison theory (Schacter, 1959) in the context of helping professions workers. They argue that because these professionals are faced with high emotional demands daily and can be uncertain about their own responses in highly charged situations, workers in these professions have a tendency for self-evaluation by comparing their emotional responses to those of their colleagues, in order to assess the validity of their reactions. Buunk and Schaufeli (1993), found that nurses stressed by work had a greater desire to affiliate with others, but at the same time they retreated socially and their actual affiliation decreased. It is suggested that social isolation is common in burnout as individuals fear the embarrassment of sharing insecurities.

An interesting aspect to social comparison theory is the direction of comparison, which can be either upward or downward. Typically, it was thought that comparing oneself in an upward way and interpreting these comparisons favourably and non-defensively is a positive adaptive function, generating effective performance and well-being (Aspinwall, 1997). In contrast, comparing self to others in an upward trajectory in a defensive, self-critical way is associated with poor functioning and well-being (Buunk et al., 1994, 2001a,b). In line with Wills' (1991) downward comparison theory, Buunk et al. (2001b) found that those high in burnout respond with higher levels of negative affect to upward comparisons, and derive more positive affect from downward comparisons. However, it is thought this benefit is temporary and may lead to the converse and interpret this comparison as indicative of their future.

1.5.2.2 Burnout as emotional contagion

Burnout is said to have a contagious nature to it, which is not surprising given the strong inter-personal aspect of the phenomena. This has been observed in case studies (Schwartz & Will 1953), and field studies (Golembiewski et al., 1986). In a study by Bakker et al (2005), amongst eighty intensive care units in Europe, some departments had higher levels of burnout and burnout complaints than other comparable units, this was shown to be the case even when controlling for job autonomy, subjectively/objectively assessed workload, ensuring like for like was being compared. Theories to explain this phenomenon suggest this is either due to colleagues mimicking the outward manifestations of burnout in a non-conscious way (Hatfield et al, 1994) or through a conscious cognitive process of 'tuning in' to others' emotions (Schaufeli & Buunk,2003). This theory resonates with me when considering the empathic nature of helping professions work and the natural inclination to tune in to others distress. Whether or not contagion plays a role in causing burnout is difficult to prove empirically but it may well be a by-product of burnout helping to trigger burnout in some cases. A few studies exist to support the theory. A study by Bakker et al, (2001) amongst GP's, found that those who received burnout complaints from colleagues reported higher levels of emotional exhaustion and subsequent negative attitudes of depersonalisation and reduced personal accomplishment than other GP's who did not receive such complaints. A study amongst nurses by Groenestijn et al, (1992), found nurses who had a need for social comparison, ie. identified as a need to learn more about others in a similar situation, were more prone to exhaustion when they perceived that many of their colleagues exhibited burnout symptoms. However, it is difficult in these studies to control for all factors which could be influencing burnout levels overall. The insight that burnout can spread like a virus is of interest to policy makers and ought to be considered when evaluating need for support early on, when and if burnout is evident within departments.

1.5.3 Organisational theoretical approaches

Organisational approaches stress the significance of organizational issues on the development of burnout. Despite the fact that the three models I have chosen to discuss are very different in terms of methodology, scope, content and empirical support, they all agree on the important factors which influence burnout, these being: Qualitative and quantitative job demands; lack of autonomy or control;

incongruent institutional goals or values, lack of social support or community and lack of rewards.

1.5.3.1 Burnout as reality shock

I have chosen to discuss this model because it illustrates how a qualitative approach can add to the richness of our understanding of burnout. There is a dearth of good qualitative studies generally within the burnout field. Cherniss (1980, 1990) carried out a series of 26 qualitative interviews amongst human service employees in the early stages of their careers and followed them up to 10 years later to explore the recovery process. His model proposes workplace characteristics interact with personal characteristics to produce stressors and how an employee copes with these stressors will determine whether or not burnout develops. Active problem solving is preferable to strategies which are defensive such as avoiding. As such, burnout is a development process which occurs over time and represents one way of adapting to work-based stress. He identifies eight negative work-setting characteristics: High workload; absence of an orientation or programme of introduction for novices; under-stimulation; limited scope of client contact; low level of autonomy; discrepancy between personal values and organisational goals; inadequate leadership and supervisory practices, and social isolation. Personal characteristics were identified rather broadly as resources outside work and career orientation. The major sources of stress brought about by the interaction of work setting and person are: Doubts about one's competence; problems with recipients; bureaucratic infringement on one's autonomy; lack of challenge and fulfilment, and lack of collegiality. Cherniss noticed changes in attitudes and outlook indicative of burnout; reduced aspirations and responsibility; loss of idealism; increased cynicism and pessimism, emotional detachment and withdrawal from work and growing concern with the self. This model was supported by cross-sectional studies by Burke et al, 1984 and Burke & Greenglass, 1988. Interestingly, in their follow-up study ten years later (Cherniss, 1980, 1990,1995), found that those who were more burnt-out early in their careers were less likely to change careers and were more flexible in their work approach. He found that these individuals typically changed to a more favourable work setting; developed special interests on the job; over time grew in terms of professional self-efficacy. His findings provide hopeful insight to suggest that early experience of burnout does not necessarily lead to long-term consequences. This model proves useful because it describes the dynamic process of imbalance, adjustment and change that occurs in helping professions personal

early in their careers and provides insight into organisational factors that can be causes of stress.

1.5.3.2 Burnout as a virulent process – the phase model

This model proposed by Golembiewski and colleagues (1988,1996) largely outside the helping professions, views burnout as a 'virulent process' that progressively develops through eight phases. As mentioned previously whilst the model is in agreement with the three dimensional model put forward by Maslach at al (1982) it proposes a different sequential order. This model proposes burnout is set in motion by different job stressors eg. work overload, lack of autonomy, co-worker conflicts. Depersonalization is considered the first phase of burnout and the least important factor, followed by lack of personal accomplishment and emotional exhaustion. It is suggested that although the virulence of the process increases through the phases, individuals may not follow each successive stage. This model is descriptive as no theoretical rationale is available. Whilst research largely favours Maslach's developmental sequence (see Lee and Ashforth, 1993), this model suggests that burnout is not a linear process and individuals may show a different sequential developmental process, although it is biased towards emotional exhaustion. However Golembiewski's work has been criticised methodologically, Leiter (1993) suggested that the modified MBI measurement tool they use is not congruent with the original version, for instance they changed the term from 'recipient' to 'co-worker' so the tool could be used outside the helping professions which changes the meaning of depersonalization dramatically. However, Golembieski's model is worth mentioning because they make clear that burnout is an intrinsic part of organisational life and associated with a host of poor job characteristics with significant negative implications for organisations.

1.5.4 Theoretical advancements: Integrative models of burnout

As research into burnout became more sophisticated so did the theoretical frameworks being developed to explain it. Whilst initially there was a tendency to either focus on individual or situational factors there was a move in more recent years to integrate these aspects rather than seeing them as either/or entities. Also in more recent times there has been a shift to gain insight into burnout by exploring its positive antithesis referred to as job engagement in the literature. I will provide a brief summary of the key developments.

1.5.4.1 Burnout as a loss of coping resources

The Conservation of Resources model (COR; Hobfoll and Freedy, 1993, Hobfoll and Shirom, 2001), has become one of the most dominant motivational and integrative models to describe burnout (Harlbesleben & Buckley (2004). It proposes that people have deep rooted tendencies to seek, retain and protect what they value, referred to as 'resources'. Resources are defined as a wide range of things such as personal characteristics eg. social skills, self-esteem; valued objects eg. fashionable clothing, tools; conditions eg. marriage; energies eg. money. Stress occurs and builds up, leading to burnout when valued resources are threatened, lost, or there is an investment in resources without a corresponding pay-off. Typically an individual employs a series of coping strategies which replenish the resources. Burnout is more likely to occur when resources are lost rather than not gained, referred to as 'primacy of loss' and the 'secondary importance of gain'. Over time coping may be unsuccessful, resulting in burnout defined as *"… a process of wearing out and wearing down of a person's energy, or the combination of physical fatigue, emotional exhaustion and cognitive wear-out that develops gradually over time"* (Hobfoll and Shirom, 1993:50). In comparison to the multi-dimensional model (Maslach, 1982), this model provides a comprehensive presentation of burnout as a complex, multi-faceted phenomenon; it includes description of the causes and symptoms of burnout in terms of resource loss and talks about a spiral of loss individuals get caught in which may involve interpersonal conflict, role ambiguity, failed promotions or time off sick. However, I struggle with the ill-defined definition of exactly what constitutes resources and upon what criteria these can be assessed. Schaufeli (2003) challenges all of the models of burnout, because they lack quantitative empirical support and takes the amount and consistency of quantitative support as a key to their validity. However, I'd argue that this model is compelling and inclusive and it is legitimate to theorise about burnout without having to put it to the empirical test, which within the context of burnout would prove an unrealistic ideal because of its complex, multifaceted nature.

1.5.4.2 The Job Demands-Resources Model (JD-R)

This model developed by Demerouti et al (2001), builds on the COR model and proposes a theory which offers a view on the psychological processes responsible for burnout and its positive antithesis referred to as work engagement, viewing burnout as a dichotomous state. It states burnout has relevance beyond the helping professions because the stressors which lead to burnout can be found in

other occupations. As such the premise of this model states that when job demands are high and job resources limited, because of negative working conditions, energy depletion occurs which undermines employees motivation and results in health impairment. Job demands are aspects of the job that require effort including physical, social or organisational aspects of the job. They are associated with psychological costs for instance burnout. Whereas job resources are characteristics of the job that help in achieving goals, diminish demands of the job or lead to personal growth. The more effort made by the individual the greater the psychological cost. This model allows for recognition that different working conditions may be differentially relevant in explaining burnout, depending on the specific occupational group under study. When job demands are high they are most predictive of exhaustion and when job resources are lacking, depersonalization or disengagement from work can occur. Conversely job resources drive the motivational process behind engagement in work. Whilst relatively young, this model has received empirical support from a study by Schaufeli and Bakker (2004), Bakker & Demerouti, (2008), Schuafeli et al (2009).

This model calls into question whether the MBI is the best tool of measurement and adopts an alternative tool, the Oldenburg Burnout Inventory (OLBI, Demerouti et al 2003), which was constructed and validated across different occupational groups. Two dimensions are included: Exhaustion, covering affective/physical and cognitive strain, and disengagement from work. A benefit of this scale is that it addresses a psychometric criticism of the MBI and includes negatively and positively worded items, however, more evidence of validity is required before it can replace the MBI (Halbesleben & Buckley, 2004).

1.5.4.3 Shifting the emphasis in the burnout construct

In recent years, research emphasis has begun to shift to include research which focusses on the positive antithesis of burnout, referred to as job engagement which describes an individual's relationship to work allowing the whole spectrum of worker's well-being to be better understood. However, this is an area which requires further research and development. Leiter, Bakker and Maslach (2014), suggest progress in this field has been modest. This shift mirrors the emergence of "positive psychology", which aims to harness change by learning from the positive psychological qualities we possess rather than focussing all of our attention on the most negative psychological outcomes in life (Seligman & Csikszentmihalyi, 2000). Some researchers, for instance Maslach & Leiter (1997), have begun to re-phrase

burnout and describe it as an erosion of engagement with work, implying a process whereby, energy turns to exhaustion, involvement to cynicism and efficacy into ineffectiveness. This relates to the direct opposite of burnout, reflected in opposite MBI scores (Maslach, Schaufeli & Leiter, 2001). Maslach (2003) suggests an important implication of research on engagement is that interventions may be more effective if they are framed not as reducing burnout but rather as a means to build engagement.

1.5.4.4 Expanding the theoretical framework

Maslach and Leiter's model (1997), alluded to above, focuses on the degree of fit or mismatch between the person and six domains of their job environment; the greater the mismatch the greater the risk of burnout and conversely the greater the fit the greater the likelihood of job engagement. This approach focuses on the enduring relationship people have with their job, and mismatch occurs when the process of establishing a psychological response leaves critical issues unresolved. This mismatch can occur in some or all of the six areas identified as: Workload (eg. excessive workload); reward (eg.lack of appropriate rewards); control (eg. feelings of inefficacy or reduced personal accomplishment), community (eg. sense of social support from colleagues), fairness (eg. if fairness is lacking) and values (eg.if conflict between personally held values and those of the organisation or seniors). Research on this model is beginning to explore the relationship between these areas. Preliminary evidence suggests the area of values may play a central mediating role for the other areas (Maslach, Schaufeli & Leiter, 2001). Maslach and Goldberg (1999) suggest this model provides an alternative way of identifying the sources of burnout and how these differ by job context and of the importance of designing interventions which incorporates situational and individual changes. The identification of six areas of mismatch expands the range of options for interventions, raising hope for more impact being made in the treatment and prevention of burnout. For instance, rather than focusing on how to cope with work overload via relaxation techniques, it may be increasingly beneficial, given the current environment particularly in the NHS, to focus on values and rewards, helping employees appreciate what they value in their work or recognise they feel rewarded or supported in what they do, helping them to increase capacity to cope with the high workloads typical in the NHS today.

1.6 Implications for the development of interventions

Despite burnout remaining a pervasive concern for organisations today, there has been comparatively little research which presents and evaluates interventions designed to reduce burnout (Halbesleben & Buckley, 2004). Typically interventions either target the individual or aspects of the organisation (Schaufeli and Buunk, 2003) and approaches can vary widely. Maslach & Goldberg (1998) suggest the eclectic range of interventions reflects the historical divide mentioned earlier; although some approaches have stemmed directly from clinical insight and have been criticised for not being based on theory or empirical support, they suggest that this pragmatic base has in fact produced interventions well grounded in the realities of what is encountered in clinical practice and may prove more helpful than interventions based on abstract or generic theories.

Individual focused interventions have been dominant both in practice and in research, despite stronger empirical evidence to suggest that situational and organisational factors play a larger role in burnout than individual ones (Maslach, Schaufeli & Leiter, 2001). These programmes typically address emotional exhaustion, the core component of burnout, by developing effective coping skills, notably relaxation and cognitive restructuring via CBT; the other two components have been notoriously difficult to change (Schaufeli 2003). A meta-analytical study by Van der Klink et al (2001) of almost 50 studies exploring the efficacy of interventions, found that CBT has been shown to be reasonably effective in treating burnout, showing medium effect size, while relaxation techniques showed small effects. In contrast workplace interventions showed no significant effects; these interventions seem scarce and are however, notoriously difficult to evaluate.

Depending on the definition and model of burnout adopted various other interventions have been developed. Some have focused on specific organisational stressors and attempted to address expectations and inequity in social exchanges: Van Dierendonck, Schaufeli and Buunk (1998), developed a group-based intervention programme which aimed to adjust employees goals and expectations to better fit their work environment; Others have focused on social support (eg. Burke & Richardson, 2000), with some evidence of efficacy. A study by Le Blanc et al (2007), used a participatory action research approach amongst oncology care providers that focused on improving the work situation, with positive results although this appeared to be short-term with employees reverting back to previous levels of stress/burnout if they discontinue use of the interventions.

Interestingly whilst there has been a move to explore the positive antithesis of burnout, there is very little evidence of research being used to develop and test an intervention programme as a result of this shift in focus. However, an exception to this is provided by Mealer et al (2012a, b). They carried out two studies amongst ITU nurses, and found that high levels of psychological resilience, is significantly related to lower prevalence of burnout, PTSD, anxiety and depression. In their second study, Mealer et al, 2012b went on to provide in-depth, qualitative insight into the mechanisms employed by resilient nurses to obviate the development of PTSD and burnout. This study found differences in worldview, social networks, cognitive flexibility and self-care strategies employed by resilient nurses in comparison to those who were classed as less resilient and carried a diagnosis of PTSD. They suggest ten psychological characteristics of resilience can be learnt via CBT including: optimism, developing cognitive flexibility, a personal moral compass, altruism, finding a resilient role model, learning to be adept at facing fear, developing active coping skills, having a supportive social network, exercising, and having a sense of humour. Mealer et al, (2012b) suggest their goal is to use this information to develop effective intervention programmes. The research by Lloyd, Bond & Flaxman (2013) alluded to earlier provides one of the few illustrations of how intervention programmes focussing on improving psychological flexibility via Acceptance and Commitment Therapy (Hayes et al, 1999) can produce positive effects in the reduction of burnout.

1.7 Summary

Whilst research into the burnout field is prolific, it has been criticised on several levels. It is overwhelmingly descriptive and exploratory in nature. Theoretical models lack empirical support. The vast majority of studies are quantitative and cross-sectional in nature making it inappropriate to claim causal inferences. The dominance of the MBI may have constrained our understanding of burnout and findings in this field often prove contradictory (Schaufeli and Enzmann, 1998). Nevertheless more sophisticated methodological techniques, statistical tools and a slowly growing number of longitudinal and qualitative designs have raised the methodological bar and generated theories and models which acknowledge the complexity of this construct (Maslach et al, 2001, Leiter, Bakker and Maslach, 2014). Schaufeli, Maslach & Leiter (2009) suggest the research challenge moving

forward is to explore how far different psychological processes are responsible for producing employees who are burnt out in comparison to those showing high levels of job engagement. Such insight could prove invaluable in helping to develop interventions which can really make a difference and recognises that whilst burnout is influenced by a complex interaction of individual and situational factors a difference can be made to help the individual function more effectively at work regardless of the complexity of this psychological phenomenon.

1.8 Rationale for study

It has been suggested that *'a more comprehensive blueprint of nurse stress and burnout in the workplace needs to be developed'* (Jennings, 2008:4). Whilst there exists a valuable body of international studies exploring burnout and to a lesser extent the benefits of specific intervention programmes, these studies are often cross-sectional and solely focus on providing insight into the individual experience of burnout and interventions and at one point in time. Recent research has sought to understand how burnout develops but conflicting theory exists, see Golembiewski et al (1986) and Leiter & Maslach (1988) for the dominant models. There is apparent need to add to the body of research exploring the development of burnout over time. Whilst longitudinal research on burnout is in evidence, it is limited and rarely explores the burnout process beyond a year and long-term. Statistical and logistic demands make longitudinal research difficult (Maslach Jackson and Leiter, 1996) and certainly proved prohibitive for this study. However, it was considered useful and feasible to adopt a retrospective lens for this study and one which also recognises the value of viewing burnout as *'an erosion of a positive psychological state'* (Schaufeli, Leiter & Maslach, 2008). As Mealer et al (2012a) suggest the presence of psychological resilience amongst ITU nurses is associated with lower levels of burnout; however, this association is relatively unexplored and *'future qualitative research is required to better understand what coping strategies and psychological characteristics are employed by resilient nurses…to buffer sever stress'* (Mealer et al, 2012a: 297). I was keen to add to the very small body of research which allows the lens to be placed on the positive antithesis of burnout.

This study intended to fill the gaps in the literature. It aims to provide new information by retrospectively exploring the factors, processes and psychological mechanisms along the nurse's journey which influence vulnerability and resilience

to burnout. It provides new, in-depth, culturally and organisationally specific insight. It also makes a point of exploring the coping strategies and psychological characteristics which resilient UK nurses hold or employ and vulnerable nurses may lack. This research was designed with the aim of providing fresh, new insight which enhances the body of knowledge relating to burnout and which has relevance to the UK, given that much of the research emanates from the US and more recently Northern Europe. The design was intended to ensure that research output can inform the development of new interventions which all nurses regardless of burnout status can benefit from, in order to prevent burnout, aid recovery and foster greater resilience long term. There are personal, professional and organisational benefits to be gained for nurses and the NHS by greater engagement in these issues not least in helping to maintain an empathic, compassionate and committed nursing workforce.

Nurses working at [redacted]) were chosen for the focus of this study because it represents a leading UK trust offering typical insight into the life of a nurse working within the NHS today. High intensity nursing roles ie.nurses working in ITU and cancer care were selected because these wards are recognised as putting nurses under particular stress long term (Ifeagwazi, 2005, Mealer et al, 2009, Gillespie, 2003).

1.9 Relevance to Counselling Psychology

A pluralistic epistemology is at the core of counselling psychology and of my practice both as a practitioner and researcher. This study was designed to further the status of counselling psychology and address some of the criticisms lodged at counselling psychologist trainees. For instance, Kasket (2012) and Rafalin (2010) suggest counselling psychologists (CoPs) often fail to embrace the pluralistic benefits of our positioning and identity, both clinically and through our research. This study tries to address this historical weakness and produce research which has direct relevance to the clients we work with, our practice and the wider community within which we work. Hence it adopts a pluralistic, multi-method approach, enhancing the study's trustworthiness and potential for generalizability in order to generate new information to aid in the development of appropriate, time relevant support for UK nurses working within the NHS.

Counselling psychologists are well placed to be able to understand and integrate nomothetic and idiographic approaches and to appreciate the value of both. By emulating this pluralistic philosophical position we are more able to engage with the different perspectives our clients or research participants bring and to respond to the needs of service and policy makers (McAteer, 2010). During my time on placement in [redacted] Staff Psychological and Welfare Services, I was very conscious of the pressures inherent within the NHS and felt that in order to be able to produce research that has relevance to our clinical practice, and potential to be transformative in terms of addressing burnout effectively, it would be most powerful if I adopted a mixed methodology approach. Whilst the primary role of my quantitative element was to aid recruitment of nurses at each end of the burnout spectrum, it would also gauge burnout levels. As Griffin & Phoenix (1994) acknowledge, when exploring a particular condition, policy makers are more likely to be persuaded by quantitative data and more able to persuade others of the necessity of an intervention or policy change if levels are considered high. I hoped this research has potential to add impetus to the commitment within counselling psychology to produce research which places the scientist-practitioner model at the heart of our identity as counselling psychologists in the UK (Corrie & Callahan, 2000). As Milton (2010) suggests our research as counselling psychologists can have a transformative effect both to our clinical practice, how counselling psychologists are viewed and how far a reach our research can have. This research seeks to join this move towards change for our profession by producing research insight which has relevance to our clinical practice and adds to the broad base of knowledge regarding burnout, in order to help the process of transformative change for both nurses working in high intensity wards in the UK and to help the NHS to offer more effective support programmes which build resilience to burnout, retain staff, increase quality of care and job satisfaction.

My role as a trainee counselling psychologist, within the Staff Psychological and Welfare Service at [redacted], provided insight into the stress and pressure faced by nurses, particularly those working in high intensity wards. It illustrated how counselling psychologists are perfectly suited to provide the kind of research led, psychological support necessary within a healthcare setting.

Chapter 2: Methodology and methods

2.1 Overview

This chapter explores the methodology I used to design this research project and the methods employed to gather and analyse the data. Initially I begin by stating the research question and discuss the epistemological, ontological, and methodological framework I worked within. This leads into a discussion of how my approach allowed for critical exploration of the construct of burnout. A detailed account of the methods I adopted follows. I explore why I adopt a 'modified' version of classical grounded theory, as outlined by Glaser and Strauss (1968), rather than relying on a prescriptive, mechanistic application of any one model of grounded theory in its entirety. Finally I provide an in-depth discussion of the process of data collection, sampling, data analysis and ethical considerations.

2.2 Research question and aims

The question which influenced the design of this study was: ***How do nurses become vulnerable or resilient to burnout?***

As previously discussed my experience working in the Staff Psychological and Welfare Service at [redacted] led me to believe research was required which would help to illuminate the significance and relevance of burnout and seek to understand how burnout develops and poses a significant threat to our nursing profession.

I therefore set out to design a research project which initially established whether burnout was an issue for high intensity nurses working in cancer care and intensive care at two sites at [redacted] It was also designed to identify and explore the process of burnout from the perspective of nurses who showed signs of being either vulnerable or resilient to burnout. Secondly a deeper understanding of the influencing factors, processes and psychological mechanisms involved in the development of vulnerability or resilience to burnout was explored. It was intended that research outcomes would inform the type of therapeutic support needed to prevent burnout and encourage resilience or

recovery; help to raise awareness of the personal costs of working in a caring profession and provide insight into the influencing factors along this journey which may challenge resilience and increase vulnerability to burnout. It was hoped research output would also encourage greater adoption of self-care/coping strategies long-term to foster better mental health and well- being, greater job satisfaction and likelihood that our nurses will stay within the nursing profession despite the challenges they face.

2.3 Methodological framework

2.3.1 Epistemological position

I adopted a pragmatic epistemological framework of inquiry in this study, which aims to seek 'a' truth which is not independent of normal human experience but reflects it through a range of means. Pragmatists maintain it may be necessary for Psychologists to use both qualitative and quantitative methods to gain a complete understanding of humans (Yardley & Bishop 2008). Pragmatism has the potential to embrace the benefits of both qualitative and quantitative approaches equally (Tashakkori and Teddie, 2003) and to be seen as a tool for action and change (Cornish and Gillespie, 2009).

My epistemological position of pragmatism reflects a broader postmodern paradigm shift within psychology generally and counselling psychology specifically away from a primary reliance on quantitative methods, to a pluralistic position which embraces both the importance of qualitative and quantitative methods (Ponterotto, 2005). Pluralism is defined by Rescher (1993: 79) as the *'doctrine that any substantial question admits of a variety of plausible but mutually conflicting responses'*. As a philosophical movement, postmodernism challenged the modernist, scientific notion that we can access 'the' truth, particularly in the context of human behaviour, attitudes and beliefs. Instead of a unifying, singular answer to a given question, this position proposes that we live in a complex world, with a multiplicity of influences from the political, personal, social, cultural and linguistic, it challenges the concept of there being metanarratives (McAteer, 2010). In response to this shift in perspective, pluralism emerged as a doctrine which at its heart embraces the notion of diversity of perspectives inherent in our search for understanding. Slife and Gant (1999) suggest that whilst the differences inherent in

each method must be recognised and mustn't be understated, if combined effectively a greater level of illumination and perspective on a particular subject can be achieved.

Within this study, I felt it was necessary to try and achieve this ideal in part because of a recognition that in order to have influence within the NHS, it is necessary to produce a piece of research which the gatekeepers and policy makers could use to justify provision to develop greater support to minimise burnout. It is increasingly recognised that a mixed method approach and one whereby the quantitative and qualitative elements support each other potentially provides the most powerful method to adopt in this context (Rafalin, 2010, Yardley & Bishop, 2008 and Griffin & Phoenix, 1994).

However, it has been argued that combining opposing methods can be problematic because of the different theoretical perspectives and paradigms each approach is based on (Yardley and Bishop, 2008). In simplistic terms qualitative research is typically rooted in 'interpretive'/'constructivist' paradigms and adopts a position of relativism which states that *'our awareness of the world is completely mediated by our particular subjective and socio-cultural experiences'* (Yardley & Bishop, 2008: 354), and quantitative research is rooted in positivist, realist paradigms which states there exists a reality and there is only one accurate way of perceiving it (Burr, 2003). Yardley & Bishop (2008) argue that the differences between the two approaches have been exaggerated and are not insurmountable. They use pragmatic theory to deconstruct perceived differences and so provide a rationale for this framework to be able to combine both methods of enquiry. John Dewey, the early pragmatist argued that the scientific method can be reconceptualised not as a neutral process of objective observation, but rather a typical human enterprise characterized by uncertainty, faith and passion (cited by Yardley and Bishop, 2008).

Cornish & Gillespie (2009) provide further impetus to this debate, they argue that a pragmatic epistemological view of knowledge provides a tool for action and changes the fundamental question we ask of knowledge from 'does the knowledge accurately reflect the underlying reality?' to 'does the knowledge serve our purposes?' (Rorty, 1999). This allows the researcher to step away from the methodological wars that dictate that one paradigm is irrevocably incompatible with the other and helps to bring them together, so long as the limitations and assumptions of each are respected, (Rafalin, 2010).

On one side of the divide, constructionists argue that because realism prioritises a single form of knowledge as 'true' it is insensitive to alternative forms of knowledge, which can lead to a stripping away of agency, individuality and recognition of the importance of social, cultural and political influences on the way humans think, talk and act (Gergen, 1992). However, Cornish & Gillespie (2009) argue that pragmatists can accept that this method can be useful to establish efficacy of an intervention or for analysing physical processes eg. Neuropsychology. Within this study it was recognised that a quantitative tool could be useful in providing convincing evidence to policy makers that a problem exists, and helpful in identifying, for the qualitative phase, individuals who were at either ends of the burnout continuum. Whilst relativism associated with constructionism brings the individual into focus this position can make it difficult to provide definitive recommendations for effective action and development of positive programmes of intervention. It is argued that pragmatism allows for a re-balancing of this dogmatic allegiance to respective philosophies underpinning scientific or constructionist knowledge, pragmatism *'avoids the problems of realism and relativism and enables both critique and action' (*Cornish and Gillespie, 2009: 5).

By keeping the principles and dialectical nature of pragmatism in mind throughout the research process this theoretical model can help to ensure the smooth integration of findings in a manner which continually explores the assumptions or claims underpinning each approach. Without an over-arching, explicit theoretical framework mixing methods can be fraught with problems (Yardley & Bishop, 2008). I agree that the different assumptions made by both positions need to be acknowledged in order to avoid transgressing and misunderstanding the relative aims of each. If combined well, each method can help to challenge and test underlying assumptions and provide further insight into different aspects of the phenomena or subject under consideration. The interpretive qualitative methodology *'ought to be able to question the meaning and validity of the concepts and measures used in the quantitative research, rather than treating them as predetermined objective realities'* (Yardley and Bishop, 2008: 354). I held this in mind throughout the research design and process in order to maintain a critical position in terms of being able to use each method to further enhance our understanding of the meaning and development of burnout as a construct and to consider validity of the measurement tool the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1996).

2.3.2 Ontological position

Engagement with the philosophical challenge of adopting a pragmatic epistemological position led me to recognise that overall I hold a critical realist ontological position which informed my methodological choices throughout. Willig (2014) asserts that a position of critical realism differs from the more direct or naïve version of realism in that it assumes that whilst data can tell us about what is going on in the material, social or psychological world, it does not do so in a manner that directly mirrors reality as naïve realists may maintain, rather it does so in a way which may need to be interpreted in order to provide access to the structures and underlying mechanisms of the psychological, social or material phenomena being observed. From this perspective, whilst it isn't necessary or expected that participants are aware of the underlying mechanisms or conditions that inform their experiences and behaviours, this does not mean they are not 'real'. Willig (2014) argues the extent to which underlying structures and mechanisms are presented with certainty varies from those that adopt a more cautious position and present them as interpretations representing possibilities rather than certainties (Eg. Frosh & Saville-Young, 2008) and those that adopt a more knowing stance and present their analyses as insights into how things actually are (Hollway & Jefferson, 2000), I strive to attain the latter position. Charmaz and Henwood (2008) suggest that in practice these lines blur and as such grounded theory is a good qualitative method for mixed methods studies. They suggest that grounded theory is essentially an interactive and interpretive method which allows researchers with either objectivist or constuctivist leanings to select grounded theory strategies that increase efficiency and effectiveness in gathering meaningful and useful data and in constructing focused analyses.

As such, this critical realist position helped to inform my decision to adopt grounded theory as my qualitative analytical framework. However, in reviewing the multiple versions of grounded theory it was felt that none wholly reflected my pragmatist/critical realist position. Hence, it was considered necessary to carefully select those elements of grounded theory that best suit my research question and which respect the underlying assumptions being made. It was felt that by adopting this approach it would avoid the pitfalls of simply plucking a methodology off-the-shelf and applying it in a formulaic fashion which Chamberlain (2012) suggests can compromise the quality of the research. However, my grounded theory approach most closely followed Glaser and Strauss' classic approach (1969). By adopting a

more flexible approach to grounded theory, I aimed to embrace the benefits of both the pragmatist and pluralist position held in this study and as a counselling psychologist. I sought to increase my level of engagement with the research question and optimise the relevance of the data collected, by adopting creative data collection and analytical methods whilst also appreciating the benefits of ensuring reflexivity and critical thought throughout (Chamberlain, 2012).

2.4 Research Design

As discussed above my ontological and epistemological position of critical realism and pragmatism informed the adoption of a mixed methods research design. Whilst both quantitative and qualitative methods were adopted, the research question primarily had an exploratory orientation, hence the focus of the study was qualitative in nature: quant **-> QUAL** (Cresswell et al., 2003). Hanson et al (2005), referred to this method as a 'sequential explanatory' design, as is common with sequential designs, data analysis is connected and integrated at the data interpretation stage and in the discussion (Hanson et al., 2005), this was also the case in this study. The quantitative element, in the form of an online survey was adopted to establish burnout levels, note emerging trends and to primarily identify nurses who were either vulnerable or resilient to burnout (See Appendix F for screen shot/link to survey). The qualitative element was designed to explore and seek to explain the processes involved in burnout.

2.4.1 Rationale for quantitative methodology: Phase 1

A quantitative method is being adopted for two key reasons, as discussed: Firstly to aid identification of nurses showing signs of burnout and resilience to burnout for the qualitative phase and secondly to gauge burnout levels within the sample being researched. It was felt the study would carry more influence if it was found there was quantitative evidence of high levels of burnout. I wanted to produce a study that reflected the particular context within which I was working, it was intended that the qualitative sample would be modelled on patterns that emerged from the quantitative data.

2.4.1.1 Measures: *Maslach Burnout Inventory-Human Services Survey (MBI-HSS; Maslach, Jackson, & Leiter, 1996).*

Whilst several conceptualisations of the burnout syndrome exist (Lloyd et al, 2013), this study draws on the work of Maslach and colleagues (2001). This model defines burnout as multidimensional, composed of three components: Emotional exhaustion (EE), this refers to feelings of being over-extended emotionally and depleted of emotional resources; depersonalisation (Dp) refers to workers' negative, callous or excessively detached feelings towards the recipients of their work and reduced personal accomplishment (rPA), describing a decline in feelings of competence and successful achievement in one's work. This study used the MBI-HSS inventory developed to identify and measure burnout because it is the most widely employed tool, used in over 90% of studies into burnout over a 20 year period (Schaufeli and Enzmann,1998). The MBI-HSS is a survey which has 22 statements which explore existence of the three components. Each item is rated by participants using a 7-point Likert scale ranging from *never* (0) to *everyday* (6). The inventory includes 9-items relating to EE, such as *"I feel emotionally drained from my work*"; five items relating to Dp, eg. *"I feel I treat some recipients as if they were impersonal objects"*; and eight items relating to rPA, eg. *"I feel I am positively influencing other people's lives through my work".* Adoption of this method helped to ensure I accessed individuals who objectively fell at each end of the burnout continuum, in order to recruit suitable people for the qualitative phase.

2.4.1.2 Psychometric properties.

The MBI was chosen because it has been tested extensively for reliability, validity and internal consistency, as is documented in the MBI manual (Maslach, Jackson & Leiter, 1996). The reliability coefficients for the three subscales, as reported by Maslach & Jackson (1996) are satisfactory with reported values for Cronbach's coefficient for internal consistency ranging from: .90 EE, .79 Dp, .71 rPA. The construct validity in terms of convergent and discriminate validity has been illustrated by numerous studies and in different sociocultural contexts (Maslach & Jackson, 1986, 1996, Rafferty et al. 1986, Schutte et al , 2000). However, whilst the psychometric qualities are satisfactory, Schaufeli et al. (1993) suggest they are not without question. It has been argued EE represents the most obvious manifestation of burnout and is the most widely reported and analysed component (Maslach, Schaufeli & Leiter 2001). This has led some to argue that the other two components are unnecessary or incidental (Shirom, 1989), however, Maslach et al (2001) suggests that on its own EE fails to capture the relationship people have with their work.

Whilst use of a tool to gauge burnout presupposes the existence of burnout as a three dimensional construct, early quantitative trends to emerge found that EE was the most dominant aspect of burnout found and the relationship this had with DP and rPA was more complex, hence it was decided that high scores on the EE dimension would be the benchmark to recruit participants showing signs of burnout for the qualitative phase and beyond this one or two of the other dimensions were ideally evident rather than only recruiting participants conforming to the traditional burnout profile. As Corey and Corey (1998) suggest burnout when viewed as a continuum allows it to be seen as a developmental process, as such, high levels of EE may be indicative of the early stages of burnout. By being flexible this allowed for a critical evaluation of the burnout phenomena as defined in the literature. However, whether or not I was to find evidence of burnout as defined by Maslach et al (1996), my critical realist and pragmatist position presupposes there exists a recognisable experience which many identify with and differs from stress in that it is more specific to the work based context from which it is observed, to this end it was felt the MBI tool gave me access to this phenomena.

The quantitative element gauged burnout levels in the high intensity fields of ITU, (including MITU/SITU, [redacted] and ITU [redacted] and nurses working in cancer care ([redacted]) and included descriptive statistics relating to burnout levels and burnout dimension trends noted. Demographics, length of time in nursing/the department and negative life experiences were gathered quantitatively and received preliminary analysis to scan for interesting trends, none emerged and as the literature is often equivocal in this respect (Schaufeli, 2003), for the purposes of this study they were not analysed further.

2.4.2 Rationale for a qualitative methodology: Phase 2

To date much of the burnout and self-care literature has been quantitative in nature. Whilst this has had the advantage of raising the profile of burnout, knowledge is often gained largely independent of subjective experience. Review of the literature provided support for the qualitative focus of this study. This method also allows in-depth examination of many factors simultaneously and holistic consideration of how they may relate to each other and change over time (Camic, Rhodes and Yardley, 2003).

A need for a research design which enabled greater understanding of the processes involved in the development of burnout and in particular, resilience to

burnout was identified. Lloyd et al (2013), suggest there is a dearth of research which examines the psychological processes and mechanisms of change by which emotional burnout interventions work, in order to add to this body of work there was felt to be particular value in a research design which seeks to gain an understanding of the factors and processes which influence the development of resilience to burnout as evidenced in individuals independently showing this capacity without taking part in interventions. It was hoped such insight could add substantive information useful at the developmental stage of designing intervention programmes. By including nurses suffering from burnout and nurses resilient to burnout I wanted to explore qualitative differences between the two and whether protective qualities identified can be learnt through targeted therapy, this approach is informed by Mealer et al (2012).

2.4.3 Adoption of grounded theory

Over the last thirty years qualitative research has grown substantially (Robson, 1993; Gilbert,2001). This thesis draws on the inductive qualitative approach of grounded theory. Grounded theory was pioneered by Glaser and Strauss in 1967 and whilst it has sociological origins it has become one of the most popular methods in the psychological field (Charmaz and Henwood, 2008). Charmaz and Henwood (2008), suggest that grounded theory served to respond to the growing need in psychological research to adopt more flexible, contextual methods which provide a better fit between psychologists theories, their practice and the subjective meanings our clients give to their lived experience. They also suggest that the objectivist and constructivist threads that Glaser and Strauss held respectively, helped to bridge the divide between objectivist and subjectivist traditions, making it suitable for a mixed methodology and enabling a challenge to traditional positivist criticisms that qualitative research lacked rigour and was 'impressionistic, unsystematic, atheoretical, anecdotal and biased' (Charmaz and Henwood, 2008: 244). Moreover, Glaser and Strauss (1967) argued that their method encourages the likelihood of data collection being efficient and effective in gaining useful, rich data consistent with the pragmatist agenda (Charmaz and Henwood, 2008). They accomplished this by the use of a 'set of procedures' which act as 'systematic, yet flexible guidelines for collecting and analysing qualitative data' (Charmaz, 2008:2).

Glaser & Strauss (1967) developed grounded theory because they were concerned that other methods, dominating sociological research, prevented the

development of new theories. They argued that their method allowed researchers to move between data and theory generation in an active, ongoing way encouraging the generation of new theory which is context specific and able to recognise the dynamic nature of the phenomenon being studied by focusing on 'process' and 'change' (Willig, 2008). Of particular relevance to this study was the emphasis grounded theory places on process which allows for the researcher to study how internal trajectories develop, are maintained and change over time.

After developing their approach, Glaser and Strauss took divergent paths (Charmaz, 2000). Glaser (1998, 2001) still adhered to positivist principles, maintaining the importance of generality, parsimony and the role of the researcher as objective and authoritative, neutrality of data was emphasised and line-by-line coding rejected. Strauss joined forces with Corbin (Strauss and Corbin, 1990) and retained elements of positivism eg. investigator neutrality and reliance on method but moved the method toward verification and brought greater pragmatist emphasis on agency and action, however, some argue and I would agree that their introduction of imposing coding paradigms on their data in the quest to discover social processes renders the method too prescriptive, limiting recognition of phenomenological insight and inhibiting analytical creativity. I also agree with Melia's concerns, he states that "I always have a nagging doubt that the procedures are getting in the way; the technical tail is beginning to wag the theoretical dog" (Melia, 1996: 376). Both Glaser and Strauss and Corbin's methods have been criticised for side-stepping questions of reflexivity and the role of the researcher (Willig, 2013), issues which limited complete uptake of these versions for this study. In response a number of scholars moved grounded theory away from the positivism and realism found in both Glaser and, Strauss & Corbin's versions and created their own versions (see, Charmaz, 2000, Seale, 1999, Clarke, 2003, Pidgeon & Henwood, 1997). Charmaz's constructivist version of grounded theory, addressed problems of reflexivity and proved very popular moving grounded theory into the constructivist paradigm. She adopts grounded theory strategies but holds that the resulting theory is constructed rather than discovered. It therefore locates the theory in time, space and circumstance rather than seeing it as general and separate from its origins, it is aimed towards abstract understanding, and sees the theory produced as one particular reading of data rather than explanation, prediction and insight into recognisable truth (Willig, 2008, Charmaz and Henwood, 2008). Whilst this approach is valuable in reintroducing the importance of reflexivity and the role of the researcher, it was felt to move the method too far from the pragmatist ideal for

this study, rendering the objective that knowledge gained should be actionable and serve our purpose, unobtainable (Rorty, 1999). It was also felt to be incompatible with the assumptions underpinning adoption of a quantitative tool and the critical realist position held that I was researching a phenomena that exists, that is recognisable, at least in part, by many of those it served to represent and increasingly a wider community.

As outlined, since its development, interest in grounded theory has proliferated so much that 'grounded theory has evolved into a constellation of methods rather than an orthodox unitary approach' (Charmaz, 2008: 161). Floersch et al (2010), suggest that the intense debates that ensue about what constitutes grounded theory make it difficult to establish a single definition. In my quest to establish the most appropriate grounded theory method to follow, whilst each version makes a valuable contribution it became increasingly apparent that no one approach in its entirety quite met my pragmatist and critical realist position. Whilst Charmaz's version provides a partial solution to the dilemma, this approach was felt to move the method too far away from the pragmatist position.

It is not my intention to provide a detailed description of all the ongoing debates surrounding grounded theory but to recognise Chamberlain's point (1999) that grounded theory has potential to be compatible with a range of epistemological perspectives, hence the possibility of using it flexibly to suit the research question and my epistemological and ontological beliefs was possible. I also agreed with Willig's (2008) suggestion that in order to maintain an approach that reaches its creative potential and avoids analytic rigidity it may be necessary to adopt an openness to grounded theory methods. It was felt this position allows a more flexible response to data collection methods, analysis and encourages the emergence of theory which can move beyond the descriptive to something with greater actionable value. With this intention in mind the next section outlines the general principles and framework which stem from classic grounded theory (Glaser and Strauss,1969) and all grounded theorists adhere to so as to develop and define the coherent and rigorous methodological approach which best suited this specific research project.

2.4.4 Grounded theory procedures

Whilst statistical representativeness is fundamental to quantitative research, in contrast, in qualitative research '*selecting informants randomly makes as much*

sense as seeking information in the library by randomly selecting a book from a randomly selected shelf' (Morse, 1994: xi-xii). Thus, *'in grounded theory…our concern is with representativeness of concepts'* (Strauss & Corbin, 1990: 190), grounded theory achieves this through 'theoretical sampling' defined by Glaser and Strauss as *'the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges'* (Glaser and Strauss, 1967:45). Hence, data collection and analysis occur simultaneously, this means that from the early stages of the study, participants are selected on the basis of their experiences relevant to the aims of the study or to be able to develop and explore further properties of emerging theory. The integration of data collection and analysis advocated by grounded theory has the added benefit of helping to prevent the researcher from feeling overwhelmed by data (Strauss, 1987), a helpful consideration.

After each interview, tapes are ideally transcribed, 'preliminary/overview analysis' is carried out to sensitise the researcher to emergent themes, ensuring 'theoretical sensitivity'; an awareness of the theoretical possibilities in the data (Glaser, 1978). Glaser suggests this ensures alternative conceptualisations aren't missed, which can occur if intensive analysis of small units of data only occurs. This is followed by line-by-line, segment-by-segment or incident-by-incident coding, depending on approach adopted and type of data being analysed (Charmaz & Henwood, 2008) and initial codes or categories assigned to small sections of dialogue or text to indicate a conceptual idea. Detailed coding is carried out via a process of 'constant comparison,' this involves moving back and forth continually between different incidents that have been grouped together by coding techniques to identify similarities and differences in emerging categories to allow the development of sub-categories, encouraging the full complexity, diversity and depth of the content to be realised as theory is developed (Willig, 2008).

'Memo writing' is recommended throughout the grounded theory approach, Charmaz & Henwood, (2008) suggest this process raises the analytical potential and level of abstraction of the emerging theory and avoids analysis remaining stuck at the descriptive level only, a criticism often lodged at grounded theory (Charmaz, 2006). Willig (2008) also suggests memo writing is useful to define codes, record theory development and trace emergent relationships.

Glaser and Strauss (1967) suggest that theoretical sampling should continue until 'theoretical saturation' is reached, the point at which gathering new data reveals no new categories or theories (Charmaz and Henwood, 2008) and '*only adds bulk to the coded data and nothing to the theory'* (Glaser & Strauss, 1967: 111). However, many researchers recognise that this is a goal rather than reality (Willig, 2008). Glaser and Strauss (1967) also suggest that grounded theory is provisional and we must be open to other emergent perspectives that may change and develop our theory further.

Glaser (1978), suggests researchers shouldn't consult previous literature prior to fieldwork in order to prevent prior conceptualisations which may contaminate emerging grounded theory. However, many contest this as unrealistic and it presupposes that researchers approach their work with no preconceived ideas or thoughts (Field & Morse, 1985). I agree with this viewpoint, I was very aware of burnout as a construct as it has increasingly become a topical issue in the popular media, and captured the imagination of the lay public with many people adopting this term as an expression of how they were feeling at any one point in time. Also in submitting our initial research ideas for ethical and University approval we were encouraged to conduct a basic literature research in order to identify gaps in research. Whilst I have endeavoured to keep an open mind about the burnout concept, I acknowledge that it would be naïve to assume that my existing knowledge and beliefs didn't influence how I approached my research at some level.

The following section illustrates how I applied the procedures recognised as fundamental to grounded theory in my grounded analysis approach.

2.4.5 Grounded theory my approach

Within this study, theoretical sampling was used at several stages. Firstly, the MBI (Maslach and Jackson (1982), was used as an initial tool to identify participants at different ends of the burnout continuum. Whilst traditional grounded theory methods would not recommend using existing theory to inform a current study, as discussed above this wasn't felt to be a barrier, a critical perspective was adopted towards burnout as a multidimensional construct. It was felt to be useful as a means to objectively identify nurses showing signs of vulnerability or resilience to burnout or distress. Other methods were considered, one modelled on Bakibinga et al's (2013) approach of asking colleagues to recommend suitable nurses renowned

for thriving and in this case showing signs of burnout, but this was felt to be fraught with problems of subjectivity, offending colleagues by pointing fingers and conflicting definitions of burnout and whether or not their understanding reflects the nominated participants perception.

Beyond this initial identification of suitable participants, trends found from the quantitative data were used to inform recruitment for the qualitative stage of research. For instance it was identified early on that whilst a small minority showed signs of burnout on all three aspects of the burnout construct, a trend emerged whereby a larger number of cancer care nurses showed high levels of emotional exhaustion but low levels of depersonalisation and high levels of personal accomplishment than ITU nurses (see Appendix G for emerging trends). This is in contrast to the literature on burnout which implies that when high levels of emotional exhaustion exist, high levels of depersonalisation (Dp) are found and low levels of personal accomplishment (PA), this pattern being seen as indicative of burnout. However, this trend appeared striking hence I adopted the approach of theoretical sampling and reflected this trend in my qualitative sample to further explore the theoretical potential of this trend qualitatively. Further emergent trends explored were the importance of negative life events and having children as factors influencing resilience or vulnerability to burnout, whilst this criteria wasn't used as recruitment criteria in the qualitative stage it did inform a line of enquiry to try to explore how and why the latter helps to develop resilience.

Within the qualitative phase theoretical sampling was also in evidence throughout: After each qualitative interview, preliminary analysis was carried out to ensure theoretical sensitivity and initial categories were assigned to small sections of dialogue or text to indicate a conceptual idea, memo writing was conducted from the earliest stage to encourage fracturing the data to optimise abstraction and analytic potential. Within this study, theory emerged from early analysis and data coding, this informed later recruitment of individuals who had experiences which could explore and extend the theory further, interview protocol was used flexibly to explore emerging theories as research proceeded. For example, nurses described orientating towards particular departments and roles which best suit their skill set and area of interest, after a process of comparative analysis, a difference was identified between nurses choosing roles where they are more able to closely follow the patient's journey because they enjoy the level of emotional engagement this affords (ie. typically nurses in cancer care) and those who enjoy the high levels of technical expertise and apparent immediate difference they can make to patients

(ie. nurses in ITU wards where patients pass through quickly). As such it became apparent that further data needed to be collected amongst nurses in ITU departments that would allow for further exploration of this issue and emergent theory, as such I extended the reach of the study by sampling nurses in ITU, [redacted] and recruiting nurses from SITU and two nurses from ITU qualitatively because initial interviews indicated a need to theoretically sample in this way. As such, new issues and relationships from and/or between the codes discovered initially were explored further.

Within this study, I recognised that theoretical saturation is a goal rather than a reality (Willig, 2008), timing made the achievement of this criteria difficult. Whilst I reached a point of feeling that new data was only serving to bulk out existing theory, there was a sense that ideally, whilst I conducted 5 interviews amongst those working in ITU, ie. three SITU/MITU [redacted] and 2 ITU, [redacted] I would have liked to conduct more than 2 qualitative interviews within ITU, [redacted][2] given emerging quantitative trends supported emerging theory. Ideally research would also be conducted in A+E another department which it is hypothesized would provide data to further explore theory emerging from ITU departments where greater satisfaction is afforded task-driven aspects of the job and how this impacts on the emerging pattern of burnout.

Throughout the process I adopted a position of reflexivity more in line with a social constructivist perspective and in this extent more in line with Charmaz's approach, because I was all too aware of the need to recognise my own role in the research process and the importance of being aware of situational and contextual factors influencing emergent theory.

It was suggested by Bartlett & Payne (1997), that research which uses only selected components of grounded theory may best be labelled 'grounded analyses'. The approach I adopted methodologically may best be described this way. (See Appendix N and O for examples of my analysis).

[2] Evidence emerged to suggest nurses show different nursing orientations and preferences, in this case either for emotionally-driven nursing styles eg, typically cancer care or more task-focussed nursing eg. ITU, each nursing orientation appears to show a different process of burnout development. I wanted to explore and confirm this theory by examining it to the point of theoretical saturation this was not possible, due to timing constraints but strong evidence emerged to support this theory.

2.5 Reflexivity

2.5.1 Personal reflexivity

On reflecting on the reasons for choosing to study this topic, my decision was informed by my experience of working within the Staff Psychological and Welfare Service, [redacted] and seeing the effects of working in a caring profession take its toll. I became interested in why some individuals appear to be more vulnerable than others. I recognised that this interest stemmed from my own personal experience of finding myself in a caring role whilst juggling a demanding career as a researcher. I noticed changes in my own well-being and enthusiasm for my job and began to take steps to develop greater resilience. When I first began to train as a counselling psychologist, I was struck by the obvious emotional and physical drain this placed on me. As my knowledge and experience as a trainee clinician grew I began to recognise certain thinking styles, self-care practices and life experiences all had an impact on resilience and the individual's ability to cope with the demands of a caring professional role. I was keen to become as robust a practitioner as possible and felt determined to try and do the best by my clients, I naturally began to explore this area of study. I recognised that my own experience, assumptions, beliefs and interests had the potential to influence the research process (Willig, 2001). This was reflected on at every stage of the process, from the sample design, initial analytical stages and during some interviews amongst nurses working in areas which personally resonated for me, I had to acknowledge this and maintain as neutral a position as possible whilst retaining empathy and rapport.

I also recognised the importance of reflecting on how the research may impact on the researcher personally and professionally (Willig, 2001), conducting the interviews at times highlighted old personal pain, which I took into supervision. The study helped me appreciate the enormous personal rewards working within a caring profession can bring but also to recognise the need to be mindful of the impact such work can have and the need to effectively process and manage this. I am left recognising the need to help raise awareness of burnout, how resilience can be developed to ensure greater personal satisfaction, well-being and maintenance of an engaged, compassionate caring professions workforce.

2.5.2 Epistemological reflexivity

Whilst a pragmatic position using mixed methods was adopted, the focus of the study is qualitative and places the need for reflexivity at every stage of the research process. By having to embrace the philosophical debates that surround methodological choices I realised I have long struggled with how to embrace both qualitative and quantitative methods. As a young commercial qualitative researcher I used to struggle with appreciating the contribution quantitative research made to 'truly' understanding human behaviour. However, as I matured professionally and set up my own business, I gradually saw the need and virtue of adopting a position of pragmatism. On entering counselling psychology, I still initially held onto the belief that quantitative tools to measure well-being, depression, anxiety etc were not of value, however, after working in the NHS and becoming more aware of accountability and need to objectively measure improvement via Core 33, Phq-9, I began to appreciate their worth. I now realise I was beginning to adopt a critical realist view of the world, and such tools can be useful and can help shine a more neutral/objective light on our clients experience and levels of distress. However, I maintain they don't tell the whole story; require further interpretation and may only be relevant to the cultural or historical context within which they are used. I also appreciate how if the limitations and assumptions of qualitative and quantitative methods are recognised they can be complimentary and compatible. As such, I wanted to try and integrate the benefits of offering a mixed method in my thesis in part as a means to grow professionally and philosophically but also because I hoped it would lead to a more impactful rounded exploration of burnout.

The fact that grounded theory in all its permutations can be compatible with a range of epistemological perspectives encouraged me to be bold enough to use it flexibly to suit both the research question and my epistemological beliefs (Chamberlain, 1999). This allowed me to be flexible in my data collection techniques, more responsive to emerging findings and go beyond description to strive for deeper analytical insight which could be actionable. It also allowed recognition that the role of the researcher went beyond that of a neutral observer and became more of an engaged witness, who may come with assumptions and experiences which continually need to be reflected on. I did this by approaching the interviews with as open as mind as possible to new emerging lines of enquiry and I strived not to be directive when sharing emerging theory but to discuss it flexibly where appropriate. Reflective practice and supervision was used to discuss underlying assumptions. Reflecting the relativist element within my analysis the

situational, cultural, social and personal conditions within which they were produced was acknowledged.

2.6 Research Method

2.6.1 Recruitment method and procedure overview

Initially Matrons and Ward Sisters were briefed about the project face-to-face and asked to help promote the project and encourage nurse participation. They were asked to hand out named research packs to all qualified nurses working in their departments, which contained a covering letter, with a unique identity code (to ensure confidentiality); a web link to the survey; a participant information sheet; a consent form (stating whether the nurse agreed or choose not to participate in the study) and debrief notes (who to contact for further support if need be). Once initial response had tailed of, nurses were re-contacted via email and asked if they wanted to take part anonymously. NB. Nurses in ITU (with exception of 2 known participants) were only contacted this way due to logistics and theoretical sampling principles ie. the need to further explore emerging theory. Willing nurses followed the link and filled out the MBI remotely in their own time. They were asked to return the consent form in a sealed envelope regardless of their willingness to participate (to protect confidentiality), via secure email or for anonymous respondents, participation was considered as evidence of consent. Personal contact details of those willing to take part in stage two were gained via returned consent forms or email. The code book linking unique codes with names was stored manually, in a locked cabinet on the researcher's premises.

Once trends emerged quantitatively and completed surveys began to slow, the qualitative sample was recruited and interviews conducted, sampling was reflective of the emergent patterns. Initially nurses taking part in phase 1, were asked to check a box saying they were willing to be re-contacted via mobile or email to take part in stage 2. Once enough participants were recruited for the qualitative study, nurses who hadn't previously chosen to take part in the study, (or if they worked in ITU, [redacted] were given the opportunity to take part anonymously, a further 32 surveys were collected this way. These data were reviewed for differences in trends due to anonymous participation. Whilst sample size was small, trends emerging from ITU, [redacted] suggest nurses were more likely to respond if they showed signs of burnout than resilience to burnout.

The individual MBI respondent data were directly relayed to and saved on a secure website, hosted at Cog Research, a reputable research company, I've worked with on and off for 20 years. They are bound by industry standards of data security and offered their services on a pro bono basis. Data were only identifiable via a numerical code, and personally identifiable data coded to ensure third parties could not read it. Data sets were relayed to the researcher via an encrypted Excel file (password protected) and saved on the researchers password protected, external secure hard-drive. Overview analysis of these data were conducted initially on excel, followed by full descriptive and cross analysis of the data set via SPSS.

2.6.2 Quantitative sample

Nurses working in: Cancer services, [redacted]; medical and surgical intensive therapy units, in the [redacted]); and the intensive therapy unit in [redacted] agreed to take part. These departments were identified to be high intensity fields to work within in terms of the demands/strains of the job (identified by literature review and Clinical Lead of SPWS, [redacted] NHS Foundation Trust). A total of 398 nurses were contacted to take part, 100 chose to participate, see Table A:

Invited to take part		Took part in survey		
		Total	Confidential	Anonymous
SITU, [redacted]	67	**24**	16	1
MITU, [redacted]	31		7	
Cancer care	150	**52**	42	10
ITU, [redacted]	150	**24**	2	22
Totals	**398**	**100**	**67**	**33**

Table A: *Profile of quantitative participants*

2.6.3 Qualitative sample

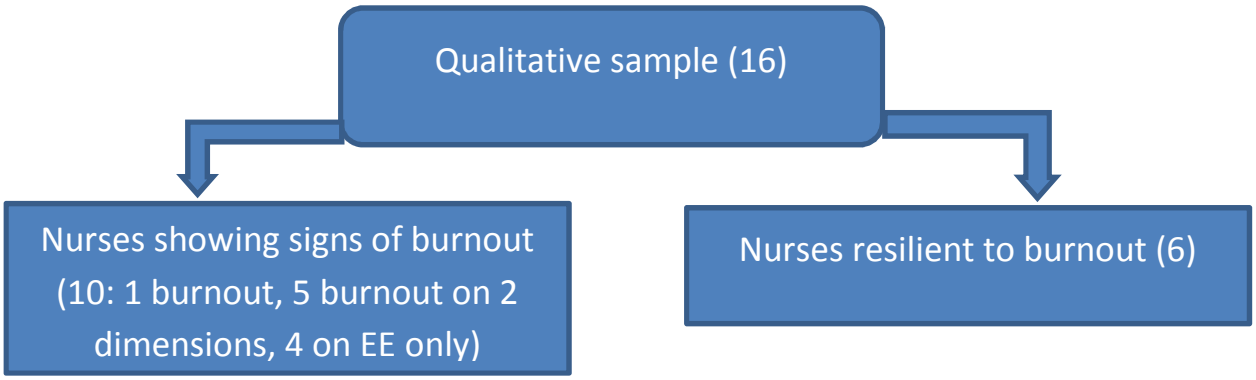

Figure A: *Summary of qualitative participant burnout profiles*

Analysis of the MBI and demographic data informed recruitment, trends observed were reflected as far as possible, some constraints were evident due to lack of willingness by some nurses to take part when re-contacted but a representative spread was largely achieved. (Note, it was not possible to provide full exploration of the role of ethnicity due to low levels of willingness to participate in the qualitative study by nurses from the full spectrum of ethnic groups working in this trust). Because of low levels of burnout on all three scales but high levels on the emotional exhaustion scale, this was taken as key criteria for recruitment initially. The following nurses were interviewed qualitatively:

- 10 nurses all with high levels of emotional exhaustion were represented. (NB. high levels of emotional exhaustion considered to be indicative of early sign of burnout). Beyond this:
    - 1 nurse interviewed showed burnout on all three scales
    - 5 other nurses showed signs of burnout on 2 dimensions (2 nurses, high EE, high Dp, 3 nurses high EE, low PA both indicative of burnout)
    - 4 nurses high levels on EE only, but interestingly showed high levels of PA

- 6 nurses falling at the resilient end of the spectrum were interviewed (ie. low score on EE and DP, high on PA on MBI), of these:

    - 5 showed signs of resilience on all three scales, (NB. two were on the boundary of resilience on one dimension)
    - 1 reported signs of resilience on two scales and moderate levels of personal accomplishment
- (Cut off points for burnout levels guided by MBI manual (Maslach et al, 1996, +/- 1 point)

See Appendix M for further qualitative demographic information.

2.6.4 Procedure

2.6.4.1 Quantitative procedure

Upon entering the MBI online survey, this followed the original MBI in content and was designed to be a dynamic, self-completion questionnaire, allowing for each question to be presented attractively, individually and automatically withdrawn from view when answered to aid engagement and focus, intended to increase reliability, this approach has proved successful commercially. Question randomisation was incorporated into the design of the survey to alleviate order bias. Further information was gained at the end of the MBI relating to demographics, ward currently working on, length of time qualified/ in job, experience of negative life events, when they occurred and whether the most significant event was felt to impact on their job. All information was coded except for ethnicity and negative life events where participants could self-define this criteria. (See Appendix F for a screen shot of the survey and link for trial).

2.6.4.2 Qualitative procedure

Flexible semi-structured interviews were conducted, whilst the interview questions were open-ended the process built in insights gained in previous interviews to evaluate emergent theoretical formulations the researcher was exploring, if deemed relevent. Broad themes were explored, this began with a retrospective look back on their journey leading to the present day: Why they chose nursing initially and how events, processes, strategies etc were felt to be more or less impactful on resilience/vulnerability to burnout. Issues to be discussed were informed by existing literature but where alternative participant-led topics emerged these were explored (see Appendix L for interview schedule and Appendix F example questions of MBI).

2.7 Ethical Considerations

The research complied with the Code of Human Research Ethics as outlined by the BPS (2014), City University London's ethical guidelines and passed NHS [redacted] Hospital Trusts ethical review. At recruitment and prior to research commencement, participants were informed of confidentiality, their right to withdraw at any stage up until the qualitative stage and one week following the interview, and their right to review a summary of research findings on request. They were advised that study outcomes remain anonymous and identities confidential. Beyond this the ethical considerations covered risks posed to the participants in terms of: Distress; inconvenience; desire for confidentiality/anonymity; changes to lifestyle; legal issues around confidentiality were also considered (NB. See Appendix Aii for full review of these ethical issues).

Chapter 3: Analysis

3.1 Analysis overview

This section begins by providing an overview of the quantitative findings and then goes on to provide a comprehensive review of the qualitative findings. The emerging theoretical model this analysis generates will be presented in the discussion chapter.

3.2 Introduction to quantitative findings

The quantitative phase of research and use of the MBI was included in the study to primarily identify nurses at each end of the burnout spectrum and ensure the burnout construct actually was being explored. It was also included to gain insight into the process of burnout development, any trends emerging in the quantitative data being reflected and explored in the qualitative phase. At the outset it was intended nurses would be recruited who fell at each extreme end of the burnout spectrum, ie. they were to record scores on the MBI which were indicative of showing resilience to burnout or scores reflective of burnout. As the results show only 6% of the sample showed burnout on all 3 scales, but 27% showed burnout on two scales including EE, several studies consider this to be evident of burnout (Brenninkmeijer & Van Yperen, 2003, Roelofs et al, 2005). However, this study, following preliminary analysis of data adopted the perspective of viewing burnout on a continuum and defines such individuals as ' vulnerable to burnout', vulnerable and burnt out nurses were approached for recruitment accordingly. This is informed by Cordes and Doherty (1993) who suggest that high scores on EE can be seen as the early signs of burnout and Goelembiewski et al.(1996) who suggest different individuals may show a different sequential developmental path. Beyond this, the quantitative stage was used to evaluate burnout levels in the sample. As such, the focus of the study is qualitative in nature hence it is the aim of this section to provide a summary only of the most pertinent quantitative findings to emerge. For the purposes of this study, statistical analysis of demographic information is not included, an outline of demographic information to emerge is provided in the methodology section.

Whilst initially it was intended that rates of burnout would be combined across all departments taking part, preliminary analysis and early qualitative insights suggested that different trends were emerging between cancer care and MITU/SITU [redacted] departments potentially providing insight into the process of burnout development and how this differs by context or nursing orientation, this is explored and discussed further in the qualitative findings section. As such, it was considered findings by department should be reported separately. However, caution was adopted because although burnout levels are compared and may be reflective of the true levels found within departments, it is important to note that due to the need to recruit participants from the quantitative to the qualitative phase, nurses were initially only guaranteed confidentiality not anonymity, this may have had an influence on willingness to take part in the study and outcomes. An effect of this recruitment strategy may have been shown amongst the ITU department, approached to take part later in the study, all were offered anonymity and confidentiality (with exception of two participants), trends emerged, although non-significant, which suggest that higher rates of burnout may be evident if anonymity and confidentiality are guaranteed across the sample.

A total of 100 questionnaires were completed in full, following screening for inaccuracies. These data were initially entered into an excel data file and preliminary analysis carried out on an ongoing basis, emerging trends were monitored and nurses showing signs of burnout, vulnerability to burnout and resilience to burnout noted in order to recruit them for the qualitative stage. For the purposes of recruitment, the raw scores were transformed from the MBI into the categorical variables of low, moderate and high as suggested by Maslach, Jackson and Leiter (1996). Following completion of the online phase, these data were entered into an SPSS data file in its raw form. Descriptive statistics of the sample were collated. To prepare the burnout data for analysis a number of checks were carried out for normality and homogeneity of variance in the sample. Tests for reliability of the subscales were not carried out because it was not considered necessary given the qualitative focus of the study and the reliability coefficients for the three subscales, as reported by Maslach & Jackson (1996), were considered satisfactory reassurance for the purposes of this study. The norm group data, provided in the MBI manual (Maslach & Jackson, 1996) is included in this section as a point of visual comparison only, comparative statistical analysis was not provided because the norm group was defined as those working in medicine, this was felt to be too broad a group to provide a meaningful point of comparison for this study.

3.3 Summary of quantitative findings

Across the sample 6% showed burnout on all three dimensions of the MBI, 27% showed burnout on two dimensions, including EE, with a further 26% showing burnout on the emotional exhaustion dimension only. Overall 53% of the sample showed burnout on at least 1 dimension, this being EE. High levels of EE were prevalent particularly within cancer care (56%) and ITU (67%) with MITU/SITU showing lower levels at 29%. In contrast to the burnout literature early trends found a variety of dimension combinations with nurses in cancer care often showing high levels of EE, but low levels of Dp in comparison to nurses working in ITU/SITU/MITU and/or high levels of EE with high levels of personal accomplishment. This trend was used to inform recruitment and exploration of this phenomenon for the qualitative stage of the study. Theoretical sampling was adopted and the vulnerable nurses who either showed signs of burnout only on the EE dimension or also showed signs of high levels of burnout on PA or high levels of Dp with high EE, were also recruited for the qualitative phase. This was to represent alternative definitions of burnout found in the literature which suggest different combinations indicate burnout as discussed above and to provide insight into the nature of the burnout process and whether or not support could be found for the theory that burnout ought to be viewed as a continuum, as suggested by Corey and Corey (1998). They state high levels of EE indicate the early signs of burnout and the other two dimensions having relevance down the line, rather than Shirom's (1989) view that the two other dimensions are incidental, irrelevant or unnecessary. Figure 1, illustrates the proportion of the sample that reported levels which indicate burnout on each of the three subscales of the MBI ie. High levels of EE, high levels of Dp and low levels of PA. The figure shows that in each department a higher percentage of nurses showed burnout on the EE scale, whereas a lower percentage showed burnout on the Dp and PA scales comparatively.

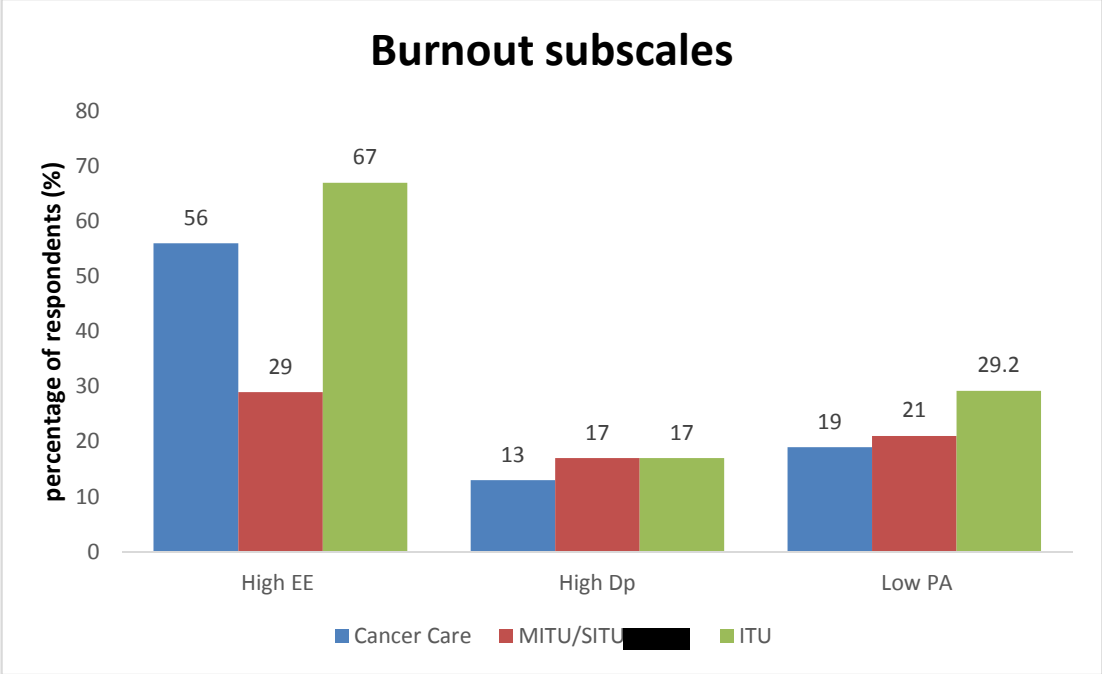

Figure 1: *Percentage of respondents showing signs of burnout on each subscale by department*

Following observation of these initial trends, statistical analysis was carried out, measures of central tendency and variability were used to examine levels of reported burnout in the overall sample. In accordance with recommendations by Maslach, Jackson and Leiter (1996), to enhance the power of the statistical analyses, original numerical scores were used rather than the categorical variables used to identify respondents for qualitative recruitment, see Figure 2 below for the mean scores of the subscales by department:

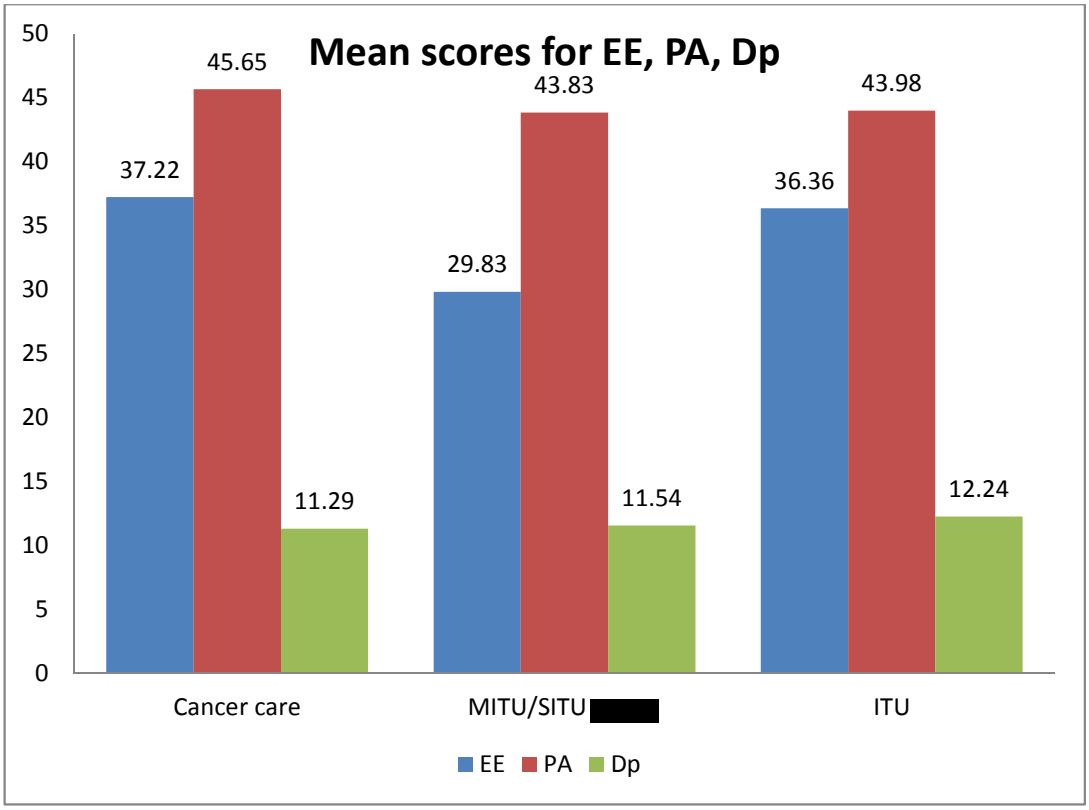

Figure 2: *Differences between mean scores by department and for EE, PA, Dp*

A difference between the mean scores in the three departments was identified. The significance of this difference was checked using inferential statistics. The data shows there was a normal frequency distribution for EE, although frequency distributions for Dp and PA appeared to indicate a slight positive and negative skew respectively (See Appendix H).

I tested whether there was a significant difference between EE, Dp and PA levels across departments. A between groups 2 tailed Anova was carried out to test the significance of the distribution between the means in the 3 departments in terms of EE, Dp and PA. A significant difference was found between departments in EE only, F (2,97) = 3.214, $p < 0.05$, p =0.045. The difference between PA across the departments was found not to be significant, F (2,97) = 0.942, p = 0.394. The difference between Dp across departments was also found not to be significant F (2, 97) = 0.92, p = 0.773, (see Appendix I).

Since EE was significant a further independent samples t-test was carried out between EE and cancer services/ITU and MITU/SITU [redacted], (see Appendix J). Significance was found t (73) = 2.316, $p < 0.05$ (Nb. this is when it is assumed a normal distribution was found in both departments with an equal variances

assumption). If non equal variances are assumed then t (49.012) = 2.392, $p < 0.05$. Because a significant difference was found it was important to try to explore why there was a significantly lower level of EE in MITU/SITU [redacted] versus cancer care and ITU [redacted] in the qualitative phase of the study, in order to see whether this can support recommendations to emerge re. intervention/strategy development to combat the threat of burnout, to be discussed later.

The means and standard deviations for each subscale are detailed below, the norm group data provided by Maslach, Jackson and Leiter (1996) is included as a visual point of comparison only, see Table B below:

		Current sample				**Maslach, Jackson & Leiter (1996)**
		Cancer care	**MITU/SITU**	**ITU**	**Totals**	**Medicine**
EE	***M***	37.22	29.83	36.36	**35.23**	22.19
	SD	13.223	12.096	9.032	**12.308**	9.53
Dp	***M***	11.29	11.54	12.24	**11.59**	7.12
	SD	5.360	5.949	4.927	**5.364**	5.22
PA	***M***	45.65	43.83	43.68	**44.72**	36.53
	SD	6.779	7.545	6.505	**6.899**	7.34

Table B: *Mean Burnout Scores (EE,Dp,PA) with standard deviation for current sample compared to MBI norm data*

3.3.1 Levels of emotional exhaustion

The mean score on the EE scale across departments was 35.23 (SD=12.308) reflecting a wide range 45 in scores. The largest variance was observed on this scale of burnout 151.492, (see figure 3 below and Appendix K for SPSS means full report).

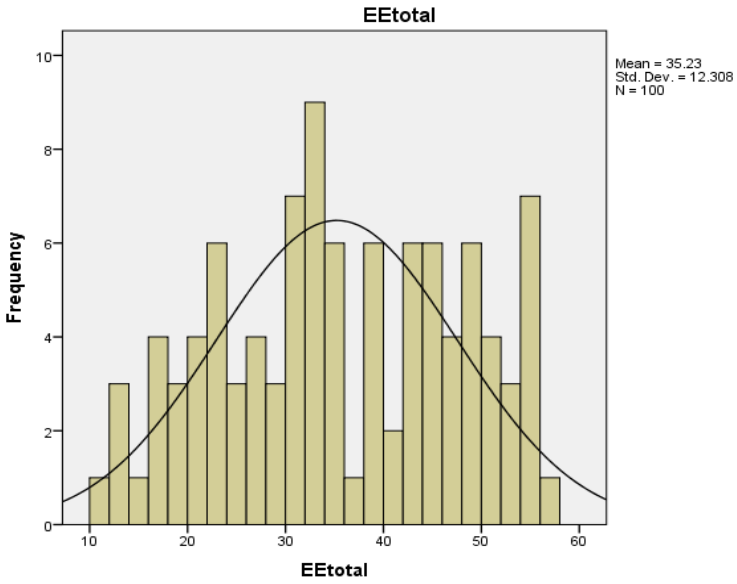

Figure 3: *Histogram showing wide variance and normal distribution in the overall EE sample*

When comparing mean levels of EE between departments, cancer care showed the highest level of mean scores of 37.22 (SD=13.223) reflecting the widest range of scores (44), it is suggested that this is due to the fact that a wide range of job roles were represented from: In-patient nurses, cancer nurse specialists of various kinds and research nurse specialists. This was closely followed by a mean score in ITU of 36.36 (SD= 9.032), interestingly the range of scores was less at 34, with variance being 81.573, it is likely that this reflects a desire by those feeling the effects of burnout to want to take part only if their anonymity could be guaranteed, suggesting that if all nurses across departments had the option to take part anonymously initially, higher levels of burnout may have been found. The lowest mean score was found in MITU/SITU at the [redacted] of 29.83 (SD=12.096), again as for cancer care the range of scores was wide at 43, the variance being 144.319, again the nature of the jobs are subtly different in MITU versus SITU which may explain this variance and the fact that most nurses taking part did so without having anonymity guaranteed, this status may have influenced the range of nurses willing to take part with those at the burnout end of the spectrum more willing if anonymity can be guaranteed, (see Appendix K, for SPSS report of mean scores).

Participants were also classified according to the extent of EE they reported by department with 56% of cancer care nurses, 67% ITU and 29% of MITU/SITU nurses reporting high levels of EE indicative of burnout. 23% of cancer care, 25%

MITU/SITU [redacted] and 33% of ITU reported medium levels of EE and 21% of cancer care, 46% MITU/SITU [redacted] and 0% of ITU reporting low levels of EE, see figure 4 below which illustrates the percentage of respondents who showed high, moderate and low levels of EE by department:

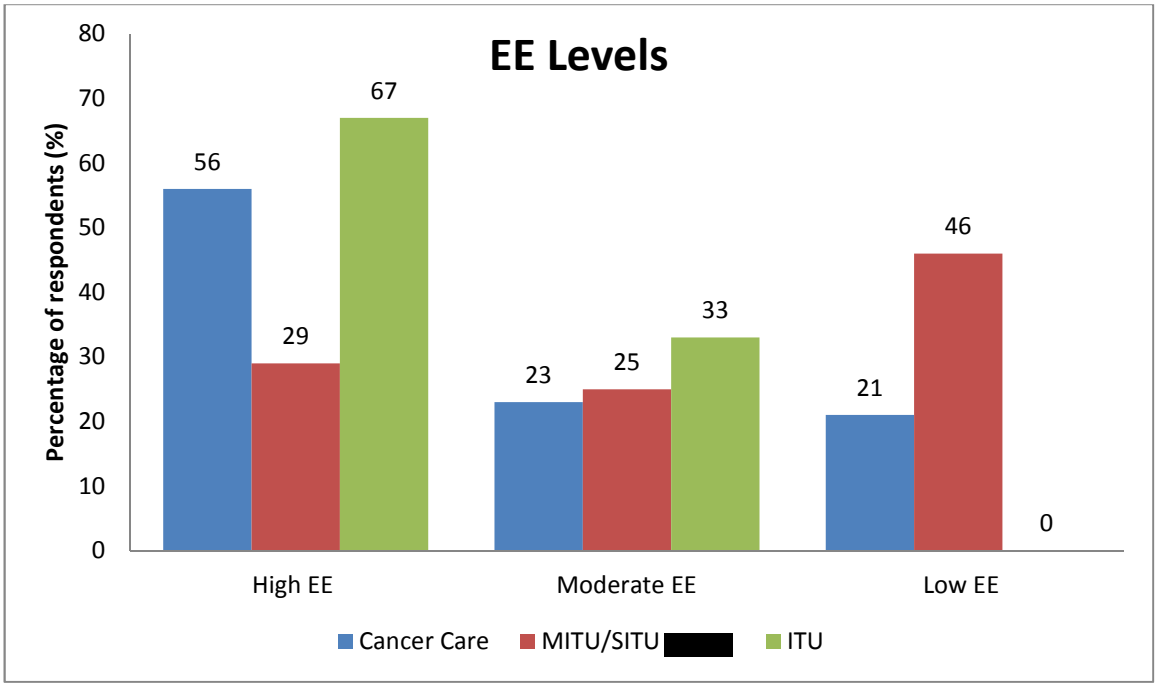

Figure 4: *Percentage of respondents scoring High, Moderate and Low ranges of EE by department*

3.3.2 Levels of Depersonalisation (Dp)

The mean score on the Dp scale across departments was 11.29 (SD=5.360) reflecting a narrower range in scores (22) and variance (28.770). When comparing mean levels of Dp between departments, cancer care showed the lowest level of mean scores of 11.29 (SD=5.360), with MITU/SITU following with mean scores of 11.54 (SD=5.949) and ITU showing a slightly higher mean level score of 12.24 (SD=4.927), the relative range and levels of variance by department didn't vary much, the scores being: CC, range (22), variance (28.732); MITU/SITU, range (20), variance (35.389); ITU, range (17), variance (24.273). Mean scores on this sub-scale fell just within the mid-range of burnout.

Reported levels of Dp were low, as figure 5 below shows, with 64% of CC nurses, 62% of MITU/SITU nurses and 46 % of ITU nurses reporting low levels of depersonalisation. 23% of CC, 21 % of MITU/SITU and 37% of ITU nurses reported moderate levels of depersonalisation and 13% of CC, 17% of MITU/SITU and 17%

of ITU nurses reported high levels of depersonalisation. The lowest level of depersonalisation was found amongst cancer care nurses, whilst these differences were not significant the trend is interesting and is explored in the next qualitative section, whereby it is suggested that nurses who orientate towards cancer care value the deeper level of patient engagement this role affords and early signs of burnout do not typically include depersonalisation but may initially involve getting more deeply involved empathically with the patient.

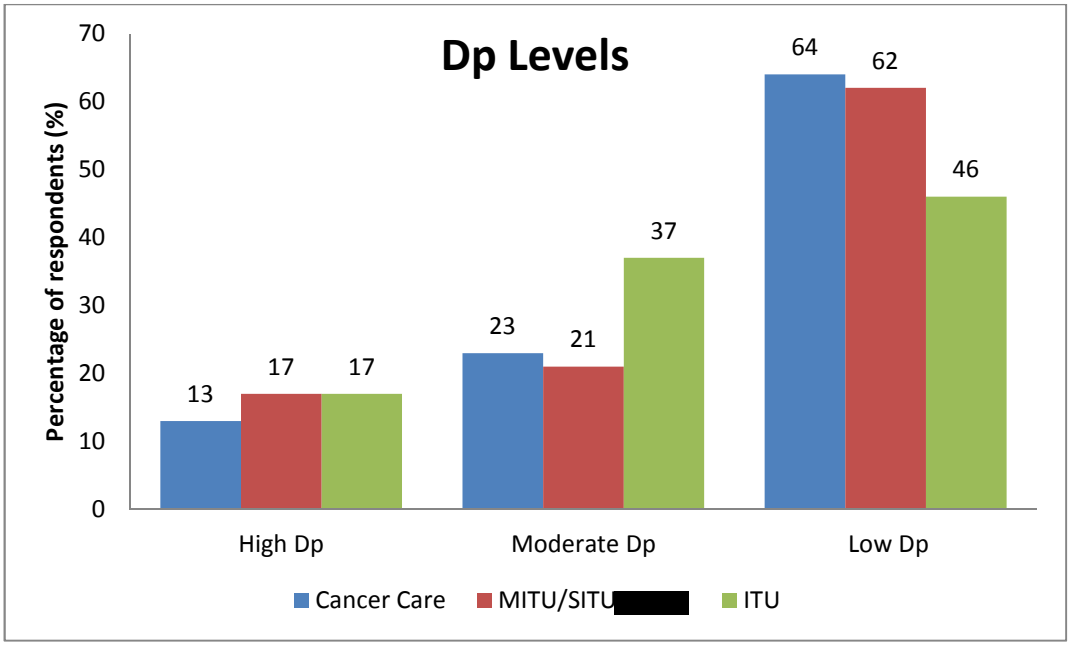

Figure 5: *Percentage of respondents scoring High, Moderate and Low ranges of Dp by department*

3.3.3 Levels of Personal Accomplishment (PA)

The mean score on the PA scale, across departments was 44.72 (SD=6.899) with the low range of scores (37) and variance (47.598) in comparison to EE scores. When comparing mean levels of PA, levels were fairly similar across departments, with cancer care having the highest levels of PA, 45.65 (SD=6.779), with MITU/SITU following with mean scores of 43.84 (SD=7.545) and ITU showing a very similar level at 43.68 (SD=7.545), the relative range and levels of variance by department didn't vary much, the scores being: CC, range (26), variance (45.953); MITU/SITU, had a slightly wider range at (35), variance (56.928); ITU, range (23), variance (42.310). Mean scores on this sub-scale fell within the high-range suggesting low levels of burnout, and high levels of job satisfaction, ie. reduced PA indicates burnout. Reported levels of PA were high, as figure 6 below

shows, with 52% of CC nurses, 46% of MITU/SITU nurses and 37.5% of ITU nurses reporting high levels of PA. 29% of CC, 33% of MITU/SITU and 33.3% of ITU nurses reported moderate levels of PA and 19% of CC, 21% of MITU/SITU and 29.2% of ITU nurses reported low levels of PA, whilst trends are not significant these figures suggest that cancer care and nurses working in MITU/SITU feel more PA and job satisfaction than nurses working in ITU.

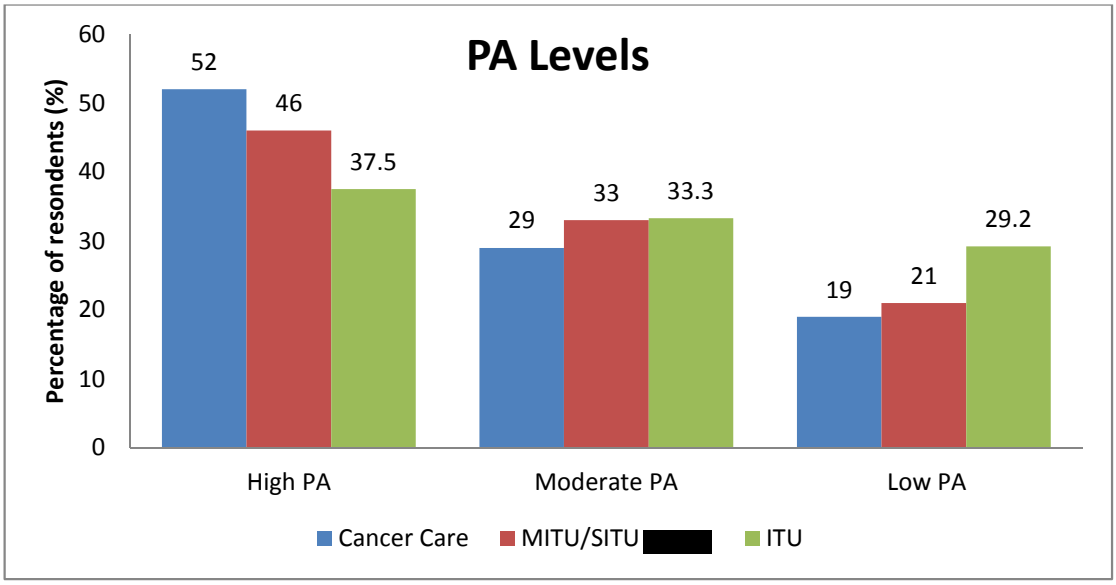

Figure 6: *Percentage of respondents scoring High, Moderate and Low ranges of PA by department*

3.4 Overview of qualitative findings

Qualitative findings suggest a number of predisposing factors influence how vulnerable a nurse is to developing burnout, with some nurses being more vulnerable and others more resilient at the beginning of their nursing careers. Whether a nurse moves from either of these initial positions, and becomes increasingly vulnerable or increasingly resilient to burnout depends on a complex interplay of internal, interpersonal and external factors which bring about a dynamic process of change. Three main categories incorporating these factors emerged from the analysis and represent the key dimensions which influence the burnout process. This journey is an ongoing, dynamic process with an over-arching core category which places the role of *'reflection, insight and adaptation'* at the heart of the process.

The core connecting category and three main categories are below in Figure 7:

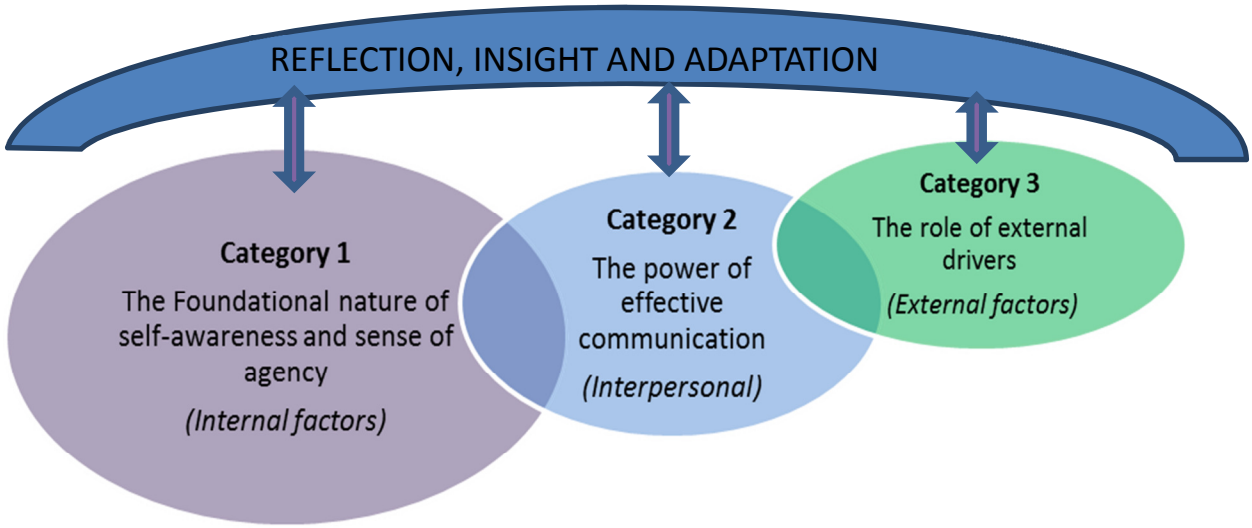

Figure 7: *The three main categories and core connecting category 'levels of reflection, insight and adaptation'*

Whilst the journey and process towards burnout or resilience is ongoing, dynamic and fluid, observable differences were identified between the journey and defining characteristics of the nurse who emerged as vulnerable to burnout at this point in time and the nurse who emerged as more resilient to burnout. A key discernible difference amongst nurses who emerged as resilient was that they showed greater capacity to be reflective, insightful and adaptable to the pressures they face in the workplace, whereas the nurse showing signs of vulnerability to

burnout comparatively lacked this reflective capacity and flexibility to respond to their circumstances in a manner which can help defend against burnout and retain resilience. This core process bears resemblance to psychological flexibility as identified by *Acceptance and Commitment Therapy* (Hayes et al, 1987), to be discussed further in the discussion. However, insight into the nurse's journey suggests that whilst a nurse may be more or less vulnerable to burnout at the beginning of their careers, movement is possible in either direction along the burnout spectrum as figure 8 below, illustrates:

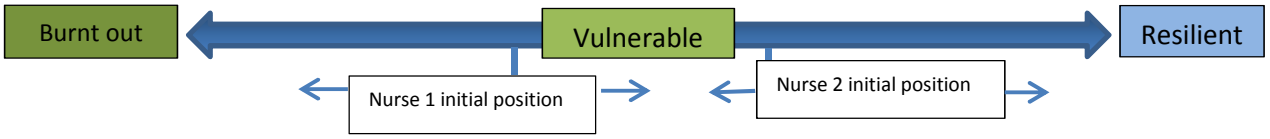

Figure 8: *The burnout spectrum*

3.4.1 Presentation of findings in the main categories

Each of the three main categories have defining sub-categories which will be presented in turn. Whilst these are presented as distinct sub-groups, they should not be regarded as reflective of a linear process; the process is in fact dynamic with sub-categories constantly inter-relating with each other. Corbin and Strauss (2007: 98) suggest process is best viewed as *'sequences or a series of actions/interactions/emotions taken in response to situations or problems'* and these relationships will be alluded to throughout. An analytical overview of each of the main categories will be provided, and for each of the lowest level sub-categories, findings will be illustrated using examples from transcript data. This has been anonymised to ensure the participant's identity is safeguarded. Examples of a memo and diagrams have been included to illustrate the analytical process and to highlight some of the key questions and differences to emerge depending on the vulnerability, resilient position identified at the time of the research. A model proposing the relationship between categories which influences whether the nurse becomes vulnerable or resilient to burnout will be presented in the next section, the discussion.

Category 1, Internal factors: **The foundational nature of self-awareness and a sense of agency** presents findings which highlight the importance of different aspects of self-awareness, sense of agency and knowing oneself in forming the foundation upon which the process towards greater resilience or vulnerability to

burnout takes place. Included in this, is a description of two key nursing styles identified as either task-focused or emotionally-driven nursing orientations. This difference has been highlighted because the findings suggest that burnout can manifest itself slightly differently depending on the nurse's primary orientation in terms of their nursing style. This raises questions as to whether one nursing orientation is more vulnerable than the other or whether the conditions under which burnout is fuelled may differ by orientation slightly. This will be discussed in later sections.

Category 2, interpersonal factors: **The power of effective communication**, explores the importance communication styles have in the development of resilience and vulnerability to burnout and uncovers the crucial role contextual issues play in creating the optimum communication environment, one which is described as understated stoicism yet open, discursive and sharing rather than one characterised by a culture of defensive stoicism and denial of vulnerability.

Category 3, external factors: **The role of external drivers,** explores the importance of various contextual factors and social support on the development or prevention of burnout.

3.4.2 Presentation of nurses resilient or vulnerable to burnout

The findings suggest that nurses who emerged from the quantitative phase as resilient to burnout, show marked, discernible differences at this point in time in comparison to nurses who emerged as vulnerable to burnout or burnt out in the key categories identified as significant in this process. The findings are presented in a manner which aims to clearly highlight these differences, however, this is not intended to create a sense these positions are fixed, rather it is intended to highlight where the nurse is within the burnout process. As the analysis will show the process of burnout is best understood as a continuum, one in which the nurse has a given start point, which varies according to predisposing factors, however, they can move either way along the spectrum or become stuck depending on the complex interplay of factors discussed which they experience on their journey. When referenced quotes will be coded as to whether the nurse emerged from phase 1 as 'resilient to burnout' (RB), these nurses showed low levels on all three burnout dimensions; 'vulnerable to burnout' (VB) nurses showed high levels of EE or EE and one other level indicative of burnout, either Dp or PA. Finally those who met the

criteria for burnout on all three levels were coded (B) for burnt out. In addition, those who work in cancer care or ITU/MITU/SITU were given the code CC or IT respectively and an interview number 1-16.

3.5 Category 1: The foundational nature of self-awareness and a sense of agency

The findings suggest that the degree to which a nurse has *self*-awareness and *a sense of agency* influences their base level of vulnerability/resilience at the beginning of their careers and provides the foundation upon which greater resilience or vulnerability to burnout evolves. The key themes highlighted within this category are presented in turn, as seen below in Figure 9a:

Figure 9a: *Category 1: The foundational nature of self-awareness and a sense of agency*

3.5.1 Knowing oneself (The Foundational nature of self-awareness and a sense of agency)

Knowing oneself is a mid-level category of *The foundational nature of self-awareness and a sense of agency* and is further divided into three lower-level categories comprising: A*wareness of the essence of self; comparative sense of self* and *awareness of values of importance.* These sub-categories were made up of six dimensions shown in figure 9b below: *Recognising qualities in self, recognising motivational drivers, comparing self to patient as defence, comparing self to role*

models, the guiding force of role model values and personal values.

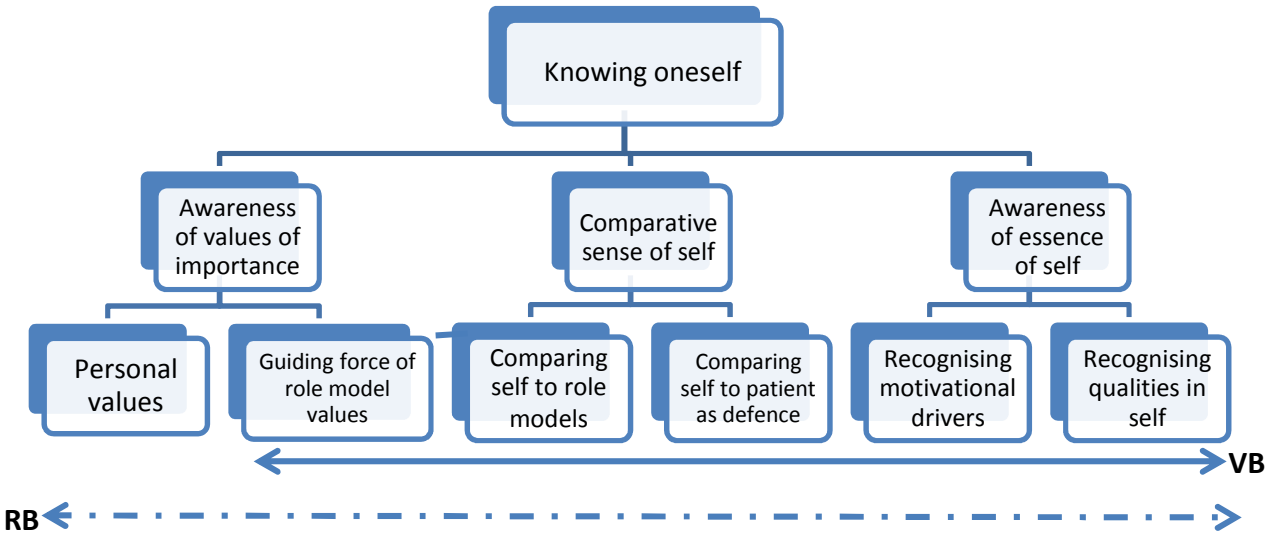

Figure 9b: *The development of mid-level categories and dimensions from the higher order category: Foundational nature of self-awareness: Knowing oneself*

As one of the opening interview questions, participants were asked why they first considered entering the nursing profession. This provided initial insight into levels of self-awareness amongst this professional group. Whilst for some their reasons appeared to be quite arbitrary and their decision presented as almost random, most nurses exhibited high levels of self-awareness as to: Why they had entered nursing; what qualities they possessed which made them suitable and what they liked about the job. At this level, *awareness of essence of self,* a tendency towards basic self-awareness was apparent across the sample, suggesting that as a professional group nurses have the capacity to be self-aware about their likes and dislikes and strengths and weaknesses. However, the degree to which the nurse also holds a *sense of agency*, a belief they can be effective and take action to positively influence their lives and nursing experience drives whether *self-awareness* can be embraced to become a positive and protective factor or not.

As the diagram above indicates, a point of difference between the resilient and vulnerable nurse positions lies partly in the level of awareness of personal values but most importantly in how these are used to guide behaviour or manage

and process the impact of working in a high intensity nursing role, relating to their degree of psychological flexibility (ACT, Hayes et al, 1987) and sense of agency. The extent to which the dimensions relating to *Awareness of essence of self and Awareness of values of importance* were viewed as dynamic and open to active management and adaptation or viewed as more of a fixed, unchanging aspect of *Knowing oneself* is also important and reflects the nurses sense of agency and position in relation to burnout. Resilient nurses typically holding the former position, characterised by a high sense of agency and vulnerable nurses the latter, a lower sense of agency, this is depicted by the broken/unbroken line respectively in figure 9b above. This is discussed further and findings illustrated by transcript data as each sub-category is reviewed in turn.

3.5.1.1 Awareness of the essence of self

3.5.1.1a) Recognising qualities in self

In deciding to be a nurse and later which specialism to enter, nurses across the sample showed relatively high levels of self-awareness and sense of self, both in terms of recognising the qualities they feel they possess and their likes and dislikes. This awareness governed their initial career choices and areas of specialism pursued, as illustrated:

> RB15CC: *"I just found something I was really good at and that I enjoyed…and was actually interested in"* (29-30)
>
> VB6CC *"I'm a people's person so I love working with the patients and also can have empathy with them to a certain extent" (23-24)*
>
> RB11CC *"I think that I'm very patient and I want to do a good job, I'm a perfectionist and I have to do a good job for that person" (43-45)*

An apparent difference between the vulnerable and resilient nurse positions lay in the way in which self is viewed, with vulnerable nurses often lacking a sense of personal agency and relating to self as being static, out of their control and largely unchangeable whereas resilient nurses showed a greater sense of agency and are more likely to relate to their sense of self as dynamic, flexible and open to adaptation. Nurses who emerged as resilient to burnout were also more aware of the aspects of themselves that can expose their vulnerability and carried a greater sense of the fluid nature of the resilience/vulnerability dynamic and the need to monitor and adapt or make changes if necessary. For instance they often showed

greater awareness of their increased fragility under certain circumstances and recognised that certain fields pose a greater threat to breaching their resilience defences and chose specialisms which wouldn't threaten this:

> RB15CC *"I felt much more strained when I worked in ITU, I just didn't enjoy it… I felt very isolated because I didn't feel the team around me, I didn't feel like I could speak to anyone about anything traumatic… I just wasn't suited to that role"* (235-241)

> RB10IT *"I was put off Great Ormond Street….I'm really glad, because actually I'm not a children's nurse at all, I think actually I would have cracked up…I don't think I could have coped with it." (86-89)*

> RB15CC *"I think I'm very kind, well I try to be, but I'm quite emotional though, and I don't know if that's the best quality to have and it's taken a while, so If I lose a patient, if a patient dies, to know that it's not my sadness, it's their sadness, when I first started nursing I used to get very upset and I actually left…I had to leave because I felt I was becoming too consumed by the sadness of other people."* (59-65)

Nurses that were more vulnerable to burnout often had, or developed, a tendency to fear changing job roles, in part because of reduced self-esteem as vulnerability to burnout grows, for others this appeared to be a reflection of their lower sense of agency, or they simply felt trapped in the job they are in due to the banding system limiting movement because of potential pay drops if they moved to a new less intensive field:

> VB3CC *"I don't really like how I've become and I've never wanted to be in this situation, it has left me confused and thinking I'm not actually fit to do anything"* (1108-1110)

> VB3CC*"I know some of them (colleagues) have struggled with anxiety and depression and have really hit the wall at some point and come back because they don't actually have anywhere else to go and a lot of people feel like they are stuck and I think most of them, they just stop caring"* (991-995)

> B7IT *"But if I could go and work somewhere else but not have to take such a big drop in pay for a while I think that would be a good thing"* (625-627)

The degree to which their sense of self is defined and expressed via their nursing role is also a key point of difference, with resilient nurses having more outlets and ways to validate and express their sense of self other than through nursing, whereas nurses who are more vulnerable are often more invested in their nursing role, it being viewed as fundamental to their expression of their sense of self. Anything threatening how they perceive themselves can lower self-esteem and threaten their sense of self, leaving them in a very vulnerable position and leading to the nurse striving all the more to reclaim this position and self-belief. This distinction is implied and illustrated in the following quotes. The first quote illustrates how a vulnerable nurse describes her level of commitment and self-belief being wedded to the job in her early career, this nurse describes how in recent months she felt over-stretched and unable to maintain her sense of self through her nursing role, leaving her unstable and showing many signs of burnout:

VB3CC *"I did a lot of night shifts, did a lot of extra shifts and yes I felt like I saved lives. I did take the work home with me then as well. My flatmate at the time said she was worried a bit about me sometimes that I did take my job a bit too seriously, I lived for it, and I didn't ever really have proper time off."* (142- 147)

In contrast a nurse who feels and emerged as resilient talked about how she had to learn to adapt and view her job differently after she felt close to burnout in her earlier career, this nurse provides a good illustration of how one can be more or less predisposed to vulnerability at the beginning of their careers, but through reflection and adoption of helpful strategies greater resilience can be learnt:

RB16CC *"At that point I was taking things very personally, I was treating the ward a little bit like grief when I shouldn't have seen it that way, I now treat it more like a job and take things less personally…Now, I don't work extra hours, I have a different attitude towards that, where I felt like, oh no I should stay, whereas now if I stay it'll be because I really need to"* (566-663)

These relative positions are depicted in figure 10 below. Visual symbolic images are used to show the resilient nurse position as a rubber ball, adaptable and resistant to external pressures and the more vulnerable nurse position, a glass ball, more inflexible, brittle, and vulnerable to external pressure, it is important not to view these positions as finite and fixed rather as reflective of the extreme ends of a continuum, the nurse being able to move either way along it, providing conditions support that movement :

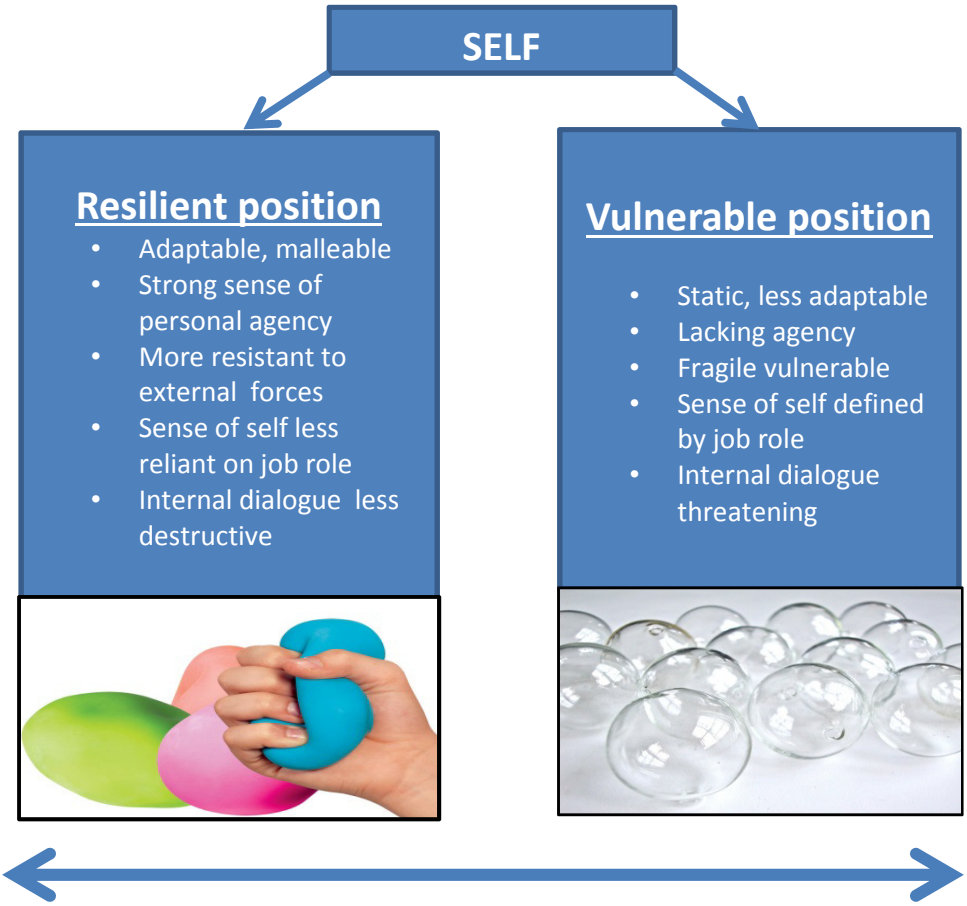

Figure 10: *Differences between vulnerable and resilient nurse positions*

3.5.1.1b) Recognising motivational drivers

Across the sample nurses described two types of nursing orientations and styles, either task-focussed or emotionally driven with nurses primarily identifying with one or the other in terms of their primary strengths and where they gain most satisfaction. See figure 11 below for how these nursing orientations/styles differ:

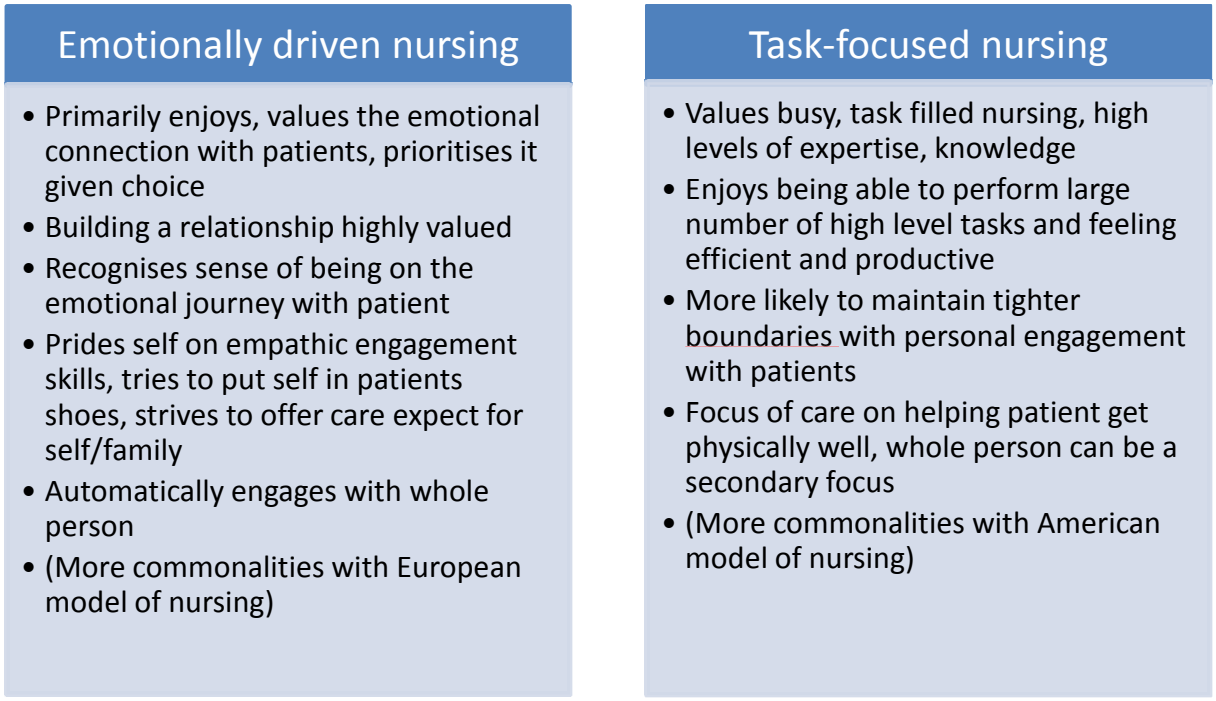

Figure 11: *Differences by nursing orientation, emotionally driven versus task-focused positions*

Senior nurses also recognised this distinction and talked about ideally forming a team which comprises a mix of nursing styles across their team, there being benefit in balancing these skill sets, as a means to provide a well-rounded, strong team which provide higher levels of care, as the following alludes to:

RB11CC: *"So where somebody isn't that good with the whole emotional aspect if somebody is dying they would be better looking after someone who is acutely ill, so the team would always balance itself out. So some people are very efficient and it's those people that don't, they can be quite open about it and they will think nothing of looking after two critically ill patients but who are actively being treated - they find that a lot easier than somebody who is dying and they don't have to do anything they just have to go and support the family they just have to go and talk and listen and sit, so their skills are not there, they are more the active. But then the team will balance out and the team knows that some are better at different things."* (259-277)

Nurses who self-identified as being more emotionally driven tended to orientate and stay longer in job roles which allow for greater expression of this, for example cancer care and to a lesser extent the longer-term care role of Medical ITU at the [redacted]. For

cancer care in particular, nurses in the study described enjoying working with patients in the long-term, throughout their illness journey, allowing themselves to really get to know their patients. In comparison nurses choosing to work and stay in ITU and Surgical ITU were more likely to particularly enjoy and pride themselves on the pace of their work and their task performance skills, a key component of their roles, as patients can be either unconscious or require high dependency care and are typically only in ITU for relatively short periods of time. This job role requires less emotional involvement with the whole person, focus being on symptom management and performing a high volume of tasks. The following illustrates perceived differences between the two types of nursing orientations/styles and how this is reflected in the nature of their chosen specialisms:

Task-focused

> VB14 IT *"There's types of, say ITU nurses that like the whole high rush of it being crazy busy….The surgical ITU nurses, they're a bit more…they like the high turnover, but probably they still develop nice relationships with the patients but it would be in a different way because they don't have the same long interaction with patients and families and they are about being busy…they must have tasks, but the tasks aren't necessarily patient focused tasks as such, like in MITU, as an example, a lot of care is taken to making sure the patient has clean hair as well as having the NORAD pumped and doing all of those great ITU things"* (388-414)

Emotionally driven nurses:

> RB11CC *"Some people are very efficient and will be very efficient, they will go into the room and do everything in an efficient manner so they've done the tasks, but I don't want to do that, I want to help the person and the tasks are the side bit .... So you know, if you're helping somebody, if you're doing an IV I don't just sit there and do the IV, I sit there and talk and say oooh you've got a picture, who's that from then? I try and find out about the person".* (54-61)

> RB15CC *"I love having a relationship with patients, I find some of these patients so inspirational, like I could literally cry and think they're so amazing… I'm so proud to work with these people and I just love it"* (416-422)

These differences are important as findings suggest the process of developing burnout can take a different development course depending on whether the nurse primarily orientates towards an emotionally-driven nursing style or a task-focussed style. This will be explored further in the second sub-category of *The Foundational Importance of Self-Awareness and a sense of agency* identified as *Awareness of the impact of nursing role and signs of burnout*. It is also important because it has an impact on the effect of the imposition of new organisational systems and models of nursing to be followed, where a nurse has an orientation to emotionally-driven nursing styles, new systems that impose higher levels of checking/ recording etc can take the nurse further away from the relational aspects of the job they enjoy and pride themselves in. If coupled with high demand and low staffing levels, over time the necessary compromises they have to make in terms of being able to practice their preferred nursing style, can leave them feeling stressed and their sense of self questioned, particularly if the nurses sense of self is heavily defined by their job role:

VB5CC *"There are huge pressures for us to meet new targets…there is just this kind of pressure put upon you which you don't have a choice in…they look at the ward and how the ward is performing, is all by this kind of criteria, realistically you can only do so much in a day… and then as a manager you are also meant to be putting me on them really … you are meant to make sure they have done all their documentation, that's very stressful for me"* (332-345)

These differences can also explain why some nurses suit a particular role over another, and can feel unduly stressed if they find themselves in roles which primarily requires their opposite skill set. This perceived personal incongruence in their work environment can be a contributory factor in the development of increased levels of vulnerability to burnout. This is also evident when nurses who are more emotionally driven transition to a more senior managerial roles. They can find this a particularly stressful period and many could benefit from more training to help them acquire the skills they require to find the new challenges they face less draining and challenging, as illustrated by a nurse that feels since becoming a manager she has felt more vulnerable to burnout:

B7IT *"I think managing staff is not something I really enjoy so much, I've sort of found myself in that job for one reason or another, so that's been quite hard…I struggle with the mountain of emails, all that side of things, the bureaucracy and stuff just seems to be overwhelming"* (302-304)

Figure 12 below illustrates how a nurse feels if their job role lacks personal congruence with their preferred nursing style and orientation:

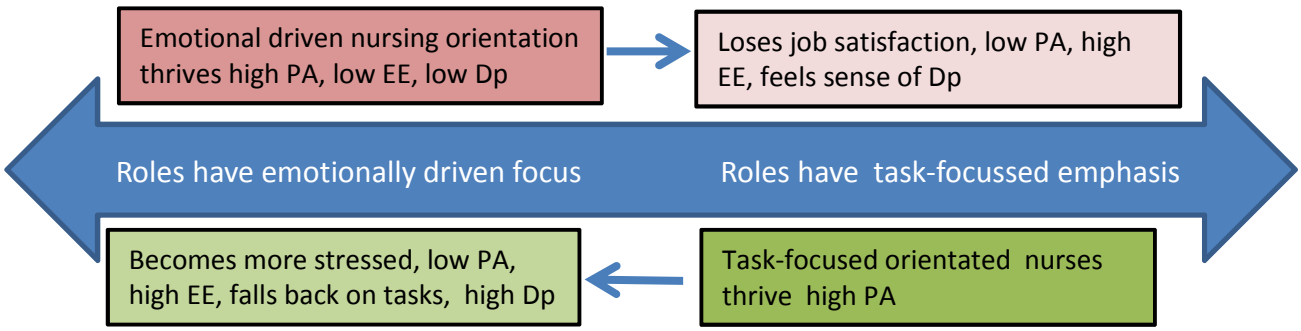

Figure 12: *Effect of relationship between job role and nursing style*

This issue raised discussion about the pressure nurses feel in the light of the Francis report to simultaneously ensure an empathic, compassionate stance whilst being under increasing pressure from the move within UK nursing towards the more task-focused American model whereby nurses are becoming increasingly skilled, with greater focus on high levels of specialist knowledge and achievement of tasks. It raises the question as to whether this shift in focus may contribute to higher levels of burnout amongst nurses that orientate towards the emotionally driven end of the spectrum as they are forced to move increasingly further away from what they value in themselves and in the job role they have chosen.

3.5.1.2 Awareness of values of importance

3.5.1.2a) Personal values

Awareness of values helps inform the decision to enter nursing, many citing the following as values-led reasons why they entered nursing:

> RB13CC: *"It's a desire that you can help people and that's just that fundamental, you know you just want a job that you know you're going to get reward out of, it's not about how much money you earn"*

Nurses showing high levels of resilience to burnout often showed a higher developed sense of what their values are, why they matter to them and had greater capacity to hold them at the forefront of their actions and strategies to guide them through managing difficult work conditions and processing the difficult emotional content of their work. They were more likely to show or have developed the ability to reflect and make changes in times when their values felt compromised, suggesting

this capacity may have a defensive function in maintaining resilience, as the following illustrates:

> RB11CC *"I have to make a difference, I think I'll always try and do the extra…I would sit longer…I'd probe a bit deeper, the care that I give is the care that I want my family to receive" (47-54) "So I think what I always say to people, because we had a death recently…and it was deeply tragic, but I know that we did the best for her…but I know we did everything we could … Yeah I think with all the failures I think at least we gave them a bit more time, or at least you know we tried our best, we really pushed it" (102-120)*

> RB13CC *"I just found that job so frustrating, so frustrating, that I just went out drinking with my friend most of the time…I reflected and thought 'oh I'm not really that person, I won't do that again'"*

This nurse went on to change jobs and take a training course to help make changes to how they approached their nursing role.

Nurses who showed signs of vulnerability to burnout, were often less clear on guiding their behaviour by their values and firmly holding onto them as a steer through difficult times or incidents. A nurse showing high levels of vulnerability to burnout described a traumatic scenario where she felt she had to compromise her values. Rather than addressing this, taking action to prevent it happening again, or communicating her distress/concerns as the resilient nurses typically do, she was left haunted and internalised the poor patient outcome as evidence that she was not a good enough nurse. By not being able to stand up for what she felt was the right thing to do, this nurse went on to develop obsessive compulsive tendencies as a means to manage her increasing preoccupation with negative internal dialogue regarding over-evaluation of responsibility:

> VB3CC *"I think I lost a bit of, because I did something I didn't believe in, I think yer I dunno, it haunted me for a long time…No so I dunno I think I'm very good at blaming myself for everything"* (775-786)

> VB3CC *"Paranoid, really paranoid as well, I am as I said, slightly OCD, when I leave the ward I clean my hands at least three times, I get changed in a certain way… I put my uniform in double plastic bags and hide them somewhere in the house until I've finished my shifts for the week until I clean them"* (648-652)

There was also a sense that rather than guiding behaviour by internal values and using these to process difficult aspects of the work, vulnerable nurses are often more likely to seek and be more sensitive to external cues of validation:

> B7IT *"I suppose I just worry about patients and their relatives, you worry about if we've been doing the right thing and that people think we're doing the right thing"* (328- 331)
>
> VB3CC *"No I think I do read into what people think… so I don't think I'm meeting their, what they expect of me as a colleague"*

The following quote illustrates how a nurse showing signs of burnout felt she had lost sight of the values that used to drive her in her early career and now suffers from low self-esteem amongst all the other classic signs of burnout:

> B7 IT *"I do make jokes at work sometimes about oh I was kind and that was in 1989, but yes I feel I have got harder and I don't think that is necessarily a good thing"*
>
> Interviewer: "*How does that leave you feeling about yourself?"*
>
> B7 IT *"Well I suppose a bit disappointed, it would be nice to feel really enthusiastic but I'm not sure that's going to happen any more… I feel that I lost a little bit, when I think back about why I wanted to do it in the first place, so some of that has gone"*
>
> *Interviewer: "Lost a little bit of that what?"*
>
> B7 IT: "*Not optimism but that sense of public spirit, public service, is there a word for that, that sense of wanting to do it to help other people"* (397-408)

As the nurses progressed along their journeys the degree to which these values can be held and followed appeared to have an impact not only on those more inclined to vulnerability but also to those previously resilient to burnout. A number of contextual issues presented the biggest threat to otherwise resilient nurses. A difference here is that resilient nurses all made changes at stages in their careers when they felt unable to carry out their jobs according to values that mattered to them, whereas the more vulnerable nurses felt stuck or carried on regardless and seemed less reflective in terms of what they felt they had sacrificed to remain in their roles.

The following illustration highlights a point in a resilient nurse's career when they felt close to burnout and they recognised the problems stemmed from problems within the system getting in the way of being able to realise what they valued in the service they could offer:

> R13CC *"Just a lack of change, lack of people listening, change, lack of people embracing change…I found that really frustrating… I was pretty close to burning out"* (415,443-446)

However, this nurse and several other cases of resilient nurses who had faced a time in their careers when they felt close to burnout all decided to take action to make necessary changes. For most this meant time out or changing jobs and trying a new nursing role they felt better suited to:

> R13CC *"I think I was overly focused on clinical problems ….it was very task oriented, and again that's very rewarding but… that was my sole focus, I think that's where it changed, 'yes I can do that, but actually I want to be a better listener as well"* (203-214)

This nurse found frustrations with the system and context they were working in prevented them from being able to approach the tasks in as efficient a way as they'd like. By recognising these limitations and shifting how they approached nursing, greater satisfaction and less stress was noted. Another resilient nurse acknowledged that she has a standard whereby if she lost enjoyment in her work she would recognise she needed to make changes:

> R15CC *"When people really hate their job… and when people are consistently miserable I just find it terrible and I think why are you here and I would know if I started not to enjoy it ….but if I woke up and thought I don't want to do this for more than a month then I would think that I need to change my role in some way because you're not beneficial to anyone"* (662-667)

In comparison the vulnerable nurses lacked a sense that they can make changes and don't need to keep doing a job if they don't find satisfaction, carrying on regardless as the above quote alludes to. Nurses who fail to recognise the negative impact of their work and who are less clear and guided by their values and fail to make changes, over time burnout develops as positive processing skills shown by resilient nurses fail to mitigate the strains of the job, leaving the nurse

jaded, exhausted and hardened by the work, as the following quote from a nurse showing signs of burnout illustrates:

> B7IT *"Looking back as a student I used to cry a lot about the patients… it has changed… well I know I'm doing it, sometimes people are talking to me and I'm making all the right responses but I'm not really taking it in, I feel like I'm acting a bit…because you see so much, there is quite a lot of misery attached to it, maybe I'm the sort of person that I've had to cut off from that now, because that (decades) worth of it, if you're the sort of person and you took it all on board how would you manage, but I don't know what the balance is between being robotic and not empathising at all and taking too much on board" (242-270)*

This nurse has stayed within her job role for a long time and has managed the impact of the job by becoming more defended but she talks about recognition of losing sight of values she once held and being a passive recipient of the impact of her work, there being a sense of being powerless to manage the impact more effectively so she can maintain job satisfaction and genuine compassion for her patients. There was also recognition that nurses that do not acknowledge they need to make changes to manage the demands and strains of the job more effectively can become increasingly angry and resentful, which left un-checked can lead to burnout contagion and seep into the fabric of the wider team:

> VB 9 ITU *" I don't want to generalise it but I do notice one theme is that they feel that the world is against them …and then they begin to isolate from the team… because they feel that kind of isolation, that they're looking for allies who are in a similar situation or share that view and that is when the whole team is beginning to, I wouldn't say disintegrate but there's certainly a lot of conflict… but we could prevent is the way, like this sort of situation when some person gets burnout and how that almost then infects the team and then causes further bad feelings"* (274-292)

3.5.1.2b) Guiding force of role model values

The findings in the lower sub-category, *Guiding force of role model values* highlights the function that role models play in helping the nurse gain clarity about the values they admire and want to emulate. Beyond the initial acknowledgement that role models had played a part in career decisions and guide nurses in how to cope with challenging aspects of their work, there was also recognition that the

principles and guiding values the role models reflected in their nursing styles were ones that became personally valued and many would try to emulate:

> RB10IT: *"I went into intensive care from there because the sister that I worked with was from ITU and a lot of the role models that I'd had as a student, that I thought were really sort of top nurses, had all spent time in ITU so I wanted to kind of emulate them and to get that kind of experience"* (48-52)

> VB6CC: *"she really was somebody that like empowered you but like had the skills but wasn't frightened to share and it all stood in my mind that even if I could be a third of what she was like then that would err, obviously I'd aspire to do more but she was so good with the patients and even like all these years down the line I just still remember the things that she taught me"* (47- 52)

Whilst both resilient and vulnerable nurses talked about the significance of role models there was a sense that for resilient nurses the process of learning from the role models was more active and dynamic, they showed signs that they had a greater sense of being able to create the type of nurse they wanted to become, whereas for the more vulnerable nurses, their admiration was more passive and they often failed to take ownership of the possibility that they may be able to adopt these styles of nursing as their own. The following shows the power of role models:

> RB16CC: *"The staff were all very nice, the manager in particular was really strong and clear about what he wanted and the sort of standards of care that he wanted and also he was very present on the ward… It taught me an awful lot about, nursing and how to look after (her client group)"* (174-179)

The importance of role models is significant; whilst mentoring schemes within this context are recognised, there was a sense that to be willing to share your knowledge and actively act as a mentor is draining but needs to be supported and encouraged if less experienced nurses are to learn new ways of managing and processing the difficult aspects of their nursing role :

> VB6:*"It instilled in me (meeting role model) that as a nurse we have to give out and be prepared to help those that are coming up and help to encourage them"* (98-100)

Mentors can also play an important role in helping nurses recognise signs of burnout, or behavioural patterns which may predispose them to vulnerability to burnout. The nurse below said the input from a mentor was fundamental in allowing her to honestly reflect on how she hadn't been coping effectively with the demands of the job and how she needed to make changes to manage the job more effectively.She took time out to travel and on her return made a concerted effort to put in place different ways of coping and processing the emotional and physical drain her job demanded:

> RB16CC: *"I didn't know I was getting close to burnout it was only…she (ward manager) mentioned to me that she thought I was really near to burnout and I was offended but actually she was right, I just didn't know it myself"*

3.5.1.3 Comparative sense of self

3.5.1.3a) Comparative influence of role models

Having a comparative sense of self helps the nurse to either develop into the sort of nurse they want to become by actively adapting and trying to emulate standards set by role models as discussed in the section above, or by embracing this comparative sense of self and consciously embracing the need to become effective role models for more junior nurses and hold this as a guiding force. Both of these factors are particularly true of resilient nurses and reflect their greater sense of being able to attend to their current environment and be flexible enough to adapt and guide their behaviour in a way which helps them achieve goals they aspire to and value. It also shows capacity to focus attention outwards which appears to have a protective role and greater potential to achieve higher levels of PA.

3.5.1.3b) Comparing self to others as a defence

Having a comparative sense of self emerged as a factor which differentiates those who are vulnerable or resilient. The first dimension in this sub-category: *Comparing self to patient as a defence* is more typical of vulnerable nurses.

Some nurses talked about comparing themselves to patients as a defence, a means to be able to distance themselves from patient suffering. For some this can be an effective strategy :

RB10IT *"One of the key things is to be able to recognise that there is always someone worse off than you are, that's the one thing that makes a difference to me, if I'm upset about something then you open your eyes and ears.. and looking outside … it's a sort of optimism, or just counting your blessings…but not wallowing in it"* (664-670)

However, whilst this strategy is effective for some nurses, the strategy can be precarious and may be a reflection of the nurse having a greater external locus of evaluation, "the extent to which ones values and standards depend upon the judgements and expectations of others, or are based on a reliance upon one's own experience' (C.Rogers, 1951:156). On closer analysis, it became apparent the mechanism can be described as an avoidant strategy, a means to suppress or avoid difficult psychological events. The nurses who alluded to this talked about the fragility of this mechanism and how it failed if enough distance couldn't be established, leaving them fearful that difficult emotions would over-whelm them:

VB 1CC *"I try really hard to just think wow, I'm just so lucky and to make the most out of everything… It hasn't happened to me yet (cancer)… I try to quantify it by age quite often, but obviously that doesn't always work because I start looking after a 30 year old and then that you know…R: And how does that affect you? Yer, yer really badly"* (Nurse, notably emotional and close to tears at this point*)* (132- 153)

Resilient nurses who talked about the impact of having loved ones becoming ill or dying noticed their vulnerability being opened up more easily in this period, because they were more influenced by external stressors and less able to distance themselves from patient suffering as they felt closer to the patient experience.

3.5.2 Awareness of the impact of nursing role and signs of burnout

Awareness of noticing the early signs of burnout were generally reported to be low. Findings suggest this may be in part because the process of developing burnout is gradual and prolonged, with subtle changes initially, the effects gradually gaining momentum, making it hard to recognise warning signs until well established or pointed out by seniors. The more resilient nurses who show greater capacity for self-awareness and adaptation typically only recognise the signs when they become really noticeable and they recognise the imperative need to make changes. In

comparison whilst the more vulnerable nurses may be aware of signs of burnout they are either unable to recognise the need to make changes to avert full development of burnout or fail to do so through fear of change or low self-belief they could cope with a different job better.

The findings confirm existence of the three dimensions of burnout identified by Maslach et al (1981) as emotional exhaustion (EE), depresonalisation (Dp) and reduced sense of personal accomplishment (rPA). For added depth the signs of burnout, self-identified by the nurses upon detailed discussion, have been clustered into six categories, as figure 13 illustrates: Physical; emotional; cognitive; interpersonal; attitudinal and behavioural. It is not the purpose of this study to explore each aspect in detail, rather the focus will be on exploring the less well documented signs to emerge, for instance cognitive factors and changes to perception of self and how the evolving process may differ depending on nursing orientation. These aspects are highlighted below by*. Physical signs have been included because they can prove to be a more tangible measure by which nurses can learn to become more alert to the need to acknowledge and reflect upon how they can make changes to prevent burnout and build resilience. Each coded item below illustrates how they relate to the original categories identified by Maslach et al (1981).

Physical	Emotional	Cognitive	Attitudinal	Interpersonal	Behavioural
Gastrointestinal	Depleted (EE)	Self-critical	Cynicism (rPA)	Overly involved *	Drink too much
Palpitations	Irritable (EE)	-ve rumination	Low satisfaction with self	Or hard to engage (Dp)	Less socialising
Achy joints	Anxious (EE)	Lack reflectivity	Defensiveness	Blurred boundary *	Time off
Fatigue	Angry (EE)	Lack global outlook	Callousness (Dp)	Snappy (EE)	More errors
Headaches	Loneliness	Over estimation of responsibility	Dehumanising (Dp)	Unable to assert self	Failure to finish tasks
Mouth Ulcers	Loss humour	Fuzzy thinking	Over identify *		Productivity slows
Weight changes	Helplessness	Fear of causing harm	Only I can help*		
Poor sleep	Fragile (EE)	Self-critical	Low satisfaction with work (rPA)		
Nausea	Tearful blunted	Black & white thinking			

Figure 13: S*igns of burnout*

3.5.2.1 Cognitive features

Nurses were asked if they'd noticed any changes in terms of their thought processes or cognitive capabilities. Some of the nurses showing signs of burnout acknowledged that either they noticed changes in their thought processes or they felt they have a different way of thinking about issues in comparison to colleagues they perceive as more resilient, characterised by a negative cognitive bias. For instance, one nurse said when she came back from maternity leave she found she was increasingly unable to manage the demands of the job, eventually being signed off sick. She had noticed she felt she had less cognitive capacity and began to change her behaviour in an attempt to manage or avoid difficult, intrusive thoughts that she may potentially harm someone by making an error:

> VB3CC *" I feel I don't have enough space in my head to think properly because of all the stress and all the double checking everything that I kind of have to manage in a certain amount of hours, I feel like that takes up most of my capacity"* (527-530)

Several nurses also talked about becoming more self-critical, less able to focus efficiently and unable to compartmentalise and leave worries behind:

> VB5CC "i*t's just I dunno, not being able to leave it behind I guess…I know that there are some things that are constantly on my mind and …anxiety about going to work…but almost anxious about leaving if you are leaving stuff undone"* (404-408)

Nurses who recognised a time in their career when they felt close to burnout also noticed cognitive changes. One nurse noticed how their ability to evaluate a situation and how they responded changed during a period when they experienced external pressures due to ill family members:

> VB10IT *" … normally when there's a very very critical situation and everyone is rushing around, I try and stand back and think what's actually happening here before I act. I think when I'm all stressed, I found myself to act more intuitively and spontaneously and there was a, I nearly made a pretty grave error, a clinical error which I sort of woke up, that would normally not happen. I don't act like that, I just rush into things and do this and do that, just do it, you know that kind of attitude, which is a pretty toxic attitude really*

in this environment and I wasn't aware that I probably had become like that until I nearly, you know caused harm to somebody." (159-165)

For this nurse there was a recognition that they weren't aware of the stress they were under and how it was manifesting itself in their behaviour and cognitive functioning. It took a near critical incident for awareness to be brought into sharp focus and reflection, discussion with close family and conscious management was employed.

Others suggest that along with physical, emotional and interpersonal signs of burnout they notice they begin to experience cognitive distortions, over-think problems, become overly pessimistic, or they notice this in other colleagues they considered at risk of burnout:

VB6CC *"My stomach gets irritated…then I get really tired then I over think…you just keep thinking if you can make things better…then I start shouting at my brothers and sisters, then I know, then I definitely know"* (326-340)

RB14IT *"Getting fixated maybe on one little thing… yes and completely, completely pessimistic, so like everything's a problem…only seeing the negative and not being able to see anything beyond that"* (558- 589)

In comparison, resilient nurses talked about developing or noticing resilient colleagues having the ability to acknowledge and accept difficult thoughts or compartmentalize effectively and focus on the important task in hand rather than getting bogged down by the volume of issues to deal with:

RB14IT *"So even if there's a lot of crap flying at them they still remember the important things, like passing on the right information or still showing some care or empathy but remembering all of the other things that they have to do to make sure that their care is ok… or it's putting it in compartments"* (596-605)

RB11CC *"I will still allow thoughts in and a thought would come in and I'd just register it and that's ok, and it will go and I will just carry on with what I'm doing. So I will still get moments of sadness but I won't dwell on it"* (359-368)

A key difference also lay in recognition or avoidance of difficult thoughts and emotions, with the resilient nurses allowing space to recognise and process or accept difficult emotions and the vulnerable nurses typically adopting strategies to avoid them. The context within which the nurse is working is of crucial importance here. The departments or wards where nurses talked about feeling supported by strong/stable leadership teams allowed them to feel free to openly discuss difficult emotions, in contrast where this wasn't the case, nurses describe feeling overwhelmed and finding strategies of denial and avoidance necessary in order to manage the emotional impact of holding rather than processing difficult emotions.

With regards to attitudinal changes, nurses showing VB or burnout suggest feeling the signs of burnout had left them with a loss of self-esteem and questioning whether the sense of self they held strongly in the early stages of their career had in fact been eroded. The following nurse talks about her reduced self-esteem, a lack of agency common to vulnerable nurses is also illustrated here:

> VB3CC: *"Yes I don't, I don't really like how I've become and I've never wanted to be in this situation, it has left me confused and thinking I'm not actually fit to do anything."* (1108-1110)

Resilient nurses also talk about finding it harder to compartmentalise as effectively following promotion to more senior positions:

> RB11CC *"I used to be able to compartmentalise a lot easier, now …I'm responsible all the time"* (359-360)

3.5.2.2 The developmental course of burnout by nursing orientation

As alluded to earlier, nurses who orientate towards emotionally driven rather than task-led nursing styles show a different developmental course towards burnout. Upon discussion, findings suggest that over time as the pressures of the role is perceived to increase, nurses initially experience increasing levels of emotional exhaustion, this was also backed up by the quantitative trends. Close analysis of qualitative findings suggest when under stress nurses will move closer to their preferred nursing style/orientation, hence emotionally led nurses are more likely at this stage to become more involved and invested emotionally in the patient and can find it hard to detach. The emotionally driven nurses reported that patient care isn't compromised, if anything the nurse becomes overly invested with patients making it hard for the nurse to maintain healthy boundaries. The following illustrates how a

resilient nurse described feeling more vulnerable to burnout in her early years, felt she was heading towards burnout and found she was unable to detach from patients effectively, or maintain healthy boundaries. At the time she recognised something needed to change and with the help of senior role models managed to learn how to step back from her patients suffering and see it as separate from her own experience:

> RB15CC *"I was crying a lot at home and also previously something which I would never do anymore because social media is so big now, there are NFC guidelines to say what is acceptable and what is not, but back then there wasn't and patients added me on Facebook, and there wasn't contact on Facebook but they were my friends on Facebook, and then my manager said that's inappropriate so I deleted them, so I didn't have boundaries and looking back I know that that was really inappropriate and they could look at my life and I could look at theirs and it was like I was more intertwined in it I guess"* (105-114) *"But I can distinguish now that I can support but also step back"* (100-101).

Signs of depersonalisation were not evident in the early stages of burnout for a nurse with an emotional led orientation. The case above illustrates how growing self-awareness helps the nurse to recognise when they become too deeply involved with patients, and how exhausting this can be and how enjoyment and a sense of personal accomplishment can begin to fade. The findings suggest that over time if changes aren't made the nurse risks getting less and less satisfaction from their work and depersonalisation can set in. This illustrates the recognition by this nurse of the need to make changes in order to build/maintain resilience. Some of the vulnerable nurses seemed less aware of this process and how draining and unsustainable it is. The first quote illustrates how a nurse who described herself as vulnerable in her early career and later learnt to adapt and become resilient to burnout, noticed her inability to maintain boundaries and acknowledged she needed to make changes:

> RB16CC *"I was just completely exhausted, I was getting quite bitter and angry about things and erm I didn't really feel I had anything left to give, I felt like I couldn't really see, it was like really small things just seemed really impossible…at that point I was taking things too personally…I used to get a lot of mouth ulcers…sore spots on my scalp… I put on a lot of weight…At*

that point I didn't really know my limitations…I wasn't very good at looking after myself…

R: *"So what do you do now that's helping you be more resilient?"*

RB16CC *"Yeah, it's knowing my limits and knowing what I can and can't change, and not feeling like I'm responsible for everything…I think what's helped me be more resilient is taking care of myself"* (560-650)

The following illustrates the process the nurse suffering burnout experienced and how she lacked awareness of the need to change her style of interaction with the patients or ways of managing the impact of work in the way the previous nurse developed greater resilience showed. This process is highlighted in figure 14 below:

B7IT *"looking back when I was a student I used to cry a lot about the patients and the sad stories and things…"*

R: *"Do you think less so now… or it doesn't affect you in the same way?"*

B7IT: *"No, it doesn't, it has changed, and I'm not sure any of my colleagues or anyone else would say that because I think I still come across as the same, but I feel myself, well I know I'm doing it, sometimes people are talking to me and I'm making all the right responses but I'm not really taking it in. Does that make sense?*

R: *"Yes totally… I completely understand".*

B7IT: *"I feel like I'm acting a bit or something…I think … because you see so much, there is quite a lot of misery attached to it and I think if you can't, or maybe I'm the sort of person that I've just had to cut off from that now, because that's 30 years' worth of it. And some people do get better but there's a lot of depressing stuff at work and I think if you're the sort of person and you took it all on board how would anyone manage, but I don't know what the balance is between being robotic and not empathising at all and taking too much on board…"*

When this first emerged as a trend in the quantitative phase, I adopted theoretical sampling to explore differences in the sample and to understand whether the process of burnout varies for nurses who describe themselves as more task-focused. This involved opening up my sampling to include nurses in ITU and I made a point of endeavouring to interview nurses working in MITU and SITU to

examine this process further. In comparison it was found qualitatively, that the task-focused nurses when under pressure typically have a different process of change and increasingly detach emotionally from their patients and become more task-focused. It was recognised that this can lead to higher levels of depersonalisation than found for emotionally driven nurses:

> VB8IT *"ITU in particular we can become very focused on numbers and figures without actually considering the patients in the bed" (155-157)*

Whilst early trends to support this theory emerged in the quantitative sample this didn't reach levels of statistical significance, reasons for this have been discussed, however, qualitative evidence was found to support the emerging theory. Figure 14 below illustrates the relationship between type and levels of Dp, PA in the initial stages of burnout as identified in the qualitative phase:

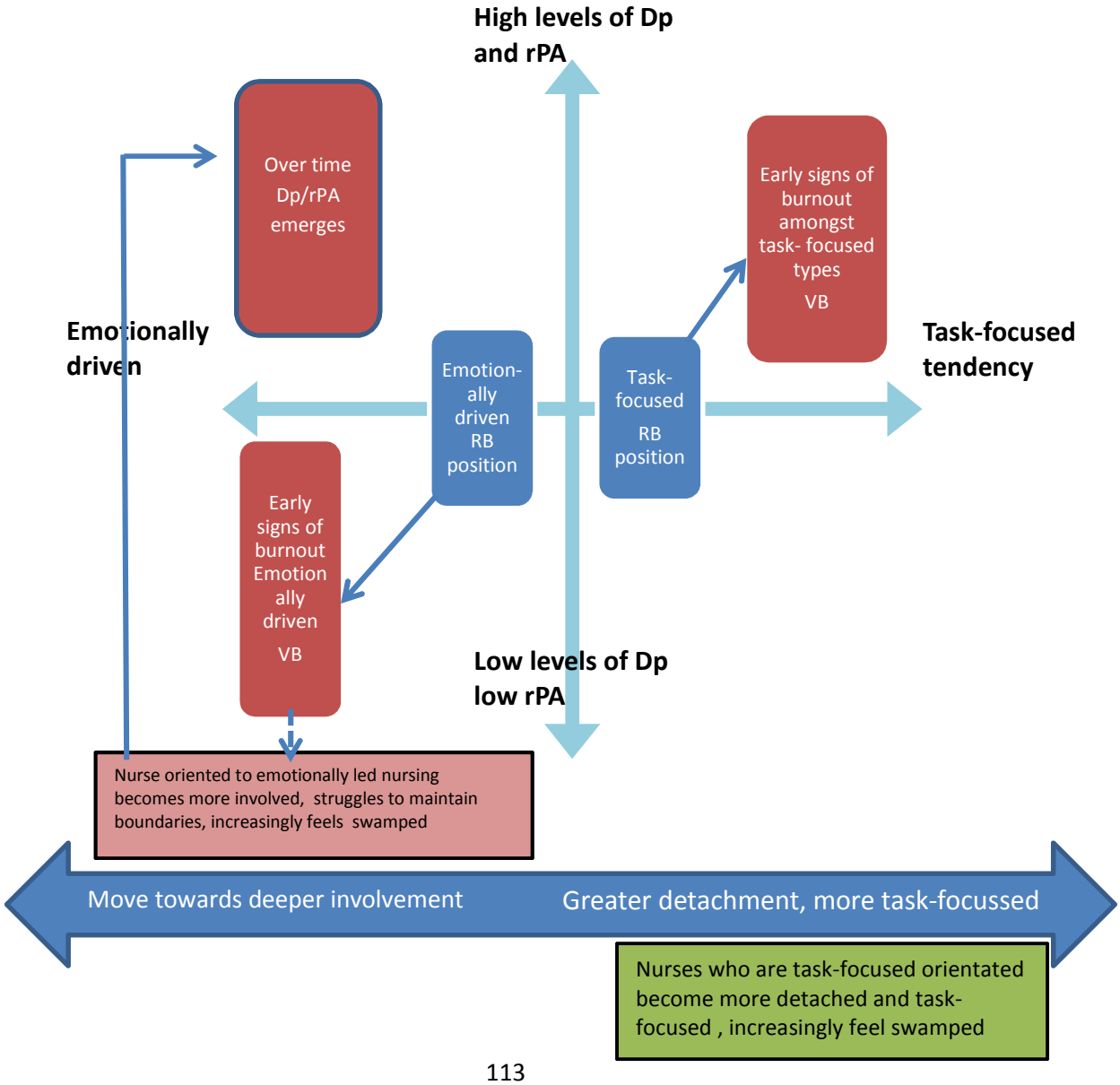

Figure 14: *Different burnout trajectory by nursing orientation*

The findings suggest that nurses who are more emotionally led, may be more vulnerable to burnout, but only if they lack the ability to recognise the impact of deep empathic engagement and fail to make changes to more effectively manage the strain this brings. This may suggest focussing on tasks may act as a protective mechanism, which may explain why when nurses orientated to task-focused nursing feel under pressure they become more task-focussed, this is discussed below with a nurse working with patients requiring long-term intensive care, who is suffering from burnout on all 3 scales:

> B7IT: *"I think people are vulnerable to burnout are people who are a bit like myself… And also people that are, and this sounds horrible but people who are more human, more sensitive, people that do spend more time with the patients and their families as opposed to the people that come in and do a perfectly technically sound job but don't communicate, get involved much with the background thing, yes I think we fall into two camps"*
>
> R: *"So who's vulnerable to burnout and who's not?"*
>
> B7IT: *"I think that people vulnerable to burnout are the people who take it more on emotionally"*

The following quote comes from a nurse who has witnessed many colleagues passing through an ITU department and how they feel burnout manifests itself in colleagues that show a predisposition towards being task-focused and how the nature of the job when busy and short staffed can encourage greater movement towards staff showing high levels of Dp:

> VB10IT: *"When you've already had about 10 referrals that day … and when they then get another problem presented, I have noticed they almost, "ah no, not another patient with IV drug user with you know various problems like Hepatitis and HIV" etc etc you know it is almost then too much and I can see that sometimes people almost look at patients as a bundle of problems rather than as a person"*
>
> R: *"And do you feel that when it's like that you kind of end up focusing on the tasks more and less on the"*

VB10IT: *"Oh yeah … I mean there was a situation, occasionally any treatment we offer has to be consented by the patient eg even if the patient is competent and there seems to be sometimes such a drive to get tasks done then we, and have them done quickly cos they then have to move onto the next patient, there's a job, what's called a job list, you know and people say "I'm not getting through my job list you know oh my god I've only got two hours left on my shift and I've still got all these people to do" and that is when people do just rush in and do sort of just ABCD and they get very annoyed if a patient says "oh I don't want that…"*

Memo 1: The initial thought process and implementation of theoretical sampling to explore the emerging theory further (see Appendix Nii) for another memo):

Memo 1 : Development of emotionally driven vs task-focused experience of burnout

Following interviews with CC nurses and SITU nurses from the [redacted] it becomes apparent nurses have different basic motivations. Analysis of 3 interviews : 2CCVB, 1SITU, VB raised possibility experience of burnout may vary too and there may be a different process trajectory. Opens up dilemma of needing to seek a bigger sample to explore whether theory is born out. After meetings and submitting amended IRAS forms managed to get into ITU but have to stick with stage at in research process ie. encouraging confidential/anonymous participation only, wonder whether this will affect burnout rates, need to check, suspect it will, also wonder whether I'll find higher Dp rates.

Emotionally driven: Emotional engagement -> stress, connection focus -> deep connection

Task-focused: low emotional engagement -> stress, focus on tasks-> detached relationship

Does level/type of connection affect vulnerability to burnout and relationship between the different components of B? Task driven more likely to fit definition: HEE, HDp, LPA. Versus Emotionally driven, unconventional expression: HEE, LDp, rPA

Might hint at different process and burnout trajectory:

Emotionally driven HEE -> rPA -> HDp vs Task-focused HEE-> HDp-> rPA

3.5.3 Awareness and engagement in active strategies to maintain resilience

Awareness of effective strategies to manage the signs of burnout and increase resilience levels were low overall, with the resilient nurses being most aware of what they feel helps them cope effectively. Many of the sample gained

this knowledge through the process of feeling close to burnout, others already have some healthy coping and self-care strategies in place.

A key point of difference as alluded to earlier is the resilient nurses sense of agency and belief that by making changes, prevention can be achieved, this attitude propels the nurse positively forward. Many of the nurses who felt vulnerable and close to burnout in the past, either took time out or changed jobs. Time to reflect and re-balance were considered key generally, the following nurse reflects on how a colleague, who felt close to burnout, took time out, and returned to the same job, but with a new perspective on how to manage the impact of the job more effectively:

> RB15CC *"My other colleague … she said she was nearly burnt out, so she left and worked for a charity for six months and then she came back I always find it beneficial to speak to her because she does a lot of mindfulness… it was just nice to have another insight… she had to step back …and now she's come back with a better feeling towards everything"* (537-551)

Being allowed to take sabbaticals or secondments to a different department was considered beneficial as a preventative measure although it was acknowledged that problems with the banding pay scales may make this unfeasible. Some senior management recognised the importance of structuring their teams to allow nurses to have adequate breaks and reprieve from more draining cases. These sisters also recognised the importance of creating an environment that is *open and sharing* allowing nurses to feel they can accept their vulnerability and say they need space from certain patients:

> RB11CC *"So if we've got somebody, we'll always ask in handover, 'are you happy to look after that person? You've looked after them for a few days, are you still happy to carry on?' And people are quite open to saying no actually, hands up I can't do this anymore, so we allow people to voice that, coz I think it would be really bad to make people feel that they've got to do it again and again and there is no choice, so we allow, you know we give people the ability to say when it's too much"* (447-445)

> B7IT *"I think it would be good if after a certain period of time you were able to take a break from work, I really think that would be a good thing and I think over the years that would have helped me."* (605-608)

A wide range of factors were noted as helpful coping/self-care strategies. It was acknowledged having children can act as a protective factor because the nurse has to develop skills to effectively compartmentalise and prioritise to ensure there isn't the need to continually work late:

> RB13CC *"You just need to focus on what's really important, what the priorities are, and that's a skill that only really came about after becoming a Dad, I don't think that skill was there before… I think most people that don't have children just spend too much time at work, they haven't got something to go home to in the same way…I don't know if that's chicken and egg with burnout, and whether one causes the other… but I think it has been very helpful, probably a bit of a lifesaver actually in many respects"* (1485- 1492)

Other nurses talk about the importance of having strong networks of friends at work and externally as key to resilience to burnout:

> RB11CC *"I think not having support, not even a relationship, not the fact that you're married, but the fact that you've got a close set of friends, and even support from the team that you work with."* (437-443)

Having a strong team to work with emerges as very important and when it is lacking the nurse can be left feeling inhibited and unable to share and reflect with colleagues:

> RB15CC *"I felt much more strained when I worked in in ITU…I didn't feel the team around me…I didn't feel like I could speak to anyone"* (235-238)

Many of the nurses acknowledge the benefit of exercise and several of the resilient nurses recognised the need to change several health and well-being aspects of their life to become more resilient, with mindfulness practice proving particularly effective for several of them:

> RB16CC *"So now I exercise more, I eat better, I make sure I get to bed early, I started using meditation and mindfulness… yeah that has really changed things a lot actually. The mindfulness in particular stops the repetitive thinking" (*665-673)
>
> RB15CC *"I did some mindfulness with my exercise, she (friend) said 'don't listen to your headphones on the way, just be open to what's going on*

around you, so it lets your mind breathe a little bit,' so I did something like that and actually I felt better for it" (544-549)

For others religion proved helpful:

VB6CC *"And also I'm religious… so I've got a whole load of friends that I have all the time around…I always think it's good to have a few good friends that if you're low…that makes a big difference"* (378-382)

3.6 Category 2: The power of effective communication

Effective communication emerges as an important factor in the developmental process of burnout both at an individual and team level. It creates a sense of professional self-efficacy & autonomy, enabling the nurse to have the confidence and courage to believe they can exercise influence in situations where they have responsibility. Where communication is problematic the conditions are set for low levels of professional self-efficacy & autonomy, factors which can increase vulnerability to burnout. A number of sub-categories were identified as important in understanding *the power of effective communication* on vulnerability or resilience to burnout as shown in figure 15a below. Figure 15b illustrates the sub-categories and their dimensions:

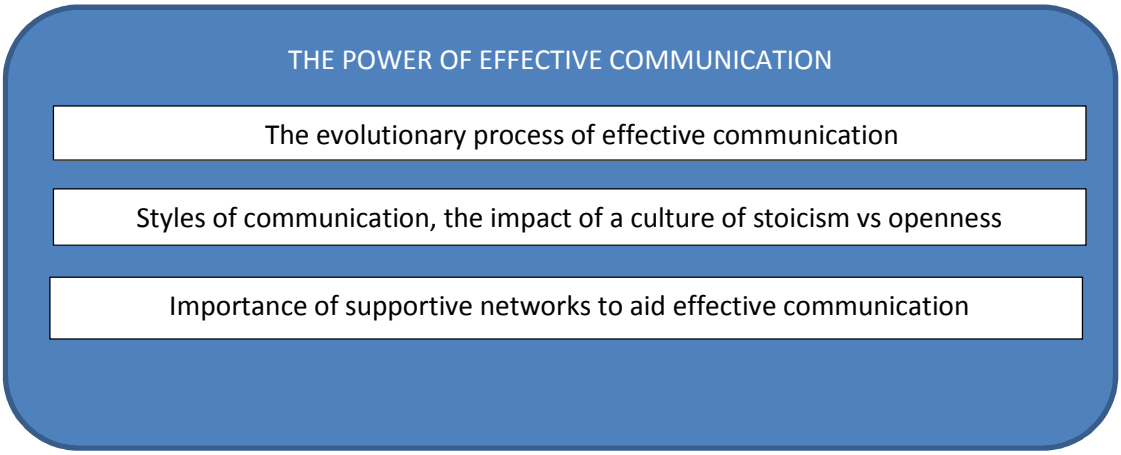

Figure 15a: *Higher order category, The power of effective communication and related sub-categories*

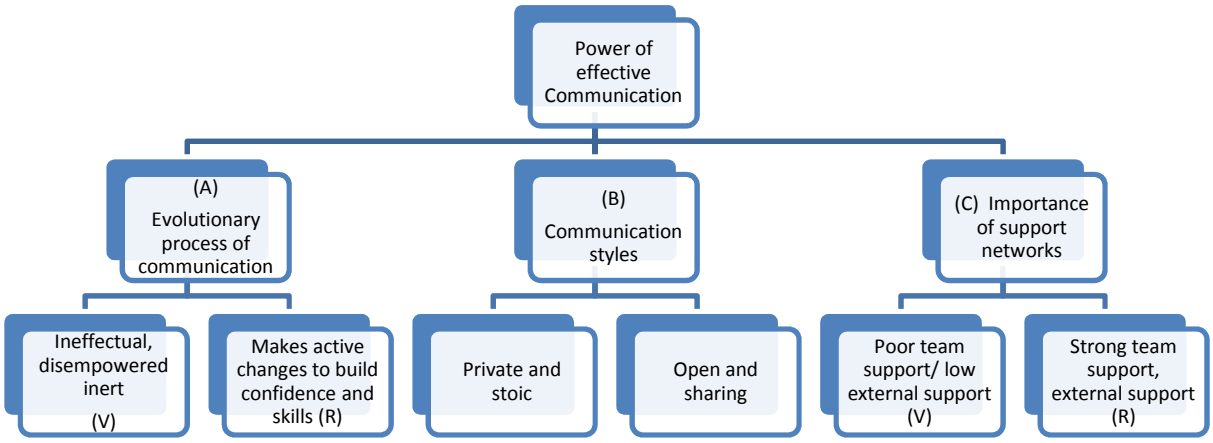

Figure 15b: *Sub-categories and dimensions informing Power of effective communication*

3.6.1 The evolutionary process of effective communication

In exploring their journey, many nurses talk about how in the early stages of their careers, following qualification, the lack of confidence in their knowledge and experience can lead to feelings of powerlessness and low levels of professional self-efficacy, leaving them unable to positively assert themselves when difficult clinical decisions have to be made. There is a sense that all nurses encounter early experiences which are difficult and transformative, and how these are handled is crucial and influences the burnout process. This section explores the personal impact and differences in the way such experiences are handled; the next section will explore the crucial importance of contextual factors on this process.

Findings suggest that nurses showing greater levels of resilience respond to early difficult situations by becoming more actively driven by their values and goals in order to seek ways to ensure greater professional self-efficacy. They recognise where their deficits are and take action to make changes. In particular the importance of acquiring further specialist knowledge was seen as fundamental to providing effective protection from the demands of the job. The following nurse discussed this process and how early in her career she felt uncomfortable and unable to voice her concern about a decision her senior made. She committed to ensuring she acquired the knowledge which would enable her to assert herself more

effectively and to help re-dress the power imbalance that can threaten feelings of self-efficacy:

> RB10IT *" When you work in ITU you talk the same language as the Doctors, I just wanted to be someone then that absolutely knew what to do, if you're going to sort of carry on in the career then you want to have that ability really…say this person is in complete heart drop…you know there's no argy bargy, there's no messing about, you know what you're doing so you communicate in the right way…the moment you speak you can get people to listen then that is an important thing in this profession*" (162-211)

This nurse talked of a critical incident early in her career which prompted her to make changes which would prevent her from feeling in a powerless position in critical situations in the future:

> RB10IT *"You know when you feel something hasn't gone right and you know maybe, there's been a few key incidents where specially as a young person, where you don't think it was done properly… You know you've got that conflict then in your head, deep down, without really being conscious of it, that's something that prompts you to want to be in a position where you are more in control… that was the major sort of turning point when I thought I'm never doing that again (not speaking up when disagree)… you get a sense of people certainly that cope better in difficult situations that are better at communicating and I think that tends to translate into someone who is more resilient and more able to cope".* (254-330).

Other resilient nurses talk about recognising the signs of burnout, in retrospect, when they felt ineffectual and unheard. Typically these nurses begin to show the early signs of burnout if these conditions continue but after a while this type of nurse is likely to decide to move on and take up a new position rather than resign themselves to the powerlessness of their position. The following nurse talked about noticing how he increasingly became angry and frustrated and noticed he was drinking more and more and losing motivation at work. In the end this nurse recognised necessary changes would not occur and changed jobs where he felt more able to hold onto what he valued, leading to him feeling more heard and satisfied:

> RB13CC: *"I was managing the …unit, but I found it very frustrating, it wasn't the patients…I became quite angry"*

R: *"So what was so frustrating?"*

RB13CC *"Just the lack of change, lack of people listening…equally frustrating when I joined here, I was furious… then I actually got my way and people listened and we made improvements"* (420- 458)

In comparison, nurses showing signs of vulnerability often talked about early difficult incidents when they felt unheard or unable to assert their perspective confidently, leaving them feeling powerless and with low levels of professional self-efficacy. In the early stages of a nurse's career, the culture of communication they are working in is particularly important in helping them to learn how to effectively process difficult situations or critical incidents, and to encourage them in the belief that they can develop the skills and confidence to become assertive communicators who feel heard and efficacious. However, in some cases, nurses lacking the environment or support of peers are left carrying difficult experiences for long periods of time, with some showing signs of trauma associated with these incidents, which came back to trouble them later in their careers. There is also a sense that these nurses are left with negative cognitions/appraisals around such events, tending to internalise this experience as evidence they aren't competent or as effective as their colleagues. Some exhibit signs of over-estimating their level of responsibility and feel burdened by this, as the following illustrates. This nurse, recently entered a difficult phase, due to low staff levels and high numbers of staff changes in her field, began to suffer flashbacks to an earlier incident in her career when she worked in a field which left her feeling unsupported and unheard, gradually signs of burnout grew within this context to the point she had to take time off:

VB3CC *" it all started after episodes with patients where I wasn't enough …a patient that basically died right in front of me without me being able to do anything, the doctor wouldn't listen erm. And again… I felt peer pressured into doing something I didn't really think was the right thing to do… and that just stuck with me for a very long time …I was left with no other option…I think I lost a bit of, because I did something I didn't believe in…it haunted me for a very long time."* (727-776).

When asked whether they felt they differed to their peers, many of the nurses who identified themselves as less resilient and in fact emerged as vulnerable to burnout recognised they were often less effective at communicating than their more resilient peers and less accepting that at times there is nothing they can do, it

being the ultimate responsibility of more senior colleagues. They can be left taking the dynamic personally and feeling overly responsible for outcomes. This was illustrated by a cancer care nurse who felt a key part of her role is as an advocate for the patient, however, the sense of low self-efficacy particularly when pitched against a doctors conflicting opinion is evident:

> VB1CC *"Well a couple of them definitely do have more resilience… I think for a lot of the time you have this rule book of how you've got to do this trial, but then the Dr's say 'yes but we're the Dr's, then you say 'but the trial is set up like this'…you know you're always protecting the integrity of the trial and the patient but I don't think I'm always that good at standing up to them, whereas some of my colleagues are better at saying 'you need to wait', it makes you feel vulnerable* (by not standing up to the Dr's) *like I'm endangering the patient… and you know if you go to* (colleagues) *they go ' oh yer well I can see that but at the same time it is kinda up to the Dr's"*

This nurse suggested her more resilient colleagues were more able to let go and accept there are times they don't get the outcome they would like.

3.6.2 Communication styles: Private and stoic versus open and sharing

Figure 16 below highlights the sub-category B: Communication styles and the associated dimensions that emerge.

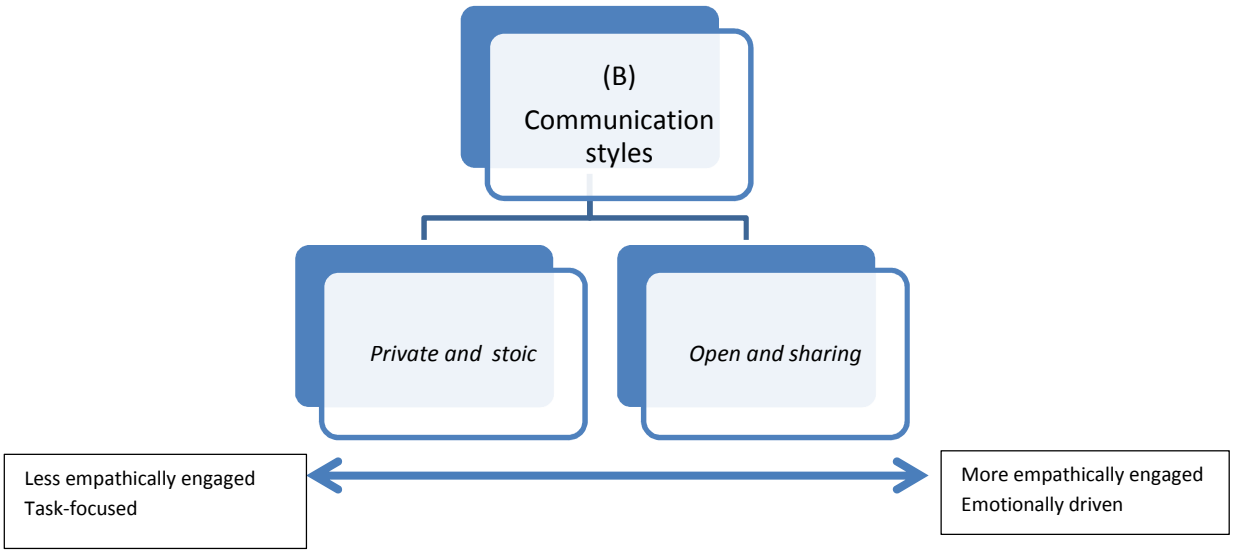

Figure 16: *Sub-category B: Communication styles*

Whilst individual factors have been the focus of explaining resilience and vulnerability to burnout so far, the crucial role of the context in which the nurse is working is brought into sharp focus when exploring the importance of communication styles and their significance in terms of contributing to whether the nurse becomes vulnerable or resilient, possibly regardless of any predisposing factors. The significance of other contextual factors will be explored further in the next section. Findings suggest whilst communication styles within a team may vary there is evidence to suggest that over time a dominant communication style can pervade and influence how a nurse is encouraged to manage the more difficult aspects of their work. This can impact on the nurses self-belief, confidence and sense of self-efficacy necessary for building resilience to burnout. These communication styles primarily refer to how the more difficult aspects of the job are handled in terms of communication styles engaged in. They can be viewed as a continuum and with *private and stoic,* or *open and shared* representing opposite ends of the continuum. To some extent these communication styles reflect the nursing orientations identified earlier, ie: Task-focused nursing styles more typically fit within a *stoic and private* communication style, with nurses preferring to simply get on with it and stoically accept the difficult nature of the job tending to turn to others less to process and share difficult scenarios or they may discuss the more technical intricacies of the job as a means of processing the work; nurses with an emotionally driven orientation typically show a communication style of being more *open and sharing* and benefit from a nursing environment which is characterised by sharing of difficult experiences, knowledge and support and are more inclined to accept, share and seek support when they feel overwhelmed, vulnerable or their confidence has been knocked. The following nurse discusses the differences the culture of communication can have on resilience with her preference being for an open sharing style:

> RB16CC "*Yeah erm the other parts that help you be resilient is your peers and the people around you and their attitude as well towards how you know, how do you deal with difficult things and their attitude to say clinical supervision or erm or how people should talk about things they are finding hard at work erm and if you work in a team where people don't, think clinical discussion or clinical supervision is a waste of time, you might then think well I'm not going to do that either where is that a sign of weakness but also having an openness to talk erm yes to talk about things as they happen as well"* (511- 530)

Ideally the overall communication culture is neither one extreme or the other, and incorporates elements of both in order to recognise the different individual communication styles and initial resistance to different styles that may be evident in a team, especially when trying to offer programmes or management styles to build resilience. The findings suggest that the managements style of communication is fundamental in driving the pervading style, it is also apparent that where there is instability in a team, ie. high senior staff turnover the communication style is less likely to incorporate an element of being open and sharing even if most of the nurses working in this field would benefit most from this style of communication, which implies that trust and a feeling of safety in sharing needs to be evident.

3.6.2.1 The complexity of empathic engagement and communication

The degree to which nurses engage empathically with their patients is usually reflective of the nursing orientation they adopt, with emotionally driven nurses typically believing they engage more empathically with their patients than their more task-driven colleagues:

> VB4IT *You can get a nurse who is really hard working but doesn't engage a lot with patients, but gives excellent care, but lacks the communication"* (318-320)

On the whole there is a sense that to be empathically engaged with your patient is a positive; it brings great rewards and job satisfaction for some and leads to more compassionate care. However, there is also debate about whether deeper empathic engagement actually leaves you more drained and vulnerable to burnout as the following quotes illustrate, the first quote outlines the experience of a nurse consciously trying to become a more empathic listener:

> RB13CC *"Weirdly enough I did the advanced comms course a few years ago and that changed an awful lot with my approach, particularly with empathy and listening, and I suppose the more psychology side of nursing, being able to listen to somebody and take on their concerns and problems, and I think that's made me a better nurse, but I think it's made me probably more vulnerable as well because you take on so much. I feel that I take on an awful lot, and I remember when I started I was quite conscious of it, I started really listening to patients' problems, not just about the clinical side but really trying to take them on board, and I remember thinking 'This is hard work, it's exhausting', you know? You take it on, but that's where the*

enjoyment is, which is really frustrating, that's where the reward is" (115-130)

The second quote explores perceived cultural differences in nursing styles and how this influences resilience:

VB4IT *"What makes you more resilient?*

R: "*What factors influence that?"*

VB4IT *"I suppose the Philippino nurses because they are, don't communicate with the patients… because they don't get involved, like the Nigerian nurses, they can work and work and work, it's the nurses like myself and other nurses who put in emotionally time and attention that get burnt out"* (455-463)

This has implications for nursing practice, because it can create conflict particularly for more emotionally driven nurses who prize this type of patient engagement, however, a balance has to be struck between the changing demands placed on the nurse to be able to deliver a high level of expertise and to increasingly have to carry out more and more tasks and checks in some roles. This can lead some nurses to feel compromised in terms of how they like to engage and communicate with their patients, although those who manage to strike a balance between the different modes of nursing manage this conflict well.

3.6.2.2 Private and stoic communication styles leading to denial of vulnerability

Where an individual, team or collective culture is overly characterised by a private, stoic communication style a culture of defensive stoicism can evolve and become problematic. It can engender a denial of vulnerability, and the nurse can be left feeling unable and fearful of admitting she is stretched or struggling, typically having to either become more task-focused, and less able to empathically engage with patients. There is a suggestion some become bitter towards the system or team or they leave their jobs or resign themselves to it and potentially turn their vulnerability inwards compounding the symptoms of burnout.

The resilient nurses who fit this category have well developed cognitive strategies which help the processing of difficult events. They are very good at

compartmentalising and focussing on the positives of a case, disengaging from negative thinking and actively applying mindfulness techniques, for example:

> RB10IT *" I must say I have wondered whether a psychologist would say that's absolutely the wrong thing to do, because I know there's all this stuff about counselling, when I was a clinical nurse here and my manager was here, she brought in a psychologist to kind of do group sessions, I was like, no way, I'm not going in talking about anything, and I think at that point the last thing I wanted to do was to talk about it, and I've recognised over the years that if I'm really bothered about something, I like to sort it out myself, in here, and not talk about it because I think it makes it worse, and I know that sort of goes against a lot of the kind of current thinking, I seem to be sane at the end of it, so I assume it works"* (902-912)
>
> RB10IT *"Yeah, once I had children it actually helped even more because you are just in a different mode, you just forget about work completely…most of the time with the kids you do just lose yourself in what you're doing"* (798-800)
>
> *RB10IT "I've just read a book…it's about mindfulness and meditation…because I recognise this in myself, that I get these things I can't quite make it stop (worry about a work issue), I've sort of labelled them and I recognise when one of them takes over, one of these obsessive little things, so that I can stop it …just by, when I recognise it I can stop it"*

There is good reason to encourage nurses to be able to self-manage the emotional content of the work. They need to be able to contain and hold the high emotions their work may elicit in themselves, patients, families and more junior members of staff. However, it is important to be able to recognise when this burden is too great, to learn to 'share' effective methods of coping with difficult content from the beginning of the nurses career and to recognise that different roles and nurses with different nursing and communication orientations may be resistant to appreciate the value of sharing and discussing difficult content. This has implications for how support services and programmes are communicated to nurses; for nurses with a task-driven orientation, the notion of being able to share and talk about difficult experiences will feel alien and questionable and therefore their value needs to be carefully communicated and alternative means of support also offered. The findings suggest that even where supervision is offered, nurses often don't prioritise it and rarely attend, particularly if they aren't held at a time that

is convenient for them. This attitude to sharing and resistance to support was evidenced in both ITU departments as the following explores:

> VB10IT *" We're starting on something like that now (*a support program), *is that erm this stiff upper lip culture particularly in Critical Care, that we are professional you know, we don't have feelings you know, we always cope with the situation, is still very prevalent. Recently as somebody says, you know when I suggested that we have, talk about our stress and our feelings and all that, someone said well if you can't cope with this sort of thing or the Critical Care, dying and stress, then maybe it's just not for you. Basically saying to the junior staff you know if you can't hack it you know, just leave so and I think that's just the wrong kind of attitude"* (423-430)

This attitude was also evident in MITU/SITU [redacted] where a psychologist had been available on site. They experienced a problem with low uptake of the service until the psychological support was presented as available to patients/families and staff, and this resulted in increased staff use of the service. It was considered that the nurses were unwilling to admit publicly or to themselves they needed to share difficult experiences but were willing to go initially in respect of the patients, once they accessed the support, they opened up and were able to benefit more from this service:

> RB10IT *"We've got a psychologist coming in once a week, so much as I'm not a fan of any sort of group sessions or counselling, I know that it isn't what I need, I do realise that it is what a lot of people need, so I think more of that. I think really good, kind of training around death and bereavement, that's the thing that bothers people out there the most and I pretty much say that across nursing as a profession, there's a lack of it, there's an expectation that you just know what to do and having support and training around that and with the counselling side, you know, psychological support for staff but just making it really easy and accessible, so I know that there's the welfare service over at 52, but the fact that we've had someone kind of hovering around here and they know that the person is coming every week, gradually people are beginning to book themselves in to see her, so it's very sort of unobtrusive, they haven't got to go off anywhere, make a song and dance about it, they can just quietly go and chat to somebody and get a bit of advice and it might just be that they recognise what they need to try and sort*

this out, you know like sleep problems or whatever, just being able to tap into it in a very sort of casual way, I think is really useful."

The benefit of offering psychological support, and in a manner which encourages uptake, was supported in the quantitative phase, where lower levels of EE found in MITU/SITU [redacted] versus Cancer Care/ITU was statistically significant.

In ITU, [redacted] a similar public resistance to the support service was apparent, and steps needed to be taken to re-name the support group:

A10IT *"We did a similar thing a couple of years ago* (offering a support group)*, and (*the psychologist) *ran it … we got a lot of negative, oh you know like 'we don't need this weekly shit and you know my god, you know it's critical care you know, you have to toughen up... I thought maybe it wasn't the right approach and then* (a survey was conducted) *and 75% of people said we need more of this and I couldn't believe it because I expected it would be voted out"* (458-468)

3.6.2.3 *Open and sharing communication style*

For nurses that show a communication style preference for being open and sharing of difficult experiences, knowledge and support, findings suggest that these nurses feel more inclined to accept, share and seek support when they feel overwhelmed, vulnerable or their confidence has been knocked:

RB15CC *"So I would say to be able to debrief is really very important and to know that you're not alone with your feelings, and to be able to compare different experiences, so I think talking to someone is very important, being able to step back and take time and I think there shouldn't be any shame saying go for a walk, a cup of tea, I think managers should maybe have teaching on being able to read when it's too much for someone"* (809-815)

However, formal support in the form of debriefing sessions can still not be embraced because staff find them difficult to attend if they are scheduled when they aren't in and there remains a reluctance even amongst this type to accept their vulnerability and admit they feel stressed, perhaps suggesting a culture of stoicism is pervasive:

VB5CC *"You know we've tried to do the debriefing sessions… but the thing is you know people have to rush off the ward to go to them and in the back*

of their mind they're thinking about what they haven't done on the ward to go to them…I think they may be good but it's getting people to do them isn't it" (828-837).

RB15CC *"I just think maybe that should be something that's more accepted* (Someone admitting they are stressed), *instead of someone saying ooh she says she's not coping, it shouldn't be looked at like that"* (687-689)

VB1CC *" I think for nurses to be able to acknowledge that they are stressed, and for it not to be seen as a bad thing …Coz I think it is viewed quite negatively. I think nurses view it quite negatively, to own up to feeling stressed, to feeling like they are not giving 100 per cent to their patients or they are not you know, it's almost, I think less so now but it used to be very much like it, you know you weren't a good nurse if you couldn't handle anything that a day threw at you" (812-* 817)

RB14IT *"… it was fascinating trying to set up the psychology thing, it really was, and the resistance was huge, and I wondered if we'd just persevered with it, like maybe it takes two or three years to get people accepting that they need help and support and that you don't have to be strong all the time, and just because you're talking to someone about your problems doesn't mean you're not going to be good at the bedside"* (1211-1217)

The findings suggest that acceptance of vulnerability is important to maintain resilience and working within a system that allows for this recognition and accommodates for it, can help manage the emotional toll on the nurse, as this discussion with a senior nurse illustrates:

RB11CC *"Yeah, coz if you're having a difficult, so if we've got somebody, we'll always ask in handover, are you happy to look after that person? You've looked after them for a few days, are you still happy to carry on? And people are quite open to saying no actually hands up I can't do this anymore, so we allow people to voice that, coz I think it would be really bad to make people feel that they've got to do it again and again and there is no choice, so we allow, you know we give people the ability to say when it's too much…I think it shows a stronger character to do that than to say no I'm fine"* (447-479)

As the above shows there is a need for a cultural shift away from a culture of stoicism and denial of vulnerability to one which accepts vulnerability and incorporates systems which build in informal acknowledgement and acceptance of the strain of the job and systems which offer support in a manner which suits the nurses and acknowledges their reluctance to admit their own vulnerability. Some departments as shown above do this, other positive examples are provided in ITU with the line system they have introduced whereby large departments split their workforce into teams which create a structure more able to offer informal support:

> VB10IT *"One more thing, we'll call teamwork or connectiveness …we've got a team of 180 nurses and they're organising 5 teams of about roughly 30-35 nurses and they're almost like families. They are so tightly knit, they cope together…make cakes together"*

3.6.3 Importance of support networks

Throughout, reference has been made to how important it is for nurses to feel supported both by their colleagues and friends and family, so they can share difficult aspects of their job or simply disengage from the job more effectively. How effective the team is in providing a supportive network also positively influences the prevailing communication style, as alluded to, ideally offering a sense of it being accepting of different styles, *sharing and open* whilst creating a sense of containment and strength. The following quotes illustrate how important having a supportive team around you can be:

> RB13CC *"I think there are always situations when there's too many patients, it's too busy and the pressure is really up, and I think nurses can cope with it. I suppose the other thing is they'll be able to cope with it as long as they can see other people in the same situation managing it quite well. So you have a really busy Friday, it's 3 o'clock, you're rushed off your feet, haven't had any lunch, by the time it gets to 6-7 o'clock it's okay because everybody's feeling the same frustrations, and as long as you can say 'Okay, well we did really well, we got through it', I think that's another thing with resilience…it's teamwork, it's a team effort"* (977-991)

> VB1CC *"I think the work is very frustrating at the moment, I mean I've been there 9 months but before that they basically had no stability in terms of management … then we were just feeling secure and then my manager said oh yes I'm moving to….., but one of the people who did temporary*

management is coming back, so we should be ok, but we were all feeling really unsettled and pressured by the Drs, and A+E have stolen half our space, and I don't blame A+E because it's not their fault, we've got nowhere to put all these new patients and about 30 trials to do. So we're still in quite a structural mess I think" (514-522)

The following nurse was proudly talking about how effective she used to be at creating a sense of 'the team' but since feeling the effects of burnout she has been less inclined; however, she talks fondly of how important her colleagues are to her:

VB2ITU *"I love my colleagues because they are so funny as well, I don't have family in the UK, I'm living on my own and I always believe they are my family and I always like to have a good relationship with them because in a way…you know maybe someone sometimes in need or help probably they're there."* (668-671)

3.7 Category 3: The role of external drivers

The findings strongly suggest that some nurses carry greater vulnerability to burnout than others, however, all nurses regardless can become vulnerable and develop burnout if contextual factors are not conducive to maintaining resilience. Beyond the significance of contextual factors, negative life events can also add to a nurse's vulnerability and serve to tip them closer to burnout. Figure 17 below, outlines the factors that can tip the balance.

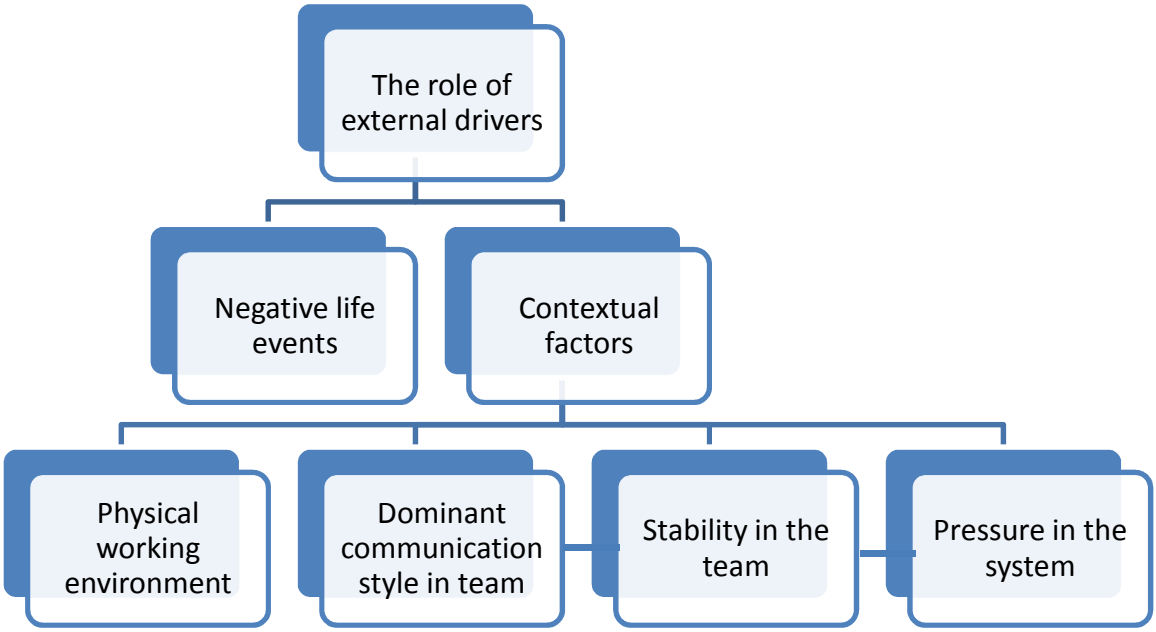

Figure 17: *Factors tipping the balance*

3.7.1 Contextual factors

3.7.1.1 Pressure in the system

Contextual factors can not be underestimated; regardless of whether or not a nurse has a predisposition to vulnerability, the context plays a significant role in the process of burnout development. Where demand on the service is high, staff shortages are problematic and/or there is a shortage of equipment the strain on the nurse grows, health and wellbeing becoming unsustainable if the system is unable to re-balance:

> VB10IT *"Now the stress comes more from demand in that there's, it's difficult to find an empty bed, discharges are complex, there's more threat of litigation"* (49-50)
>
> VB2ITU *"All this cutting the budget for the NHS, we are now doubling up* (in ITU 2:1 patient/nurse ratio vs 1:1), *so the working load …it's so heavy... It's really hard because I have to work like a yo yo"* (366-377).
>
> VB5CC *"We worked on a ward that was appallingly staffed and you were leaving you know, you weren't doing your best by people in a long way, and people would complain and I used to think actually you are quite right to complain"* (420-425)

VB1CC *"it's not being able to leave it behind I guess, and you know just having it on your mind, I know that there are some things that are constantly on my mind and ... and anxiety about going to work, what you're going to find when you get there but also like almost anxious about leaving if you are leaving stuff not done, actually you have to leave stuff not done otherwise you would just be there all the time, so it's that difficulty"* (404-408)

RB13CC *"I would say the easier way to avoid burn out is to give nurses enough time to do their job properly and the tools to do it … and to give them the time with patients, and I think that probably goes further than anything else, perhaps further than any counselling, it really is 'Just let me do my job properly, give me the tools to do my job'.* (969-977)

The sample included two nurses who had spent many years working in ITU and cancer care respectively and the growing pressure within the system and shortage of staff and equipment in the case of the ITU nurse had left them increasingly stressed and exhausted both emotionally and physically at the end of each day. Both nurses had to take time off for stress related sickness; one nurse decided to reduce her hours by half because she was no longer able to manage the full-time workload she had previously managed effectively for decades. The other nurse was considering leaving nursing altogether after being so passionate about it at the beginning of her career. Both also showed signs of suffering from vicarious trauma which began to prove problematic years after triggering incidents occurred but weren't effectively processed. One nurse highlighted below had developed a fear of having a heart attack and had attended A+E at the end of a shift recently because of this fear. She talked about a badly managed traumatic incident involving a heart attack, which she keeps fearing will happen to her:

R *"So how do you feel at the end of a shift?"*

VB2ITU *"Exhausted…I really feel so tired, shoulder blades are painful, I drink a lot of water, I need to rest for a while, and I'm always scared that I'll be in A+E again…I've always got it in my mind if I've got a busy day and I feel like oh my God, I don't want to have these palpitations"* (511-528)

3.7.1.2 Stability in the team/dominant communication style

The findings suggest that the *stability in the team* also becomes difficult to maintain when the *system is under pressure* and there is a higher staff turnover

than is ideal which makes it hard for an open and supportive communication style to be in evidence, hence the nurse is left operating in an environment where denial of vulnerability and a culture of stoicism becomes the dominant mode of operating, potentially exacerbating burnout levels. The following excerpts provide insight into the past experience of a nurse, which is characterised by denial of vulnerability and a private/stoic communication style, leaving the nurse feeling isolated:

> VB5CC *"I felt in a constant state of anxiety, everything you did you felt was being looked at, being criticised, being used against you, you know constantly, you know, I would say I was depressed, always erm … trouble sleeping, had kind of you know life just became about work you know nothing else really…"* (439-443)

> VB5CC *"And the fear of going to work, and the fear at work as well, and the problem was that it didn't have enough staff..."* (493-496)

3.7.1.3 Physical working environment

The physical environment emerged as an influencing factor in helping to maintain a nurses resilience and in some cases can add to the process of burnout development. Nurses talked about finding certain physical working environments more conducive to feeling supported by the team and physical changes in environment stressful to adjust to:

> R16CC *"That move* (to a new building) *was very difficult, it changed the ward completely, from being a small ward to being bigger… and half of the beds are side rooms and only two small bays, whereas before it was sort of an old-fashioned ward, big bay… with only three side rooms…It was very different erm physically because everything was further spread out, I mean the extra walking we'd do….erm it changed the way you worked as a team, because you don't, you work alone a lot more"* (253-266)

Another nurse, also found the new environment stressful and discussed the fear she felt if an emergency happens:

> VB3CC *"I had a bit more control because my patients were all in the same room …if you're in a side room you have no clue about what is going on outside…sometimes you can hear the bells go off, but you have no way of knowing which room and if it's one of your patients they can be left for ages buzzing…because we don't have time to keep going to answer each others*

bells…I feel stressed, I really worry all the time, I positively go and check all the time" (238- 260)

This nurse said when working abroad she felt more supported by team members and able to practice safely when working in an environment where there were more open bays, finding this layout less anxiety inducing, an alarm system also alerted them to the level of need/emergency and the location number visible inside side rooms.

Whilst on the whole the new Macmillan Centre was received positively, and felt to be conducive with creating a positive working environment, there were considered to be a few minor problems for CNS's who feel there can be a lack of private space when bad news is being delivered and difficulties being fully aware of where you may be needed, with Dr's getting frustrated if they can't get the nurse's attention:

> VB6CC "*because of like the Macmillan centre is that big it's not as obvious to see, when we were in the Rosenheim Building that's a smaller building so you were sort of able to catch them (the Dr's) but you can't do that in the Macmillan Centre because it's big and you've got loads of doctors"* (262-266)

Nurses working in cancer research reported feeling devalued by the lack of space afforded them:

> VB1CC *"It's quite unsettling… they keep saying we're the place for research but you don't necessarily feel that valued do you as a team, if you suddenly lose 50% of your space and you've got uncertainty about where we are going"* (526-528)

3.7.2 Negative life events

The occurrence of negative life events affects nurses in different ways; for some regardless of their predisposition to vulnerability, it can be seen to positively enhance their ability to empathically engage with their patients:

> RB16CC *"It was a difficult time, especially when my* (relative) *died, it did help me think about aspects of nursing in different ways, it didn't happen straight away that's for sure, but it did help me think more about what it's like when someone really close to you is unwell erm,*

*whereas sometimes I think I can be quite depersonalised and just forget what that's actually like" (*753-758)

For others this can be a difficult period and their vulnerability to burnout increases as they find they lose the ability to effectively compartmentalise and overly identify with their patients to the point that it becomes draining and unhelpful. For some cancer care nurses in particular the knowledge they hold can become a burden when they have a loved one suffering from cancer. For nurses in this situation, whether or not they have vulnerable tendencies; support, time and compassion is important to help guide them back to a greater level of resilience. The following nurse talks about what it was like to carry on working in cancer care after a relative was diagnosed with cancer:

VB1CC *"It's funny it gave me more attachment to them in a way, even more so than normal, trying to imagine what it would be like in their situation…I was really washed out, really fragile"* (276-289)

3.8 Core category: *Reflection, insight and adaptation*

The nurse's journey begins with a predisposition to vulnerability or resilience to burnout, which places them at higher or lower risk of developing burnout. An ongoing and dynamic process will influence which direction they move along the burnout spectrum. This involves the complex interplay of internal/interpersonal/external factors which fall within the three core categories identified earlier and shown in figure 19. The process is mediated by how capable the nurse is to be self-reflective, how insightful they are to be able to interpret what this reflective process reveals and whether they then have a sense of agency and capacity to be able to adapt to their stressful circumstances and change how they respond or engage with the difficult aspects of working as a high intensity nurse. Resilient nurses have the most developed capacity in all three areas and as we move down the continuum this diminishes, critically, nurses become less able to adapt to their circumstances.

3.9 Summary

This section has provided an in-depth analysis of each of the categories influencing burnout development, a theoretical model to emerge illustrating how these factors inter-relate is provided in the discussion.

Chapter 4: Discussion

4.1 Overview

In this discussion chapter I'll begin by restating my research aims and outcomes and go on to present the emergent theory and conceptualisation of the working model I have developed which summarises how nurses become resilient or vulnerable to burnout. I will review the key aspects of this model, setting them in the context of the core categories identified earlier and discuss how the research findings are supported by and contribute to existing literature. I'll also identify the theoretical, methodological and practice implications and identify further research questions to emerge. I will discuss the strengths and limitations of the study and close the chapter by providing a reflexive discussion of the impact of the research at an epistemological and personal level and explore the implications this carries both personally and for counselling psychology as a profession.

4.2 Restating the research aims

This study adopted a pragmatic epistemological framework which retrospectively explored the nurse's journey post qualification, to gain a better understanding of the process by which nurses become resilient or vulnerable to burnout. In order to do this a mixed methods approach was adopted, the primary focus being qualitative. Initially all nurses working in either cancer care, ITU [redacted]) or Medical/surgical ITU [redacted] were invited to take part in the quantitative phase of the study, which involved filling out an online survey establishing levels of burnout via the MBI and accruing demographic information. 100 participants took part. Descriptive statistics were used to provide initial statistical analysis of these data and emergent burnout trends were noted and explored further qualitatively. Of the 100 who took part in phase one, 16 nurses were invited back for the qualitative phase which involved taking part in a semi-structured 1:1 interview, six of these nurses were resilient to burnout, 9 vulnerable to burnout (ie. 5 showing signs of burnout on two dimensions, 4 on one), one was burnt out on all three dimensions of the MBI. The qualitative phase was designed to retrospectively explore the

processes and factors which influence resilience and vulnerability to burnout. A modified version of classical grounded theory was adopted which allowed development of a theoretical model of burnout to be presented in this section.

4.3 Summary and integration of quantitative findings

Overall 53% of the sample showed burnout on at least 1 dimension, this being EE. 6% showed burnout on all three dimensions of the MBI, 27% showed burnout on two dimensions, including EE, with a further 26% showing burnout on the emotional exhaustion dimension only. This study, in line with other contemporary researchers (Brenninkmeijer and Van Yperen, 2003, Roelofs et al., 2005), initially defined nurses who were burnt out if they had high burnout scores on at least two MBI dimensions including the emotional exhaustion scale. However, following exploration of this trend in the qualitative phase, I found evidence to suggest burnout should be viewed as a continuum rather than a dichotomous state, in line with Corey and Corey's (1998) assertion. As such I felt it more appropriate to view and label these individuals as vulnerable to burnout rather than burnt out per se. High levels of emotional exhaustion was apparent in 56% of nurses from cancer care and 67% from ITU [redacted], and 29% in MITU/SITU [redacted] The difference between CC/ITU and MITU/SITU was found to be statistically significant. The reasons for the statistical difference observed between the levels of emotional exhaustion found between MITU/SITU [redacted] and cancer care and ITU [redacted] can only be speculated upon. MITU/SITU is relatively small unit, with a long-standing, stable senior team, who have supported the weekly presence of a counselling psychologist to support staff. Whilst initially take-up was slow, once barriers were addressed take-up increased offering more nurses one-to-one support. It is speculated that these two factors may have had an impact on reducing burnout rates and be more conducive to creating a culture which encourages resilience to burnout. Another interesting trend to emerge was that where high levels of emotional exhaustion was apparent, nurses from cancer care were more likely to show high levels of personal accomplishment and/or low levels of Dp than was the case for nurses working in Intensive care (ITU/MITU/SITU). This trend was unconfirmed statistically, qualitative insight suggests these nurses were in the early stages of burnout, supported by Cordes and Dougherty (1993). Whilst suffering emotional exhaustion they often retain job satisfaction and compassionate care and

some may become overly invested in their patients, further theory to explain this discussed later.

4.4 The emergent theory and model of burnout

The model to emerge from this study, defines burnout as a maladaptive response to work-based stressors. It is a continuous and dynamic process of change which involves the interplay of internal, external and interpersonal factors. At the heart of the process, how reflective, insightful and adaptable a nurse is will influence how vulnerable or resilient they are to burnout. As pressure builds, negative adaptive changes occur indicative of burnout processes, characterised by: Exhaustion, including physical, emotional and cognitive exhaustion and change; depersonalisation/cynicism towards recipients in their care, or their work and feelings of reduced personal accomplishment. The process of burnout development is complex, variable and unique to the individual and situation they find themselves. However, recognisable patterns emerged which suggest the process of burnout development varies depending on nursing orientation. It is proposed nurses who orientate to emotionally-driven nursing styles typically show high levels of emotional exhaustion, gradually followed by reduced personal accomplishment and lastly depersonalisation; whilst nurses with a task-focused preference typically show high levels of emotional exhaustion followed by depersonalisation and/or personal accomplishment. The pervasive dominant culture in a team will also influence burnout development: A culture of understated stoicism and acceptance and collective management of vulnerability and acknowledgement of different communication and nursing styles create optimum conditions to encourage resilience to burnout and conversely a culture of defensive stoicism and denial of vulnerability increases the likelihood of vulnerability to burnout.

This model bears resemblance to Cherniss's model (1990) and also supports his longitudinal findings that nurses experiencing burnout early in their careers, who remain in the job, can become more flexible and adaptable in their work approach and grow in terms of professional self-efficacy. It also supports Maslach's (1981) original conception of burnout in that it acknowledges the presence of all three dimensions in its definition of burnout, but it goes further to challenge their conception of the exhaustion dimension by broadening it in line with Pines and Aronson's (1981) and Shirom and Melamed's definition (2005), and it

also provides new insight by suggesting that burnout progressively develops in different ways depending on internal/external and interpersonal factors and nursing orientation, similar to those identified by Garden (1991) as indicative of the Jungian personality types, identified as 'thinking' and 'feeling' types.

The model below, figure 18, illustrates the key factors at play which govern whether a nurse becomes resilient or vulnerable to burnout. The colour coding broadly relates to the categories each element has emerged from (see figure 19, for a reminder of the original analytical categories). The arrows/cyclical symbols reflect the dynamic, complex and fluid nature of the process, highlighting how any nurse regardless of whether they are more or less predisposed to be vulnerable to burnout can move in either direction, thus providing support for burnout to be viewed as a continuum, rather than a dichotomous state. Bordering each end of the spectrum reference is made to the pervasive culture which influences resilience or vulnerability to burnout. At the heart of the process reference is made to the importance of how reflective, insightful and adaptable the nurse is, the arrows indicate that resilient nurses show signs of having a higher developed sense of these qualities than vulnerable nurses.

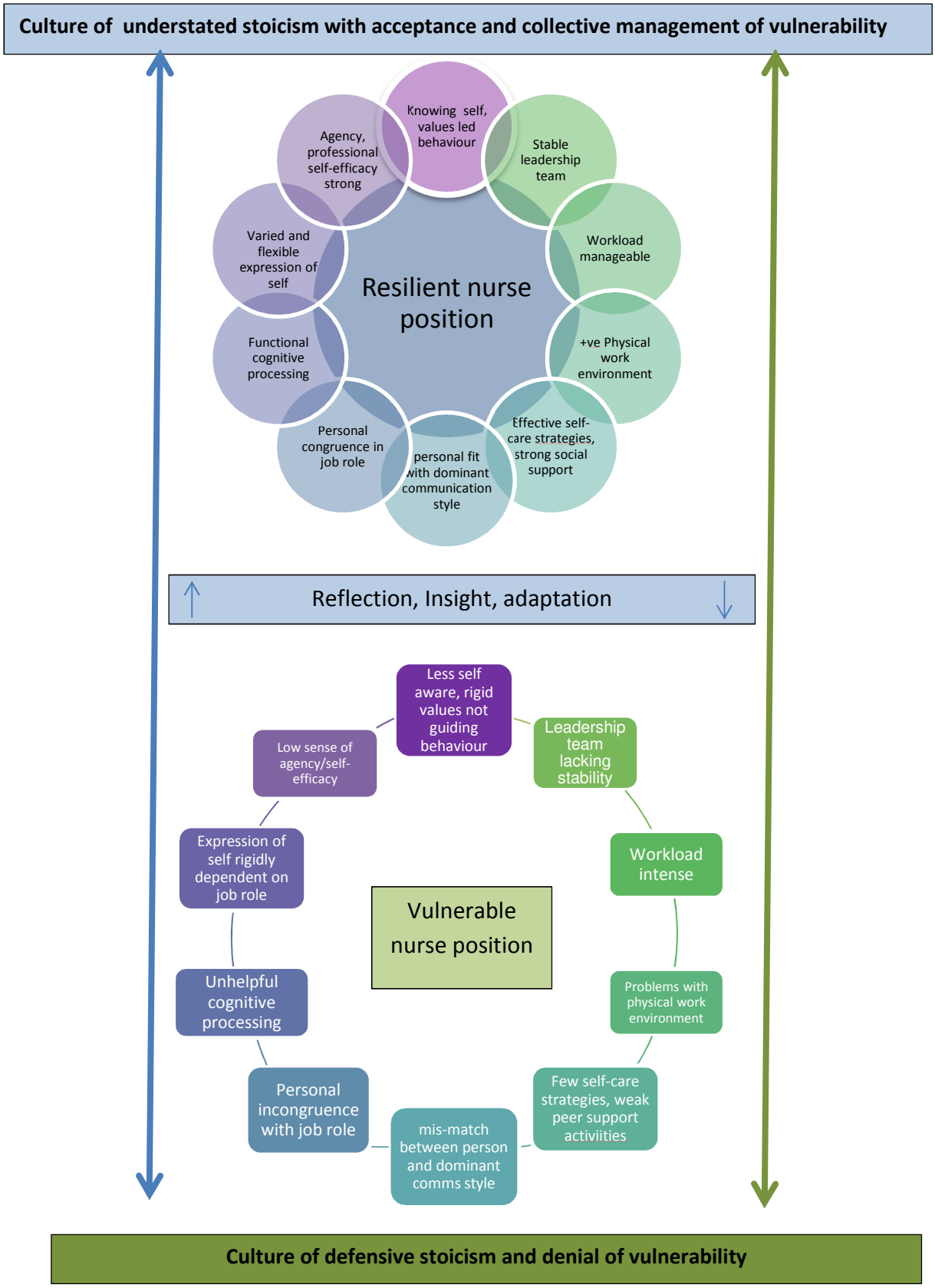

Figure 18: *The process which influences development of resilience or vulnerability to burnout*

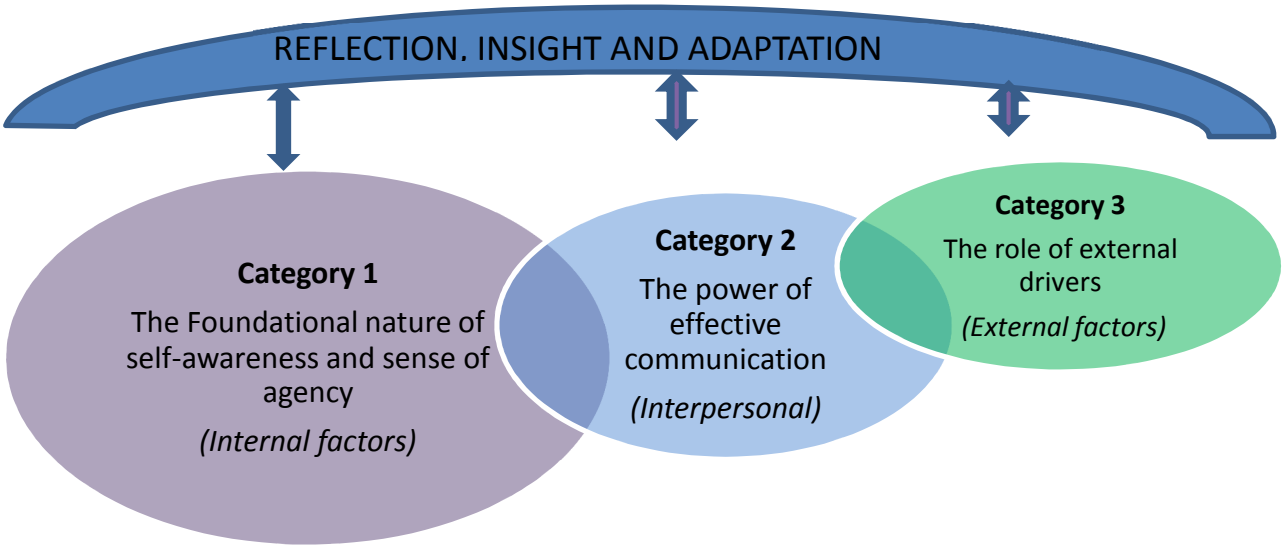

Figure 19: *The three main categories and core connecting categories*

4.4.1 Category 1: Foundational nature of self-awareness and sense of agency – Internal factors

Several key findings emerged from this category which are worth reflecting on further. Whilst nurses as a professional group are relatively self-aware in terms of having a basic sense of self and recognise their likes/dislikes and strengths/weaknesses, there are two key areas within this category which crucially influence vulnerability and resilience to burnout. These are i) the extent to which nurses are aware of their values of importance and whether they use them to guide their behaviour and ii) how self is viewed ie. whether they hold a sense of personal agency and relate to their sense of self as dynamic, flexible and open to adaptation or alternatively see self as static, out of their control and unchangeable. Resilient nurses typically show a greater sense of agency. This insight supports Enzmann's (1996) research which stated that those with passive coping styles were more likely to be vulnerable to burnt out. Resilient nurses were also more aware of the aspects of themselves that can leave them feeling overly vulnerable in certain situations and job roles and what action is needed to maintain effective defences against difficult aspects of the job. They believe they have capacity to make change and are willing to do so, enabling adaptive behaviours to maintain resilience to work stressors and risk of burnout.

Findings suggested that the nurse who shows signs of vulnerability to burnout often suffer from low self-esteem. The importance of this in the burnout process was supported by a study by Pfennig and Husch (1994). My study also points to low self-esteem being linked to low professional self-efficacy, and a lower sense of agency which can create fear and resistance to change leaving them stuck in their roles and open to the ongoing damaging effects of stressors. Findings suggest the vulnerable nurse position suggests their sense of self is often wedded to their job role and when difficulties at work threaten their sense of self they can initially strive even harder to regain balance and maintain their job defined self-identity, before gradually becoming fully burnt out and letting go, expressing frustration about a loss of who they felt they used to be as a nurse. Garden's psychodynamic theory (1991) of a self-regulatory process may account for this aspect of the burnout process, whereby as the nurse's preferred personality function of being a 'feeling' type or 'emotionally-driven' as identified here, is threatened, in a quest to defend the attacked sense of self, the psyche attempts to re-balance by pulling on the opposite dormant sub-conscious function of being more 'thinking'/ task-focused or vice versa depending on the preferred personality orientation.

This category also draws attention to the importance of recognising internal motivational drivers, represented by nurses who orientate and recognise their core strengths as being either task-focussed or emotionally-driven. This insight has implications at the individual and group level. Whilst the ideal nursing style would and does comprise aspects of both, this may be rare, and diminishes as stress builds. There may be an argument to suggest senior managers recruit on the basis of core strengths, reflected in key skill sets, to ensure optimum functioning of the team. By reflecting a good balance of skill sets (if that is what is required for optimum functioning), greater guidance at the individual level about the nature of the job may also encourage greater job-person fit at recruitment stage. This theoretical development fits the theory identified by Maslach and Leiter (1997) which links the degree of fit between the person and different domains of their work environment and burnout risk, but builds on the theory by providing an explanatory framework which explains how individual factors can create this mismatch. It is also important to ensure that when nurses, recognised for their people skills are promoted to senior roles there is a greater need to support them with managerial training programmes which prepare them more effectively for their new job role which may have less of a natural job/person fit.

This finding regarding different nursing orientations is supported by Garden's psychodynamic theory (1991) already alluded to and goes further to suggest that each type of nurse may have different burnout trajectories, which was confirmed by trends that emerged in the quantitative phase of the study. This is also confirmation that burnout should be viewed as a continuous process in line with Corey and Corey (1998). This insight has two key implications: Firstly, the MBI could be used to identify the stage of burnout a nurse is at in order to develop more targeted interventions. This may result in cost savings and better long-term outcomes as interventions will be more effectively targeted to tackle the most pressing issue. Secondly, this insight has implications for nursing policy, as it raises the issue of how to integrate the move to more American based models of nursing which prioritises task-based efficiency outcomes, in a manner which does not alienate the workforce. This shift could inadvertently lead to higher levels of burnout, notably depersonalisation, the very thing the Francis report was trying to prevent. Perhaps there are more flexible ways of moving nursing in this direction, one which allows for greater acknowledgment of different styles and retains the nurse's sense of self and self-esteem derived from the job.

The insight which states resilient nurses have a higher developed sense of their values and typically rely on them to guide behaviour through difficult aspects of their work, adds to the small but growing body of work which suggests this represents psychological flexibility: The ability to be flexible and adapt behaviour and coping responses when values are compromised, evidence that having a highly developed sense of values carries a positive defensive function. This supports Acceptance and Commitment Therapy's theoretical model (ACT:Hayes et al, 1999) and provides further support to Lloyd et al's work (2013) which sought to understand how an ACT intervention program can be used to cut into the burnout process. It also provides further validation to Leiter and Maslach's model (1997) that explores the degree of fit between the job and person and suggests that *'the area of values may play a central mediating role for other areas'* (Maslach, Schaufeli & Leiter, 2001). This provides further confirmation ACT would provide a suitable model to help clients recognise and reconcile when they feel there is a mismatch between their values and those of the organisation they are working for, or even between the values the organisation promote and what occurs in practice. Of course this may necessitate work also being carried out at organisational level to recognise the conflict workers feel and to work together to create a set of values for the workforce and management that carries consonance for all. It is important that values that

have long been identified as core to the NHS be reflected upon and integrated at each stage of the nurses journey too, from informing recruitment to guiding the nurses and mentors behaviour and helping to create the optimum pervasive culture of communication. Ideally, NHS organisations should not only strive to apply these values to patients but to their staff alike. The key NHS values of relevance here are a sense of: 'Working together'; 'respect and dignity' and the recognition of different needs; 'commitment to quality of care' and one which also welcomes feedback from staff as well as patients; 'compassion' and feeling valued; 'improving lives' by improving the health and well-being of not only its patients and communities but also staff and holding at its core a sense that 'everyone counts' (NHS Choices, 2015). Counselling psychologists could prove to be the necessary advocates to bridge the gap here and ensure comprehensive integration of core NHS values at organisational and individual level.

The category: T*he comparative sense of self*, advocates the benefits of having strong senior members as effective role models and mentors. This is in line with social comparison theory (Buunk & Schaufeli, 1993), which suggests that if nurses are able to compare themselves in an upward direction this is a positive and holds an adaptive function in helping the nurse develop greater resilience. This study stresses the importance of supporting nurses in their mentoring roles and ensuring that if policy changes come into place in 2017, which may see larger trainee nurses entering the workforce, organisations put in place systems which can offer greater support to qualified nurses to ensure the increased need for mentoring does not add to the burden of their job roles and inadvertently lead to higher levels of burnout. This study also found evidence to support the downward comparison theory by Wills' (1991) and Buunk et al (2001b), whereby nurses more vulnerable to burnout can have higher levels of negative affect when comparing themselves to those above them and positive affect from downward comparisons, and yet this benefit may be temporary with the converse occurring long term. This study witnessed this in vulnerable nurses who typically judged themselves negatively against their seniors and had adopted a strategy whereby they found comfort from comparing themselves positively to those whom they were caring for, as a means to cope with the difficult impact of looking after terminally ill patients for instance. This study offers a theory to explain this process whereby this strategy is adopted as an avoidant strategy, a means to suppress or avoid difficult feelings but, evidence suggests this coping strategy is fragile and can back-fire particularly if a loved one becomes ill, negating the safety net of negative comparison.

Key findings to emerge from the category: *Awareness of the impact of nursing role and signs of burnout,* suggest that awareness of the consequences of burnout and strategies to manage it are low suggesting need to raise awareness of the signs, preventative and self-care strategies to avoid burnout and build resilience. Beyond this, the consequences of burnout were found to be extensive, as noted by Schaufeli and Enzmann (1998) suggesting the MBI may be too limited in scope in terms of what it measures. I would also suggest, in agreement with Pines and Aronson (1981), Shirom and Melamed (2005) and Kristenson et al (2005), a more comprehensive definition of emotional exhaustion should be incorporated in the definition of burnout which includes physical, cognitive and emotional depletion. Findings do however, exist which confirm the importance of all three dimensions of burnout and whilst I agree with Schaufeli (2003) that exhaustion and depersonalisation are the core elements of burnout, I suggest that reduced personal accomplishment is also a defining element of burnout, it proving useful in targeting those showing signs of being vulnerable to developing burnout before the process becomes too advanced and moves onto depersonalisation. I would ideally like to see an amended MBI being developed for the caring professions, one which carries a broader acknowledgement of what constitutes exhaustion and has less contentious, polarising items and which carries greater cross-cultural relevance. I would also like to see the personal accomplishment items re-phrased to imply negative attitudes for psychometric consistency, which would help analysis and encourage researchers not to dismiss it because they find it difficult to establish a correlation with the other two dimensions, which I suggest may purely be a statistical artefact, in line with Schaufeli and Taris (2007). In terms of definition, burnout's extension outside the remit of the caring professions, whilst unexplored by this study carries intuitive validity, so long as burnout is always used in relation to a work based context, or role that carries a large caring component. Extensions of the construct to include marital burnout (Pines, 1996) run the risk of diluting the construct so it lacks distinction, credibility and discriminate validity.

4.4.2 Category 2: The power of effective communication-interpersonal factors

This category, introduced the importance of interpersonal factors in the burnout process via *the power of effective communication*, it is important to note that the interpersonal aspect of burnout permeates across all categories.

This section illustrates how powerful effective communication can be in fostering resilience to burnout by influencing professional self-efficacy and sense of autonomy which can in part come from increasing confidence derived from experience, specialist training and specific communication courses. Evidence suggests that organisational moves to encourage higher levels of nurse specialism and improved communication skills is beneficial in terms of helping to produce a workforce that feels more confident and able to make autonomous decisions when need be. The role of professional self-efficacy and autonomy in the burnout process is supported by Cherniss' longitudinal work (1980,1990). He found those burnt out early in their careers, were able to grow in professional self-efficacy, through a flexible process of change and acquisition of new knowledge. This supports this studies focus on the importance of a sense of agency and adaptation. This study illustrates how growing in self-belief creates more effective communication with colleagues encouraging a sense of autonomy, all key ingredients to grow resilience. It also found evidence to suggest the benefits of the organisation encouraging ongoing staff training goes beyond improving expertise, communication and feelings of self-efficacy and helps leave the employees feeling appreciated. Work by Buunk and Schaufeli (1993), incorporating social exchange theory, provides insight into this process: Nurses suffer in particular because their caring work has high costs due to low levels of reciprocity. The organisation may need to play a key role in making up this deficit by ensuring staff in such unbalanced cost/benefit roles may need extra schemes and management styles which leave them feeling appreciated. Training, flexible working and secondments/sabbaticals were suggested as helpful in this way. However, this study picked up strain within the system whereby following the Francis Report there is pressure to ensure a compassionate workforce but austerity measures, efficiency drives and moves towards an American style of nursing mean nurses increasingly have to adopt practice which is more task driven. For nurses who prefer emotionally-driven nursing styles this can create pressure and additional stress, a factor which could raise vulnerability to burnout. It was also noted that courses which encourage empathic engagement styles such as the advanced communication course, whilst positive in creating more empathic nurses can leave nurses increasingly vulnerable if left without knowledge of how to manage the impact deep empathic engagement can bring. This may be particularly true for task-driven nurses who by shifting communication styles may move out of what was their protective comfort zone.

The study also noted the importance of recognising communication styles and how they differ according to nursing orientation. Very little research exists which explores this area, certainly in the context of counselling psychology. However, this study sheds light on the significance of communication styles fuelling the burnout process if they become too extreme an expression of any one type and if the dominant style in the leadership team is at odds with the majority of the team they are managing. The two types identified were open and sharing typically reflective of emotionally-driven nursing styles and private and stoic more commonly held by task-driven nursing styles. Recent work by Breevaart et al. (2014) alludes to the importance of leadership behaviour on burnout prevention. This study begins to shed light on how if the dominant communication style becomes one of defensive stoicism and denial of vulnerability these conditions can foster burnout whereas a communication culture which is neither one extreme or the other but recognises communication differences and has a degree of understated stoicism and is characterised by acceptance and collective management of vulnerability, nurses at both ends of the communication spectrum can be better supported and resilience to burnout fostered.

4.4.3 Category 3: The role of external drivers- external factors

This study confirms that contextual factors play a significant role in burnout development and can not be excluded from theoretical models seeking to explain it. Key factors include staffing levels, availability of resources, stability of teams, management/team and organisational styles of communication. This study supports the models by Cherniss (1980, 1995), Golembiewski et al, (1996) and Maslach and Leiter (1997) that seek to offer integrative models which acknowledge the importance of individual and organisational factors. Further discussion of these issues lead this thesis into the realms of occupational psychology. This is beyond this study's scope but it is crucial to recognise that counselling psychologists are perfectly placed to integrate the relevance of internal/external factors into our practice and the services we offer within a workplace setting. It is also crucial we recognise the relevance of these issues in our formulations if a comprehensive understanding of burnout is to be appreciated, and for therapy to target these issues where necessary, by considering the extension of our service to one of mediation and collaboration between management and staff, or where interpersonal conflict is a key stressor to explore and recognise the relevance of these issues when

working at the individual level. It is also important that counselling psychologists function at group/team level when signs of burnout become evident within a team to avoid burnout contagion and that we work closely with senior management teams to offer an integrated policy which can neutralise the potential for burnout to spread like a virus.

4.5 Implications for practice

This study has far reaching implications for nursing practice, selection, training and intervention development. Whilst psychologists typically function at an individual level, the multifaceted nature of burnout suggests that if our therapy works within a vacuum it is unlikely to have lasting effect. As, Milton (2010) suggests, counselling psychologists who work to further staff health and well-being are perfectly placed to begin to offer an integrative programme which seeks to have effect at the individual, interpersonal and organisational level. Research has also noted that whilst individual focused interventions have been dominant there is stronger empirical evidence to suggest that situational and organisational factors play a larger role in burnout (Maslach, Schuafeli & Leiter, 2001), suggesting these ought not be ignored when developing interventions and strategy to target burnout.

From an individual perspective, nurses from initial training and beyond should be encouraged to be more *reflective, insightful, and adaptable* as the core over-arching category states. Ideally nurses need to be encouraged to become more self-reflective in order to become more aware and insightful of what aspects of the job leaves them feeling overly vulnerable and to notice signs they are succumbing to the stresses of the job. Given that awareness of the signs of burnout are so low, awareness raising of these signs is a fundamental starting point for any intervention strategy. A range of tailored strategies should be explored to help nurses discover what they can do to prevent a breach in their constructive defences. Depending on how over-whelmed the nurse feels and at what stage in the burnout process they are deemed to be, flexible intervention programmes should be adopted. These may function on a one-to one basis if the nurse is showing high levels of burnout, or at group level if levels are felt to be moderate or if the primary need is to build greater resilience to burnout rather than reverse the effects of burnout.

A therapeutic approach which helps vulnerable nurses build their self-esteem and belief in their sense of agency is recommended. ACT (Hayes et al, 1999) provides a useful therapeutic approach in this context because it encourages a greater sense of being able to guide behaviour according to meaningful values thus building self-esteem, reclaiming agency and helping the nurse become more flexible, adaptable and able to live in the moment. Work by Lloyd et al (2013) attests to ACT's potential in this field, although more studies of its kind are needed. Whilst the NHS faces huge challenges and it may be increasingly difficult for nurses not to compromise their values, ACT can help ensure a realistic expression of values and defence of self despite the odds. Interestingly resilient nurses showed much greater capacity to be reflective of their thought processes and accept and recognise difficult emotions, evidence that ACT methods may be highly beneficial in this context. CBT has also been shown to be effective (Van der Klink et al, 2001) and could prove helpful and complementary in offering relaxation/anxiety management techniques, behavioural strategies and/or thought challenging techniques to address distorted thinking patterns, build self-esteem, encourage behavioural change in terms of becoming more boundaried and able to compartmentalise work. Help to build confidence to broaden networks and outlets outside work which can build a stronger sense of self which is less job dependent would also prove helpful. Practitioners should look for evidence that the vulnerable nurse has adopted avoidant strategies to manage difficult internal dialogue and/or seeks external cues of validation and emphasis should be placed on modifying these patterns.

At the organisational level, strategies that help to foster a greater sense of autonomy and professional self-efficacy would prove helpful. These can be in the form of on-going training to create a sense of feeling skilled, effective and more able to be assertive in communication. Consideration of secondments/sabbaticals to another department or time off as a means to help the vulnerable nurse reflect on the need for re-evaluation of coping strategies and foster the healing process as well as to make changes to reverse the burnout trajectory and prevent burnout contagion are worth considering.

The impact of findings in the sub-category C*omparative sense of self* for counselling psychologists lies in the role we can play when working in staff health and well-being services. We can help raise awareness of the need for senior staff members to act as positive role models to guide others in management of vulnerability and the difficult aspects of the job, this can be done through resilience workshops.

At the interpersonal level, counselling psychologists should also incorporate psychoeducation about effective and different communication styles, delivered at individual, group and management level. It is also important to help teams examine their dominant communication styles and shift extremes to become more able to accept communication differences and promote a position which produces a culture of understated stoicism, acceptance and collective management of vulnerability. It is also important to ensure the benefits of adopting this communication style is carefully communicated and varied means of support suggested to allow space for nurses with different communication styles to comfortably express concerns eg: Emotionally driven nurse may welcome psychological support off site/on site or open discussion of difficult cases/experiences in supervision/team debriefings but more task-driven, private types may resist this and prefer informal structures such as the fostering of regular, strong peer support. This should be encouraged particularly in large teams, evidence suggests that adopting strategies that foster informal peer support is positive, for example in large teams, collegial style structuring of the team to establish smaller peer support groups.

Because burnout is a multi-faceted process which involves the interplay of internal, interpersonal and external factors a systemic interactional based therapeutic approach may prove helpful if we are to have real, lasting effect. Whilst this model has its roots in family systems therapy it has the benefit of placing context at the heart of the therapeutic approach and has increasingly been shown to be relevant and helpful in addressing work-based systemic problems particularly within public and voluntary health and welfare agencies (Stratton, 2010). It is primarily concerned with shifting problematic interpersonal and interactional dynamics that shape and maintain psychological problems and helps to locate problematic feelings and behaviours in the context of the wider system by exploring these interactional patterns and dynamics (Heatherington et al, 2015). This approach not only helps the individual function more effectively within the system they inhabit but it can also help systems develop new patterns of interacting which allow for wider organisational growth and change. This would be particularly useful in teams/departments or the wider organisation where a defensive stoic culture of communication is characteristic, which can leave the nurse feeling isolated, unsupported and more vulnerable to burnout.

How burnout support is marketed is something worth considering. The recent shift in focus towards positive psychology and resilience building may provide a means to attract the more difficult to reach staff and go a long way to slowing

down the creeping advance of burnout from becoming a debilitating all pervasive consequence of austerity measures and cuts in the NHS.

4.6 Methodological and theoretical implications

The pragmatic epistemological position adopted allowed me to embrace the benefits of the postmodern paradigm shift reflected in the pluralistic position we hold as counselling psychologists. By adopting a mixed method approach, I was able to have confidence that I was exploring the burnout construct; identify trends in terms of the process of burnout development and explore the meaning of this more fully in the qualitative phase. As Slife and Gant (1999) suggest, mixing methods provided a greater level of illumination and perspective. The flexible and reactive nature of the adapted classical grounded theory approach I used allowed for the development of a theoretical framework which explained this phenomenon, challenged traditional process models and provided new insight into how the process may differ by preferred nursing orientation. As Glaser and Strauss (1967) predicted, grounded theory principles enabled me to move between data and theory development in an active, ongoing way encouraging the development of new theory. It also provided evidence to support the notion that burnout is a continuous process and one which challenges views that burnout is a dichotomous state. Whilst I appreciate this is useful if a cut-off needs to be established to access treatment or financial compensation, I would suggest that this may be counter-productive and bar development of strategies which seek to access and more effectively target burnout at earlier stages of development allowing a focus on resilience building rather than assuming burnout is inevitable and stepping in to treat the worst case scenarios. This position also avoids stigmatising nurses who are suffering burnout and by focussing on and promoting support as a means to encourage greater resilience and health and well-being, we will stand a better chance of increasing engagement with this issue by a wider cross-section of our nursing community.

Qualitative insight into the nature of burnout served to add weight to the perspective held by Kristenson (2007) and Demerouti et al.(2003) which suggests the dominance of the MBI may have served to limit and constrain our understanding of burnout. Ideally the MBI needs modification as discussed previously.

This study also showed me that Glaser's view that the researcher should not read any literature before they begin the research carries some advantages. Whilst

this purist position is unrealistically ideal, I can appreciate the benefits of limiting exposure to in-depth literature. I read a small quantity of literature to identify research gaps a good year before I went into field. It was interesting how I felt uncontaminated by previous theory by then. In not referencing the literature and only having basic knowledge of it, I found this process liberating analytically, it allowed me to feel connected and immersed in the uniqueness of my respondents experiences and I felt more likely to discover a unique aspect that hadn't previously emerged. I would advocate staying true to this principle as far as possible, although debate continues to rage about the pro's and cons of this issue, (see Field & Morse, 1985, McGhee et al. 2007, for discussion).

The method of recruiting both nurses showing vulnerability and resilience to burnout was particularly useful in helping to identify the significance of the process of adaptability. This was also helped by adopting a retrospective stance in the qualitative phase. I had considered adopting a narrative approach but, recognising that grounded theory would allow me to explore the process of burnout more effectively it was rejected.

4.7 Methodological strengths and limitations

A number of methodological strengths and limitations of the study are recognised. Firstly various strengths emerged: Use of a mixed methodology allowed me to gain insight into the resilient and vulnerable nurse's position. Although the MBI tool seemed frustratingly limited in some ways, it did serve the primary purpose of objectively identifying nurses at both ends and indeed various points along the burnout spectrum, and allowed observation of trends providing insight into how burnout developed, coupled with a qualitative approach this allowed me to gain insight into the complex and variable nature of burnout. One of the most valuable aspects of the study stems from representing the positive end of the burnout spectrum, and by exploring the burnout construct through a retrospective lens. As a result of this, I was able to understand the burnout processes by including nurses that emerged as resilient, I was able to gain insight into experiences earlier in their career which vividly described how they felt burnt out and the process by which they managed to pull themselves out of it, providing hope and confidence that even the most burnt out nurses can become resilient given the appropriate support. We need to recognise of course that arguably these accounts could have suffered from self-

reporting issues around memory, such as exaggerating or forgetting key aspects of the experience.

In terms of limitations, there were several. When anonymity and confidentiality were guaranteed, burnout rates were higher than if only confidentiality was guaranteed. This is not surprising but it did limit participation and the conclusions I could draw from the quantitative data, raising questions about statistical representativeness.

Due to ethical requirements stating that all communication should mention burnout (eg. on the participant information sheet and poster, see Appendix B and C), knowledge and sensitivity to the topic of burnout may have posed a barrier to participation particularly amongst those concerned about their levels of stress. I have also previously discussed reservations about the negative and pejorative wording of the depersonalisation scale, initially I did wonder whether low levels on this scale may reflect unwillingness to publicly and personally admit to the behaviour implied. However, qualitative probing reassured me that this was not an issue to be unduly concerned about.

It has been suggested that by recruiting participants who are currently working, this can contribute to a selection bias of the 'healthy worker effect' (McMichael, Spirtas & Kupper, 1974). If only employed professionals are represented this may result in under-representation of burnout levels, which may explain why low levels of burnout on all 3 dimensions was found. However, this study was interested in also exploring the whole burnout continuum, making this population particularly rich. It has been suggested by Cordes and Doherty (1993), that EE is the key dimension of burnout and can be indicative of early signs of burnout, Maslach et al. (2001), suggest it is the basic stress dimension of the syndrome. As such, despite this sample comprising primarily those in work, it has served to highlight stresses in the workforce. The Office of National Statistics produced a survey which showed that the healthy worker effect is less strong in non manual as opposed to manual workers (McMichael, 1976; Carpenter, 1987). However, ideally this study could have benefitted from representing nurses who have recently left the profession. Despite this fact, four of the nurses included in the burnout section of the qualitative sample had taken time off work/ cut hours or sought counselling support for stress related illness.

Whilst instructions encouraged staff to conduct the survey in their own time, on their own, there was no way to control for this, as such it is unclear whether

responses were influenced by others. However, given the nature of shift patterns and business on wards etc, this was considered highly unlikely to have adversely affected outcomes.

At the outset, it was hypothesized that participation rates would be low, which is why different departments were approached. In an ideal world it would be preferable to represent one department or field more comprehensively than was possible to ensure representativeness of the sample. However, by gaining a broader reach and keeping the criteria within high intensity nursing roles a degree of homogeneity was achieved. Because the primary role of the quantitative element of the study was to aid recruitment in the qualitative phase, sample size became less of an issue.

Whilst I identified different nursing orientations, it would have been helpful if I could have recruited more ITU [redacted] staff to fully explore the task-focussed nursing orientation. Whilst insight was gained, I was unable to reach theoretical saturation.

Whilst ideally I would have had greater representation of different ethnic groups, it was not possible to adequately represent this factor in the qualitative stage of the research, hence the role of ethnicity and different cultural attitudes to burnout or indeed the cross-cultural relevance of the burnout construct was not fully explored in this study. However, reference was made to beliefs about culturally different nursing styles and models of training making nurses trained in countries outside Europe more resilient to burnout. The role of ethnicity remains an area in need of closer examination in future research. It is also worth exploring and considering other ways to encourage greater engagement with the research process amongst ethnic groups who may be reluctant to take part, such as building relationships with individual nurse who can act as research advocates to aid recruitment.

4.8 Future research

The limitations discussed raise issues for future research. The potential for studies to offer mixed methods has been demonstrated by the study. All too often burnout studies are quantitative, and have relied on the MBI. Whilst in recent years research has also included longitudinal studies, many of these have not been able

to track the journey of the nurse and only review burnout status a year later. However, Maslach and Leiter's (1997) longitudinal research proved useful and the present study also illustrates how important it is to get a long-term perspective. Whilst a limitation of this study lies in the fact that it was a retrospective study and may suffer from participant bias, recall proved very powerful and detailed, leading to invaluable insight into the processes involved. I would advocate that it is in the interest of hospital trusts to carry out on-going longitudinal burnout research, tracking nurse burnout status from qualification and beyond, to gain more of an insight into key trigger points in a nurses career and to build in pre-emptive educational programmes from the point of training to support nurses in practicing well-being and preventative burnout strategies.

The findings strongly suggest that further research into the impact of leadership behaviours on the prevention and promotion of burnout is needed. This was also suggested by Breevart et al (2014). Although not chosen as a focus of this study, considerable insight was found which supports the importance of encouraging senior members of staff to place emphasis on their role model status to guide younger nurses in positive ways to manage and process the difficult aspects of their job.

Whilst this study sheds light on the psychological processes involved in the development of burnout and evidence was found to suggest that this varies by preferred nursing orientation, and potentially department, more studies need to be conducted to explore and evaluate the impact and incidence of different nurse orientations and whether the link with burnout trajectories can be verified statistically.

There is a need to continue the recent trend for research to explore the experience of nurses at the positive, opposite end of the burnout spectrum. Inclusion of these nurses proved to be one of the most valuable aspects of this study. It would be particularly advantageous to conduct further research specifically amongst nurses who have managed to reverse the burnout process away from burnout to one of resilience. This would again involve longitudinal research designs certainly in terms of measurement. It would also be advantageous to engage more nurses at the end point of burnout because historically burnout research has been carried out amongst those still in work, as such a whole swath of those suffering from the very syndrome that is being researched are missing from the literature. This study managed to include workers at various stages of the burnout process,

and whilst other researchers have accepted scores on just two dimensions of burnout I would argue that this is reflective of participants being 2/3^{rds} along the burnout spectrum. The single burnout respondent I managed to recruit qualitatively did indicate that they reflect a more complete and entrenched version of burnout than those only exhibiting vulnerability to burnout but this cohort is essential to understand, as it is hypothesised that many nurses may be burnt out but manage to stay under the radar or leave the profession.

4.9 A pause for reflexivity

4.9.1 Epistemological and methodological reflexivity

At the beginning of my journey to become a counselling psychologist, I had no idea how I was going to adapt to this role. Making the clinical leap has felt natural and the reason why I persisted, however, making the academic leap so long after leaving further education, seemed onerous initially but in reality it required a side-ways step given my background in research. My initial reluctance and nervousness to adopt a mixed method approach was unfounded largely. The flexibility of my grounded theory approach did not leave me feeling like everything had to be placed in neat boxes, in fact the opposite was the case. It helped provide form and clarity to a complex emerging picture. The quantitative use of the MBI proved useful and illuminating and added power to the need for engagement at policy level. This approach satisfied my deeply pragmatic need to produce research which is actionable and can bring about change. By adopting an amended version of grounded theory and rejecting Charmaz's social constructionist grounded theory approach, for reasons discussed earlier, I was able to carry through my critical realist position at every stage of this research process. I hope it helped to produce work which is not just considered a nice to know, but carries greater influence with policy makers and has real actionable benefits which are transferable to a wider audience that may enact change.

By engaging with these epistemological, ontological and methodological issues I feel I have matured as a commercial and psychological researcher and clinician. Through adopting a pragmatic epistemological position, I feel more able to appreciate the benefits of offering a pluralistic approach to respond realistically to market pressures to produce effective work which is evidence based and able to be

validated using techniques a wider audience will respond to. In future I hope I will be more open minded, informed and able to effectively engage with using quantitative techniques and tools to complement my natural orientation of preferring a qualitative quest for understanding and knowledge.

I'll continue to maintain Cornish and Gillespie's (2009) position when grappling with the frustrations and complications of working pluralistically. They suggest that by adopting a pragmatic epistemological view of knowledge, we provide a tool for action and continually ask the question '*does our knowledge serve our purposes?'* rather than grappling with whether our knowledge reflects one socially constructed moment in time and context or whether we are reflecting a reality that can only be perceived in one way. Pragmatism offers a helpful route through this dilemma, as was shown in this study, I adopted the position that burnout is a complex multifaceted phenomenon that varies by individual, context and a whole raft of other factors. However, we as counselling psychologists can through our research, find a path through this complexity and offer a guiding, informed hand which helps to redirect people back onto a healthier course of their journey. I hope I have shown that by avoiding becoming too wedded to one doctrine or another and trying to emulate what it means to be a counselling psychologist by adopting a flexible, creative and tailor made approach to our research and practice, we can reverse the contagious effects of burnout and help to create a workforce which is engaged positively with their work, producing individuals who are happier, healthier and more able to live the fulfilling lives they deserve.

4.9.2 Personal reflexivity

Conducting this study has had a profound effect on me both personally and professionally. Whilst I recognise I felt pretty close to burnout myself on several occasions during this process, I emerge from this process feeling better able to manage the effects of working in the caring professions to become a more resilient practitioner more able to guard against the threat of burnout. I feel I have grown in terms of how I view the world, I feel less blighted by black and white thinking and the need to ally myself vociferously to any one particular camp. I am more able to see that whilst we have predispositions and natural orientations this does not preclude change, movement and growth. I now more clearly understand why I chose to train as a counselling psychologist, and what this means in terms of what we have to offer the workplace: I feel better able to enjoy sitting comfortably amongst colleagues from different disciplines and appreciate what each of them

have to bring to the mix. Through exploring how nurses once suffering the effects of burnout now command a position of resilience, I have also found a way of embracing and managing my natural inclination to deeply identify, engage with and empathise with others and yet remain more resilient to effects this way of being and working can have. I now also feel more confident about being able to share the knowledge I have gained from this study to make a real difference. I think as a counselling psychologist we have to be the ones who can offer direction to help create a workforce which can be resilient enough not only to withstand the pressures faced today, but to thrive within our chosen professions, I hope I will also go on to experience for many years the benefits this quest for knowledge into the burnout process has brought.

4.10 Concluding comments

Whilst research into burnout is extensive, it has been overly dominated by quantitative research, produced conflicting findings and left many confused about how to clearly define and manage the insidious nature of burnout. This study has produced a model which can provide fresh insight into burnout, one which acknowledges the constructs usefulness and recognises the need to see burnout as a continuous process and a complex phenomenon with various internal, interpersonal and external factors influencing it. It states that whilst acknowledging each experience is unique and complex, we can recognise key aspects common across sufferers and we can offer informed advise as to how to develop interventions and policies which can help to reduce the incidence of burnout to build a workforce more resilient to the pressures faced today not just within the NHS but also beyond the caring professions. This study has enabled me to grow professionally and I hope to add impetus to the need to offer more informed support to tackle the threat burnout can have on our modern healthcare workforce if left ignored.

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Appendices

List of appendices

Appendix A: i) Ethics approval (City/[redacted]

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology,** prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc **D.Psych** [•] n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

The Nurses' Journey : How does the nurse develop burnout or build resilience to burnout

2. Name of student researcher (please include contact address and telephone number)

Nicola Dawson. Staff Psychological and Welfare services, [redacted]

3. Name of research supervisor

Professor Carla Willig

4. Is a research proposal appended to this ethics release form? **Yes**x
No

5. Does the research involve the use of human subjects/participants?**Yes**x
No

If yes,

a. Approximately how many are planned to be involved?

100-200 (Quant.)

b. How will you recruit them?

By promoting the benefits of the study to ward managers and asking if it would be possible for me to brief ward teams personally and ask nurses directly after their shifts or when on breaks if they'd like to take part. I will ask each quantitative participant if they are willing to be re-contacted and call them via phone or email them to recruit for the qualitative phase.

c. What are your recruitment criteria?

(*Please append your recruitment material/advertisement/flyer)*

Quant: All to be nurses working on high intensity wards eg.A+E, ITU, Maternity. Qualitative: 6 nurses suffering from Burnout identified by the MBI working on high intensity wards. 6 nurses showing healthy burnout profiles working on high intensity wards for 3+ years.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes
No x

d1. If yes, will signed parental/carer consent be obtained? Yes
No

d2. If yes, has a CRB check been obtained? Yes
No

(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification)*.

Quant: Each nurse will be asked to fill out the Maslach Burnout Inventory self-report questionnaire which takes 20mins- ½ hr. digitally on an IPAD. I will be present to provide a verbal briefing and contact no. if problems are encountered.

Qual: 12 nurses will be invited to attend an in-depth, semi-structured interview conducted by myself. Each interview will last 1 hour.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes x No

If yes,

a. Please detail the possible harm?

By carrying out the MBI participants may become more aware of the strain they are under at work and how this is affecting them, this may increase anxiety levels initially. However, debriefing materials will be provided for all outlining where to go for support if concerns are raised. Participants for whom the research raises any concerns personally will be advised to contact the Staff Psychological and Welfare Services at [redacted] where they will be offered confidential support, they will be advised that study outcomes remain confidential. The depth interviews will also prove supportive and helpful as an exploration of their own self-care strategies will be examined and evaluated as will comparative strategies used by other nurses.

b. How can this be justified?

A feature of burnout is that the individual can be unaware of the effects of burnout until they are showing negative signs of it. By taking part in the study, awareness will be raised and recognition that self-care/coping strategies can be employed to minimise symptoms will help management long-term.

c. What precautions are you taking to address the risks posed?

I'll be contactable by email or phone at [redacted] SPWS in the quant. Stage, to address any queries whether re. Practicalities or concerns the questionnaire raise. I will also suggest to those invited to take part in stage 2, that participation in the qual. Stage can prove supportive and helpful in managing the stress of the job. I will provide information outlining further resources for support with links to information about burnout and self-care. If participants have high scores and express concern I will suggest they contact the Staff

Psychological and Welfare Services, [redacted] where they can receive therapeutic support or attend regularly held stress management workshops.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes x

No

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes **No x**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Paper-led consent forms will be taken. Anonymised, electronic quantitative data will be collected for stage 1: the Maslach Burnout Inventory and automatically sent electronically to Cog research who will be hosting this survey, it will receive a unique identity code. Personal details will be taken manually and separately to the main MBI. Qualitative interviews will be recorded digitally and transferred to a password encrypted electronic devise and transcribed and printed onto paper, once transcribed and the study written up and Viva passed they will be deleted.

12. What provision will there be for the safe-keeping of these records?

Data from the MBI will be collected on an electronic devise, responses to this survey will be anonymised and given a unique identity. The Quantitative survey will be hosted with Cog Research, a member of The Market Research Society Company Partner Scheme, they meet all data security requirements laid out by the society. Cog Research are also registered with the Information Commissions Office and conform to their policies to uphold data privacy, they have been approved to work for several highly sensitive Government departments

such as HMRC and Dept. of Work and Pensions and several companies in the banking sector eg. Barclays Bank and AIMIA (Nectar loyalty cards).

All personal, contact details will be collected manually and held in a locked cabinet on [redacted] premises of the Staff Psychological and Welfare Services.

The Consent forms will be paper-led and held in a locked cabinet on [redacted] premises of Staff and Psychological Welfare Services.

Interviews will be digitally recorded and conducted so as not to elicit personally identifiable information, they will be assigned a unique ID and held on a password encrypted hard drive and held in a locked cabinet on researchers premises until transcription. Upon transcription any identifying features will be anonymised to protect identity but not skew meaning of the content, “a friend at work” rather than “Sarah at work”. Once transcribed and analysed, paper transcripts will be held in [redacted] locked premises along with other sensitive information and electronic copies of the interviews from the qualitative interviews will be deleted once the project is written up and Viva passed.

13. What will happen to the records at the end of the project?

Consent forms will be kept for 12 months in accordance with the requirements of City University London policy. The forms will be registered and stored with the record management system within the NHS Trust and securely destroyed using the Trust's Confidential Waste Management procedures.

All hard copies transcripts will be registered and stored within the record management system within the NHS Trust and stored for 7 years in accordance with the requirements of City University London and then securely destroyed using the Trust's Confidential Waste Management procedures.

Electronic copies of the interviews from the qualitative interviews will be deleted once the project is written up and Viva passed.

14. How will you protect the anonymity of the subjects/participants?

UK Data Archive recommendations will be adhered to.

Confidentiality of quantitative data:

The data set of the MBI will have no identifiers, this data set will be attributed a unique identity code only.

The additional demographic information will include age in years of respondent only, a code for the: Department they work on, how long they have been working on the ward and presence and type of significant negative life event experienced in recent years, this will be filled in by the researcher at time of interview.

The personal contact details will be taken as hard copies only, first names only taken and a mobile no. or an email address. This will be held in a locked cabinet on [redacted] premises of the Staff Psychological and Welfare Services.

Confidentiality of Qualitative data:

When anonymising qualitative material, such as transcribed interviews, if identifiers emerge no matter how subtle, they will be replaced by pseudonyms, replacement terms or vague descriptions rather than crudely removing altogether as this can distort the data or even make it unusable. Hence a good level of anonymisation will be achieved, avoiding unrealistic or overly harsh editing, whilst maintaining maximum content. The researcher will not collect disclosive or directly identifiable data, ie. full names will not be asked for.

Indirect identifiers in the qualitative data will be anonymised to prevent identification when linked to other publicly available information sources. Anonymisation will take place at the time of transcription. Researcher will create an anonymisation log of all replacements etc and store separately from the anonymised data files.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

I will provide information outlining further resources for support with links to info. re burnout and self-care. I will inform them of how they might most effectively utilize these resources. Participants with high scores will be made aware of the potential for self-referral to gain support from the Staff Psychological and Welfare Services at [redacted] It is hoped that a workshop will be developed and offered in the 6 months following cessation of the research.

They will also be advised that they can contact me or my field supervisor [redacted] with any further queries following the quant. phase. They can contact me to discuss their burnout scores and explore awareness of levels and effective strategies to address them if they wish.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher [redacted] ---------- Date [redacted]

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted ✓

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature ----[redacted]---------- Date-[redacted]

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature -[redacted]---- Date [redacted]

[redacted] NHS

NHS Foundation Trust

Joint Research Office

Office Location: [redacted]

Postal Address: [redacted]

Tel: [redacted]
Websites: [redacted]

FINAL R&D APPROVAL – NHS PERMISSION

15/08/2014

Chief Investigator: Professor Carla Willing

Dear Prof Willing,

Project ID: 14/0338 (Please quote in all correspondence)
REC Ref: PSYETH(UPTD) 13/14 56
UKCRN ID: N/A
Title: The nurses' journey: How does the nurse develop burnout or build resilience to burnout?

Thank you for registering the above study with the Joint Research Office [redacted] I am pleased to inform you that your study now has local R&D approval (NHS permission) to proceed and recruit participants at [redacted] NHS Foundation Trust, subject to the Sponsor's written 'green light' confirmation.

Please note that all documents received have been reviewed and this approval is granted on the basis of the key documents provided which have obtained a 'notice of favourable opinion' by the Research Ethics Committee (REC):

Document	Date
REC notice of favourable opinion and list of documents reviewed by the REC	20/05/2014
MHRA notice of acceptance letter(if applicable)	N/A
Agreement between sponsor and [redacted] if applicable)	N/A
ARSAC licence (if applicable)	N/A

As Principal Investigator you are required to ensure that your study is conducted in accordance with the requirements on the attached sheet. These include the conditions of your NHS permission.

Please note a summary of the study will be obtained from IRAS A6-1 for the [redacted] which is available to the public at [redacted]

Do not hesitate to contact a member of the team should you have any queries.

Yours sincerely,

[redacted]

[redacted]

Appendix A: ii) Ethical issues

Ethical consent

All participants were nurses currently employed by [redacted] Hospital Trust and capable of providing informed consent. All nurses were encouraged to read accompanying documents explaining the research, by providing consent this confirmed that they had read and understood what the research involved, that their participation was entirely voluntary and they could withdraw within the conditions laid out. All participants taking part in phase 1, excluding anonymous participants, were asked to check a box saying they were willing to take part in the second stage of the study. They were advised they had the right to review a summary of the research findings on request.

Risks

Participants were automatically provided with information regarding support services they could access if necessary (see Appendix E). Participants for whom the research raised any concerns personally were advised to contact the Staff Psychological and Welfare Services at [redacted] where they could access confidential support.

Participants were informed at the beginning of the study that the research explored job-related attitudes, the impact of stress and negative life events and how to develop resilience. Whilst it was acknowledged that Maslach and Jackson (1996) recommend not alerting participants to the fact that the survey is measuring burnout, due to varying beliefs about burnout, this was not possible due to NHS stipulations to be as open and transparent as possible. Hence participants were informed at the beginning of the study, by a title on the PIS/poster that the research explored 'the nurse's journey: How does the nurse become vulnerable or resilient to burnout'. It was decided that participants would not be informed of their burnout scores specifically unless they asked for them in which case I would inform them and provide scores confidentially and privately and would provide supporting information about how they can receive confidential support from the Staff Psychological and Welfare Service if their results concerned them.

Other forms of risks identified were:

- Distress
    - There was the possibility that participants may have become distressed during the interview. This was managed by ensuring participants were made aware they didn't need to disclose anything they felt uncomfortable about and could pause or stop the interview at any time. All participants were de-briefed following the interview and given material detailing where they could go for further support.
- Inconvenience
    - Inconvenience in terms of time needed to take part was managed by ensuring the online interview was short (8-10mins in total) and interviews (approx. 60 mins). The researcher was available to fit in with the nurse's schedule or need to re-arrange/cancel.
- Desire for confidentiality/anonymity
    - During the course of data collection it became apparent that much encouragement to take part was required. After consultation with key senior nursing personnel it was decided that the opportunity to take part anonymously would be welcomed, this was built in towards the end of phase 1. This didn't elicit a huge response but helped to boost numbers. Because approval was sought for ITU to take part during the latter phases of anonymous data collection, it was deemed ethical and necessary given timing constraints for this department to take part anonymously too, however, 2 participants took part confidentially and agreed to take part in the qualitative phase.
- Changes to lifestyle:
    - Engagement with the research issue may have led to the realisation that steps needed to be taken to make changes to lifestyle to manage effects of their job more.
    - Debriefing materials provide supportive information which helped participants make lifestyle changes.

Legal, Confidentiality

It was considered unlikely that any issue requiring consideration of limiting confidentiality would arise, however, the principles of the British Psychological Society (BPS) (and legal and professional obligations generally) were adhered to. The BPS (2014) guidelines are there to address the exceptional cases where there

is sufficient evidence to raise serious concerns about a) the safety of the participant; b) the safety of other persons who may be endangered by the client's behaviour; or c) the health, welfare or safety of children or vulnerable adults; or in response to legal obligations.

Participants were informed about the bounds of confidentiality. The researcher explained that all information wouldn't contain any identifiable content and remain anonymised and for the purposes of the research only. Participants who took part in the second stage of the research, ie. the qualitative interviews, were made aware that the interviews would be recorded and material stored in a secure environment. Interview transcripts had any identifiable content removed or changed to protect anonymity. Participant information was held under ethical and legal obligations of confidentiality and only basic demographic information such as age, referenced only as current age in years. Where participants provided their email and mobile numbers, these were stored separately from the signed consent forms, with a unique identity code and did not appear on the quantitative data set.

Multiple roles

The premise for this research was first considered whilst working as a trainee Counselling Psychologist in the Staff Psychological and Welfare Service offering counselling support for staff, if a previous client was approached and qualified for participation in the qualitative phase of the study, confidentiality regarding content raised in the course of counselling will be respected and left up to the discretion of the participant whether they feel any issues previously disclosed had relevance to this study and vice versa. The researcher was clear with two clients who qualified under this category that she was working in her capacity as a researcher and not a therapist and was careful not to overstep this boundary.

Appendix B: Recruitment poster

[redacted]
NHS Foundation Trust

CITY UNIVERSITY LONDON

NURSES NEEDED FOR RESEARCH INTO

The Nurse's journey: How does the nurse become vulnerable or resilient to burnout?

Have you ever wondered what personal characteristics, life events and coping strategies lead one nurse to cope more effectively with the pressure of work than another?

We are looking for volunteers to take part in a study exploring these issues.

Your participation would involve: filling out an online survey (5-10 minutes) and may involve being asked to attend a follow-up interview session with a researcher

You would be asked questions about:
How you feel about your work and how it impacts on you. If you are asked back for an interview you will be asked to share your journey as a nurse exploring the significance of different events, coping strategies and personal characteristics on your ability to cope.

For more information contact me at
[redacted]

Field Research Supervisor: [redacted]
This study has been reviewed and received ethical clearance from City University London. Ethics approval no: PSYETH(UPTD)13/1456

If you would like to complain about any aspect of the research please contact [redacted]

Appendix C: Participant Information Sheet

[redacted]

NHS Foundation Trust

CITY UNIVERSITY LONDON

City University London

Psychology Department
Service

Social Sciences Building

Whiskin Street

London, EC1V OHB

[redacted]

Staff Psychological and Welfare

[redacted]

Email:
[redacted]

Website:
[redacted]

PARTICIPANT INFORMATION SHEET: THE NURSES' JOURNEY: HOW DOES THE NURSE BECOME VULNERABLE OR RESILIENT TO BURNOUT?

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Thank you for interest in my project. You are being invited to take part in this research study exploring your journey as a nurse, exploring what factors influence how you cope with the demands of your job and how you build resilience. The project has two stages to it:

- The first stage involves answering a series of questions electronically exploring how you feel about your work now, how you feel your job affects you and whether you feel any significant, negative life events have had an impact on your ability to cope with the demands of your work.
- The second stage aims to explore your journey in more detail, examining the factors along the way which have influenced how you cope or sometimes struggle to cope with the pressures you face at work, it will also explore a range of strategies you or others have adopted which help to maintain well-being on this journey.

The study is being conducted by Nicola Dawson and will form the basis of my doctoral thesis in Counselling Psychology at City University London.

Why have I been invited?

You have been approached because you work in a high intensity ward and the pressures of the job can be particularly exhausting and challenging. It would be really valuable to learn from your experience in order to provide new insight to help others cope with the pressures

of the job and potentially to aid the development of new supportive programs which inform nurses about pressures the job places on them, the need to adopt coping and self-care strategies and how to do this effectively in order to ease this journey.

In the 1st stage of the project all nurses working in high intensity wards and cancer care will be invited to participate. In the second stage 12 nurses will be asked to carry out a follow-up interview, they will be invited because they represent a range of experiences in terms of how they feel about the impact of their work, negative life events, life-stage and number of years in nursing, in order to get a full range of experiences. These individuals will be chosen depending on results of the questionnaire and other demographic details including age, length of time in job, relevance of significant, negative life events.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. Even if you decide to take part you are still free to withdraw at any time leading up to the second stage of the project and without giving a reason, and within 1 week following the interview in the second stage of the research. You are of course free to let me know if questions are too personal and would prefer not to answer them.

What will happen if I take part? Will my information remain confidential?

If you take part in the first stage of the study, this will involve you filling out a short questionnaire online, in your own time, which should only take you 10 minutes maximum. If you are then asked to take part in the second stage this will involve attending an interview session conducted by myself, which will last 1 hour, we will have a conversation about the journey you have travelled as a nurse and what factors you feel have positively or adversely influenced how you cope and feel about your work.

Data obtained initially in phase 1 will not be directly attributable to you, it will be anonymised and saved on a secure server, hosted by Cog Research a reputable, research company: http://www.cogresearch.com/index.html. Data can only be accessed by myself via an FTP facility (File Transfer Protocol), this is used to provide secure transmission of anonymised data which protects the password, username and encrypts the content. The data may also be sent to me as an encrypted excel file (password protection) and saved on a password protected external hard-drive for the purposes of analysis and stored in its own locked cabinet. On completion of the research and Viva all original data will be securely destroyed and only descriptive analysis tables saved.

In the second stage sessions will be digitally recorded for the purposes of the study only, any identifiable personal information will be anonymised and not divulged. Contact details will be asked for separately in phase 1 and only accessed by the researcher in order to make contact with you if you are invited to take part in the second stage of the study. This information will be securely stored in a locked cabinet and kept confidential.

The 1st stage of the research will take place in your own time and the 2nd stage at the Staff Psychological and Welfare Services, [redacted]

What are the possible disadvantages and risks of taking part? The study may raise concerns for you about your work and how you are coping. If you find you are worried by the impact your work is having on you or the issues raised by the study raises safeguarding issues, with your permission you will be guided to additional support and resources regarding self-care offered by The Staff Psychological and Welfare Services, [redacted]

What are the possible benefits of taking part?

Many research participants find participation in studies of this kind can help towards creating a better work environment and encourage the provision of better support. It can also prove helpful in thinking through how you are coping. The first stage of the study can help you become more aware of the impact of your work and whether or not you feel the need to seek support or make adjustments in your life. The second stage of the study also has the added benefit of raising awareness of the impact of negative life events, effective self-care and coping strategies and help you to remain more resilient.

What will happen to the results of the research study?

The information you provide will be analysed and written up in an anonymised form. This will form part of a research project. The results may be presented at conferences or within the University faculty and may be published in a scientific journal so they are available to other researchers. Data will be kept securely for 7 years in accordance with good research practice. Following this it will be destroyed.

Will I get to see the research?

Yes if you would like to receive a copy of the summary of the final report let the researcher know at the time of the interview and we will email or send a copy in the post.

Who has reviewed the study?

This study has been approved to proceed by the [redacted] Joint Research Office (14/0338) and has received ethical approval by City University London, Psychology Department, Research Ethics Committee, approval number [PSYETH(UPTD)13/14 56].

Further information and contact details

If you have further questions about the study, please contact Nicola Dawson:

Nicola Dawson, Trainee Counselling Psychologist, City University London, Email: [redacted]

(Further contacts if necessary are : The field supervisor, [redacted] the Academic Supervisor Professor Carla Willig, City University London, [redacted] Tel. [redacted])

What if there is a problem?

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is:

The Nurses' journey: How does the nurse become vulnerable or resilient to burnout?

You could also write to the Secretary at:
[redacted] ,Secretary to Senate Research Ethics Committee,Research Office, E214, City University London,Northampton Square,London,EC1V OHB.
Email: [redacted]
Study no: PSYETH(UPTD)13/14 56

Thank you for taking the time to read this information sheet.

Appendix D: Consent Form

[redacted]

NHS Foundation Trust

CITY UNIVERSITY LONDON

City University London
Psychology Department
Social Sciences Building
City University
Whiskin Street
London, EC1V OHB

[redacted]

Email: [redacted]

Website: [redacted]

Centre: [redacted]

Study and City University London, ethics approval number: PSYETH(UPTD)13/14 56

Participant Identification Number for this study: ……

CONSENT FORM

Title of Project: **The Nurses' journey: How does the nurse become vulnerable or resilient to burnout?**

Name of Researcher: **Nicola Dawson**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **[DATE:]** version **[VERSION:]** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and I am free to withdraw at any time leading up to the second stage of research, and if I take part in stage 2, within 1 week following the interview in the second stage of the research without giving a reason. ☐
3. I agree to take part in the above study.
4. I do not agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature

Tel/M:_____ email:_____ (In case of recall for stage 2)

Appendix E: Debrief information

[redacted]

NHS Foundation Trust

CITY UNIVERSITY LONDON

City University London

Psychology Department
Service

Social Sciences Building

Whiskin Street
House

London, EC1V OHB

[redacted]

Email: [redacted]

Website: [redacted]

Debrief Material

PERSONAL SUPPORT

- Self-referral to Staff Psychological and Welfare Services, [redacted] for one-to one psychological support:
  - Staff Psychological and Welfare Service [redacted]
- Self-referral stress management workshops are held by Staff Psychological and Welfare Service, [redacted]
- You can also talk to your GP if you are worried about your health.

SELF CARE RESOURCES

- Book and meditation CD rom: Mindfulness: A practical guide to finding peace in a frantic world – Mark Williams & Danny Penman.
- Website to find a local mindfulness course: bemindful.co.uk
- Meditation Apps: 'Take a deep breath' (google/ Apple App. Store)
- [redacted], NHS Sport and social club. [redacted]
- Local leisure centres for Yoga/dance/exercise classes.

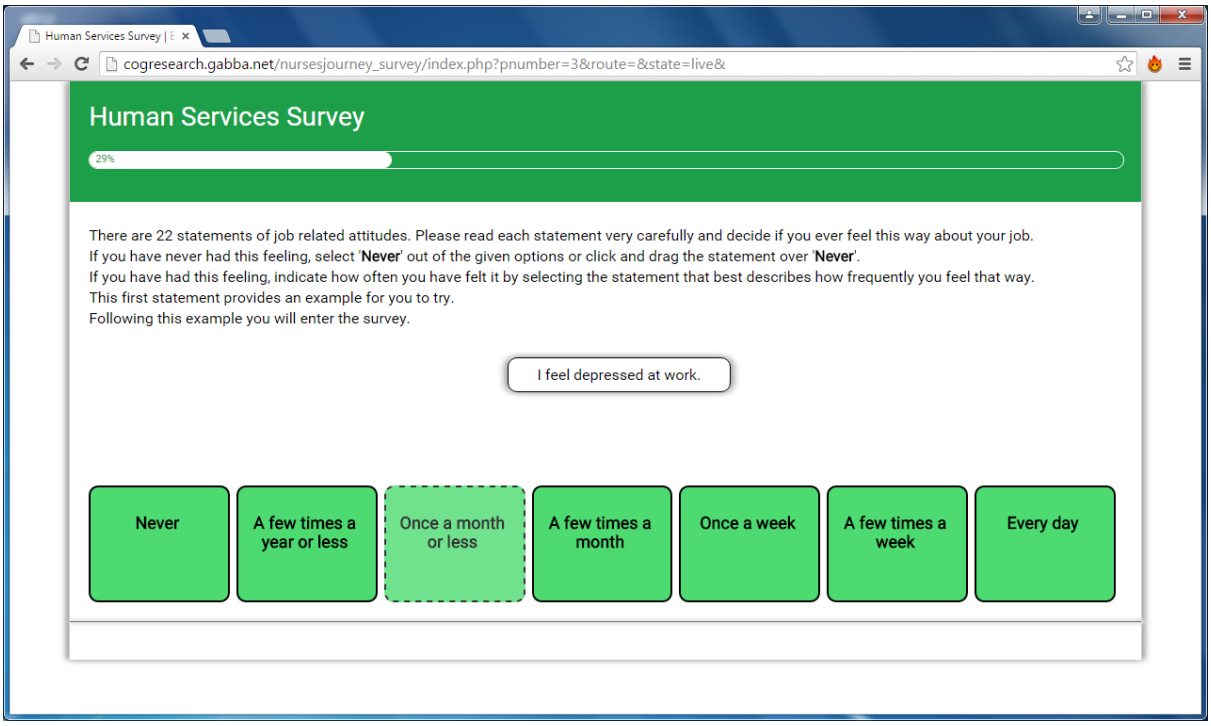
Please contact the researcher with any further questions or feedback raised from taking part in the study. Nicola Dawson [redacted] Thankyou for your participation.

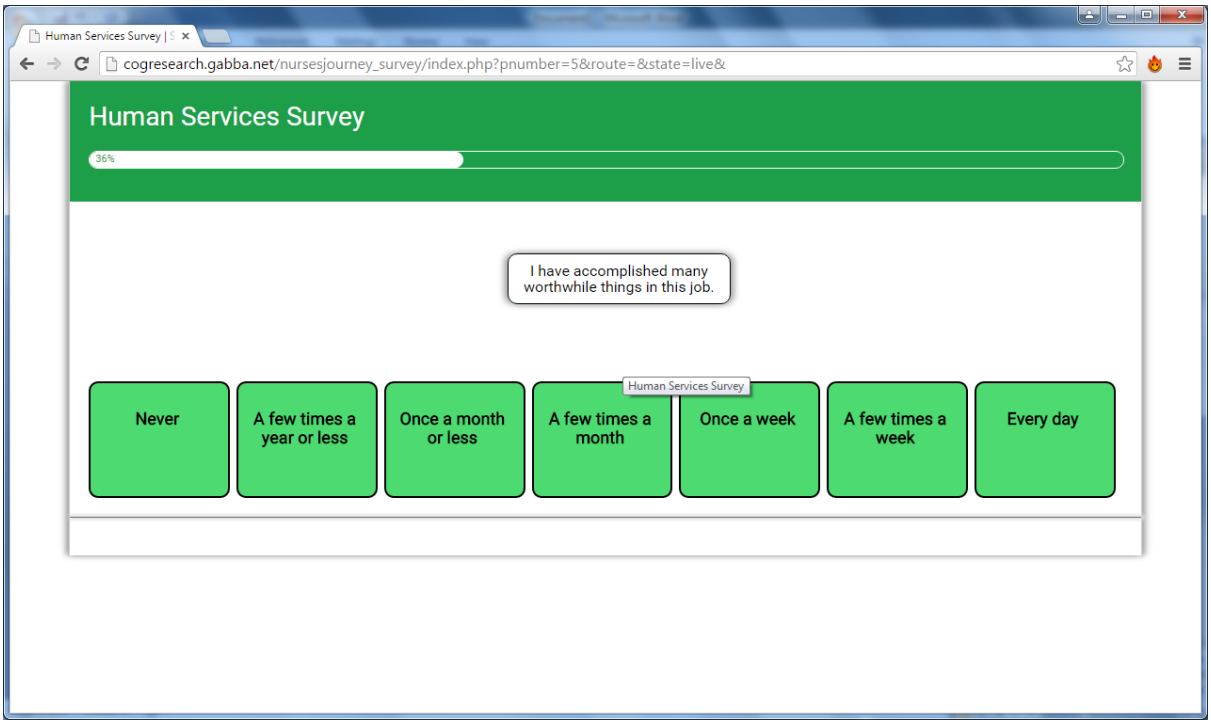
What if there is a problem?

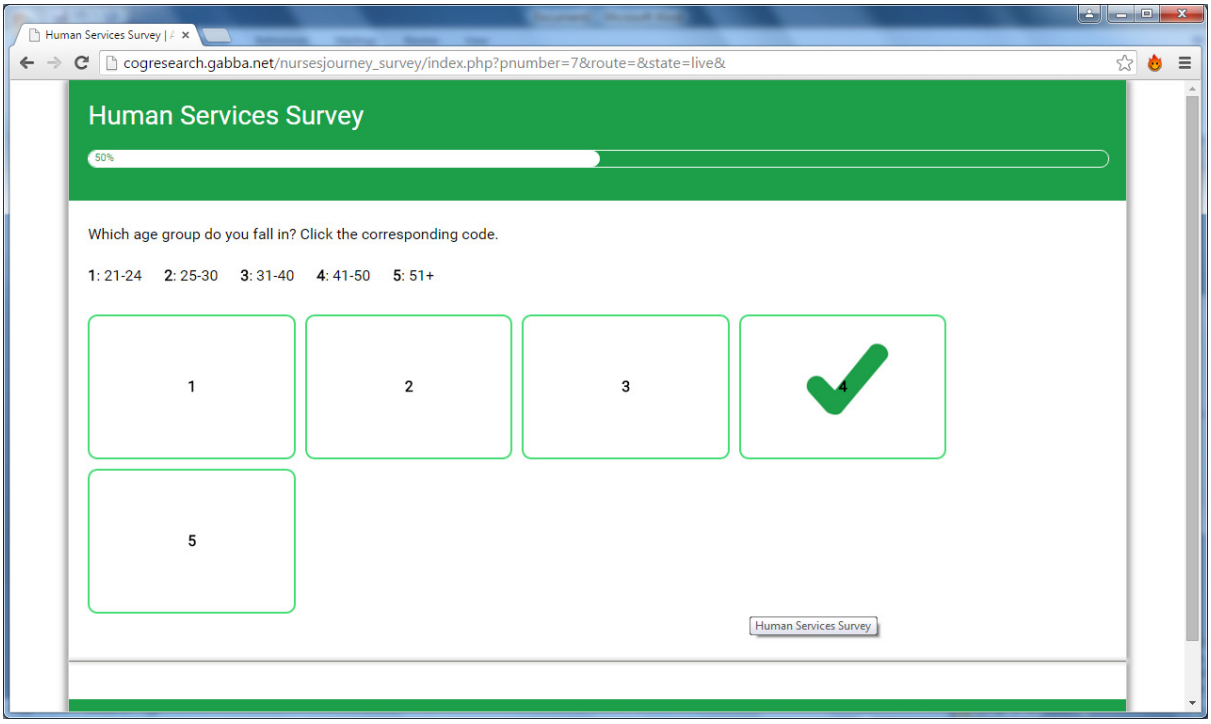
If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is:
The Nurses' journey: How does the nurse become vulnerable or resilient to burnout?
You could also write to the Secretary at:
[redacted] ,Secretary to Senate Research Ethics Committee, Research Office, E214, City University London, Northampton Square,London,EC1V OHB.
Email:[redacted]
Study No: PSYETH(UPTD)13/14 56

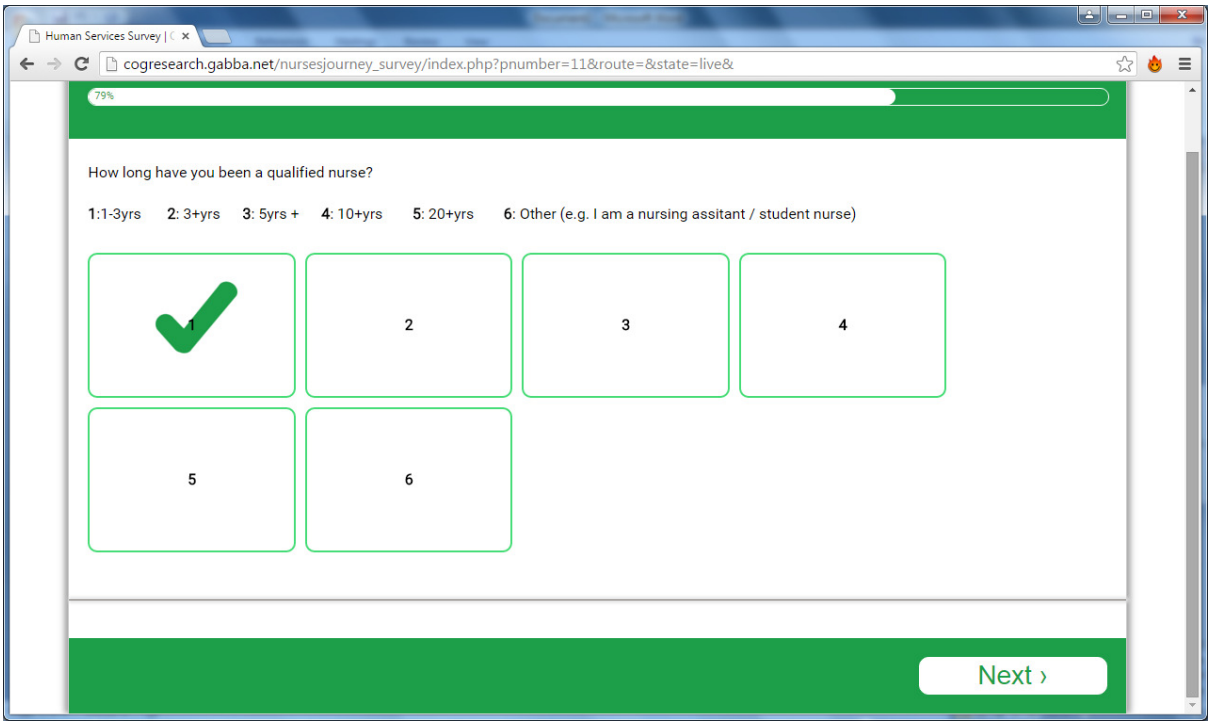
Appendix F: Online Survey

The following provides an example of the content of the online survey and a review of the content of the survey (Nb. The full MBI is not provided due to copyright restrictions)






Human Services Survey | A
cogresearch.gabba.net/nursesjourney_survey/index.php?pnumber=7&route=&state=live&
Human Services Survey
50%
Which age group do you fall in? Click the corresponding code.
1: 21-24 2: 25-30 3: 31-40 4: 41-50 5: 51+
1
2
3
4
5
Human Services Survey


Human Services Survey | C
cogresearch.gabba.net/nursesjourney_survey/index.php?pnumber=11&route=&state=live&
79%
How long have you been a qualified nurse?
1:1-3yrs 2: 3+yrs 3: 5yrs + 4: 10+yrs 5: 20+yrs 6: Other (e.g. I am a nursing assitant / student nurse)
1
2
3
4
5
6
Next ›

[redacted] NHS

NHS Foundation Trust

CITY UNIVERSITY LONDON

Participant Questionnaire

Follow the link to experience the survey:

http://cogresearch.gabba.net/nursesjourney_survey/?state=preview

Sample of Maslach Burnout Inventory and additional demographic information

There are 22 statements of job related attitudes. Please read each statement very carefully and decide if you ever feel this way about your job.
If you have never had this feeling, tick 0 out of the given digits alongside each statement.
If you have had this feeling, indicate how often you have felt it by circling the number (from 1-6) that best describes how frequently you feel that way. An example is shown below.

How often:

0	**1**	**2**	**3**	**4**	**5**	**6**
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Everyday

*Statement **How often** (0-6)*
I feel depressed at work: *0 1 2 3 4 5 6*

(circle)

1. I feel emotionally drained from my work.	0 1 2 3 4 5 6
2. I feel used up at the end of the workday.	0 1 2 3 4 5 6
7. I deal very effectively with the problems of my recipients	0 1 2 3 4 5 6
8. I feel burned out from my work.	0 1 2 3 4 5 6
9. I feel I am positively influencing other people's lives through my work.	0 1 2 3 4 5 6
10. I have become more callous towards people since I took this job.	0 1 2 3 4 5 6
11. I worry that this job is hardening me emotionally.	0 1 2 3 4 5 6

What gender are you:
:___(Coded)_____

Age in years only
:___(Coded)_____

Can you describe your ethinicty:
____(Uncoded)_____

How long have you been a qualified nurse?
____(Coded)_____

Which department do you work in
:_____(Coded)_____

How long have you worked in this department:
___(Coded)_____

Have you experienced any significant , negative life events : YES NO (circle)

- What was this?:
  __(Uncoded)_____

- When was this?
  ___(Coded)_____

Did you notice it affected how you felt at work? YES NO (circle)

What is your current cohabitation /relationship status?

___(Coded)_____

Appendix G: Early quantitative trends to emerge

Incidence of burnout by department

Burnout total: 53% of total sample	**CC**	**MITU/SITU** [redacted]	**ITU**
Burnout on 3 dimensions	1	2	**3**
Burnout on 2 dimensions	12	3	**6**
Burnout on 1 dimensions	16	2	8

Burnout patterns to emerge

The following table shows the burnout trends to emerge. Coding relates to high, medium or low scores on each dimension of the MBI, ie. Emotional exhaustion (EE), Depersonalisation (Dp), Personal Accomplishment (PA) always referenced in this order.

Burnout on all three dimensions: High EE, High Dp, Low PA = HHL

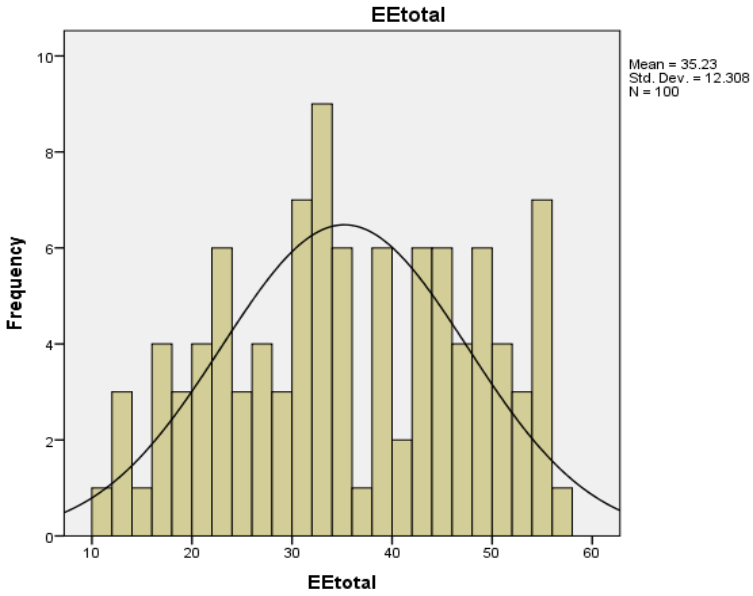
Following patterns emerged:

	HHL	**HHM**	**HLM**	**HLH**	**HLL**	**HHH**	**HML**	**HMM**	**HMH**
CC	1	2	**4**	**7**	3	4	3	3	3
MITU/SITU	2	2	0	1	1	0	0	0	1
ITU	3	2	1	2	2	0	1	2	4

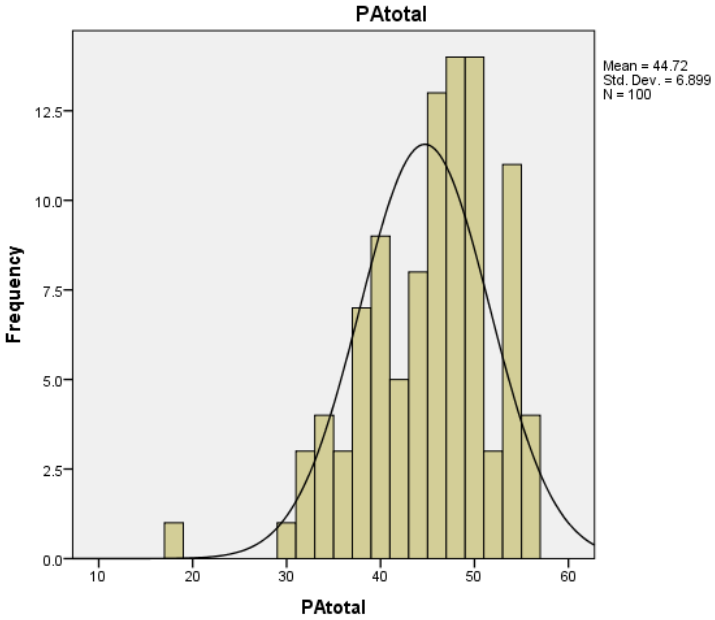
NB. high levels of EE, coupled with low levels of Dp/ high PA were more common in CC, reasons for this trend were explored in qualitative phase and theory formulated

Appendix H : Frequency distributions

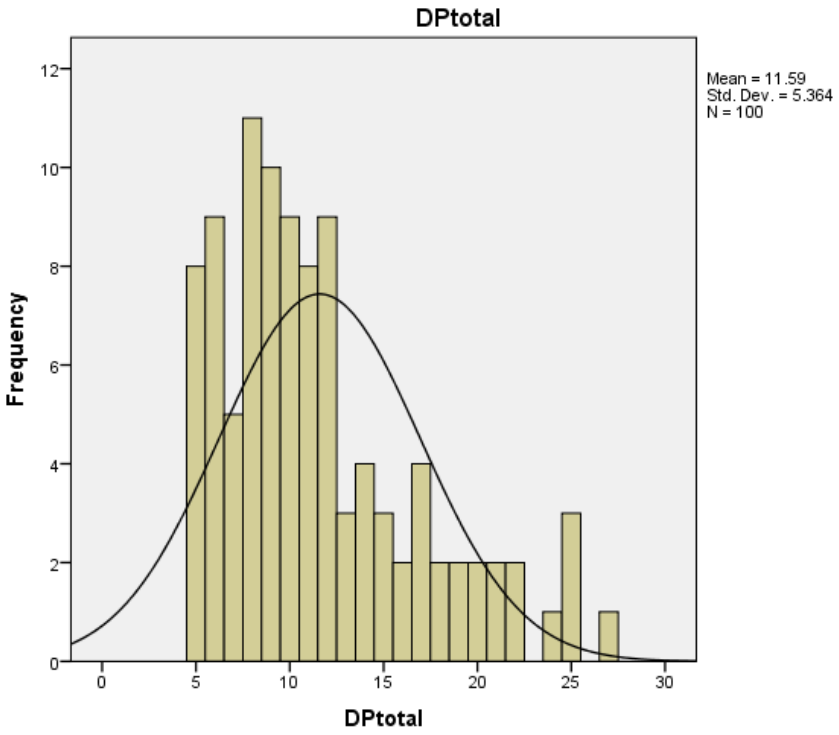
The distribution of scores on each of the three subscales in the MBI are presented in histograms below. The frequency distribution for EE was normal:



Frequency distribution for PA showed a negative skew.



Frequency distribution for Dp showed a positive skew.


DPtotal
Mean = 11.59
Std. Dev. = 5.364
N = 100
Frequency
DPtotal
0
2
4
6
8
10
12
0
5
10
15
20
25
30

Appendix I: 2 tailed Anova

2 tailed Anova to test significance of difference between the means in the 3 departments:

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
EEtotal * Department	Between Groups	(Combined)	931.989	2	465.995	3.214	.045
	Within Groups		14065.721	97	145.007		
	Total		14997.710	99			
PAtotal * Department	Between Groups	(Combined)	89.740	2	44.870	.942	.394
	Within Groups		4622.420	97	47.654		
	Total		4712.160	99			
DPtotal * Department	Between Groups	(Combined)	15.083	2	7.542	.258	.773
	Within Groups		2833.107	97	29.207		
	Total		2848.190	99			

Appendix J: Independent *t* test

Independent *t* test to test significance of difference between EE in MITU/SITU versus CC and ITU

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
EEtotal	Equal variances assumed	.964	.330	2.316	73	.023	7.382	3.188	1.029	13.736
	Equal variances not assumed			2.392	49.012	.021	7.382	3.086	1.180	13.584

Appendix K: SPSS means full report

Report

Department		EEtotal	PAtotal	DPtotal
Cancer services	Mean	37.22	45.65	11.29
	N	51	51	51
	Std. Deviation	13.223	6.779	5.360
	Median	38.00	47.00	10.00
	Grouped Median	37.33	47.14	10.18
	Std. Error of Mean	1.852	.949	.751
	Sum	1898	2328	576
	Minimum	12	29	5
	Maximum	56	55	27
	Range	44	26	22
	First	30	31	11
	Last	33	47	12
	Variance	174.853	45.953	28.732
	Kurtosis	-1.157	-.565	1.355
	Std. Error of Kurtosis	.656	.656	.656
	Skewness	-.303	-.477	1.272
	Std. Error of Skewness	.333	.333	.333
	Harmonic Mean	31.32	44.55	9.34
	Geometric Mean	34.46	45.12	10.24
	% of Total Sum	53.9%	52.1%	49.7%
	% of Total N	51.0%	51.0%	51.0%
MITU / SITU at NHNN	Mean	29.83	43.83	11.54
	N	24	24	24
	Std. Deviation	12.096	7.545	5.949
	Median	26.50	45.00	10.00
	Grouped Median	26.67	45.50	10.20
	Std. Error of Mean	2.469	1.540	1.214
	Sum	716	1052	277
	Minimum	11	18	5
	Maximum	54	53	25
	Range	43	35	20
	First	49	39	25
	Last	31	45	12
	Variance	146.319	56.928	35.389
	Kurtosis	-.669	5.134	.275
	Std. Error of Kurtosis	.918	.918	.918
	Skewness	.417	-1.918	1.080
	Std. Error of Skewness	.472	.472	.472
	Harmonic Mean	24.89	41.75	9.25
	Geometric Mean	27.39	42.98	10.28
	% of Total Sum	20.3%	23.5%	23.9%
	% of Total N	24.0%	24.0%	24.0%
ITU	Mean	36.36	43.68	12.24
	N	25	25	25
	Std. Deviation	9.032	6.505	4.927
	Median	35.00	45.00	12.00
	Grouped Median	35.00	44.67	11.33
	Std. Error of Mean	1.806	1.301	.985
	Sum	909	1092	306
	Minimum	21	32	5
	Maximum	55	55	22
	Range	34	23	17
	First	45	41	18
	Last	43	50	12
	Variance	81.573	42.310	24.273
	Kurtosis	-.617	-.886	-.972
	Std. Error of Kurtosis	.902	.902	.902
	Skewness	-.032	-.180	.464
	Std. Error of Skewness	.464	.464	.464
	Harmonic Mean	34.02	42.70	10.42
	Geometric Mean	35.22	43.20	11.30
	% of Total Sum	25.8%	24.4%	26.4%
	% of Total N	25.0%	25.0%	25.0%
Total	Mean	35.23	44.72	11.59
	N	100	100	100
	Std. Deviation	12.308	6.899	5.364
	Median	34.00	45.00	10.00
	Grouped Median	34.17	45.62	10.29
	Std. Error of Mean	1.231	.690	.536
	Sum	3523	4472	1159
	Minimum	11	18	5
	Maximum	56	55	27
	Range	45	37	22
	First	30	31	11
	Last	43	50	12
	Variance	151.492	47.598	28.770
	Kurtosis	-1.046	1.106	.393
	Std. Error of Kurtosis	.478	.478	.478
	Skewness	-.098	-.812	1.014
	Std. Error of Skewness	.241	.241	.241
	Harmonic Mean	30.05	43.39	9.56
	Geometric Mean	32.79	44.11	10.50
	% of Total Sum	100.0%	100.0%	100.0%
	% of Total N	100.0%	100.0%	100.0%

Appendix L: Qualitative interview schedule

1) Introduction

- Exploring journey as a nurse and how you find you cope with the pressures of the job and how this may have changed over time
- Discuss MBI findings at the end if wish

2) The journey

- Set the frame as a journey to be explored (use timeline as guide)
- When did you decide to become a nurse
    - Why chose nursing as a profession
    - Describing self what qualities do you have
        - Why is nursing a good fit with you
    - Are there any key personality traits you recognise which fit nursing
        - Anything about self which feel helps or hinders resilience/vulnerability levels
- Describe your career path
- When 1st entered profession, how did you feel about the job
    - (PA)What did you love about the job
        - What did you find difficult about the job back then
    - (EE) What emotional/physical strain did it have on you
        - How did you cope then
    - (DP)How did you find working with patients, what did you get from this aspect of the job

3) Demands of the job, today

- For each has it changed now, how, why
    - *(PA)* Best bits about the job/ worst bits of job
    - *(EE)* Emotional strain of the job, how does this effect you
    - *(Dp)*Have you noticed a change in how you feel towards your patients, how,why
- How does being a nurse takes it's toll on you, describe the impact on you
    - Has this changed over time, how, do you handle things differently now vs past
- How do you feel when dealing with difficult situations at work, how are you left feeling at end of difficult shift

    - How have you changed in terms of how you feel the pressure or manage it
- How does working in *high intensity wards* vs other wards compare
    - What do you get out of working in this department
    - Do you notice it takes more or less of a toll on you vs other wards, how

4) Influencing factors on vulnerability and resilience to burnout

- What factors influence how vulnerable or resilient to stresses of job you feel
    - Spontaneous generation, rank in terms of importance
- Prompt for influence of following on vulnerability/resilience to the pressures of nursing
    - Personal factors
    - Work based factors eg. work load, management, organisational pressures
    - Cognitive processing ie. How you think/process difficult situations/cases (find self taking cases home, ruminating, worrying or do you process/rationalise/ leave behind difficult situations on a daily basis)
    - Health issues
- Noticed any areas feel struggle in comparison to others eg.leaving behind difficult cases, coming down from high adrenaline situation etc
- Has influence of factors changed over time, how, what is the impact now, what's changed
- Have you learnt to handle stress of job differently, how, why

5) Self-care strategies

- Do you know of effective ways to manage the demands of the job effectively
- Any behaviours, activities, strategies engage in which help care for self and help you cope
        - How are they effective, what level do they help you
        - How important are they to you,
- Provide examples of difficult days and what you've done to manage your stress
    - Physical, Emotional strategies, Cognitive, Social, Professional, Negative coping mechanisms

- Any other colleagues particularly resilient/vulnerable to the job, how, why, what's different?
- What support do you get in managing the demands of the job
    - Would you like any additional support, what

6) Negative life events: Key stages/ events impact on vulnerability/ resilience (*personal loss)*

    - Home life demands at different times on journey
    - Key life changes
- How changed in terms of impact of the job or managing your job following these events
    - How are you different now vs how did you manage to remain unaffected
    - Did it change how you feel about your work or your patients, how, why
    - Did it change how you found you were coping with your job
        - At what point did you notice changes
        - Were you able to manage these effects, did you know what to do to cope more effectively
- How do strategies compare to those of other nurses you know, what can you learn from them

7) Concluding thoughts

- Brainstorm self-care, support, strategies that'd be helpful
    - physical/emotional/organisational/social/spiritual
    - Does this differ by life-stage etc, how, why
    - Explore tried and tested self-care, support strategies (debriefing, meeting friends, exercise, relaxation activities)
        - Fit with context work and life
        - Fit with individual
- Has perception of self and your qualities changed over time?, how why
- Your future in 5 years as seen by the nurse
- How did you find answering some of the survey questions, did anything surprise you?

Appendix M: Qualitative sample specification

10 nurses all with high levels of emotional exhaustion were represented. (NB. high levels of emotional exhaustion considered to be indicative of early sign of burnout). Beyond this:

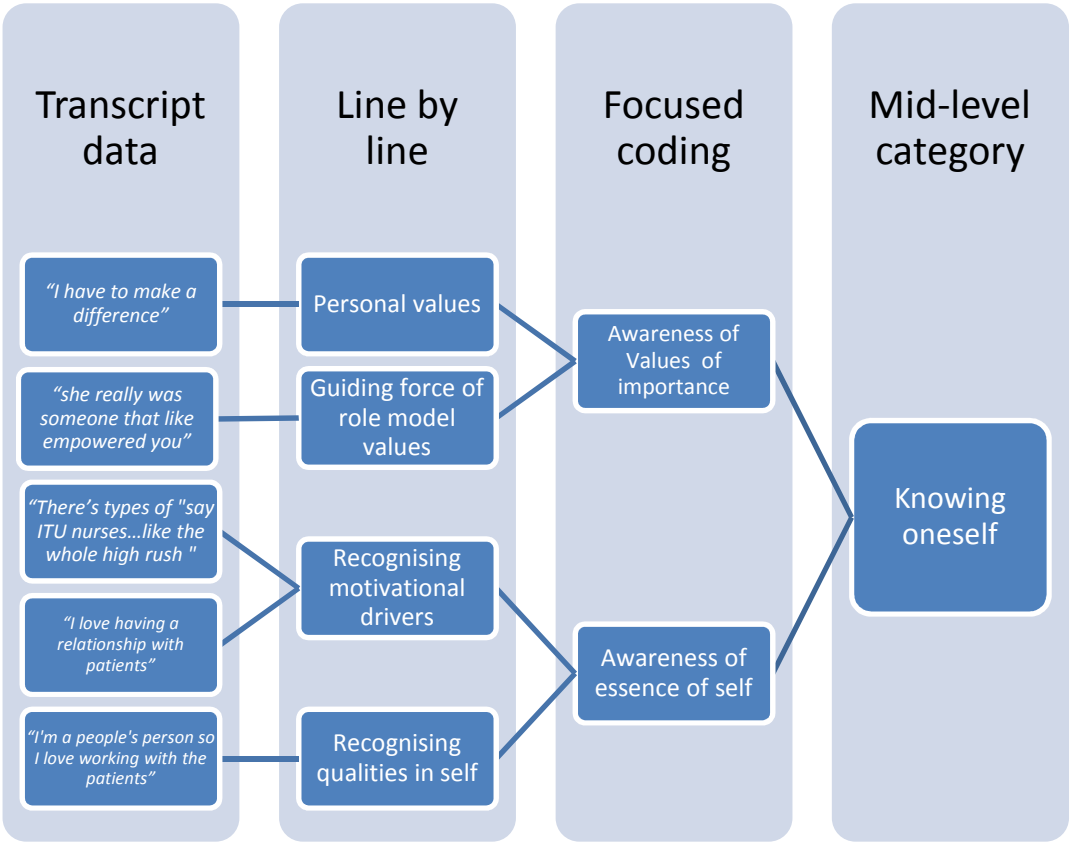
- 1 nurse interviewed showed burnout on all three scales
- 6 other nurses showed signs of burnout on 2 dimensions (2 nurses, high EE, high Dp, 4 nurses high EE, low PA both indicative of burnout)
- 3 nurses high levels on EE only, but interestingly showed high levels of PA
- 2 nurses had been in the high intensity role for 1-3yrs, 3 for 3yrs+, 3 for 5yrs+, 1 for 10yrs +, 1 for 20yrs+

- 6 nurses falling at the resilient end of the spectrum were interviewed (ie. low score on EE and DP, high on PA on MBI), of these:

    - 5 showed signs of resilience on all three scales, (NB. two were on the boundary of resilience on one dimension)
    - 1 reported signs of resilience on two scales and moderate levels of personal accomplishment
    - NB. 1 had been in a high intensity role for 1-3yrs, 1 for 5+ years, 4 for 10+, as such scores were felt to be reflective of resilience rather than because they had only recently entered this field of work

Appendix N: Example of qualitative analysis

i) Development of a mid-level category



ii) Example of memo

Emerging significance of values-led behaviour as a mechanism to guard against burnout: mid process

Self-awareness doesn't just stem from ability to know what like/dislike, awareness of values can act as a guiding force not only in relation to career choice /specialism orientate to but also in context of managing the difficult aspects of job. Had two interviews now whereby resilient and experienced nurses have learnt to hold onto guiding principle that matter to them in how they go about their work and how they process the impact of loss of patients.

I've noticed the nurses showing signs of burnout have less capacity to do this, they seem less aware of their values, less able to articulate them at least, but also less able to allow them to guide them, they seem more preoccupied with what they did wrong, or how others perceived them, less able to compartmentalise the incidents and move on and more inclination to add to their bank of evidence to support negative self-perceptions or frustrations in the system.

ACT model highlights importance of values driven behaviour.

Later in journey compromise on values can be significant precursor to reduction in PA link to category 'Reflection, insight, adaptability'

Suggestion ACT as a model may be effective model in treatment/prevention of burnout, work around raising awareness of values and benefit of values-driven behaviour **.** Sign that differences exist between V & R nurses in how developed this sense is. R have high levels of awareness and insight into what values of importance and necessary to hold on to. V less aware

Section B: Client case study

.....

Beyond the signs of burnout: Reversing obsessive compulsive tendencies

.....

Section C: Publishable Paper

.....

How does the nurse become vulnerable or resilient to burnout?

.....

Nicola Dawson: Formatted according to author guidelines of *Applied Nursing Research*

How does a nurse become vulnerable or resilient to burnout?[4]

Nicola Dawson. *Department of Psychology, City University London, Northampton Square, London, EC1V OHB, United Kingdom*

Abstract

This research adopts a mixed methods approach, with qualitative focus, to retrospectively explore how the high intensity nurse becomes vulnerable or resilient to burnout. 100 intensive care/cancer care nurses completed an online survey measuring burnout levels, using the MBI. 53% showed burnout on at least 1 dimension of the MBI (EE)[5]. 16 nurses were interviewed qualitatively: 10 showed various degrees of burnout and 6 showed resilience to burnout. Findings suggest burnout is a continuous, multi-faceted process involving a complex interplay of *internal/interpersonal/external* factors, with the inherent preference for task-focused or emotionally-driven nursing orientations variably influencing burnout development. A key mediating factor in resilience/vulnerability lies in how *reflective, insightful and adaptable* a nurse is. Findings suggest far reaching implications for selection, training policy, nursing practice and intervention development which functions at individual/interpersonal and organisational level.

Keywords: Burnout - Vulnerable - Resilient - High Intensity Nurse - Mixed methods

1. Introduction

Nurses in the UK currently face significant challenges: Austerity measures and efficiency drives have led to NHS trusts being forced to cut frontline staff and training places, whilst an ageing population has also increased demand

[4] To be submitted to Applied Nursing Research (Impact factor = 0.73)

Corresponding author: Nicola Dawson, E-mail: nicola.dawson.1@city.ac.uk. Address: Department of Psychology, City University London, Northampton Square, London,EC1V 0HB, United Kingdom

[5] EE is the emotional exhaustion dimension of the MBI, considered the most important dimension in burnout