

RESOLVING OCCUPATIONAL BURNOUT:  
EXPLORING FACTORS IN PERSONAL RECOVERY THROUGH AN ENHANCED  
CRITICAL INCIDENT TECHNIQUE

by

Sarah Woolgar

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, a thesis/dissertation entitled:

Resolving occupational burnout: Exploring factors in personal recovery through an enhanced critical incident technique

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**Examining Committee:**

Dr. Norman Amundson, Counselling Psychology

Supervisor

Dr. Ishu Ishiyama, Counselling Psychology

Supervisory Committee Member

Dr. Rhea Owens, Education, Health, and Behaviour, University of North Dakota

Supervisory Committee Member

## ABSTRACT

Occupational burnout is used to describe working individuals who feel emotionally exhausted, have developed negative perceptions about the people they work with and their work environment, experience detachment from their surroundings, and feel reduced accomplishment at work (Bährer-Kohler, 2013; Maslach, 1993). This qualitative research aims to understand the factors that have helped, hindered, or were wished for by adults who have suffered from moderate to severe occupational burnout and feel that they have since recovered in the past three years.

All participants were first screened for retrospectively moderate to high occupational burnout symptoms using the Maslach Burnout Inventory- General Survey (MBI-GS; Maslach, Jackson, & Leiter, 1996). Following this assessment semi-structured interviews were conducted with twelve participants using a format consistent with the Enhanced Critical Incident technique. The analysis of categories focused on helpful and hindering incidents. There was also a consideration of what would have been helpful for participants.

In the helping category of critical incidents, support, empowerment, meaning making, better work-life balance, and hope captured the broad themes. In the hindering category of critical incidents, difficulty transitioning, systemic concerns, a lack of time away from work, and a lack of resources made recovery more difficult. Participants endorsed some wish list items including better access to professional help, the workplace appropriately addressing burnout, greater support from the workplace and colleagues, and more time for rest.

## LAY SUMMARY

Occupational burnout is a common condition where working people find themselves emotionally exhausted, cynical about their work, and less effective than when they started.

This thesis explores the factors that helped or hindered people's ability to recover from occupational burnout and the factors they wished they could have had during their recovery.

There were several broad factors that helped: support from others, feeling empowered, making time for rest and hobbies, making meaning out of their burnout and life, having a better balance between work and life, and feeling hopeful. Participants felt hindered by societal and workplace ideas of work, a lack of time away from work, a lack of resources, and transitioning to a new workplace or way of being. Participants also created a wish list of factors they felt may have been helpful like increased professional support, better support and understanding from their workplace, and more time to rest.

## **PREFACE**

This thesis is an original, unpublished, independent product of the author, Sarah Woolgar, who completed all work, including research design, participant recruitment, data collection, analysis, and manuscript write-up.

This research received ethics approval from the University of British Columbia's Behavioural Research Ethics Board (BREB). The certificate number of ethics certification obtained for this study under BREB was H18-01844 under the title "Resolving occupational burnout: Exploring factors in personal recovery through an enhanced critical incident technique".

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generally always know the best thing to say. This work would have been impossible without you and that is what you help me with: you make the impossible possible.

## **DEDICATION**

I would like to dedicate this work to my participants and others who have experienced occupational burnout. I hope that this research brings you hope that recovery is possible.

## **Chapter One: Introduction**

### **1.1 Statement of the Problem**

In the field of counselling psychology, we have access to a great deal of research on the process of becoming burned out from work and what that feels like to individual people. What we do not have is a body of research discussing what is involved in recovering from occupational burnout. Occupational burnout is a construct used to describe working professionals who feel emotionally exhausted, have developed negative perceptions about the people they work with and their work environment, experience detachment from their surroundings, and feel reduced accomplishment at work (Bährer-Kohler, 2013; Maslach, 1993). Occupational burnout affects many people across all adult demographics (Carod-Artal & Vazquez-Cabrera, 2013). This research aims to understand some of the factors in the recovery from occupational burnout

Recovery, as a process, instead of an endpoint, is common in research on mental illness (Repper & Perkins, 2003). This thesis will focus on personal recovery, wherein the individual is the arbiter of deciding where they exist in a recovery journey rather than a dichotomous clinical outcome (Slade, 2009). This research asks participants who consider themselves recovered from burnout what factors were useful to their recovery, what factors were not useful, and what factors participants wished that had when in the process of recovery from occupational burnout. This research endeavours to fill a current gap in existing research as well as aid clinicians and researchers in establishing programming for helping clientele with occupational burnout.

### **1.2 Background**

**Occupational Burnout.** Occupational burnout is a multidimensional syndrome, as it occurs due to an environmental interaction with a person and it can affect multiple facets of a person (Muheim, 2014). A key part of burnout is its direct relation to the person's ability to manage prolonged, high levels of stress within a working or caregiving environment. Schaufeli, Leiter, and Maslach (2008) characterize a primary risk of burnout as a continual situation wherein demands of the position outweigh the ability of the person to fulfill those demands. This overload increases the likelihood that the person will experience emotional exhaustion, physical exhaustion, and become depersonalized (Aydemir & Icelli, 2013). This becomes especially difficult if the person at risk has a role which is ambiguous in responsibilities and they feel that they do not have tools necessary to make decisions related to their role.

Burnout is more likely when structural issues are present within an organization so while causes may be partially external, there is an internal process occurring within the person who is becoming burned out (Arman, Hammarqvist, & Rehnsfeldt, 2011; Aydemir & Icelli, 2013; Ekstedt & Fagerberg, 2005; Pines, 1993; Gustafsson, Norberg, & Strandberg, 2008). Pines (1993) calls burnout the "high cost of high achievement" (pg. 37) because the success the person receives from work has a high level of meaning to them. A person facing burnout tries to handle the demands of their position and their abilities to fulfill those demands. Simultaneously, there is an inner process which tries to address identity and meaning in life, which becomes solely attached to the work environment (Arman et al., 2011; Ekstedt & Fagerberg, 2005). A more existential theory of burnout is that it occurs when that inner process is repeatedly thwarted for the advancement of outer demands. A person who is becoming burned out must continuously ignore their personal wants, needs, and desires to

fulfill those of their work (Ekstedt & Fagerberg, 2005). The evaluation of importance of family and friends also declines and produces interpersonal difficulties as a person becomes burned out (Hakanen & Bakker, 2017). Interestingly, research suggests that unlike depression, interpersonal relations within the workplace do not suffer in the same manner (Bährer-Kohler, 2013). Additionally, it is common to see burnout coincide with depression and various physical illnesses (Ahola & Hakanen, 2014). While occupational burnout is not in the DSM-V as a mental disorder, there are many similarities between depression and burnout and a somewhat reciprocal relationship between the two constructs (Ahola et al., 2005; Ahola & Hakanen, 2007). Burnout often predicts depressive symptoms, whereas depression only partially predicts occupational burnout.

Previous studies have shown that certain groups become more susceptible to cardiovascular and musculoskeletal disorders, as well as sleep disturbances (Ahola & Hakanen, 2014; Constantino, de Souza, de Assis, & Correia, 2013; Kim, Ji, & Kao, 2011). There are also economic and business repercussions to burnout, including employees missing work, either through paid or unpaid leave, or leaving positions completely. Social work, as a field, has high turnover rates which is directly related to employee burnout (Kim et al., 2011). With physicians, occupational burnout can lead to reduced clinician hours and early retirement. A recent study suggests that this costs Canadian provincial health care systems between \$168.2 million to \$252.4 million (Dewa, Jacobs, Thanh, & Loong, 2014). Overall, occupational burnout is a process that can have lasting repercussions psychologically, emotionally, and physically, as well as career and economic domains.

**Recovery.** There are two common conceptualizations about recovery from a mental illness. The first is clinical recovery (Slade, 2009). Clinical recovery is a dichotomous,

observable outcome, as rated by a clinician, within a set of guidelines not bound by individual factors. Succinctly, a clinician decides whether one has recovered from an illness and does not assume that an individual is cured or relieved of pathology but rather that it is within a defined state of remission. A second, more humanistic approach is personal recovery (Bonney & Stickley, 2008; Slade, 2009). While there is no agreed upon definition of what personal recovery means, there have been numerous studies that have thematic similarities. First, personal recovery from mental illness is viewed as a journey, not an outcome as conceptualized in clinical recovery (Slade, 2009). This also means that personal recovery is individualistic and each person is capable and culpable for determining what it means to recover from an illness. It also denotes that recovery is not a linear process, but morphs according to context, needs, and abilities of the person recovering (Corrigan & Ralph, 2005; Repper & Perkins, 2003). Some researchers consider clinical recovery to be a subset of personal recovery, wherein it is evidence that makes personal recovery more likely (Slade, 2009).

A meta-analysis of 97 papers from 13 different countries showed that the common themes for personal recovery from mental illnesses existed within five broad categories: connectedness to others, hope and optimism for the future, identity, meaning in life, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Psychological well-being is the hallmark of personal recovery (Corrigan & Ralph, 2005; Slade, 2009). Therefore, focus of personal recovery is on how functional a person feels and how meaningful they feel their life is. A person is more likely to consider that they are recovering if they feel that they live with meaning, comfort, and validation, regardless of whether they still experience symptoms or not (Corrigan & Ralph, 2005). Empowerment is necessary; when a person

experiences a mental illness, they must feel that they have the autonomy to make changes that they feel would be most beneficial.

### **1.3 Rationale for the Study**

Currently, only a small amount of literature exists on recovery from occupational burnout with most literature focusing on the prevention of burnout (Kim et al., 2011; Walter, Plaumann, & Krugman, 2013). Most literature focuses on the process of becoming burned out, prevention of, or specific programming to alleviate the symptoms of burnout and does not examine personal recovery from burnout (Hetland, Sandal, & Johnsen, 2007; Gustafsson et al., 2008; Nullalong, 2013). Consequently, two preeminent researchers within the field of occupational burnout have noted the lack of literature surrounding recovery from severe burnout (Hakanen & Bakker, 2017). This study intends to fill a qualitative gap in the literature exploring personal recovery from occupational burnout.

An overarching review of current literature exploring burnout recovery focuses on the effects of particular programming or personal factors that aided with recovery (Drybye, et al, 2010; Salimen, Andreou, Holma, Pekkonen, & Mäkikangas, 2017; Salimen, Mäkikangas, Häätinen, Kinnunen, & Pekkonen, 2015). A notable but older study looked at personal coping with work stress, which included burnout, from a qualitative perspective (Bernier, 1998). Grounded theory methodology created a six-stage process to reflect recovery in the participants. A common thread through these studies is the emphasis placed on personal agency, self-awareness, and social support. This study also intends to complement literature on the personal experiences of the process of becoming burned out, which could be conceived as the antithesis to recovery (Arman et al., 2011; Ekstedt & Fagerberg, 2005; Gustafsson et al., 2008). As personal recovery emphasizes well-being, resilience, and



personal growth, an exploration into recovery from burnout would aid in infusing positive psychological constructs into the field (Garrosa & Moreno-Jiménez, 2013; Slade, 2009).

Research into occupational burnout and recovery from it may be necessary from a clinical perspective as well. Occupational burnout is common and many clinicians will encounter clients experiencing it; moreover, occupational burnout is common in helping professions such as psychology, social work, and nursing (Walter et al., 2013). Clinicians may find that if knowledge of what attributes contribute to successful personal and clinical recovery are available, they may be more competent in aiding their clients through recovery. This could include an approach that honours personal recovery in tandem with clinical recovery.

#### **1.4 Aim of the Study**

In this thesis, enhanced critical incident technique (ECIT; Butterfield, Borgen, Maglio, & Amundson, 2009) provides a framework to discover the experiences of participants who feel that they have successfully recovered from burnout. As there is little data on personal recovery from occupational burnout, ECIT is ideal for the exploration of this topic. Using semi-structured interviews until exhaustion is reached between participant-defined themes, this method can elucidate factors in recovery (Butterfield, 2009). This method complements the construct of personal recovery (Slade, 2009) as it utilizes participants for credibility checks, thus carrying the theme of participants as empowered experts of their experience.

#### **1.5 Conclusion**

Occupational burnout affects many individuals globally and is marked by depersonalization, emotional exhaustion, and reduced personal accomplishment (Schaufeli,

Leiter, & Maslach, 2009). Often, it is conceived of a position wherein an employee may find their work personally important, however, the demands of their position far outweigh their ability to fulfill them in a sustained and long-term manner (Ekstedt & Fagerberg, 2005). This decimates an inner process that sustains identity and fulfillment of personal wants, needs, and wishes. Burnout has implications in mental and physical health as well, including comorbid depression and cardiovascular issues (Ahola & Hakanen, 2014). Understanding how individuals heal from occupational burnout, from a personal recovery perspective, may aid in reducing a well-known literature gap in the field (Hakanen & Bakker, 2017; Slade, 2009). It may also lead to future research to increase resources available to individuals, clinicians, and researchers in the treatment of occupational burnout.

## Chapter 2: Review of the Literature

### 2.1 Introduction to Occupational Burnout

Occupational burnout, as originally characterized by Freudenberger (1975), is a construct used to describe working professionals who feel emotionally exhausted, have developed negative perceptions about the people they work with and their work environment, experience detachment from their surroundings, and feel reduced accomplishment in their work (Maslach, 1993; Schaufeli, Lieter, & Maslach, 2009). Burnout is a multidimensional syndrome, as it occurs due to an interaction between individual factors and that individual's environment (Muheim, 2014). A key part of burnout, which differs from work stress, is how it is directly related to the person's ability to manage prolonged, high levels of stress within a working environment. As a person becomes more burned out, they struggle to meet the demands of the environment and may begin to limit their personal needs to meet the needs of their occupation.

Originally, burnout was defined through human-services occupations, such as nursing, social work, and mental health work (Schaufeli et al., 2009). Both Maslach and Freudenberger conceptualized burnout separately but virtually simultaneously (Muheim, 2014). Earlier in its conceptualization, burnout was conceived as mostly a physical malady, however, in the last two decades, more work has acknowledged the psychological toll (Schaufeli et al., 2009). Burnout can exist within environments beyond work; caregiving and education are common environments where burnout is often experienced (Schaufeli et al., 2009). For the sake of brevity, this thesis will focus on occupational burnout.

## 2.2 Symptoms of Occupational Burnout

**Physical.** The most comprehensive information for burnout correlated with physical illness comes from the Finnish Health 2000 study, which was representative of Finland's population over 30 years old (Ahola & Hanaken, 2014). Physical illness was more common for individuals and the higher the score on the Maslach Burnout Inventory- General Survey (MBI-GS; Maslach, Jackson, & Leiter, 1996), the higher the prevalence of physical illness. Of employed women who scored in the high range of the MBI-GS, musculoskeletal disorders were very common (47%; Ahola & Hakanen, 2014); people with mild burnout 36% and those without burnout had a 28 % prevalence. Musculoskeletal pain was noted to occur primarily in the neck and back. Employed men commonly experienced cardiovascular disease, including 28% with severe burnout scores and 20% with mild burnout compared to 14% of the general population.

A longitudinal study following social workers (n= 406) for three years showed a strong relationship between physical disease and burnout, especially when participants fell within the moderate to high burnout range as specified by the MBI-GS (Kim, Ji, & Kao, 2011). A similar relationship was shown between cardiovascular and musculoskeletal disorders as seen in Ahola and Hakanen (2014; Kim, Ji, & Kao, 2011). A positive correlation was present between burnout and gastrointestinal disorders, headaches, and respiratory infections (Kim, Ji, & Kao, 2011). These physical health problems, when reported within the initial assessment, were still present and worsened a year later. Social workers who scored higher on burnout in the initial assessment also reported worsening of physical health during the first year.

People with burnout state that they battle constant fatigue and decreased immunity (Constantino et al., 2013). As with the theoretical process models, fatigue is more common at first in non-workplace environments, such as returning home from work and finding that there is no energy to do anything productive. While Kim et al., (2011) found that there was not a significant relationship in their population of social workers, many people who experience burnout also struggle with disordered sleep (Constantino et al., 2013). This may be common among people who experience anxiety due to work stress.

**Psychological.** A common factor in cases of burnout is depression (Ahola & Hakanen, 2014). Not only are some indications of burnout being similar to depression, such as lack of meaning in life or fatigue, but burnout often predicts the occurrence of a future depressive episode. The exhaustion dimension of the MBI-GS correlates highly with depression inventories (Ahola & Hakanen, 2014). A distinction between burnout and depression disorders is that depression can occur in any context, whereas burnout is specific to work-type situations. However, burnout symptoms often coalesce into all aspects of daily life when a person is exposed to prolonged exposure to work stress. Certain researchers see burnout as a form of depression (Hallsten, 1993).

Ahola and Hakanen (2007) propose that through regression analysis of a longitudinal study, burnout predicted depressive symptoms when participants were faced with job strain. However, when regression was performed on depressive symptoms, depression was only partly responsible for burnout from job strain. A similar study with teachers suggested that teachers who scored highly on burnout still felt that they could be potentially successful in the classroom, whereas teachers who had depression did not see potential success (Ahola & Hakanen, 2007). This suggests that although the relationship between burnout and depression

is somewhat reciprocal, burnout is a far greater predictor of future depression. This relationship will be discussed further a section below regarding burnout and its connection to mental illness.

**Emotional.** Emotional exhaustion is one of the key symptoms of burnout (Nuallaong, 2014; Maslach, 1993). The emotional presentation of a person who is burned out may be dulled or disengaged (Nuallaong, 2014). When an individual scores within the severe burnout range of the MBI-GS, it is likely that their emotional systems overlap greatly with the emotional presentation of depression (Schaufeli & Buunk, 2003). They may feel great sadness and dysphoria. The Swedish National Board of Health and Welfare's version of the ICD-10 notes that irritability and emotional instability are part of the diagnosis of burnout (Schaufeli, Leiter, & Maslach, 2009).

### **2.3 Factors in Developing Occupational Burnout**

**Protective factors.** A regression analysis of  $n = 527$  by Siltaloppi, Kinnunen, and Feldt (2009) measured daily recovery experiences as moderators between work stress and occupational well-being. Over 80% of the participants had education beyond a high school diploma, 68.2% worked in a permanent job, and 86.8% worked full-time hours. There was an almost even split between public and private sector employees. Using a hierarchical multiple regression, demographic variables were first entered to control for effects of occupational well-being then psychosocial work characteristics (job control, supervisor effects, and time demands) were added in step two. The moderators (psychological detachment, relaxation, mastery, and control) were added in step three. Results showed that mastery and psychological detachment act as protection from requiring additional recovery when a position lacks job control. Those two moderators had a positive correlation on occupational

well-being. Relaxation was a factor in protection against exhaustion when participants faced high time demands (Siltaloppi et al., 2009). This research was cross-sectional and therefore it is difficult to denote any causation in the model.

**Occupational and environmental.** Schaufeli, Leiter, and Maslach (2008) characterize a primary risk of burnout as a continual situation wherein demands of the position outweigh the ability of the person to fulfill those demands. This overload increases the likelihood that the person will experience emotional exhaustion, physical exhaustion, and become depersonalized (Aydemir & Icelli, 2013). This becomes especially difficult if the working role of the person at risk is ambiguous and the employee feels that they do not have tools necessary to make decisions related to their role. Shift work and exposure to daylight can also influence burnout symptoms (Aydemir & Icelli, 2013; Cañadas-De la Fuente, Vargas, San Luis, García, Cañadas, & De la Fuente, 2015). Rotating shift work was particularly destructive, especially with health care workers (Cañadas-De la Fuente et al., 2015).

Additionally, leadership style can be a great threat to employee burnout. Although research within this field is relatively new and sparse, recent work suggests that destructive leadership patterns can lead to subordinate burnout (Breevaart, Bakker, Hetland, & Hetland, 2014). A constructive leader is one who seeks to enhance worker well-being, and motivation, as well help the employee achieve goals. These factors are generally protective for employees. Leadership that is considered destructive, such as a supervisor who resorts to aggressive tactics or avoids their employee, generally leads to a higher chance of occupational burnout for that employee. Most studies have focused on more overt behaviours, such as rudeness and continual expression of anger towards employees, even

when the anger is due to something an employee is not responsible for (Breevaart et al., 2014). This greatly contributes to the emotional exhaustion of the person at risk of burnout.

A small portion of studies show that passive-avoidant styles of leadership can also contribute to burnout (Breevaart, et al, 2014). Often, passive-avoidant supervisors are unavailable to employees when they need support, avoid decision making, and employee contact. This can lead to ambiguity in the employee role, role conflict, and conflicts with colleagues. A survey at an Information Technology firm found that passive-avoidant leadership lead to an increase in emotional exhaustion and cynicism and even after controlling for neuroticism in employees, this leadership style still had a moderate effect on burnout (Hetland, Sandal, & Johnsen, 2007).

**Individual.** Current research suggests that the working environment contributes more to burnout than individual factors, however some individual traits still moderate burnout effects (Aydemir & Icelli, 2013; Visser, Smets, Oort, & de Haes, 2003). Medical professionals, including doctors and nurses, have been extensively studied in relation to burnout. Self-report measures administered to n= 68 medicine and psychiatry residents noted that participants were more likely to experience burnout when they possessed less mindfulness-related skills (Chaukos et al., 2016). Additionally, an inverse relationship occurred between coping skills (the ability to manage stress, be aware of stress, restructure negative cognitions, institute self-care and boundaries, and choose appropriate responses to stress) and burnout symptom scores on the MBI (Chaukos et al., 2016). A study of Spanish nurses indicates that the degree to which participants felt emotionally exhausted was inversely correlated with conscientiousness, agreeableness, extraversion, and openness, whereas levels of neuroticism increased (Cañadas-De la Fuente et al., 2015).



Other personal traits may directly impact susceptibility to burnout. In a study of 2400 Dutch medical specialists, which included doctors, psychiatrists, and radiologists, researchers found that a perfectionistic attitude did have positive relationship with burnout symptomology, whereas when participants were more likely to experience burnout when they felt that they could not live up to professional standards (Visser, Smets, Oort, & de Haes, 2003). Additionally, when workers have an external locus of control, they are more vulnerable to burnout as they often do not employ appropriate problem-solving and coping skills; this is especially true when workers are faced with a high workload (Aydemir & Icelli, 2013).

#### **2.4 Burnout from a Cross-cultural Perspective**

Occupational burnout is common across many cultures worldwide (Nguyen, Kass, Mujtaba, & Tran, 2015; Santos, Mustafa, & Gwi, 2015; Ting & Jinfu, 2015). In a cross-cultural study comparing, task, relationship, and work overload stresses in Japanese and German working adults, there were no significant differences between work overload and the stress that individuals felt (Nguyen et al., 2015). The Maslach Burnout Inventory- General Survey (Maslach, Jackson, Leiter, & Schaufeli, 1996) has been translated and validated into over 40 languages, signifying that there is a universality to occupational burnout and the ways in which individuals react to prolonged work stress. Yet, there may be culturally and systemically different ways in the antecedents to burnout affect individuals. For instance, in a comparison between American and Chinese workers, Chinese workers were more likely feel stress when considering work mistakes, indirect conflict, and employment conditions whereas Americans were more affected by a lack of job control and direct conflict (Liu,

Spector, & Shi, 2007). In understanding burnout, it may be useful to remember cultural and systemic messages that individuals may receive about work.

## **2.5 The Process of Burnout**

Understanding how a person may become occupationally burned-out may aid in understanding the context of recovery. Occupational burnout is not static, in that the process is ever shifting, and interactional between situational factors and personal factors (Bakker & Costa, 2014; Schaufeli, Leiter, & Maslach, 2009; Hakanen & Bakker, 2017). The following section reviews the literature pertinent to internal processes that occur in a person as they become burned-out from their work.

Depending on the perspective of the practitioner, burnout can appear via multiple processes. Some researchers, particularly in Scandinavian countries, view burnout as an existential process (Arman, Hammarqvist, & Rehnsfeldt, 2011; Pines, 1993; Gustafsson, Norberg, & Strandberg, 2008). Pines (1993) calls burnout the “high cost of high achievement” (pg. 37) because the success the person receives at work has a high level of meaning to them. While the person facing burnout tries to handle the demands of their position and their abilities to fulfill those demands, there is an inner process which tries to address identity and meaning in life (Arman, Hammarqvist, & Rehnsfeldt, 2011). Burnout occurs when that inner process is repeatedly thwarted for the advancement of outer demands.

Initially, the person feels an inner motivation to work and finds meaning in this work (Ekstedt & Fagerberg, 2005). The motivation shifts to a deep responsibility to their work however, as the person’s duties increase, they begin to struggle with work demands (Ekstedt & Fagerberg, 2005; Gustafsson, Norberg, & Strandberg, 2008). The person struggles with their self-image and identity in the face of their inability to fulfill multiple duties, which may

or may not be incongruent to their inner goals (Gustafsson, Norberg, & Strandberg, 2008). Here we begin to see physical manifestations of burnout, such as poor sleep or gastrointestinal problems, but they are often ignored as the fear of failure increases (Arman, Hammarqvist, & Rehnsfeldt, 2011; Ekstedt & Fagerberg, 2005).

To combat their threatened self-image, the person who is in the process of complete burnout cuts off their self-reflexivity. They are often a person of “doing” rather than “being”; they become alienated from their own feelings (Ekstedt & Fagerberg, 2005). Arman, et al. (2011) state that the person also feels alienated as a human being from others; they feel misunderstood by others and do not know how to demonstrate their suffering. As they have ignored their physical and psychological manifestations of burnout and fatigue sets in, the person reaches what Ekstedt and Fagerberg (2005) call the “bottom.” The person has fully burned out and the amount of suffering is now too great and too deep to ignore. One participant within Ekstedt and Fagerberg’s (2005) qualitative study described the bottom thusly,

“It just felt like you’re lost, as if you are falling. Like, ‘I can’t live any more. I just want to get swallowed up in all this.’ I felt I was going to die. It was like, ‘I can’t cope with this anymore.’” (pg. 64)

The bottom is treated as a moment of acceptance and the beginning of the pathway to reconstruct (Ekstedt & Fagerberg, 2005). When the person reaches this point, they begin to see the long pathway leading to burnout and reach for help (Gustafsson, Norberg, & Strandberg, 2008).

Viktor Frankl, founder of Logo therapy and existential psychoanalyst, conceived of burnout as the loss of meaning in a person’s life (Malach-Pines, Neal, Hammer, & Icekson,

2011; Ulrichková, 2012). Often, when work contains existential significance for a person, they begin a position with high hopes and expectations (Malach-Pines et al., 2011). When the ability to live to one's own values is disrupted, as is likely when a person cannot meet demands, they become depleted (Ulrichková, 2012). The depletion occurs physically, mentally, and intellectually, within the noetic sphere. The physical and mental depletion is what researchers would conceive as standard symptoms of burnout- sleeping disorders, sadness and irritability, and anhedonia (Ulrichková, 2012). Frankl calls this noetic sphere an "existential vacuum"; life lacks meaning, a person becomes easily bored. Frankl and Längle, a mentee of Frankl's, go so far to say that the deepest and most difficult form of burnout is internal. When a person loses their existential motivation, as opposed to externality where a person may only withdraw from others, it becomes difficult to rekindle that motivation. Logo therapy aims to bring the burnout sufferer back by reinvigorating personal basic motivation (Ulrichková, 2012).

Freudenberger, the original conceptualizer of burnout, conceived burnout as a 12-stage psychodynamic cycle (Nuallaong, 2013). The person first feels the compulsion to prove their competence and ability to work. By working harder, they hope to convince others that they are irreplaceable. This is often referred to as the "workaholic" stage (Ulrichkova, 2012). Because they work harder, they neglect physical, emotional, and psychological needs, such as denying appropriate sleep or family time. Often, physical symptoms of stress begin to show, such as headaches, but they are often ignored (Nuallaong, 2013; Ulrichova, 2012). To avoid self-conflict, the person blunts their emotions and revises their values to continue working. They deny that their behaviours are problematic and may go so far as to blame

others for their frustrations. This includes a growing insularity against social contact (Nuallaong, 2013).

The person withdraws completely, sometimes using substances as a form of stress release instead of healthy coping mechanisms (Nuallaong, 2013). Others begin to see a large change in behavioural patterns and attitudes due to their overwork. Because the person is now isolated and unable to cope with work, they feel depersonalized and no longer can recognize their own needs. This depersonalization leads to a feeling of emptiness, which the person may try to disable through impulsive behaviour such as drug or alcohol use and overeating (Nuallaong, 2013). The person becomes depressed; they feel hopeless, exhausted, and lack meaning in life. Finally, the person has reached the last stage: burnout. Often enough, this includes suicidal and self-harming thoughts. Their physical body may require medical treatment after a great deal of time ignoring physical symptoms (Nuallaong, 2013).

Malach-Pines (2002) goes farther with psychodynamic theory and posits that we choose occupations that allow us to re-enact childhood experiences, particularly significant ones. The greatest desires in a career are considered ungratified childhood wants and needs and when these desires are unattained, burnout occurs. Further, Malach-Pines (2002) implies that without understanding the base motivations for burnout, both conscious and unconscious, treatment would be ineffective.

## **2.6 Occupational Burnout and its Connection to Mental Illness**

There is controversy regarding the distinctness of occupational burnout in relation to depression (Bianchi, Schonfeld, & Laurent, 2015; Ahola et al., 2005). Some researchers believe that occupational burnout is a form of atypical depression (Bianchi, Schonfeld, & Laurent, 2014; Bianchi et al., 2015). Others believe that occupational burnout has an overlap

in nosology with depression, yet they are distinct constructs (Ahola et al., 2005).

Understanding occupational burnout as a mental illness is necessary for understanding recovery from burnout, especially as recovery literature is written with mental illness in mind (Slade, 2009).

Although earlier conceptualizations of occupational burnout have made connections with depression (Hallsten, 1993), recent work by Ahola and colleagues (2005) have sought to decipher quantitative data exploring depression and burnout. The overlap between burnout and depression was analysed using data from the “Health 2000 Study,” which is a Finnish government organized study of 3276 employees between the ages of 30 and 64 (Ahola et al., 2005). Using the Maslach Burnout Inventory- General Survey (Maslach et al., 1996) and the Composite International Diagnostic interview, participants were assessed for both burnout and depression. In the population sampled, 25.2% fulfilled criteria for mild burnout and 2.4% fulfilled criteria for severe burnout. Additionally, 5.6% of participants met criteria for minor depressive disorder, 5.2% met criteria for major depressive disorder, and 1.2% met criteria for dysthymia. Half of individuals with severe burnout had a depressive disorder, with major depressive disorder being most common (40.2% of severe burnout individuals; Ahola et al., 2005).

Individuals with major depression disorder who also had burnout scored markedly higher on all three factors (exhaustion, cynicism, and lack of professional efficacy) of the MBI-GS than individuals with mild or no depression (Ahola et al., 2005). While no gender difference was evident in burnout symptoms and major depression disorders were more common for women than men, men were at greater risk of having both major depression and severe burnout. The results of this research suggest that while depression and burnout are

very closely related, they are separate constructs. A limitation is that the work is cross-sectional and therefore, no causal model can be applied. Additionally, the cut-off for severe burnout was quite liberal, meaning that there could be additional participants added into this category when they do not meet actual criteria.

Bianchi and colleagues (2014) posit that the overlap between depression and burnout has been underestimated and that depression should be assessed as part of diagnosis and management of burnout. Atypical depression, wherein mood reactivity is present, there is sensitivity to interpersonal rejection that results in impairment, and altered biomarker functioning for cortisol exists, shares some features with burnout. To attempt to resolve the issue of etiology, Bianchi et al. (2014) used 5575 French teachers between the ages of 22 and 65 (78% female), and administered the MBI-GS (Maslach et al., 1996). Within the group, researchers separated out participants with the most severe burnout scores and those who had a very low score or a score of zero. The Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) was used to establish provisional depressive disorder diagnoses using the DSM-IV criteria (Bianchi et al., 2014). Additional demographic data was also taken, including questions regarding atypical depression features, personal history, and employment. For participants who scored highly on the MBI-GS, 90% of those met diagnostic criteria for depression, of which 85% of those had major depression. Of those with major depression in this group, 63% of them met the criteria for atypical depression. Only 3% of participants in the no burnout group met criteria for depression. Post-hoc analysis also suggested a stepped model of burnout, wherein as the burnout became more severe, depression became more severe (Bianchi et al., 2014).

Bianchi and colleagues (2014) caution against hypothesizing that depression and burnout can be comorbid, as they argue that there is still a lack of a clinical distinction for burnout. In this study, burnout was measured according to endpoint, which is that burnout was fully realized after a long-term process took place. One important point that is made is that these results show that if burnout is separate from depression, it is no less debilitating or concerning, and therefore, it requires appropriate treatment. Limiting factors in this study was first that it was cross-sections. Additionally, there was a high ratio of females, meaning that the results are difficult to generalize beyond women, and the participants were all teachers.

A review of 92 studies on burnout and depression yielded an interesting overview of this current controversy in burnout research (Bianchi, Schonfeld, & Laurent, 2015). First, the distinction between depression and burnout remains conceptually murky. Depressive symptoms do exist within the conceptualization of burnout, as symptom overlap, as evidenced by studies above and within this review. Secondly, some studies suggest that burnout is distinct, yet others say that it is indistinct from depression (Bianchi et al., 2015). This is especially true at end-stage burnout, where the symptoms are very severe. While burnout can be psychometrically distinguished from depression, it is difficult to fully equate that with the validity of the construct itself. Further compounding this issue is that if burnout is treated as a diagnosable entity, some researchers believe that burnout may be a phase in developing depression or that depression contributes to burnout in the workplace. The argument becomes very cyclical. Bianchi and colleagues (2015) reiterate that the absence of an agreed upon diagnostic criteria of burnout handicaps research, as it is not present in the DSM-5 or as a separate entry in the ICD-10. More systematic clinical observation would be



required to remedy this. Despite these issues, the authors seem to conclude that the distinction between depression and burnout is at least partially supported by literature, although there are concerns, as noted above. Beyond the distinction between the two entities, there also appear to be many similarities, suggesting that there may be similarities within recovery as well.

## **2.7 Personal Recovery**

When denoting recovery from mental illness, there are two main conceptualizations of what recovery means. First is the dichotomous outcome of clinical recovery (Slade, 2009). Clinical recovery is a term often used by medical professionals to denote whether a patient is recovered from their illness or not. It is an objective, observable, and defined outcome as stated by a professional, who uses a tool like the DSM-5 as a guide. It is not client focused, but bestowed by the expert in the diagnosable illness. A strict biomedical lens on clinical recovery would require an absence of symptoms (Bonney & Stickey, 2008). Clinical recovery can be a useful conceptualization of recovery; it enables clinicians to sequentially determine whether their abilities and treatments are still required or if treatment is ineffective (Slade, 2009). However, clinical recovery is less emphasised in counselling psychology, which is client-centred.

Personal recovery is client-based (Corrigan & Ralph, 2005; Slade, 2009). Recovery is conceived of as an individually defined journey wherein the person who experiences the illness directs their most appropriate and helpful way to recover. Personal recovery eschews essentialism and conceptualizes the person beyond an illness in what they find meaningful, their roles, their abilities, and possibilities (Slade, 2009). It is inherently empowering as a recovery stance for the person with the illness. Because personal recovery is such a personal

and individualistic conceptualization of recovery, the process of recovery is nonlinear (Drake & Whitley, 2014; Slade, 2009). Amering and Schmolke (2009) suggest that until personal recovery processes can be revealed as fully as possible, in numerous cultural and contextual situations, qualitative research is necessary to capture individual experiences.

## **2.8 Literature of Personal Recovery from Mental Illness**

A systemic review of 97 papers on personal recovery from mental illness focused both on characteristics and processes of recovery (Leamy et al., 2011). The papers were primarily from English speaking, western countries, including the United States, the United Kingdom, and Canada. Of 87 papers identifying the characteristics of recovery, 50% of those identified recovery as an active process. Another 29% of papers identified recovery as an individual and unique process (Leamy et al., 2011). Recovery was considered a non-linear process (24%) and a journey (20%). Given these numbers, there appears to be some homogeneity regarding conceptualizing what personal recovery means, however, it does not appear fully agreed upon by all researchers.

Most recovery stages in the papers reviewed could be mapped onto the trans-theoretical model of change, which begins with pre-contemplation, proceeds to contemplation, preparation, action, and ends with maintenance and growth (Leamy et al., 2011). For instance, one study conceived of recovery as first being stuck, then learning to accept help, believing, learning, and becoming self-reliant. Another study conceived of recovery as first reawakening hope, reconceiving of self beyond a psychiatric disorder, then moving towards engagement instead of withdrawal, and finally actively coping instead of passively adjusting. One of the difficulties with this review is the narrative synthesis approach could have been more inclusive. Secondly, the thematic categorization of data may

not be replicable other researchers. Thirdly, and most practically, there still seems to be a disconnect between idiographic knowledge (perspective of the individual who is recovering) and nomothetic knowledge (group level perspective).

Onken and colleagues (2002) studied a cross-section of Americans who were recovering from a psychiatric illness in a governmental report. Using grounded theory methods, the report describes the responses of ten focus groups focusing on what helped or hindered mental health recovery. Recovery was found to be a deeply personal journey; however, some common themes were produced (Onken et al., 2002). Recovery was conceived of as an interaction between characteristics of the individual, their environment, and the cross-section of factors between the two. The overarching themes produced were self/whole person, hope/ sense of meaning and purpose, choice, independence, social relationships, meaningful activities, peer support, formal services/ service staff, and basic resources. Not attaining basic needs, like food, decent and affordable housing, a means of communication, and healthcare, greatly hinder recovery. Participants also reported that having supportive relationships were beneficial and that isolation, which includes the stigma associated with an illness, inhibited recovery (Onken, et al, 2002). Personhood and the connectedness and meaningfulness of the relationship with the inner self was both affected by and affecting recovery. Beneficial characteristics included self-reliance, self-determination, and self-advocacy. Hindering characteristics included shame, invalidation, fear, and not taking personal responsibility.

An interesting note is that Onken and colleagues (2002) found that the formal system that exists in the United States was considered a hindering factor by participants, marked by limited access, bureaucracy, a narrow focus on bio-psychiatric orientation, and poor-quality

services that do not follow best practice guidelines. These hindering qualities increased the shame and hopelessness of participants and reduced their self-determination. In some cases, the existence of this formal system was repeatedly traumatic for some participants. They concluded that a system that is person-oriented and which promotes empowerment and positive functioning would be most beneficial to those recovering from psychiatric illnesses (Onken et al., 2002).

A review of recovery from severe mental illnesses, like schizophrenia and major depression, discussed the commonality of agency and autonomy in various papers (Drake & Whitley, 2014). Independent housing, wherein people had choices over the type of housing and its location, enabled people recovering from severe mental illness to have a private and safe space. Employment was helpful, primarily because of the structure it created in day to day life as well as imparting meaningful social interactions and a feeling of normalcy. All the qualitative studies that Drake and Whitley (2014) reviewed suggested that recovery from severe mental illnesses were best when people could make their own decisions regarding their treatment and felt empowered.

Tew and colleagues (2011) examined how social factors were integral to personal recovery from mental illness in a systemic review. When people experience a mental illness, it is common for them to retreat from social contexts in their life. Beyond that, an illness may make wanted participation in social activities like work or recreational pursuits difficult to impossible. Paternalistic or coercive mental health services can socially defeat a person experiencing a mental illness, which can make it difficult for them to reconnect to social support. The crisis of a mental illness can have profound effects on the social identity of the experiencer, particularly if they are already in a marginalized community, such as an ethnic

minority or LGBTQ member (Tew et al., 2011). When the stigma of an illness is internalized and subsumed into identity, it can become a barrier in recovery. Social connectedness, whether it be an interpersonal relationship or inclusion into a wider community, has been shown to have positive effects on recovery outcomes.

Interpersonal relationships can either help or hinder the recovery process, as it all depends on individual dynamics (Tew et al., 2011). Relationships between a person experiencing a mental illness and another may be beneficial if the relationship can adjust through recovery. Initially, the person experiencing mental illness may require just the ability to “stand alongside” (p. 10) of another, but as recovery progresses, it may be important to create a relationship with greater reciprocity and equality. The latter stages help increase feelings of personal agency as well. There have been recommendations in the literature regarding using family or systemic therapy to guide support for people recovering from illness (Tew, et al, 2011). Encouraging new social relationships may key to recovery, both in terms of peer relationships with others who experience similar difficulties but also within a system apart from their illness. Additionally, social capital and inclusion, at a societal and community level, contributes to self-confidence, some types of personal functioning, and meaning (Tew et al., 2011). This can include work, volunteering, and remaining active in a community. A necessary qualifier to this is that the participant is active in these domains, instead of passive. Social inclusion emphasizes empowerment and reducing societal stigma, as important factors in recovery.

## **2.9 Factors Useful or Not Useful in Personal Recovery**

The literature consistently suggests these four key concepts exist in personal recovery: hope, responsibility, identity, and meaning/ purpose (Andersen, Oades, & Caputi,

2003; Lapsley, Nikora, & Black, 2002; Leamy et al., 2011; Slade, 2009). Individuals recovering from a mental illness found it necessary to find and maintain hope, feel empowered to take responsibility for their own life and wellbeing, redefine their self and their identity in the face of change, and find meaning and purpose in their life. Hope is not merely optimism for the future but the belief in oneself and one's agency, as well as taking inspiration from others. Responsibility goes beyond self-determination as it includes building independence and becoming more willing to take risks (Mead & Copeland, 2000).

Redefining the self and identity can include overcoming the stigma attached to the mental illness, as well as the integration of the meaning of illness into their own self (Jacobson & Curtis, 2000). The creation of meaning and purpose may mean that the person changes values, attitudes, and goals, as well as defining the meaning of the illness to them.

**Hope.** As briefly mentioned above, hope encompassed many domains of recovery. While hope can be future oriented, from an optimistic standpoint, much of the hope expressed regarding recovery involved identity (Amering & Schmolke, 2009). Much of the literature describes feeling hopeful about regaining control over the sense of identity and that it would not be subsumed by the illness. This also mean that an individual can hope that attributes of their illness, if chronic, may somehow manifest positively into a new identity. Hope also occurs interpersonally (Onken, et al, 2002). Individuals find it more helpful to interact with significant others and mental health professionals when there is a sense of optimism regarding their illness. The goals that can be derived from hope also give a sense of meaning and purpose. A systemic review by Bonney and Stickley (2008) suggests that hope is instrumental in the recovery process.

**Responsibility.** Often, mental illness can significantly inhibit feelings of control over one's body and mind. Reassuming control over one's self and treatment enables the person with a mental illness so redefine the identity as one which is effective and able (Mead & Copeland, 2000; Davidson, 2005). A person should have the ability to make decisions and identify and value their personal needs in the recovery process and that the ability to make these choices is empowering (Bonney & Stickley, 2008). Creating an environment wherein treatment is mandatory or choice is not possible can significantly thwart personal recovery.

**Redefinition of self and identity.** Identity can be greatly shaken when a person experiences a mental illness (Slade, 2009). First, it becomes necessary to acknowledge the limitations that the illness may create however, by integrating the illness as part of the identity, the person may be able to see positive aspects or new talents despite the earlier limitations. As formal mental health services can be essentializing and reduce the person down to an identity of patient, the person may have to work hard to redefine their identity as multidimensional (Onken et al., 2002; Davidson et al., 2005). A person who has a mental illness may work hard to overcome the societal stigma and social consequences of the illness itself, marking their resilience and capability (Jacobson & Curtis, 2000).

**Meaning and purpose.** As with identity, a person recovering from a mental illness will re-evaluate and conceptualise how to create meaning and purpose in their lives (Slade, 2009; Bonney & Stickley, 2008). Purpose could come in the forms of daily roles that they take on, as a partner, friend, family member, or work colleague. This purposeful role fulling shows normal and functional aspects of contributing to that person's community, as well as fulfilling a social role (Davidson et al., 2005). Aspects that may have been previously rewarding may now not be or they may be even more precious. The person may take more

introspective understanding, in that they create a personal and internal explanation both for their illness, as well as the context of that illness.

## **2.10 Occupational Burnout and Personal Recovery**

Hanaken and Baker (2017), preeminent researchers in burnout, have noticed the lack of research into recovery from severe burnout. While there is some research intersecting these two constructs, there remains a gulf between the research surrounding symptomology, risk factors, antecedents, and consequences, and recovery from burnout, particularly from a personal recovery lens. The following section explores the literature available regarding recovery from occupational burnout.

Bernier's (1998) grounded theory analysis of recovery from burnout and coping with work-related stress is most similar to the aim of this thesis. Bernier (1998) conducted narrative interviews with 36 participants, who were primarily in human services fields, such as social work. From this data yielded a structure of the process of recovery for people with burnout or severe work stress. The stages included an admission that their current condition was abnormal, that of burnout symptoms, which occurred gradually. Bernier (1998) mirrors the process that Eksedt and Fagerberg (2005) illustrate as "the bottom." The subjects further describe distance from the workplace, often through sick leave, with an average of three and a half months, using other diagnoses, like depression, to justify the leave. During the time away from their workplace, participants entered stage three, restoring their health through reducing tension and creating enjoyment. This de-escalation resulted in stage four, wherein participants examined the values and how they resulted in unrealistic expectations that precipitated the burnout. Bernier (1998) notes that it was the most difficult stage to define and the most painful experienced by participants, as they examined old values and



implemented new ones. Stage five involved exploring new working possibilities and finding positions or adjusting current positions that would incorporate new values. This stage was very long for some participants, depending on resources and requirements. Finally, in the last stage, participants made the change in their work-life. Interestingly, only one participant out of 20 stayed within the same position previous to their burnout.

Bernier (1998) also coded coping strategies in this study. Participants felt that it was important to seek reassurance from both themselves and significant others regarding their accomplishments. Participants sought to understand the causes of their burnout, both in the realm of internal and environmental factors. Finding support, while important to participants, was not given as strong of an endorsement. Support was received from family, friends, and professional resources like therapists and physicians. Over three fifths of participants received some form of psychotherapy within their recovery process. Other factors noted in aiding participants in recovery was a lack of pressure to return to work, financial support, and organizational support.

Bernier's (1998) study focuses on the conception of recovery as coping with a change or loss. The researcher admits that the generalizability of the data may be compromised because of the interaction between environmental and interpersonal areas. Additionally, while the participants did show signs of occupational burnout, the expert check by a psychiatrist suggested that the severity of the burnout symptoms was less than witnessed in practice. Therefore, outcomes may be different in a severe burnout population.

Salminen and colleagues (2015) interviewed 12 clients who were in government funded rehabilitation from occupational burnout in Finland. Participants, who identified as female except for one male, were interviewed at a seven month follow up after completing a

15 days' worth of programming. Content analysis on semi-structured interview elicited one overarching theme of participants having their own well-being in their own hands and four categories. The overarching theme reflected an increase in agency or empowerment, personally, in proxy through rehabilitation professions, or collectively as a support group.

Support was a significant feature for participants; they valued the group support that they received in their rehabilitation programming because it made them feel less alone in their struggle. Support was also received from family, friends, and professionals as part of the rehabilitation program. Awareness of how burnout affected the bodies and minds of the participants was considered both normalizing and motivation to seek help. Participants also felt hopeful that the knowledge of their past burnout would protect against future burnout. Self-approval created increased self-respect and assertiveness that allowed for participants to feel that they could request changes in their workplace or implement new ways of being. Finally, regaining joy in the participant's life space enabled positivity, a reengagement with hobbies and social activities, and seeking out space to enjoy time by one's self.

A difference between Salminen (et al., 2009) and Bernier's (1998) work is that participants within Salminen's study did not change jobs, signalling a more individual-level factors oriented recovery. Additionally, this study reflects the participants who are participating in a long-running, government funded burnout rehabilitation program, whereas many North American workers with burnout cannot rely on such targeted programming. A methodology was not mentioned in this article, beyond using several validity checks and a semi-structured interview format although this researcher believes it likely that content analysis was used. It is not known if exhaustiveness was utilized in creating categories.

Salminen and colleagues (2017) followed up the previous study with a two-year longitudinal study of a thematic narrative analysis of four female individuals who attended the same government rehabilitation program in the previous study. The common themes were the benefit of the attended rehabilitation course, supervisor support, and personal factors. The rehabilitation course was useful to participants due to its transmission of knowledge, as well as the affirmation and support received. Supervisor support was a large factor in both positive outcomes as well as a participant deciding whether they would return to the same position. The more supportive and adaptive a supervisor at aiding the participant in the return to work, the more likely the participant would stay in the same position. Personal factors were participant dependent in this study, likely because the sample size was so small. Salminen (et al., 2017) denote that there was great variation in narratives presented, however, it can be argued that a larger sample size would have shown greater cohesiveness in experience. As the research population was taken from the rehabilitation programming, it is difficult to generalize the narratives of the participants beyond their own experiences.

A quantitative study of medical students in the United States explored how factors associated with resilience both protected and enabled recovery from burnout using multivariable logistic analysis (Drybye, et al, 2010). While the study had many students ( $n = 792$ ), only 99 of that total group had recovered from burnout at a 1 year follow-up. In univariate analysis, factors that led to successful recovery had less fatigue and lower stress scores at a rate of 8% for every decrease in a point on fatigue and stress scores. Perceived support (38%, OR 1.38) and interest (29%, OR 1.29) from faculty members, as well as satisfaction with the learning environment (28%, OR 1.28) were also indicative of successful recovery from burnout. A multivariable logistic analysis demonstrated that students were

more likely to recover from burnout if they were not a member of a visible minority (OR 2.34) or working during medical school (65%, OR 0.35). A limitation of this study is that several measures were only administered at one point in the study, making it impossible to understand within-group variations as well as fully capture students who became burned-out by the 1-year follow-up. Additionally, the study measured student and academic environments, making it difficult to fully extrapolate resilient recovery from burnout in a wider setting.

### **Chapter 3: Research Methodology**

This thesis used an enhanced version of Flanagan's (1954) Critical Incident Technique (CIT). Flanagan (1954) originally developed the CIT to explore a functional description of an incident, factor, or activity and was used as a selection and classification system for members of the United States Army Air Force. CIT is a qualitative method and has previously been used in organizational and industrial psychology, however, CIT is also noted for its appropriateness in counselling psychology (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009; Woolsey, 1986). Woolsey (1986) notes that CIT acts as an exploratory tool to build theories and find differences, describe attributes, and capture factual phenomena. Originally, CIT was used in post-positivist research paradigms, however some researchers have stated that when the CIT is used within a post-modern environment, it becomes more interpretive (Butterfield et al., 2009; Chell, 1998). In this case, as the thesis looked for factors that can be attributed to an outcome, CIT was used within a post-positivist lens.

The Enhanced CIT (ECIT; Butterfield et al., 2009) differs from Flanagan's (1954) original conceptualization by introducing additional validity checks, as well as two additional steps. The first additional step was used to ensure context and give space for the narrative of the participant at the beginning of the research interview. That enabled the researcher a stronger ability to ask more specific probes and clarifications regarding the participants experience and elicited richer data. Secondly, a wish list category was created to elucidate factors which the participants wished they possessed in the context of the studied incident (Butterfield et al., 2009).

#### **3.1 Rationale for Using ECIT**

As this thesis attempts to describe the factors occurring in personal recovery from occupational burnout, ECIT works well to explore a not fully developed theory and describe the attributes of personal recovery (Woolsey, 1986). For instance, we can hypothesize that participants will state that “social support” was a helpful factor in a specific event, i.e., recovery from occupational burnout. ECIT would probe further to ask what aspects of social support was useful; perhaps it was a close relationship or regular meetings with a support group? Participants within this study are considered the experts about what factors were useful, not useful, or they wished they had possessed during their personal recovery process.

By employing ECIT in the exploration of personal recovery from burnout, an important and necessary contribution to the current gap in the literature of these intersecting constructs can occur. Additionally, ECIT allows for deeper insight into the recovery process, which can then be applied to more targeted treatment modalities. Understanding personal recovery from burnout can aid counsellors in effectively working with clients who suffer from occupational burnout and may be useful in understanding other forms of burnout as well, including caregiver burnout. Further, to this researcher’s knowledge, no previous studies in burnout have used CIT as a method.

### **3.2 Procedure**

The first step in using ECIT was to establish a clear and concise aim of what is being researched. Butterfield et al (2005, pg. 478) asks “what is the objective of the activity?” and “what is expected of a person engaged in this activity?” Within this particular study, the focus was on the personal recovery from occupational burnout and what factors facilitated, inhibited, or were wished for during that process. These constructs, personal recovery, and occupational burnout, have been discussed in the first two chapters. The aim was to

understand what these factors were in the recovery process specific to occupational burnout from people who have self-identified as fully recovered from occupational burnout.

**Participants.** When using the ECIT, the sample size is not dependent on the number of the participants but on the number of critical incidents (Butterfield et al., 2005; Woolsey, 1986). Data collection stopped when exhaustiveness had been reached within the categories of critical incidents. When exhaustiveness was reached at eight interviews, this researcher used the recommendation that at least half the amount of interviews take place with new participants to confirm that sufficient coverage has been reached (Amundson, Borgen, & Butterfield, 2014). Therefore, there was no set amount of participants required but for this research, the researcher reached exhaustiveness at eight participants and thus added four additional participants.

The researcher interviewed 12 individuals with high moderate to severe occupational burnout, as operationalised by the MBI-GS. The scores of the MBI-GS are discussed in the chapter on findings. Participants were between the ages of 22-39 ( $M = 28.92$ ; 8 female-identifying, 4 male-identifying). Five of the participants identified as Asian, four of the participants identified as Caucasian, and three participants identified as East Indian. There was no particular occupation that participants were in at the time of their burnout. Three participants were in administrative positions, two participants were in media, and the remaining participants were a nurse, an auxiliary medical worker, a teacher, a military member, a manager, a customer service representative, and a retail worker. The average weekly time spent at work for participants during their burnout experience was  $M = 45.42$  hours.

***Inclusion and exclusion criteria.*** Prospective participants, via an intake telephone interview, met the inclusion criteria as stated below. First, participants were to be between the ages of 18-65, speak and read English fluently, and willing to participate in an interview. Participants were required to have recovered from occupational burnout within the last three years, as a way to ensure that the experience of burnout and the factors involved in personal recovery were still memorable and recallable. Finally, participants were asked, via telephone, to complete the Maslach Burnout Inventory- General Survey (MBI-GS; Maslach, Jackson, & Leiter, 1996) while primed to think of what they were experiencing at the worst point in their occupational burnout experience. The question they were asked, before beginning the MBI-GS, is: “Please answer the following questions as if you were answering when you felt the most burned out from your occupation.” Individuals who received a score above a 3.20 on the Exhaustion scale, 2.20 on the cynicism scale, and a below 5.00 on professional efficacy scales on the MBI-GS were invited to participate in the study. These cut offs are designated as the upper third of the range of burnout as operationalised by the MBI-GS (Maslach et al., 1996). The MBI-GS was used as a way to confirm that participants experienced moderate to severe symptoms of occupational burnout prior to identifying as recovered. The inclusion and exclusion data is within the “Screening Questionnaire” found in Appendix C. An example of the MBI-GS is found in Appendix D.

***Participant Selection and Recruitment.*** After receiving approval from the University of British Columbia’s Research Ethics Board, the researcher sent out a series of flyers (see Appendix I) to nearby public spaces. This included educational institutions, medical clinics, an online paid research study listing service with the University of British Columbia, and human services organizations. The flyers specified that participants received or self-



identified a previous diagnosis of burnout or work-related stress that severely interfered with their ability to work and that they self-identified as recovered. In the process of screening participants, the researcher ensured that no dual relationships or conflicts of interest occur. The researcher was cognizant of sampling issues due to snowball style participant recruitment by attending to participant characteristics such as gender, ethnicity, and occupation. Demographics, as stated above, suggest this concern was largely avoided.

Prospective participants also received information on the study's significance and purpose, methods, time commitment, potential outcomes, and criteria for participation (see Appendix A). The contact information for the researcher was available for participants to contact directly. All participants were given consent forms prior to the screening interview (see Appendix E).

**Protocol.** An interview guide was created before the first interviews with participants to ensure consistency (Butterfield, et al, 2009). In this thesis, interview questions were formulated to elicit information regarding the participant's recovery from occupational burnout and what factors were useful to them, not useful, or desired in their personal recovery. Included in this protocol were questions that were designed to produce information regarding the critical incidents and how they were important for the participant. The interview guide is found in Appendix F.

At the beginning of the interview, participants were administered the MBI-GS again, this time while primed to think about how they feel about their current working situation. This was meant to confirm that the participant felt that they have reached a significant level of recovery from their occupational burnout experience. Participants were considered sufficiently recovered if their scores on the three subscales are within the lowest half of

scores as per manual guidelines (Maslach et al., 1996). Results from the differences between retrospective scores and recovered scores are found in the chapter on findings.

**Data Collection.** Data collection commenced with a semi-structured interview that occurred in person or via an online videoconferencing program, like Skype. Only one participant chose to meet over Skype. The interviews were conducted in English. Consent forms were read through with participants before the start of the interview and participants were reminded that they could withdraw their consent at any time and their confidentiality would be upheld, regardless of withdrawal. Participants were reminded of the limits of confidentiality, as per the Canadian Counselling and Psychotherapy *Code of Ethics* (2007). During this time, the participant were re-informed regarding the purpose of the study and the protocols associated. Participants were given a \$20.00 CAD honorarium before the beginning of the interview. All interviews were audio recorded and then transcribed verbatim.

In order to yield richer data, Butterfield and colleagues (2009) recommend building rapport by eliciting background information in an empathetic and validating manner. This provides the researcher with both context and demographic information. While not the focus of this thesis, the researcher began the interview process by asking about the participant's experience of becoming burned out. This enabled the researcher to understand the level of burnout experienced along with how burnout affected them. This also served as a second check to ensure that participants did meet the criteria for occupational burnout. Questions about participant's burnout experience allowed the researcher to build rapport and establish a space for the participant to feel safe enough to tell their story. Follow-up questions were asked to both probe and clarify statements of the participants.

The researcher followed the recommendation of Amundson and colleagues (2014) and devoted time at the end of the interview to summarize the critical incidents and wish list items. This ensured an internal credibility check to ensure that agreement in content existed between each participant and the researcher. Further, after each interview, each participant was contacted through email or phone to verify the interview summary as participant crosschecking.

**Data Management.** Data was kept in an encrypted and password protected USB available to the researcher or in hard copy, within a locked cabinet. Consent forms were stored separately from research data in another locked cabinet and data was be as de-identified as much as possible, using only participant's identification number.

### 3.3 Analysis

Appropriate analysis of the data is considered the most important but challenging step within the CIT process (Butterfield et al., 2005; Woolsey, 1986). First, understanding and utilizing the frame of reference, personal recovery from occupational burnout, was necessary. This included the understanding of what the research could be used for, which in the case of this thesis was understanding the importance of factors in recovery from a counselling perspective so that clinicians can be guided in recovery processes. A categorization scheme was created that reflected the summaries of participants noted factors but maintained the specificity and comprehensiveness of the data (Butterfield et al., 2005). Similar incidents became grouped. Finally, the level of specificity and generality was determined. The process is inductive so categories were determined by the themes that the researcher saw in the data (Butterfield et al., 2005).

Using the three randomly selected transcripts, the researcher extracted the incidents that helped, hindered, and were wished for in the participant's recovery. An incident that is critical, and therefore, extracted, had examples of the incident (Butterfield et al., 2005). This provided the context needed to be able to refer to the frame of reference. A colour scheme was chosen for each type of incident (helping, hindering, and wish list) in a word document. The contextual information was kept with the incident to continue to orient the frame of reference.

From the first three transcripts, the researcher had enough information to start creating categories. The frame of reference, that of understanding personal recovery from burnout for the purposes of counsellor understanding, was necessary to keep in mind (Butterfield et al., 2005). The inductive reasoning used for categorization meant that categories morphed, which is why using a word document and working electronically was most effective. The similarities and differences between incidences was constantly considered during this process as categories separated and merged depending on the direction of the data. Further, that document was useful when it is sent to participants for crosschecking once data collection was finished. Operational definitions were created for each category as they solidified and these are found in the chapter on findings. For a category to be considered viable, at least 25% of participants must have recalled an incident within the category (Butterfield et al., 2005). That works as a credibility check, along with eight other checks described below:

**Audiotaping interviews.** All interviews were audiotaped as this helped the researcher to not miss any important incidents in an interview. There is a much higher

likelihood that transcripts, and therefore raw data, were accurate as it could be reviewed at leisure. Audiotaping interviews also aided in descriptive validity.

**Interview Fidelity.** To ensure that the ECIT method is being followed, as well as adherence to the interview guide, an expert on ECIT was consulted throughout the interview and analysis stage. The expert also provided the researcher with ongoing support in the research process through continual discussion. The interview questions were followed in the same order during each interview.

**Independent extraction of critical incidents.** A quarter of the transcripts were provided to a person independent to the researcher so that they could extract which items fall into critical incidents and wish list items. This is compared against the researcher's extractions and a percentage of agreement is computed. The transcripts and coding tables were forwarded to another researcher with experience in using ECIT methodology as part of an exchange. The researcher for this thesis had aided the independent reviewer with her thesis in the previous year. Following extraction there was an agreement rate of 92.5%. A final agreement rate of 100% was met after discussion between parties regarding differences.

**Exhaustiveness.** Determining when exhaustiveness occurs is important. In the working document, the emergence of new categories was coded into the data, along with the participant ID. A recommendation by Amundson, Borgen, and Butterfield (2014) is that after exhaustiveness is reached, half as many interviews are conducted as an additional credibility check. No new critical incidences occurred after the eighth transcript. An additional four interviews were conducted to ensure that exhaustiveness was indeed reached.

**Participation rates.** To assess the relative strengths of a category, as well as establishing the credibility of a category, a participation rate is calculated by the number of

participants whose responses were coded into a category divided by the number of participants. The minimum threshold for a category to become a participation rate was 25%. These results are covered in Tables 3, 4, and 5 of the Findings Chapter.

**Placing incidents into categories by an independent judge.** In this credibility check, 25% of the incidents and wish list items that the researcher had extracted were placed into categories that the researcher created and given to an independent judge. One masters level student was recruited to sort the randomly chosen items to match to operationalized categories. A match rate of 88% was achieved. A common threshold for agreement is above 80%. A common rule in the case of a discrepancy between the independent categorizer and the researcher, used by Butterfield, Borgen, and Amundson (2005), is to use the participant's preference that has been identified during crosschecking.

**Cross-checking by participants.** At the end of each interview, the researcher summarized the participant's factors that helped, hindered, or were wished for but un-obtained during their personal recovery from occupational burnout. This acted as the first participant cross-check to ensure that data was collected correctly from the interview. After the initial analysis was completed, a second interview with participants took place through email or phone. There were three purposes to this interview. First, the researcher was seeking feedback on the items extracted from the participants first interview. Next the participant ensured that the categories that their items have been placed in reflect their experience, and third, any follow-up questions were answered that arose during the researcher's initial analysis. Out of 12 participants, nine participants crosschecked their data. Feedback was very positive and no changes were made.

**Expert opinions.** The categories created were submitted to three experts within the field of burnout and recovery from mental illness. The experts are asked if the categories would be useful to them, if any categories are surprising, and if there is anything missing based on their experience. Butterfield et al., (2005) suggests the following questions be asked to the experts:

1. Do you find the categories to be useful?
2. Are you surprised by any of the categories?
3. Do you think there is anything missing based on your experience (Butterfield et al., 2005; Flanagan, 1954)?

The first expert is Dr. Michael Leiter, professor of psychology at Deakin University in Australia. Dr. Leiter is considered an expert on researching occupational burnout. In his career, he has previously held the position of Canadian Research Chair in Occupational Health and Wellbeing at Acadia University, Nova Scotia. He has several books and has published numerous peer-reviewed articles on occupational burnout over 25 years. He is also a co-author of the MBI-GS, the measure used within this thesis. Dr. Leiter has provided his opinion from the perspective as an expert researcher in occupational burnout.

Andrew Herfst, MA, RCC, CCC. is a Vancouver-based clinical counsellor who has been treating occupational burnout. Mr. Herfst's practice has a special interest in working with individuals in high-stress occupations, such as first responders and medical professionals. He is endorsed as a clinician by the BC Professional Firefighters Association as a culturally competent clinician and is certified by the Justice Institute of BC in Critical Incident Stress Management. Mr. Herfst has provided expert opinion from the perspective of a clinician on the findings.

Dr. Denise Hall, CCC, CVRP-F will provide further opinion on findings as a clinical expert. She is a Certified Vocational Rehabilitation Professional and her practice focuses on vocational rehabilitation, career exploration, and disability management. Dr. Hall has written about compassion fatigue and how organizations impact burnout and compassion fatigue. Additionally, she her consulting practice works to promote psychological and physically healthy workplaces.

All expert opinions are presented in the Findings Chapter.

**Theoretical agreement.** There are two parts to theoretical agreement. First, the data should articulate the underlying assumptions made in the study. Secondly, relevant literature is compared to the categories. As this ECIT is exploratory, a lack of support for a category may suggest new knowledge uncovered and may indicate that more study may be needed to fully understand its significance. This section will be discussed more within the Discussion Chapter.

### **3.4 Role of the Researcher**

I felt that this research was necessary from a personal perspective, in addition to an academic and counselling perspective, because of my own experience with severe occupational burnout. The burnout followed a similar pattern as references in Ekstedt and Fagerberg (2005), wherein the job demands greatly exceeded my ability to fulfill them. Instead of creating boundaries and recognizing the harmfulness of the work environment, with my own naivety as a young worker, I worked harder to try to meet work demands. I began to have daily thoughts of self-harm. I no longer felt like I had a distinct personality and I had left behind many hobbies. I became physically unhealthy. When I met with “the bottom”, I was completely physically, psychologically, and emotionally exhausted. My



recovery process took two years. When I reflected on my recovery process, I was unable to find any guidance on what recovery looked like for others with occupational burnout.

One thing that I feel most grateful for is my successful recovery. There were many things that helped me along the way. I took considerable time off work and in the end, decided to not return to the position that I had burned out in. I had a very supportive partner and family; I learnt to trust them when they expressed concern about my well-being. I had a wonderful psychologist, who I saw weekly- and then bi-weekly, for over a year. During this time, I faced significant and disabling health concerns and was supported by a team of physiotherapists who helped me feel at home in my body. I also spent time learning new skills for fun, such as learning viticulture and sommelier theory. Excelling at a new skill bolstered my confidence and reminded me that life could be enjoyable. I created new goals that felt more congruent with my identity. Recovery felt like re-learning how to experience and enjoy living as myself.

This experience has given me great empathy towards individuals with occupational burnout and I hope that understanding recovery may aid individuals in recovery faster. While I have proceeded with empathy, my stance has remained as objective as possible. My hope is that the additional credibility checks have ensured the data is as clean as possible.

## Chapter 4: Findings

This data includes 12 participants interviewed for this study. The results found in this chapter will be discussed in further detail and in relation to literature in the Discussion chapter. Across the entire study, there was a total of 197 helping critical incidents, 96 hindering incidents, and 14 wish list items that met the 25% participation rate threshold. Helping critical incidents were first arranged by six major categories and within four of those major categories, another 11 subcategories emerged. Hindering critical incidents were arranged by four major categories, two of which had seven subcategories between them. Only four wish list items met the 25% participation rate threshold.

At the beginning of this section on findings, data will show the differences between retrospective and present scores for each subscale on the MBI-GS as well as any other quantitative contextual data. Helping and hindering critical incident sections will each start with a table for critical incidents demonstrating participation rates as well as the number of critical incidents within each category. Each critical incident section will then conclude with a definition of each category with examples from participants of critical incidents that met the participation rate threshold. The wish list table will be introduced after the critical incident sections and also conclude with definitions of categories that met the participant rate threshold.

### 4.1 Quantitative context

Participants spent an average of 8.09 months recovering from burnout. All but one participant changed jobs after experiencing burnout with 58 % of participants returning to post-secondary education, either for a bachelors or graduate degree.

**Burnout as quantified by the MGI-GS.** (Shaufeli, Leiter, Maslach, & Jackson, 1996)

**Retrospective MBI-GS scores.** Participants met the thresholds established in the methods section. All participants in this study scored within the moderate to severe burnout range on all three subscales.

Table 1: Retrospective MBI-GS Scores

Sub-scale	Mean	Std. Deviation	N
MBI-GS Cynicism	4.63	1.17	12
MBI-GS Emotional Exhaustion	5.18	.38	12
MBI-GS Personal Efficacy	4.17	.70	12

**Present MBI-GS scores.** Participants generally exhibited results on MBI-GS scores consistent with low to moderate burnout symptoms.

Table 2: Present MBI-GS Scores

Sub-scale	Mean	Std. Deviation	N
MBI-GS Cynicism	2.04	1.46	12
MBI-GS Emotional Exhaustion	2.50	1.56	12
MBI-GS Personal Efficacy	4.59	.87	12

**Differences in MBI-GS scores.** There were large differences between two of the subscales present and retrospective scores. This suggests that participants identifying as recovered was congruent with a quantified ideal of recovery. The subscales, emotional exhaustion and cynicism, are both conceptualized as more significant in relation to moderate to severe burnout than personal efficacy (Leiter & Maslach, 2016; Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001). There was little difference between retrospective and present personal efficacy subscale scores.

## 4.2 Helping Categories

Table 1: Helping Categories

#	Category Title	Participant coding	Participation Rate ( <i>n</i> = 12)	Total Incidents
1	Support		<i>12/12; 100%</i>	
	a. Friends and family	3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 15, 16	<b>12/12; 100%</b>	34
	b. Professional	7, 9, 15, 16	<b>4/12; 33%</b>	6
2	Empowerment		<i>12/12; 100%</i>	
	a. leaving the job in which participants experienced the burnout	3, 4, 5, 6, 7, 9, 11, 12, 13, 15, 16	<b>11/12; 92%</b>	16
	b. Moving from full-time to part time	10	1/12; 8%*	1
	c. Recognition of needing change and then making decisions regarding self and future	3, 4, 5, 6, 7, 9, 11, 12, 15, 16	<b>10/12; 83%</b>	37
	d. feeling financially able to leave a job	7, 12, 16	<b>3/12; 25%</b>	5
3	Physical and Mental Rest/ Rejuvenation		<i>10/12; 83%</i>	
	a. time off before returning to work	4, 5, 7, 9, 10, 12, 15, 16	<b>8/12; 67%</b>	14
	b. Physical/ mental wellness activities	3, 5, 7, 9, 10, 12, 13, 15, 16	<b>9/12; 75%</b>	14
4	Meaning Making		<i>10/12; 83%</i>	
	a. recognizing the systemic nature of burnout	4, 5, 6, 9	<b>4/12; 33%</b>	10
	b. making meaning out of experience	5, 6, 9, 12, 16	<b>5/12; 42%</b>	12
	c. making life and work meaningful	4, 6, 7, 11, 12, 16	<b>6/12; 50%</b>	17
5	Better work/life balance	4, 6, 7, 9, 10, 12, 13, 16	<b>8/12; 67%</b>	13
6	Hope that decisions would make burnout better	4, 5, 6, 7, 9, 11, 13, 16	<b>8/12; 67%</b>	19

\* This category will not be included.

Italicized major categories and bolded subcategories met the endorsement rate requirement of 25%.

Among participants, six major categories were established and within those six categories, 11 sub-categories were created. Only one category did not meet the minimum standard of a 25% endorsement rate. It will not be discussed in this section.

**1. Support:** Support is defined as any participant saying that they felt helped by an emotional, physical, or psychological connection to another person, whether burnout was directly discussed between parties or not.

*A. Informal Supports.* (e.g., friends and family)

Examples:

“I felt like they were my most counselor-ish experienced so I chose them to share with. It felt really good and they made me realize a lot of things I didn't realize. They said to me, ‘Yeah, why should you be miserable at your work, you should be happy, I mean if you can you should be happy at all time?’ So that is like a negative feeling right off the bat, they don't think it's right for me either, so having that support from them even though they're not entirely in my shoes is a huge, huge relief.” (P4)

“...that summer I kind of like was talking to good friends like wingmen that I had in the Air Force and that had left and I was asking them what they did, how they applied what they learned. Just going to people that I trusted and I gave them credit for their insights.” (P9)

“...the first thing, I understood that you always have somebody who cares really deeply. It could be maybe your family member or a friend or even a person who is working as a supporter...” (P16)

*B. Professional/ Formal Support.* (eg. A psychologist, mental health professional, doctor, or trained peer, etc. in either a group or individual setting). Two additional participants specified that they received professional help related to their burnout in study questionnaires meaning that the participation rate in this category would have included half of the participants.

Examples:

“I was going to a therapist that specialized in talking to vets because of the non-disclosure agreement aspects that I've alluded to in this talk and one of the things

that I brought up was how several times in the course of that sort of me saying ‘Well are we going to rectify this, these bad things that happened?’ A not uncommon refrain was ‘You're so naive thinking that way or you're such an optimist thinking that way’ to the point where- - and I think this ties back to the burnout for me because burnout is so intrinsically tied to cynicism, because you have to detach the emotionality from what you're experiencing otherwise it's a pain that demands to be felt. But my therapist came back and said ‘No don't classify it as naivety, don't classify it as a fault or stupidity or Pollyanna optimism. It's a sense of idealism towards what you believe should be the case or what the bill of goods that was sold.’” (P9)

## **2. Empowerment**

*A. Leaving the job in which the participant experienced burnout.* This category is defined as participants either changing position within the same field or leaving their particular field all together. Key words like quitting, leaving, transferring, etc., appear in the interview. This category includes individuals who have decided to return to school instead of finding employment and individuals who have transferred to a different department or task within the same organization. Sometimes this category is found in context and not directly stated in the interview even though the participant has since changed jobs. Data is available quantitatively through a brief survey as well.

Examples:

“...just not having that job in the hospital field and then of itself a big stress relief is one of my biggest factors.” (P4)

*B. Moving from full-time to part-time work in same position.* (did not meet endorsement threshold)

*C. Recognition of needing change and then making decisions about the self and future.* The participant decides that they can no longer withstand the effects of their burnout symptoms and decides that a change is required in the way that they are living their life. Often this decision is related to leaving their job, moving away, returning to school. The decision is conscious.

Examples:

“I realized it when I caught up with my friends and realized that they're not unhappy going to their work every day unlike myself. I shouldn't be doing this to myself. I should feel happy about it. I think that's when I realized I should really be about seeking something- - some other opportunities.” (P4)

“When I first started I told myself like ‘Oh, I don't think I'll ever go to higher acuity or something that means like that training maybe I'll just do something more relaxed, go to the community sector I'm guessing’. But then I started looking into it and I think I just needed that change in the cycle and I ended up going to higher acuity.” (P5)

“I was like I'm done, I went to the Air Force and I said I don't owe you anymore time, I'm like my contract is going to end at the end of this year, the Air Force was drawing down people, they were getting rid of people and I was like why don't they get rid of me too.” (P9)

“I decided to buy ticket and get back to my hometown to spend this illness time with my parents...” (P16)

*D. Feeling financially able to leave a job.* The participant feels that they have the resources to be able to not work in the position they are in. In this category, participants are included who have moved back in with family and are not feeling financial pressures to return to work.

Examples:

“I think the big thing was I was financially stable. I could make the move to Canada with my wife's and my savings and make the career change that I wanted to but if I didn't have that there was no way I'm could leave my job.” (P7)

“I could stay with my family and they would be okay with it, I know a lot of people don't have that. So I think I was really fortunate that way because I was incredibly privileged to actually have that option in life because I didn't have any major responsibilities at that point.” (P12)

“...if you know that you're completely secured, you have a place where to live, you have your parents supporting you, then you just maybe can waste this time.” (P16)

### **3. Physical and mental rest/ rejuvenation**

A. *Time off before returning to work.* This category is defined as the participant specifically taking time to rest before working again. Sometimes this is defined more as a helpful vacation and sometimes the leave from employment is long-term. During anything defined as time off, the participant does not work and devotes time to rest.

Examples:

“I did take a break from not working in the hospital anymore for about six months or so.” (P4)

“...I took at least a month off between moving back to Canada.” (P7)

“So I took six months off and then once I started applying for the MBA, I didn't work. I was doing a couple of freelance jobs but all of them were from home. So I didn't actually go into a workplace for almost a year and a half.” (P12)

B. *Physical/ mental wellness activities.* This category is defined as participants specifically participating in activities that promote physical or mental wellness. This category includes hobbies, exercise, taking time for the self, nutrition, and resting appropriately as well as things that may be defined therapeutically as “self-care”.

Examples:

“...so a little bit more exercise, a little bit more of the yoga which had a little bit of a more meditative focus.” (P5)

“I think I gained like 20 pounds probably because I was not drinking. I stopped drinking because I didn't need to anymore and then I was eating more, sleeping more and exercising.” (P7)

“Like 99% of them [social media] giving you some kind of negative information, shocking information maybe even something like really outrageous. So I decided first of all to curate my- - well not curate but somehow limit my usage of all those social medias, all those Instagram channels.

I just decided, I want only good news in my life, I want to focus on all those negative issues, I know maybe it's not that bright outside and we do have a lot of problems and things that we have to think about and somehow deal with it but I just don't want to have all this negativity every single day of my life, because I was feeling so vulnerable at the time.” (P16)



#### 4. Meaning making.

A. *Recognizing the systemic nature of burnout.* Participants recognize that they are not the only ones in their job field or organization that are experiencing burnout. Some of that acknowledgement may include the realization that the way that they are feeling may be endemic to the workplace and not specifically a deficiency within them as an individual.

Examples:

“Although I wasn't in contact with most of them, I found out that they are, from friends of friends, just a couple of other ones and saying it feels they're not in the field anymore. It was such a huge relief and I felt happy. Not that they are suffering but that I'm not the only one.” (P4)

“I think that I asked them about how they were feeling just to maybe like confirm that it was normal to see if anybody else is feeling the same thing.” (P5)

“...you have to look out for your peer group, you have to look out for other people and if you're a manager you have a special responsibility to look out for your subordinates. And when those failures happen, which are structural, they are institutional, burnout happens and that's when you can lose bright minds and a lot of potential.” (P9)

“It was kind of like this phase of like ‘I fucked up, I fucked up, I fucked up’ and then eventually being like ‘No, I did my job, I was successful at my job, I was very good at my job’, the Air Force didn't give me any recourse to deal with these things, in fact they were kind of taking me down this gilded path of- -again I can't emphasize those enough here's a three-year script for Ambien take as much as you want.” (P9)

B. *Making meaning out of the burnout experience.* Participants discuss ways in which their burnout has been important to them. They may use their experience to help others, to advocate, or to understand how the experience will affect the ways in which they consider their future work.

Examples:

“Interviewer: To use those skills differently and then to also find out that you had new ones, different ones.

Participant: Yeah, so I realized it was actually- - I was one of those people that was able to talk to anyone which is nice and I thought that that might also help me with my degree right now because I feel like it's so much about that's what I'm learning- that I mean it's a skill that sort of transfers.” (P12)

“I think part of it was having that student, it didn't help in entirety I guess but having the student- sort of doing something different and feeling like I was making a difference.” (P5)

“I realized that I had become this advocate for self-care by just being- like my inability to say like, ‘Well this is the way things are like we just kind of- - we're told that we have to compartmentalize and just live with it and just allow this to be the way that baseball is played within military analysis.’ And going to people that are still in or people that have left, that are struggling and then when I would like ask a question about something be like ‘Hey how are you doing man? You used to cover Syria, with all the shit that's going on in Syria now, how are you doing?’” (P9)

*C. Making life and work meaningful.* After the burnout event, the participant conceptualizes work and life as requiring meaning for their long-term well-being. This could mean exploring a new field of work, doing work that is personally meaningful, or finding meaningful experiences and relationships outside of the workplace that are more significant than they were prior to burnout.

Examples:

“Yeah I just took I think the most positive thing for me was taking a priority of what should I do with my life and I guess for that level was: my marriage and my child was my top priority so I should make decisions based on that.” (P7)

“I want to help people like to be a social worker or something like that because I simply feel that that's what I like. I really like it and I do not have to choose my future career according to- - I don't know to the wage level to- - well everything that I have to keep in mind when I was choosing my profession in Russia.” (P16)

**5. Better work and life balance.** This category is defined as the participant establishing time for work and rest following burnout. The participant may make an active choice to no longer engage in the same level of involvement in a workplace in order to have time for more rest, time with loved ones, hobbies, and physical activities.

Examples:

“I like that it’s not as stressful as my hospital job. I’m not expected to do a whole lot of things in a wide spectrum. I know what my tasks are and then when I have time, I can go up to my managers or partners and ask if they need anything else- just let me know.” (P4)

“Sometimes you can't do both but I think that- -maybe that was a newspaper article that Jeff Bezos said like you know his philosophy is you cannot- -there's no such thing as work-life balance. You just made a decision: whether you want your work or your family.” (P7)

“Because I didn't feel that I do have a life. I was thinking I just work- that's it and life is not work. Life is finding a balance between the things that you are like obligated to do and the things that you just simply want to do.” (P16)

**6. Hope that decisions would make burnout better:** In this category, participants allude or outright state that they have hope that things will improve, either with burnout symptoms or finding new work. The decisions that participants made to leave work, try a new position, or choose other parts of their life to improve upon made them feel more hopeful.

Examples:

“I guess there's nothing wrong just to simply try different types things. Of course, it's hard when you fail, of course you feel desperate maybe at the beginning but I was thinking about all those scientists who did experiments maybe for years and it took them maybe thousands of approaches or tests and finally they got somewhere and maybe there is the like a special meaning behind that.” (P16)

“...hope and the knowledge that there was something else, something new and chance that I guess I would be able to do a little bit more, so learn a little bit more, especially the training of the program.” (P5)

“It means finding a job all over again, I don’t have any background experience in it, no educational- -how should I say it- -like the right foundation to support me in that field, I do not have anything related to that but I believe that I can do this, and I can do anything if I put all of my effort into it. And just refraining from thinking that my next job will be the same as my previous one that was really helpful, I just wanted a break from all of it. I just wanted to start and try things again.” (P4)

### 4.3 Hindering Categories

**Table 4: Hindering Categories**

#	Category Title	N Participant	Participation Rate	Total Incidents
1	Difficulty Transitioning		<i>9/12; 75%</i>	
	a. doubt	4, 6, 7, 11, 12, 15	<b>6/12; 50%</b>	13
	b. adapting to a new environment	7, 11, 9	<b>3/12; 25%</b>	6
	c. difficulty coping emotionally	4, 5, 7, 9, 12, 16	<b>6/12; 50%</b>	17
2	Systemic Concerns		<i>11/12; 92%</i>	
	a. feeling alone	4, 5, 6, 15, 16	<b>5/12; 42%</b>	8
	b. personal expectations of work	3, 4, 10, 16	<b>4/12; 33%</b>	8
	c. social comparison to peers	4, 5, 9, 12	<b>4/12; 33%</b>	5
	d. workplace, familial, or societal attitude towards work and burnout	3, 4, 5, 6, 7, 9, 10, 12, 13, 16	<b>10/12; 83%</b>	31
3	Not having enough time off	4, 5, 6, 7	<b>4/12; 33%</b>	4
4	Lack of resources	4, 10, 16	<b>3/12; 25%</b>	4

Italicized major categories and bolded subcategories met the endorsement rate requirement of 25%.

#### 1. Difficulty transitioning

A. *Doubt*. This category is defined as participants wondering if they made the right choice in leaving their previous position. In this category, participants may question whether or not work or burnout can get better. Doubt has an opposite effect of hope in that the person feels a limitation in what is achievable or possible, including the recovery itself.

Examples:

“So I was like, ‘Oh my God I just gave up a very valuable career and bet my family's entire life savings, my wife and my life savings on this career change. If I don't make it through this then we're homeless.’” (P7)

“...first, there is a self-doubt I would say. Like that happens- like okay what have I done is it really- [Interviewer: Is it the right thing?] Is this really the right thing because I have obstructed my natural flow that was going on. So like- is this the right way? And I would say that a small fear I had: I would say that I would be leaving my country go into a different thing, leaving your parents behind.” (P11)

“It was jarring at the same time because these were questions that I was asking myself but when people ask me these questions, I really don't know how to answer

and then they get certain expectation and so I kind of have to be okay with that. I had to be okay with the fact that I didn't know what I was doing with that.” (P12)

*B. Adaptation to a new environment.* Participants may struggle to adapt to a new workplace or to become a student after time away from work where their burnout occurred and/or time off. They may struggle to adapt to new challenges emotionally or skill-wise.

Examples:

“I thought school would be super easy but people are really smart here. I’m really slow in math now which is really depressing for me because I was really good at math in high school and calculus was not too bad in- - I did 101 and 180 in my first year and that wasn't too bad.

Coming back to school was like ‘Oh my God I don’t even know how to do basic like-it’s called function’... I moved from like managing- - like being a head of a team to being like at first being beside first year group who had way better stuff than me. So I had like maybe an inferiority complex going on there.” (P7)

*C. Difficulty coping emotionally.* The participant struggles in their recovery period to feel psychologically well. This includes the participant discussing issues like depression, anxiety, and isolation. Any mental health related concerns belong in this category. There may also be struggles with identity in this category.

Examples:

“I went back to school and then I got the part-time job and then the stress went away because maybe I could feel I could see that in my heart- - my blood pressure went down [but then] anxiety just went through the roof. Because like I had a lot more time because I felt like a lot more free time means a lot more time to bring worries, regrets and to worry about the future.” (P7)

“...that are just they're [the parts of identity that were disrupted by work] part of who I am now and there are parts of it that day to day, week to week, once a month. I'll be making baked mac and cheese and I'll just be like mad at the flour, I insist on being this way because it's me like exerting control over this way like, oh shit, okay, yeah I'm not going to do that anymore. It is like adjusting that lens to just kind of recognize what's like the how and the why that I'm doing things” (P9)

## **2. Systemic concerns**

A. *Feeling Alone*. Participants may feel like they were the only one that became burned out in the workplace where their burnout occurred. There may be a mindset of being defective, feeling shame, and hiding from co-workers, friends, and family that they feel burned out. The participant may find it difficult to confide in others regarding their burnout and may indicate some relief from burnout if they do discover that others are experiencing similar difficulties.

Examples:

“Feeling like I was in it alone. [Interviewer: Do you want to give me an example of that?] I wouldn't have been if I felt comfortable enough to share it with my best friends but yes, at the same time, I feel embarrassed because all of my friends are about the same age as I am. I don't know why I had this thought that if I'm going through this, they're probably going through the same thing as well, why am I talking about it in a way that I'm complaining about my work. I felt like it shouldn't be and I'm not that kind of person so I didn't do that, I didn't share but I should have been comfortable enough to do that. (P4)

“I just found myself- - well I wasn't thinking about myself as an adult, like a real adult, I still had to like maybe maintain that self-confidence and all those things. So I had that idea in my head, okay if they told me that I have to start, I have to start. Not accepting help from anyone else.” (P16)

B. *Personal expectations of work*. The participants expectation of working may contribute to their burnout symptoms or prolong them. For instance, a participant may feel that they have to work a certain number of hours or a certain type of job because their perception of work is that it should feel difficult or exhausting.

Examples:

“I want to do this and it has to work out, so I have to endure this no matter what. It's non-negotiable you have to do this and no matter what you're feeling you're going to pull through your spine here, you just have to do it.” (P4)

“I coached myself on thinking that I can overcome it myself, I can help myself. Then that idea that was constantly running through my head like ‘I'm strong enough, I can deal with it by myself but no, don't waste any more time on getting into

that course, those courses or whatever because you have a person right in front of you who can help you, she has this education.” (P16)

“I think like that was also a fact that I think while I was working so much I got used to the fact that maybe this is what it should be like, ‘Oh we all should be working this hard and feeling this tired afterwards.’” (P10)

*C. Social comparisons.* The participant will compare where their peers are at in their career and struggle psychologically with being burned out when they believe that their peers are not experiencing burnout. This category was more common in participants who felt “stalled” in their careers.

Examples:

“...especially with some of [my] peers who are working in the business field, went to on Sauder [business] school and they're climbing up the ladder. There's things as I am and they are climbing up the ladder but I am starting back from square one.” (P4)

“I think people post highlights of their life right [in social media], which is what happened. So when you're not doing anything and you're unsure about your life, it can act as a trigger to like what you should be doing and so there was so much of that. So I deactivated Instagram first because Instagram was very pretty and it's great but it's also I feel like it can foster a sense of ‘Oh I'm not doing anything with my life when I should be, look at all these people doing all these amazing things.’” (P12)

*D. Workplace, familial, and/or societal attitudes towards work and burnout.* This category defines multiple things. First, workplace and societal perceptions may inform participants that the burnout results from the worker’s individual deficiencies with no influence from wider organizational structures. Secondly, societal values regarding work may place the onus on individual workers rather than employers to not become burned out. Thirdly, whatever environment the worker is in may not discuss or have language for burnout. Forth, the structure and values of the worker’s family or culture may make it difficult for a worker to feel supported in their choice to leave their job due to burnout.

Examples:

“So in Korea it was like tunnel vision because everybody there's like I was really- - I remember one psychologists in- - during my day like working the radio like just listening to them and also be able to meet them so one psychologists was really- - because she says there's a certain phenomenon normally called scarring in Korea. So once you take something that is not- -perceived as abnormal then you're scarred on your resume and personal life. For example, you have a mental breakdown you take a year off work that's on your resume forever. So you're basically scarred...” (P7)

“Maybe there were people, not that close friends but still people who told me like it's not a problem, you're just like overthinking , unsupportive people like ‘You have a great job, you have to hold it, you have to stick with this company, everybody's suffering, you're not the only one, well you're not suffering, it's just the way you look at it maybe there is no problem, you just have to think about it differently or maybe look at it the other way.’” (P16)

**3. Not enough time off.** The participant may feel that they were unable to take the time off necessary to participate in rest and rejuvenation before returning to a workplace. The participant may also stipulate that they would have felt that their recovery would have accelerated had they had more opportunity to rest without juggling new workspace responsibilities.

Examples:

“...it felt like lack of time in my ability to do those other things. Well maybe some time off would have been good. I think the fact that I was still working full-time and doing the shift work, that was a thing that was a major hindrance. [Interviewer: So shift work was not making it easy for you?] It was like physical as well as mental toll on myself, so I wasn't able to process things at a 100%.” (P5)

“I think that's the lack of time is one another thing. [Interviewer: So that's like a hindering thing, the lack of time, so lack of time to think things through, to make a future career decision? That sounds like you feel pressure.] Take some time on our own, for our own.” (P6)

**4. Lack of resources.** The participant finds barriers to their recovery because they may lack essential financial, emotional, medical, familial, or professional support. For instance, a participant may have to return to work early because they do not have the



financial ability to remain unemployed. A participant may also feel their recovery was hindered by not having enough individuals around them to support them.

Examples:

“But then I had to make ends meet, I had to get back into the workforce... Then though- - I mean it's hard to make a living in Vancouver, I don't think that's possible or feasible. (P4)

#### 4.4 Wish List Items

**Table 5: Wish List Items**

Category Title	Participants	Participation Rate	Total times mentioned
1. Professional help	12, 7, 5, 9	<b>4/12; 33%</b>	7
2. Workplace appropriately addressing burnout	13, 9, 7, 5	<b>4/12; 33%</b>	6
3. More support from workplace and colleagues	12, 9, 13	<b>3/12; 25%</b>	3
4. More time for rest	5, 7, 13	<b>3/12; 25%</b>	3
5. Better education about burnout and recovery	7, 5	2/12; 17%*	5
6. Exposure to the job/ workplace culture/environment before making a commitment to stay in a job	4, 13	2/12; 17%	3
7. Supportive friends	6	1/12; 8%*	3
8. Acknowledgement of how their job affected them	9	1/12; 8%*	1
9. Not asking for help quickly enough	16	1/12; 8%*	1
10. More empathy towards self	13	1/12; 8%*	1

\* Categories will not be included in this section.

Only four categories met the minimum endorsement threshold rate of 25% for wish list items. Six categories did not meet minimum requirements. Two participants in the sample reported that they had no items to place on the wish list. Items meeting the threshold are discussed below.

**1. Professional help:** In this category, participants felt that their recovery would have improved if they had a professional in the form of a mental health clinician or professional with experience and knowledge of burnout.

Examples:

“I actually wish I'd gone to therapy at the time. I wish I had like taken more time out for therapy, I feel like it would have helped- you know, I feel that your family, your boyfriend and everyone is great but they all come with their inherent biases and they all know you through before.” (P12)

“...just that one visit at the anxiety group just made me like gain so much perspective in life. I'm like ‘Wow, people really have crippling anxiety. I got nothing to worry about but I'm really glad I came here and shared my thoughts.’ Yeah- I think if I had something called like a burnout group, if I knew something about that or that even came to my mind at the time... I think my acceleration of like to get where I am now would have been much faster.” (P7)

**2. Workplace appropriately addressing burnout:** Participants felt that they received very little acknowledgement from their workplace and employers, particularly in workplaces addressing burnout as a systemic and organizationally based concern. Participants wished that their workplace had better programming or even the admission from their workplaces that burnout could occur within the environment.

Examples:

“...the intensity of my experience that sort of tapering would have been a lot easier if the VA had just been like “Okay, this is where you're living now, you know what, here is your avenue, this is the network of therapist that you can go talk to, these are your avenues for what happened. Just them saying here's all this stuff, that would have been a huge help.” (P9)

“I think maybe more interaction with my big boss. So my office had like 16 staff so I was very close to my team and my team leader, but the big boss, who is our Dean, she is the leader of all the team leaders. But I feel that her style is quite detached because as long as everything is working she does not really talk to staff at my level.” (P13)

**3. More support from workplace colleagues:** In this category, participants wished that they had received better support from colleagues and/ or their workplace regarding their burnout.

Examples:

“...I had a great support system but at the same time, I wish I had more support from my friends in the journalism world. Which I didn't have. A lot of them were trying to sort of force me to come back.” (P12)

**4. More time for rest:** Participants felt that their recovery would have improved if they had received more time away from work or had more time in each day to devote to rest. One participant in this category stipulated that they had a small child, making it difficult to fully rest.

Examples:

“I think I just wanted like a change of pace really, maybe some time off, maybe better shifts I guess, like a change of my schedule.” (P5)

“...maybe more time to reflect, write down my thoughts. I think it just happened that immediately after I finished my job then there was this mad rush with like moving here and then studying, becoming a student again. Also, I did not really have the luxury to process, but now that it is December holiday I am hoping to really think through things.” (P13)

#### **4.5 Expert Opinions**

As part of the validation process, three individuals with expertise in burnout have reviewed the findings of the study. Dr. Leiter found that the findings were important as participants in previous studies had not met the severity of symptoms captured within this thesis. He acknowledged the consistencies between his knowledge and the participants need to leave positions and careers in order to recover. One surprising aspect of the findings for Dr. Leiter was that participants did not suggest that their employers were helpful in their recovery and that there were very few workplace resources mentioned. I think this may be an additional challenge that participants faced as many of them were experiencing burnout while still in a developmentally early career stage and they may have not had the resources of more seasoned employees like greater vacation time or accrued wealth.

Andrew Herfst found the categories to be useful and that they clearly captured many of the important incidents in clinical practice. He also felt that the emphasis on hope was a crucial part of the recovery process in his practice. Like Dr. Leiter, he was surprised that so

many participants had left their employers and that participants felt that was a necessary step in recovery. Yet, Mr. Herfst also surmised that in his practice that specializes with front-line workers, many of his clients greatly tie their identity to their work and leaving employment is less viable and therefore, his clinical population may differ from this study's participants. Mr. Herfst also felt that there was other helping or hindering incidents that he encountered in his clinical practice that were missing from this data. This included trust, self-awareness, creating boundaries, better control of a work schedule, and training factors. Some other items were partially encapsulated in categories listed but less specific, such as health basics and social support from colleagues. The limitations of the study in light of these additional factors will be discussed further in the limitations section of the discussion chapter.

Dr. Hall has suggested that in light of the systemic and organizational concerns regarding burnout, she felt that this piece was missing from the critical incidents. Participants touched on either feeling that acknowledgement of systemic concerns was helpful or felt hindered by these concerns. Dr. Hall has suggested that she finds it imperative that organizations share the responsibility of healing from occupational burnout, which includes addressing the workplace culture neglecting burnout as a workplace issue. Dr. Hall did not mention any other concerns regarding her opinion of the data.

## **Chapter 5: Discussion**

### **5.1 Introduction**

The aim of this thesis was to begin to understand what helped or hindered individuals recovering from occupational burnout. The specific perspective taken was that recovery was a personally defined process by each participant. Common themes did emerge in the data. In this section, first a general discussion will occur of the thesis findings. The findings will then be compared to the relevant literature. Expert opinions will follow this section. Implications for counselling psychology, limitations, and future directions conclude this chapter.

### **5.2 General Discussion**

A feature of this thesis research is that participants felt that more practical concerns, like finances, time off, and appropriate resources appeared as endorsed as existential concerns like meaning making and hope. These themes are relayed in other research, both related to occupational burnout and recovery from mental illness (Salminen et al., 2009; Onken et al., 2002). More so, these findings indicate that much of the recovery process is highly personalized, thus requiring broader themes. There appeared to be an interaction between tangible resources and personal characteristics affecting the recovery process. Recovery may be a reverse parallel process to the environmental and systemic aspects of a workplace and individual characteristics interacting and contributing to becoming burned out.

A tangible resource could be as simple as financial stability or more complex as support from a family member. Participants felt that these aspects contributed to their recovery and yet when these resources were not present, their recovery was hindered. An example of this was that time off was an important aspect of recovery but when time away

was limited, participants felt hindered. Time specifically allotted for rest became a wish list item for some participants who felt hindered by a lack of time off. Systemic issues also helped or hindered recovery. While participants felt helped in recognizing that their burnout was at least partly due to understanding that the issue was endemic to their workplace, the same concern often hindered them. The participant may have wanted to change the ways that they interacted with work but cultural and workplace systems may have made change difficult or impossible.

Personal characteristics and how the participant interacts with the systems they exist in seems to have an effect on recovery. Participants felt that it was helpful to have informal supports but only if their supportive individuals were actually supportive. They felt hindered in moments where family members may have struggled to understand why participants had left a viable career. Participants also felt hindered by social comparison wherein they may have felt doubt that they made the best decision when they saw others existing in careers and not struggling. Emotional coping also affected some participants more than others; this may have been due to personal characteristics, the amount of support that the participant perceived, the level of meaning the work had to the participant, the severity of burnout symptoms, or underlying unknown history. There are still many unknowns and they would be better understood through further study.

I was surprised during data collection that many participants struggled to come up with wish list items and many participants hesitantly suggested some things that they believed may have made recovery easier. This is captured by the low endorsement rates in all wish list items. Hindering categories also had less endorsement than helping categories. These results may have been different if the research was conducted on participants still in

recovery who may have been able to articulate what they needed as opposed to participants who had already recovered. Participants did not struggle to recall the most helpful factors in their recovery.

### **5.3 Categories as they relate to previous research on recovery from occupational burnout**

One of the hopes of this thesis was to address the knowledge gap between burnout and recovery. There is a handful of studies that address this topic. Findings from this study suggest that there are factors in recovery that are important to individuals and it reflects some of the findings in previous studies. Like Bernier's (1998) initial grounded theory study, the vast majority of participants in this thesis did not continue to remain employed in the occupation in which they had burned out. This thesis's participants also came from a variety of cultural and career backgrounds, whereas Bernier's participants were primarily working within human services fields. This thesis had an additional strength that participants rated the MBI-GS highly when recounting their burnout symptoms, quantifying that participants in this study had high burnout symptomology.

Support was deemed most important in this thesis as well as other studies (Salminen et al., 2017; Salminen et al., 2009; Bernier, 1998). Participants in both studies sought reassurance and feedback on their value, accomplishments, and suffering. They were hindered when they felt they lacked support. Participants in this thesis also were more likely to feel that recovery went well when they did not feel pressure to return to work and had the resources necessary during their recovery. In Salminen and colleagues (2009) study where participants had received group therapy, support was just as important. Participants in this

thesis requested similar things to Salminen's study in regard to more professional help, destigmatization of burnout, and better education about what burnout was from their workplace.

The content analysis from Salminen and colleagues (2009) elicited themes similar to what was found within helping categories in this thesis. The overarching theme of empowerment in Salminen's study is captured within the larger helping category, Empowerment, in this thesis. Similar themes were also found in addition to the support category in the above paragraph. Participants in Salminen's study found it important to regain joy, similarly to participants within this thesis who reengaged with hobbies, sought better work-life balance, and normalizing their burnout experiences with co-workers. Differences may have been due to participants in Salminen's study participating in government funded rehabilitation whereas participants in this study may have wished for but for the most part, received little formal support.

#### **5.4 Categories as they relate to MBI-GS**

**Emotional exhaustion.** Support was the highest endorsed category of all critical incidents. All participants found that their recovery was most helped by the informal support they received from their friends, family members, co-workers, or for some, formal support by professionals. Emotional exhaustion is defined as a potent factor in occupational burnout by many researchers (Aydemir & Icelli, 2013; Ekstedt & Fagerberg, 2005; Schaufeli, Leiter, and Maslach, 2008). In the interviews conducted in this thesis, all participants mentioned how emotionally tired they became as they tried to meet the demands of their work.

The importance of support may be that by participants either sharing that they needed support with those they trusted or even knowing the option was there, some of the weight of the emotional exhaustion was lifted. Support was based in trust and understanding that the



participants could share and perhaps have their experiences of occupational burnout validated. Support was also helpful for participants in recognizing that their overall feelings about their work-life and the dread some felt about attending their jobs was not something that everyone felt about work. About half of participants had hindering critical incidents related to either feeling alone or having difficulty coping emotionally and the interview data suggested that when these participants reached for support, it contributed positively to their recovery. Additional research could explore the relationship between emotional exhaustion in the MBI-GS with support seeking and isolation from support.

Emotional exhaustion, as operationalized by the MBI-GS, may also relate to the major helping critical incident category of physical and mental rest. A large majority of participants endorsed the major category and smaller but still significant majorities endorsed taking time away from work and participating in physical and mental wellness activities. Some of the activities that participants endorsed, like exercise, meditation, and yoga, would perhaps act to reduce the amount of stress that participants felt while working. Cherished activities, like hobbies, may have acted to reconnect the participant to joy.

The time spent away from work was also important. For some participants, this involved a vacation and for others, it was the time in between occupations. The time away from working may have acted as a way to increase emotional capacity and if the position in which participants became burned out was particularly emotionally taxing, time away may have allowed for participants to mentally and emotionally process their experience. Time away from work could have allowed for a space for participant to re-assess their engagement with daily living and values.

Wish list items also highlighted the importance of support, which participants may have connected to alleviating their emotional exhaustion. For instance, in the Professional Support wish list category, one participant felt that attending a burnout support group would have accelerated recovery. Another category, 'More Support from Workplace and Colleagues, specified that they would have found increased support from their co-workers more beneficial.

**Cynicism.** Cynicism in the MBI-GS relates to the negative or indifferent attitudes that an individual may have towards work, including the amount of value one feels their work may have (Schaufeli et al., 2008). As cynicism increases, work becomes less meaningful. As occupational burnout is often related to an individual's work commitments taking up more space in daily life than personal commitments, when work becomes less meaningful, the individual may view their life as becoming less meaningful. Engagement in all activities may drop as a result. Given the high MBI-GS cynicism subscale scores participants had in relation to their burnout, particularly compared to their cynicism subscale scores after recovery, it is possible that work and the participants experience of working felt devalued.

The helping critical incident category of meaning making was another highly endorsed category. Within this category, the three subcategories endorsed the different ways that participants may have tried to combat the cynicism they felt during their burnout experience. Half of participants endorsed ways in which they found making their life and work meaningful helpful towards their recovery. This included making different priorities than the participant had pre-burnout, such as placing a greater emphasis on time with family or hobbies. Some participants also sought to increase the meaning they felt in their

occupational domains, such as choosing a new career that had greater meaning to them or finding ways in which to make their current occupation more meaningful.

Participants also felt their recovery was helped by making meaning out of their burnout experience. One participant highlighted the way in which her skills that she learned in the position where she burned out were just as important outside of that position. Another participant found that his experience of burnout was made more meaningful by helping others who faced the same difficulties. Participants seemed to find that although the burnout was very difficult, the experience of recovery and the skills learned in the career led to important information about who they were that they may have previously overlooked.

It was also meaningful for participants who recognized the systemic nature of burnout. Some participants suggested that they initially had thought that their burnout was related to personal deficits. Literature (Muheim, 2014; Schaufeli et al., 2008) suggests that burnout is an interaction between systemic issues and personal characteristics. Participants felt that they were helped in their recovery by understanding that they were not alone in their burnout experience. It may have helped participants reconnect that the work that they did may have been more meaningful and the lack of engagement they felt with work was not due to their workplace expectations. In the hindering category, workplace, familial, or societal attitude towards work and burnout, many participants indicated that the messaging they received regarding work was that work should feel tedious and only the luckiest of individuals actually enjoy or find work meaningful. Internalized societal messaging about work may have additionally hindered participants ability to recover if their conceptualizations of work are that they should find work exhausting or without meaning.

Hope, the antonym of cynicism, was endorsed as a helpful critical incident category. In this category, participants hoped that the decisions and changes they made would contribute to their recovery process. Participants discussed hope in being able to re-engage in work and their lives in a way that was different than pre-recovery. Hope may act as an antecedent to reengagement in work but more study is needed to ascertain whether or not this is a relationship. Hope was also goal-oriented, in that the decisions that participants made were a way to look forward.

**Personal Accomplishment.** The personal accomplishment subscale of the MBI-GS measures the increased ineffectiveness that an individual may feel as burnout progresses in severity (Schaufeli et al., 2008). The helping critical incident category “better work-life balance” was endorsed by the majority of participants. Participants who had begun working again felt that they found it important that they could complete tasks in the daily work without feeling overwhelmed. Participants also seemed to assess what job demands they could actually fulfill given the other facets of their lives, like family or hobby-related activities, now having greater importance. In the hindering critical incident, sub-category related to difficulty transitioning, Adaptation to a New Environment, some participants felt frustrated that they were not as efficacious in their new environment as in their previous work.

### **5.5 Categories as they relate to literature on occupational burnout**

**Research on symptoms.** The category Physical and Mental Rest relates strongly to the need to address the physical symptoms of occupational burnout. In interviews, some participants complained of a lack of sleep or difficulty falling asleep while struggling with their burnout. Time off allowed these participants to re-regulate their rest patterns. The

literature suggests a relationship between occupational burnout, symptoms of anxiety, and disordered sleep (Constantino et al., 2013). Physical rest could also be regulated by the increased physical exercise that some participants found helpful during their recovery period. In the hindering category, Not having enough time off, four participants stated that they would have recovered faster if they had received more time off, with two participants saying they felt that they did not sleep enough due to family responsibilities and shift work. Shift work is a known risk factor in developing burnout symptoms (Cañadas-De la Fuente, Vargas, San Luis, García, Cañadas, & De la Fuente, 2015).

Depression and occupational burnout correlate strongly, particularly when burnout symptoms are more severe (Ahola & Hakanen, 2014; Schaufeli & Buunk, 2003). This relationship is detailed more closely in Section 2.5 of the literature review. Some researchers do not believe there is a difference between the two constructs (Bianchi, Schonfeld, & Laurent, 2015). The strong correlation between the two constructs may point to the importance of various supports participants felt were helpful or were wished for in the data. All participants found it important to receive informal support and a third of participants received professional support during their recovery period. Half of the participants felt that they had difficulty coping emotionally during their recovery period in the hindering sub-category, Difficulty Coping Emotionally. In this category, participants struggled with some symptoms that sounded like depression and anxiety. The highest endorsed wish list category, Professional Help, also suggests that participants felt that their burnout symptoms were more overwhelming than they initially expected and they would have benefited from professional mental health support.

**Systemic concerns.** As discussed in the literature review, occupational burnout is conceptualized more as a systemic than individual issue (Aydemir & Icelli, 2013; Visser, Smets, Oort, & de Haes, 2003). Burnout is often conceived as an individual struggling to meet the demands of a work environment and limiting their own personal needs (Muheim, 2014). Some systemic issues, beyond high workload, are the leadership styles. Aggressive or avoidant leadership styles are correlated with higher rates of burnout among employees (Breevaart, Bakker, Hetland, & Hetland, 2014). Participants found that recognizing that their burnout experience was not necessarily the result of a personal deficit, either by recognizing others in similar jobs as feeling similar or recognizing the devotion and skill they had in their work, was helpful in their recovery process. Some participants specifically recognized that the issues of their burnout were systemic ones and not reflective of them as an individual worker but the result of poor leadership or a devaluation of employees within a larger structure.

In the hindering category, a majority of participants felt that they struggled with the systemic attitudes, whether it was in their family, workplace, or societally. Participants may have felt that regardless of whether or not the issue of burnout was systemic, the blame for their burnout was treated like a personal deficit. One participant discussed the concern of resume scarring in South Korea, wherein taking time away from work due to mental health concerns would have made it difficult to be employed in the future. Another participant discussed the ways in which their workplace actively shamed employees for complaining about the workload. The wish list item Workplace Appropriately Addressing Burnout suggests that participants wished that the issue of burnout was addressed systemically in their workplace, through addressing methods like leadership style or resources made available.

Additionally, in the hindering category, participants felt their recovery was slowed by feeling alone in their burnout struggle and comparisons they made against their peers. This may relate to overall conceptualizations of what working means in the social systems that the participants were working in. Participants may have felt personally defective in their working life, regardless of the pressures they may have faced. One participant stated that when she found out that others were similarly suffering, she felt better. Social comparison may have contributed to burnout symptoms because of social conceptualizations that others struggled far less in their working life. Finally, personal expectations of work may have negatively influenced recovery if the messaging participants faced was that work should feel difficult and exhausting. Those messages appear more societally based than individually based.

**Meaning making.** If work is considered to be an existential aspect of a person, then burnout would result in the sufferer of burnout lacking meaning in a core aspect of their life (Malach-Pines, Neal, Hammer, & Icekson, 2011; Ulrichková, 2012). Important values may be dropped as the individual becomes more burned out (Nuallaong, 2013). The category, Meaning Making, and its sub-categories, may act as a way to reinvigorate the aspects of participants life that were meaningful but damaged by the burnout. In the findings, meaning came from many places, including new careers or learning new skills, purposely making decisions about what is meaningful in life, or making meaning out of the experience of burnout itself. Creation of meaning where there previously may have been a vacuum may be an integral aspect to recovery.

## **5.6 Categories as They Relate to Recovery from Mental Illness**

**Empowerment and responsibility.** The findings in this study do mirror some themes found in the research related to personal recovery from mental illness. The helping category

of “Empowerment” mirrored aspects of Onken and colleagues (2002) grounded theory study on recovery from mental illness. Themes of choice, independence, self-advocacy, and having the necessary resources to make changes are mentioned by participants in these findings as well. Participants made decisions regarding their employment and often, this coincided with leaving their position. Participants may have partially left their employers during their burnout period due to the understanding that recovery may have not been feasible. As with the findings in this study, not having met basic needs like food and housing hindered recovery (Onken et al., 2002).

Empowerment, in the form of individuals making their own decisions in regard to their healing, were themes in other research related to recovery as well (Drake & Whitley, 2014; Mead & Copeland, 2000). This is similar to participants in this study finding importance in making decisions about their own future in relation to their experience of burnout. In this thesis’s findings, Doubt was considered a noticeably hindering sub-category, which may have been directly related to the amount of risk-taking participants felt was possible. Doubt also connected to hope in the findings, wherein participants had moments where they felt less hopeful that their decisions would actually lead to empowerment.

**Hope.** In mental illness recovery, hope is usually defined more as a renegotiation of identity in light of experiencing a chronic condition (Amering & Schmolke, 2009). In this thesis, participants specified that hope was related directly to the improvement of their burnout symptoms and the ways in which their decisions made in the empowerment category would lead to new and better things. Hope appeared more goal-driven in some of the literature (Bonney & Stickley, 2008) and in this thesis. Participants appeared to create new goals related to their working and personal lives that may have increased hope.



In the hindering categories, Doubt and Difficulty Adapting to a New Environment may have affected the way that hope interacted in the helping category. Struggling to learn a new skill while combating the symptoms of burnout may have an effect of weakening the hope that participants may have felt. It may have also increased the level of doubt.

**Meaning and purpose.** Recovery literature suggests that it is necessary to re-conceptualize and evaluate how meaning and purpose is created in daily life (Slade, 2009). In this thesis, participants found it helpful to understand their burnout experience and derive meaning from it as well as evaluate how work and life could become more meaningful.

**Redefinition of self and identity.** Jacobson and Curtis (2000) discuss how societal stigma and social consequences of having a mental illness affect recovery. Participants in this thesis felt that they were particularly hindered by the systemic expectations regarding work, either from their workplace, their family and friends, or societal messaging. The stigma that participants faced regarding burnout may have prevented them from asking for the support they needed from others but especially the workplace. Stigma also forced participants to downplay the amount of suffering that they felt during their burnout, particularly when support systems gave negative societal messages about the meaning of work. Workplace messaging surrounding burnout and support from co-workers and the workplace may also have been wish list items due to the amount of stigma and derision a person with burnout can face in the workplace.

### **5.7 Implications for Counselling Psychology**

**Support is necessary.** All the literature related to recovery, whether it specifically encompasses occupational burnout or mental illness, specifically refers to the importance of individuals receiving support. In this study, all participants felt that support was helpful to

recovery, whether it was informal or formal. As counsellors, we should address the client's support system to help them understand what forms of support feel most useful and where it might be best to obtain that support. It may also be important for clients and counsellors to explore how to ask for support. Some participants felt alone in their struggle but felt helped when they reached out. As burnout often happens to individuals who are generally quite capable, asking for support may be difficult for them to do. Awareness of barriers to support, whether they are systemic or individually based should be addressed when working with clients who have occupational burnout.

**Burnout is based in a system.** Burnout is considered an interaction between the system of the workplace and individual characteristics (Muheim, 2014). In this study, all but one participant left their employment during their recovery. This may have meant that the system of the participants workplace may have not been capable of addressing the needs of the participant. Many of the participants required at least temporary removal from the system in order to rest.

There is the issue of participants finding it helpful or hindering that there were systemic attitudes towards work that were harmful towards their well-being. In some aspects, participants felt helped because it aided them in recognizing that they were not deficient employees. Yet systemic aspects hindered and created doubt that they would find any relief that a new position within a new work structure would be an improvement. Individuals with burnout may require more care in teasing apart the individual contributions to their burnout as opposed to the structural contributions, particularly if the client is only able to see their individual deficiencies. It may also be necessary to explore cultural meanings of work for the client and the ways in which their family conceptualizes work.

**Explore meaning.** Participants endorsed that meaning making was a helpful aspect of recovery. It may be helpful for clients to explore what aspects of the experience of burning out were meaningful. How does burnout affect their view of themselves, their ability to be a productive worker, but also their identity and life outside of work? The client may also need to reassess what their values are and ways in which they can continue to live by their values. For instance, one participant realized that his family were extremely valuable to him and yet he had distanced himself from them to fulfill work obligations. An appropriate therapeutic action would be to help him as a client reconnect to his family members. Another way to address meaning is to explore how to infuse values into the client's work in order to reduce future cynicism.

**Recognize that recovery takes time.** Participants with severe burnout endorsed that time away from work was beneficial to their recovery. Aside from that, recovery took time. Clinicians may need to consider that clients with burnout will recover somewhat from at least taking a break from work but the additional therapeutic work, such as meaning making and addressing how the systemic facets of burnout have affected the client, take more time to unravel.

**Explore the transitions.** Clients may be between positions or considering changing careers if they feel that their current employer cannot be a resource for recovery. These transitory periods might induce some anxiety-provoking ambiguity, increasing the amount of doubt and negative emotions a client experiences. It may be helpful for clinicians to address client goal-setting to help the client feel that they are moving forward. Clients may also need help addressing their anxiety.

**Address what self-care means.** Participants discussed various activities that aided in their recovery, including taking time for their hobbies, exercise, and improving diet. Clinicians may need to help the client explore what feels rejuvenating, which could include discussing what a healthy balance between work and life activities are. Clinicians may also need to help clients cultivate self-compassion for their burnout experiences, particularly if the client places value on being a “capable” person who is achievement oriented.

### **5.8 Limitations and Future Directions**

This thesis does have several limitations. The small sample size limits generalizability to the larger public. Participants also skewed younger and there may be differences in categories amongst individuals who are well-established in their careers. The population was also well-educated with a majority of participants obtaining at least some post-secondary education. Secondly, the results are not longitudinal. Interviews occurred at one point only and may not fully capture the experience of recovery. Thirdly, by using self-report participants may or may not completely remember their experience of burnout. Further, on the MBI-GS, there are not scales related to ascertaining the validity of a participant’s truthfulness so participants may have either exaggerated or downplayed their symptoms of burnout and recovery. The researcher tried to amend this issue somewhat by having each participant recount their burnout experience in the interview. This allowed the researcher to check participant burnout symptoms with theoretical knowledge. Finally, not all the participants completed the full participant cross-check, despite numerous attempts by the researcher to contact all participants to receive feedback. This was somewhat ameliorated by the summaries that the researcher made at the end of each interview.

There are many ways in which future research could be generated from this project. Replication would be a necessary first step to see if another sample of participants recounted similar results. Further results may also allow for a more comprehensive theory of recovery to be built. In light of the cultural and systemic components related to recovery, it may be wise to further explore in cross-cultural examples how cultural traditions may fit within the recovery process. Theory could be tested further through using measures to quantitatively operationalize facets of recovery like hope, empowerment, meaning making, systemic concerns, and well-being. The field may be helped by using a larger sample size to understand the relationships between all the parts that contribute to recovery. This researcher believes that there is certainly a model underlying recovery which could help pinpoint where resources may be the most potent for a person recovering from burnout. As there is still very little research in this area, and this thesis contributes a small step in addressing that, there is more work to be done in understanding how people recover from occupational burnout.

Additionally, I believe that research stemming from this work could inform clinical and industrial practices. Many employers recognize that occupational burnout is an issue affecting the productivity of their workers and organizations should place more responsibility on ways in which to change or modify workplace culture to ensure that their employees feel supported and continue to work for them. Clinical interventions could work to first help the individual with burnout to manage their emotional exhaustion and then move into a therapeutic format that works to help the client understand their values. Those values could then be used to create goals that align with ways in which work and life could become more meaningful.

## 5.9 Conclusion

Recovery from burnout appears to be just as multifaceted as the process of becoming burned out. Participants in this research were able to pinpoint many helpful factors in their recovery including support, empowerment, meaning making, balance, and hope. Several factors also hindered them. Difficulty withstanding the transition brought up negative emotions, doubt, and frustration. Systemic issues and lack of resources also made recovery difficult. Participants wish list items were highly related to the idea of support and their workplace supporting them through their burnout. This research is a small step in understanding what recovery from occupational burnout is as well as identifying some ways in which factors may affect recovery from a counselling perspective. More research needs to be done on this topic in order to create a more comprehensive theory of recovery from occupational burnout.

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## Appendix A: First Contact/ Study Information Script

Thank you for your interest in our study on recovering from occupational burnout. My name is Sarah Woolgar and I am a co-investigator for this study along with Dr. Norman Amundson from UBC. This study is for my thesis research for my Masters of Arts in Counselling Psychology at UBC. Would this be a good time to tell you a little bit about our study? (*omitted sentence if through email*)

Our study is looking at what helps, hinders, or were things people wished they had when they were in the process of recovering from occupational burnout. We are looking for individuals who experienced a moderate to severe level of burn out within the last three years and now feel recovered. We're planning on having two interviews with each participant if they meet the study criteria. The screening intake that we'll do on the phone is used to make sure that all of our participants have met a certain severity of burnout before they recovered as well as some general questions about their experience. That includes the type of position you were in during burnout and general questions about employment then and now.

As I mentioned the study requires two interviews, the first of which will either take place in person or with videoconferencing (like Skype). If we meet in person, we'll try to pick a place that is convenient for you. In this interview, I'll ask questions about experiences of burnout but mostly focus on the experience of recovery and what made the burnout go away. The second interview is so that I can make sure that the information we've collected is correct and will either be by phone or email. The first interview should take no longer than an hour but can take up to two hours and the second interview will take no more than half an hour. We're providing a \$20 honorarium as well. All of the data we collect will be de-identified in order to keep participant's information confidential. Would it be possible to send you an email or letter mail with more study information in it? It is a consent form and if you are still interested, we can proceed with a screening intake.

- If yes, get email and send consent form.
  - o Arrange time to call back. "When would be a good time to call back? I'll require about 15 minutes of your time to go over our screening questionnaire."
- If no, thank for time.

## Appendix B: Screening script

Hello \_\_\_\_\_. It's Sarah Woolgar calling from the Recovering from Occupational Burnout study. Did you have a chance to read over the consent form?

Do you have any questions?

Our criteria for the study is pretty specific and therefore I will need to ask some brief questions about your burnout experience. Some of these may feel personal in nature but if there are any questions you'd prefer not to answer, you can simply say that you'd like to pass. I also will read out and have you answer a questionnaire as you are remembering about how you felt when you were most burned out.

If the criteria is met, we'll set up an appointment for the interview. The information I collect today will be de-identified using a participant ID# and added into the study data. This data will be kept on UBC property in a locked lab. If the criteria is not met, I will destroy the intake questionnaire with your information on it at the end of this phone call. I will let you know when we finish this intake whether or not the criteria to enter this study has been met. Do you have any questions? Would this be a good time to proceed with an intake interview? It will take about 15 minutes.

Do I have your consent to proceed with the intake interview?

### ***Complete screening questionnaire***

Thank you for completing the interview. At this moment, the criteria is/is not met.

- Either thank person for their time and reiterate that the intake questionnaire will be destroyed OR
- Set up an interview. Remind participant of limits of confidentiality if space chosen is more public.
  - o "Before we choose a place to meet, I would like to mention that since we'll be talking about some things that may be quite personal, it would be best if we could meet in a place that not only is comfortable and convenient for you but is also private. This way, we won't have to worry about others overhearing our conversation. I would suggest a place like your home, a booked room in a library, and I also have a space at UBC where we could meet. What sounds good to you?"

### Appendix C: Personal Recovery from Occupational Burnout Screening Questionnaire

First name, Last Initial:

Contact Information:

Age:

Gender: M / F / Other: \_\_\_\_\_

#### Burnout Experience

Have you think you have experienced occupational burnout from previous work? Y / N

How long ago did you experience your occupational burnout? \_\_\_\_\_

Please briefly describe the position in which you experienced occupational burnout. Include job type, FT/PT, etc.

On average, how many hours did you work per week in the position that made you feel burned out? \_\_\_\_\_

Do you still work in this position? Y / N

If so, how long have you held this position? \_\_\_\_\_

If not, how long did you work within this position? \_\_\_\_\_

Do you currently work? Y / N

If not, is that related to your experiences in the position in which you burned out? Y / N

Did you experience any serious health conditions at the time of burnout? Y / N

If yes, what was the condition? \_\_\_\_\_

Administration of the MBI-GS (retrospective)

Scores: Cynicism: \_\_\_\_\_ Exhaustion: \_\_\_\_\_ Personal Accomplishment: \_\_\_\_\_

#### Recovery Experience

Do you feel recovered from your burnout experience? Y / N

How long have you felt recovered from occupational burnout? \_\_\_\_\_

Suitable for study: Y / N

Date of Interview: \_\_\_\_\_

## Appendix D: General Survey

Wilmar B. Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson, 1996  
*The purpose of this survey is to discover how staff members view their job, and their reactions to their work.*

**Instructions:** On the following page are 16 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number “0” (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 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	Once a month or less	A few times a month	Once a week	A few times a week	Every day

### Example Questions

**How often:**  
(0-6)

**Statements:**

1. \_\_\_\_\_ I feel emotionally drained from my work.
2. \_\_\_\_\_ In my opinion, I am good at my job.
3. \_\_\_\_\_ I doubt the significance of my work.

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Jackson. All rights reserved in media. Published by Mind Garden, Inc.,

[www.mindgarden.com](http://www.mindgarden.com)

## Appendix E: CONSENT FORM

“Resolving Occupational Burnout: Exploring Factors in Personal Recovery Through an Enhanced Critical Incident Technique”

<b>Principal Investigator:</b>	Dr. Norman Amundson, Professor University of British Columbia Department of Educational & Counselling Psychology, and Special Education Phone number omitted for publication
<b>Co-Investigator and Interviewing Researcher:</b>	Sarah Woolgar, MA Student University of British Columbia Department of Educational & Counselling Psychology, and Special Education Phone number omitted for publication

We are doing a research study about what factors are helpful and unhelpful in feeling recovered after a person has experienced occupational burnout. A research study can be a way to learn more about people, places and organizations and can help to improve our way of life. This particular study is being conducted by Sarah Woolgar, a graduate student from the University of British Columbia in Counselling Psychology for the completion of her thesis. If you decide that you would like to be a part of this study and meet the criteria from the screening interview, you will be asked to attend a 1 – 2 hour interview where you will be asked a variety of questions about your occupation, occupational burnout experiences, and what helped or did not help you recover from occupational burnout.

The information gathered may be used to inform mental health professionals and researchers about the experience of recovery from occupational burnout; primarily, the study will focus on the conditions that aided or did not aid recovery. The interview can take place in a number of locations, although preference is made for spaces that are more private and quiet to ensure your confidentiality. As the participant, you can decide where you would like the interview to take place. Some suggestions include a booked room in a public library, your home, or the researcher’s private office space on UBC campus. The researcher will digitally record the interview in order to make sure she has enough information. Identifying information such as your name and date of birth will not be recorded. These audio files will be erased after the study is over.

There will be a second telephone/e-mail contact with you, which will last approximately thirty minutes. At this time, you will be given the opportunity to verify that what we recorded was true and that there is nothing more you want to say. The total participation time we expect from you is approximately 2-2.5 hours within a 3 to 6 month period.

### **What you can expect to receive for your participation:**

Participants in this study will receive a \$20 honorarium. If the interview begins and you decide that you do not wish to continue, you may still keep the honorarium.

### **Privacy/ Confidentiality**

Any information that might identify you in this study will be kept confidential. Only trained Research Assistants who are approved by the Primary Investigator will have access to the data. You will not be identified by the use of names or initials in any reports of the completed study and instead, your information will only be assigned an identification number. All research documents will be kept in a locked filing cabinet in a locked office at the University of British Columbia. Computer data files will be encrypted and password protected for your privacy. The audio recorded will be transcribed by a professional transcriptionist or the research team and have signed agreements of confidentiality. The audio recordings will be destroyed once the researchers have completed the study. The transcripts will only be identified by a participant identification number and any identifying information will be deleted from transcripts.

### **Benefits/Risks to Your Participation**

Data collected from this study will contribute to knowledge about what is involved in recovery from occupational burnout. Findings might show that there are ways that mental health professionals could aid in helping individuals recover faster. There are not many risks known if you choose to participate in this study. All identifying information will be eliminated from any documents produced from the study, ensuring confidentiality of both the participant and workplaces.

The researchers do not think there will be much discomfort associated with this study, although talking about your burnout experience may lead to some temporary negative feelings. If at any point you feel you want to stop, you can. You will still be able to keep your honorarium. Attached to this consent form is a list of community resources such as counsellors and crisis lines in case anything we asked you has made you sad, angry or has brought back difficult memories.

### **Contact for Information About the Study**

If you have any questions or would like more information about this study, you may contact Sarah Woolgar (Interviewing Researcher and Co-Investigator) at *contact information omitted for publication*.

When we finish this study we will write a report about what we've learnt. If you would like to be contacted with the results of the study once the study is complete, please check this box

### **Contact for Concerns About the Rights of Research Subjects**

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at *contact information omitted for publication* or if long distance e-mail *contact information omitted for publication* or call toll free *contact information omitted for publication*.

### **Consent**

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your reputation or employment.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

I, \_\_\_\_\_, consent to be in this research study: "Resolving Occupational Burnout: Exploring Factors in Personal Recovery Through an Enhanced Critical Incident Technique".

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Thank you for your willingness to participate in this study.

**Counselling Resources** (*contact information omitted for publication*)

**Fraser Health Crisis Line**

The Crisis Line provides immediate, free, and confidential emotional support, crisis intervention and community resource information to people of all ages, 24 hours a day – everyday.

**Family Services of Greater Vancouver, Counselling Program**

Counselling fees based on household income. Master's-level therapists. Program has a dedicated intake worker who can also refer to other counselling services or groups. Offices in Vancouver, Richmond, Burnaby, New Westminster and Surrey.

**New Westminster UBC Counselling Centre**

Free counselling for the general public by counselling psychology graduate students, supervised by a psychologist.

**ProChoices Community Therapy Clinic**

By-donation (\$20.00 min) feminist counselling services provided by supervised master's-level and intern narrative therapists.

**Moving Forward Family Services**

Free and pay-by-donation counselling for individuals and families. Offices in Surrey and South Vancouver. Graduate-level counsellors and counselling interns.

**Simon Fraser University - Counselling Clinics Surrey Clinic**

**Burnaby Clinical Psychology Centre**

Counselling for adults, children and youth provided by supervised graduate students in counselling psychology. Services at the Surrey clinic are free and at the Burnaby clinic are offered on a sliding scale.



## Appendix F: Interview Script

Participant ID: \_\_\_\_\_

1. Before we get started, I wanted to disclose to you that part of the reason why I am interested in occupational burnout is that I experienced it in the past. Before I entered grad school, I worked in a career where I experienced burnout. This has made me curious about others experiences. If you would like to know more about my experience, I am happy to share it with you after our interviews.

I am interested in hearing about your experiences and also what helped or hindered your ability to overcome burnout and what you wished you had but didn't receive when you were in that process. Feel free to stop me at any point to ask questions and I might stop you as well to gain clarification. You do not have to answer all of my questions, as you have the right to pass or to also end the interview at any point. Does this sound alright to you? Do you have any questions before we begin?

Before we begin with the interview, I would like you to fill out this measure according to how you are feeling right now. (*Hand MBI-GS to participant*)

2. Tell me briefly about when you felt most burned out.

Possible follow-up questions:

What were you doing or what was your occupation at that time?

What did that experience look like for you? What was it like for you?

When did you notice that there might be a problem?

When you noticed how burned out you were, what were some of the first things you did?

3. Let's switch to your experience of overcoming burnout. Tell me about what that was like for you.

4. What was most helpful to you while you were overcoming burnout? What happened or what did you do that was helpful?

Possible follow-up questions:

How was it helpful?

Can you think of an example?

Is there anything else that you can think of that helped your recovery?

5. What hindered or hurt your ability to overcome burnout? What got in the way?

Possible follow-up questions:

How was it hindering?

Can you think of an example?

Is there anything else that you can think of that hindered your recovery?

6. What do you wish you had or experienced in the process of overcoming burnout that would have been more helpful to you?

Possible follow-up questions:

How do you think this would have helped you?

Is there anything else that you can think of that you wished you'd had during your recovery?

7. Reflect back helpful, hindering, and wish list items said by participants. Does this sound right to you?

Follow-up questions: Is there anything you'd like to add?

8. I have a few demographic and follow-up questions to ask about your experiences.

**Appendix G: Demographic Information**

ID#: \_\_\_\_\_

Age (current): \_\_\_\_\_ Age or age range at burnout: \_\_\_\_\_

Gender: M / F / Trans-male / Trans-female / Agender / Write In: \_\_\_\_\_

Ethnicity (please circle one or more, as necessary):

Caucasian/ European/ White Canadian?
First Nations, Indigenous, Metis, and/or Inuit
Asian (e.g., Chinese, Japanese, Korean, and Taiwanese)?
East Asian (e.g., East Indian, Pakistani, Sri Lankan)?
Black- Canadian or African American?
Black- African?
Middle Eastern?
Latinx/ South American?
South Asian/ Pacific Islander (e.g., Cambodian, Indonesian, Laotian, Vietnamese)?
Caribbean?
Additional, please specify:

Occupation during burnout: \_\_\_\_\_

Did you change occupations following burnout: Y / N

Current occupation: \_\_\_\_\_

Time (in months) spent overcoming burnout: \_\_\_\_\_

Did you access mental health services during the time you were overcoming burnout?

Y /N

If so, what kind of service? \_\_\_\_\_

If so, how long (in months) did you receive mental health services? \_\_\_\_\_

**Appendix H: Confidentiality Agreement for use with Transcription Services**

Research Study Title: "Resolving Occupational Burnout: Exploring Factors in Personal Recovery Through an Enhanced Critical Incident Technique"

1. I, \_\_\_\_\_ transcriptionist, agree to maintain full confidentiality of all research data received from the research team related to this research study.
2. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.
3. I will not make copies of any audio-recordings, video-recordings, or other research data, unless specifically requested to do so by the researcher.
4. I will not provide the research data to any third parties without the client's consent.
5. I will store all study-related data in a safe, secure location as long as they are in my possession. All video and audio recordings will be stored in an encrypted format.
6. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the research team or permanently deleted. When I have received confirmation that the transcription work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the research team or destroyed, pursuant to the instructions of the research team.

Transcriber's name (printed) \_\_\_\_\_

Transcriber's signature \_\_\_\_\_

Date \_\_\_\_\_

## Appendix I: Study Advertisement



THE UNIVERSITY OF BRITISH COLUMBIA

### Did you experience occupational burnout? Do you feel better now?

Did work leave you feeling:

- Emotionally exhausted?
- Cynical, pessimistic, or disenfranchised about your job and/or your colleagues?
- Like you were accomplishing less each day than when you started?

Do you feel like you've **recovered** from burnout and burnout no longer affects your work?

- Have you felt recovered within the past three years?

If so, researchers at the University of British Columbia are looking for participants for a study on **recovery** from **occupational burnout**. What is involved?

- One 1-2 hour interview in person or via videoconferencing
- One 30 minute interview via phone or email

Participants must:

1. Be between the ages of 18-65.
2. Be fluent in English (written and spoken).
3. Experienced burnout symptoms related to their employment.
4. Identify as recovered from their burnout symptoms within the past three years

Participants will receive a \$20 honorarium.

For more information or to sign up, contact:

Sarah Woolgar, Graduate Student, UBC: [sarah.woolgar@ubc.ca](mailto:sarah.woolgar@ubc.ca)  
call Sarah [604-822-2235](tel:604-822-2235)

or

Dr. Norman Amundson, Professor, UBC: [normand@ubc.ca](mailto:normand@ubc.ca)  
call Dr. Amundson [604-822-2235](tel:604-822-2235)

Study Title: Resolving Occupational Burnout: Exploring Factors in Personal Recovery Through an Enhanced Critical Incident Technique  
Version Date: 2018/09/27